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Implementation of PDCA Cycle in Improving Communication Skill-Set for Training the Future Health Care Professionals

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Abstract: ***The research was conducted to evaluate the soft skill competencies and communication among future healthcare professionals. By assessing the level of knowledge, attitude, practices, and skill sets using pre- and post-tests, and taking feedback, data is collected for process improvement in the training program. The Plan, Do, Check, and Act (PDCA) Cycle helps in setting processes for implementation and improving training modules for communication and soft skill competency. The PDCA cycle is utilised as a managerial tool for the improvement process in a process setting. The approach helps in competency mapping and evaluating the training module for healthcare managers. This tool helps enhance the quality of the training program by assessing the participants' preparation from their perspective. Data are compared using the pre- and post-test scores. Results include both quantitative and qualitative data collected as feedback to assess the effectiveness of the training module. Data is collected on the level of preparation of the participants, their expectations for taking the course, and the level of interaction with the training program. Data is collated, compiled, analysed, and interpreted for evaluation and analysis. The research provides insights into customer satisfaction, decision-making capabilities, the importance of rewards and recognition in training and development, and changing domains in the quality healthcare management sector. The skill sets and competencies that were outcomes included Communication, Collaboration, Team Leadership, Change Agent, Motivation, Analytical Skills, and Logical Skills. By taking participants' feedback, the outcome analysis and the effectiveness of training can be evaluated. Through evaluation of results, process improvements, seamless coordination, and continuous improvement are implemented. The research concluded as an outcome measure to improve training programs and enhance the quality of services.***

Keywords: Training; Quality; Management; Effectiveness; Continuous-Improvement.

I. INTRODUCTION

A systematic approach has been undertaken by using managerial tools in the preparatory stage of the training program (Christopher & McNicholas, n.d. [1]).

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Regarding the implementation of the process, the PDCA cycle is adapted for process improvement. PDCA is one of the quality assurance tools that is adapted for end-to-end integration and seamless process setting without deviations from the main objectives of the training program (Coury et al., 2017; Taylor et al., n.d. [2]). The training course instructor/Trainer will identify the skills offered in the tool based on their relevance to the course material and the participants' suitability.

II. LITERATURE REVIEW

A. Why and how is the PDCA cycle used in training the skill sets?

The PDCA (Plan-Do-Check-Act) cycle consists of four steps, serving as an approach used as a tool in business and for implementing training program processes. This is one method that relies on continuous testing of the possible solutions (Deshpande & Munshi, 2019 [3]). Results are compared and the implementation process is steadily refined for quality enhancement (Christopher and McNicholas, n.d. [4]).

Planning: In the planning stage, the cause of the problem is identified, and data is collected from the initial stage itself. The problem is understood by identifying the causative factors in the statement. Here, in the training program, the critical factor is to understand the vision, mission, and values of the health care industry which is service-based, and set the goals and determine the target for the training program as what needs to be achieved and what is the best way to meet those goals(Matsuo & Nakahara, 2013 [5]). To gain a better understanding, a flow chart was prepared in a snapshot, as depicted in Fig. 5, for a clearer understanding of the tasks involved in the planning stage. At this stage, the tasks bar includes: inspection of standards of training material, maintenance of budget, Recourse assessment as logistics, Training material preparation, manpower allocation, adjustment of standards, training plan and planner finalization, failure detection procedure, team involvement plan is considered as most essential tasks that were performed (Dolev et al., n.d.[6]).

Execution/Do: In the 'Do' phase, the planned activities are taken into the process and the approved plan is made for achieving and measuring the results along the way (Etchells et al., 2016[7]). To be involved in execution, trust is gained and allows the people in the system to contribute to the improvement of the training program, the crucial elements are collected as data over some time (Hindiarto et al., 2020[8]).

At this stage, an inspection of the training program's set process is conducted, and any required modifications or adjustments are undertaken. Root-cause analysis (RCA) and corrective actions for any necessary actions are implemented at this stage of the training program (Galimullina et al., 2020[9]).

Check: Once the execution phase is completed, it is made understandable to benchmark the data against the data from the planning phase of the training program. Checking the process for proper results and also checking whether the training program is in the appropriate framework without any deviations, results are collected for the next step(Campana, 2010[10]). The checking stage has been structured explicitly into multiple tasks, including maintaining budget assessments, result reporting, updating team information, failure reporting, preparing solutions and improvements, and failure identification. This stage is crucial as verification and validation of reports are also conducted. As there must be no deviation from the set process in the training program, checking and verifying are a necessity. This checking process is crucial as the critical path of the training program should not deviate from the objectives that need to be achieved (Pursley, n.d.[11]). A check is a critical path for measuring the achievable goals that are explicitly set as objectives of the training program.

