

UNIVERSITY OF CAPE COAST

**ASSESSING THE IMPACT OF TRAINING ON THE PERFORMANCE
OF HEALTHCARE PROFESSIONALS: A CASE STUDY AT THE
HOLY FAMILY HOSPITAL, NKAWKAW**

BERNARD ADJEI

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HEALTHCARE PROFESSIONALS: A CASE STUDY AT THE HOLY
FAMILY HOSPITAL, NKAWKAW

BY

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Business, College of Humanities and Legal Studies, University of Cape Coast,
in partial fulfillment of the requirements for the award of Master of Business
Administration in General Management

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DECLARATION

Candidate's Declaration

I hereby declare that this project work is the result of my own original research and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's Signature:

Date.....

Name: Bernard Adjei

Supervisor's Declaration

I hereby declare that the preparation and presentation of the project work were supervised in accordance with the guidelines on supervision of project work laid down by the University of Cape Coast.

Supervisor's Signature:

Date:

Name: Dr. Nana Yaw Oppong

ABSTRACT

Training of health professional has evidently impacted positively on the skills and knowledge of health professional. One key area of improving professional's knowledge and patient's outcome has been through continuing training. The study conducted at Holy Family Hospital, was to assess the impact of training on the performance of healthcare professionals. Specifically it sought to assess the different kinds of training the hospital and other stakeholders organize for the health professionals, to determine whether the training given improve the knowledge and skills of the professionals. A survey design was conducted for a target population of about three hundred and fifty staff (350). About one hundred and fifty (150) of this population was sampled and interviewed through convenience sampling technique. The study found that majority of the staff has attended training within the past one year prior to this research. Moreover, it was no doubt that clinical care was the main focus on the type of training the facility organized for its staff members. The study concludes that training of health staff has improved the knowledge and skills of the staff interviewed and this may be as a result of the mode of delivery during training which focus on patient centeredness. Further conclusion can be drawn that the training has resulted in change of ideas and with this; improvement in clinical care specialty and reduction in maternal mortality are paramount. In making recommendation for future policy direction, the study suggested that staff should cooperate with management and consider in-service training as a package for higher performance. Again budget allocation for in-service training should be effectively apportioned irrespective of financial constraints.

KEY WORDS

Clinical Care, Customer Care, Holy Family Hospital, Training,
Pharmacovigilance, Public Health, Primary Healthcare, Questionnaire,
Reproductive Health, World Health Organisation.

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Finally to all whom in one way or the other made this work a success.

DEDICATION

I dedicate this study to the glory of God, my wife, my children, siblings, my parents, who supported me earnestly towards the fulfillment of my studies and to all those who have contributed in diverse ways.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ATLS	Advanced Trauma Life Support
BNHS	British National Health Service
CDC	Centre of Disease Control
ENC	Essential Newborn Care
FDA	Food and Drugs Authority
GHS	Ghana Health Service
HIV	Human Immune Deficiency Virus
IPT	Intermittent Preventive Treatment
IST	In-Service Training
MCI	Management of Childhood Illness
NHDR	National Healthcare Disparities Report
NRP	Neonatal Resuscitation Program
NTC	Nurses' Training College
MEBCI	Making Every Baby Count Initiative
SRN	State Registered Nurses
SPSS	Statistical Package for the Social Science
OPD	Out Patient Department
PALS	Paediatric Advanced Life Support
USA	United State of America
WHO	World Health Organisation

CHAPTER ONE

INTRODUCTION

This chapter contains the background, problem statement, objectives of the study, research questions, significance of the study, scope of the study, limitation and delimitation and organisation of the study.

This study was done to assess the impact of training on the performance of healthcare professionals at Holy Family Hospital, Nkawkaw. It was very important in conducting this study to improve the quality of healthcare delivered to patients. Although this study was conducted at Nkawkaw, many previous studies similar to this have been conducted. These include; Hoppe (2013) which highlighted on training approach and developmental ideas and others. This study conducted would inform management of the hospital to strategies the best training needs that would address the various gaps in the care delivery and also theoretically help researches in line with this topic.

Background of the Study

There is evidence that training on the job for health professionals can increase their skills and performance. From other study, a number of trials have examined whether specific skills training for health professionals leads them to have greater success in helping their patients in diverse case management. Example of this is the study by (Calvin, 2014) on the topic “Enhancing Patient Experience by Training Local Trainers in Fundamental Communication Skills”. He emphasizes that such training through communication skills enhanced expressions of empathy, increased pain control, improved blood pressure control, weight loss, appropriate use of antibiotics, glycosylated hemoglobin levels and many other outcomes.

Training of health professionals have always aimed at improving professional's knowledge and patient's outcome. In drugs administration poor knowledge and practice of pharmacovigilance has necessitated training of healthcare professionals for better detection, assessment, understanding and prevention of adverse effects or any other possible drug related problem (Barone, 2011). The effectiveness of this system revolves on the active participation of the healthcare practitioners which centre on their own skills. Healthcare professional's knowledge and attitudes to adverse drug reaction (ADR) and ADR reporting play vital role to report any cases of ADR. Positive attitudes may favour ADR reporting by healthcare professionals.

Some health training in smoke cessation interventions provide instruction in the use of local, state-funded tobacco cessation services, the fax-referral service, clinical system supports and billing for the provision of services. The training addressed specific factors associated with provider intervention behaviors, including motivation, knowledge, self-efficacy, importance, effectiveness, barriers and preparedness (Appligate, 2008). In such trainings, objectives were to prepare nurses to describe the PHS Clinical Practice Guideline interventions and how they are implemented, to identify Food and Drugs Authority (FDA) approved medications for treating tobacco use, and describes how these medications are used.

In achieving the training objectives, targeting the right caliber of staff is something that should not be compromised. Many training design are structured on pre and post training assessment. The pre-training assessment instrument is structured questionnaires that focus on the type of case or condition under consideration (Sheffer, 2009). If the training focus on certain population under the health provision, the questionnaire gathered information

about provider gender, ethnicity/race, history, frequency of seeing the effects of certain practice on the health of patients; level of pro-activity in addressing health practice use; and perceived success in helping patients to improve outcome. Perceived knowledge and attitudes about the treatment and management of condition including level of motivation, knowledge about interventions, self-efficacy, effectiveness of interventions, importance of barriers, and preparedness (Lancaster, 2000)

Pre training assessment items are usually assessed on a discrete analogue scale of 0 to 10 with 0 being “none or not at all” and 10 being “the most possible.” The pre-test are administered immediately prior to the training. The post-training assessment are questionnaire assessing the quality of the training and presentation, extent to which objectives were met and provider knowledge, attitudes and behaviors assessed in the pre-test , including levels of motivation, knowledge, self-efficacy, importance, effectiveness, importance of barriers, and preparedness. The post-test are administered immediately after the training.

However, training that are designed on assessment have some limitation being that the findings are based on self-report. This must be taken into consideration when interpreting the data, because healthcare providers tend to over-report the frequency with which they engage in interventions (Conroy, 2005). Accordingly, the pre-training reports and robust post-training improvements must be interpreted cautiously. Another limitation is the lack of evidence to demonstrate that the reported increases resulted in an increase in the frequency of actual intervention behaviors.

Although increases in motivation, knowledge, self-efficacy, effectiveness, preparedness and related constructs are highly correlated with higher frequency of engaging in these intervention behaviors, and this training clearly increased levels of these constructs, the study does not provide direct evidence that the training actually increased the frequency of these clinical interventions. Further investigation is needed to provide evidence in that regard (Crew, 2008). It is evidenced that other health professionals and nurses who attend even brief, 1-hour training in evidence-based treatment for specific cases and diseases use and demonstrate statistically significant positive increases in case-related knowledge and attitudes. Although it is known that nurses are effective at delivering treatments for many cases, there have been questions about what type of training is needed for them to become effective at delivering proper interventions.

However, studies suggest that just a brief training is effective at increasing motivation, knowledge, confidence, perceived importance, perceived effectiveness, perceived importance of barriers and preparedness, all of which are important in the effective delivery of these interventions (Applegate 2008).

Training for health professionals is crucial especially for nurses. Nurses are the largest group of healthcare providers in the world and have an extended reach into the case or disease population (Miller, 2009). They are also effective in providing treatments for inpatients. Some health data suggest that a brief, didactic training in the case specific treatment and protocols can significantly increase the frequency with which nurses perform these effective interventions.

Increasing the frequency with which patients receive these interventions by training nurses to deliver this important treatment routinely would have a major impact on patient's health and wellbeing.

For instance given the tremendous impact of anti-retroviral drugs on health and the immediate and major health benefits for HIV/AIDS patients, providing all health professional with training on the efficacy of the drug could have a major impact on the health of millions of such patients and their families worldwide (WHO, WHO model formulary, 2008). Nurses and care givers are well-positioned to deliver these effective treatments and with a brief training have the potential to have a larger impact on the prevalence of the disease.

Decreasing the prevalence of many diseases is a public health priority in the country although there is considerable debate about the methods by which this is best achieved. Population strategies, including legislation, government economic decisions, and public health reforms toward certain conditions have an important role. However, healthcare professionals are also in a position to contribute to achieving national targets for reducing the prevalence in the population.

There is substantial evidence that the advice and support given to adolescent about sexual activities by healthcare professionals in primary care settings can achieve abstinence rates of between 5% and 10% with minimal intervention programmes and between 15% and 30% with more intense interventions. However the kind of training and support depends on the training the professional have received (CDC, 2004). Although many clinicians will find these rates low, they could translate into a substantial public health benefit if consistently provided, as approximately 80% of adults have contact with a healthcare practitioner, usually in primary care, at least

once each year. It is disappointing, therefore, that the number of adolescence who report receiving advice on sexual abstinence from health professionals is low. This may probably due to lack of proper skills and knowledge for some of the professionals.

Increasing the amount and quality of interventions from primary care health professionals is frequently cited as a way of realising this potential health gain. Providing training in case management is one possible method for doing this, and various courses and methods are available. However, whereas individual studies have shown that training affects doctors' activities, there has been doubt about the extent to which this translates into changes in patients' behaviour.

Some researchers have addressed this issue by systematically identifying and quantitatively reviewing the evidence from randomised controlled trials that have studied the effects of training healthcare professionals to provide advice on some specific diseases and supporting them in doing so. According to Centre of Disease Control (2004) it hypothesized that training healthcare professionals is more effective than no training in increasing the awareness about personal treatment for diabetic patients who are offered advice. And it was paramount that those who have training in that direction are able to give good medical and clinical advice than those without training.

