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Implementing a National Accreditation Programme in Kuwaiti hospitals:
Understanding the impact, facilitators and barriers using a multiple methods approach

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Abstract

Background and aim: Accreditation is a process of evaluating an organisation. It comprises a self-assessment against a set of standards and an external evaluation followed by a report. The trend towards implementing healthcare accreditation has reached the Middle East, since the World Health Organisation reported, in 2003, a lack of accreditation programmes in this region. Many countries in the Middle East, including Kuwait, have been developing and implementing accreditation programmes since then. The aim of this research was to explore implementation of the accreditation programme in Kuwait general hospitals from the multiple perspectives of the healthcare professionals involved.

Methods: The research employed a multiple methods approach with three inter-linked studies. The first study was a systematic review of the international literature that explored the implementation of accreditation programmes. Data analysis was guided by Normalisation Process Theory (NPT). The second study was a documentary analysis of the accreditation reports of six general Governmental hospitals. The third study involved interviews with twenty-five participants, from two general hospitals, who represented different professional backgrounds and were all self-assessment team members. The accreditation implementation process was explored in depth, focusing on the impact of the programme and the factors that influenced the process. Both the documentary analysis and the interviews were analysed by thematic analysis. The findings of the three studies were then synthesised, using Normalisation Process Theory.

Results: The findings from the three studies identified four broad areas representing the process of accreditation implementation: understanding the accreditation process; engagement with the accreditation process; the work of accreditation; and monitoring the impact of accreditation. Within these themes, key factors were found to influence the successful implementation of the programme. These were: understanding the process; individuals' engagement; communication and teamwork; leadership support; resources; infrastructure; adaptation of Standards; and education and training. The evidence for the impact of accreditation programmes on healthcare services in the systematic review was inconclusive. However, accreditation was perceived, in the interviews, to have a positive organisational impact. On the individual level, the findings identified the process of

implementing accreditation to impact positively on the personal development; improve working relationships; and the morale of the teams.

Conclusion: This thesis has contributed to the evidence for the implementation of accreditation in the hospital setting and its impact, from the perspective of accreditation self-assessment team members. Furthermore, it provides valuable insights for policy makers within the Kuwaiti healthcare context in future planning and monitoring of the National Accreditation Programme.

Table of Contents

List of Tables

List of Figures

List of Boxes

List of Appendices

Abbreviations

ACS	American College of Surgeons
ANAES	Agence Nationale d'Accre'ditation et d'Evaluation en Sante'
BLS	Basic Life Support
CAGR	Compound Annual Growth Rate
CAQDAS	Computer-assisted qualitative data analysis software
CASP	Critical Appraisal Skills Programme
CCHSA	Canadian Council on Health Services Accreditation
CFIR	Consolidated Framework for Implementation Research
CONSORT	Consolidated Standards of Reporting Trials
CQI	Continuous Quality Improvement
DALLAS	Delivering Assisted Living Lifestyles at Scale
DIPOM trial	Diabetic Postoperative Morbidity and Mortality Trial
EMR	Eastern Mediterranean Region
EMRO	World Health Organisation Regional Office for the Eastern Mediterranean
GCC	Gulf Cooperation Council
GDP	Gross Domestic Product
IAP	International Accreditation Programme
ISQua	International Society for Quality in Health Care
JCAHO	Joint Commission for the Accreditation of Health Care
MOH	Ministry of Health
NAP	National Accreditation Programme
NPT	Normalisation Process Theory
OPEC	Organisation of the Petroleum Exporting Countries
QI	Quality improvement
QP	Quality Physician
RE-AIM	Reach, Effectiveness, Adoption, Implementation, and Maintenance
TQM	Total quality management
TSHAS	Trent Small Hospital Accreditation Scheme
UAE	United Arab Emirates
WHO	World Health Organisation
WTO	World Trade Organisation

Glossary

Accreditation	A self-assessment and external peer review used by healthcare organisations to accurately assess their level of performance in relation to established standards, and to implement ways to continuously improve the healthcare system.
Continuous Quality Improvement	A management philosophy used by organisations to better their processes.
Framework analysis	A type of qualitative analysis involving the use of a framework to sift, chart organise and analyse data.
Framework synthesis	A type of qualitative synthesis involving the use of a framework to analyse data from multiple qualitative studies.
Normalisation Process Theory	A middle range theory that can be used to understand the processes involved in the implementation and embedding of a set of tasks.
Performance indicator	A measure that a sector or organisation uses to define success and track progress in meeting its strategic goals.
Standard	The desired and achievable level of performance against which actual performance can be compared.
Surveyor	An official inspector of something, especially for measurement and evaluation purposes.
Thematic analysis	A type of qualitative analysis that involves pinpointing, examining, and recording patterns (themes) within data.
Total Quality Management	A system of management based on the principle that every member of staff must be committed to maintaining high standards of work in every aspect of a company's operations.

xv

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Author's declaration

I, Azari Alhaleel, confirm that I as the named author conducted the research study detailed in this thesis. I was responsible for the conception, design and undertaking of all aspects of the research under the supervision of Professor Catherine O'Donnell and Professor Jillian Morrison. I declare that all the material presented in this thesis is my own work unless specifically stated otherwise.

Azari Alhaleel

January 2018.

Introduction

1.1 Introduction

This chapter aims to introduce the concept of healthcare accreditation and to briefly describe the National Accreditation Programme in Kuwait. It also explains the aims and objectives of this research, and provides an overview of the structure of the thesis.

1.2 Background

Many changes and developments have occurred over the past years, particularly in the healthcare sector, as a result of new interventions, successful breakthroughs or increased awareness of the needs of patients. One of the important values adopted by almost all organisations is ensuring safety and maintaining quality standards in the provision of their services. When it comes to healthcare systems, quality improvement is a priority (Sprague, 2005, Chassin, 2013, Wilson, 2014). One definition of quality is 'meeting and exceeding the needs and expectations of patients and/or other customers, with a minimum of effort, rework and waste' (Berwick et al., 1991). This has led to a range of quality approaches being adopted by the healthcare sector, like Total Quality Management (TQM) and Continuous Quality Improvement (CQI). Another approach is accreditation, which has built a solid reputation as a preferred method to promote organisation-wide quality (EMRO, 2003, Montagu, 2003, Melo, 2016).

Accreditation of healthcare organisations is not a recent concept, it goes back to 1917 when the American College of Surgeons (ACS) established the Hospital Standardisation Programme to ensure healthcare quality of hospitals (Roberts et al., 1987). The United States was the first country in which the concept of accreditation was formally introduced by the creation of the Joint Commission for the Accreditation of Health Care Foundation (JCAHO) in 1951 (Lichtman et al., 2009). This concept developed in the 1960s in

countries like Canada and Australia, and was introduced in Europe in the 1980s. Before the end of 1990s, the concept of accreditation was being used all over the world to set standards of quality in healthcare institutions.

Accreditation is based on optimum standards and encourages healthcare organisations to pursue continual excellence (Gyani, 2012). The literature offers a range of definitions for accreditation, and as Scrivens (1997a) notes 'there is no clear, single view of the definition'. One comprehensive definition is offered by The National Agency for Healthcare and Evaluation, which views accreditation as '…an evaluation process carried out by independent professionals external to the healthcare organisation and its governing bodies, focusing on its functioning and practices as a whole. It aims to ensure that conditions regarding the safety, quality of care and treatment of patients are taken into account by the healthcare organisation'(Pomey et al., 2004). The accreditation cycle starts with an internal self-assessment of the organisation, followed by an on-site survey evaluation by external professionals, and ends with a report giving an overall assessment of the organisation. The focus of the work reported in this thesis is on the first component, the self-assessment process, as it represents 'the fundamental basis of accreditation'(Al-Assaf and Akgun, 2009), and the last component, the accreditation report, which includes the evaluation of the organisation's performance from the surveyors perspective.

The most important objectives of hospital accreditation are illustrated in the following table.

Table 1.1 Objectives of hospital accreditation

Enhanced health systems	Integrating and involving hospitals as an active component of the healthcare network.
Continuous quality improvement	Using the accreditation process to bring about changes in practice that will improve the quality of care for patients.
Informed decision-making	Providing data on the quality of healthcare that various stakeholders, policy-makers, managers, clinicians and the public can use to guide their decisions.
Improved accountability and regulation	Making healthcare organisations accountable to statutory or other agencies, such as professional bodies, governments, patient groups, and society at large, and regulating their behaviours to protect the interest of patients and other stakeholders.

Source: (EMRO, 2003)

However, for accreditation to achieve those objectives, much consideration must be put towards the process of implementing the programme. The literature identifies many key factors that may facilitate or hinder that successful implementation. Education is found crucial in preparing for accreditation, and training leaders as well as staff makes them understand the process better (Bruchacova, 2001, Thurber and Read, 2008). Resources in terms of budget, employees, and time are fundamental when an organisation is embarking on accreditation implementation (James and Hunt, 1996, Pongpirul et al., 2006, Bateganya et al., 2009, Saleh et al., 2013). Other key elements that may affect the successful implementation of the programme are leadership, commitment and engagement of staff, and teamwork (Rad, 2005, El-Jardali et al., 2008, Lanteigne and Bouchard, 2016).

The global interest in accreditation is because its considered a tool for improving the quality and safety of the healthcare services, however, there is a knowledge gap in evaluating the impact of accreditation on healthcare organisations (Braithwaite et al., 2012) and existing evidence on the value of healthcare accreditation in the literature is modest and inconclusive (Miller et al., 2005, Braithwaite et al., 2010, Saleh et al., 2013). Some studies have been sceptical about the benefits of accreditation on quality of care, for example, a study by Keeler et al. (1992) suggested that there was no relationship between the accreditation process and improvement in the quality of care. As a result, many have stressed the importance of further research to be conducted to justify its' merits (Scrivens, 1998, Braithwaite et al., 2006).

1.3 The National Accreditation Programme

Accreditation has been welcomed internationally (Scrivens, 1998, Simon et al., 1998, Shaw, 2003). Governments, users, professionals, managers, and insurers are putting in place new methods to guarantee public liability, transparency, self-regulation, quality development, and cost effectiveness and accreditation is part of this (Shaw, 2001).
The World Health Organisation Regional Office for the Eastern Mediterranean (EMRO) stressed the importance of establishing national systems to support healthcare accreditation in the Middle East (EMRO, 2003).

Establishing and introducing the National Accreditation Programme (NAP) has been a key landmark in the development of quality and safety approaches in Kuwaiti healthcare. From 2001 onwards, the NAP has been steadily progressing, with the initial foundation of the Quality and Accreditation Directorate in 2001, followed by the establishment of the Accreditation Higher Committee in 2003. Collaboration with Accreditation Canada resulted in two consecutive agreements extending from 2008-2017, with the main objective of utilising their expertise in the field of healthcare accreditation to design and establish the National Accreditation Programme customized specifically to the Kuwaiti local context.

While considered a voluntary process in many other countries, healthcare accreditation in Kuwait is a ministerial requirement initiated by the Government. The accreditation cycle in Kuwait is 3 years; this time period was selected because it's not too long a time period to promote and maintain continuous improvement, nor too short, thus giving the hospital enough time to work on the recommendations (Shaw, 2004).

In the NAP, the hospital is informed of the survey visit around 6 – 9 months in advance, during which time the teams work on implementing the National Accreditation Standards and preparing all the required documents. The self-assessment report is uploaded 6 weeks before the onsite-visit. The onsite survey then runs over a period of 5 days with 6 surveyors participating. The process involves document review, site tours, observations, and interviews with employees as well as patients. Following the visit, the surveyors complete their report, uploading their feedback into the accreditation software. This software programme then calculates the final result of the evaluation, assigning one of three possible statuses: substantial accreditation, partial accreditation with conditions, or pre-accreditation status. The substantial accreditation status is an indicator of the excellence of the organisation.

Since accreditation was first introduced to health organisations in Kuwait, there has been a lot of resistance, managerial as well as clinical. Both agreements with Accreditation Canada cost the ministry of health a total of 2,446,000 British Pounds. Furthermore, many local resources were allocated and used by the hospitals during the process of implementation for administrative, educational, and structural requirements. This has

emphasized the importance of producing convincing, evidence- based arguments about the potential benefit of such an intervention, and identifying the possible influential factors that affect the process of implementation.

1.4 Research aim and objectives

The overall aim of this research is to explore implementation of the accreditation programme in general hospitals in Kuwait from the multiple perspectives of the healthcare professionals involved.

The research questions explored in this thesis are:

- What are the facilitators and barriers of accreditation implementation, as described in the international literature?
- How did accreditation impact on the services, from the perspective of healthcare professionals engaged in the accreditation programme as demonstrated in the international literature?
- What were the areas for improvement identified during accreditation visits to the general hospitals, as part of the NAP in Kuwait?
- How did the accreditation process impact on healthcare professionals and what was their view of its organisational impact in Kuwaiti hospital settings?
- What were the facilitators and barriers affecting the implementation of the NAP in Kuwait from the self-assessment teams' perspective?

1.5 Methodology

This thesis adopts a qualitative multiple methods approach. The first study was a systematic review of the literature (Chapter 5) that explored the various factors affecting the process of implementing accreditation programmes, and how these programmes impact on the healthcare services from an organisational as well as individual perspective. The search identified 21 papers that met the inclusion criteria. This study used a framework approach to analyse the data, guided by Normalisation Process Theory (NPT).

The second study was a documentary analysis of accreditation reports of six general hospitals (Chapter 6) that served to investigate surveyors' recommendations about the organisational effort in the process of accreditation implementation, and what, from their perspective, affected the successful implementation of the standards. This study applied thematic analysis to the data generated from the reports.

The third study (Chapter7) conducted semi-structured interviews with 25 self-assessment team members from various professional backgrounds to provide a deeper insight and understanding into the accreditation implementation process. Thematic analysis was also adopted for the interview analyses, similar to the second study. These three studies were integrated in the discussion chapter (Chapter 8), contributing to a deep understanding of the accreditation implementation in hospitals, by eliciting the views and experiences of those most closely related to the programme.

1.6 Structure of the thesis

The chapters of this thesis are structured as follows. Chapter 2 provides a description of the State of Kuwait including its historical development, culture, and economy. This chapter then addresses the healthcare system in Kuwait; explains its key demographics; and discusses some health reform initiatives. Chapter 3 provides a description of the background literature on healthcare accreditation, focusing on the historical development and different definitions. It then discusses the research methodologies of accreditation, and highlights professional views about it. Finally, it discusses the National Accreditation Programme in Kuwait, its development, and main features, and the affiliation with Accreditation Canada.

Chapter 4 describes the research methodology used in this study, by presenting first the research aim and questions. The chapter commences by introducing the philosophical and methodological foundations of this research, and the theoretical framework underpinning the study and the reasons for its adoption. The research methods used (systematic review of the literature, a qualitative analysis of accreditation related documents, and semi-structured interviews) are then presented, explaining their design, method of data analysis, and strengths and weaknesses.

The findings of this research will be presented in the following three chapters divided into; systematic review in Chapter 5; documentary analysis of accreditation reports in Chapter 6; and qualitative analysis of interviews with self-assessment team members in Chapter 7.

Chapter 8 provides an overall discussion of the findings, strengths and limitations of this research and, finally, recommendations for Ministry of Health and for future research.

1.7 Role of the Researcher

When engaging in a research study the researcher is bound by certain parameters designed to ensure the validity and reliability of the results. An important element to scientifically investigate any phenomenon, whether qualitatively or quantitatively, is for the researcher to maintain objectivity. True objectivity is somewhat of a misnomer, since all humans are products of their environments, experiences, and cultural norms, which inevitably affects their worldview. This is why objectivity can be rather tricky when the research is investigating human subjects, especially if the researchers have become part of what they are studying. The researchers should also be aware of reflexivity, which entails a circular relationship whereby the researchers are aware that their very presence might be impacting on what they are studying and vice versa.

My role as a quality physician and being part of the National Accreditation Programme in Kuwait since it was first introduced in 2008 is particularly relevant to this study not only because of my clinical knowledge of accreditation, but also because I worked hand in hand with many of the teams in hospitals during the process of training and implementation of the National Accreditation Standards. This raised the potential problem of participants feeling comfortable to convey their true reflection of the intervention, including giving negative feedback. Also, my positive beliefs in accreditation were carefully considered during the process of this research. The systematic review helped to balance my optimism about accreditation into more of an inquisitive view where I was curious to investigate the programme and compare the findings across the methods in order to develop an unbiased view of the process and its impact on other healthcare professionals.

While this particular research did not involve complete immersion into the subjects' environment, the same principles of maintaining objectivity do apply. It was especially

important that any notions the researcher may have had regarding possible outcomes did not impact on how participants were asked questions. More specifically, it was important to ensure that the flexibility allowed in a semi-structured interview did not give way to leading questions. According to Russell Bernard (2011), targeted questions, such as 'Wouldn't you agree that…' can convey bias and affect the researcher's results because some participants may answer in a manner to please the investigator, rather than with their own impressions of a situation (Bernard, 2017). On the other hand, probing questions are acceptable since they are asked only to elicit more information about a specific topic without being biased. The researcher prepared the interview schedule prior to any fieldwork to help minimise using leading questions; this was done in collaboration with both supervisors, to ensure an external opinion of the interview schedule was obtained. Also during the interview the researcher made an effort to avoid any word forcing and encouraged the participants to speak freely and elaborately in answering the interview questions.

Chapter 2- State of Kuwait

2.1 Introduction

This chapter aims to profile the State of Kuwait, exploring its historical development, culture, economy, and the healthcare system.

2.2 State of Kuwait

Kuwait in English means the "little fort", and indeed, it is a small country in Asia on the shores of the Arabian Gulf. The State of Kuwait is located at the North Western side of the Arabian Gulf, with a total land area of approximately 17,818 km2. It's bordered to the south by Saudi Arabia, and shares a 195 km border with Iraq to the north and west (Alpen Capital, 2014). Al-Kazemi and Ali (2002) argue that this geographical location among strong neighbours explains the presence of large American and British armed force in Kuwait, especially after the Iraqi invasion of Kuwait on August 2nd 1990.

Kuwait is one of several oil-rich countries in the Middle East and has been ruled by the Al-Sabah family since its establishment back in the early eighteenth century. Notwithstanding its small geographical and population size, Kuwait occupies an important economic position and has strategic influence in world affairs (Al-Kazemi and Ali, 2002). This is attributed to the fact that Kuwait is a member of all the major international organisations including OPEC (Organisation of the Petroleum Exporting Countries) and the WTO (World Trade Organisation). Also, Kuwait's relationship with the United States, United Kingdom, France and Russia is quite strong. Furthermore, it is among the largest oil exporters globally, with 8% of the world's oil reserve (Stiftung, 2014).

Even though, nowadays, the State of Kuwait is considered one of the wealthiest countries with a Gross Domestic Product (GDP) reaching $114 billion in 2015 (TWB, 2017), not too long ago the entire economy depended on pearl diving and ship building (Meleis, 1979).

Citizens of Kuwait enjoy many privileges from the State, including free medical care, free education, guaranteed employment, government-supported housing, and even financial

assistance with marriage expenses. Furthermore, electricity, water, and gas are provided at a reasonable stabilized cost (Stiftung, 2014).

Kuwait democracy was first apparent in the 17th century, when the populace elected their first ruler, Sabah Bin Jaber. Kuwait initiated the first elected parliament of all Arabian Gulf countries in 1963. This specific election granted Kuwait more security economically as well as politically (Bourisly, 2009). This early political maturity is reflected in the highly respected Constitution among Kuwaitis, which is not prominent in other states of the region. Islam is the religion of Kuwait, as stated by the Constitution, and Shari'a represents the main source of legislation. However, the country in general functions by civil institutions and modern laws (Stiftung, 2014). Today, Kuwait is divided into six Governorates, or regions, to facilitate public sector service delivery and organisation.

2.3 Kuwait's rise and development

From the time of its establishment in 1716 to the beginning of the oil era in 1946, Kuwait developed slowly but steadily, depending economically on pearling, trading, and seafaring. It was a period of poverty, suffering, and hardship. Kuwait took the lead in the shipping trade due to the advantage of owning many ships as well as talented and experienced native people. An important feature in the Kuwaiti heritage was (and is) the dhow (wooden boat). It is crafted entirely by hand, and the profession is passed down through generations. The boat had a distinctive shape and was recognised as the Kuwaiti style by international sailors from a far distance (Abd-Elbary, 1993, Bourisly, 2009).

This allowed an export-import trading relationship to be established between several countries, where Kuwaitis would export their ships in return for sugar, coffee, spices, and many other goods from India and Yemen ((Bourisly, 2009). Another major craft was pearl diving, an industry that dominated between 1700 and 1950, reaching a peak around the year 1912. Pearling was a highly skilled occupation, however, in 1920 the Japanese succeeded in culturing pearls, which resulted in the collapse of this much needed trade (Al-Nakib, 2013).

Kuwait had the advantage of oil production and shipment years in advance of the other Gulf countries, which was then reflected in its development ahead of other neighbouring countries. This probably contributed to the fact that Kuwait acquired its independent political status and emerged as a state well before the States of Qatar, Oman and the United Arab Emirates (Abu‑Ayyash, 1980). With Kuwait's newfound wealth as oil revenues poured in from the first shipment of oil in 1946, there was a focus on urban development and social reform. The Government sought the expertise of western architectural firms in order to modernise Kuwait and replaced the old town with a redeveloped city centre that would predominantly reflect the commercial sector of the country (Al-Nakib, 2013). As a result of the extensive development of the city centre, the population was relocated outside the city boundaries, resulting in the emergence of new residential areas. These included new primary care centres, schools, gardens and trees, and even public libraries and theatres (Al-Nakib, 2013).

This amazing journey is beautifully described by Gardiner and Cook (1983) in their book titled, Kuwait: the making of a city, 'there was no breathing space between ancient and modern, rags and riches; from a tiny place in the sand on the edge of the Gulf, Kuwait hurtled like a missile into the high technology of the mid-twentieth century. And over the next thirty years, the new city of Kuwait, optimistic, imaginative, confident and utterly modern, was conceived, planned, built, re-planned and rebuilt. The unique creation of oil, the story of this city is astonishing'.

2.4 Kuwaiti society and culture

The population of Kuwait in 2017 was 4,437,590. Of this 1,351,955 were Kuwaitis (Public Authority for Civil Information, 2017). The high proportion of expatriates accumulated over the years started first in the 1950s with the discovery of oil needing a skilled labour force to take part in many development projects. Since Kuwait had a small population at that time, this led to significant immigration from neighbouring countries (Abu‑Ayyash, 1980) resulting in a twenty fold increase in the population between 1950 and 2013 (Stiftung, 2014). Abu‑Ayyash (1980) described the immigration movement from two perspectives. First, he explained it as immigration from neighbouring Arab countries due

to political instability, lack of freedom, and economic retardation; and second, as immigration to job opportunities, free healthcare and education, and the absence of taxes.

The Kuwaiti population is generally young, with about 11% of the population aged below 14 years; and only 3.9% aged 65 and more (**Figure 2.1**).

Figure 2.1 Population pyramid demonstrating the Kuwaiti population according to gender and age group
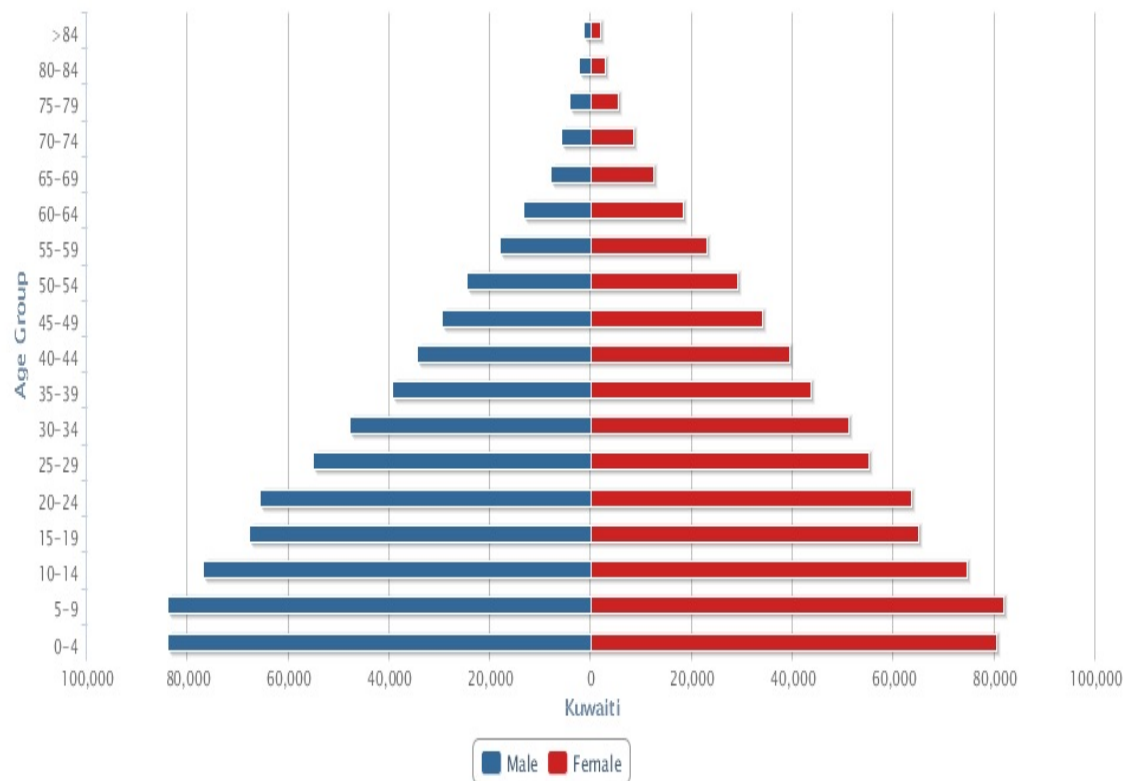
Source: (Public Authority for Civil Information, 2017)

The literacy rate in Kuwait, estimated to be 93.9%, is among the highest of the region. This is mainly a result of an extensive high-quality education system, which accommodates the student from kindergarten to a post-graduate programme, entirely free of charge and equally accessible by both genders (Meleis, 1979, Stiftung, 2014).

Culture distinguishes one group from another and is usually defined as an assembly of taken-for-granted assumptions, expectations, or rules for being in the world (Adler and Jelinek, 1986). The culture of the Kuwaiti people is rich and diverse due to a long period of

exposure to new customs and ideas, resulting in a developed sense of competition and spirit of honour and virtue, although there is also an adherence to the traditional route of authority and group bonding (Al-Kazemi and Ali, 2002).

Kuwaiti people are happy and courteous, with a strong feeling of nationalism, developed over the years from the advantages provided by the Government in education, healthcare, job allocation, housing, and other public services (Meleis, 1979). Those public rights represent important articles in the Constitution of Kuwait that was issued in 1962 by the Amir of the State of Kuwait at that time, Abdullah Al-Salim Al Sabah. In relation to health, Article 15 assures that 'The state cares for public health and for means of prevention and treatment of diseases and epidemics' (Abd-Elbary, 1993).

The public sector workforce is made up of 80% of Kuwaiti citizens, in contrast to the private sector, where few incentives are available for Kuwaitis to seek employment. To change this, the Government administered the 'Kuwaitize' plan in the private sector, stating that all companies must maintain a fixed percentage of Kuwaiti citizens in their workforce. This decree became effective in 2010 and affected mostly the banking sector, telecommunications, investment and finance, and the petrochemical division.

Kuwaitis have a lot of freedom to pursue their interests and ambitions, with men and women having equal rights as declared by the Constitution. Women's rights gained a significant victory by the introduction of women's right to vote and be elected for the parliament in 2005 (Stiftung, 2014). As a result, three women were members of the 2012 parliament out of fifty members, and two were ministers out of a total sixteen.

The Kuwaiti press is among the freest in the region and serves as a positive example of democratic journalism, although there are some limitations in reporting, in relation to religion or criticism of the ruler. There are several daily newspapers that act as a public forum for political activities, with many regular columnists. Reporters Without Borders ranked Kuwait in its 2015 World Press Freedom Index, as 90th out of 180. However, compared to other countries in the region, Kuwait is the first followed by Lebanon (98th), then Qatar (115th) (Tetreault, 1995, Stiftung, 2014).

Tetreault (1995) describes three key institutional pillars of Kuwaiti society. She identifies the mosque to be the centre of the religious life, the work place and market to be the core of the economic aspect and the 'Diwaniyya' as the vital part of its social life. The Diwaniyya existed in Kuwait way back even beyond memory, and it refers to the separate part of the house where men and their visitors gathered, and it is an indispensable part of a Kuwaiti mans' life (Bourisly, 2009). These three institutions are deeply integrated into Kuwaiti society and hold great value and power in spreading information and discussing crucial opinions, mostly political. This role is further enhanced by the multigenerational, extended family structure in Kuwait (Tetreault, 1995).