Act: Based o n the analysis and the results obtained from the training program conducted, decisions are undertaken for the likelihood of adding value to the training program(Trainer Manual for Soft Skills Applied in Entry Level Occupations (To Deliver Soft Skills in Conjunction with the Course Technical Curriculum, NVQ II-IV), n.d.[12]). At this stage, maintenance of the budget, standard document review, resource assessment, manpower allocation, training plan review, and team improvement plan are undertaken (Continisio et al., 2021[13]).

III. OBJECTIVES

1. To implement the PDCA cycle as a tool in developing the communication skill-set training program.
2. To assess the effectiveness of the training module in improving soft skill competencies for health care managers.
3. To utilise the PDCA cycle for process improvement, seamless coordination, and continuous improvement purposes.

IV. METHODOLOGICAL DESIGN

Aim: To develop and validate a module for training healthcare managers in enhancing their soft skill competencies for healthcare managers by using the PDCA cycle (Everett, n.d. [14]).

Content development of Module: The module helps in enhancing the soft skill competencies of health care managers by the following steps:

A. Learning objectives:

1. Through a literature search on reputable websites, the learning outcomes are determined.
2. By using the training manual and asking the subject experts to validate the training module.

B. Contents:

1. A systematic approach for the training in health care quality as a model with proper sequencing of the training requirements in the hospitals and health care management organizations (Touloumakos, 2020[15]).
2. As an integrated model, imparting the soft skill competencies along with hard skills by using a training manual and standard operating procedure (Tsey et al., 2018[16]).
3. To determine whether the module is practical, we need to compare all desired components and assess whether it meets the set expectations (Jelenc et al., n.d.).[17]).

C. Teaching-learning experience:

1. By conducting lecture programs, PPT presentations, focused group discussions, and interactions, and utilising training tools, the learning objectives are accomplished.
2. Interactive sessions were subsequently conducted using study material, employing a module-based approach. By using the training manual, the lectures are conducted, and they are also video recorded and reviewed for continuous quality improvement (Ford & Robinson, 2015[18]).

D. Training Assessment:

1. The pre-test questionnaire is administered before the training program.
2. The post-test questionnaire is provided and administered after the training program has been conducted for the participants.
3. Feedback questionnaires and post-implementation informal discussions with the participants.

E. Validation of the module:

a. Content validity:

1. Expert opinion and discussion in Semi-structured interview sessions.
2. Course document developed from users' perspectives and analysed with a panel of expert inputs at healthcare consortiums conducted exclusively for content improvement.
3. The content validity is not evaluated numerically, but rather judged by the researcher from the perspective of optimising resources and outcome-based verification and validation.

b. Face validity:

To assess face validity, 12 experts in the field of healthcare management, including external and industry experts, as well as 12 teaching faculty members who were professionals, evaluated the course content, module framework, and semantic, cultural, and conceptual equivalence of the training module. The pre-test and the post-test are administered to the pilot study group of 20 students. Once the panel of experts reached a consensus, the final versions of the pre-test and post-test were determined, and the misunderstanding index for each question was elaborated.

F. To emphasize the same in a stepwise manner, here is the framework proposed:

1. Experts and subject training faculty and judges were invited for interactions for their suggestions (Gibbs & Miller, 2014[19]).
2. Informal feedback and discussion with the participants.
3. A questionnaire to test the knowledge, attitude, and practices assessed by each participant.
4. A structured questionnaire, administered with a 5-point Likert scale, provides feedback.

Sampling method: The selection of participants was all the students who enrolled in the MBA-HHM (Master of Business Administration in Human Health Management) program. The focus group approach method was employed. Participants were provided with information about the training program, and participation was voluntary. Anonymity was maintained as no information about participants was used for identification purposes. A simple random sample was considered for piloting, and a sample size of 20 was utilised. The pilot study sample data was not included in the main research study purposefully. The training program consisted of 125 students for pre- and post-test assessment. Feedback was collected from all participants to assess and evaluate the training program for continuous improvement purposes.

G. Source of Data:

a. Checklists with pre-test and post-test questionnaires based on the training module.
b. Informal interviews and observations.
c. Subjective and objective feedback.

Study Setting: Participants were given a pre-test questionnaire before commencing the training program. Data are collected using pre-test surveys, questionnaires, interviews, and observations.