Programmes designed to train health professionals to provide skill delivery are clearly effective in increasing a number of maternal and neonatal outcomes, including the number of women who delivered at hospitals and health facilities. It is sometimes important to note that training alone is

unlikely to represent a useful investment of resources, unless it is linked to organisational changes that facilitate the intervention. This is consistent with recent review of 50 randomized controlled trials covering a wide range of subjects and types of intervention.

The review found that educational strategies that helped practice and were reinforced by follow up and reminders were major determinants of successful continuing medical education. This conclusion is particularly relevant in considering the generalisability of these results to primary care within the British National Health Service (Eddy, 2008).

Nurses, pharmacists, and physiotherapists and other clinical staffs are all well placed to facilitate better medical care. In addition, given the importance attached to organisational and fiscal factors in supporting training interventions, training programmes which take specific account of the circumstances of the setting of care, such as British general practice, require evaluation. Training can be expensive, and simply providing programmes for healthcare professionals, without addressing the constraints imposed by the conditions in which they practise, is unlikely to be a wise use of healthcare resources.

Where training can be provided at a lower cost, it may be worthwhile to do so, given that some improvements in care process can be expected. However, in general such training may be associated with high cost and therefore for most settings it is difficult to justify the conduct of routine in-service neonatal and paediatric training courses primarily based on models developed in high-income countries. Success of in-service training of health-care professionals depends on a number of factors, but two are especially important: (i) appropriately skilled and required numbers

of instructors; and (ii) suitable, locally adapted training materials. In low-income settings, resources are often inadequate to ensure both these factors.

In addition, it is important to ensure the sustainability of in-service courses. Continuing medical education and regular training have been shown to increase short-term knowledge and attitudes of health-care workers. The introduction of appropriate routines and protocols could also result in better management of patients and more efficient use of resources. In poor countries, many babies and children with serious illnesses die even though they have been cared for in hospitals. One reason for this may be that health workers in these countries often are not properly trained to offer the care that these children need.

In developing countries most deaths among seriously ill children who come into contact with referral level health services occur within 48 hours of being seen (Berkley, 2005). It is possible that good quality immediate and effective care provided by health professionals could reduce these deaths (Nolan, 2011). Provision of appropriate care is, however, dependent on the presence of adequately skilled health personnel at the point of delivery (WHO, Make every mother and child count, 2005). To improve health workers capacity to provide effective care for seriously ill children and adult with emergency conditions in low-income countries, a number of in-service training courses, mainly based on developed countries' models, are proposed.

These courses include: neonatal life support courses (e.g. Newborn Life Support (NLS), Neonatal Resuscitation Program (NRP)), paediatric life support courses (e.g. Paediatric Advanced Life Support (PALS), Paediatric Life Support (PLS)), life support / emergency care elements within the Integrated Management of Pregnancy and Childbirth (e.g. Essential Newborn

Care (ENC)) and components of other in-service child health training courses that deal with care of serious illness (e.g. Emergency Triage, Assessment and Treatment (ETAT), Control of Diarrhea Diseases (CDD) and Acute Respiratory Infections (ARI) case management programs and the training components of the Integrated Management of Childhood Illness (IMCI) strategy). Although such formalised educational programs vary in origin, scope and target audience, they are typically aimed at in-service rather than pre-service training, and are short and intensive with a structured approach to the presentation of their clinical subject. The World Health Organisation (WHO) has recently added to this list the 3½ day course based upon and validated against the Advanced Paediatric Life Support (APLS) course in Malawi (Gove, 2009)

This course is aimed specifically at lower income settings and is intended to improve prompt identification and institution of life saving emergency treatment for very ill children. These life support courses emphasize early recognition of neonatal/paediatric emergencies and prevention of cardio-respiratory arrest (and mortality) through resuscitation. The more general CDD and ARI programs were developed by the WHO in 1980, in recognition of the high childhood mortality due to diarrhea/dehydration and pneumonia for the very ill neonate or child and focus on case management training rather than life-support (Forsberg, 2007).

While these courses concentrate predominantly on community or outpatient based management, where there is good evidence for their success (Sazawal, 2011), they also include guidance on management of very severe illness. These disease-specific training approaches were incorporated into the broader package of the IMCI strategy. Here the particular focus for management of the

very ill child is the decision to refer to hospital and provide pre-referral management. In addition to this, the WHO has developed a specific five-day course on hospital management of severe malnutrition (WHO, Training course on the management of severe malnutrition, 2012). In-service training, however, costs both time and money: for example, the cost of the 2-day European Paediatric Life Support (EPLS) course is estimated to be about USD 190 per trainee in Kenya (Personal communication with ME, 2009). These costs include allowances for the trainers (e.g. travel refunds), course materials (e.g. course manuals, consumable teaching aides, etc) and hotel costs for the participants. Apart from the sometimes high costs of providing courses (recovered in high income countries often with high course fees), attendance at such courses often means that important staff (instructors and participants) are absent from their normal duties with potential disruption to patient care and for some a loss of personal income (Jabbour, 2006)

At Holy Family Hospital, Nkawkaw, it cost the facility not less than GH¢ 500.00 in organizing a day's training for it staff. Despite their cost, however, emergency care courses are a thriving enterprise in many high income countries, as reflected in their ever increasing number and variety (Jewkes, 2003). In the hope that they might improve the quality of care in many low- and middle-income countries, considerable global efforts and investments have gone into their further development, refinement and adaptation to meet individual country needs (Baskett, 2005).

Yet despite these investments and the faith placed in them by many organisations and institutions, clear evidence of the effectiveness of these courses in improving health workers ability to manage seriously ill children or neonates appears lacking. Two Cochrane reviews from the Injuries Group

have examined the effectiveness of Advanced Trauma Life Support course (ATLS), for ambulatory crews (Sethi, 2001) and hospitals (Shakiba, 2003), respectively, in reducing mortality and morbidity for victims of trauma of any age. The pre-hospital review (Sethi 2001) identified one small randomised controlled trial (n = 16) while the hospital review (Shakiba 2003) did not find any relevant randomised controlled trials. The Cochrane review authors concluded that there is no clear evidence that ATLS training impacts on the outcome of victims of trauma.

The effectiveness of in-service training of health professionals depends on changes in health worker practices which, possibly, should precede any impact on mortality or morbidity. This review investigated if there are systematic differences in health workers' professional practices (i.e. more appropriate management or referral of seriously ill children/newborns or both), patient outcomes (mortality and morbidity), or health resource use (e.g. drug use, laboratory tests) and services utilization (e.g. length of hospitalization, return visits) after in-service training in emergency care or care for the seriously ill newborn or child. Information regarding the effectiveness of such in-service training courses is required to enable low-income countries to priorities the health interventions they invest in.

Statement of the Problem

Health care delivery is very essential to mankind as it has a lot of influence on one wellbeing. Hospital clients (Patient's) who access service care delivery expects best practices, good conduct and high level of professionalism from health care professionals. Moreover a lot of clients envision better health outcomes thus good health indicators that would ensure

them of better medical treatment. Notwithstanding these expectations from patients, the hospital is posse with challenges that makes it difficult to meet client expectation.

Paramount of these problems include poor customer service, high still birth rate, lateness of staff towards duty, weak supervision control at departmental level, high level of occupational health related issues. These problem encounters in the hospital poses a serious threat in terms of quality health care delivery. Globally and moreover at the national level, health sector are confronted with problems with regard to providing quality care. Holy Family hospital, Nkawkaw is not isolated from these problems which in some instances have affected the performance of the hospital.

In addressing these problems there has been some intervention through training of professions in line with some of the problems listed above. The hospital within a period of one year have organized training in the areas of clinical care, maternal and reproductive health, customer care, occupational health for its staff to improve on service delivery. Moreover in investigating how the training organise for the employees has addressed the facility problems and improve on performance indicator that this study was conducted.

Objective of the Study

The objectives of the study were classified under both general and specific objectives.

General Objective

The study was done to assess the impact of training on the performance of healthcare professionals at Holy Family Hospital, Nkawkaw.

Specific Objectives

The objectives of the study are:

1. To assess the different kinds of training the hospital and other stakeholders organize for the health professionals.
2. To determine whether the training given improve the knowledge and skills of the professionals.
3. To assess the quality of care and health delivery of the professionals after receiving the training.
4. To assess the general outcome the hospital derives from training her professionals.

Research Questions

The research questions of the study are:

1. What kinds of training are organized for the healthcare professionals?
2. Do the kinds of training organized for health professionals improve their knowledge and skills on the job?
3. How do the training impact the quality of care delivered by health professionals of the hospital?
4. How does the hospital benefit from training of it professionals?

Significance of the Study

Each year, worldwide, there are nearly 11 million deaths among children below the age of five years, almost all of them in low- and middle-income countries. Almost all of these deaths are avoidable using existing interventions, but in under-resourced settings there is a lack of adequately trained health-care personnel to implement the available interventions. In

order to improve the quality of clinical care provided by health-care professionals, several in-service training courses (based primarily on training models developed in high-income countries) have also been proposed.

In-service training refers to training of selected health-care professionals to help them develop specific clinical skills (The World Health Report 2005). Our hope for good future in terms of economic stability, good development and better standards of living all depend on better health for our people through quality training of professionals. It is my fervent hope that findings of this study would serve as a further directive to policy makers and other stake holders in improving health outcomes including, maternal situations, public health concerns, stillbirths and other abnormal birth outcomes.

This study is to assess the impact of training on health professionals. The study will help identify various training models. It will also help create the awareness and educate health workers in the Hospitals as well as the communities in the Municipality and ascertain the need for continue training of professionals for positive health outcomes. Last but not the least, the study will enable the researcher make the necessary recommendations to the Health Services to help improve care and meet necessary targets.

Scope of the Study

As a result of constrains, the researcher has restricted himself to the Holy Family Hospital, Nkawkaw in the Eastern Region of Ghana. Nkawkaw is the capital of the Kwahu West Municipality. Nkawkaw is a rapidly expanding town of about 98,000 residents. Located on the main Accra – Kumasi trunk road, Nkawkaw is 155km North of Accra and 102km South of Kumasi. It also

serves as the gateway to the Afram Plains, located on the Akuapem – Togo ranges.