2.5 Kuwait's Economy

Kuwait's economy is mainly dependent on oil and petrochemical industries. In recent years, the country has had high income from investments as well. The oil industry accounts for most of the gross domestic product (GDP), although this makes Kuwait's economy highly susceptible to changes in global oil demand, as well as international oil market prices (TWB, 2017).

Much of the oil earnings are used to support services like healthcare, education and housing loans for Kuwaiti citizens, leading to the development of a supportive welfare state. Furthermore, precaution to the possibility of oil reserves running out, the Government has kept a yearly 10% of its revenues since 1976 (which further increased to 25% from 2012) as a special reserve fund for future generations. This fund alongside the general reserve fund was estimated to be more than $296 billion in 2011, and is managed by Kuwait Investment Authority (Stiftung, 2014).

The climate in Kuwait does not encourage agriculture, and food production is minimal accounting for less than 2% of the GDP. As a result, Kuwait is highly dependent on food imports, with the exception of fish, and around 75% of the water is either distilled from seawater or imported (EMRO, 2006, Ministry of Health, 2013b).

2.6 Health in the Eastern Mediterranean region (EMR):

The WHO Eastern Mediterranean region (EMR) comprises 21 countries, extending from North Africa to West Asia. It includes the Gulf Cooperation Council (GCC) countries of Kuwait, Bahrain, Oman, Saudi Arabia, Qatar and United Arab Emirates (UAE). In west Asia are Iraq, Yemen, Syria, Jordan, Lebanon and Palestine, as well as Afghanistan. In Africa it includes the Maghreb countries (Algeria, Libya, Morocco and Tunisia), Egypt, Somalia, Djibouti, and Sudan (Mandil et al., 2013). The EMR is thus quite heterogeneous in nature. Some countries are fortunate to have a high income due to oil revenues permitting them to establish strong healthcare systems. However, progress is uneven between the EMR countries and some have unfortunately seen their health status deteriorate due to conflicts and political instabilities. See **Table 2-1** for key health indicators for the EMR countries.

Generally speaking, citizens of countries suffering from long-term conflicts, like Afghanistan, Sudan, and Somalia, are estimated to have the lowest life expectancy in the EMR, at between 48 to 59 years. In contrast, the GCC countries have the highest estimated life expectancy of between 76 and 79 years. This pattern is reflected in other key indicators of health, for example maternal and infant mortality rates are much higher in the countries with conflict, lowest in the GCC countries. Per capita spend on health is also much higher in the GCC countries compared to the other countries of the EMR.

Table 2-1 Key health indicators for EMR countries

Country	Life expectancy at birth (Years)	Infant mortality rate Per 1000 live births	Under-5 mortality rate Per 1000 live births	Maternal mortality ratio Per 100 000 live births	Per capita total expenditure on health US $ exchange rate
Afghanistan	61	66	91	396	55
Bahrain	77	5	6	15	1067
Djibouti	62	54	65	229	137
Egypt	71	20	24	33	151
Iran	74	13	16	25	432
Iraq	70	27	32	50	305
Jordan	74	15	18	58	336
Kuwait	78	7	9	4	1507
Lebanon	80	7	8	15	631
Libya	75	11	13	9	433
Morocco	71	24	28	121	189
Oman	76	10	12	17	678
Palestine	73	18	21	45	304
Qatar	79	7	8	13	2043
Saudi Arabia	76	13	15	12	808
Somalia	54	85	137	732	…
Sudan	63	48	70	311	115
Syria	76	11	13	68	43
Tunisia	76	12	14	62	309
UAE	77	6	7	6	1569
Yemen	64	34	42	385	74

Source: (EMRO, 2015)

2.7 The Healthcare System in Kuwait

The healthcare system in Kuwait is well organised, and has expanded its delivery system in order to provide free, high-quality health services, accessible equally to all the population. It focused on building capacity among health professionals, alongside providing advanced medical technology. The system is composed of primary, secondary and tertiary levels established in the early 1970s. The Kuwaiti population pyramid (**Figure 2.1**) reflects a low mortality- high fertility country. However, the anticipated increased proportion of elderly citizens between 2000 and 2020, alongside a higher life expectancy, will pose a challenge for the health system including increased chronic disease and multi-morbidity (Shah et al., 2002).

The Ministry of Health is the primary provider of healthcare services in Kuwait as explained in more detail in Section 2.7.2. However, health services are also available through the private sector and oil company hospitals. Kuwait's healthcare market increased at a Compound Annual Growth Rate (CAGR) of 18% over the period between 2004-2009 reaching $2.3 billion in 2009, and in the Government budget of 2011-12, over $3.5 billion was allocated for the public healthcare system (Alpen Capital, 2014). The private sector is mainly pursued because people believe it provides a better quality service, which has further encouraged an increase in the number of private hospitals in Kuwait to twelve, with a total bed capacity of 1041(Ministry of Health, 2013a). In the public sector, there are 15 Government hospitals; of which six are general hospitals and nine are specialist centres (see Section 2.7.3).

In 2012, there were 909 doctors and 2593 nurses employed in the private sector. On the other hand, the number of physicians working for the Ministry of Health was estimated to be 6472; of these 3869 were Non-Kuwaitis. There were also 16500 nurses working for the public sector, although only 7.5% are Kuwaitis (Ministry of Health, 2013a). Outpatient visits in the private hospitals reached 2,209,973 in 2012, with obstetric and gynaecology visits accounting for18.8% of these visits. This was similar to the public hospitals, where the total number of outpatient visits in the same year was 2,495,121, although the main specialty visited there was orthopaedics (11.1%).

In the public healthcare system each residential area is served by a primary care centre, with six Governmental hospitals located in five of the six governorates, with two located in the Capital. The specialised hospitals, on the other hand, are situated in the Capital governorate and provide services to patients regardless to their area of residence as long as they get a referral letter from either their primary care centre or general hospital (Burney et al., 1999).

2.7.1 Historical Development

The Ministry of Health, founded in 1936, is one of the largest Ministries in Kuwait. However, the history of healthcare in Kuwait dates back to 1910. With the help of religious missionaries, a hospital for men was established in 1911 and another one for women later in 1919 (EMRO, 2006, Kronfol, 2012a). In the late 1940's, when the Government began

receiving oil revenues, a national, social and economic development plan was established, with healthcare among its priorities (Abd-Elbary, 1993). Real health development started with the opening of the Amiri hospital (one of the largest general hospitals in Kuwait) in 1949. A comprehensive healthcare programme was also established providing free services to the citizens of Kuwait (EMRO, 2006).

The Kuwaiti experience in healthcare was expanded to offer structural support to neighbouring countries by helping to build health centres and hospitals. The Secretariat of the Gulf Ministers of Health, which was established in 1975, further enhanced the regional cooperation in the health sector through the combined purchase of medicine and medical supplies, which meant best quality medicines at discount prices. This collaborative approach was extended to education and training. In 1978, the Arab Board for Medical Specialisations was established in Syria. In addition, a Masters of Epidemiology programme commenced in 1983 at Ain Shams University in Egypt (Kronfol, 2012a).

2.7.2 Ministry of Health Organisational Structure

The Ministry of Health has a central organisational structure, which oversees the strategic direction of healthcare in Kuwait, with organisation and delivery devolved to regional level. The central organisational structure has an extensive remit. The Minister of Health chairs the Ministry, assisted by the Undersecretary. There are twelve Assistant Under-Secretaries, who supervise many central directorates, as illustrated in **Figure 2.2**. Even though the roles and functions of each directorate are clearly stated in ministerial decrees, some overlap and duplication is evident between them. The Ministry relies on paper-based communication across departments and with the regions in all official correspondence despite an initiative to increase the degree of computerisation.

Figure 2.2 Organisational chart of the Ministry of Health in Kuwait

Kuwait is divided into six health regions in accordance with the six governorates as illustrated in **Figure 2-3**, which operate as independent decentralized administrative units. Each health region is responsible for implementing the action plan of the Ministry. Furthermore, it is the health region's responsibility to provide different levels and specialties of healthcare for the population of the region, and to provide training programmes for it's medical, technical and administrative staff (EMRO, 2006).

Figure 2-3 Governorates of Kuwait
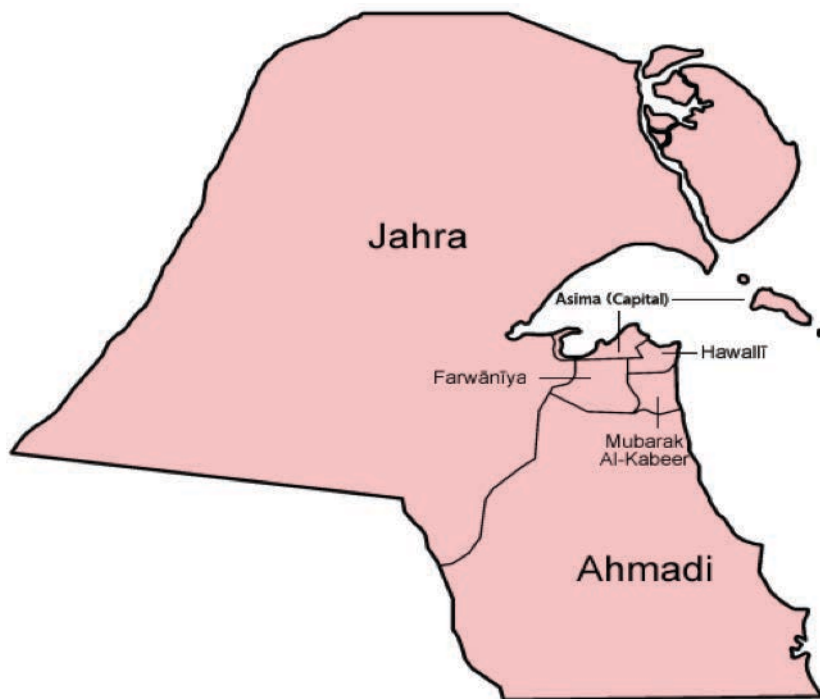
The population served ranges from 254,999 in Mubarak Al-Kabeer region to 1,169,312 in Al Farwaniyah region as shown in **Table 2-2**.

Health region offices are responsible for general hospitals, several primary care centres, and specialised clinics. The office is headed by a regional director who oversees the health

services technically, administratively and financially in accordance with the duties assigned to him by the ministerial decree. In addition, the regional office is responsible for the private sector within the territory (EMRO, 2006).

Table 2-2 Population by Nationality and Governorate and by Gender

Governorate		Total		Kuwaiti		Non-Kuwaiti	
Capital		568,567		255,540		313,027	
Ahmadi		959,009		286,707		672,302	
Jahra		540,910		185,819		355,091	
Al Farwaniyah		1,169,312		236,433		932,879	
Mubarak Al-Kabeer		254,999		156,451		98,548	
Hawalli		939,792		230,759		709,033	
Male	Female	Male	Female	Male	Female	Male	Female
		2,773,724	1,663,866	662,907	689,048	2,110,817	974,818

Source: (Public Authority for Civil Information, 2017)

2.7.3 Services provided by the Ministry of Health

Curative, preventive, and rehabilitative services are provided through primary healthcare centres located in residential areas. Secondary healthcare services, providing in-patient as well as outpatient services, are provided for the population by six general hospitals. Specialty hospitals providing tertiary healthcare cover other medical specialties (Burney et al., 1999); this is discussed in more detail later in this section. In 2012, the number of physicians working in the Ministry of Health was estimated to be 6472; of those 60% were non-Kuwaitis. In addition, a total of 16500 nurses were employed, of whom only 7.5% were Kuwaitis. The number of physicians per thousand population was 2.7 (Ministry of Health, 2013a).

The primary care centres are considered the gatekeeper to hospital-based health services, with 94 centres spread over the country, offering family medicine, child care, maternity care, dentistry, diabetic care, preventive medical care, nursing and pharmaceutical services. Some larger primary care centres provide more extensive services including dermatology, asthma clinic, dietician clinics, laboratory services, and diagnostic imaging.

Al Farwaniyah health region serves the largest percentage of the population as demonstrated in **Table 2-2**. In 2012, the primary care centres in Kuwait recorded a total of 18.1 million patient visits, of which 24% were in Al Farwaniyah health region. Of these visits, 65.2% were for Kuwaitis and 34.8% were other nationalities (Ministry of Health, 2013a). In the late 1990's, a small nominal fee was applied to expatriates in return for health services (Burney et al., 1999). However, in 2011 health insurance became compulsory for all non-Kuwaitis (Alpen Capital, 2014). The primary care centres refer patients to hospitals if further specialised care is needed. Al Farwaniyah hospital has the biggest number of beds (857) followed by Al Adan (806) and Al Jahra hospital (756) (Ministry of Health, 2013a). Hospitals consume around 40%-70% of the health budget and employ half the physicians and two-thirds of the nursing staff.

The Kuwait World Survey conducted in 2013 in collaboration with the WHO and the executive board of the Gulf Cooperation Council Ministers of Health, provided vital information about healthcare use and health related behaviour. About 79.2% of Kuwaiti respondents stated that they had received outpatient care in the last three years while 24.6% reported needing inpatient care. In the case of Non-Kuwaiti respondents, 70.5% reported the use of outpatient care, while 20% stated using inpatient care (Ministry of Health, 2013b).

The third level of care provided by the Ministry of Health is through nine specialised centres. These include a Maternity hospital, Psychiatric hospital, Chest Diseases hospital, Orthopaedic hospital, Physical Medicine and Rehabilitation hospital, Infectious Diseases hospital, as well as the Kuwait Centre for Cancer Control, the Kuwait Centre for Allergic Diseases, and a Neurology Diseases hospital. In 2012, the total number of beds in the specialised hospitals was reported to be 2555. In the psychiatric hospital there were 764 beds, followed by the maternity hospital, with 431beds. More details illustrated in **Table 2-3**.

Table 2-3 Selected health services and manpower data in the MOH Specialty Hospital for year 2012

Hospital	Beds	Outpatients visits	Emergency visits	Doctors
Orthopaedic	300	183580	148359	219
Physical Medicine	75	39951	0	41
Maternity	431	116597	16577	238
Chest Diseases	329	91002	0	160
Infectious Diseases	206	11949	20629	39
Psychiatry	764	56116	5951	85
Neurology Diseases	363	274018	122239	154
Kuwait Centre for Cancer Control	197	63262	0	136
Kuwait Centre for allergic disease	36	98554	0	35

Source: (Ministry of Health, 2013a)

The main causes of hospital admissions in 2012 were ischemic heart disease (4.6%), pneumonia (2.9%), chronic tonsillitis (2.6%) and infectious diarrhoea and gastroenteritis (2.5%) (Ministry of Health, 2013a).

2.7.4 Health status and demographics

Statistics indicate that in Kuwait, life expectancy at birth in 2015 was 78 years for both males and females (EMRO, 2015); this is a 20 year increase from 1960, and is higher than the median global estimate of 70 years (Mandil et al., 2013).

In addition, the incidence of communicable diseases decreased substantially; instead the burden of disease has shifted towards non-communicable diseases (Abdul Rahim et al., 2014). Rising incomes and urbanization are leading to an increased prevalence of life-style diseases such as diabetes, cardiovascular and cancer cases. For example, Kuwait is ranked number eight in the prevalence of diabetes globally. Ischaemic heart disease and road injuries were other major causes of death in 2015 as demonstrated in **Table 2-4**.

Table 2-4 2015 Ranking of the most cases of deaths in Kuwait

Rank	Disease
1	Ischaemic heart disease
2	Road injuries
3	Cerebrovascular disease
4	Congenital defects
5	Lower respiratory infection
6	Alzheimer disease
7	Diabetes
8	Chronic kidney disease
9	Hypertensive heart disease
10	Neonatal preterm birth

Source:(Institute for Health Metrics and Evaluation, 2015)

While Mandil et al. (2013) describe injuries to be one of the main reasons for both mortality and morbidity in the GCC states, along with road traffic accidents, non-communicable diseases such as cardiovascular disease and cancer are predominant (Abdul Rahim et al., 2014). Health-related risk factors such as smoking, physical inactivity and obesity are also major problems in Kuwait amongst adults (Abdul Rahim et al., 2014). For example, the age-standardised prevalence for smoking was 17.0% (males: 31.2%; females: 2.8%); for physical inactivity was 64.5% (males: 56.9%; females: 72.1%); and for obesity was 42.8% (males: 37.2%; females: 52.4%). These figures are the highest in the GCC countries and the EMR.

These changing patterns of disease will inevitably impose new demands on the organisation and management of the healthcare system and will be the key drivers for future planning of health policy.

2.7.5 Challenges of the healthcare system

The Kuwait healthcare sector faces many challenges related to infrastructure, financing, human resources, and the burden of non-communicable diseases. Although there has been much effort put towards establishing a strong infrastructure, and even with the fast growing pace of the healthcare sector, there is a delay compared to developed countries regarding hospital beds, advanced laboratories, and clinics, creating a demand – supply

imbalance (Alpen Capital, 2014). The number of beds in 2012 according to the statistics was 6714, giving the number of beds per thousand population at around 2.2, which is low compared to the world average of 3.0 beds per 1000 population (TWB, 2017).

The financial infrastructure is a crucial element in any health system. It is very challenging to be able to establish cost-effective and equitable approaches, which will result in good health outcome, stable financial status, and consumer satisfaction. While Government health expenditure accounts for 85.8% of the total health spending in 2014 (TWB, 2017), there are challenges especially with the high prevalence of obesity, cancer, and diabetes, in addition to a significant lack of preventive initiatives. To address this matter the Government has considered reforms such as increasing private sector participation and implementing health insurance for Kuwaiti nationals, which will be discussed in the following section.

Shortages in healthcare employees represent another challenge to the MOH. In Kuwait, the average number of doctors per 1000 population is 2.7, while in developed countries the average is 3.4 doctors per 1000 population (Institute for Health Metrics and Evaluation, 2015). There is also a high dependency on expatriates in the medical field in general. The percentage of Kuwaiti physicians decreased in the Governmental healthcare system from 40.7% in 2008 to 39.8% in 2012. In nursing, the situation is even worse, although the percentage of Kuwaitis among nurses slightly increased from 7.4% in 2008 to 7.5% in 2012 (Ministry of Health, 2013a).

2.7.6 Health regulatory reforms

In view of these challenges, the necessity of health reform and policy regulation has arisen. One of the key initiatives proposed by the Government was the establishment of the Public Health Authority, responsible for all medical practice licensing, private certification, healthcare accreditation, insurance services, treatment abroad, and information technology. The proposal was presented to the Kuwaiti Parliament in 2010. However, there has been a substantial delay in enacting this law, mainly attributed to the political instability Kuwait has experienced in the past few years, which resulted in Parliament's dissolution in 2011 and again in 2012. The political system has stabilized since 2012, leading to better

performance of the Government, and the Public Health Authority is again a priority in it's agenda (Stiftung, 2014).

Another health reform strategy was the Public-Private Partnership project, which proposes building and operating three new hospitals and fifteen primary care clinics, as well as providing insurance to expatriates. As a result of cooperation between the Government and private sectors in healthcare in Kuwait, a retiree insurance system was signed and launched in 2016, with around 107,000 retired Kuwaiti citizens offered yearly coverage up to 17,000 Kuwaiti Dinars each (equivalent to 42,000 British Pounds).

On a wider scale and as a reflection of the cooperation among the GCC states, it was also proposed by the Council to integrate the medical records of all GCC nationals into smart ID cards. This smart ID card is already in action and functions as a passport when travelling among the GCC states. This initiative will help eliminate barriers to accessing medical attention when and wherever needed by the nationals across the GCC states (Alpen Capital, 2014).

The final initiative, and most relevant to this thesis, was the affiliation of the Kuwaiti health system with an international body, Accreditation Canada, to establish and support the National Accreditation Programme (NAP) for healthcare services. Two agreements were signed between the MOH and Accreditation Canada, the first contract lasted two years starting from 2008, and the second contract runs through a seven-year period from 2011. The primary objective of this collaboration is to evaluate and improve the quality and safety of the healthcare services for both the provider and recipients. This will be discussed in greater detail in Chapter 3.

2.8 Summary

This Chapter has provided an overview of the State of Kuwait, describing its development over the years, including cultural and economic aspects. This Chapter also explained the healthcare system in Kuwait, which is intended to facilitate a better understanding of the issues related to this study.

Chapter 3- Accreditation

3.1 Introduction

This chapter aims to introduce the concept of healthcare accreditation, and it is divided into two main sections. The first part is concerned with the background and developmental history of accreditation in the healthcare sector, its definition, constituent parts and general evidence about its impact. The second part provides a description of the National Accreditation Programme (NAP) in Kuwait, concentrating on the establishment of the programme, its features and the process of implementation.

A range of literature and sources were used to inform this chapter. First, papers identified during the systematic review (reported in Chapter 5) that were broadly relevant to the overall thesis, but did not meet the inclusion criteria of the review itself, were used in this chapter. The work of key researchers in the area, such as Braithwaite, Greenfield and Hinchcliff in Australia, and El-Jardali. Alkhenizan and Shaw in the Middle East, was also reviewed. Second, a range of relevant websites were identified and searched. These included the Ministry of Health, Kuwait; the World Health Organisation; the Joint Commission and its international site, the Joint Commission International; and Accreditation Canada International. Finally, my own knowledge and expertise from working in the field of accreditation in Kuwait was also helpful.

3.2 History of accreditation

Accreditation started in the early twentieth century and has developed steadily, extending its scope and becoming increasingly prominent in international healthcare (Heidemann, 2000, Rawlins, 2001). It emerged in the USA as an approach to developing and supporting the hospital environment for clinical practice and training. In 1917 the American College of Surgeons (ACS) detected a defect in the records system of many hospitals, which led to the introduction of the Hospital Standardisation Programme comprising core and minimum requirements of data recording (Scrivens, 1995, McIntyre et al., 2001). In 1951 the process evolved as the ACS along with other professional bodies combined to form the Joint Commission on Accreditation of Hospitals. Later expansion of the organisation's scope

and remit, including the development of accreditation in primary care and other healthcare sectors (for example, home care), led to the organisation being renamed in 1986 to the Joint Commission on the Accreditation of Healthcare Organisations (JCAHO). The trend of quality-focused accreditation encouraged other countries to develop their systems. For example, Canada established Accreditation Canada in 1958, and Australia the Australian Council on Health Care Standards in 1974. It wasn't until the 1980s that accreditation organisations extended to Europe, in particular the UK, Spain, Portugal, The Netherlands, Finland, Italy and France (Shaw and Brooks, 1991, Shaw, 2000).

At first the primary focus of the accreditation systems was hospital care. However, over time this scope expanded to include other services like the ambulatory care facilities, nursing homes, rehabilitation care and primary care (Al-Assaf and Akgun, 2009). Furthermore, it became a widespread method internationally and had been adopted by many health systems around the globe (Braithwaite et al., 2006). This has been supported by both the JCAHO and Accreditation Canada, both of whom have developed international accreditation organisations (Joint Commission International and Accreditation Canada International).

Another key organisation in international healthcare accreditation is the International Society for Quality in Health Care (ISQua), which looks after the development of the accreditation bodies and implementation of standards. Formed in 1985, ISQua has its own set of standards and procedures and conducts an International Accreditation Programme (IAP) that certifies the standards of accreditation bodies.

Thus, there are many national bodies for the regulation of standards and promotion of different methodologies important for improving the quality and services and many seek consultation from ISQua for management support and performance measurement (Benedicte Juul et al., 2005). What is, arguably, more important is to have a clear definition and understanding of the term 'accreditation' and its purpose.

3.3 Definition and purpose

Accreditation is a process used by the healthcare sector to carefully evaluate the performance of hospitals and other healthcare institutions and sectors in order to attain and maintain pre-defined standards. It is regarded as a comprehensive, transparent, overarching process that offers education and training alongside the monitoring and evaluation aspects (Bukonda et al., 2003).

There are varying definitions in the literature for accreditation reflecting its approach, scope, and purpose. For Pomey et al. (2005), accreditation is 'a means of publicly recognising that a healthcare organisation meets predetermined national standards' and that 'recognition of the accreditation process is based on an external peer assessment of how well an organisation complies with standards and how well it performs'. Accreditation is thus viewed as a tool for change that affects all areas of the organisation and all actors. Accreditation can permit Governments or national bodies to apply and monitor changes in healthcare settings (Pomey et al., 2004, Fortes et al., 2011).

Scrivens (1997a) states that an ideal model of accreditation 'would have the characteristics of voluntary participation, standards against which compliance is assessed, assessors who are external to and independent of the participating healthcare organisation, and a single measure which denotes the degree of compliance with the standards'. The International Society of Quality in Healthcare defines accreditation as 'a self-assessment and external peer review used by healthcare organisations to accurately assess their level of performance in relation to established standards, and to implement ways to continuously improve the healthcare system' (ISQUA, 1998).

Thus, key features of accreditation include nationally agreed standards and a process of external review to determine how well a healthcare organisation is meeting those standards. However, deviation from this ideal model can be expected depending on the healthcare system policy and structure, and recent direction in regulating accreditation programmes involves national Governments as main regulators (Shaw, 2015). Another key issue is whether accreditation should be mandatory or voluntary, with different countries taking different approaches. For example, while hospital accreditation remains voluntary in

Canada and the UK, it is compulsory in France (Pomey et al., 2005, Fortes et al., 2011). However, arguments have been made that mandatory accreditation makes the hospital focus their services and resources towards meeting the standards laid out in the accreditation manual, rather than service delivery and the wellbeing of patients (Pomey et al., 2005). Additionally, Shaw (2003), in his evaluation of accreditation, suggested that most organisations change their mode of operation only during the process of implementing accreditation and during the on-site survey, but this way of working is quickly lost again once accreditation has been achieved.

Another component of the accreditation process is teamwork, as is evident in the World Health Organisation (2003) description 'Accreditation is usually performed by a multidisciplinary team of health professionals and is assessed against published standards for the environment in which, clinical care is delivered'.

Despite different approaches to the process of accreditation, there is general agreement that one of the main outcomes should be the improvement of care and service delivery, as is clear in the mission statement of the Joint Commission: 'to continuously improve the safety and quality of care provided to the public through the provision of healthcare accreditation and related services that support performance improvement in healthcare' (Greenfield and Braithwaite, 2008).

Accreditation can thus have a range of objectives, with the process of implementing accreditation likely to be as valuable as the outcome of the intervention itself because it is believed to influence organisations in a number of ways, as outlined in **Box 3-1**. (Hurst, 1997, EMRO, 2003, Al-Assaf and Akgun, 2009, Shaw et al., 2013):

Box 3-1 Impact of accreditation on healthcare organisations

- Stimulates continuous quality improvement efforts

- Influences informed decision- making

- Increases the organisations' efficiency and reduces costs

- Facilitates staff training and offers an educational tool

- Provides an effective evaluation tool

- Standardises the healthcare services

- Fosters teamwork and motivation among staff

Thus, while there are different definitions of accreditation, key components are: measuring practice to established standards; using professional surveyors to carry out this evaluation; producing a survey report for the organisation; and providing accreditation recognition or status (Montagu, 2003). In order to achieve all of this, there is a need for effective team working within the organisation applying for accreditation. Taking account of these components, the accreditation definition thought to be most suitable to describe accreditation in Kuwait was the ISQUA definition, namely:

'[Accreditation is] a self-assessment and external peer review used by healthcare organisations to accurately assess their level of performance in relation to established standards, and to implement ways to continuously improve the healthcare system' (ISQUA, 1998).

3.4 Accreditation research methodologies in the literature

Øvretveit and Gustafson (2002) investigated and analysed a range of approaches used in evaluating different quality improvement programmes including accreditation. In doing so, they highlighted that such programmes are complex in nature, and in addition are themselves implemented into complex settings. In addition, such quality improvement programmes can run for a long period of time and yield both short and long-term effects. As a result, identifying effectiveness and attributing that to the quality improvement programme can be problematic (Øvretveit and Gustafson, 2003, Marshall et al., 2013).

Ovretveit and Gustafson suggested a number of research methods that have been used to evaluate quality improvement initiatives with a certain degree of success (Øvretveit and

Gustafson, 2002, Øvretveit and Gustafson, 2003). They described descriptive case designs, audit, and retrospective evaluations as three approaches, which are relatively easy to conduct, but with the limitation of not being able to predict the outcome of a certain quality programme. On the other hand, prospective and comparative designs using a 'theory testing' approach were considered more informative about the relationship between cause and effect while reducing the possibility of another external influences.