During the training program, as an intervention, participants are given free rein to interact and understand the concepts through group discussions. This will enable participants to engage freely and communicate with team members, facilitating comparison among inter-group members and within themselves, both before and after the training program, as they reflect on the interventions undertaken**.**

Interviews are conducted with a set of semi-structured questions vetted by a group of subject experts. Questions are designed to include both subjective and objective questions. A 5-point Likert scale is used for objective questions. For objective questioners, to quantify their responses, they are also asked yes/no questions. This is followed by a dialogue box that allows respondents to share their perspective on subjective questions.

The post-test survey questionnaire was also administered to all participants after the training program to assess the level of training competencies acquired and the communication skills developed.

A feedback form was distributed, and participants were allowed to provide their opinions and suggestions for improving the training program. Analysis of the feedback form would be conducted for critical thinking and comments that can be incorporated into further training and development programs(Meher et al., 2021[20]).

Study tools: Research tools such as Semi-Structured interviews, focus group discussions, surveys, observation, and feedback form analysis are used.

Sampling method: The entire batch of students admitted to the MBA-HHM program is considered a sample for interventions. As the competencies are to be matched with on-job training and for imbibing these as learnings for their future endeavours, the acceptance was from the entire core group of students.

Study subjects: All students of the MBA program in the hospital and healthcare management sector are participants. The study subjects are identified as students pursuing healthcare management studies in hospitals, as per the entire institute's admission procedure. The target group consists of students pursuing a Master's degree in Business Administration. The survey method is used, and participants consent to participate in the study. The target group consists of individuals aged between 20 and 40 years old.

H. Inclusion and exclusion criteria:

Inclusion criterion: All those who are being trained in the healthcare management sector will serve as a back-end support system for the organisation. This includes the technical management sector, administrative teams, and day-to-day operation personnel (Mayer et al., 2008[21]). In addition to the clinical team and clinicians, the rest are considered potential individuals for training purposes. This includes students pursuing an MBA-HHM, as their primary focus is on the work sector.

Exclusion criteria: Individuals who did not wish to participate in the training program could opt out of the virtual training and competency-building program as an alternative. Another exclusion criterion was those who had chosen to be entrepreneurs themselves and felt that training was not necessary. They were given the option to exit the training program. The exclusion criteria were discussed with the participants, who were allowed to decide otherwise.

V. ETHICAL CONSIDERATIONS

After the participants had given written informed consent to undergo the training, a questionnaire was provided that explained the advantages, benefits, risks, and consequences involved in the training program. Information security, data confidentiality, and the security of the data results were briefed to all participants. To ensure that their identity would not be revealed in the feedback, ethical clearance was obtained. The research ethics review committee evaluated the training material and the pre-test and post-test questionnaires. The training faculty and the expert committee for ethical clearance endorsed the feedback form. As data relevance and significance were communicated adequately to all training participants and the entire team, information security was explained in detail. As no patient information or adverse events were involved, obtaining ethical committee clearance was seamless.

VI. RESULTS

Observatory findings of training: The specific competencies involved in the training were self-reported by participants in the feedback form collected after the training program.

Some participants experienced a shift in personality as their traits were identified. Coming to terms with being open, conscious, and more agreeable was observed in the participants' findings. Being directive, goal-oriented, persistent, and motivated in behaviour were some of the changes in attitudes among the participants. The drive to consider 'emotions' as part of the learning process was distinctly noted (By et al., n.d.).[22]). Few of the participants had developed awareness, recognized the skills, and understood the feelings, emotions, and moods adaptively(Paul & Dissanayake, 2020[23]).

As participants of the training program are future managers of the healthcare industry, it was an interesting perspective to see the interdependence, group behavior in general and emotional intelligence with cognitive ability involved productively (Rosak-Szyrocka, 2015[24]). As this training gained huge attention and changed the perception of language delivery and mindset for interacting with people and patients. Understanding each other as social beings, the attention perspective of giving solutions to the end-user was the essence of communication skill-set competency training sessions(Beheshtifar & Norozy, 2013[25]). The participants were more adapted to the social world, and their abilities for social situations were explicitly learned. The skill sets provide the flavour for life! By understanding one's feelings and those of others, and being aware of the impact on decision-making, is the learning flavour of training and development (Mehta & Singh, n.d.).[26]). The unique experience of being humanistic and enjoying being a human being is an integral part of emotional intelligence, which plays a pivotal role in our professional life(Furnham, 2012[27]).

Results of pre- and post-tests: All precautions were taken to avoid data skewing and bias, and random sampling techniques were utilised to assess the data from the questionnaires.

The total number of participants was 125. For each question, the pre-test and the post-test scores were compared and documented on the bar graph. During the random sampling process, 125 samples were analysed and interpreted.