The Hospital started as an Out-Patient Clinic in 1949 by the Missionary Sisters, Servants of the Holy Spirit (SSpS). In 1957, a Maternity Ward was added and in 1958 the first doctor was employed. In 1960 it was registered as a Mission Hospital after the addition of more Wards and an Operating Theatre. In 1965, the current Out-Patient Department was built. The Emergency Ward was opened in 1983 for overnight detention and observation of patients and for casualty treatment.

Holy Family Hospital acts as a District Hospital (Level C) for a diameter of at least 60km spanning Anyinam to Juaso-South to the North with Ntronang to Tease West to the East, an area of approximately 43.2 sq. kilometres. It refers patients mainly to the teaching hospitals – Komfo Anokye in Kumasi and Korle-Bu in Accra, as well as to St. Joseph's Orthopaedic Hospital in Koforidua. In 1974 the Nurses Training College started to train Enrolled Nurses (EN's). This programme was discontinued by the government in 1984 to give way to the State Registered Nurses (SRN) Training Programme. The first year's intake of SRNs graduated from the Nurses' Training College (NTC) in 1987.

Delimitations of the Study

The findings would be delimited to the study area due to resource constraints and time. Also, only hospital staffs who have received any form of additional training on the job was recruited for the study. Other coordinators who are in charge of in-service shall participate in the study.

Limitation of the study

The study was limited to the responses provided by the respondents. The findings of the study were based on the nature of training as it is now since it is a descriptive cross-sectional study. Resources and time constraints also affected the sample size which will directly affect the generalisability of the study.

Organisation of the Study

The study has been organized into five chapters.

Chapter one which is the introductory part consist of the background of the study, problem statement, objectives of the study, research questions, significance of the study, scope of the study and organisation of the study.

Chapter two is a review of related literature about the topic from books, internet, journals and magazines.

Chapter three describes the methodology, which includes the research design, population, sample and sampling, research instrument, data collection procedure and data analysis plan.

Chapter four focuses on data analysis and the interpretation of data.

Chapter five which is the last contains the summary of findings, conclusions and recommendations of the study.

CHAPTER TWO

LITERATURE REVIEW

INTRODUCTION

In this chapter, the researcher reviewed existing literature on the topic and other related fields that formed the basis on which the present study is founded. Five sub-headings were dealt with in this chapter. These are: the kinds of training being organized for health professionals; the impact of the training on the knowledge and skills of the professionals; the impact of the training on quality of care delivered by health professionals; the benefit of the hospitals derive from training its professionals and chapter conclusion. The first four headings relate to the four objectives of the research.

Training organized for health professionals

In finding possible solutions to both existing and currently challenges, thus problems with poor customer service, high still birth rate, lateness of staff towards duty, weak supervision control at departmental level, and high level of occupational health related issues, it is to note that various training is being organized for the health staff. With the broader aim of empowering the professionals both their knowledge and skills, the training also helps to give the best to patients as well as improve health indicators at the facility, at district, regional and national levels (GHS, 2014).

In reviewing the various kinds of training organized for health professional, Ghana Health Service an agency under Ministry of Health have categorized the training into three (3) main specialties (GHS, 2014). These include Public Health, Clinical Care, and Management. These areas cover both

clinical and non-clinical activities at all levels of health care which are directed to improve staff efficiency and better patient care.

In providing this training, at the facility to the national level health partnership with other institutions contributes a lot to the success of these programmes. It is no doubt that improving health care quality is not the sole responsibility of government or of the private sector. Public-private partnerships to develop and use measures that guide progress toward high-quality, affordable care are essential. Because quality is ultimately very personal, these partnerships have included and must continue to include all perspectives, especially in all health expect that trains and improve quality of care (Haskard, 2008).

Training approach should focus on developmental ideals and supportive organisational environments, and should be aligned with today's business realities, including compressed career progression pathways, budgetary cuts and constraints, highly competitive environments, and market-driven economic philosophies (Hoppe, 2013). Designing, delivering, evaluating, and clearly documenting the benefits of training using the some of the current information as listed above will allow the human resource management function to be a strategic, organisational player and to move away from the negative connotations associated with this function in the twentieth century.

Public Health training for professionals covers a lot of areas in the field of health. Child health training aims to reduce children disease morbidities and mortalities. This include proper care for neonates and infant thus children under five years old. Child health training equips professionals for better child welfare clinic services, immunization and school health services as well.

Moreover, reproductive health training tries to improve family planning, ante and post natal services and skill deliveries. With these, post training evaluation measure indicators such as ante and postnatal coverage, number of skill deliveries in a period, mothers sleeping in intermittent treatment nets, Haemoglobin level and HIV status of pregnant women, intermittent preventive treatment (IPT) coverage, maternal mortalities, outcome of babies delivered (sex, birth weight, live or stillbirth , birth abnormalities), baby friendly hospital initiatives, etc (GHS, 2013).

Moreover, other public health training includes disease control and surveillance as well as nutrition. On disease control and surveillance training, it focuses on the prevalence of diseases and how best it can be well manage. It also keeps track on facilities morbidities and mortalities and most especially how best certain conditions can be eliminated. It was through this effort that conditions such as Guinea worm and other childhood killer diseases have been eradicated. On nutritional training the focus have been Growth Monitoring and Promotion with the attention on how to help underweight children. Other indicators that measure nutritional status include breast feeding, Vitamin A supplementation program, anaemia control and nutrition commodities (GHS, In-service training guide, 2013).

More importantly, public health training for professional also focuses on occupational health. This training helps to identify various risk factors in the job and how best they can be avoid, how to make employees live healthier, and best possible ways to reduce medical bills on behalf of their staff. In improving this situation, the training measure indicators such as severity of injury as reported by the staff as well as screening program for employees.

Moreover in reducing staff absenteeism rate, occupational health trainings and policies accesses how sickness results in work day off for staff (GHS, In-service training guide, 2013).

Another main stream of training for health professionals is under clinical care. Nursing case practice and case management are under clinical care. This training equips professionals on how to follow accepted protocols and standard of operation in managing certain conditions. Better case management is a very important aspect to clinicians especially. For instance malaria case training has help to improve the testing rate of malaria before treatment. Again HIV management has helped to reduce the level of stigmatization that many professionals gave to HIV/AIDS patients.

Moreover, drug administration under pharmacy and diagnostic services all work importantly under clinical care. Health professionals training in these areas seeks to improve many indicators which benefit patients. For instance, rational use of medicine indicators focus on areas such as number of medicines prescribed for patients, number of medicines prescribed by generic name, and also from essential drug list , number of patients encounter that had antibiotics and injections. This training is also aimed at reducing medication errors, adverse drug reaction and improves drug dispensing. On diagnostic services, the training empower professionals to adopt modern method of clinical investigations. This covers areas such as laboratory, x-ray and scan services. Laboratory training improves the three (3) units, including Haematology, Microbiology and Biochemistry (GHS, 2013)

On management training in health care, aspects such as client-employee relations service, computer application, quality assurance, financial management, procurement and health information management are all

important. The customer care training places client at the centre of care whereby staff gives their best to the patient. With customer care, the client is always right and care is focus on them. The computer application focus on e-Health were by employees are trained on modern technological method whereas quality assurance training geared towards staff performing to meet various health standards and practices (GHS, In-service training guide, 2013).

Moreover, financial management training of employee's has direct better financial administration of hospitals. It ensures proper accountability and transparency as well as prudent way of mobilizing funds and spending them. This training usually target staff in finance department of all level together with various facilities managers. Procurement training tries to highlight to employees especially management of facilities, pharmacy and medical stores various laws and regulations governing procurement standards whereas Health information training aimed at producing quality and timely data for decision making.

At Holy Family Hospital, Nkawkaw, majority of training are plan and executed in line with what have been discuss above. In the year 2015 about eighteen (18) different training were under listed to empower the staff and give the best to the clients. The table highlights Holy Family training plan for 2015 indicating the various topics, target group, duration of training and source of funding (Holy-Family, 2015) .

Table 1: In-service Training Plan for 2015

	Title	Target Group	No. of Participants	Duration	Source of Funding
	Clinical Care				
1	Customer Service	All hospital staff	300	3 days	HFH IGF
2	Occupational Health & Safety for hospital staff	Hospital staff	200	4 days	HFH IGF
3	International Statistical Classification of diseases in Psychiatry (ICD10)	All Nurses	150	2 days	HFH IGF
4	Quality Assurance	All hospital staff	200	2 days	HFH IGF
5	Administration of Oxygen	Nurses	120	2 days	HFH IGF
6	Management of IV fluids in CCF	Nurses	120	2 days	HFH IGF
7	Post OP care of prostatectomy	Nurses	100	2 days	HFH IGF
8	Management of neurological cases	Nurses	100	2 days	HFH IGF
9	Management of CVA with seizures	All Nurses	120	4 days	HFH IGF
10	Management of senile dementia	All Nurses	120	4 days	HFH IGF
11	Management of Stress	All Hospital Staff	250	3 days	HFH IGF
12	Resuscitation of CCF	All hospital staff	200	3 days	HFH IGF
	Safe Motherhood and Child Health				
13	Neonatal resuscitation	Midwives	100	2 days	HFH IGF
14	Breeding Delivery	Midwives	28	2 days	HFH IGF
	Management				
15	Records Management	All Hospital staff	120	2 days	HFH IGF
16	Computer Excel and PowerPoint	Interested Staff	40	5 days	HFH IGF
17	Introduction to business letters	Nurses	40	2 days	HFH IGF
18	Folder/E-archive Management	Records Staff	17	4 days	HFH IGF

Source : Hospital Annual Report for 2015

Impact of training on knowledge and skills of health professionals

Medical facilities have a vested interest in improving employees knowledge and skills through training. Engaging health care providers of all types in efforts to enhance patient experience is of high interest. Worldwide report in patient experience surveys and complaints show that patient's desire enhanced communication from their providers (Bonvicini, 2009) . Systems are particularly looking to involve care givers in these initiatives, and there is widespread agreement that health workers training are necessary for optimal patient-centered care.

In improving patient and physician interaction until recently, medical schools and residency programmes largely did not include fundamental communication training, and most practicing physicians do not undergo such training. Prior literature supports the efficacy of training in communication skills for all healthcare providers. Enhanced communication skills enhanced expressions of empathy, increased pain control, improved blood pressure control, weight loss, appropriate use of antibiotics, glycosylated hemoglobin levels, among many other outcomes (Cooper, 2011). Training program in health commonly evaluate baseline knowledge, attitudes and skills and conduct input, process and outcome evaluations.