Braithwaite et al. (2006) suggested a prospective, multi-method, multi-disciplinary, multi-level, collaborative approach for researching health sector accreditation. The design they presented was complex and interrelated, employing both quantitative and qualitative methodologies, due to the multi-dimensional nature of healthcare performance. Again, however, a limitation is attributing causality of healthcare improvement to the accreditation programme.

The paper by Daucourt and Michel (2003) examined the most frequent areas of improvement identified in the first 100 accredited hospitals in France. For this, they adopted a quantitative approach, analysing the accreditation reports. So again, although no clear link could be attributed to the accreditation process and outcome, this work did find that even when accreditation status was granted, all hospitals received recommendations for improvements. In addition, there was a trend towards larger hospitals receiving more serious recommendations from the French Accrediting College.

Different authors have measured the impact of accreditation programmes in a variety of ways and many have used a mixed method approach (Hurst, 1997, Scrivens, 1997a, Pomey et al., 2004, Paccioni et al., 2008, Jaafaripooyan, 2014, Lanteigne and Bouchard, 2016). This approach allows the qualitative aspect of the methodology to provide a better understanding of the implementation of accreditation in terms of its impact on staff and the impact of the setting, while the quantitative aspect provides data and allows the results to be generalized (Miles et al., 2013).

Other studies have employed only qualitative approaches in examining the performance of healthcare accreditation programmes or focus on different aspects of the programmes (Bukonda et al., 2003, Walker and Johnson, 2009, Melo, 2016). For example, Pomey et al.

(2010) adopted a case study design and collected data through documentary analysis, interviews, and focus groups. They justified this multiple method data collection as addressing both the complex intervention and generating an understanding of contextual aspects in the association between accreditation and impact on quality.

3.5 Professional views about healthcare accreditation

Professional background and position within an organisation are likely to be important, and managers have suggested that the main criterion for assessing the effectiveness of an accreditation system is the satisfaction of the staff with the process (Scrivens, 1997a).

The accreditation process requires much work from the healthcare organisation. Therefore, staff are at the centre of the process, and their full cooperation, involvement and engagement will impact on the implementation and determine its success. Accreditation led to a variety of reactions among healthcare professionals. While it was perceived as an important stage in the hospitals' evolution (Pomey et al., 2004), accreditation was often experienced as bureaucratic programme (Greenfield and Braithwaite, 2008, Paccioni et al., 2008). However, Pomey et al. (2004) demonstrated that while the accreditation process was seen as bureaucratic due to the commitment to attend meetings and complete the standards manual, it was also viewed by hospital staff as participatory and consensual owing to the opportunity to speak ones' mind freely regardless of the position one had in the organisation.

Greenfield and Braithwaite (2008) conducted a review of the accreditation literature and identified 66 articles from a range of international settings. They found some articles which demonstrated the support and agreement of the health professionals involved toward accreditation, while on the other hand other studies showed that professionals were critical and labelled the process as bureaucratic and time consuming. One argument Greenfield and Braithwaite (2008) presented to explain this contradiction was that different professional groups might have different perceptions towards accreditation. Paccioni et al. (2008) also explained these opposing views of accreditation as bureaucratic or not, depending on the degree of involvement of the staff in the preparation phase, suggesting that the less involved staff were, the more they perceived the process as bureaucratic.

Many staff also viewed the process to be highly demanding, stretching them beyond their duty and daily work (Greenfield et al., 2011). Employees reported being forced to work overtime, or even take the work home with them just to be able to accomplish the tasks required by the standards. Additionally, physicians displayed a sceptical view towards the accreditation process. According to them, they answered to their patients, caregivers, peers and the families of their patients, and not to any evaluation agency or association (Steiner et al., 1995, Alkhenizan and Shaw, 2012). This clearly suggests that such a mindset would reduce the willingness of staff to engage with the accreditation process.

When 299 administrators of hospitals in rural areas of the USA were asked about the reasons they did not participate in accreditation, most reported that, in their opinion, the implementation of accreditation brought no significant changes in accredited hospitals, and that it was a waste of resources, money, and quality time of the staff (Brasure et al., 2000). In contrast, in a study in India, 97 hospitals owners were interviewed and all were in favour of introducing accreditation programmes. The interest of stakeholders implies how accreditation is seen as a tool for marketing and attraction of the population. Nevertheless, they also reported that the biggest barrier to implementation was financial (Nandraj et al., 2001).

One study conducted in a teaching hospital in Australia reported the views of senior staff and managers on accreditation. They were less positive than in the Indian study, saying that the programme offered little impact on patient care as compared to the resources utilised in the implementation process (Fairbrother and Gleeson, 2000). Another study in Thailand explored the barriers in implementing hospital accreditation standards from professionals' perspective and identified five major issues, which were: having enough human resources; information management; engaging employees to participate; needing a sufficient budget; and the need for multidisciplinary care (Pongpirul et al., 2006).

These studies suggest that while physicians seem to have a negative attitude towards accreditation citing the demanding nature of the process, managers of health facilities are

in full support of the process since they see it as a way to assure quality in healthcare services (Alkhenizan and Shaw, 2012).

3.6 Accreditation and organisational change

Accreditation can lead to widespread organisation change. For example, it has been suggested by Ouchi (1979) that the employees involved in the accreditation scheme can influence quality management in the organisational culture through organisational standards, values, expectations and beliefs. Organisational change aims at improving services by, though not exclusively, creating a safe environment, establishing and organising the patient records and archiving (Daucourt and Michel, 2003), and creating a well-managed reporting system. Other impacts on the organisation might include improving communication (Pomey et al., 2004) and ensuring uniformity in the standard of care delivered (Scrivens, 1997a). A three year pilot scheme monitoring accreditation in the south west of England suggested the benefits gained by the organisation after the survey process to include team building, improvement of data systems, greater networking between managers, and review of operational policies (Shaw and Collins, 1995).

(Hurst, 1997) evaluated the nature and value of small and community hospital accreditation by studying the Trent Small Hospital Accreditation Scheme (TSHAS), using a mixed qualitative and quantitative method approach. The results of the study identified organisational change as an important driver because it networked community hospital and staff, spread good practice and involved staff at all levels.

Pomey et al. (2004) showed that accreditation implementation created change in individual departments as well as across hospitals. This result was obtained from a longitudinal explanatory single case study using qualitative and quantitative methods over a six-year period, an approach which is costly and time consuming. The changes perceived included improving patient management, adopting new values by placing the patient and family at the heart of all processes, and like the findings in Shaw and Collins (1995) and Hurst (1997) studies, developing networks with other partners in the healthcare system.

A quantitative interventional before-after study analysed data from 51 sites participating in an RCT in Copenhagen that underwent international accreditation as well as participating in the Diabetic Postoperative Morbidity and Mortality Trial (DIPOM trial). The authors identified a 28% increase in the availability and quality of clinical guidelines (Benedicte Juul et al., 2005). Two limitations were demonstrated by the authors that might weaken the findings of the research; one is that only an associative relationship could be established between the DIPOM Trial and/or the accreditation process and the findings. Another limitation was that only the dissemination and quality of the guidelines was studied and not how the guidelines were implemented.

A multiple-case longitudinal study was conducted over a period of 24 months and data was collected by using a group interview, 14 semi-structured interviews, internal documents, non-participant observations and a questionnaire distributed at the beginning and at the end of the study (Paccioni et al., 2008). Some findings complement the change in organisation due to the accreditation process in the way that all the employees were encouraged to participate in the development of quality objectives in their departments, furthermore tools were developed to measure client satisfaction, and procedures were optimized in order to address user complaints. Also a quality improvement team was formed in order to encourage staff to look for opportunities for improvements based on quality problems they encounter.

Greenfield and Braithwaite (2008) collected data by a systematic review of major health bibliographic databases, consultation with accreditation agencies and the snowballing technique, which yielded 66 documents meeting the search criteria. Findings regarding organisational change were reported particularly in six areas: administration and management, medical staff organisation, review systems, organisation of nursing services, physical environment and safety, and finally, hospital role definition and planning.

The following sections will introduce the National Accreditation Programme in Kuwait, illustrating its development over the years, with the technical support and guidance of Accreditation Canada.

3.7 National Accreditation Programme (NAP) in Kuwait

Accreditation has been welcomed with much keenness internationally (Scrivens, 1998, Shaw, 2003). Governments, users, professionals, managers, and insurers are hastening to put in place new methods to guarantee public liability, transparency, self-regulation, quality development, and cost effectiveness (Shaw, 2001). The World Health Organisation Regional Office for the Eastern Mediterranean (EMRO) stressed the importance of establishing national systems to support healthcare accreditation in the Middle East (EMRO, 2003).

Hospital accreditation emerged in Kuwait as a Government initiative. It was one of the first countries in the Middle East to begin laying the groundwork in accreditation, preceded only by Lebanon (El-Jardali, 2006, Kronfol, 2012b). Accreditation was regarded as an important initiative for healthcare in Kuwait because it aimed to accomplish the following:

- Provide a comprehensive approach to quality and patient safety.
- Ensure adherence to international best practice.
- Demonstrate commitment to quality, accountability, and increased credibility of the healthcare organisations.
- Strengthen interdisciplinary team effectiveness, contributing to better patient outcome.
- Provide on going self-assessment of performance against defined standards.
- Decrease variance in practice between healthcare providers.

The stages of development of the NAP in Kuwait are explained in the following sections.

3.7.1 The beginning (2001-2006)

Healthcare accreditation in Kuwait was first introduced in October 2001, by establishing the Quality and Accreditation Directorate (Ministerial Decree 358/2001). This initial phase extended for six years and consisted of five primary objectives: create an organisational structure for the programme, prepare the accreditation documents, recruit and train surveyors, develop awareness programmes for healthcare providers and the public, and

implement the basic requirements of accreditation in hospitals. During this phase, the aim was not to evaluate the quality of the service, but to ensure that the hospitals were meeting the basic requirement of the service, such as developing operational policies, structural facilities and a general awareness of the accreditation programme.

1- Establishing an organisational structure for the programme:

The Accreditation Higher Committee is the highest authority in the NAP, as demonstrated in **Figure 3.1** and was established in 2003 (Ministerial Decree 145/2003). The Committee was further amended in 2006 and 2009 by the Ministerial Decrees 136/2006, and 303/2009 respectively. It is chaired by the Undersecretary of the MOH and represented by 10 members.

Figure 3.1 The organisational structure of the NAP

The mission of the committee was to prepare an overall view of the accreditation programme for hospitals, including a draft for the basic Accreditation Standards.

The second level is the Quality and Accreditation Directorate, which is responsible for all executive actions related to accreditation in Kuwait. The accreditation department is divided into two sections, hospital accreditation, and primary healthcare accreditation. The Directorate responsibility towards accreditation is summarised in the following points: prepare the accreditation manuals; process the survey application forms; follow up on the progress of accreditation programme implementation; coordinate the survey activities for the hospitals; execute all recommendations from the higher committee; prepare and implement the training programmes for the surveyors and the accreditation coordinators.

The third level is the Quality and Accreditation Office in the hospitals, which is composed of one quality physician and between two to four nursing staff. Each hospital has its own Office, and its objectives were mainly to increase the accreditation awareness among healthcare providers and follow up the implementation of the basic requirements by the departments.

2- Prepare the accreditation documents:
Developing the formal documents required for accreditation is an initial step in the journey of accreditation. The Standards draft was developed by reviewing international accreditation standards and also by referring to the ministerial decrees. The draft was then revised by the health region directors, hospital directors, central directorates and the specialty boards. Modifications were carried out based on their feedback, and the final version of the 'Basic Requirement for Accreditation Preparation' manual was completed. Other necessary documents were also written like the Guideline manual for the surveyors and Application forms.

3- Recruit and train surveyors:
66 candidates were recruited, from different specialties in the Kuwait hospital system (for example physicians, dentists, pharmacists, physiotherapists, and nurses). The training programme was conducted in affiliation with Oklahoma University at that time. By the end of the training programme 33 surveyors were certified by the Ministry of Health.

4- Develop awareness programmes for healthcare providers and for the public:

The Quality and Accreditation Directorate prepared the awareness programme. The material was then introduced to the hospitals through the quality physicians allocated there. The public, however, was reached mainly through mass media.

5-Implement the basic requirement of accreditation in hospitals:

This was the final stage of the first phase of the programme, where a total of 15 hospitals carried out the self-assessment process and completed the application forms to conduct the survey. The basic requirements were about the organisational structure, human resources, and key documents. However, due to the time constraints within the programme, only 12 hospitals were surveyed, and they each received an evaluation report.

3.7.2 First agreement with Accreditation Canada (2008-2010)

The beginning of the National Accreditation Programme (NAP) in Kuwait was basic and low scale. Nevertheless, the programme became more extensive, gained momentum and rose to international standards starting from 2008 through a partnership approach between the Government and a private organisation, by signing the first contract with Accreditation Canada for two years (Ministry of Health, 2008). Accreditation Canada (formerly known as The Canadian Council on Health Services Accreditation-CCHSA) is a national, non-profit, independent organisation created in 1958 (Touati and Pomey, 2009). It is one of the best-known international consultation bodies with the knowledge and experience necessary to support the requirements of the National Accreditation Programme. The agreement sought to deliver two objectives: first, the development of customized standards specifically for Kuwait; and second, the recruitment and training of accreditation surveyors (Ministry of Health, 2008).

1) Development of Standards:

Standards, covering 12 domains, were developed for hospitals under the guidance of Kuwait MOH Advisory Committee. Healthcare standards are defined as 'statements that define performance expectations and /or structures and processes that must be in place for a hospital to provide safe, quality care, treatment, and services' (Vallejo et al., 2011). The establishment of an Advisory Committee provided vital input and guidance towards the

development of hospital standards, paying attention to the existing healthcare structure, laws, and legislations. Some standards needed adjustments according to the local culture in Kuwait, like for example separate male/female sections in some specialities like interventional radiology and physiotherapy. Such local adaptation is supported in the literature, as the more relevant the standards are to an individual system and culture the more likely they are to be implemented (Hinchcliff et al., 2013). The 12 domains are categorised as follows,

- Patient Care Standards, which include: Emergency Service, Maternal/Child Care, Medical Care, Specialised/Intensive Care, and Surgical Care.
- Clinical Support Service Standards, which are: Diagnostic Imaging Services, Laboratory Services, and Pharmacy Services.
- Non-Clinical Support Service Standards, which include: Environment, Information Management, and Human Resources.
- Leadership, which covers both the governance and management aspects of the leadership.

The second phase Standards differed from the first phase Standards in two ways: first, they were more service oriented than departmental oriented. Second, they are multidisciplinary, more elaborate and cover much more than just the basic requirements of the health service. For each of the domains mentioned above, a self-assessment team was formed. This team was responsible for implementing the Standards, providing the required documents and finally completing the self –assessment form by rating each Standard and identifying the strengths and weaknesses for each criterion. Again, as in the first phase, a quality physician was assigned in each hospital. Moreover, two accreditation coordinators were nominated from the hospital employees to form a team.

Each Standard was composed of the Standard itself, followed by criteria that appear below each Standard and describes the specific steps to be taken or activities to be done to comply with that standard. A guideline accompanied each Standard to provide further information on how to interpret it or the criteria. Finally a rating scale was used to indicate the level of compliance the hospital has achieved for a single criterion of a standard and also for the Standard itself. The rating scale that has been selected is a five-point scale using the numbers 0-4. The level of compliance indicated for each of the five points of scale is:

- 0= No compliance

- 1= Partial compliance (1—25%)

- 2= Partial compliance (26-50%)

- 3=Partial compliance (51-75%)

- 4=Substantial compliance (76-100%)

- NA=Not applicable

Box 3-2 illustrates an example of the Standards format.

Box 3-2 Example of Standard format

Patient Care: Medical

1.0   There is a defined process for admitting the patient to the service (Standard)

1.1 the patient is evaluated at the point of contact to match the patient to the hospital service (Criteria)

0   1   2   3   4   NA (Rating Scale)

(Guideline): When admitting a patient, regardless of whether it is for in-patient or ambulatory care, the service must ensure that it is capable of meeting the patients care needs. If this is not possible, a process is in place for stabilizing the patient and/or referring the patient where those care needs can be met.

Source: (Ministry of Health, 2011b)

The Standards were pilot tested in 3 hospitals, two general hospitals, and one tertiary care hospital and were further revised based on the evaluation results of the pilot and the focus groups feedback. The final revised version was printed and distributed to all 15 Government hospitals to be implemented.

2) Recruitment and training of accreditation surveyors:

A total of 40 surveyors were selected and recruited by a ministerial committee, based on fulfilling certain selection criteria, and those who passed the interview were chosen to complete a surveyors' training programme administered by Accreditation Canada consultants. The training included an orientation to accreditation and the Kuwaiti

Accreditation Programme and process, surveyor roles and responsibilities, interview and observation skills directly focused and related to the Kuwait Standards, and managing group dynamics.

The first contract ended successfully in achieving the required objectives.

3.7.3 Second agreement with Accreditation Canada (2011-2017)

The affiliation was renewed between the Ministry of Health and Accreditation Canada. However, this contract reflected a wider scope, with larger scale objectives and ran through a period of six years starting from 2011 (Ministry of Health, 2011a). The objectives of the second contract were: annual standards maintenance and the development of four new Standard sections for Rehabilitation, Mental health, Cancer Care and Gynaecology; recruiting 80 MOH Accreditation programme surveyors (40 for hospitals, 40 for primary healthcare); supervising two hospital accreditation cycles, the first accreditation cycle was from 2012 – 2014, and the second cycle from 2015 – 2017; developing and delivering training programmes; offering a Canadian study tour for the hospital surveyors; and developing software to automate the accreditation process in hospitals. A well-organised schedule outlining the time frame for each of the deliverables has been drafted, and agreement between the two parties was established.

1) Standards maintenance:

Annual revision is conducted for the 12 domains Standards. The MOH Advisory Committee revises the Standards based on feedback from the hospitals and surveyors. Also the development of 4 new Standard sections for Rehabilitation, Mental health, Cancer care and Gynaecology was completed. Working groups were composed for each new Standard area where, along with the input of the Advisory Committee, multidisciplinary teams wrote and edited the Standards. The Standards were piloted with the support of the Canadian surveyors acting as mentors and final evaluation and revision of the Standards after the pilot was conducted.

2) Recruitment and training of 80 MOH accreditation programme surveyors (40 for hospitals, 40 for primary healthcare).

3) Fourteen Governmental hospitals participate in two accreditation cycles:

The first accreditation cycle was from 2012 – 2014, and the second cycle was from 2015 – 2017, and all the hospitals participated in both cycles. The hospitals completed the self-assessment, participated in the onsite survey, received the accreditation survey report and followed up on recommendations, see **Figure 3.2**. This provided Kuwaiti surveyors with an opportunity to acquire and solidify their surveyor skills under the guidance and mentorship of experienced Accreditation Canada surveyors.

Figure 3.2 The three years Accreditation cycle

4) Develop and deliver training programmes:

The training programme targeted the self-assessment teams, coordinators, surveyors and MOH employees who are involved in accreditation. Education and training are considered an integral component of the accreditation process, and help to prepare the participants face the challenge of a newly introduced intervention (Thurber and Read, 2008).

An annual Canadian Study Tour was organised as part of a training programme for the Kuwaiti surveyors, where each year six surveyors participated as observers in a survey in a hospital in Canada.

5) Develop software to automate the accreditation process in hospitals:

This work is still in progress and will help to understand the trends in the healthcare system, also to achieve increased efficiencies in storing the information electronically. The use of advanced technology proved to facilitate data collection and entry, thus helping the surveyors in faster delivery of a report and easy retrieval of the purpose of analysis (Cleveland et al., 2011). The software is composed of: an organisational portal, including self-assessment application; surveyor application; and report editing application.

As with the first agreement, this also was successful in delivering all the objectives, and this has helped a lot in establishing and operating a well-structured National Accreditation Programme.

3.8 Main features of NAP

In most cases, especially in developed nations where accreditation has a long well-established history, the process is undertaken by a non-governmental, independent body (Montagu, 2003). Nevertheless, in recently established programmes, there appears a trend towards more government-based ownership of accreditation than an independent non-governmental entity (World Health Organization, 2003, Shaw et al., 2010b, Shaw et al., 2013).

The NAP was developed and implemented by the MOH in collaboration with Accreditation Canada, making the Ministry play both the assessor and assessed part in the initiative. Taking the lead in pursuing quality improvement is needed by the ministries of the countries in the Eastern Mediterranean Region (EMRO) to ensure ownership of the process, which leads to more accountability to the programme (EMRO, 2003). This approach has an advantage in proving that the Ministry is fostering the programme and showing committed efforts in evaluating and improving healthcare services (Pomey et al., 2005). As a result, and because application to the accreditation programme was free, it also encouraged a healthy competition environment with-in and among the hospitals (Cleveland et al., 2011).

The second feature of the NAP is that it is mandatory for all the Governmental hospitals to participate. This is a natural result of the previous feature since the Government initiated

the programme, it is required from all Governmental hospitals to participate (ISQUA, 1998). External pressure from legislation by law has been reported among other factors to assist in the successful implementation of the programme (Greenfield et al., 2012). However, it might also make participants view the programme less favourably and see it as overly bureaucratic and intrusive. For example, mandatory accreditation of healthcare services was reported to put hospitals under pressure, and shift the paradigm from improving quality to complying with surveys (Pomey et al., 2005, Devkaran and O'Farrell, 2015).

Third, the cycle of accreditation is repeated every three years, see **Figure 3.2**, a common feature of many other accreditation programmes (Vallejo et al., 2011). In between surveys, the hospitals are obliged to work on the evaluation report comments and prepare for the next visit.

The final feature of the NAP is related to the recruited surveyors, as they represent a varying range of disciplines and specialties; however, all are Kuwaiti nationals because the process of training is expensive and so investment has been concentrated in people who are more stable and permanent in the country.

3.9 Summary

Accreditation's swift development in recent times has been driven by the external consumers of accreditation – government, purchasers, and public – rather than by the original consumers, the professional themselves (Schyve, 2000). However, as further considered in Chapter 5, the evidence of its impact on healthcare delivery is variable. While there are a number of definitions, key features include the development of standards, the measurement and reporting of organisations' adherence to those standards, and the use of multidisciplinary teams to implement and monitor the standards.

In Kuwait, the NAP has developed over the years since its introduction in 2001 with tremendous effort and resources invested in it. However, to date, there is no formal structure in place to evaluate the implementation process and the programme impact. This is partly what this work will seek to do, as described in the next chapter.

Chapter 4- Research Design and Methodology

4.1 Introduction

This chapter aims to describe the research design process, specifically exploring the methods used in this research and the rationale for their selection, outlining the strengths and weaknesses of each method. In addition, it discusses the advantages conferred by using an appropriate theoretical framework, and then justifies the selection of Normalisation Process Theory (NPT). Detailed descriptions of the methods and data analysis techniques are contained in each of the results chapters, which follow this chapter.

4.1.1 Rationale

Using a multi methods design, this study attempts to identify the impact of the National Accreditation Programme (NAP) on the hospitals involved in this study from the perspective of healthcare professionals and to identify barriers to the implementation process. The multi methods approach comprised a systematic review of the literature, a qualitative analysis of accreditation related documents, and semi-structured interviews with 25 self-assessment team members. Implementation research is greatly strengthened, however, by the use of a theoretical framework to guide data collection and analysis (Eccles et al., 2009, Forster et al., 2011). Here, the framework used was Normalisation Process Theory (NPT).

4.1.2 Research Questions

This research aimed to explore the implementation of the accreditation programme in Kuwait from the multiple perspectives of the healthcare professionals involved. To address this aim, the following questions were investigated.

- What are the facilitators and barriers of accreditation implementation, as described in the international literature?
- How did accreditation impact on the services, from the perspective of healthcare professionals engaged in the accreditation programme as demonstrated in the international literature?

- What were the areas for improvement identified during accreditation visits to the general hospitals, as part of the NAP in Kuwait?
- How did the accreditation process impact on healthcare professionals and what was their view of its organisational impact on Kuwaiti hospital settings?
- What were the facilitators and barriers affecting the implementation of the NAP in Kuwait from the self-assessment teams' perspective?

4.2 Research philosophy

Research approaches in applied health research fall into one of three broad approaches: quantitative, positivist approaches; qualitative, interpretivist approaches; and mixed methods approaches, combining the two (Clark, 2000, Amaratunga et al., 2002). Before describing the approach taken in this work, it is helpful to explore some of the differences in the philosophical paradigms laying the foundation for qualitative and quantitative research methods. As Fisher Jr and Stenner (2011) stated, 'Qualitative researchers tend to think of meaning as local and subject to the particulars of time and place, whereas, quantitative researchers are interested in broader generalities that remain stable across specific contexts'.

According to Bernard (2017) 'The central position of positivism is that experience is the foundation of knowledge'. Biomedical researchers tend to subscribe to the positivist paradigm, through which they attempt to answer questions with the rigorous testing and analysis of quantifiable variables. The positivist approach is based on the fact that a phenomenon is reduced from the whole to the simplest elements to facilitate analysis (Baum, 1995, Amaratunga et al., 2002). In contrast to the positivism paradigm, the interpretive approach stresses the need for a more sociological perspective and relies on subjective interpretations of observed human behaviours. Interpretivism emphasizes the understanding of the human experience inductively and holistically within specific settings. This approach focuses on understanding experiences from the participants' point of view (Ritchie et al., 2013).

Table 4-1 Key features of positivist and interpretive paradigm

Theme	Positivist paradigm	Interpretive paradigm
Basic beliefs	- The world is external and objective - Observer is independent - Science is value free	- The world is socially constructed and subjective - Observer is part of what is observed - Science is driven by human interest
Researcher should	- Focus on facts - Look for causality and fundamental laws - Reduce phenomena to simplest elements - Formulate hypotheses and test them	- Focus on meanings - Try to understand what is happening - Look at the totality of each situation - Develop ideas through induction from data
Preferred method in the research	- Operationalising concepts so that they can be measured - Taking large samples	- Using multiple methods to establish different views of the phenomena - Small samples investigated in depth or over time

Source: (Amaratunga et al., 2002)

As this study wanted to understand the impact of accreditation from the perspective of the health professionals involved, and affected by, the process, it adopted an interpretist approach. This choice was made in relation to the research questions focusing on the experiences of the self-assessment team members participating in the accreditation implementation process, aiming for depth and richness in understanding the change imposed on the organisation by the intervention within its real world context.

4.3 Research design

While there are numerous methodological approaches one could take in order to answer the aforementioned research questions, for a more nuanced understanding of the various factors impacting on the implementation process, a multi methods qualitative approach was chosen. This incorporated a systematic review of the international literature, a qualitative content analysis of the accreditation reports for six General hospitals, and semi-structured interviews with twenty-five self-assessment team members across two general hospital settings.

4.3.1 Qualitative research

Qualitative research was described by Denizen and Lincoln (2011) in their SAGE Handbook of Qualitative Research as :

'A set of interpretive, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations, including field notes, interviews, conversations, photographs, recordings and memos to self…qualitative research study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them'.

The value of qualitative methods have long been recognised among healthcare researchers, with the qualitative approach recognised as leading to a better understanding of the human experience, and thoroughly exploring the views and opinions of the participants (Baum, 1995, Mays and Pope, 1995, Pope and Mays, 1995). The interest in the qualitative paradigm has increased and researchers now appreciate the importance of both quantitative and qualitative approaches in addressing a certain aspect of a research problem, making them as Creswell (2013b) described 'different ends on a continuum'.

Qualitative data can be grouped into four basic approaches as illustrated in more detail in **Table 4-2**.

4.3.2 Strengths and weaknesses of qualitative research

Qualitative research has certain characteristics making it an appropriate fit for our research problem, allowing the researcher to explore the subject from different perspectives. It provides a complex, detailed approach to evaluate the accreditation programme and understand the context in which participants view the intervention (Creswell, 2013a). Other key features of qualitative research as described by Ritchie et al. (2013) include: the ability to answer what, why, and how questions instead of how many; the focus on addressing processes; and the flexibility of the data collection time and the use of different methods for data collection, which are subject to adaptation for each research. The wide range of data collection methods (**Table 4-2**) available under the umbrella of qualitative research gives the researcher the flexibility of choice, considering certain aspects. For instance, the research questions, the resources available and time frame, key individuals engaged, and accessibility to site and/or materials all influence the choice of methods (Ritchie et al., 2013).