Since the data collection was itself blinded and quality by design (QBD) was initially being incorporated, the scores were as follows:

For each objective-type question, the question was based on individual capacity building, which had five multiple-choice options. The correct answers were compared after verifying the answer keys, and the pre-test and post-test were compared individually.

The data was plotted in a graphical representation as a bar graph as follows:

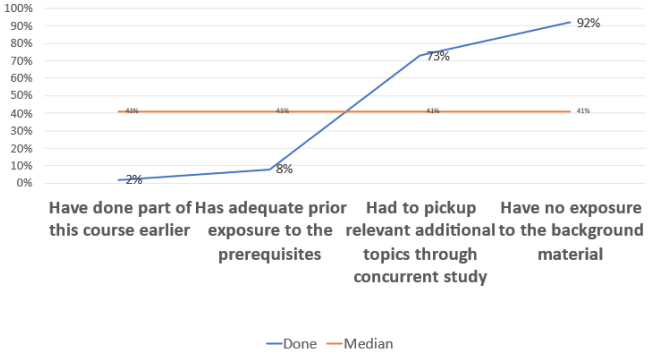

Fig. No. 1: Showing preparation for the course by the participants.

Inference of the data:

1) Have taken part in this course earlier: 2% of the participants had undertaken this course earlier.
2) Has adequate prior exposure to the prerequisites: 8% of the participants had prior exposure to the prerequisites.
3) Had to pick up relevant additional topics through concurrent study: 73% of participants had to pick up relevant additional topics through concurrent study.
4) Have no exposure to the background material: 92% of the participants had no exposure to the background material.

Interpretation:

• Less than 2% of the participants had been exposed to this training earlier. Only 8% had prior exposure to the prerequisites. These percentages and data confirm that this course was very new to the rest of the participants and differed from their usual learning and teaching sessions.
• More than 73% of the participants were able to pick up relevant additional topics. Ninety-two per cent of the participants had no previous exposure to the background material. These percentages and data confirm that a large set of participants were able to gather newer inputs and information from this training program. The training program was relatively new and performed innovatively, as the participants had no prior exposure to the background materials.

4. The expectations for taking the course by the student are:

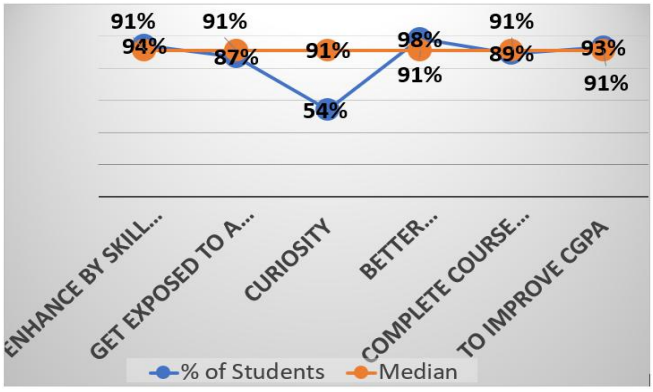

Fig. No. 2: Showing the run chart of the participant's expectations for taking the course.

Inference of the data: The expectations for taking the course by the student are:

1. Enhance by skill base in the area of specialization: 94% of participants.
2. Get exposed to a relevant subject: 87% of participants.
3. Curiosity: 54% of participants.
4. Better Employment Opportunity: 98% of participants.
5. Complete Course requirements: 89% of participants.
6. To improve CGPA: 93% of participants.

The Median is at 91%, which is indicated by the orange line in the run chart.

Interpretation:

- Most students were keen on enhancing their skills in the specialized area.
- The participants wanted to get exposure to the specific subject as a specialization.
- The level of curiosity among the participants was below the mean value.
- The participants were seeing this training as a better opportunity for employment and were willing to complete the course as a requirement.
- Most participants wanted to improve their overall scores as CGPA, which provides higher grades after passing the master's degree course.

VII. QUANTITATIVE ANALYSIS/FEEDBACK

Q. 1. Describe briefly the course in your own words:

a. One among the participants mentioned that they had a deep understanding, saying, "It was hard for me, especially, to be able to understand and express the way I feel". The outcome, in terms of a skill set, was Emotional self-awareness.

b. The participants replayed "Till date, it is difficult for me to say and stand up for my rights". The outcome, in terms of a skill set, was Assertiveness.

c. One of the participants answered, "I don't feel good being nice about myself for the actions performed". The outcome in terms of skill set was self-regarded.

d. Participants with previous experience could relate and answer, "I preferred others to make and handle the decisions for me." The outcome was Independence.

e. A participant was free to express the learning as "Now, I am sensitive to the feelings and emotions of others". The skill set learned was: Empathy.