It most happens that, the training being organized impact positively on the knowledge and skills of health workers. The desire long term impact of training is to improve organisational and programme performance and, ultimately, to contribute to the achievement of national demographic and health goals. It is sometimes difficult to demonstrate and link training and these long terms results because of many factors other than training that are

involved. However it is possible to demonstrate the impact of training on staff skills and performance (Abbatt, 2007).

It has always been important to link performance and training. There is no doubt that improved knowledge and skills impact positively on employees performance. Improved knowledge of health workers affects their critical job tasks. For instance, improving midwives knowledge about skills delivery has a high tendency of reducing maternal mortalities.

Improved staff knowledge helps to bring the best out from the staff. In linking performance and training, experts in interpreting data assess training factors that influence performance as well as non-training factors (organisation, environmental etc). In the aspect of training factors, baseline evaluation in the form of pre-test and other strategies help to determine the trainee's levels of knowledge, attitude and skills before training whereas outcome evaluation assesses new or improved knowledge and skills after training (Abbatt, 2007).

Knowledge and skills development after training impact a lot on individual performance (on-the-job application of new knowledge, attitude and skills; work that meet or surpasses professional or organisational requirement), organisational performance (quality of services, client satisfaction), program performance (use of modern clinical method) and regional or national demographic and health indicators (decrease in birth, fertility, infant mortality and maternal mortality rate) (Feuerstein, 2013). At the national level, improved knowledge and skills of health professionals combine with other factors have helped the country to achieve elimination of Guinea worm cases, polio, and neonatal tetanus etc.

Moreover at Holy Family Hospital, Nkawkaw where the study was carried out, in improving staff knowledge and skill through training witness some in-service training events.

In 2015, the hospital ensured effective customer care through training in customer service for all her staff. Moreover records staff improved their knowledge on electronic filing system through E-archive management system. In reducing occupational hazard, injury and better health for hospital staff, occupational health and safety workshop was organized for staff. Additional about three (3) different in-service training were done for midwives and paediatric nurses in improving neonatal and child health as well as reducing their mortalities. These include; 'Making Every Baby Count Initiatives', 'Helping Babies to breath', 'Essential Care for every baby'. Moreover in improving the case detention rate, TB orientation workshop was organized for all clinical staff. Through this training, the knowledge of staff have help to screen more patients for TB. It isn't surprise that by the end of 2015, case detection rate has increase by 8% compared to 2014 (Holy Family Hospital, 2015).

The impact of training on quality of care delivered by health professionals

Health care quality according to Institute of Health Care Improvement (2008) is getting the right care to the right patient at the right time and at every time. The article further elaborated on three basic dimensions including: structure, process, and outcome. Structure represents the basic characteristics of physicians, hospitals, other professionals, and other facilities. It describes whether there are well educated health professionals, appropriate hospitals, nursing homes, and clinics, as well as well-maintained medical records and good mechanisms for communication between clinicians (Guilbert, 2008).

The human resource element plays important role in the structure of healthcare and most especially the impact of training given to them to strengthen health care. Element of good training sometimes form the basis of quality care given to patients. In the United State for instance, the National Healthcare Quality Report tracks the health care system through quality measures, such as what proportion of heart attack patients received recommended care when they reached the hospital, or what percentage of children received recommended vaccinations. In delivering this care to patients, quality health would be ensured if proper training had been given to care givers (Mager, 2012).

Quality indicators in some areas have improved, such as the percentage of patients who are counseled to quit smoking. For example, the percentage of patients receiving recommended care after a heart attack has increased more than 15 percent between 2002 and 2006 in United States. However, measures of patient safety, such as appropriate timing of antibiotics received by adult patients having surgery and inappropriate medication use by the elderly, showed an average annual improvement of 1 percent. In addition, the report reflects larger improvements associated with public reporting by providers of performance (Mager, 2012).

In the study done by (Werner, 2009) the emphases that through training of professional there has been some progress in reducing care disparities in California (USA). For example, the disparity between the rates of black and white hemodialysis patients who receive adequate dialysis has been eliminated, and disparities in childhood vaccinations rates for different racial groups have been reduced. However, the most recent National Healthcare Disparities Report (NHDR), AHRQ's companion report to the

NHQR, shows that most disparities in health care quality and access are either staying the same or actually getting worse. The NHDR showed that more than 60 percent of disparities in measures of quality have stayed the same or worsened for Blacks, Asians, and poor populations. Also, nearly 60 percent of disparities have stayed the same or worsened for Hispanics.

Many studies have shifted their attention from documenting that health care organisations and clinicians have the right equipment and training to deliver excellent care (structure), to assessing whether that competence is reflected in day-to-day care (process and outcomes), it has become clear that performance is often less than ideal (Binzen, 2012).

Enormous strides in developing and implementing scientifically based measures of quality have been made that reflect current science as well as patients' experiences. The National Quality Forum, a private US voluntary consensus organisation, now endorses quality measures through a transparent process involving clinicians, hospitals, health plans, employers, and patients. Training professionals in quality improvement models for instance helps health organisations to developed strategies that link engagement in quality improvement initiatives with continuing education and specialty certification, rather than assuming that formal education in health care automatically results in excellent care (Khurana, 2005).

As a result of focusing on actual performance after training health professional, it can be seen clearly where improvements are needed. For instance where biomedical innovations mean that health care is often far better than it was 10 years ago, we also need innovations in care delivery to accelerate the pace of improvement especially after training. Translating scientific advances into better care for all requires the capacity for making that

information available to clinicians and patients when care is delivered, and incentives and infrastructure to make this achievable, of which training plays an important role (Khurana, 2005).

The outcome/benefit the hospital derives from training its professionals

Medical outcome reflects the end result of care. Did people get better? What was the risk-adjusted mortality rate? Was disease or disability reduced or prevented? Was it reduced as much as it could have been, given what we know is scientifically possible? All these are some questions that come in mind when discussing about outcome. We need to be able to measure the outcomes of care so that we know which types of care really help patients and so that we can look to instances of poor outcome for opportunities for improvement. In the same line it is better to assess outcome or benefits the hospital derives from training its professionals (Batalden, 2007).

Health institutions today are forced to function in a world full of change and complexity, and it is more important than ever to have the right employees in order to survive the surrounding demands. Some research like (Parsley, 2006) indicate that inadequate and inefficient management of employee in institutions has resulted in low productivity and high turnover rate and one of the leading causes of institutional failures. The resource based approach contends that organisations can develop a sustained competitive advantage only if its activities create value in a unique way, one that competitors cannot easily copy (WHO, Innovative Care for Chronic Conditions. Building Blocks for Action., 2012). In line with medical care, it presents the picture that, one key benefit of hospital training its staff is efficiency on the part of the employees. This leads to better health outcome, reduction in medical errors and efficient use of hospital resources.

Beside the field of health care, present day companies, just like the companies in the past, strive to maximize their profit and increase proficiency by finding the time and resources to train their workforce. The organisation shall: a) determine the necessary competence for personnel performing work effecting product quality. b) Provide training or take other action to satisfy these needs. c) Evaluate the effectiveness of the actions taken. d) Ensure that is personnel are aware of the relevance and importance of their activities and how they contribute to the achievement of the quality objectives. e) Maintain appropriate records of education, training, skills and experience” (Epstein, 2008).

This standard requires that the organisation identify competency needs for all personnel whose activities affect product quality. This task will include a large majority of the organisation. Assessments of the training must be conducted and records must be maintained and easily accessed. These two elements are describing the minimum requirements for establishing an effective training system important competitive factor that needs to be taken into consideration while managing business (Briere, 2007).

In similar experience in the health care industry most of the hospitals including Holy Family Hospital, Nkawkaw arrange training and developments for the employees. Organisations have to balance both production effectiveness as well as efficient workforce to be successful. Even though a care givers by law has managed to find the right employees, this is not enough. A crucial factor is to make employees best and reduce the unnecessary errors and improved quality of care. Talented employees can be a source of advantage for an organisation (Briere, 2007) but how to achieve this may be a major challenge.

What do employees want from their organisation in order to feel committed? The answer is they need security of their future that is only with the training and development. In a research by (Pfeffer, 2008) he finds indications that training and development is a major element for firm, performance. Job satisfaction is affected by the worker and the work itself. This highlights that for better performance hospital administrators and management shouldn't comprise on training and development.

In a complex world of today, health issues have many legal implications. A July 2008 study of AHRQ found that potentially preventable medical errors that occur during or after surgery may cost employers nearly \$1.5 billion a year ("Impact of Medical Errors on 90-Day Costs and Outcomes: An Examination of Surgical Patients," in the July 2008 issue of Health Services Research). Care for surgery patients who experienced acute respiratory failure or post-operative infections increased the cost of their care by 100 percent! This brings to bear that reduction in medico legal issues also bothers on training of health professions as well as to avoid unnecessary errors (Kohn, 2008).

Another most important benefit that hospital derives from training and development of its employees are better health outcome. Some indicators that measure hospital performance includes; Client satisfaction surveys, OPD attendance, re-admission rate, mortality rate, bed utilization, case fatality rate, patients insurance coverages, skilled deliveries, still birth and maternal death rate, Caesarian section rate, Rational use of medicines, antigens coverages, antenatal registrants and attendance, rate of successful surgeries etc (Varkey, 2011).

At Holy Family Hospital, Nkawkaw, in the interventions to improve many health outcomes, training and development had been used to record to achievement. For instance, after customer care training in early 2015, client satisfaction survey saw a much improvement between the relationships staff and clients from about 87% to 96% over one year period also being the highest over five years trend analysis. The hospital recorded about 18/1000 live birth in its still birth rate in 2015 as compared to 23/1000 live birth in 2014.

Moreover, neonatal mortality reduced from 17/1000 admissions to 13/1000 between 2014 and 2015. This could also be attributed several in-service training revolving around ‘project five live’ and ‘making every baby breath initiative’ that focus on infants and neonates. The hospital in improving its medical records system also organized training for the record staff in 2014. By the end of 2015 the number of misfiled folders have reduce from about 17% to about 9%. In improving the testing rate of malaria cases before treating, post malaria workshop in early 2015, saw the 100% testing before treating by the end of 2015 as compared to 83% the previous year (Holy-Family, 2015).