Table 4-2 Data collection approaches in qualitative research

Observations	Gather field notes by conducting an observation as a participant.
	Gather field notes by conducting an observation as an observer.
	Gather field notes by spending more time as an observer than as a participant.
	Gather field notes by spending more time as a participant than an observer.
	Gather field notes first by observing as an outsider and then by moving into the setting and observing as an insider.
Interviews	Conduct an unstructured, open-ended interview and take interview notes.
	Conduct an unstructured, open-ended interview, audiotape the interview, and transcribe the interview.
	Conduct a semi-structured interview, audiotape the interview, and transcribe the interview.
	Conduct a focus group interview, audiotape the interview, and transcribe the interview.
	Conduct different types of interviews; e-mail, face-to-face, telephone.
Documents	Keep a journal during the research study.
	Have a participant keep a journal or diary during research study.
	Collect personal letters from participants.
	Analyse public documents.
	Examine autobiographies and biographies.
	Have participants take photographs or videotapes.
	Conduct chart audits.
	Review medical records.
Audio-visual material	Examine physical trace evidence.
	Videotape or film a social situation, individual, or group.
	Examine website main pages.
	Collect sounds.
	Collect e-mail or discussion board messages.
	Gather phone text messages.
	Examine favourite possessions or ritual objects.

Source: (Creswell, 2013a)

The use of more than one method in qualitative research creates room for the researcher to adopt the approach that best suits the research aim and objectives. Additionally, these different methods of data collection enable a wide coverage of the subject being researched. Through this, it is possible for one to gain greater understanding of a phenomenon where the variety of methods enables the researcher to develop a research design using one method and pursue a follow up utilizing another tool, hence increasing the scope of the study (Barbour, 1998, Creswell, 2013a, Ritchie et al., 2013).

Qualitative approaches are particularly helpful in exploring and understanding the implementation of complex interventions (such as accreditation) into complex organisational settings (as found in hospitals) (Pope and Mays, 1995, Amaratunga et al., 2002, Benzer et al., 2013, Portela et al., 2015).

Qualitative methods have the advantage of accessing information that is not accessible through a quantitative approach, such as professionals' views and beliefs. In addition, they are helpful in illuminating distinctions and recognising patterns among variables. It has also proven to be valuable in generating and testing hypotheses (Pope and Mays, 1995, Sofaer, 1999). Another advantage of qualitative data is its role as a supplementary source for quantitative data in a mixed method approach, where it helps to explain, validate or clarify the results (Amaratunga et al., 2002).

The work of qualitative researchers has been argued to lack reproducibility and generalizability. Indeed there are many on-going debates among researchers related to the validity and reliability of qualitative research methods due to the perceived subjectivity involved in data collection and analysis (Baum, 1995, Barbour, 1998). Additionally, the data may be collected well, but the foundation of data interpretation will vary according to the researchers. The fact that the analysis of information is based on a personal perspective means that different researchers might interpret one set of data differently (Sofaer, 1999). In addition, the collection of data during the research using methods such as interviewing requires the researcher to be in full control of the process. Any failure may lead to loss of crucial evidence or even miss focusing on the important issues (Hall and Rist, 1999). The discussion may, therefore, end up moving into other topics that are not helpful or part of the researcher's initial aims.

Qualitative research offers a range of data collection tools as mentioned earlier, however, these can be time-consuming and more demanding of commitment and cost. Also it may become difficult for the researcher to combine the results of all the tools of the research in one final synthesis due to the range of approaches under the qualitative umbrella (Barbour, 1998).

From their perspective, Mays and Pope (1995) expressed the difficulty in both domains of research, quantitative and qualitative, in collecting data on the 'actual truth' as they further explain 'in quantitative data analysis it is possible to generate statistical representations of phenomena which may or may not be fully justified since, just as in qualitative work, they will depend on the judgment and skill of the researcher and the appropriateness to the question answered of the data collected'. This emphasizes how the two methods of

research are not necessarily in competition, but each helps to explore a different aspect of the story, as Yin (2013) elaborates on how each research approach uses distinct data collection tools, data analysis methods, and therefore each has their own advantages and disadvantages.

Considering other research designs, quantitative methods were not the best choice to address the research questions in this research because it is deductive in nature, concerned mainly with verifying theories through closed questions (Creswell, 2013b). An exploratory approach was a better fit to evaluate the complexity of individuals' views of accreditation and how they interpret those interactions and experiences, that might be missed in a quantitative approach (Sofaer, 1999).

4.3.3 Rigour

While it is clear that there are benefits to combining different qualitative approaches within the one overall study, there are overarching considerations in relation to qualitative research more generally that need to be considered. In the health field, qualitative methods have been criticised as 'unscientific' especially with the dominance of quantitative methods (Mays and Pope, 1995). The main criticism of qualitative research is that it is not based on scientific approaches but rather on personal perceptions and understanding (Baum, 1995).

Rigour is, however, possible and can be reached through three main ways: research validity, findings reliability, and triangulation in data collection (Creswell, 2013b). When it comes to rigor, the issues of personal interest create a sense of blindness. Researchers may be subject to personal bias when conducting qualitative research and only provide an analysis based on their point of view (Mays and Pope, 1995) – thus a key issue is for researchers to be reflexive in their choice of methods and role in the research process.

Research should aim to be as comprehensive as possible by the utilization of multiple tools of qualitative research. Using several methods can provide different angles and interpretations on the subject topic, and this can strengthen the findings of a study (Baum, 1995, Hall and Rist, 1999, Patton, 1999). In this work, the researcher achieved method triangulation by seeking data from different independent sources and data collection

methods in order to test for consistency or inconsistency, offering the chance to illuminate the understanding of the phenomenon under study (Mays and Pope, 1995, Patton, 1999).

The data collection and analysis methods described later in this chapter were carefully followed. In each results Chapter (Chapters 5, 6 and 7), a detailed and thorough account will be provided about data collection and analysis.

4.3.4 Using multiple qualitative methods

For this research the researcher employed the study design illustrated in **Figure 4.1**. Mixed methods designs entail the use of both qualitative and quantitative methods in one study. Pope and Mays (1995) justify this combination as follows: first; qualitative research can set the grounds for quantitative research, second; qualitative research can supplement quantitative data to increase its validity, third; qualitative methods can complement quantitative methods in an attempt to explore a complex phenomena.

Figure 4.1 Multi methods qualitative research design
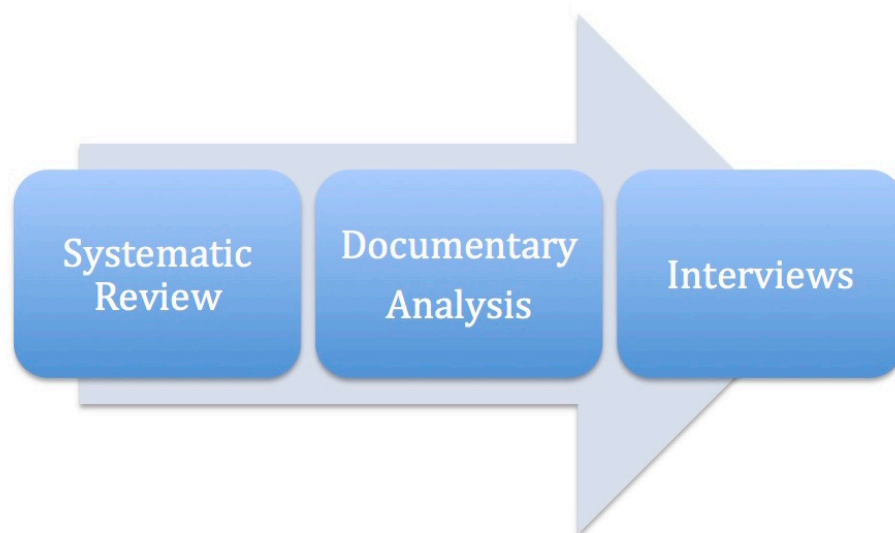
An alternative approach, however, is the multi methods qualitative design, which refers to combining two or more qualitative methods for the purpose of addressing the study overall aim, even if each method answers a different question/questions (Barbour, 1998, Morse and Cheek, 2015).

Morse and Cheek (2015) argue that, unlike a mixed method approach, a multi methods qualitative study is easier to conduct due to a lesser dependability of the different methods on each other, until the final synthesis where all the results are combined to address the study aim.

Studies can benefit from combining different qualitative approaches. These benefits include bringing different insights to the phenomenon under study, where each method contributes to the research aim, offering a more comprehensive approach and understanding. Also it helps to implement different methods at different stages of the research as the research unfolds, where for example a focus group can be used to develop an interview schedule. Another benefit is the ability to triangulate findings within a single study (Hall and Rist, 1999, Ritchie et al., 2013). Thus, it is clear that researchers are attempting to combine two or more aspects of research for the purpose of strengthening internal and external validity and reliability and decreasing potential biases (Thurmond, 2001).

Triangulation in research refers to the use of two or more data sources, investigators, methodological approaches, or theoretical perspectives, see **Table 4-3** (Carter et al., 2014). Dowell et al. (1995) explain it further 'in triangulation, a comparison is made by looking at the same problem in different ways. The findings from alternative sources enable researchers to make more subtle and sophisticated analyses. Any marked differences can be highlighted, investigated and explained'.

Table 4-3 Types of triangulation

Data source	Collection of data from different types of people, to accomplish multiple perspectives and data validation.
Investigator	Participation of more than one researcher in a study to provide multiple observations and conclusions.
Method	Using multiple methods of data collection about the same phenomenon (Interviews, observation, and field notes).
Theory	Adopting different theories to analyse and interpret data.

Source: (Carter et al., 2014)

There are many claimed advantages from the use of triangulation in research. Data source triangulation and methods triangulation helps to complete the view of a phenomenon from all perspectives, and information gathered from multiple sources and methods complement each other to enhance understanding (Thurmond, 2001, Oliver-Hoyo and Allen, 2006). This adds to the credibility of the data gathered and increases confidence in the results attained (Barbour, 1998, Ritchie et al., 2013). Furthermore, theoretical triangulation provides an in-depth analysis, and guides the researcher towards accepting or rejecting the findings (Carter et al., 2014). Investigator triangulation seeks to reduce bias during data collection, coding, and analysing, when two or more investigators participate in verifying and interpreting findings. The group discussion between researchers to compare their feedback aids in solving conflicts and explaining perspectives, until an agreement is reached, thus increasing the reliability of the outcome (Thurmond, 2001, Creswell, 2013a).

Despite the advantages of triangulation as described in the literature, the large amount of data generated and the time required to manipulate those multiple approaches poses a challenge. Concern has also been raised regarding employing multiple methods without a clear description of the research strategy, or definite explanation of the input expected from each method and how it relates to the research aim, which ends up with a poorly designed study (Thurmond, 2001, Carter et al., 2014).

This work was conducted by a single researcher, although, as will be described in the results chapters (Chapters 5,6,7) my PhD supervisors were fully involved in the process of data analysis. Also, as discussed in Section 4.5.1, the work was underpinned by a single theory of implementation. However, triangulation was achieved through the use of

multiple methods and the collection of data from different sources and individuals by conducting:

(1) A theoretically informed systematic review of the international literature.

(2) Qualitative analysis of six general hospitals accreditation reports.

(3) Qualitative interviews with professionals who are engaged in the accreditation programme.

A schematic representation of the triangulation design is shown in **Figure 4.2**. Each method in the diagram generated results that were compared to the results of the other methods.

Figure 4.2 A triangulated design for data collection
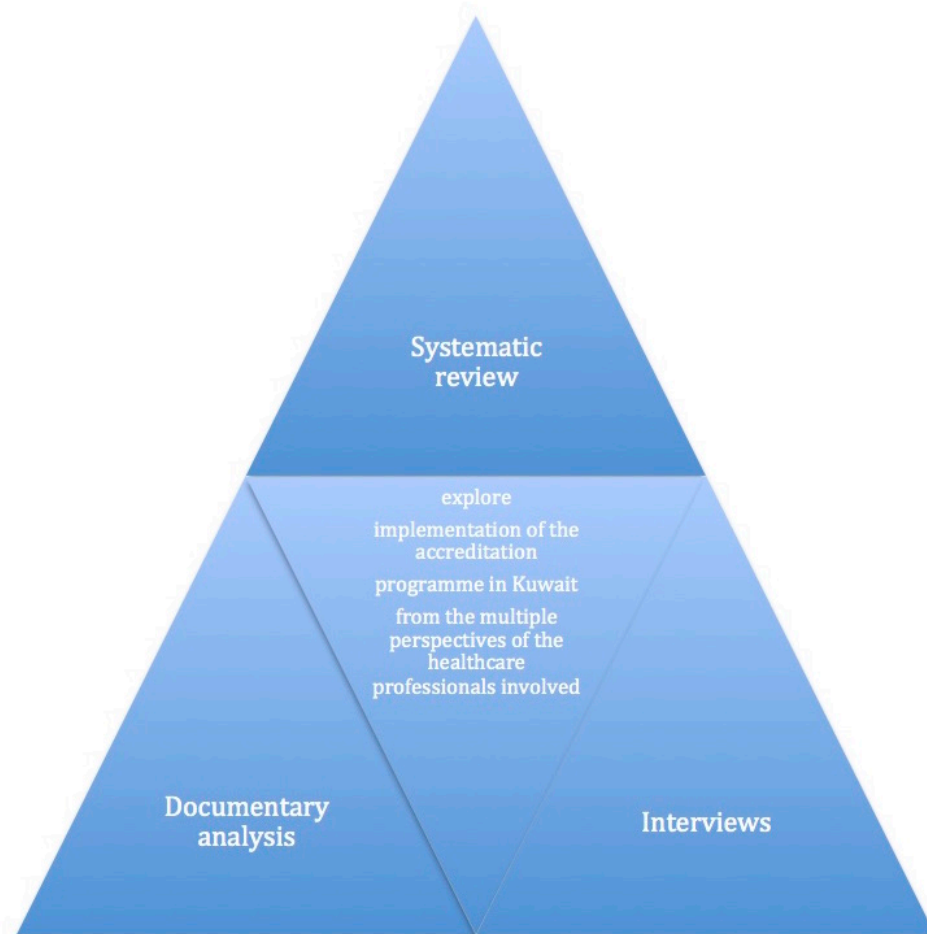
While it is important to consider the different strands of work and how they inform each other, this can become disjointed and unconnected. One way to ensure cohesion across the work is by the use of an appropriate theoretical framework. This will be discussed in the next section.

4.4 Theoretical frameworks

4.4.1 Why use theory?

Understanding the implementation of complex interventions, such as accreditation programmes, can be enhanced by the use of theory (Reeves et al., 2008, Eccles et al., 2009, Davidoff et al., 2015). Advantages include providing a framework that is generalisable across settings, helps in the generation of new knowledge, and provides a guide for analysis (Davidoff et al., 2015, O'Donnell et al., 2017). Theory also enhances our identification and understanding of the barriers to implementation and can draw out attention to the context and setting in which implementation takes place (Sales et al., 2006, Forster et al., 2011, Craig et al., 2013, Davidoff et al., 2015, Marshall et al., 2017).

Theory is described as 'an organised, heuristic, coherent, and systematic articulation of a set of statements related to significant questions, providing a generalisable form of understanding' (McDonald et al., 2004). Theory can operate at different levels as illustrated in **Table 4-4**.

Table 4-4 Levels of theory

Grand theory	- Abstract
	- Broadly applicable across different area and subjects
Middle-range (big) theory	- Less abstract
	- Address specific phenomenon or concepts
	- Can be incorporated into testable propositions or questions
	- Can inform intervention development
Programme (small) theory	- Specific to certain components of an intervention
	- Explicitly links a programme's processes and inputs to its intended outcomes

Source: (O'Donnell et al., 2017)

For a study such as this, the use of mid-level theory was the most suitable allowing, as it does, the development of testable propositions or questions that can be used to shape data collection. O'Donnell et al. (2011) argue for a dynamic theoretical framework, which incorporates various data sources provided by the different methodological approaches in order to strengthen the validity and reliability of the evidence. While some frameworks are

helpful in evaluating programmes and interventions, others address both the development and the evaluation (Gaglio et al., 2013). From this, the next important task was to identify a theoretical framework that best fitted the needs of the study.

4.4.2 Theories of implementation

How and why interventions become, or fail to become, embedded in every day routine is an issue of high importance for researchers. However, which theory to select requires careful consideration. Tabak et al. (2012) reviewed the theories and frameworks used in dissemination and implementation research in 2012, identifying 61 models (Tabak et al., 2012). Some of these dealt only with the dissemination of research, others with implementation and some considered both. Nilsen also reviewed theories used in implementation science, suggesting that implementation theories have three broad aims: describing and supporting the translation of research into practice; understanding and/or explaining what influences implementation; and evaluating implementation (Nilsen, 2015).

An early theoretical framework concerned not with implementation, but with health systems, is the Donabedian framework, which sheds light on the quality of care as a function of structure, process, and outcomes (Donabedian, 1966). Structural factors stand for material resources, human resources, and organisational structure, while process denotes the course of the service from both patients' and professionals' perspectives, and outcomes relates to the results of the service (Donabedian, 1988). The three components are interdependent and as Donabedian (1988) described it 'Good structure increases the likelihood of good process, and good process increases the likelihood of a good outcome'.

This approach might help inform the researcher about how the process of accreditation may improve the healthcare services; however, it didn't help to highlight the facilitators and barriers encountered during the implementation process. Furthermore, there is difficulty in categorising aspects of care into the three strands of the Donabedian framework due to overlapping of the boundaries among them, which result in inconsistency in its use (Goldstone, 1991, Closs and Tierney, 1993).

Thus, while Donabedian's framework is helpful in drawing attention to the components of the system, there was a need to use a recognised theory of implementation. One of these is

the Reach, Effectiveness, Adoption, Implementation, and Maintenance (RE-AIM) that was developed more than 16 years ago to help evaluate interventions and public health programmes (Glasgow et al., 1999). The dimensions of RE-AIM are explained briefly in **Figure 4.3**.

Figure 4.3 Elements of the RE-AIM framework

Source: (Ory et al., 2015)

Although the model assumes that all five components are equally important and hence equally weighted, this is not accurate. A recent review of the use of the RE-AIM framework was carried out by Gaglio and colleagues found that the most commonly studied component of Re-AIM was 'reach', i.e. who were targeted and engaged within the implementation process; 'maintenance' was reported least often (Gaglio et al., 2013). These authors also suggested that "reach" was the most frequently reported but also the most incorrectly used, because there was confusion between the definitions of reach and adoption. Finally it was reported that the application and monitoring of the model requires training and special expertise (Glasgow et al., 1999, Gaglio et al., 2013, Ory et al., 2015).

Another framework that was introduced in 2009 is the Consolidated Framework for Implementation Research (CFIR). It is comprised of five main domains, and aims to explore 'what works where and why across multiple contexts' (Damschroder et al., 2009). **Figure 4.4** demonstrates all the sub-constructs of the model distributed across the five main domains.

Figure 4.4 Consolidated Framework for Implementation Research model
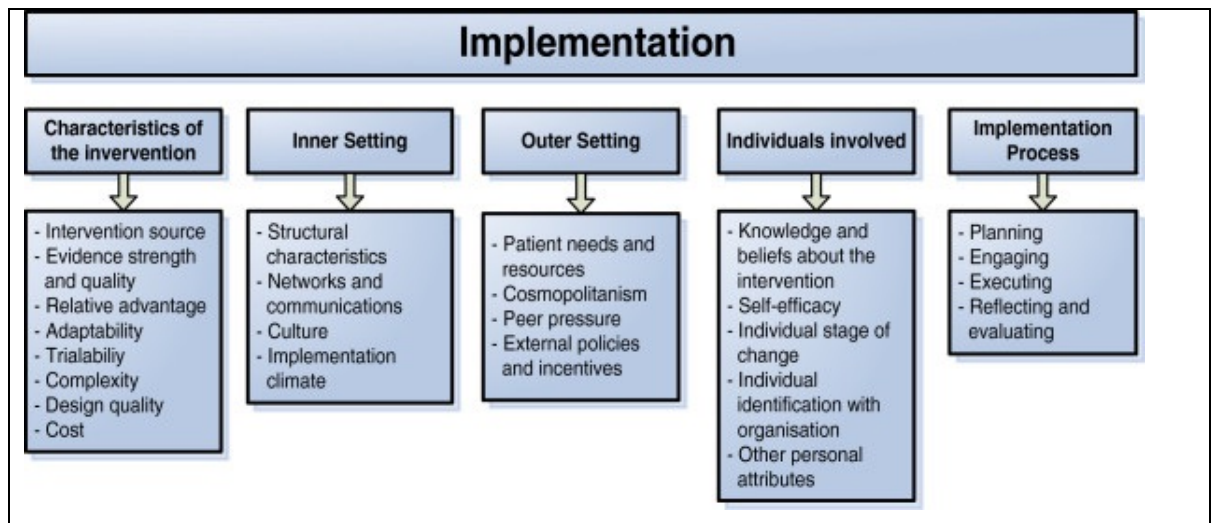
Source: (Damschroder et al., 2009)

The CFIR model has the advantage of flexibility in research design, because it can be used to guide data collection and/or analysis (Ament et al., 2012, Damschroder and Lowery, 2013). The aspect of flexibility is also evident in the incorporation of the model constructs and sub-constructs, where the researcher is not obliged to apply the entire model, but can choose what serves the study aim and focus (Damschroder et al., 2009). The model, as Damschroder and colleagues (2009) argue, can provide useful evaluation of interventions in three different stages: prior to implementation to assess the requirements of the intervention and establish potential barriers and enablers; during implementation to monitor any unexpected obstacles; and post-implementation to evaluate impact and outcome.

Despite how comprehensive and flexible the CFIR model seems, a recently published review recognised a few limitations in its use. It was found that the majority of the studies incorporated the framework into the data analysis phase only. There was also a reported

problem about linking CFIR sub-constructs to intervention outcomes. Also variation in the use of the sub-constructs was identified among different researches, without a clear explanation of the selection made (Kirk et al., 2016).

While these frameworks are all useful and could potentially be applied to this research, a decision was taken to use Normalisation Process Theory (NPT). There were several reasons for this: first, NPT focuses attention on the process of implementation (Tabak et al., 2012); as a mid-level theory, it was possible to develop data collection methods underpinned by NPT; and, finally NPT was seen to operate at a number of levels in a healthcare system, including at the level of individuals, organisations and communities. This, therefore, was a particular reason to select NPT as the theoretical framework to guide this project. An additional consideration was that it was a theoretical approach used previously by my primary supervisor in the evaluation of complex interventions in healthcare settings (Murray et al., 2010, Mair et al., 2012, O'Donnell et al., 2017).

4.4.3 Normalisation Process Theory

Normalisation Process Theory (NPT) was developed to address the way new practices become integrated into the social context of a setting by focusing on the work individuals and groups have to do in order to accomplish this integration (May et al., 2009, May and Finch, 2009, Murray et al., 2010).

It is a middle-range theory as Shojania et al. (2004) explain 'A middle-range theory is more limited in scope, addresses specific phenomena, and is intended to guide empirical inquiry as well as action or practice. It encompasses a limited number of concepts and a limited aspect of the real world. Middle range theories are made up of relatively concrete concepts that are operationally defined and can be empirically tested'. Thus, a mid-range theory can address implementation in diverse settings of practice and environments, and can be developed by researchers to generate testable questions (Boudon et al., 1991, Nilsen, 2015).

Although initially developed to better understand the implementation of e-health interventions, NPT has now been used in a variety of studies including the dallas (Delivering Assisted Living Lifestyles at Scale) programme implementation evaluation

(Devlin et al., 2016), the RESTORE study that aimed to investigate and support the implementation of training initiatives to support communication across international settings (MacFarlane et al., 2012), the implementation of nutritional guidelines in Australia (Bamford et al., 2012) and self-management support in chronic disease in England (Kennedy et al., 2014).

A review by McEvoy et al identified many papers that found NPT to be beneficial because 'the findings suggest that NPT is a theoretical framework that facilitates understanding of experiences of healthcare work at the individual, as well as the organisational level', furthermore, it was found that 'NPT provides a useful framework for understanding the processes that affect the implementation, embedding, and integration of new technologies into healthcare systems'. It was also recognised that NPT had been used to guide recommendations for the future implementation of programmes, and finally, assisted in the development and design of interventions (McEvoy et al., 2014). An additional advantage of NPT is that it has been applied to secondary analysis of published papers in a review of reviews (Mair et al., 2012), as well as to original qualitative research.

NPT focuses on four constructs to help us better understand the work of implementation. These are: coherence, cognitive participation, collective action, and reflexive monitoring, see **Table 4-5**. The first NPT construct, coherence, is concerned with how individuals and groups understand and conceptualise the intervention, and how it is similar or different from other practices. It includes: differentiation, which addresses how practices differ from each other; communal specification which relates to the notion of shared understanding of the aims, objectives and expected outcome of the practice; individual specification that is about the personal understanding of tasks and responsibilities of the practice; and finally, internalisation, which is concerned with individuals understanding the value and importance of the introduced practice (May and Finch, 2009, Mair et al., 2012).

Table 4-5 NPT constructs and sub-constructs

Coherence	Cognitive participation	Collective action	Reflexive monitoring
Differentiation	Initiation	Interactional workability	Systemisation
Communal specification	Enrolment	Skill set workability	Communal appraisal
Individual specification	Activation	Relational integration	Individual appraisal
Internalisation	Legitimation	Contextual integration	Reconfiguration

(Top row lists the construct, in bold, with the related sub-constructs below)

The second construct, cognitive participation, is the relational work done to establish and sustain new ways of working. So it is related to how individuals are identified and organised, to engage with the intervention. It is necessary for the participants to organise themselves and commit to the process of change, in relation to shared beliefs about what is acceptable and appropriate practice. This also has four sub-constructs and they are: initiation, which is the work done by stakeholders to drive the new practice forward; enrolment, which involves stakeholders working together and 'buying into' the practice; legitimation, that is the belief that it is right for the participants to be involved in the practice; and activation refers the actions and procedures needed to sustain the practice (May et al., 2011).

The third NPT construct, collective action, focuses attention on the work individuals do to enact the intervention, as May and Finch (2009) explain it 'Embedding is dependent on work that defines and operationalises a practice'. Those goal-oriented actions might include acceptance, compliance, or resistance. This construct is crucial because the process of embedding depends on the work that outlines and operationalises a practice. Sub-constructs include: skill set workability which pertains to allocating the work in accreditation and how it fits with existing skills and job roles; contextual integration which addresses supporting and resourcing tasks in their social context, and the overall fit of the practice with organisational goals and context; interactional workability which concerns the degree to which a new practice is enabled or delayed by the routine day job; and relational integration which is about developing relationships and building confidence with

the newly introduced practice and with networks of professionals around it to overcome any barriers to implementation (May et al., 2011, Mair et al., 2012).

The fourth and final construct of the framework, reflexive monitoring, is concerned with the ways in which the implementation of a new practice is continuously evaluated both collectively and individually to assess its advantages and disadvantages. The appraisal may be undertaken in a structured formal manner or in a less-structured, informal way (May and Finch, 2009, McEvoy et al., 2014). The sub-constructs are: reconfiguration which indicates any ideas about modifying or developing the practice based on evaluation and experience; communal appraisal which reflects regular and formal assessment of the process of implementation and its impact within the organisational context; individual appraisal which relies on personal judgment of the value and outcome of the practice; and systemisation which involves developing ways of evaluating the practice impact from both formal and informal feedback (May and Finch, 2009).

Table 4-6 offers an explanation of the process of operationalising normalisation process theory in terms of the key questions that arise from the constructs and sub-constructs. These questions can, in turn, be used to inform the development of data collection tools and/or data analysis. How this was developed in this study will be explained more fully in the results chapters.

Thus, the use of NPT enabled me to consider the barriers and facilitators to implementation of accreditation in a more nuanced way, considering how individuals and groups had to think about, engage with and monitor the impact of accreditation in their own hospital settings.

Table 4-6 Framework of operationalising NPT

Coherence Can stakeholders make sense of the intervention?	Cognitive participation Can stakeholders get others involved in implementing the intervention?	Collective action What needs to be done to make the intervention work in practice?	Reflexive monitoring Can the intervention be monitored and evaluated?
Differentiation: Do stakeholders see this as a new way working?	Enrolment: Do the stakeholders believe they are the correct people to drive forward the implementation?	Interactional workability: Does the intervention make it easier or harder to complete tasks?	Systematisation: Will stakeholders be able to judge the effectiveness of the intervention?
Individual specification: Do individuals understand what tasks the intervention requires of them?	Initiation: Are they willing and able to engage others in the implementation?	Skill set workability: Do those implementing the intervention have the correct skills and training for the job?	Individual appraisal: How will individuals judge the effectiveness of the intervention?
Communal specification: Do all those involved agree about the purpose of the intervention?	Activation: Can stakeholders identify what tasks and activities are required to sustain the intervention?	Relational integration: Do those involved in the implementation have confidence in the new way of working?	Communal appraisal: How will stakeholders collectively judge the effectiveness of the intervention?
Internalisation: Do all the stakeholders grasp the potential benefits and value of the intervention?	Legitimation: Do they believe it is appropriate for them to be involved in the intervention?	Contextual integration: Do local and national resources and policies support the implementation?	Reconfiguration: Will stakeholders be able to modify the intervention based on evaluation and experience?