f. A participant expressed, "People think that now I am sociable and can be approached". The skill set adapted was: Interpersonal relationship building.

g. One of the participants expressed and said, "I feel now for people and I would like to help them". The skill set learned: Social responsibility.

h. A participant explained, "My approach to overcoming problems and difficulties is by a structured way and moving step by step with precautions". The outcome and the skill set learned were: Problem-solving.

i. One of the participants expressed, “Most of the time, it was hard for me to adjust to new circumstances and conditions”. The outcome was: Reality testing.

j. A participant explains the present situation as "It's easy for me to adjust to the new job environment and new conditions". The learning was: Flexibility.

k. One of the participants expressed, "I know how to deal with and handle upsetting problems". The skill set imbibed was: Stress tolerance.

1. One of the participants, who is presently learning, expressed, "It's a problem to handle and control my anger". The skill set was: Impulse control.

Many participants had expressed specific competencies, such as happiness, self-actualisation, and optimism.

Q. 2. Any recommendations to improve the course content?

As a recommendation, participants suggested increasing the number of sessions for the group activities, as they enjoyed the group games and the FAQ. Due to limited time availability, the number of hours was specifically tailored to the desired number. Another recommendation was that learning was more enjoyable in the case of role play, as it was theme-based. Some participants wanted to involve multiple trainers for each session. As these sessions employed structured, module-based learning, their recommendation was well taken.

Level of preparation:

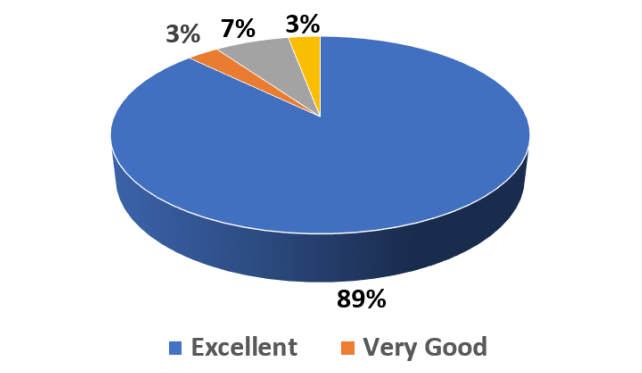

Fig. No. 3: Pie chart showing the level of preparation.

Inference of the data: Regarding the level of preparation for the training program:

1. Ninety-nine per cent (89%) of the participants rated it as Excellent.
2. Three per cent of the participants rated it as Very Good.
3. 7% of the participants said Good.
4. 1% of the participants said 'Poor'.

Interpretation:

- As most of the participants, 89% of them, mentioned that the level of preparation for the training program was Excellent.
- As very few of the participants, 3% of them, have mentioned that the level of preparation for the training program was Very Good.
- A few of the participants, 7% of them, said that the training program preparation was Good.
- About 1% of the participants mentioned poor training preparation.

5. Level of interaction:

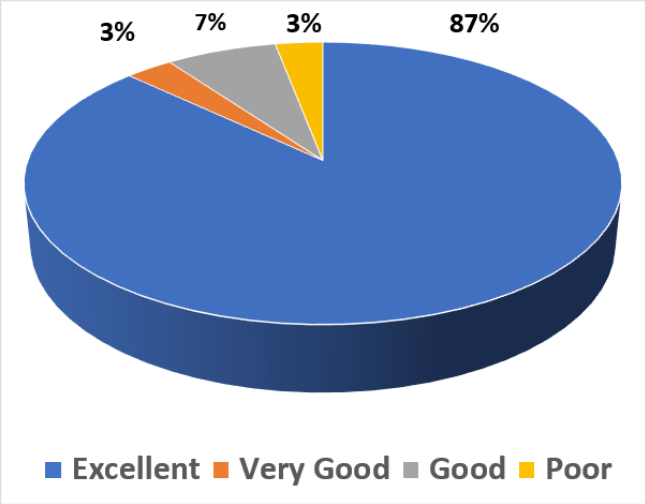

Fig. No. 4: Pic chart showing the level of interaction for the training program.

Inference of the data: Regarding the level of interaction for the training program:

1. Eighty-seven per cent of the participants rated it as Excellent.
2. Three per cent of the participants rated it as Very Good.
3. 7% of the participants said Good.
4. 3% of the participants said 'Poor'.

Interpretation:

• As for most of the participants, 87% of them said that the level of interaction during the training program was Excellent.

• Very few of the participants, 3% of them, confirmed that the level of interaction was Very Good.

• A few of the participants, 7% of them, said that the level of interaction was Good.

• A very few of the participants, 3% of them, have said that the level of interaction was Poor.