Chapter Conclusion

The chapter reviews various literatures in line with the research objectives and questions as discussed in chapter one. In reviewing different write ups, they were discussed in line with the current situation at Holy Family Hospital, Nkawkaw where the study was carried out. Statistics of the hospital form important aspect in this chapter as indicators were assessed vis-à-vis the training the staff had received.

CHAPTER THREE

RESEARCH METHODS

Introduction

This chapter presents the proposed design for the study. It looks into the type of study, research setting, target population, sample size and sample and sampling method, as well as the data collection and analysis methods employed. It also describes the ethical considerations that are considered relevant to the study. A quantitative explorative design was conducted. The purpose for choosing the design is meant to conduct an in- depth exploration in all aspects to assess the impact of training on performance of healthcare professionals and provide a general view on issues that would be needed to enhance the situation.

Research Setting

The research was conducted at Holy Family Hospital, Nkawkaw. The hospital was selected because of its strategic location on the Kumasi-Accra highway. Moreover the difference health professionals make its good for the facility to be selected for this research.

Research Design

A survey design was conducted. Exploratory research examines the relevant factors in detail to arrive at an appropriate description of the reality of the existing situation (Brink & Wood 2001). Descriptive research provides an

accurate account of characteristics of a particular individual, event or group in real-life situations (Polit & Hungler 2004). A descriptive design was used for the purpose of developing theory, identifying problems with current practice, justifying current practice, making judgments, or determining what others in similar situations are doing (Waltz & Bausell, 2002). The purpose of a descriptive design was to provide the perceptions and views of the respondents about the phenomenon studied (Burns & Grove 2005). The purpose for choosing the design was meant to conduct an in-depth exploration in all aspects to assess the impact of training on performance of healthcare professionals and provide a general view on issues that was addressed to enhance the knowledge of staff and management about the situation. The strength of this design lies in the fact that, it strives to develop new knowledge and also it is a flexible research design that provides an opportunity to examine all aspects of the problem being studied. However the sense of confidentiality and objectivity and error contribute to the weakness of this design. Subjects that respondents are questioned may not always be truthful and instead will give answers that they feel that the researcher wants to hear.

Population

The target population was limited to staff at the hospital. Moreover, staff that plays management role were also sampled and interviewed. The hospital has a total staff strength of about three hundred and fifty (350) made up of both clinical and Para-medicals.

Sample

Questionnaires were issued out to hundred and fifty staff which represented the sample size. These include both clinical and Para-medical

staffs. This figure represents about half of the total staff strength of the hospital.

Having an idea of the staff population, it becomes beneficial for finding out the minimum sample size required (thus less costly) to achieve a prescribed degree of precision (thus the minimum degree of precision acceptable). The conclusion on the sample takes into consideration the resources and time constraint as well as not compromising on the accuracy of the results. Hospital statistics reveals that about two hundred and ten (210) staff reports to work out of the total three hundred and fifty (350). The difference is as a result of those enjoying their off duties or on annual leave. This represented a proportion (P) of about 0.60 with a margin of error (d) of 0.08.

This implies that:

$$d = 0.08 \quad p = 0.60 \quad N = 350 \quad Z^{\alpha/2} = 1.96$$

$$\begin{aligned} n &= Z^2_{\alpha/2} p(1-p) / d^2 \\ &= (1.96)^2 (0.6)(0.4) / (0.08)^2 \\ &= (0.24 \times 3.8416) / 0.0064 \\ &= 0.921984 / 0.0064 \\ &= 144 \end{aligned}$$

Approximately one hundred and fifty was used.

Sampling Technique

Non-probability or convenience sampling was used because questionnaires were distributed to the staff at Holy Family Hospital, Nkawkaw. Not every staff was included in the study because some were on leave.

Instrument

Instruments refer to devices used to collect data such as questionnaires, tests, structured interview schedules and checklists. Polit and Hungler (2004) define a questionnaire as “a method of gathering information from respondents about attitudes, knowledge, beliefs and feelings”. A questionnaire was designed to gather information about training impact on performance of health professionals. It was structured based on the research questions. Validity and reliability was adhered to in the study. Validity refers to the degree, to which an instrument measures what it is supposed to measure. (Polit and Hungler, 1987). Reliability is the degree of consistency with which an instrument measures an attribute it is supposed to be measuring (Polit and Hungler, 1987). To achieve this, the questionnaire was shown to the research supervisor for comments and any corrections, after which pre-testing was done. A sample of 10 staff were selected for the pre-tested exercising to find out if the objectives of the study would be met by the data collected and also if the questions were of standard in order to prevent vague or irrelevant questions before the final administration of the questionnaire to respondent. The strength of the instrument used lied in its ability to gather the relevant information pertaining to the aim of the study. However its weakness was the fact that it couldn't gather all the necessary views from the respondents as it was closed ended questionnaire.

Data Collection Procedures

A period of about two weeks was used to collect the relevant information from the staff. Permission was sought from the hospital administration and departmental/wards supervisors. The purpose of study was

explained to them and those on duty who were less busy were interviewed. Others too filled the questionnaire without any assistance.

However the data collection period was not excluded from few field challenges. Paramount among them where staff refusing to answer certain important questions on the questionnaire thereby results in non-responses. Moreover some staff misplaced theirs leading to reprinting and escalating cost of the study. It was also difficult in tracing some of the staff to retrieve the answered questionnaire due to the shift nature of their work.

Data Analysis

Data analysis involves compiling, selecting and entering data into the computer files, inspecting it for errors and running tabulations and various statistical tests to derive proper findings for the study. The statistical package for the social science (SPSS) version 20 was used to analyze the data which was presented in the form of charts, graphs, and tables. This software is used in analyzing quantitative data. Questionnaires are first coded in it and the analyses toolbar is used to perform the necessary analysis.

It is important to adopt the correct statistical technique for any research problem. In this study, estimate of proportion values was used and they were presented in tabular and pictorial forms.

Validity and Reliability

Reliability refers to the degree of consistency or accuracy with which an instrument measures the attribute it is designed to measure (Polit & Hungler 1997; Uys & Basson 1991). If a study and its results are reliable, it means that the same results would be obtained if the study were to be replicated by other researchers using the same method. A pretest utilizing **staff members**, excluded from the actual research, with similar characteristics to

the study sample was conducted to determine the clarity of the items and consistency of the responses. “Validity refers to the degree to which an instrument measures what it is supposed to be measuring” (Uys & Basson 1991). Validity can be sub-categorised as external and internal validity. Internal validity encompasses whether the results of the study are legitimate because of the way the groups were selected, data was recorded or analysis performed. External validity, often called “generalizability”, involves whether the results given by the study are transferable to other groups (i.e. populations) of interest (Last, 2001). This study was designed to achieve both internal and external validity. The study about impact of training on the performance of healthcare professionals at Holy Family Hospital, Nkawkaw can be implemented at different health facilities and achieve the same results.

Ethical Considerations

This is of great importance considering the rights, protection from harm, privacy and confidentiality of respondent. An introductory letter was collected from the Business school, University of Cape Coast to officially introduce the researchers to the appropriate authorities and participants. During the administering of the questionnaires, the purpose of the study was explained to potential participants and their voluntary participation sought. Thus, confidentiality was assured during and after the study.

Chapter Summary

In conclusion about this chapter, a survey design was conducted at Holy Family Hospital with a sample size of one hundred and fifty staff. Non – probability sampling was used through questionnaires. A period of two weeks

was used to collect the relevant information from the staff and SPSS version 20 was used to analyse the data.

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

Introduction

The study is to assess the impact of training on the performance of health care professionals at Holy Family Hospital, Nkawkaw. One hundred and fifty (150) staff were sampled and fundamental analysis was performed on them. The analysis of the data was done by using Statistical Package for Social Sciences (SPSS, version 20) and it was essentially descriptive (i.e. percentages and frequencies). The chapter is organized as Socio-demographic characteristics; different kinds of training the hospital and other stakeholders organize for the health professionals; impact of training on knowledge and skills development of the health professionals; the impact of training on quality of care delivered by health professionals; and outcome/benefit the hospital derives from training its professionals.

Data Analysis

Socio-demographic characteristics

Age of Respondents

Table 1 reveals a high majority of staff between 21-30years being 60%. About 18.7% were between 31-40years with the least of 2% for those who are 51years and above. The age structure of the respondents being a sample data depicts a youthful staff population. About 90% of the respondents were below 40years.

Table 2: Age category

Age Category	Frequency	Percent
20years and above	15	10
21-30years	96	64
31-40years	28	18.7
41-50years	3	2
51years and above	8	5.3
Total	150	100

Source: Field data, Adjei 2018

Marital Status of Respondents

More than half of the respondents of about 96 (64%) were single as compared to about 54 (36%) who have married. The outcome of this indicator does not come as a surprise as it confirms the age structure. From Table 1 about 111 (74%) of the staff interviewed were below 30years of age and this might be high contributor to the situation where majority of them are single.

Table 3: Marital status

Marital Status	Frequency	Percent
Single	96	64
Married	54	36
Total	150	100

Source: Field data, Adjei 2018

Religion of Respondents

About 142(94.7%) of the respondents were Christians as compared to 8(5.3%) who belongs to the Islamic faith. From previous survey conducted by the hospital in their Staff Satisfaction Survey the ratio of Christians to Muslims in

the facility was about 7:3 (Quality Assurance Report, 2015). Although no scientific research have been done to investigate why majority of the staff are Christians it is highly suspected that the ownership of the facility as mission (Catholics) might be high contributor.

Table 4: Religion of respondents

Religion	Frequency	Percent
Christian	142	94.7
Islam	8	5.3
Total	150	100

Source: Field data, Adjei 2018

Level of Education of Respondents

About two-thirds of the respondents of 125 (83.3%) were Diploma/HND holders while about 16 (10.7%) have had their bachelor's degree. The structure of the level of education gives an indication that the hospital has the expertise to provide health care to patients.