Source:(O'Donnell et al., 2017)

4.5 Methods of data collection

As mentioned previously, multiple qualitative methods were employed, in line with the research objectives. At the beginning, a systematic review was conducted. This work will be reported in Chapter 5. Fieldwork was then conducted in Kuwait: this comprised documentary analysis of the hospitals' accreditation reports (reported in Chapter 6) and semi-structured interviews with key personnel involved in the self-assessment teams, in Chapter 7. The actual methods employed in each study will be reported in the appropriate chapter. The following section seeks to illustrate the overall relationship between the systematic review and the research methods deployed during this research, highlighting the strengths and weaknesses of those methods.

4.5.1 Systematic Review of the Literature

A literature review is an extremely important element towards building the foundation for any research; however, depending upon the researcher's objectives, there are different types of literature reviews that can be utilized. In a traditional literature review, the researcher attempts to explore heterogeneity among primary studies descriptively. However, this type of literature review often results in the researcher creating an individualised and biased narrative, with no protocols in place to guide the type of research identified and included and to account for bias e.g. in terms of the literature included and excluded or the weight given to methodologically flawed papers.

In order to address these limitations, the systematic review was developed. According to Petticrew and Roberts (2008), a systematic review is often used to test a single hypothesis or a related sequence of hypotheses and 'strives to comprehensively identify, appraise, and synthesise all the relevant studies on a given topic'. While a systematic review of the literature is not always necessary, there are some guidelines to help a researcher evaluate when this type of review would be beneficial. Petticrew and Roberts (2008) identified that a systematic review is needed if there is any uncertainty about whether research has been previously conducted on a specific topic; for instance, when assessing the usefulness of services or developing a new policy for implementation. They also asserted that it may be advantageous to conduct a systematic review when there is an extensive collection of research for a given topic but certain research questions remain unanswered, or 'when a general overall picture of the evidence in a topic area is needed to direct future research efforts'. This was particularly the case in this work, when a body of research on accreditation did exist, but almost none of it was set in countries like Kuwait. Once established that a systematic review would be helpful, there are key features of a systematic review that are important to consider. Many of these issues are described in the PRISMA and AMSTAR guidelines for the reporting of systematic reviews (Shea et al., 2007, Moher et al., 2009).

4.5.1.1 Literature search process

The process involved in a systematic review incorporates five steps to ensure the legitimacy and relevance of the literature evaluated (Greenhalgh et al., 2008). This process is initiated with properly structured questions that the review seeks to answer. For the systematic review in this PhD, there were two key questions: (1) what are the facilitators and barriers of accreditation implementation, as described in the international literature? and (2) how did accreditation impact on the services, from the perspective of healthcare professionals engaged in the accreditation programme as demonstrated in the international literature?

Once the research questions are clear, the second phase of a systematic literature review is to identify relevant research studies through the utilization of multiple databases and resources (Khan et al., 2003, Shea et al., 2007, Moher et al., 2009). In order to ensure reliability and account for any search bias, the same key words and techniques should be used across all databases, as far as possible. Following the search strategy, the next key step is to formulate clear inclusion and exclusion criteria to identify and include papers that are within the scope of the review. Details of the search strategy and inclusion/exclusion criteria used here are given in Chapter 5.

4.5.1.2 Quality appraisal of the studies

The third step of the systematic review involves a quality assessment of the selected research studies. Accordingly, there are some basic questions that should be answered during this process (Greenhalgh et al., 2008). First, one should assess if the methods used are clearly described, if there are any sources of bias, if the research design was appropriate and how well it was conducted. In addition, data analysis methods are assessed and a judgement made as to whether the data justified the conclusions. This quality gauge ensures that the results of the research are reliable and robust. It is important to note that papers are not rejected if they are of poor quality; however the quality does impact on the confidence that we can have in the final results.

Quality assessment varies depending on the study design being reviewed. Many comprehensive guidelines are therefore available for assessing study quality such as the 5-

point Oxford Quality Rating Scale (Jadad et al., 1996), Critical Appraisal Skills Programme (CASP) (Singh, 2013) and the Consolidated Standards of Reporting Trials (CONSORT) (Begg et al., 1996).

4.5.1.3 Data analysis

The fourth and fifth steps in a systematic review of the literature involves summarising the literature and finally, reaching conclusions based upon the evidence. However, this leads to important decisions about how papers are summarised, as approaches to data synthesis are dependent on the types of research generated from the review. For quantitative outcomes, the meta-analysis approach is often employed, assuming that the studies are similar enough to allow combining of data (Bailar III, 1997, Dixon-Woods et al., 2007). Bartolucci and Hillegass (2010) define meta-analysis as 'the process of combining the quantitative results of separate (but similar) studies by means of formal statistical methods'. When the research outcome is purely qualitative, or integrates both qualitative and quantitative data, a narrative synthesis or thematic approach is often used.

Barnett-Page and Thomas (2009) further elaborated on the different types of narrative synthesis approaches like meta-ethnography, where qualitative data from different studies are aggregated in order to generate new knowledge and insights. Textual narrative synthesis arranges studies according to their characteristics, context, and quality appraisal, with findings generated by comparing and contrasting data for similarities and differences. A more complicated approach is the meta-study type, where the process of analysis is divided into analysis of findings, analysis of methods, and analysis of theory.

Another, more structured approach, is that of thematic analysis which can be used to synthesise mixed method results of a systematic review, such as identified in the review conducted in this PhD (Dixon-Woods et al., 2005, Thomas and Harden, 2008). Thematic analysis involves the identification and development of descriptive themes, but has a flexibility that allows the possible integration of the qualitative and quantitative evidence. Thematic analysis also lends itself to the application of a theoretical framework to the papers identified because in contrast to inductive thematic analysis, theoretical thematic

analysis generates more focused and detailed data that addresses the research questions (Braun and Clarke, 2006).

One challenge in a thematic analysis is to consider what information in a paper constitutes 'data' and how to extract and use that data (Thomas and Harden, 2008). To facilitate this, and to enhance integration with the later work of qualitative analysis of six hospital accreditation reports and interviews with professionals who are engaged in the implementation process, a framework synthesis approach was used with the study's theoretical framework – NPT – used to provide the 'framework'. Framework synthesis offers a structured approach to identifying and coding qualitative text in a paper, with identified text then mapped to a priori themes, in this case the constructs and sub-constructs of NPT, while remaining alert to other data that might not fit NPT (Barnett-Page and Thomas, 2009, Kastner et al., 2012). This approach has been applied to other reviews, in particular a review of reviews reporting on the implementation of e-health programmes (Mair et al., 2012).

4.5.1.4 Strengths and weaknesses

A well-structured, rigorous systematic review is often regarded as the 'best' evidence because it attempts to identify all relevant research in a field and to appraise that in a systematic manner. Collecting data from various studies adds power to the evidence, and helps to detect differences that individual studies were unable to confirm (Bartolucci and Hillegass, 2010, Phillips et al., 2011). Mallett et al. (2012) further demonstrate how conducting a systematic review improves the quality of the research through 'transparency, greater breadth of studies included, greater objectivity and reduction of implicit researcher bias, and by encouraging researchers to engage more critically with the quality of evidence'.

Despite the added value of a systematic review, a number of limitations can affect its quality. Wallace et al. (2012) identified three key issues in their systematic review about the barriers to the uptake of evidence to systematic reviews and meta-analysis. First, lack of knowledge and understanding of the process and how to implement it. Second, lack of motivation and perceived uselessness of the reviews. Third, lack of free access for many

databases when the financial resources of the researcher are limited. Another limitation that can affect the process is the subjectivity in screening the results among the researchers, although the use of multiple screeners – as was carried out in this work – can reduce that bias, as can piloting the screening process (Mallett et al., 2012).

4.5.2 Documentary analysis

Traditionally, qualitative research methods have been associated with interviews and participant observation; however, documentary analysis is another data collection method of value. Fitzgerald (2007) defines documentary analysis as 'a form of a qualitative analysis that requires readers to locate, interpret, analyse and draw conclusions about the evidence presented'.

There are several uses for documents in fieldwork, with the most significant use to supplement and augment evidence from other methods of data collection (Yin, 2013). Documents can also help to identify important features in a case or an event (Fitzgerald, 2007), or may help to inform the research process, for example by helping to select fieldwork sites or participants (Shaw et al., 2004).

4.5.2.1 Document description and analysis

Many types of documents can be retrieved and used as a valuable source of data, including administrative reports, letters, e-mails, agendas, meeting minutes, and even articles and news clippings (Yin, 2013). In this study, the accreditation reports produced by the on-site survey teams (as described in Section 6.2.2) were recognised as an important source of data about the barriers and implementation priorities identified by the surveyors in each site. In this way, the surveyors' views could then be compared and contrasted with other healthcare professionals interviewed in the final stage of the study.

Hsieh and Shannon (2005) identify three different approaches to qualitative documentary analysis: conventional document analysis, directed document analysis, and summative document analysis. In a conventional document analysis, the researcher may thoroughly scrutinize all the data for relevance in order to identify key concepts. These are coded and organised to identify emergent themes, and how they are related and linked.

A directed document analysis approach is more structured than a conventional analysis, and is usually implemented in order to add further description to a pre-existing theory. Unlike a conventional document analysis, a directed approach uses predetermined codes to categorise text; however, in the event data does not fit within a code, they will be assigned a new code. Although a directed document analysis approach offers a method of adding to existing theory, it does have some downsides. Namely, this approach has a tendency towards bias, since the researcher enters the study with expectations about outcomes; as a result, findings may be more in line with the initial theory, rather than contrasting or challenging that theoretical view. Nevertheless, bias can be addressed by assigning an objective external reviewer to analyse the predetermined codes, thus increasing their robustness (Hsieh and Shannon, 2005).

The third category of document analysis identified by Hsieh and Shannon is a summative approach. Accordingly, 'A study using a summative approach to qualitative analysis starts with identifying and quantifying certain words or content in text with the purpose of understanding the contextual use of the words or content' (Hsieh and Shannon, 2005). In contrast to the conventional and directed approaches, a summative approach analyses a variety of documents in order to ascertain the frequency of word usage and then attempts to interpret the meaning of the text. While a summative approach to document analysis allows for a general understanding of word usage, broad meanings inherent in the data may be overlooked.

In this work the use of a theoretical framework and a similar analytical approach for both the documents and the interview meant that the analysis was directed. This will be discussed in more detail in Section 4.7.

4.5.2.2 Strengths and weaknesses

One of the advantages the researcher must acknowledge when reviewing a document is the fact that it was produced originally for another purpose other than the research itself, and as such, is not influenced by the data collection process. This prior existence of the documents helps in decreasing the bias during data analysis and interpretation, where the researcher cannot influence the content or lead the participants (Shaw et al., 2004,

Fitzgerald, 2007). Other advantages associated with using documents are: their accessibility and easy retrieval with less requirement for approval, and, as written evidence, the time and cost of transcribing them are saved (Creswell, 2013b).

Like any other method, document analysis entails certain limitations to its use. The materials maybe incomplete or inaccurate, and this may affect the validity (Creswell, 2013b). The document may display limited relevance to a research objective and only answer part of the inquiry, which explains the need to use it alongside other methods of data collection (Shaw et al., 2004). Yin (2013) explains that selection bias and reporting bias are other identified weaknesses of documentary analysis, where the selection of the documents is incomplete or the reporting reflects the bias of its' author.

4.5.3 Interviews

Mays and Pope (2000) identify interviews as the most commonly used qualitative data collection tool in healthcare settings. The use of interviews serves the purpose to 'explore the views, experiences, beliefs, and /or motivations of individuals on specific matters' (Gill et al., 2008), which allows for a deeper exploration of the phenomenon under study.

4.5.3.1 Types of interviews

Three main types of interviews are recognised: first, the structured interview which entails a fixed pre-determined set of questions, allowing for little or no variation within the course of the interview, ultimately narrowing the participant response to the least possible input. Second, the unstructured or in-depth interview in which there is often much less organisation in the structure of the interview. However, this can make it difficult to manage and time consuming. Third, the semi-structured interview which is organised around a set of pre-determined, open-ended questions, not only allowing the course of the interview to be flexibly structured, but also enabling the interviewer to probe for more elaboration and address further issues emerging during the interview (Gill et al., 2008).

As this work was seeking to address pre-defined issues related to the impact of accreditation and was clearly underpinned by a theoretical framework, semi-structured interviews were selected as the most appropriate option. An additional advantage was that

the use of an interview schedule was helpful in supporting the researcher through the process of interviewing.

4.5.3.2 Interview technique

DiCicco‑Bloom and Crabtree (2006) have argued for the development of a positive relationship while performing the interview by respecting the interviewee and displaying confidence in their responses and information. This raises the issue that an interviewer must possess certain skills and awareness for him or her to conduct a successful interview and establish a trusting atmosphere for the interviewee to express his or her opinions and share their experience.

 The process of interviewing demands a certain sequence of steps that are listed below (Creswell, 2013a):

- Determine the questions that will be answered by the interviews.

-Select the interviewees who are involved in the phenomenon and can best answer the questions.

- Decide what type of interview best suits the research aim and the researcher circumstances (telephone, or face-to-face interviews).

- Develop the interview schedule including the interview process and the questions.

- Pilot test the interview questions for further refining.

- Establish the place to best conduct the interview.

- Before beginning the interview provide the participant with a consent form to sign and discuss briefly the purpose of the interview and the estimated time to complete it.

- Ask permission to audio record the interview, explaining how all recordings will be handled with confidentiality.

- Practice good interview manners by respecting the participant and being a good listener.

The methods in Chapter 7 will demonstrate how these steps were met during the conduct of the interviews.

4.5.3.3 Strengths and weaknesses

Interviews can be highly flexible, suit many settings, and provide a great source of in-depth data (Cassell, 1994). However, despite the advantages of the interview technique, there are certain limitations associated with it. For example, some degree of influence may affect the interviewee responses and lead to some degree of bias if the participants are unknowingly affected by the interviewer's status or position, or if they try to prove that an intervention is working (Boyce and Neale, 2006, Yin, 2013). Interviews can also be time-consuming, due to the many steps required to complete the process. It takes time to carry out the interview, then transcribe it and finally analyse it (DiCicco‑Bloom and Crabtree, 2006). However, the use of qualitative data analysis software can help in the analysis stage, particularly in supporting the organisation and retrieval of coded data for later analysis and comparison.

Another limitation is the differences acknowledged in human nature, where not all people have the skills of being perceptive and articulate, and this could affect the quality of the data obtained (Creswell, 2013b). Ritchie claims that one challenge that could be encountered during the course of the interview is when the topic is sensitive and may elicit an emotional response like anger or embarrassment from the interviewee, and this can first be detected through body language. In such situations, it is important that the interviewer remains calm and in control and tries to reassure the participant and encourages them to express their feelings (Ritchie et al., 2013).

In this research semi-structured interviews were adopted with the self-assessment team members to elicit their views on the implementation process of accreditation and their perception of its impact on healthcare services. A semi-structured approach was chosen as it gave a structure to each interview, while allowing some flexibility in the questions, which helped in further exploring any key issues that might emerge during the interview. The one-to-one interview was anchored on the fact that participants were conveying their actions, experience and insight about an issue within their social context through verbal communication. Accreditation is a complex intervention that was introduced into an already multi-layered and complicated system. One-to-one interviews permitted a fuller exploration of the individual's experience, motives and view of the process. Such an

approach also helped to uncover the impact on both the individuals and the services as well as the barriers and facilitators of implementation (Creswell, 2013a, Ritchie et al., 2013).

4.6 Data analysis

Qualitative data analysis does not start when the data collection is complete. In fact, it is a continuous process throughout the entire period of the qualitative research, which means that qualitative data collection and analysis are overlapping rather than sequential (Ziebland and McPherson, 2006, Burnard et al., 2008). Different approaches can be taken to qualitative analysis, depending on the type of research being conducted (Burnard et al., 2008, Barnett-Page and Thomas, 2009). For this work, thematic analysis was the approach selected.

4.6.1 Thematic analysis

Thematic analysis is one of the most widespread analytical methods used in qualitative research (Burnard et al., 2008, Braun and Clarke, 2014). It involves analysing texts and transcripts, identifying emerging codes and themes, and labelling segments of the data according to those codes and themes. Braun and Clarke (2006) in their paper 'Using thematic analysis in psychology' helped to establish guidelines for thematic analysis, emphasizing its role in generating an in-depth, detailed, and complex account of data as a stand-alone analysis approach.

Thematic analysis was chosen for the data generated from the documents and the interviews because it's a flexible approach that copes with a range of data types, and aims to identify the main themes contained in the data (Thomas and Harden, 2008). The thematic analysis method begins by familiarising oneself with the data as a whole and reading through the documents and texts to grasp a general sense of the information. Then the process of coding follows; this means organising, categorising and labelling key concepts in the data. Miles et al. (2013) define a code as: 'most often a word or short phrase that symbolically assigns a summative, salient, essence-capturing, and/or evocative attribute for a portion of language-based or visual data'. Codes are constantly revised and compared to help group together similar codes and label them into a theme. Themes are described as ' general propositions that emerge from diverse and detail-rich experiences of

participants and provide recurrent and unifying ideas regarding the subject of inquiry'
(Bradley et al., 2007). Those themes are further revisited and revised, and descriptive
names are assigned to them in preparation to produce the final report.

To help with the process, the Framework approach was used (Ritchie et al., 2013).
Framework analysis is composed of five stages: familiarisation; identifying a thematic
framework; indexing; charting; mapping and interpretation. This method appeared suitable
to use due to the application of a predefined framework (NPT), which helped to develop a
deeper understanding of the phenomenon under study.
The detailed method is described in Chapters 6 and 7.

4.7 Summary

This chapter has outlined the overall research design used in this work and the theoretical
framework that underpinned it. In doing so, I have considered the broad strengths and
weaknesses of the research approaches used. The next three chapters report the actual
studies conducted. The detailed methodology, procedures, results, and discussions for each
method are described within each chapter. Ethical approval is described in Chapter 7.
Finally the closing chapter includes a synthesis of the findings from the three studies, a
general discussion and provides recommendations and conclusions.

Chapter 5- Systematic Review

5.1 Introduction

This chapter focuses on the systematic review of the literature exploring and assessing (1) the facilitators and barriers to the implementation of accreditation and, (2) the impact of accreditation programmes on the healthcare services in hospitals from the perspective of healthcare professionals.

This chapter will provide a detailed description of the search strategy, inclusion and exclusion criteria and the data analysis approach, before going on to provide a description of the included studies. Reflecting on the theoretical framework, the findings of each study are then mapped to the constructs of Normalisation Process Theory.

5.1.1 Rationale

Healthcare accreditation is a complex intervention, and its implementation poses a challenge to any organisation. The process of embedding the intervention into the normal routine of the hospital faces many obstacles and barriers, while certain facilitators are vital for successful integration.

Systematic reviews are a recognised approach to collecting, appraising and synthesising bodies of research in a clearly defined area (Bambra, 2011). In particular, systematic reviews can help to identify gaps in our knowledge. There have been other systematic reviews conducted into the impact of accreditation programmes (Greenfield and Braithwaite, 2008, Al Awa et al., 2011b). One examined the views of healthcare professionals towards accreditation, however, the paper didn't provide clear selection criteria, nor did it use a theoretical framework to inform our understanding (Alkhenizan and Shaw, 2012). The use of theory, as outlined in Chapter 4, helps us to understand how changes take place within an organisation, and identifies the components and dimensions of accreditation implementation.

Another recently published review of the literature addressed the factors affecting implementation of accreditation programmes and the impact of the accreditation on quality improvement in hospitals (Ng et al., 2013). However, it had two limitations. First, the outcome measure of impact focused only on quality of healthcare, which is insufficient because it didn't consider the impact on patient safety, which represents an integral part of the Standards. Second, the search was limited to two databases and might have resulted in missing relevant publications.

A systematic review was an appropriate method for answering the research questions described below for several reasons. First, it offered an opportunity to consider the implementation of a complex programme across a range of research studies. Second, the impact of accreditation on healthcare services and the barriers of implementation have been previously researched and explored in different ways by many groups. Third, this approach enabled me to identify and critique the data generated from this previous research. The approach to capturing all the significant facilitators and barriers in the process of implementation was informed by NPT.

For the purpose of this review, and as previously explained in Chapter 3, accreditation was defined as 'a self-assessment and external peer review used by healthcare organisations to accurately assess their level of performance in relation to established standards, and to implement ways to continuously improve the healthcare system' (ISQUA, 1998).

5.1.2 Research questions

- What are the facilitators and barriers of accreditation implementation, as described in the international literature?
- How did accreditation impact on the services, from the perspective of healthcare professionals engaged in the accreditation programme as demonstrated in the international literature?

5.2 Methods

A protocol for this systematic review was developed and registered with the PROSPERO database (http://www.crd.york.ac.uk/PROSPERO/). Full details of the methods are detailed here.

5.2.1 Search strategy

The search strategy described here was initially developed and conducted by another PhD student, Lamia Al-Aradi, as she was conducting a systematic review of the impact of accreditation on primary care services and was also supervised by my primary supervisor (COD). I was then involved in the discussions about the search strategies for the substantive searching, conducted in Spring 2014. All other steps of the review were conducted by myself, as detailed.

Following initial scoping work, a substantive literature review was conducted in the Spring of 2014. This was developed following discussion with my supervisors, in collaboration with Lamia Al-Aradi and with a librarian at the University of Glasgow. This search strategy was adopted from the Greenfield and Braithwaite (2008) health sector accreditation research systematic review. The main keywords used in the search included: accreditation; Joint Commission on Accreditation of Healthcare Organisations; healthcare services; healthcare quality; and professional attitudes. For full details of the search strategy, see **Appendix 1**. Other terms, such as Quality Improvement (QI) and Total Quality Management (TQM) are often discussed alongside accreditation; however adding quality management and improvement terminologies affected the search results dramatically, identifying a large number of papers which were not about accreditation, but focused more on QI and quality criteria for healthcare management. Therefore, in the end, these were not included in the searches.

Five databases were searched: Scopus, Medline, Embase, Cochrane Library and Science Direct. These were chosen because they cover healthcare and organisational literatures and were felt to give broad coverage of the relevant research fields. As far as possible, the same terms and procedures were employed for all of the databases. Other searching, such as searching the grey literature or hand searching journals, was not undertaken due to the

time limit of the PhD. The time frame for the search was from 2003 to 2013. 2003 was selected as the start year for two reasons: (1) this was the year that the Canadian Council on Health Services Accreditation (CCHSA) published their first report titled "National Health Accreditation Report"; (2) this was also the year when the Kuwaiti MOH launched its Agenda for Change by establishing the organisational structure for accreditation. Therefore, pragmatically, it was thought to be a good starting point for a 10-year search of the literature.

The searches identified 5497 papers, of which 4225 were duplicates and removed in Endnote. The remaining 1272 papers were imported into DistillerSR for screening and data extraction – described in the following sections.

5.2.2 Inclusion and Exclusion criteria

All 1272 papers were uploaded into DistillerSR for screening and review. DistillerSR is a web-based screening and data extraction software that provides a systematic and organised approach to the review, with the advantage of easy access because it is web-based. Furthermore, it is able to generate comprehensive reports about the systematic review. The titles and abstracts of all 1272 papers were independently screened by the researcher and Professor Catherine O'Donnell (COD). At this stage, references relevant to the aim of this review were included according to the inclusion and exclusion criteria stated in **Table 5-1**. Any conflicts were discussed between them and, if needed, referred to the second supervisor (JM) for resolution.

Table 5-1 Level 1 abstract screening

Inclusion criteria	Exclusion Criteria
• Focus on accreditation • Focus on the process or implementation of accreditation • Outcome about accreditation impact	• Focus on accreditation of educational programmes • Surgical or medical procedures accreditation • Single discipline accreditation e.g. laboratory accreditation

A total of 178 references were potentially eligible for inclusion in the second stage of the review. A full paper review level was set into the software, and the full texts were retrieved

and attached. At this level, the full text of the articles were reviewed and compared against more detailed inclusion criteria as seen in **Table 5-2**. Papers were not excluded on the basis of study design, as it was recognised that different approaches – both quantitative and qualitative – might be used to gather the views of healthcare professionals.

Two reviewers, myself and the primary supervisor (COD), screened the full-text papers independently according to the inclusion and exclusion criteria. In the case of any conflict in any paper, the reviewers read the paper and reached agreement through discussion. A total of 157 references that clearly did not meet the inclusion criteria were excluded at this level; 21 eligible papers were included in the review.

Table 5-2 Level 2 full-text screening

Inclusion criteria – the article must:
• Consider hospital accreditation
• Must have data (so editorials, commentaries, opinion pieces excluded)
• Include an outcome about the impact of accreditation on quality and safety of healthcare
• Address the facilitators and barriers of the implementation
• Reflect a professional perspective
• Be available as a full-text paper
• Be published in English

5.2.3 Data extraction and quality assessment of the studies

The next level in Distiller comprised completion of the data extraction and quality appraisal forms of all the 21 eligible papers.

5.2.3.1 Initial data extraction

The first stage of the review was to map the type and range of studies included in the review. To facilitate this, a data extraction form was developed by myself and agreed by the supervisors Professor Catherine O'Donnell (COD) and Professor Jillian Morrison (JM). The form was a useful tool for organising the information from each reviewed study. It summarised the citation; the study design; data collection method; location and duration;

sample size; ethical approval; population involved; aim; key findings; and limitations of the study. Again, this was conducted by two reviewers (myself and COD) to ensure rigor in the characterisation of the studies.

5.2.3.2 Quality appraisal

A key task in a systematic review is to assess the quality of the included studies (Ryan et al., 2012). Quality appraisal is the process of applying rules of evidence to a study in order to evaluate the validity of data, methodology, conclusions, ethical consideration and robustness of reporting, bearing in mind that the rules of evidence may vary with study type (Last et al., 2001). The purpose of this was not to further exclude studies, but to gain some knowledge as to the methodological quality of the published literature and to acknowledge the strengths and weaknesses of the included papers.
As this review included a range of study designs, several recognised appraisal checklists were used.

The scoring sheet for the systematic reviews was based on the PRISMA checklist items (Moher et al., 2009). Eight questions were used to examine the quality of systematic reviews. The assessment of each study involved assessing the search method, the selection process, data extraction, bias elimination and data presentation. A score of either 0 or 1 was awarded to every section, and the higher the overall score a study achieved, the better the methodological quality of the paper. The following overall scale was applied: a score of 0-3 meant a poor quality study; 4-5 indicated a fair quality study; and 6-8 meant a study of good methodological quality.

With respect to the methodological quality of the qualitative studies, a scoring sheet was developed based on the one used in the Critical Appraisal Skills Programme (CASP http://www.casp-uk.net/) and later used in the Scottish Evidence-Based Practice Course (http://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/ebp/checklists/#d.en.19536). A checklist of eight questions was used to screen the quality of the papers by critically assessing the study design and appropriateness, data collection and analysis, bias, and ethical aspects. A score of 0 (poor), 1 (fair) or 2 (good) was estimated for every question. The final result was assessed as 'good' if there was no poor score

assigned to the paper: 'fair' if there was one poor score: and 'poor' for two or more poor scores.

With the wide range of descriptive studies in this review (survey, cross-sectional, cohort, and routine data analysis) we used a mixed method tool to encapsulate these quantitative methods. Moreover, we tried to cover all the important aspects of the different methods. A total of twelve questions were set covering the method of data collection, case selection, potential bias, and data analysis. A similar scoring system to the qualitative studies list was implemented in this section. See **Appendix 2** for scoring sheets.

5.3 Theoretical coding and data analysis

As described in Chapter 4, the use of a theoretical framework can help to order the analysis and focus attention on key issues, in this case the facilitators and barriers to the implementation of accreditation as described by the healthcare professionals involved (Sandelowski et al., 2012, Gough, 2015). While there were a range of theoretical approaches that could be used, for this work we selected Normalisation Process Theory (NPT) to underpin and inform data analysis (May and Finch, 2009). This was explained in greater detail in Chapter 4.