VIII. DISCUSSION

This PDCA cycle is an effective way to improve both efficiency and efficacy in the training program that teaches skill sets. It's one of the management practices that helps drive the process and is straightforward: using the proper solutions to achieve effective outcomes and accurate results for competency development in soft skills.

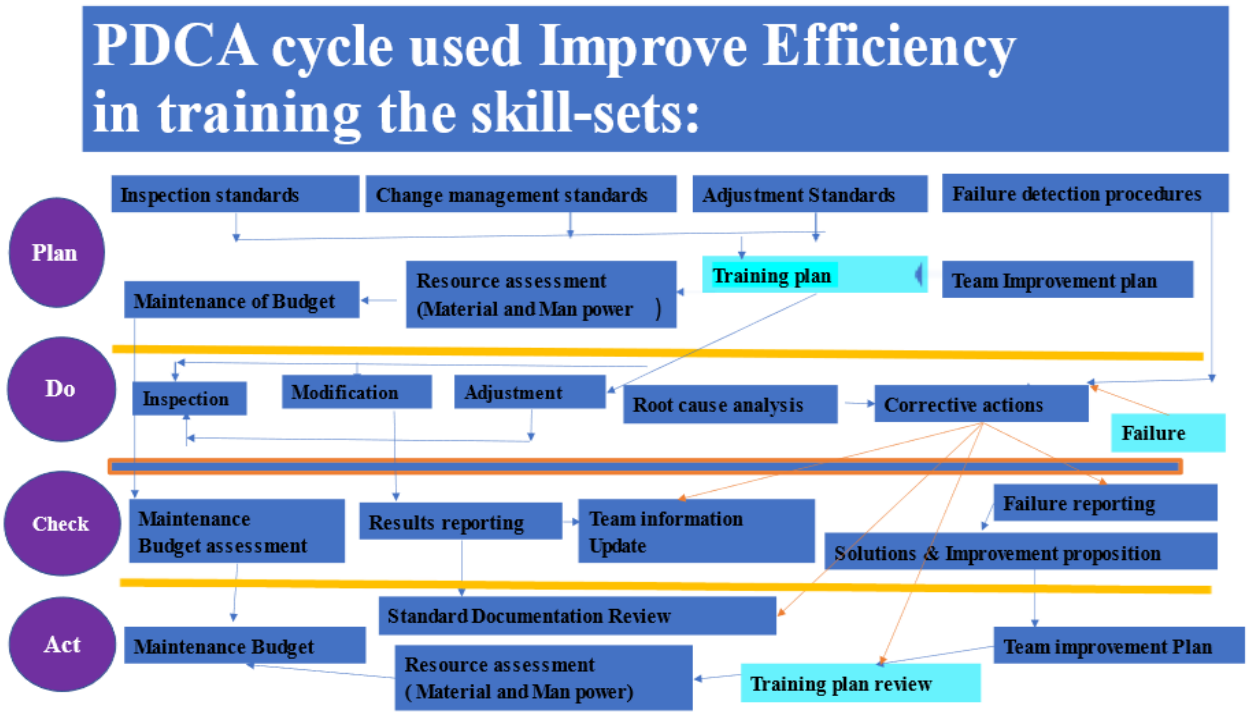

Fig. No. 5: PDCA cycle used in improving the efficiency in the training of the skill sets.

How the PDCA cycle is used in the training program for skill development in practice: To create a positive learning process and make the environment conducive for the participants, rich and diverse learning tools as skill sets, the managerial framework needs to be re-established and re-examine the workplace again to improvise the working processes (Etchells et al., 2016). There is a horizon of opportunities that can be developed as skill sets with proper inputs and suggestions from a standardized training program. When the process of working is made user-friendly, well-established, and satisfactory for continuous improvement, learning an agile and innovative way, creativity at the core, values are adopted, quality management is adapted from the initial stages, and facilitating the continuous improvement time and again,

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The PDCA cycle becomes most suitable as a context for using as a problem-solving tool. This is one of the management strategies for adapting to the process (Matsuo and Nakahara, 2013). The processes, once established in a definite way, made trainers more friendly, and the system's full-proofing efficacy was enhanced, resulting in a more result-oriented approach (Coury et al., 2017). The checks and balances need to be improvised as the evaluation process is adapted and new routines are developed at the action/implementation phase. Strict standards must be adapted to ensure the appropriateness of results, and the desired manpower can perform quality work by clearly communicating the desired outcomes. Human core values and concept-based learning, when adapted with a well-defined management strategy, can lead to measurable outcomes.