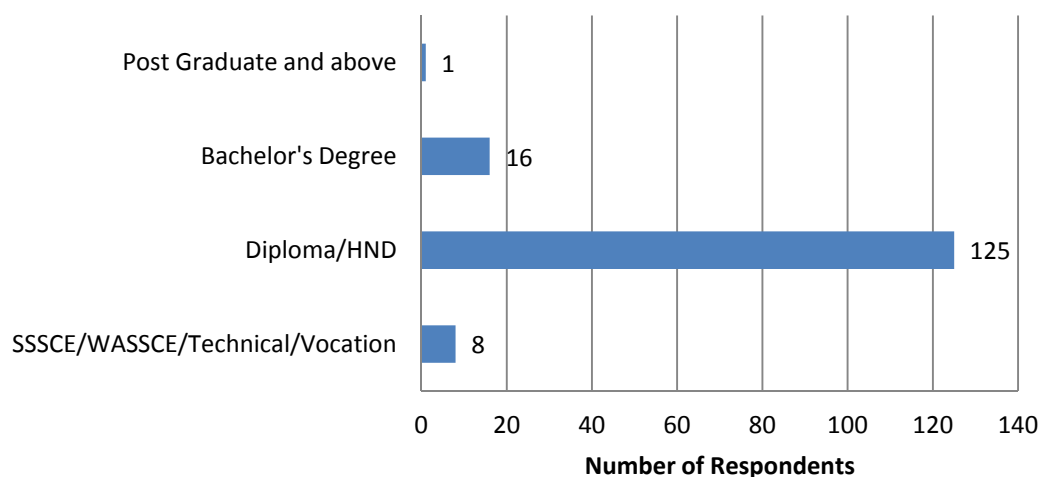


Fig 1: Education of Respondents

Number of working years

About 117(78%) of the respondents being the majority had work in the facility less than five years. This can be analytical reason that although majority of them have had health training, they might lack a little work experience. However the above table agrees with the age structure in the sense that about 74% were below 30% and by inference with majority of them being diploma holders implies that they would worked for less five years by 30years.

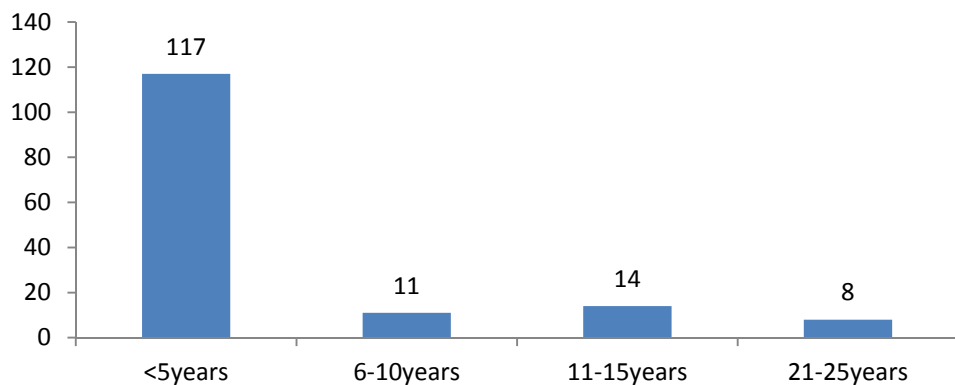


Fig 2: Number of working years of respondents

Different kinds of training the hospital and other stakeholders organize for the health professional

The Presence of In-Service Training Coordinator

About 146 (97.3%) of the staff were aware of the presence of in-service training coordinator as compared to 4(2.7%) who were novice. Although it was expected for every staff to be aware, the high acclamation of the staff knowing the existence of such a coordinator.

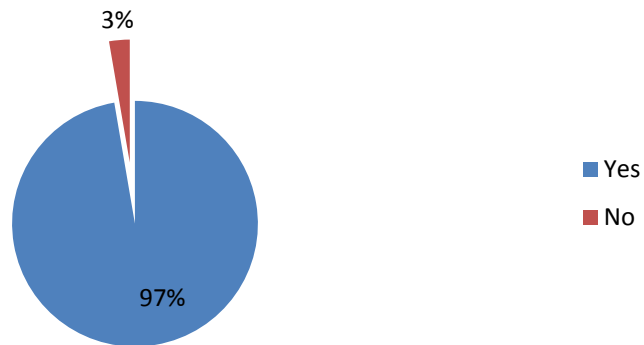


Fig 3: Presence of in-service training in the hospital.

Attendance of In-Service Training within the past one year.

It was attested by 96(64%) respondents that they have attended training within the past one year. By inference it implies that, these professionals were empowered in knowledge and skills, and moreover the training also have help them to give the best to patients as well as improve health indicators at the facility (GHS, In-service training guide, 2014).

Table 5 Participation of In- service training

Indicator	Frequency	Percent
Yes	96	64
No	54	36
Total	150	100

Source: Field data, Adjei 2018

Training in line with work?

Of the 96 respondents who have attended training within the past one year, about 84 (87.5%) agreed that the training was in line with their work whereas about 12 (12.5%) believed otherwise. With regard to those claimed it wasn't

in line with their work, it is believed that they attended training which was in the contest of health but not related to their direct job description.

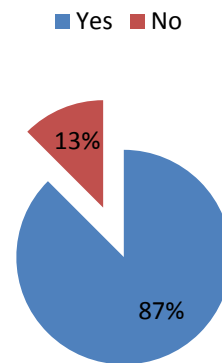


Fig 4: Training being in line with work

Types of training available at the workplace

About 126 (84%) of the respondents did indicated that clinical care forms majority on the type of training followed by public health 20 (13.3%) and management 4 (2.7%). With clinical care and public health being the majority means that there is much focus on the prevalence of diseases and how best it can be well manage.

Table 6 Types of training

Indicator	Frequency	Percent
Clinical Care	126	84
Public Health	20	13.3
Management	4	2.7
Total	150	100

Source: Field data, Adjei 2018.

The predominant type of training for staff

Close to the above indicator about 121 (80.7%) of the respondents stated clinical care training as the most organized for staff and 29 (19.3%) stated public health. Clinical cares as a type of training come as no surprise with majority of the nature of the work being clinical in nature. This kind of training by extension implies that it empowers the staff to treat conditions to the best of patients, reduce medical errors, improves drug dispensing, adopting modern method of clinical investigations.

Table 7 Predominant type of training

Indicator	Frequency	Percent
Clinical Care	121	80.7
Public Health	29	19.3
Total	150	100

Source: Field data, Adjei 2018

In addressing the kinds of training organised for healthcare professional, the study therefore in table 6 and 7 reveals clinical care and public health as specialty that the hospital focus most in developing the competency of her staff.

Impact of training on knowledge and skills of the health professional

Impact of the training on work performance

About half of the respondents, 84 (56%) believed that, it has improved their skills and knowledge, 51 (34%) declared that it has improve better care for patients whereas 15 (10%) stated adhering to occupational safety. This agrees with Bonvicini (2009) stating that ‘engaging health care providers of all types in efforts to enhance patient experience is of high interest worldwide report in

patient experience surveys and complaints that they desire enhanced communication from their providers'. Moreover Abbatt (2007) stated that the training being organized impacted positively on the knowledge and skills of health workers.

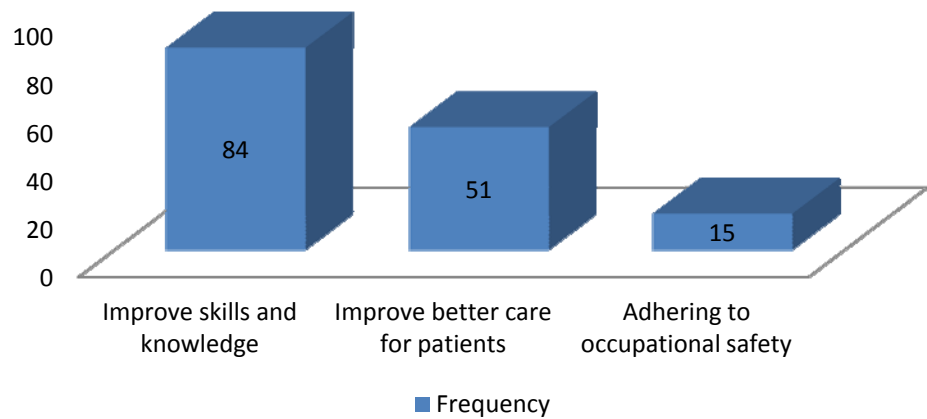


Figure 5: Training and Staff knowledge on patient's centeredness

Source: Survey at Holy Family Hospital.

Does training equip staff knowledge about patient centeredness?

It was highly acclaimed by majority of the respondents of about 142 (94.7%) that training equip them with knowledge about patient centeredness and however opposed by 8 (5.3%) who expressed otherwise. Although about 56% of the respondents in the previous indicator who indicated that it improve skills and knowledge there was a wide variation in Table 12 of almost all of them agreeing that training equip staff knowledge about patient centeredness.

Table 8: Training empowering staff

Indicator	Frequency	Percent
Yes	142	94.7
No	8	5.3
Total	150	100

Source: Field data, Adjei 2018.

How training has impacted on staff knowledge and skills of work

About 79 (52.7%) of the respondents believed that there has been an improvement in their skills of work as a result of training whereas 51 (34%) agreed on better care to patients. With regard to reduction in medical errors they were about 17 (11.3%). Improved knowledge and skills of health professionals doesn't in the long run impact positively on national health indicators. Improved in maternal and child health services are all as a result of better knowledge and care to patients.

This therefore addresses

Table 9: Impact of training on staff knowledge and skills

Indicator	Frequency	Percent
Improve on the skills of work	79	52.7
Better care to patients	51	34
Reduction in medical errors	17	11.3
Effective staff-patient communication	3	2
Total	150	100

Source: Field data, Adjei 2018

Any change of ideas as compared to the previous due to training?

About 130 (86.7%) of the respondent agreed that training has influenced or resulted in change of ideas as compared to the previous whereas 20 (13.3%) believed otherwise. The change in idea confirms the fact that it has improved their knowledge and skills on the work. For instance that the hospital, training such as “Making Every Baby Count Initiative” has resulted in a lot of change idea about best practice in new born babies.

Table 10: Change of idea due to training

Indicator	Frequency	Percent
Yes	130	86.7
No	20	13.3
Total	150	100

Source: Field data, Adjei 2018.

Positively affected area of training

With many of the respondents indicating clinical area as the top area of training specialty, there was no doubt that 100 (76.9%) of the respondents agreed that it has been positively affected due to training of health professionals. This was followed by Public Health 19 (14.6%) and Management 11 (8.5%). Which good impact on clinical areas, it was revealed by the facility that, for instance screening of patients for Tuberculosis has increased by 45% from 2015 to 2016 half year.