Given that the systematic review contained a range of quantitative and qualitative studies, the data synthesis used in this review had to be able to incorporate these different approaches. As discussed in Chapter 4, the approach taken was to use a framework approach, informed by the Normalisation Process Theory. This type of research synthesis has been described as synthesis by configuration, i.e. that diverse sets of findings are arranged or 'configured' into coherent patterns, often according to a pre-defined theory (Barnett-Page and Thomas, 2009, Sandelowski et al., 2012). The researcher adopted the framework analysis for three reasons. First, a statistical meta-analysis was not possible due to the lack of interventional or experimental studies, such as randomized controlled trials. Second, there was a marked variety and complexity in the accreditation interventions assessed, the organisational impact or lack of impact, and the barriers and facilitators to the implementation process. This heterogeneity meant that quantitative comparison of outcomes between studies was difficult, and indeed was probably inappropriate. Third, there was a considerable range of research designs employed within the accreditation

literature including quantitative, qualitative, and mixed-method (Barnett-Page and Thomas, 2009). The analysis described here was guided by the four constructs of the NPT and their respective subs constructs and was informed by the work of Mair et al, who used NPT to analyse the international literature on the implementation of e-health systems (Mair et al., 2012).

The process of analysing the 21 included papers broadly followed Spencer and Ritchies' five stages of framework analysis mentioned in Chapter 4. The first stage was *familiarisation*, where the researcher began by reading all the 21 eligible articles several times to be familiar with the data and become immersed in the data.

The second phase was to *identify a thematic framework* with the constructs and sub-constructs of the NPT framework used as a reference for the researcher and the supervisor (COD) in the process of coding all the data. Using the framework reported in Mair et al. (2012), as well as other NPT papers (Murray et al., 2010, McEvoy et al., 2014), a preliminary coding framework was developed. This was revised following discussions with the primary supervisor (who has extensive experience of applying NPT to implementation research) and then tested against 2 included papers. The framework took the form of 16 questions to apply to the included papers, for example: *Do stakeholders see accreditation as a new way of working?* This was coded under Coherence, Differentiation. **Table 5-3** shows the NPT coding framework to which the articles were coded. Adopting a predetermined conceptual framework can raise concerns of forcing the data to fit pre-selected codes. This can be avoided by adding a construct to the framework addressing any data falling outside the NPT coding. Mair et al. (2012) in their systematic review reported that 6% of data did not fit into the NPT framework because it either represented an attitudinal or technical aspect or because it reflected general and vague contextual data.

Both the researcher and (COD) prepared the framework by first reading three papers in detail and then developing and reviewing the coding framework. This was discussed together in a coding clinic to resolve any discrepancies in understanding. See **Table 5-3**.

Table 5-3 NPT based coding framework for accreditation

Coherence (Sense-Making Work)	Cognitive Participation (Relationship Work)	Collective Action (Enacting Work)	Reflexive Monitoring (Appraisal Work)
Differentiation: Do stakeholders see accreditation as a new way of working? Is it different to current practice? C1	Initiation: Are key individuals willing and able to drive forward the implementation? Can they engage others in the implementation? CP1	Skill set workability: How accreditation fitted with existing working practices? Do those implementing the intervention have the correct skills and training for the job? Does it affect division of labour? CA1	Reconfiguration: Do individuals try to alter a routine or a process, when required, to accommodate the standards requirements? Will stakeholders be able to modify the intervention based on evaluation and experience? RM1
Communal specification: Do individuals share understanding of the aims, objectives and expected benefits of accreditation? C2	Legitimation: Do individuals have the sense that it was right to be involved in accreditation? CP2	Contextual integration: The overall fit of accreditation with organisational goals and context. Is there organisational support? This can be at local, regional or national level. CA2	Communal appraisal: How will stakeholders collectively judge the effectiveness of the intervention? RM2
Individual specification: Do individuals understand their specific tasks and responsibilities in implementing accreditation? C3	Enrolment: Are individuals able to organise themselves, and others, to drive forward the implementation? (Engaging with others (health professionals) regarding the accreditation and implementation process to gain their support) CP3	Interactional workability: Does accreditation make it easier or harder to complete tasks or do the routine "day job"? CA3	Individual appraisal: Assessing individually the value of accreditation and effectiveness of the intervention to impact the service. How will individuals judge the effectiveness of the intervention on them and their work environment? RM3
Internalization: Do all stakeholders understand the potential benefits and value of the intervention? C4	Activation: Do participants collaboratively define the actions and procedures needed to sustain involvement in accreditation? CP4	Relational integration: Do the participants Develop relationship and confidence with other professionals? Do they have confidence in the new intervention? CA4	Systemization: How are problems and benefits identified from feedback, formally or informally? RM4

NVivo (version 10) was used to support the data analysis. It is a computer-assisted qualitative data analysis software (CAQDAS), which helps in managing large amounts of qualitative data. A project was created for the systematic review, where all the 16 constructs of the NPT were included as nodes. One more node was further added and

named (outside) to include any data not fitting within the predetermined NPT codes. Following this, the 21 PDFs were transferred into the NVivo project for the analysis.

Third was the *indexing* phase*,* where each paper was viewed as a piece of qualitative data and coding focused primarily on the results and discussion sections of each paper. Reading the paper, codes were applied to pieces of text discussing barriers and facilitators or the process of implementation and thought to map to the four NPT domains (coherence, cognitive participation, collective action, reflexive monitoring) and the sub-constructs of NPT (**Table 5-3**); this coding was carried out by both the primary supervisor and myself. Regular coding clinics were held to discuss the application of the codes and discrepancies in coding, where they occurred. Pieces of text thought to relate to the process of implementing accreditation, but not codeable to NPT were still coded, in order to capture anything that might fall outside the NPT framework.

The fourth stage was *charting,* which entailed categorising the extracted codes into charts according to themes and sub-themes based upon the relationships between the codes. The NVivo software enabled the researcher to generate the charts, or reports. The charts, or reports, grouped together similar codes with reference to the relevant paper specified next to each text segment, thus facilitating comparison across the papers. Those were further reviewed and refined by several meetings with supervisors until the final version was reached.

Last, *mapping and interpretation* was carried out where the data was examined for associations, patterns, and interpretations, for example, by comparing different accreditation systems or analysing different professional groups perspectives. This process was guided by going through the charts, reviewing the coding texts and comparing the data across the charts.

5.4 Results

5.4.1 Overall characteristics of the included studies

As mentioned previously, 21 papers were eventually eligible for the systematic review as the flowchart illustrates in **Figure 5.1**.

Figure 5.1 Flowchart of included papers

```
┌─────────────────────┐
│    Full search      │                    ┌──────────────────────────┐
│    (n= 5,497)       │───────────────────▶│   Duplicates excluded    │
└─────────────────────┘                    └──────────────────────────┘
           │
           ▼
┌─────────────────────┐
│   Title/Abstract    │
│     screening       │
│    (n= 1,272)       │
└─────────────────────┘
           │                      ┌──────────────────────────────────┐
           │                      │ Papers excluded (n= 1094)        │
           │                      │ -Not about accreditation= 845    │
           │                      │ -Accreditation standards= 43     │
           │─────────────────────▶│ -Accreditation of education      │
           │                      │ programmes= 57                   │
           │                      │ -Accreditation of procedures=    │
           │                      │ 15                               │
           │                      │ -Accreditation of professions    │
           │                      │ or single setting= 64            │
           │                      │ -Others= 70                      │
           │                      └──────────────────────────────────┘
           ▼
┌─────────────────────┐
│ Full paper screening│
│      (n=178)        │
└─────────────────────┘
           │                      ┌──────────────────────────────────┐
           │                      │ Papers excluded (n= 157)         │
           │                      │ -Not about accreditation= 54     │
           │                      │ -Not data driven= 47             │
           │                      │ -Not set in hospitals= 29        │
           │                      │ -Full paper unavailable= 11      │
           │─────────────────────▶│ -Not focused on barrier or       │
           │                      │ impact= 6                        │
           │                      │ -Not focused on professional     │
           │                      │ views= 5                         │
           │                      │ -Further duplicates= 5           │
           │                      └──────────────────────────────────┘
           ▼
┌─────────────────────┐
│ Papers included in  │
│ the review (n= 21)  │
└─────────────────────┘
```

5.4.1.1 Study Details

Of the 21 studies included, most were located in the United States (6) followed by Australia (4), Saudi Arabia (3) and England (3). This might be attributed to the fact that both the USA and Australia have been pioneers in developing health accreditation systems, through establishing The Joint Commission and The Australian Council on Healthcare Standards, respectively. Other papers were located in Hong Kong, Thailand, Italy, Turkey and Denmark (one paper each). Before 2011, there were 9 papers published; the numbers increased in 2011 (6 papers), with 3 each in 2012 and 2013.

5.4.1.2 Quality appraisal

Methodological approaches of the included papers included descriptive studies, systematic reviews and qualitative methods. There were 12 descriptive studies, of which seven studies employed a survey as a data collection tool. Out of these seven, one supplemented a survey with interviews and document review as a case study and another supplemented the survey with routine data analysis. The remaining five depended mostly on routine data analysis.

Descriptive studies*:*
Overall, there were 12 studies employing descriptive methodologies. Seven studies used cross-sectional surveys, with one of them incorporating routine data analysis and another using interviews as well. Five studies focused on routine data analysis. When judged against the checklist, three of the routine data analysis studies were rated as good quality (Lutfiyya et al., 2009, Schmaltz et al., 2011, Mills and Gillespie, 2013), one was fair (Al Awa et al., 2011a) and one was of poor quality (Sriratanaban and Wanavanichkul, 2004). This last study on hospital wide quality improvement in Thailand was rated poor due to the lack of a clear statement of the research question. Also, there was no information given on the percentage of the total population who participated in the study, nor whether the study population was representative of the target population. In addition, no effort was made to address any sources of bias.

Half the studies using surveys as their main data collection method were of poor quality, with only two scoring well (Braithwaite et al., 2010, Al Awa et al., 2011c). The reasons for

the low score were that many essential elements were either missing or not mentioned. Longo et al. (2007) in their study failed to specify the source of cases identified and the representativeness of the sample. Moreover, no clear explanation was presented regarding the pilot phase of the survey nor were there any attempts to clarify sources of bias. Two more articles (Benedicte Juul et al., 2005, Seren and Baykal, 2007) scored poorly for the same reasons.

Systematic reviews:

Four out of six reviews were of good quality (Flodgren et al., 2011, Greenfield et al., 2012, Hinchcliff et al., 2012b, Ng et al., 2013), one was rated fair (Alkhenizan and Shaw, 2011) and one poor (Fortes et al., 2011). The good quality studies demonstrated a clear search strategy with well-stated inclusion and exclusion criteria with study selection, data extraction and quality assessment conducted independently by at least two members of the team. The review by Alkhenizan and Shaw (2011), while of acceptable quality, did not mention if the two authors contributed to study selection or data processing independently. One review was rated poor because it lacked many essential elements. There was no search strategy presented; no inclusion/exclusion criteria; no measures to reduce bias; and the data extraction method was missing.

Qualitative studies:

Three studies were identified to be qualitative in nature, of which two scored well in quality assessment (Balogh and Cook, 2006, Hinchcliff et al., 2013). The third study was rated of poor quality because it lacked a clear statement of the aim of the research, leading to an inability to clearly assess the appropriateness of the research design or the data collection method. Furthermore, ethical issues were not taken into consideration nor was there a clear statement of the findings (Vanoli et al., 2012).

5.4.2 Key findings of included studies

Most studies included in this systematic review focused on the impact of the accreditation, for example, Lutfiyya et al. (2009) compared quality indicators between accredited and non-accredited hospitals. Schmaltz et al. (2011) also aimed to examine the association between accreditation status and performance measures. However, fewer studies explicitly

tried to identify facilitators and barriers, which could contribute to the successful (or unsuccessful) implementation of accreditation programmes. These key findings are summarised in **Table 5-4**.

More than half of the papers (13) explored the ways in which accreditation programmes impacted on the quality and safety of the health services under study. Performance quality indicators provided a helpful tool to evaluate accreditation impact in five of the selected studies, measuring the impact of accreditation on various aspects of the service, for example general clinical performance, patient involvement, patient mortality and hospital acquired infections (Lutfiyya et al., 2009, Braithwaite et al., 2010, Al Awa et al., 2011a, Al Awa et al., 2011c, Schmaltz et al., 2011). Four papers evaluated the impact of accreditation by conducting systematic reviews of the literature (Alkhenizan and Shaw, 2011, Flodgren et al., 2011, Hinchcliff et al., 2012b, Ng et al., 2013). They found that evidence was inconclusive about the impact of accreditation programmes on organisations.

Two studies focused on nursing-related outcomes to evaluate the effect of the Magnet accreditation programme, with one study investigating the association between patient falls and Magnet status (Lake et al., 2010) and the other one observing the effect of Magnet accreditation on both pressure ulcers and failure to rescue (Mills and Gillespie, 2013). While Mills and Gillespie found that Magnet accreditation status had no impact on the indicators of performance they selected to study (pressure ulcers and 'failure to rescue'), Lake et al did document a decrease in fall rates, although this appeared to be associated with a concomitant increase in nursing staffing.

The last two studies investigated the impact of accreditation on the quality and safety of healthcare services by a different approach. One study examined the availability and quality of clinical guidelines (Benedicte Juul et al., 2005), and reported that accredited units use of guidelines increased with accreditation. The other investigated the degree of implementation of patient safety systems and identified a significant improvement in implementing safety systems with accreditation status (Longo et al., 2007).

Factors found to influence the implementation process of accreditation were explored in five studies. Sriratanaban and Wanavanichkul (2004) Balogh and Cook (2006) and Hinchcliff et al. (2013) all investigated the enabling and inhibiting factors in the process of accreditation implementation using a qualitative approach. Interviews and focus groups with key individuals were conducted in all three studies. Moreover, documents related to accreditation were also analysed for any informative data. One study explored the factors by conducting a systematic review (Ng et al., 2013) and the last one sought the opinion of nurses reflecting their readiness for change through the use of an online survey (Caldwell et al., 2009). Many factors were identified as important in aiding the process of implementation including the involvement of key stakeholders and their ability to recruit staff, communication and teamwork, training and education and financial incentives.

The remaining four studies indirectly addressed the impact of accreditation on services and the barriers to implementation by focusing on other aspects of the programme. Fortes et al. (2011) attempted to analyse the accreditation proposal in three countries, focusing on the health policy and regulations underpinning the introduction of the intervention and the financial funding available in each country. The main purpose of the second paper was to compare the self-evaluation and the subsequent surveyors' evaluation. This report, however, helped to shed light on some defects in the process and emphasized the gaps observed during preparation of the survey visit and the on-site visit (Vanoli et al., 2012).

Another study conducted in Istanbul discussed the relationship between receiving a quality certificate and the organisational culture. Furthermore, the authors aimed to identify attitudes of healthcare professionals towards this change (Seren and Baykal, 2007). In doing so, they identified the importance of a cooperative culture in directing the attitude of the professionals involved towards change. In the last study, Greenfield et al. (2012) evaluated the development and implementation issues of healthcare accreditation standards in a systematic review. They found only one study discussing the implementation process by identifying several enablers and barriers, while all the remaining studies focused on the impact of standards on the service. **Table 5-4** summarises the description of the studies.

Table 5-4 Descriptive summary of the selected studies

Study	Aim of the study	Type of study/ Data collection method	Key findings
1- Fortes et al, 2011 France, UK and Cataluña	To find out about the relevant aspects of the strategies of these countries' institutions that adapted accreditation to national circumstances in the healthcare policy arena	-Systematic review Literature - Document review	- Although there are similarities in the basic approaches and standards used, there are different models of accreditation. - Setting standards raises the question of who should define them and how they should be monitored. - Accreditation's methodology cannot be seen only as a voluntary process for assessing quality in healthcare or perceived as tool for certification and regulation. - Interests in accreditation can be driven by a number of different forces, which depend upon the model adopted. Therefore, it can only be understood in the policy arena of each country.
2- Balogh and Cook, 2006 England	To explore the process of implementing the Magnet accreditation process in Rochdale NHS trust	Case study - 26 interviews with senior staff (managerial, medical, nursing) - Document analysis - Field notes	The work of applying for Magnet accreditation built upon a previous 2-3 year programme of shared governance and clinical leadership throughout the Trust. Senior staff felt this had been an essential foundation to applying for Magnet status Impact: - Process allowed staff to review their practice and contributed to other QI initiatives. - Magnet allows lessons to be learned and shared across the organisation. - Medical and AHP professionals contributed to process, as well as nursing staff. Challenge: - Costs incurred - Terminology interpretation - Focus on nursing - Duplication of documents
3- Al Awa et al, 2011 Saudi Arabia	To examine the perception of nursing staff on the quality of patient care and patient safety after implementation of accreditation scheme. To identify any contributing factors that can explain changes.	Before and after descriptive study -Cross-sectional survey, pre and post accreditation with registered nurses	The comparison of percentages of those who answered Agree and Strongly agree pre and post-accreditation items showed post-accreditation improved perception on the quality of patient care and patient safety and promoted good safety practices. Accreditation has an overall statistically highly significant perceived improvement on quality of patient care and patient safety ($p<0.001$). Impact: Improvement is noticed in: - Nursing Clinical Information. - Patient Medication Information. - Risk Management Information. - Risk Prevention. Challenge: Multi-cultural, multi-language environment.

4- Lutfiyya et al, 2009 US	To determine whether process measures used in U.S. centres for Medicare and Medicaid Services Hospital Compare database differed between hospitals with and without accreditation status.	- Cross-sectional study - Routine data analysis from 730 critical access hospitals	The differences between accredited and non-accredited rural critical access hospitals for 4 out of 16 hospital quality indicators were statistically significant (P 0.01) and favoured accredited hospitals. Also, accredited hospitals were more likely to rank in the top half of hospitals for 6 of the 16 quality measures.
5- Mills and Gillespie, 2013 US	To compare the effect of Magnet status on nursing sensitive patient outcomes 1-Hospital rates of pressure ulcers 2-Hospital rates on failure to rescue	Descriptive Secondary analysis of routine data Five years (2001-2005) of patient and hospital data.	Comparative analysis demonstrated no significant differences for risk-adjusted rates for pressure ulcers and failure to rescue.
6- NG et al 2013 Hong Kong	-To identify factors that influence accreditation implementation - To assess the impact of accreditation process on quality improvement in public hospitals	Systematic review	Strengths: - Increased staff engagement and communication - Multidisciplinary team building - Positive changes in organisational culture - Enhanced leadership and staff awareness of continuous quality improvement Weaknesses - Organisational resistance to change - Increased staff workload - Lack of awareness about continuous quality improvement - Insufficient staff training and support for continuous quality improvement - Lack of applicable accreditation standards for local use - Lack of performance outcome measures. Opportunities - Identification of improvement areas - Enhanced patient safety - Additional funding - Public recognition, - Opportunistic behaviours - Funding cuts - Lack of incentives for participation - Regulatory approach to mandatory participation.

7- Braithwaite et al, 2010 Australia	To determine whether accreditation is associated with self-reported clinical performance and independent ratings of four aspects of organisational performance	-Blinded assessment of random sample of organisations wide Questionnaire - Routine data analysis	Accreditation performance was significantly positively correlated with organisational culture (rho=0.618, p=0.005) and leadership (rho=0.616, p=0.005). There was a trend between accreditation and clinical performance (rho=0.450, p=0.080). Accreditation was unrelated to organisational climate (rho=0.378, p=0.110) and consumer involvement (rho=0.215, p=0.377).
8- Longo et al 2007 US	To identify the organisational characteristics that predicts greater implementation of patient safety system, in terms of both extent of systems and progress over time.	Descriptive Repeated Survey Two-factor quasi-experimental design. Administered to hospitals (n=107) completing both surveys	Using the overall measure, Joint Commission-accredited hospitals showed statistically significant improvement, as reflected in the sum score (p = .01) Non-accredited hospitals did not show statistically significant improvement (p = .21) Joint Commission accreditation was the key predictor of patient safety system implementation. Management type and urban/rural status were secondary predictors.
9- Schmaltz et al, 2011 US	To examine the association between Joint Commission accreditation status and both absolute measures of, and trends in, hospital performance on publicly reported quality measures for common diseases.	Descriptive Analysis of routine Performance data for 2004 and 2008 for US acute and critical care obtained, and augmented with JC performance data	- The Joint Commission accredited hospitals performed better than non accredited on most of the publicly reported measures - Accredited hospitals had larger gains over time, and were significantly more likely to have high performance in 2008 on 13 out of 16 standardised clinical performance measures and all summary scores.

10- Sriratanaban and Wanavanichkiul, 2004 Thailand	To report on planning and implementation of hospital wide quality improvement programme required for accreditation	Case study Mixed Qualitative: - Document review - Interviews - Observation Quantitative: - Two in-house surveys of hospital staff (2002, 2003)	A range of critical success factors identified for successful implementation including: (1) Role of leadership (2) Need for quality strategists (3) Physician involvement & participation in QI teams (4) Vertical & horizontal communication (5) Performance drivers (6) Simplicity in CQI (7) Value of a learning culture Impact: Quality improvement noticed in: - In-patient mortality - Patient satisfaction - Reporting of patient risk incidents - Number of serious incidents. - Management of hospital resources Challenges: - Communication gaps - Complicated QI tools - Financial cost
11- Al Awa et al, 2011 Saudi Arabia	To assess the impact of accreditation process on patient safety and quality of care at a hospital in Saudi Arabia	Descriptive before and after study Analysis of routine data (119 performance indicators)	The following areas had the corresponding number of indicators that were found to be sensitive to accreditation and that significantly improved post-accreditation: Four indicators of perioperative mortality and rates of neonatal mortality per 100 NICU admissions ($p<0.05$). Healthcare-associated Infections: sixteen out of twenty-six measured indicators ($p<0.05$). Blood utilization: One out of two measured indicators, i.e., total number of blood transfusion reactions ($p<0.05$). Surgeries and invasive procedure: Two out of seven measured indicators, i.e., total number of unplanned returns to surgery within 48 h and rate of unplanned returns to surgery per 100 operations ($p<0.05$). Two out of eight measured indicators, i.e., total number of patients who survived after the first CPR and rate of survival after first CPR per 100 coded patients ($p<0.05$). Two out of eighteen measured indicators, i.e., rate of pressure ulcers per 1000 admissions and total number of the occurrence variance reports ($p<0.05$).
12- Alkhenizan and Shaw 2011 Saudi Arabia	Evaluate the impact of accreditation programmes on the quality of healthcare services	Systematic review	General and subspecialty accreditation programmes significantly improve the process of care provided by healthcare services by improving the structure and organisation of healthcare facilities. Some studies also showed improvement in clinical outcomes and a significant impact on some subspecialties due to subspecialty accreditation programmes.

13-Caldwell et al, 2009 US	To test hypotheses associated with a model which explains individuals' readiness in early stages of a change	Correlational survey design On line Survey for registered nurses	Change specific context such as research culture in manager and nurse formal education moderated the positive influences of the organisations' procedural justice actions. Procedural justice was stronger if the manager exhibited a culture of research and negative effects of low justice were mitigated when the nurse had a higher level of formal education.
14- Hinchcliff et al, 2012 Australia	To examine accreditations evidence base by providing a comprehensive, systematic identification and narrative synthesis of all empirical research published prior to 2012.	Systematic review	Majority of studies published since 2006, in USA and focused on acute care. Organisational impacts and relationship to quality measures were frequently addressed. Financial impacts, consumer and patient satisfaction and survey and surveyor issues were infrequently addressed. The literature is limited in terms of the level of evidence and quality of studies but highlights relationships among accreditation programmes, high quality organisational programmes and safe clinical care.
15- Lake et al 2010 US	To identify the relationship between hospitals Magnet status, nursing unit staffing and patient falls.	Cross – sectional study Routine data analysis from 5,388 units in 108 Magnet and 528 non-Magnet hospitals	The fall rate was 5% lower in Magnet versus non-Magnet hospitals. An additional RN hour per patient day was associated with a 3% lower fall rate in ICUs. An additional licensed practical nurse or nursing assistant hour was associated with a 2 -4% higher fall rate in non-ICUs.
16-Vanoli et al, 2012 Italy	To compare between the self and peer evaluation of accreditation and to describe the early results of a programme of accreditation	Qualitative Documents review (Evaluation, self and peer)	The programme of professional accreditation has the potential to describe, monitor and improve clinical; and organisational performance in internal medicine

17-Seren and Baykal, 2007 Turkey	To define organisational culture in hospitals that have received quality certificates and to identify attitudes of healthcare personnel toward change.	Quantitative - Information form - Culture scale - Attitude toward change scale Physicians and nurses	The lowest scores on the attitude Against Change scale (poorest attitude towards change) were found in staff in public hospitals, those who perceived top executives as autocrats and in those unwilling to participate in quality studies. Participants in a power culture were least open to change
18-Hinchcliff et al, 2013 Australia	To advance knowledge in the area of effective accreditation implementation by identifying factors that enable effective implementation of accreditation programmes across different healthcare settings.	Qualitative: - Focus group (39) - Interviews (8) With diverse healthcare stakeholders	Nine themes that collapse into four discrete, individual, programmes. Participants highlighted Organisational and system level factors. Critical enablers of accreditation programmes are: Accreditation programme is collaborative, valid and uses relevant standards Accreditation is favourably received by health professionals Healthcare organisations are capable of embracing accreditation Accreditation is appropriately aligned with other regulatory initiatives and supported by relevant incentives
19-Greenfield et al, 2012 Australia	To generate new insights and bring transparency to healthcare accreditation standards	Systematic review	There is a lack of robust empirical evidence examining the development, writing, implementation and impacts of healthcare accreditations standards
20- Flodgren et al, 2011 UK	To evaluate the effectiveness of external inspection of compliance with standards in improving healthcare organisation behaviour, healthcare professional behaviour, and patient outcomes	Systematic review	No firm conclusion could be drawn about the effectiveness of external inspection systems, only two studies fulfil the inclusion criteria

| 21- Benedicte Juul et al 2005 Denmark | To examine the availability and quality of clinical guidelines on perioperative diabetes care before and after accreditation | Interventional before – after study.

51 units (38 surgical, 13 anaesthetic) in nine hospitals | The proportion of units with guidelines increased from 47% to 75% after the trial.
More accredited units adopted guidelines after the trial.
Quality of systematic development scale and clinical scales improved significantly in accredited and non-accredited units.
Improvement in systematic development scale was higher in accredited units |

With such a diverse range of studies, both in terms of methodological approach and study focus, it was difficult to identify any clear patterns with respect to factors enabling or preventing the implementation of accreditation in a way that impacted on quality and safety, particularly in relation to the healthcare professionals involved. For that, an analysis using NPT as an analytical lens was carried out.

5.4.3 NPT informed framework analysis

Although qualitative analysis of text does not usually focus on the number and distribution of codes, here it helped to focus attention on which areas research into the implementation of accreditation had focused on. Over the 21 papers, 352 pieces of text were coded to NPT. The NPT construct of reflexive monitoring was the most frequently coded, with 43% of all the assigned codes. This indicated a particular interest in reporting the monitoring and appraisal work carried out by those involved in the implementation of accreditation, either individually or as groups.

The second most coded NPT construct referred to the actual work of implementation, namely collective action, with 27% of the assigned codes. Collective action is concerned with enacting work of implementing accreditation, focusing on what needs to be done to make the intervention happen in routine practice and considers not only the work involved but also the resources required to support that work.

Cognitive participation, or engagement work, was the third most frequent NPT construct, with 18% of the codes. This construct includes consideration of the work required to encourage others to commit to the programme and sustain their involvement. The construct coded least often was coherence, which is the NPT construct that focuses on individual and group understanding of the intervention and what it is trying to achieve. These findings are now discussed in turn.

5.4.4 Definitions of accreditation

The first step to understanding the accreditation programme is to encapsulate a general definition for accreditation. Several of the included papers defined accreditation as a process during which the organisation assesses and measures its performance against pre-set standards to improve and maintain healthcare quality (Braithwaite et al., 2010, Al Awa

et al., 2011c, Hinchcliff et al., 2012b). Although some authors put forward a clear definition of accreditation, other papers didn't provide a clear definition for accreditation and some would describe only what the programme entailed. **Box 5-1** outlines some of the definitions extracted from the papers.

Box 5-1 Accreditation definitions from the selected papers

- A programme that requires a hospital to apply total quality management principles, perform self-assessment of quality performance, and work on quality assurance and customer-focused continuous quality improvement. (Sriratanaban and Wanavanichkul, 2004)

- A public recognition by a national healthcare accreditation body of the achievement of accreditation standards by a healthcare organisation, demonstrated through an independent external peer assessment of that organisations' level of performance in relation to the standards. (Ng et al., 2013)

- An evaluation system, voluntary and reserved, for the acknowledgment of the existence of previously defined standards in structure, process, and results, aiming to stimulate the development of a culture of continuous improvement in the medical-hospital assistance quality and protection of the populations' health. (Fortes et al., 2011)

- An evaluation process in which an objective group (accrediting body) examines a healthcare organisation to ensure that it is meeting certain standards established by experts in the field to improve its quality of care given. (Seren and Baykal, 2007)

- A voluntary programme sponsored by a non-governmental organisation, in which trained external peer reviewers evaluate a healthcare organisations' compliance and compare it with pre-established performance standards. (Alkhenizan and Shaw, 2011)

A common feature among the previous definitions was the two characteristics of an accrediting agency and external assessment by surveyors. Only two definitions stated that it was a voluntary programme, and one definition mentioned the self-assessment part of the process. When compared to the accreditation definitions listed in Chapter 3, some similarities were found, like public recognition, which is included in Pomey et al. (2005) definition of accreditation, and also the voluntary feature of the programme stated by Scrivens (1997a) as a characteristic of accreditation.