A. Benefits of Competency mapping and soft skill training as a tool for enhancing the quality of care:

a) Customer satisfaction: Customer satisfaction is paramount, and this factor contributes to achieving high, target-oriented results. When it comes to the efficient utilisation of inventory and logistics, policies must be explicitly established to facilitate effective communication as a strategy and prioritise communication as a tool to enhance outcomes. As healthcare managers, the message must be conveyed effectively by the sender and delivered accurately as a messenger. As a receiver, the effectiveness of communication is determined only by understanding the meaning of the communication rendered, and precise actions are undertaken accordingly.

b) Decision-making: In healthcare management, both external and internal factors play a vital role. The decision regarding inventory management and managing uncertainty during fluctuating demands remains a challenge. Every inventory excess or shortage of a resource needs to be scientifically managed efficiently. These decision-making capacities can be ascertained in situations that require communication and soft skills to be applied. The problem can be redefined as a situation analysis, and the response can be predefined according to the policies. Communication, such as telephonic conversations, the read-back phenomenon, verbal order entry policy, emergency and critical information alerts, and prioritisation of messages for coding in digital messages, needs to be properly established as a policy matter.

c) Importance of reward and recognition in training and development: Proper and timely reward and recognition of participants and trainers must be performed, which is an integral part of the training program. This component is often neglected and frequently taken for granted in many organisations. This serves as a motivational factor for both the competency trainer and the trainee, encouraging them to maintain the trainer role as a prospect for career development. Most organisations are committed to offering incentives and perks. On-the-spot and unexpected incentives that equate to earnings for those who demonstrate job competency are the best way to reward and recognition. It is not equivalent to job completion aspects. Corporate training with clear agendas must instantly revitalise employees, which helps eliminate fundamental issues of reluctance among participants in personal and skill development aspects. These recognitions should be provided in a timely and instant manner, which yields job satisfaction.

d) Changing domains in quality healthcare: In healthcare, work areas are performed by a multi-team system for patient care. Each team aims to provide safe and efficient care involving the coordinated activities of a multi-team system (Davison et al. 2012). Changes in a scenario with or without patients are best suited for the implementation of protocols, such as evacuation processes in disaster management, and the implementation of codes in hospitals has been integral. With standard operating procedures in place and components of quality care-taking of prime importance, simulation of fire safety management, emergency handling during baby abduction, code blue situation handling, external bomb threats, and evacuation processes are considered simulation processes. The logical reasoning and ability to think and act in an emergency have to be well-planned and executed. In healthcare management, the back-end support system must be robust, and the awareness of functionality in emergencies must be addressed strategically. For all these, communication as a skill set plays a pivotal role in the planning and execution of the processes.

Discussion on the Advantages and Disadvantages of the Collected Feedback: Using these predefined templates for feedback has advantages, as they encourage participants to respond. It fosters a deeper connection and enhances interpersonal communication among participants. The proposed method improves the richness of the collected data. The disadvantages are that it is very time-consuming to collect, collate, compile, analyse, and interpret the data. As there are multiple sub-components, such as role-playing with a team of participants, quizzes and FAQs, and assignments, the training program is more of a shop-in-shop model in itself. Feedback is not based on the task-based activities performed by the participants, but rather on the input provided and the methodology incorporated from a single perspective. It has scope for further improvement, and a non-statistical model has been adopted. This feedback data is a matter of fact to improve the following training programs, taking into account the inputs and suggestions. The feedback is more objective-oriented, and the framework of the training is to add to, rather than delete, any sections of the training.

A rich knowledge base is created through theories of communication, researched using 15 models of communication, along with a pragmatic model designed to achieve better outcomes for participants.

Outcomes of the analysis of training:

By the consensus of all the subject experts, by discussing and taking inputs from the training participants and also involving trainers for their suggestions, the primary attributes as competency skill-sets that were selected for the training and competency mapping were performed, which is diagrammatically represented as follows:

Fig. No. 6 Competency mapping and soft skill training tool.

As competency mapping helps the participants at the individual level to carry out and evaluate their learning process, it also serves as a motivational factor. This is one of the key elements for the success of training soft skill competencies. These competency mappings can be made a self-directed and self-paced process for participants to cultivate their emotions, thoughts, behaviours, competencies, habits, and skills. The competency mapping must be individualised, and customisation can be performed. There are numerous benefits to conducting competency mapping for participants, so an activity-based approach is employed at the initial stages of the training program.

At the end of the training session, it also enables participants to pursue their own goals and aspirations, as well as conduct self-assessment and evaluation to track their progress. At specific points in time, evaluations can be scrutinised and feedback made available at regular intervals.