Table 11: Positively affected area of training

Indicator	Frequency	Percent
Clinical Care	100	76.9
Public Health	19	14.6
Management	11	8.5
Total	130	100

Source: Field data, Adjei 2018

The research findings revealed that training organized for health professionals improve their knowledge and skills on the job and also result in better care to patients.

The impact of training on quality of care delivery by health professionals

Training as the basis of quality health care

All respondents not even excluding one staff testify to the fact that training forms the basis of quality health care. According to Mager (2012) in delivering care to patients, quality health would be ensure if proper training is given to care givers and upon this basis that the staff provided the above response.

Table 12: Training as the basis of quality health care

Indicator	Frequency	Percent
Yes	150	100

Source: Field data, Adjei 2018

Continuous In-service training results in improvement model for better health care?

In highly agreed by 146 (97.3%) of the respondents that continuous In-service training results in improvement model for better health care. None of the staff disagreed with this indicator, but however about 4 (2.7%) of them were not certain. With the assurance of these improvements brings to the forth that it helps health organisations to developed strategies that link engagement in quality improvement initiatives with continuing education and specialty certification, rather than assuming that formal education in health care automatically results in excellent care Khurana (2005).

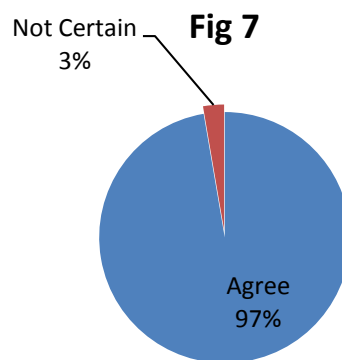


Fig 6: Continuous In-service training results in improvement model for better health care?

Area of significant improvement

About 75 (50%) of the staff being the majority indicated good customer care as a significant improvement due to continues training of staff followed by about 64 (42.7%) who stated reduction in mortality. Indeed the hospital organized customer care training for its staff in year 2015 and can be infer that this has change the attitude of most staff. Moreover in confirming the

reduction in mortality with hospital statistics in was realized that which maternal mortality reduce from 11 in 2014 to 7 in 2015 but a slight increase in general mortality rate from 3.0 to 3.1 in the same year interval.

Table 13: Area of significant improvement

Indicator	Frequency	Percent
Reducing Mortality	64	42.7
Good Customer Care	75	50
Improve Maternal Care	7	4.7
Quality Child Health Care	4	2.7
Total	150	100

Source: Field data, Adjei 2018

Development of disease protocols

About 83 (55.3%) of the respondents were aware of hospital protocols that has been developed as a result of training whereas about 67 (44.7%) were on the blind side. It is strongly believed that the introduction of appropriate routines and protocols could result in better management of patients and more efficient use of resources. The development of these protocols agrees with the strategic plan of Center of Disease Control (2011), which came out as guidance document to assist hospitals in developing or updating their protocols for screening and isolation for communicable diseases of urgent public health concern (i.e., diseases with greater likelihood of spread to others, and with higher likelihoods of more severe morbidity or mortality).

Table 14: Presence of disease protocols

Indicator	Frequency	Percent
Yes	83	55.3
No	67	44.7
Total	150	100

Source: Field data, Adjei 2018

Some protocols developed by the hospital

Of the 83 respondents who stated that the hospital has developed protocol, Infection prevention protocol ranked high among list, 42 (50.6%). Moreover Neonatal Sepsis and Malaria were about 20.5% and 19.3% respectively being aware by the respondents. For instance in 2011, Centre of Disease Control (CDC) suggested in their protocol guidance that, a single patient presenting to the emergency department/clinic with fever/rash or fever/respiratory symptoms suggestive of a communicable disease of urgent public health concern (e.g., measles, meningococcal disease, SARS, avian influenza, smallpox, or plague.

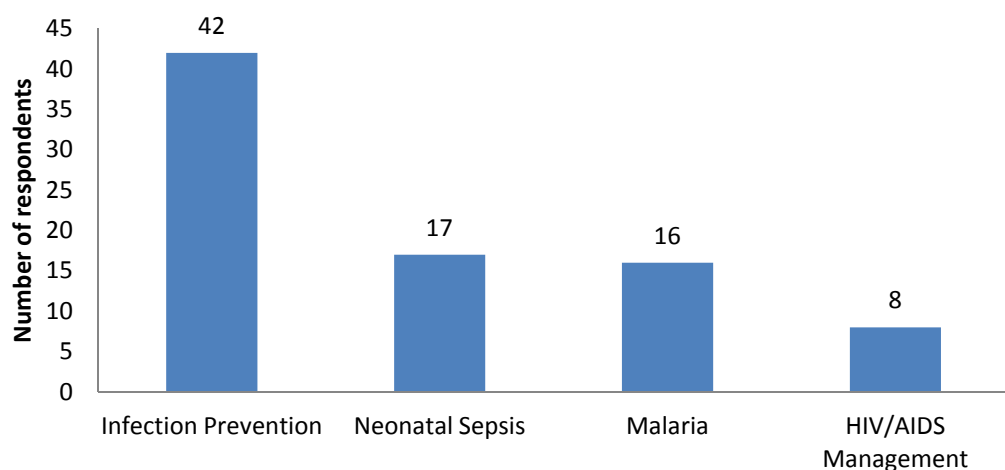


Fig 7: Some diseases protocol developed by the hospital.

Outcome/benefit the hospital derives from training its professionals

Hospital assessing benefit it derives from training its professionals

As medical outcomes reflects the end results of care, about 128 (85.3%) of the respondents came to consensus that the hospital assess benefit it derives from training its professionals. By this assertion from the staff indicates that the facility has a way of measuring its outcome of care to know which is best for patients. In the study by Batalden (2007) it stated it categorical that it is better to access outcome or benefits the hospital derives from training its professionals.

Table 15: Assessment of benefits derived from training

Indicator	Frequency	Percent
Yes	128	85.3
No	22	14.7
Total	150	100

Source: Field data, Adjei 2018.

Medium use by the hospital to assess performance

Of the 128 respondents who believed that the hospital assess benefit derives from training, about 60 (46.9%) being the majority stated it is done through annual report documents, 36 (28.1%) stated performance review meeting, 16 (12.5%) indicated In-chargers and ward meetings as well as management meeting each. In the direct perspective of the hospital annual report, it contains the facility statistics in trend analysis which always compares current year performance to the previous. Moreover as many indicators the fact that the hospital have an In-service training coordinator, his/her report always try to assess performance in contest with training being organized.

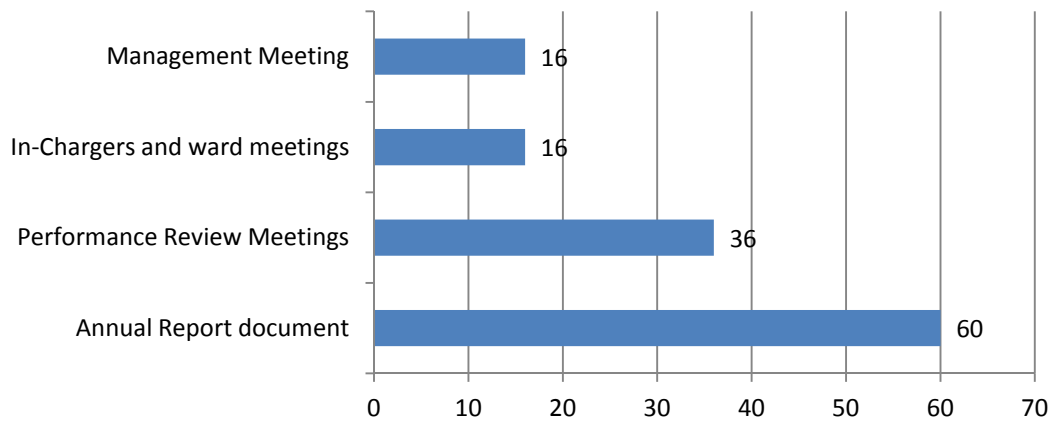


Fig 8: Medium use by management to assess performance.

Effect of training on some health indicators

About 81 (54%) of the respondents believed general mortality rate has reduced, 45 (30%) indicated reduction in maternal mortality rate. Moreover 15 (10%) claimed stillbirth rate has reduced whereas 9 (6%) also believed absconded has gone down. In confirming this from the hospital actual statistics it was found that mortality rate has however increased slightly from 3.0% in 2014 to 3.1% in 2015 whereas stillbirth also has increased from 24.3/1000live births to 29.4/1000live births. However indicators which confirm what the respondents said were absconded rate and maternal deaths. Whiles absconded rates decreased from 5.2/1000 admissions in 2014 to 3.6/1000 admissions in 2015, maternal death also shows a reduction from 2.7/1000live births to 2.2/1000live births in the same period. This makes both absconded rate and maternal death rate significant in the respondents claim (Hospital Annual Report, 2015).