5.4.5 Understanding the accreditation process

When implementing a new intervention or new way of working, it is important that those involved understand it fully and can 'make sense' of it in their own setting. In particular, the different components of the intervention or programme must be clearly defined, and also the roles of the participants. Indeed, stakeholders are obliged to differentiate between accreditation and other regulatory systems, ensuring that no conflict or overlapping occurs (Hinchcliff et al., 2013). In NPT terms, this 'sense-making' or understanding work is captured under the construct of 'coherence', **Table 5-3**.

Several papers contained data which examined whether organisations, and the professionals working in them, viewed accreditation as a new activity, distinct from other types of quality improvement activity or not. Using NPT to focus on this sub-construct of differentiation highlighted that accreditation was seen as firmly linked to other quality improvement activities. For example, Al Awa et al. (2011c) suggested that:

> The role of accreditation in hospitals will address the issue of patient safety and risk management as a part of quality improvement and hospital performance. (Al Awa et al., 2011c)

This seemed particularly true in a paper reporting on the implementation of the Magnet process of accreditation in a hospital in England:

> The NHS Trust Board [at the named hospital] wished to seek external recognition for this work to help meet the requirements of several national policy initiatives introduced in the NHS Plan [English health policy document]: the Modernization agenda, clinical governance, the National Institute for Clinical Excellence, the Commission for Health Improvement and the Human Resources Framework. (Balogh and Cook, 2006)

This led to this hospital using quality improvement work conducted in the two to three years previously as a foundation for the work of implementing Magnet accreditation, suggesting that while accreditation may be seen as new activity, it was firmly rooted in past activity.

As well as recognising accreditation as an activity, it was also important that participating organisations recognised the accreditation body, such as Magnet or the Joint Commission on Accreditation of Healthcare Organisations (Lutfiyya et al., 2009).

There was almost no consideration of the views of individual stakeholders or professional groups with respect to accreditation. There was more, however, in relation to the way in which organisations as a whole went through it.

At the level of individual departments, it was again the Magnet journey that illustrated the way in which an individual department might begin to see the benefits and relevance of taking part in an accreditation programme. This helped individual departments' understanding of the significance, value, and benefits of accreditation:

> As the Magnet journey proceeded it became apparent to the staff that accreditation systems can have the ability to assist each other. For example, the Mental Health Department – initially unenthusiastic about another accreditation venture – found that some of the methods and evidence they had used were readily adaptable to Magnet, and that Magnet helped them with a continuous approach to quality improvement. (Balogh and Cook, 2006)

This paper, reporting on a case study exploring the process of Magnet accreditation, presented evidence that the successful implementation of the intervention (i.e. Magnet accreditation) relied heavily on understanding its' aim and values by all the stakeholders (Balogh and Cook, 2006). This included the hospital Board and all departments within the hospital. Rochdale NHS trust board attempted to seek Magnet accreditation because they believed it would enable them to show 'The organisational commitment to improving professional practice through its commitment to on-going professional education, Its commitment to be a good employer of professional staff, Its desire towards a culture based on leadership principles and developed decision- making, the need for the whole organisation to become involved in the reconfiguration process, the need to attract into Rochdale a workforce, which is committed to delivering the organisational mission in a whole new environment'.

Most of the stakeholders were interested in the initiative from the beginning, as they believed it would improve the quality of care.

Another issue that emerged from this NPT-informed analysis of the papers in the systematic review was the need for a shared understanding of the aims, objectives and expected benefits of the intervention among the participants and their understanding of the roles assigned to them. However, it was recognised that the professional disciplines involved could have different views about the accreditation programme being implemented and its component parts. A shared understanding proved to be vital for organisations to develop a shared view of the aims and benefits of any accreditation programme being implemented (Hinchcliff et al., 2012a, Vanoli et al., 2012). Thus, while some papers reported on the potential disconnection between approaches to quality and safety issues and the perceived aims of accreditation standards (Hinchcliff et al., 2012b), others suggested there was evidence for a common language (Vanoli et al., 2012):

> …. Illustrated the Magnet process as a journey. The focus on the process also served to ensure the Trust paid attention to identifiable benefits aside from gaining an award, which in turn enabled them to entertain in a positive light the possibility of failure. Thus, although the Magnet journey had a clear destination, the Trust's view was that the manner of getting there was equally – if not more – important. (Balogh and Cook, 2006)

> The first consideration that stems from this programme of accreditation of internal medicine wards by peers is that, in comparison with other models of certification or accreditation, the medical teams under evaluation shared with their peers a common language and attitude to tackle clinical problems, which greatly facilitated the auditing process. (Vanoli et al., 2012)

However, the challenge of developing universal standards that clearly articulate specific organisational requirements was widely acknowledged. This was discussed in the following paper:

> There's got to be a shared understanding of what they [standards] mean. It's impossible if the organisation understands the standard to be one thing and the surveyor understands it to mean another. (Hinchcliff et al., 2012b)

5.4.6 Engagement with the accreditation process

Key aspects of implementing any complex intervention, including accreditation, are (1) to get the right people involved; and (2) for them to ensure that others are motivated to participate. This engagement and participation work is considered in the NPT construct of cognitive participation (see **Table 5-3**). However, as described earlier, these relational and cognitive aspects of the process of implementation were mentioned less frequently in the literature than the actual work of accreditation. Sub-themes that emerged under this theme were: professional attitude; engagement and participation in the accreditation process; good-working relationships; and leadership.

5.4.6.1 Professional attitude

Professionals' resistance to participate in the process was reported to be a barrier to improvement, and so a big effort was required in order to engage professionals. In NPT terms, this means that individuals had to be willing to get involved and drive the implementation (enrolment and initiation) and see themselves as the right people for the job (legitimation). This was exemplified in the following two extracts, one taken from the study of Magnet accreditation in a single hospital (Balogh and Cook, 2006) and the other from a narrative synthesis review (Hinchcliff et al., 2012b):

> I would have liked to have a willing volunteer to take it on board for the unit but none came forward, and I didn't want to push any one into it who wasn't interested because I think you should have people who are interested and committed to it. So that's why I put myself forward. (Balogh and Cook, 2006)

> Seven studies explored the development of accreditation programmes, identifying a number of common barriers (e.g. lack of stable funding source) and facilitators (e.g. engagement of key stakeholders). In one study, staff participation in an accreditation process was found to have promoted a quality and safety culture that crossed organisational and professional boundaries. (Hinchcliff et al., 2012b)

Professional attitudes towards the aims and process of accreditation strongly affected the chances of their participation and this negative attitude was recognised as a key barrier to a successful implementation as stated below:

> One of the most important barriers to the implementation of accreditation programmes is the scepticism of healthcare professionals in general and physicians in particular about the positive impact of accreditation programmes on the quality of healthcare services. (Alkhenizan and Shaw, 2011)

Another study that aimed to find the relationships between change and organisational culture in hospitals also demonstrated how implementation of change 'can be affected by several factors, including healthcare professionals' desire to perform their work differently and to participate in decision making processes more dominantly, as well as to change their behaviours'(Seren and Baykal, 2007). Accordingly Alkhenizan and Shaw (2011) suggested introducing educational strategies for all the professionals in an organisation, to describe the aims and benefits of accreditation to the healthcare services, in order to decrease their resistance to participation and increase their understanding (which, in NPT terms, relates to the construct of coherence).

5.4.6.2 Engagement and participation

Another strand identified as an important factor was encouraging staff to engage and participate in the process. A number of papers reported on the impact of employees' willingness to participate in the process of successful implementation of accreditation. It was reported in several papers that in order to engage others in the process of implementation it was necessary to create a need for change and to explain how the intervention may improve healthcare services (Sriratanaban and Wanavanichkul, 2004, Caldwell et al., 2009, Braithwaite et al., 2010, Ng et al., 2013). Again, from an NPT perspective, it could be argued that in order to improve engagement and participation, an organisation must first spend time improving understanding and coherence.

> Several strategies – such as informing the staff about external threats and needs for change, internal QI campaigns, and linkage to medical education and research activities and performance evaluations – were used to promote participation. (Sriratanaban and Wanavanichkul, 2004)

Staff readiness to accept these changes had a pivotal role in a successful implementation, as reported by Caldwell et al. (2009). They used the term '*unfreeze*' to describe staff efforts to accept the change. Hinchcliff et al (2013) described the staff that tried to engage

their colleagues in this work as *"change champions"*; in their qualitative study, one participant used the following terms:

> Engaging with the organisation in terms of we are here to assist and support you. This is a partnership. This is not an audit. This is not a tax investigation where we're just going to tick boxes or cross-boxes. If that partnership can develop, then there's a real opportunity to educate and support and strengthen and sew those seeds that the organisation can then continue to grow in the continuing cycle of improvement. (Hinchcliff et al., 2013)

This suggested that the organisational ethos was also important in ensuring that professional attitudes towards accreditation were positive. One study suggested that direct and active participation in the process of change could create a more positive attitude towards any newly introduced programme. For example, the organisation needed to include the employees in workshops, committees, and project teams, thus creating a sense of ownership among them (Seren and Baykal, 2007):

> The hospital set up five pilot cross-functional quality lead teams:
> 1-Infection control committee, 2- Emergency care patient care team,
> 3- Medication system team, 4- The laboratory and x-ray services team,
> 5- Operating room team. (Sriratanaban and Wanavanichkul, 2004)

This wider participation and engagement was also a feature of the Magnet hospital accreditation reported by (Balogh and Cook, 2006):

> The Senior Nurse Practice Development (PD) who had initially declined to apply for the post proposed a three-person project team consisting of himself, the Nurse Director (ND), and the Deputy ND and this was accepted. This team led the project until successful completion in April 2002. ……. Two main groups were established to steer the project. The Magnet Pilot Project Board handled processes external to the Trust and was the forum for liaison on six occasions between [name of local town], the ANCC and other UK stakeholders including the NHS and RCN [Royal College of Nursing]. A second group, the Magnet Advisory Board of internal NHS Trust staff and external advisors met more frequently. The main co-ordinating work within the Trust was undertaken by the project Team supported by a proactive administrator.

While this extract points to the importance of engagement and participation – both within the organisation and externally – it also highlighted the amount of work that setting up and maintaining such links requires. This work associated with accreditation implementation will be discussed further in Section 5.4.7.

5.4.6.3 Good-working relationships

Good communication among hospital staff and constructing multidisciplinary teams was identified as a key implementation facilitator in some studies (Sriratanaban and Wanavanichkul, 2004, Seren and Baykal, 2007, Ng et al., 2013, Hinchcliff et al., 2013). Good-working relationships helped to create a positive organisational culture, where experiences and responsibilities were shared and distributed. For example, a study of a hospital-wide quality improvement in Thailand demonstrated the vital role of vertical and horizontal communication, and pointed out how communication failure may lead to obstacles:

> Frequent gaps in communication between physicians and nurses, as well as between physicians from different specialties, can result in failures to provide proper care and intervention in a timely manner, conflicting information for patients and families, and even medication errors. (Ng et al., 2013)

While,

> Good communication within hospitals and the establishment of multidisciplinary teams, in which physicians participate actively, could facilitate the success of continuous quality improvement. (Ng et al., 2013)

For the new intervention to be accepted by the participants, it was essential to build accountability and confidence among themselves and within the system. Using the lens of NPT, this is considered to be a key part of the enacting work of implementation (relational integration). Several studies documented how the collaboration between hospital staff and establishing multidisciplinary teams to help with implementing the standards was an important facilitator in the process (Sriratanaban and Wanavanichkul, 2004, Seren and Baykal, 2007, Al Awa et al., 2011a, Vanoli et al., 2012, Ng et al., 2013):

> The accreditation process involves participation by frontline staff to senior management, and provides an opportunity for improving staff communication and sharing of values on quality improvement. (Ng et al., 2013)

> As an initiative started by professionals and not by external authorities and/or hospital administrators, it [accreditation] fosters the involvement of clinicians in the clinical governance of their hospitals. (Vanoli et al., 2012)

5.4.6.4 Leadership

Key individuals' involvement and their will to drive the initiative forward by engaging others was an important component in the implementation process, and was identified as a key facilitator in many studies (Sriratanaban and Wanavanichkul, 2004, Balogh and Cook, 2006, Seren and Baykal, 2007, Caldwell et al., 2009, Braithwaite et al., 2010, Hinchcliff et al., 2012b, Hinchcliff et al., 2013, Ng et al., 2013). A positive correlation between accreditation performance and leadership was reported in some studies (Seren and Baykal, 2007, Caldwell et al., 2009, Braithwaite et al., 2010, Ng et al., 2013).

> Leadership commitment, support, and quality management were predictors of quality improvement during and after the accreditation process. (Ng et al., 2013)

One study explored the relationship between change and organisational culture in hospitals by comparing different styles of management. It revealed how adopting a democratic managing style encouraged employees to embrace the change more readily than an autocratic management (Seren and Baykal, 2007). The authors attributed this to the culture of different types of public and private hospital – while this could not be tested, it does suggest that wider contextual factors may also be influential in the likelihood of accreditation being successfully implemented:

> Taking into consideration managerial approaches and structures of hospitals in Turkey, we were not surprised to find differing organisational cultures among private and public hospitals. That the cooperation culture was prevalent in private hospitals could be associated with several factors, including the absence of extremely centralist and bureaucratic management structure, more use of teamwork, emphasis on employee satisfaction as well as patient satisfaction, and continuous communication and cooperation among personnel. Such an organisational structure could be expected to have positive consequences on the attitudes of employees toward change. On the other hand, in public hospitals, an autocratic and extremely bureaucratic organisational and managerial structure is often assumed, which could be linked with the prevalence of power culture in these institutions. (Seren and Baykal, 2007)

Sriratanaban and Wanavanichkul (2004) suggested in their study many approaches for successful implementation of accreditation and stated how 'a good approach would be to have participation from senior medical staff members who are respected by their colleagues, knowledgeable about the selected patient care areas, and willing to contribute.

They may act as advisors or consultants to QI teams without spending too much time working on details'.

Two systematic reviews of good quality reported on how leadership support and involvement had a direct effect on quality improvement during and after the accreditation process (Hinchcliff et al., 2012b, Ng et al., 2013). Another study conducted in Saudi Arabia reported how the commitment and support of leadership positively influenced accreditation (Al Awa et al., 2011c). In a case study performed in England (Balogh and Cook, 2006), the nursing director described the importance of effective leadership as follows:

> Establishing a leadership culture was extremely difficult and challenging. Delivering Magnet, hard as it's been, has been more of a logistical challenge, so that's why I'm very clear about preparing the organisation for a culture and leadership capability.

Another healthcare professional mentioned in another qualitative study the relationship between accreditation and leadership, and explained it as:

> Leadership is what drives quality and safety because it requires people's motivation. Accreditation is really what drives or gives us direction, but you won't get very far if you don't have that leadership and support. (Hinchcliff et al., 2013)

5.4.7 Work of accreditation

The NPT construct of collective action focuses on the actual work – the enacting work – that is required in the implementation of an intervention or programme of work. In particular, this construct focuses attention on whether the intervention makes routine work easier or harder (interactional workability); whether those involved have the correct skills and training for the job (skill set workability); if those involved have confidence in the intervention (relational integrations); and whether local and national resources and policies support the implementation (contextual integration). These were all important considerations in the literature on accreditation, although there was a particular emphasis on wider policy and resources, as well as on standards adaptation; and training and education.

5.4.7.1 Resources

Many papers reported on issues to do with resources and/or policies (Sriratanaban and Wanavanichkul, 2004, Balogh and Cook, 2006, Fortes et al., 2011, Greenfield et al., 2012, Hinchcliff et al., 2012b, Ng et al., 2013, Hinchcliff et al., 2013). Resources could refer to staff, financial resources, and time and applies both locally, within hospital settings, and regionally or nationally. Financial incentives for hospitals and participants were identified as critical implementation enablers. In the United States, participation in accreditation allowed the hospital to be part of Medicare, which in turn provided a major source of funding. Financial incentives as a driver to participate were also recognised in Lebanon and Brazil (Hinchcliff et al., 2012b, Ng et al., 2013). In a qualitative study of stakeholder views in Australia, financial incentives to participating organisations were seen as fundamental to successful implementation, as exemplified in the following extract:

> Financial incentives offered by governments and insurers to encourage organisational participation in programmes were frequently highlighted. …. One stakeholder explained it in the following terms "Putting a financial incentive on the table gathers the swinging voters… a significant number of practices are participating because there are financial returns. (Hinchcliff et al., 2013)

This view was also expressed in a systematic review of the factors affecting hospital accreditation:

> Hospital participation in accreditation programmes may be associated with direct financial incentives, such as core funding or reimbursement. It has been suggested that the strongest drive for hospital accreditation could be the prospect of additional funding. (Ng et al., 2013)

Unsurprisingly, lack of financial resource was considered a barrier. Greenfield et al. (2012), in their review, reported three factors that hindered a successful implementation, lack of external incentives or pressure, organisational policies and culture, and cost and resource constraints.

Staff and time constraints came to the fore when considering the workload implications of accreditation. As well as being part of the local context for accreditation, workload also fitted into the NPT sub-construct of interactional workability, i.e. to ensure successful implementation, accreditation should not make the routine 'day job' harder. The workload

associated with accreditation was frequently mentioned in the included studies as a major obstacle to implementation. Not only did those taking part in accreditation require significant release from daily activities, but also sometimes, participants were contributing their own time in order to accomplish the work (Balogh and Cook, 2006, Vanoli et al., 2012, Ng et al., 2013). For example, from the paper reporting the case study of Magnet accreditation:

> However, supporting and developing the work of the Champions was not straightforward. One of the critical aspects of the Champions' position was that their work required significant release from 'normal' clinical duties: 'I suppose the difficult thing for the directorate is getting the champions away to get to the meetings, the half days, the workshops whatever, and then giving them time to disseminate it to everybody else. (Balogh and Cook, 2006)

Hospitals undergoing accreditation also spent a lot of time setting up systems and committees to oversee the work; many activities required extensive audits, development of data collection and management systems and 'significant workload in terms of administrative tasks' (Ng et al., 2013). Others described setting up multiple committees to steer the process through all of the relevant and contributing departments (Sriratanaban and Wanavanichkul, 2004).

One issue this raised was the tension between having the resources to provide routine patient care and resources being diverted to accreditation activities, as summed up in the following data extract:

> Professionals were characterized as often harbouring doubts about the ability of accreditation to promote organisational and health system improvements. Such views were linked to broader questions regarding the allocation of time and attention to quality improvement practices, as opposed to patient-centred clinical care, within healthcare organisations. The issue was summed up in this way: "Clinicians are so busy providing care, they really don't get quality. It's just a pain…quality is some person from some unit hidden in the bowels of the hospital… asking them to go over a whole heap of information because some people roll up with clipboard. (Hinchcliff et al., 2013)

In this way, accreditation not only impacted on the daily clinical job (interactional workability), but also on clinicians' confidence in the process and purpose of accreditation

(relational integration) – in this example negatively. There were, however examples where the process of accreditation had improved collaboration and, one would hope, confidence across departments:

> The accreditation process was the engine to the implementation of a culture of change and it contributed positively to the overall improvement in the adherence to hospital policies and procedures. The good collaboration between physicians, infection control specialists, clinical epidemiologist and nurses led to better nosocomial surveillance and strategies. (Al Awa et al., 2011c)

Few papers reflected on the workability between accreditation and the staff, and how it impacted on the implementation (relational integration). There was evidence that the intervention encouraged teamwork among the participants and facilitated multidisciplinary team building. It was noted that staff were more involved in decision-making, which was further reflected in their confidence in the quality of care as a result of accreditation implementation (Braithwaite et al., 2010, Greenfield et al., 2012, Ng et al., 2013). In the literature the interactional workability of accreditation within the organisation was debated. Two systematic reviews demonstrated controversial responses towards this matter, as one study revealed how standards improved the staff working conditions and quality of life, creating an attractive workplace for recruiting employees (Greenfield et al., 2012), while another study explained how implementing the standards made it difficult for the staff to practice their daily routine work (Hinchcliff et al., 2012b).

Accreditation was also suggested – by some – to lead to external confidence in a hospitals' quality of care (Braithwaite et al., 2010). It was evident in the literature that different countries took different approaches to implementing accreditation programmes, due to wider political, social and economic structures in which healthcare is situated, and accordingly different models had been formulated and emerged (Ng et al., 2013). One study reported how the economy of a country affected the accreditation agenda. In countries with a high income, implementing accreditation was aimed mainly at safety improvement, staff development, patient awareness and clinical performance. Low-income countries, on the other hand, focused on the basic structures of the healthcare services and on improving access (Flodgren et al., 2011).

It was demonstrated by many studies that no one model of accreditation existed and changes to the elements and characteristics of implementation programmes were governed by many factors within the health systems of countries (Braithwaite et al., 2010). Some papers identified how health systems and government policies interfere with the characteristics of accreditation programmes, demanding certain adjustments to the process.

5.4.7.2 Training and education

It is critical to have detailed strategies on how to sustain accreditation. Education and training of the hospital staff on accreditation and quality improvement was recognised as an important implementation facilitator (Sriratanaban and Wanavanichkul, 2004, Braithwaite et al., 2010, Greenfield et al., 2012). In fact, Balogh and Cook (2006) mentioned the approach of a hospital to activating Magnet by organising a major national conference:

> One of the ways in which staff interest was maintained was through the hosting of a major national conference in April 2001 on Magnet and other quality improvement approaches. (Balogh and Cook, 2006)

The allocation of existing resources to provide training programmes to leadership and staff, and the technical support available on-site were important facilitators in the process (Sriratanaban and Wanavanichkul, 2004, Ng et al., 2013):

> Essential educational and training programmes on the standards and continuous quality improvement and facilitator techniques were organised for hospital executives and other hospital leaders. (Sriratanaban and Wanavanichkul, 2004)

Education has been reported, among other factors, to assist in the successful implementation of accreditation programmes and they are: 'external pressure from legislation and accreditation; the use of technology and self-evaluation as tools to leverage change; organisational culture characteristics; research; and peer education' (Greenfield et al., 2012).

5.4.7.3 Standards adaptation

One notable area of work was the adaptation of existing standards to fit particular settings. Balogh and Cook (2006) and Sriratanaban and Wanavanichkul (2004) highlighted the challenge employees encountered when aligning existing documents with implementing standards, and explained the difficulty in applying external standards when there wasn't an appropriate system in place:

> The main task then became a process of discovering how existing processes and their associated records might match up to the standards. The Magnet champions directed the collection of evidence, and they in turn recruited others, including junior staff to help identify sources of evidence. Staff now found their main difficulty was to put it all together because it's scattered around all different areas. (Balogh and Cook, 2006)

> Existing quality assurance programmes, such as quality control circles (QCCs) in the nursing department and the 5-S programme, were integrated into the Hospital Accreditation programme and expanded throughout the organisation. (Sriratanaban and Wanavanichkul, 2004)

Other factors identified as influencing implementation and adaptation of standards into existing structures included health policies, local laws and regulations and compatibility with the social and economic aspects of the health system to encourage cultural acceptance of the intervention by the healthcare professionals (Sriratanaban and Wanavanichkul, 2004, Greenfield et al., 2012, Ng et al., 2013). This is illustrated in the following data extract:

> The interplay between regulation and the [accreditation] standards… it's that whole. What's missing, from my perspective, is that whole community and industry and, you know, government, like, holistic idea of everything that we want to achieve from the system, rather than just the portions… all the different bits that we are trying to separately achieve…We're still working at cross purposes to some extent. So the issue from my perspective is really… the global consideration of how that fits in. (Hinchcliff et al., 2013)

This meant that effort was clearly required for organisations to be able to meet the standards, and initiatives had to be adopted to make that work happen:

QI steering committee revised its strategic and operational plans and allocated additional resources to undertake improvements to help meet the Hospital Accreditation Standards. (Sriratanaban and Wanavanichkul, 2004)

Implementing the accreditation standards and collaboration between the accreditation teams allowed us to approach full compliance with infection control in a more systematic way. (Al Awa et al., 2011a)

This led Hinchcliff and colleagues (2012), in a comprehensive systematic review, to question the ability of standards to address complex events within the healthcare system suggesting that 'the focus on meeting a large number of accreditation and other regulatory standards may deter more substantial organisational and system-level efforts to fundamentally improve critical problems'.

5.4.8 Monitoring the impact of accreditation

The NPT construct of reflexive monitoring focuses attention on the work that needs to be done to support monitoring and appraisal (**Table 5-3**). This might be through the use of formal or informal methods of monitoring (systematization), both collectively but also by the individuals involved (communal and individual appraisal). It also draws attention to whether or not those involved in the intervention can modify the intervention based on evaluation and their experience (reconfiguration).

Most of the identified papers considered the impact of accreditation, often by trying to monitor impact on organisational or clinical outcomes. Some, however, also considered impact in terms of professional development and interpersonal development. These are discussed in turn.

While the collection of data and ability to measure impact is clearly a desirable outcome, at least one paper suggested that the 'true value' of accreditation might lie in its 'softer' impact:

The true value of accreditation may lie in its ability to generate discussion and stimulate change in general. The ability to ascertain the impact of accreditation depends on the measurement techniques available for measuring impact there it could be described as an imprecise science and best described perhaps as a management consultancy approach to problem solving, rather than a tool for measuring the organisation's performance. (Al Awa et al., 2011a)

5.4.8.1 Organisational impact

A key issue that has been subject to considerable discussion is whether healthcare professionals and – importantly – patients see any impact from accreditation on the quality of the clinical services provided. There was, however, no clear answer to this, with both positive and negative impacts identified. See **Table 5-5**. The reasons for a lack of a clear answer about impact are first, a wide range of standards have been studied and audited across the included papers, with no collective approach to the methodology to collect and analyse data. This was commented on in relation to the Middle East by Al Awa et al:

> Saudi Arabia as one of the first countries in the Eastern Mediterranean region to implement healthcare accreditation standards had however, little or no data describing its impact on the quality of patient care. It is not possible to draw direct comparisons between the outcomes of such a process in different countries due to multiple variations in the accreditation process, the local legislation and cultural factors. (Al Awa et al., 2011a)

Although some studies did try to compare accredited and non-accredited hospitals, these were not always well matched, see **Table 5-5**. Methods used to monitor performance included formal approaches such as audits and cross-sectional surveys, as well as more informal feedback mechanisms amongst staff. There were, however, almost no formal approaches reported of collecting patient views of the impact of accreditation.

Accreditation was found to be associated with significant improvement in performance indicators related to acute myocardial infarction, heart failure and pneumonia, while no difference was detected in performance indicators related to screening for, and administering, pneumococcal vaccine, and surgical infection prevention (Lutfiyya et al., 2009, Alkhenizan and Shaw, 2011, Schmaltz et al., 2011, Hinchcliff et al., 2012b). One systematic review with a good quality rating identified inconsistency of the effect of accreditation on clinical aspects of service delivery. For example, while some studies demonstrated that implementing standards related to trauma care, prenatal care, post partum care, stroke care, breastfeeding and pain management improved the service, others demonstrated no measurable effect for prenatal and delivery care, nor any improvement in postoperative respiratory failure (Greenfield et al., 2012).