There are various practice tools, such as assignments, which are order-dependent and provided to participants at specific time intervals during the training program. Every assignment is built on previous learnings, and as a development process, a time-paced approach is adopted. This allows for flexibility and a phased pattern, providing students with adequate time for instruction, reflection, and the incorporation of practices into their day-to-day management. This allows for feedback and evaluation to be the same for all participants. These methods are highly adaptive from the learners' point of view, as they can be used as flexible and dynamic tools.

Limitations:

1. The training program was implemented in one institution of international rapport. To gather diverse inputs and viewpoints, implementing studies in different healthcare organisations with varying participant samples will yield a wide range of practical implications, challenges, and suggestions.
2. As this was a pre-budgeted activity, the financial aspects, including profits and benefits in monetary terms, are not considered. The value proposition is viewed from the participant's perspective, rather than from a monetary gain perspective.
3. The validity of the training content is not evaluated numerically, but rather judged from the researcher's perspective for process improvement and optimisation purposes.
4. In this training program, operational efficiency is a key focus. The quality enhancement motive is considered by adapting managerial tools such as the PDCA cycle. The failures and consequences are predicted and eliminated at the design stage. Risk reduction and mitigation during the training program and its evaluation are not performed in this research study.

IX. CONCLUSION

1. Managerial tools, such as quality by design, quality assurance, and quality control, were adapted to develop the structure, process, and outcomes of the soft skill training program.
2. Specific management strategies and tools, such as the PDCA cycle, were adapted to specific areas for better outcomes.
3. Training aids, such as checklists with pre-test and post-test questionnaires, informal interviews, observations during the training program, and subjective and objective feedback, were utilised to implement and assess the effectiveness of the training module in improving soft skill competencies.
4. Competency mapping of skill sets and concepts developed through teaching and experiential learning in a blended learning program, designed to enable participants to become their change management agents.
5. The end-user perspective, along with participants' and trainers' in-depth insights, was utilised in collaboration for module development and evaluation.

DECLARATION

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Conflicts of Interest/ Competing Interests	No conflicts of interest to the best of our knowledge.
Ethical Approval and Consent to Participate	No, the article does not require ethical approval or consent to participate, as it presents evidence.
Availability of Data and Material/ Data Access Statement	Not relevant.
Authors Contributions	I am the sole author of the article

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AUTHOR PROFILE

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Industry experience: +23 years

An astute performer with 23 years+ of extensive experience in Health Care services & the capacity to handle hospital administration and healthcare management within the responsibility. A passionate technocrat with professional enrichment in the areas of the healthcare service sector: Operations, Quality and Accreditation, Strategy management, Projects management, Research and development, Training and Capacity Building, and IT & Digital innovations.

Rich knowledge and expertise in formulating and effectuating strategies aimed at sustaining profitability in business operations. Experience in managerial and technical support, troubleshooting, and functional development, as well as expertise in processes, has helped me apply and enhance current skills, acquire new skills, and contribute constructively to the development and transformation of reputable organisations.

My academic accomplishments have equipped me to deliver high-quality teaching by developing various modules tailored to the needs of management students and faculty, and drafting policies for stakeholders. Research and development have been my primary focus in global healthcare, positively impacting people's lives.

A resourceful and conscientious person who always strives to achieve high standards, remaining calm under pressure with the ability to multitask and prioritise workloads to meet tight deadlines and balance time management with continuous improvements. Working well within a team environment or on own initiative with excellent communication and people interaction skills, with the ability to develop good relationships with the understanding and appreciation of customer needs. The existing skills can be enhanced and new ones developed with a willingness to undertake any further training to aid job efficiency.

As a mature, passionate health professional, academic, and researcher, I possess a high degree of self-motivation to complete any work to the best of my abilities. I have excellent communication and organisational skills, enabling me to manage my time efficiently. I am a good-humoured, friendly, reliable, and trustworthy individual, with the ability to collaborate well in a team setting as well as to work independently with initiative.

Publications:
https://orcid.org/0000-0002-1919-66272.
9 publications in Scopus and Web of Science.
4 conference publications.
4 Website article publications
35 CPD's with credit hours.
15 MDP, AMDP.
About 200 Conferences and webinars with certifications.
1 National poster presentation award- Best prize.
Guest faculty in health care management.
Participated in over 500 webinars during the COVID-19 pandemic.
32 health care projects.
Expertise: NABH/QAI/JCI Accreditation, Hospital Operations and Administration, Quality and patient safety, Health care IT, Business intelligence, Business communication, data analytics, Audits and continuous improvement programs.
Academic teaching experience of 2 years as Assistant Professor in SIHS, SIU(DU).