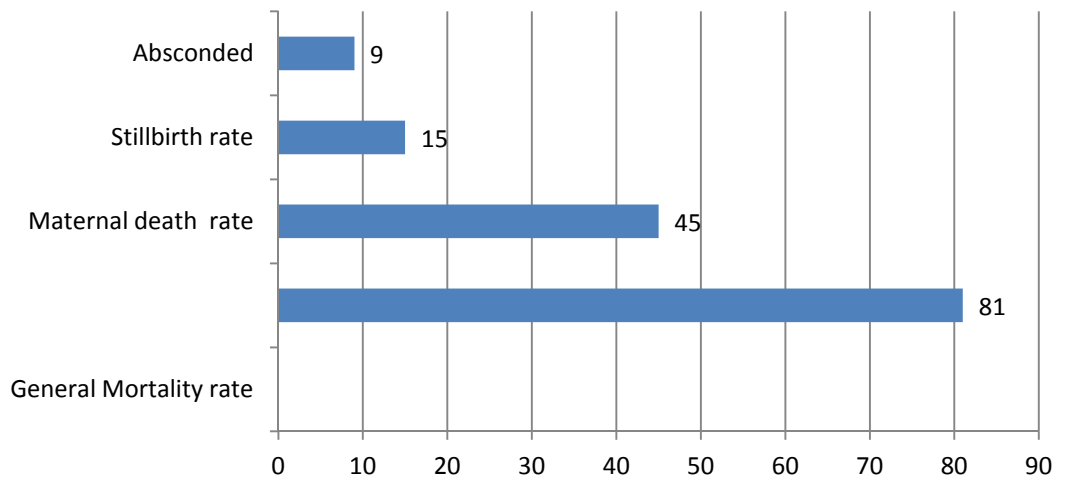


Fig 9: Effects of training on some health indicators

Impact of health outcome on the hospital’s global image

Majority of the respondents stated attracting new clients to the facility is major health outcome on the hospital’s global image, 97 (64.7%). This was followed by 42 (28%) who indicated maintaining it qualified and experienced staff. It could be infer that training of professionals especially in customer care results in better communication and in long run attracting clients. Moreover such training motivates staff and always makes to prefer the facility to any other health institution. This assertion agrees with Kandampully (2008) who stated that ‘maintaining and expanding customer loyalty through effective communication is significant for any service company’s long term success’

Table 16: Impact of health outcome on the hospital’s image

Indicator	Frequency	Percent
Attracting new clients to the hospital	97	64.7
Freeing the facility from legal issues	11	7.3
Maintaining it qualified and experienced staff	42	28
Total	150	100

Source: Field data, Adjei 2018

Impact of health outcome and revenue generation

A high number of about 142 (94.7%) believed that positive health outcome may result in increase in revenue and vice versa. Moreover, about 8 (5.3%) have the intention that health outcome have no correlation with revenue generation. It is no doubt that, positive health outcome reflect on the corporate image of the hospital. Smith and Clark (2012) reported that quality of physician, advanced technology, and overall quality all have a strong and positive relationship with the hospital image. Similarly, Nguyen and LeBlanc (2008) explained that the collective perception of service quality from repeated service encounters is expected to form the overall corporate image of the company.

Table 17: Positive health outcome and revenue generation

Indicator	Frequency	Percent
Yes	142	94.7
No	8	5.3
Total	150	100

Source: Field data, Adjei 2018

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

Summary of the results

The study was conducted at Holy Family Hospital, Nkawkaw. It was organized into five (5) chapters. Chapter one was made up of background of the study, statement of the problem, objective of the study, research questions, significance of the study, scope of the study, organisation of the study. With respect to chapter two, various literatures from previous studies were reviewed in line with the research objectives. Moreover chapter three was about the methodology. It was organized under the following subheadings; Research setting, Research design, Population, Sample, Sampling technique, Instrument, Data collection procedures, Data analysis and Ethical considerations. Again, data from the previous questionnaire were analyzed using the SPSS version 20 in chapter four. Data was structured using tables and other forms of graphical presentations. Discussions were done by comparing results from the data analysis to other previous studies.

Some significance findings from the study included the fact that, clinical care and public health are the main kinds of training being organised for the health professionals and as such training of health staff has improved the knowledge and skills of the staff interviewed. The hospital through its training activities has been able to develop protocols for certain diseases of which infection prevention dominated the list. Another important significance assertion from the study was the fact that majority of the staff claimed that

professional training has helped to reduce general mortality rate and also better health outcomes helps to attract new clients to the hospital.

Conclusion of the Study

In conducting the study to achieve the stated objectives, there is no doubt that findings from this study can be compared to what was stated for better conclusion to be made. First and foremost, the research was conducted to assess the different kinds of training the hospital and other stakeholders organize for the health professionals. Evidence from the study shows that, the hospital has in place In-service training coordinator and moreover majority of them have attended training within the past one year this study was conducted. This has empowered them in terms of knowledge and skills irrespective of the number of working years. It was no doubt that clinical care and public health were the main types of training the facility organized for its staff members. This therefore concludes that the hospital focus on the wellbeing of their patients as well as proper disease prevention. Secondly the study was to determine whether the training given improve the knowledge and skills of the professional. The study confirms that training of health staff has improved the knowledge and skills of the staff interviewed and this may be as a results of mode of delivery during training which focus on patient centeredness. Further conclusion can be drawn that the training has resulted in change of ideas and with this clinical care specialty has been affected positively.

Again, the study had an objective to assess the quality of care and health delivery of the professionals after receiving the training. It was found out from the study that all respondents agreed that training of health care professionals sometimes form the basis of quality health care which confirms

the study of (Mager, 2012). Continues conclusion can be drawn to the fact that training of health professionals results in significance improvement in good customer care and development of some disease protocols for better treatment and management. Finally another significant objective from the study was to assess the general outcome the hospital derives from training her professionals. The study found out that staff are convinced that the hospital assess the benefit it derives from training its professional through its annual report. Another conclusion is the fact that their believe of reduction in maternal mortality confirms the hospital statistics and moreover better health outcome attracts new clients and improve revenue generation base of the hospital.

The study also concludes on some limitations with respect to the fact that the study was limited to the responses provided by the respondents, findings of the study were based on the nature of training as it is now since it is a descriptive cross-sectional study. Finally resources and time constraints also affected the sample size.

Recommendations

Based on the above results from the survey the following have been recommended.

1. Management of the hospital should make much effort to train her professionals for higher qualifications as it had about sixteen (16) bachelor's degree holders and only one post graduate as compared to one hundred and twenty five (125) Diploma/ HND holders.
2. With about two-thirds of the staff working for less than five years reveals that Management should have a comprehensive human resource plan to maintain its professionals.

3. With about 30% of the staff, not attending in-service training within the past one year reveals that, effort should be made by the hospital to organize training for all cadre of staff.
4. Other forms of training especially public health and management related issues should be improved as done for clinical situations.
5. Effort must be made by the hospital to improve the quality of child health care as about 2.7% only indicated that training has significantly improvement in this area.
6. All disease protocols develop by the hospital should be properly known to all staff. About 44.7% indicating that they are not aware of such protocols doesn't improve clinical care quality.

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APPENDIX

RESEARCH QUESTIONNAIRE: TO ASSESS THE IMPACT OF TRAINING ON THE PERFORMANCE OF HEALTH CARE PROFESSIONALS: A CASE STUDY OF THE HOLY FAMILY HOSPITAL, NKAWKAW

Dear respondent, this questionnaire is being used to gather data on the research topic 'to assess the impact of training on the performance of health care professionals. A case study at Holy Family Hospital, Nkawkaw. The study is for academic purpose only and any information you provide will be treated with confidentiality and will be used for academic purpose only. Please, participation is voluntary and the information you will provide in this study will have no effect on you. Your identity is not required anywhere on this study.

SECTION A: DEMOGRAPHICS

Instruction

Kindly respond to the questions by ticking (✓) where options are provided, or state your opinion or comments when needed in the space provided.

1. Age
 - a) 20years and below []
 - b) 21-30years []
 - c) 31-40years []
 - d) 41-50years []
 - e) 51years & above []
2. Marital Status
 - a) Single []
 - b) Married []

c) Widow(er) []

d) Divorced []

3. Religion

a) Christian []

b) Islam []

c) Traditional []

d) Others (specify).....

4. Educational qualification

a) Middle School/JHS and below []

b) SSSCE/WASSCE/Technical/Vocational []

c) Diploma/HND []

d) Bachelor's Degree []

e) Post Graduate and above []

5. Number of working years at the Hospital.

a) Less than 5years []

b) 6-10years []

c) 11-15years []

d) 16-20years []

e) 21-25years []

f) 25years and above []

SECTION B: DIFFERENT KINDS OF TRAINING THE HOSPITAL AND OTHER STAKEHOLDERS ORGANIZE FOR THE HEALTH PROFESSIONALS.

6. Does the hospital have in place an In-service training Coordinator?

Yes () No ()

7. Have you attended in-service training being organised by the hospital within the past one year?

Yes () No ()

8. If yes to Q7, was it in line with your work?

Yes () No ()

9. What are the various type of training available at the workplace (organise for staff)?

.....
.....
.....
.....
.....

10. Training organise for staff usually centred on which specialty? (Kindly choose the most predominate)

- a. Clinical Care []
- b. Public Health []
- c. Management []
- d. Other; specify.....

11. Of the speciality chosen in Q9, Kindly state one area which is of a high interest to the facility and usually trains its staff for better health care.

.....

SECTION C: IMPACT OF TRAINING ON KNOWLEDGE AND SKILLS OF THE HEALTH PROFESSIONAL

12. How has the training being received equipped or change you with regard to your work performance?

.....
.....
.....
.....

13. Does the mode of delivery during training equipped your knowledge about patient centredness?

Yes [] No []

14. How has the training impacted on your knowledge and skills of work?

- a) Improve on the skills of work []
- b) Better care to patients []
- c) Reduction in medical errors []
- d) Effective staff-patient communication []
- e) Other; specify

15. Has any training influenced or resulted in change of ideas as compared to the previous

Yes [] No []

16. If yes to Q14, which of these areas was most positively affected?

- a. Clinical Care []
- b. Public Health []
- c. Management []

**SECTION D: THE IMPACT OF TRAINING ON QUALITY OF CARE
DELIVERED BY HEALTH PROFESSIONALS**

17. Training of health care professional sometimes form the basis of quality health care

Yes [] No []

18. Continuous In-service training results in improvement model for better health care.

a) Agree [] b) Not Certain [] c) Disagree []

19. Which area of health care quality has training resulted in significance improvement? (Kindly Tick One)

a) Reducing Mortality []

b) Good Customer Care []

c) Improve Maternal Care []

d) Quality Child health Care []

20. Has the hospital based training resulted in disease protocols that have impact on the quality of care of patients

Yes [] No []

21. If yes, Kindly indicate one condition which protocol was developed out of in service training

.....
.....
.....
.....

SECTION E: OUTCOME/BENEFIT THE HOSPITAL DERIVES FROM TRAINING ITS PROFESSIONALS.

21. Does the hospital assess the benefit it derives from training its professionals?

Yes [] No []

22. If yes to Q21 above, how is this assessment performed at the hospital.

(Multiply Choice)

- a) Annual Report document []
- b) Performance Review meetings []
- c) In-chargers and ward meetings []
- d) Management Meeting []
- e) In-service coordinators' report []

23. Training of health care professionals in this facility has reduced which of these indicators? (Kindly Tick One)

- a) General Mortality rate []
- b) Maternal death rate []
- c) Stillbirth rate []
- d) Absconded rate []

24. How does better health outcome impacts on the hospital's global image.

- a. Attracting new clients to the hospital []
- b. Freeing the facility from legal issues []
- c. Maintaining it qualified and experienced staff []
- d. Receiving awards []

25. Does better health outcome impact on the revenue generation base of the hospital

Yes [] No []