Table 5-5 Studies aimed to assess clinical services improvement due to accreditation

(Lutfiyya et al., 2009) USA	To determine the effect of accreditation status on quality measures in rural critical access hospitals.	Cross-sectional study using hospital comparison data in 730 hospitals	4 out of 16 quality measures were significantly better in accredited hospitals: 1-AMI: * Aspirin on arrival 2-Heart failure: *ACE inhibitor *Smoking cessation advice 4-Pneumonia: * Smoking cessation advice
(Lake et al., 2010) USA	To determine the association between hospital Magnet status, Patient falls, and nursing unit staffing.	Retrospective Cross-sectional study National data base of nursing quality indicators 5,388 nursing units	-Patient fall rate is 5% lower in Magnet hospitals
(Schmaltz et al., 2011) USA	To determine the association between accreditation status and hospital performance on quality measures for common diseases.	Performance data for 2004 and 2008 augmented with Joint Commission performance data	13 out of 16 quality measures were significantly better in accredited hospitals: 1-AMI: *ACE inhibitor for LV dysfunction *Beta blocker at discharge *Composite AMI score 2-Heart failure: *Discharge instructions *Assessment of LV function *ACE inhibitor for LV dysfunction *Smoking cessation advice *Composite heart failure score 3-Pneumonia: *Oxygenation assessment *Pneumococcal vaccination *Timing of initial antibiotic therapy * Smoking cessation advice *Composite pneumonia score
(Al Awa et al., 2011a) Saudi Arabia	To determine the association between accreditation status and performance indicators.	A 4 year retrospective and prospective study design Clinical indicators (81): *Mortality (15) *Infections (26) *Medication use (5) *Blood utilization (2) *Surgery invasive procedure (7) *CPR (8) *Adverse events (18)	Significant improvement due to accreditation in: Perioperative mortality rate Neonatal mortality Health-care associated infections 3-Medication use and error reporting mechanism 4-blood transfusion reaction Return to surgery within 48 hours post operatively Improved CPR management 7-Decrease in pressure ulcers
(Mills and Gillespie, 2013) USA	To determine the association between accreditation status and: *Pressure ulcers *Failure to rescue	Retrospective (5years) secondary data analysis	No significant difference was found in: *Pressure ulcers *Failure to rescue

Another study conducted in Saudi Arabia reported a significant difference in perioperative mortality rate, healthcare-associated infections, medication use, cardio-pulmonary resuscitation, and return to surgery within 48 hours post-operatively, when measured pre and post accreditation (Al Awa et al., 2011a). There was also a significant association between accreditation status and pressure ulcers, patient fall rates, hospital length of stay, and trauma survival rates, which was further reflected in increased patient satisfaction with the healthcare services (Braithwaite et al., 2010, Lake et al., 2010, Al Awa et al., 2011a, Al Awa et al., 2011c, Alkhenizan and Shaw, 2011, Mills and Gillespie, 2013).

A number of studies addressed the positive impact of accreditation standards on clinical guidelines. An interventional before-after study conducted in Denmark that aimed to compare the availability and the quality of clinical guidelines between accredited and non-accredited units, demonstrated that accreditation had a significant effect on most of the units (Benedicte Juul et al., 2005). Two systematic reviews further documented a positive relationship between accreditation and clinical guidelines (Hinchcliff et al., 2012b, Greenfield et al., 2012).

There was conflicting evidence in the literature about whether accreditation affected quality and safety of the service. One cross-sectional study carried out in Saudi Arabia revealed significant improvement in the quality of patient care and patient safety indicators, including: nursing clinical information, patient medication information, risk management, and nursing action to prevent risk, as a result of accreditation (Al Awa et al., 2011c). However, other studies found no significant association between them (Braithwaite et al., 2010, Alkhenizan and Shaw, 2011, Flodgren et al., 2011, Ng et al., 2013). Further studies found no impact of accreditation on indicators for: organisational accessibility and completeness of records (Hinchcliff et al., 2012b); comprehensive discharge instructions for patients with heart failure (Lutfiyya et al., 2009); and document control and organisation of care (Greenfield et al., 2012).

A total of 4 studies discussed the extent to which accreditation programmes promote the implementation of CQI (Continuous Quality Improvement) activities, with a positive relationship found between accreditation status and CQI projects (Sriratanaban and Wanavanichkul, 2004, Longo et al., 2007, Braithwaite et al., 2010, Ng et al., 2013). Thus,

accreditation may promote the implementation of quality management systems like internal audits, risk management, patient safety system and documentation management. Exposure to the process of accreditation has also been shown to affect the organisational culture in a positive way. A number of researchers reported improvements in organisational effectiveness reflected in: better adherence to policies and procedures (Al Awa et al., 2011a) and promoting high quality processes and structure (Braithwaite et al., 2010, Alkhenizan and Shaw, 2011, Hinchcliff et al., 2012b, Ng et al., 2013).

However, Lake et al highlighted one of the tensions in measuring such data and then trying to attribute effects to the process of achieving accreditation status. They conducted a cross-sectional study looking at the hospital Magnet status, nursing staffing and rate of hospital-based patient falls and nursing provision (Lake et al, 2010). Finding that fall rates were lower in Magnet-accredited hospitals, with nursing staffing levels having little impact, they commented on the weakness of a cross-sectional design to identify causality and added:

> [A] hypothesised causal sequence is that the nursing excellence acknowledge by Magnet Recognition translates into safer practice and fewer patients falls. However, the converse may be plausible: hospitals with fewer falls happen to become Magnet hospitals. (Lake et al., 2010)

5.4.8.2 Individual and interpersonal impact

Some researchers examined the effect of accreditation programmes on staff satisfaction. There was evidence of positive views towards the benefits of accreditation, with staff expressing satisfaction with the process and indicating that they preferred to remain employed in an accredited institution (Sriratanaban and Wanavanichkul, 2004, Al Awa et al., 2011c, Alkhenizan and Shaw, 2011, Greenfield et al., 2012, Hinchcliff et al., 2012b, Mills and Gillespie, 2013). In one study, it was reported that accreditation increased job satisfaction, as reported in the following extract:

> I don't know whether it's been Magnet, or shared governance or the overall change in culture that's brought it about but certainly…[we think] our complaints came tumbling down, and now in nursing [we] are looking for nursing complaints and they just aren't there. (Balogh and Cook, 2006)

One area that did not get much attention was how organisations, and their staff, might use the findings from accreditation reports to develop services and improve quality of care.

Vanoli et al. (2012) in their paper documenting a voluntary programme of accreditation in Italian internal medicine units wrote:

> Special attention was paid in the accreditation programme to the written report produced at the time of hospital discharge, because this report is a key instrument with which to guarantee an adequate flow of information and communication between the hospital and the family physicians, in order to optimize healthcare continuity. The results of peer evaluation indicated that adherence of the discharge report to standards, both general and disease-specific, was largely overestimated in the frame of self-evaluation. The evidence of this defect, as documented during site visits, should stimulate the internist to improve this key medical document. (Vanoli et al., 2012)

This, together with a lack of explicit reporting or on-going monitoring and adaptation post accreditation, might suggest that the focus is often on the accreditation itself, rather than seeing it as a continuous process of quality monitoring and improvement.

5.5 Discussion

5.5.1 Overview of the findings

A systematic review was employed to investigate the process of healthcare accreditation programmes and their impact on the services from professionals' perspective. It also aimed to identify the barriers and facilitators of implementation. In all, 21 studies were included in the systematic review that met the inclusion criteria. The four main themes (understanding accreditation process, engagement with accreditation process, work of accreditation, and monitoring accreditation impact) were mapped to the NPT codes, as demonstrated in **Figure 5.2**.

It is worth noting that the literature was dominated by studies on the impact of the intervention on the services, while very few reviews explored the overall process of implementation or its impact on professionals. The studies were mainly of good quality, and only a few were assessed to be of poor quality, nevertheless, all of them were included to draw conclusions aimed at answering the systematic review questions.

A key component of NPT is the assumption that there is work across different areas of implementation and that certain actions either facilitate or hinder a successful

implementation of a complex intervention (May et al., 2009). However, while there are four areas of work necessary for successful implementation, the published literature on accreditation does not equally address the different aspects necessary for accreditation programmes to be successfully embedded. Existing research does not recognise the critical role of making sense of the intervention (coherence), while there was much more research focused on the accreditation programmes monitoring and evaluation (reflexive monitoring), focusing largely towards comparing the achievements against standards.

Lack of data coded to the individual specification sub-construct raises the concern of bypassing a crucial step, creating a barrier in the process of implementation. Individual departments and professions involved must be fully aware of their role and responsibilities for them to be a productive part of accreditation. Furthermore, there was almost no consideration of the fit of the intervention with existing staff skills and roles (skill set workability). Therefore, literature has demonstrated the importance of enhancing an educational and training process for all the hospital employees to overcome the gap in a common understanding of accreditation programme aims and objectives among all the participants from stakeholders to surveyors and hospital employees. In addition, further attention is needed to explore how the intervention interacts with the existing roles and responsibilities of the participants.

This robust theoretical underpinning of the data analysis allowed the researcher to think more about the work required across the different stages of accreditation. It demonstrated that understanding the concept of accreditation and defining the different roles and responsibilities of the participants is key to successful implementation. Also getting people on board and engaging them in the process, while convincing them that this is essential to their work and represents part of their daily jobs is an important factor. The actual work of accreditation, which as the data demonstrate can be divided into two sections, work done before beginning the implementation (training, forming teams, establishing committees) and work related to implementing the standards (writing policies, executing quality and safety plans) and are both equally important for successful embedding. Finally, monitoring the programme to know if it works, and what actions are required to rectify any barriers identified in the process, and to illuminate the benefits of the programme on the service and the staff.

Figure 5.2 Diagrammatic representation of the 5 themes and the underlying mapping to the NPT constructs
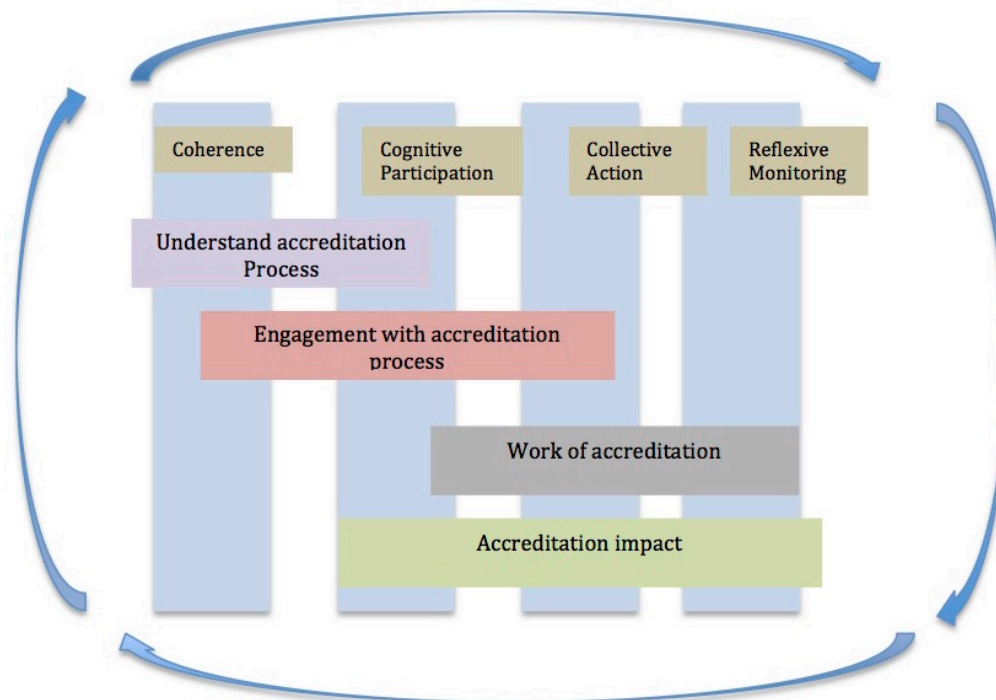
5.5.2 Implementation factors

There was evidence in this systematic review of key facilitators to the implementation process, including leadership support and key individuals' engagement, communication and teamwork, and education and training. Financial incentives and workload were the main challenges expressed by professionals during the implementation. Economic considerations are a persistent concern especially in developing and low-income countries, where the priorities of accreditation programmes are influenced by the social, political and economic factors of each country (Bukonda et al., 2003, Shaw, 2003, Alkhenizan and Shaw, 2012).

The findings illustrate how the factors influencing the process of implementing accreditation overarch; see **Figure 5.2**. For example, the aspects of understanding the programme and engagement in the process are linked together, because the results have shown that if professionals understand the programme and its claimed benefits, this will enable them to engage more readily. The vice versa is also true, as people getting involved and engaged in implementation will increase their knowledge about it. The work required to successfully implement accreditation is also mapped over three of the NPT constructs While most of the data related to the work of accreditation coded to collective action, there was evidence of overlap among the constructs, as data coded into cognitive participation (introducing training programmes, release from clinical duty) represented part of the work of accreditation. Also within the work of accreditation a link was found between the work done by the staff and how it affected their perception of accreditation (individual appraisal).

5.5.3 Accreditation impact

While accreditation programmes aim to improve the structure and process of healthcare services, the available evidence about successful achievement of this aim is debatable. The evaluation of the impact on clinical care and on the quality and safety aspect of the service was largely dependent on using clinical performance indicators, which can yield strong quantitative evidence. However, it concluded that there was improvement in some areas and specialties and not others. One should consider the strength of the causal link between the clinical indicator outcome and accreditation implementation, especially due to the complexity of the healthcare organisation system in order to establish a conclusion. Furthermore it is challenging to clearly identify which element to measure within a multi-level complex intervention (Hinchcliff et al., 2012b). Comparison between accredited and non-accredited hospitals helped in yielding possible differences due to accreditation, but failed to provide information about whether the results were transferable to other settings.

In terms of the impact of accreditation programmes on the healthcare services, no conclusions could be drawn, and this is consistent with findings from another systematic review (Brubakk et al., 2015).

Data related to evaluating accreditation impact was spread across three of the NPT constructs, see **Figure 5.2**, because in the codes it was evident that the accreditation implementation impacted on the working relationships of the staff, by enhancing teamwork and communication. The impact of implementing the programme on the work aspect of the programme, and the effect on the workload of the staff and allocating resources in an organisation were also evident in the data.

5.5.4 Limitations and strengths

The search was limited to publications from 2003 – 2013. The reason for this time frame was to associate it with the emergence of the quality agenda in Kuwait. Although this might be viewed as a limitation, this approach was agreed upon as an appropriate choice because accreditation programmes are evolving and changing over time, due to constant evaluation and scrutiny. Thus it is more appropriate to current practice to focus on the past decade than on historical evaluations (Daucourt and Michel, 2003, Smits et al., 2014, Greenfield et al., 2016). Another limitation in the search scope was the language restriction because only English language papers were included, and this might have led to missing some pertinent papers written in foreign languages. However, there were no resources available for translation. Another limitation that might have imposed a degree of restriction on the search was not searching the grey literature or hand searching journals. This was due to the time limit of the PhD. Nevertheless, the search conducted was extensive and proved to address the research aim.

One strength of this systematic review was adopting a robust theoretical framework to underpin data analysis. Adopting NPT as a framework for analysing and synthesising the data of the systematic review contributed to a better understanding of the complex intervention that is accreditation, providing a more balanced view between evaluating the process of implementation itself as well as measuring the impact of the programme. Moreover, the theoretical framework proved to be valuable in addressing the gaps in the literature by highlighting the areas that require more research. One limitation of this approach is the possibility of 'shoehorning' the data into the framework constructs, however, the constant reviewing of the codes with the supervisor minimized this possibility, and few texts were coded outside the framework because it addressed unrelated issues like the date of establishment of some accreditation programmes and other technical

aspects. Another strength was demonstrating the results using an interpretive rather than a descriptive approach, and this added more meaning and perspective to the data instead of just summarising the similarities and differences between the studies.

5.6 Summary

In this chapter a systematic review was conducted to explore the accreditation implementation process within the international literature. The analysis, guided by NPT, identified the work needed across the implementation of the programme as 1) understanding the intervention, 2) engaging staff into the process, 3) work required to support the process, and 4) monitoring the impact of the intervention. There appeared to be more focus in the literature on studying the impact of the programme than the process of implementation itself. The understanding of the programme was generally poor and the literature added little to this, which allows for research opportunities to explore this aspect of introducing change in an organisation. In Chapter 7, which involves interviews with the accreditation team members, these findings will be explored in more detail and within the local context allowing for comparison and contrasting of the results among the different study strands in this research.

Chapter 6- Qualitative analysis of the accreditation reports

6.1 Introduction

This chapter reports on the second strand of research in this PhD, which aimed to examine the recommendations of the surveyors about identifying areas of improvement in the process of accreditation implementation. First, in order to set the context in which implementation was occurring, a description of the six hospitals is provided focusing on the characteristics and the clinical services in each. A detailed description of the hospital accreditation reports is also included, highlighting the parts of the documents that were related, and of interest, to the research aim.

6.1.1 Rationale

Hospital accreditation reports are written following the accreditation visit conducted by trained professionals (surveyors) to Governmental Hospitals as part of the Kuwait National Accreditation Programme. The surveyors are Kuwaiti healthcare professionals who were trained by Accreditation Canada as part of the agreements. These comprehensive reports, explained in more detail in Section 6.2.2, contain valuable information about the hospitals' performance in relation to pre-defined Standards. They contain the opinions of the surveyors about the clinical and organisational areas amenable to improvement that are identified during the process of the visit.

As discussed in Chapter 4, documents are considered as a useful source of evidence, and their analysis is commonly combined with other qualitative methods in studying the same phenomenon as a means of triangulating data (Bowen, 2009, Wesley, 2010). The overall aim of this research was to explore implementation of the accreditation programme in Kuwait from the multiple perspectives of the healthcare professionals involved, and the accreditation reports were used as a source of data to address part of the research aim, which is the surveyors' views. In addition, the findings of this study are triangulated with the findings from the systematic review and the interviews in the final Synthesis Chapter.

6.1.2 Research question

- What were the areas for improvement identified during accreditation visits to the general hospitals, as part of the NAP in Kuwait?

6.2 Methods

Silverman (2015) explains how 'documents are to be used as a resource for social scientists in order to get a better overall picture of how a social institution operates'. Drawing on this here, a qualitative content analysis approach was selected for the hospital accreditation reports targeting the recommendations written by the surveyors about the areas for improvement in each section of the Standards.

6.2.1 Description and selection of hospitals

Fourteen Governmental hospitals completed the first cycle of accreditation (2012-2014), with six of them classified as general hospitals (explained in more detail in Chapter 2). After consultation with my supervisors, I decided to focus on the reports of only the six general hospitals and exclude the sub-specialty centres, which provide tertiary care. This decision was based on the fact that the general hospitals covered a range of clinical specialties as well as other support services, whereas the tertiary care hospitals focused on only a small number of clinical areas. The six chosen hospitals all have Medical, Surgical, Emergency, and Specialised/Intensive care services. In addition, three of the hospitals also have an Obstetric and Gynaecology service.

The six general hospitals also represent different parts of the country, urban and rural, as shown in **Figure 6.1**. Thus, it was felt that this would provide a better picture of the accreditation process, covering a wider number of clinical specialties.

It is worth noting that the hospitals are not distributed equally across the Governorates, as the Capital has two general hospitals serving its population, and two Governorates located in the south of the country are assigned one general hospital between them. This is because

the two Governorates in the south were originally one as per the establishment of the Governorates in 1962. It was originally called Ahmadi Governorate. However, in 1999 it was divided into two, Ahmadi and Mubarak Al-kabeer.

Two of the general hospitals, Al Farwaniyah (in Al Farwaniyah Governorate) and Adan (in Al Ahmadi Governorate), offer their services to the largest size of population (Kuwaitis and non-Kuwaitis), where each serves over a million people. The Capital (Al Asimah), with two general hospitals, and Al Jahra (north Kuwait) Governorates accommodate half a million people each (Public Authority for Civil Information, 2017).

Figure 6.1 Distribution of the hospitals among the Governorates
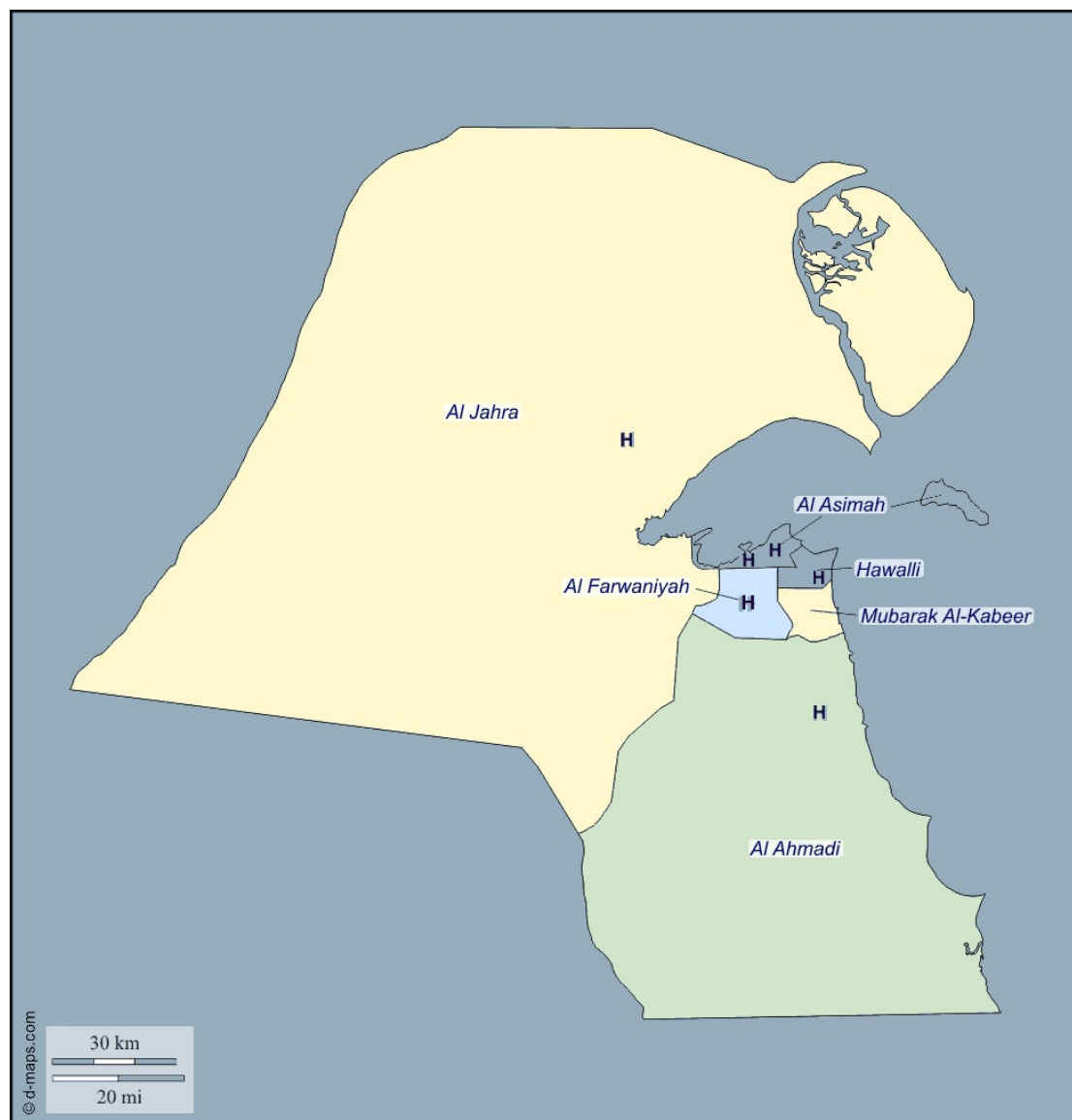
The accreditation surveys which are analysed in this chapter were conducted in the six hospitals as part of the first cycle of accreditation, and took place as follows: two hospitals surveyed in 2012, two in 2013, and two in 2014.

6.2.2 Description of documents

The accreditation report represents the final stage of the accreditation survey visit. These documents give an official report about the hospitals' performance written by the accreditation surveyors and are reviewed by the Higher Committee of Accreditation. The reports are very similar in terms of their content and structure, and are composed of about 60-70 pages, containing many sections that provide a comprehensive analysis of the entire organisation as demonstrated in **Table 6-1**.

Table 6-1 The contents of the accreditation report

Accreditation summary	
Results overview	- Surveyors' commentary
	- Overview by Standard set
	- Overview by patient safety required area
Detailed results and recommendations	- Results by Standard set
	- Results by patient safety required area
Focus group feedback	- Client focus group
	- Community partners focus group

The report begins with an accreditation summary of one page including: the hospital name; the date of the visit; the accreditation decision; the Standards sections revised; and the evaluation team members. The next section in the report is an overview of the results summarised in about 15 pages, and includes: the surveyors' commentary regarding the visit, addressing the survey objectives and the successes and challenges identified; an overview by Standards set; and an overview by patient safety required areas, with both sections evaluated by using a rating scale from 0 to 4. The third and main section in the report, which is on average around 35 pages, includes detailed results and recommendation about each Standard set and patient safety required area. There are 12 Standard domains as explained previously in Chapter 3, and in each domain there are a number of Standards, see **Table 6-2**.

Table 6-2 National Accreditation Programme Standards categories

Standards category	Standard domain	Number of standards
Patient Care Standards	Emergency service	7
	Maternal/child care	7
	Medical care	7
	Specialised /intensive care	7
	Surgical care	7
Clinical Support Service Standards	Diagnostic imaging service	7
	Laboratory service	7
	Pharmacy service	7
Non-Clinical Support Service Standards	Environment	20
	Information management	10
	Human resources	7
Leadership	Leadership	10

Source: (Ministry of Health, 2011b)

In each section of the Standards the surveyors add their recommendations about areas for improvement according to their observations during the site visits. This allows them to highlight deficiencies and obstacles relating to the implementation of accreditation in that area and suggest areas for improvement, like the examples in **Box 6-1**.

Box 6-1 Example of the surveyors comments in the accreditation report

Areas for improvement:

Team Name: Medical

The quality improvement plan misses detailed action plans and ways of measurement and time frames.

Areas for improvement:

Team Name: Emergency

 Triage system needs to be reviewed and standardised among all casualty areas.

The recommendations were written collectively by the six surveyors assigned to each one of the hospitals. At the end of each day's visit, the surveyors discussed their findings and resolved any ambiguities or differences of opinion with respect to the scores being assigned and their identification of areas for improvement. The decisions made are guided both by the criteria laid out for each Standard and their experience in the field.

The last section of the report includes feedback from a focus group of clients and community partners.

6.2.3 Documents retrieval

The researcher has worked in the accreditation department of the Ministry of Health since 2004, and was part of the NAP implementation in the Governmental hospitals since it was first launched in 2008. The researcher obtained approval of the study protocol, see **Appendix 3**, from both the Ministerial Ethical Committee in Kuwait and the Research Ethics Committee, College of MVLS, University of Glasgow (see Chapter 7 for more details). This included the tools for data collection in this research as interviews and documentary analysis (accreditation reports). As a result, it was possible to obtain the accreditation reports written for the six hospitals between 2012 and 2014 through the Accreditation Software, which the researcher has the permission to access, both professionally as MOH staff and ethically, as a PhD student at the University of Glasgow.

6.3 Data analysis

It was decided to take a different approach to data analysis from the systematic review, where analysis focused on coding data using a theoretical framework underpinned by NPT. Here the researcher chose an inductive approach, in analysing both the documents reported in this Chapter and the interviews reported in Chapter 7. Thus, the data itself guided the analysis rather than a pre-determined theory. This approach was adopted to allow for more flexibility in coding because, unlike the systematic review analysis, there was no preconceived framework to code the data.

As described above, the analysis focused on the parts of the report that considered areas for future improvement, thus, thematic analysis was used to code data from the surveyors' recommendations on areas for improvement as discussed in more detail in the Research Design Chapter (Chapter 4).

The researcher began by reading through the reports to get a general idea of the content and to become familiar with the data. To make things more manageable the researcher created Word document files for each of the six hospitals and transferred the part chosen for analysis into these files, labelling the data according to the Standards' section it was taken from so it could be traced to the original document for context. See **Appendix 4** for an example.

After several readings, factors influencing the implementation process were initially and broadly identified, for example, communication, physical structure, IT and information. Two reports were then coded by both the researcher and supervisors, using the broad codes identified, followed by discussion of the initial codes generated with the supervisors for any feedback. Discrepancies in data interpretation were resolved through group discussion. Then the researcher proceeded with coding all the data. The codes were typed on the Word document next to the related section. See **Table 6-3** for an example of initial coding framework.

Table 6-3 Example of initial coding framework of recommendation

Report text	Code
Fire preparedness should be addressed immediately	- Importance of workplace safety - Emergency readiness
Expand the infection control plan to the rest of the hospital	- Communicate plans
Allocate proper space for bio-medical engineering	- Space issues
An orientation programme needs to be established for all the staff working in the hospital	- Develop orientation programme - To involve all staff in the programme
A proper triage room and formal triage protocols must be set up with clear definition of ranking criteria and expected waiting times	- Allocate space for triage room - Write triage protocol
Medication reconciliation requires special attention, in terms of definition and implementation	- Focus on medication reconciliation implementation

During the process of initial coding, the generated codes were continually compared, both across accreditation reports and with supervisors, to review interpretations and meaning, aiming for consistency and saturation (Hewitt-Taylor, 2001). This helped to reduce the subjectivity that can arise when only one person codes qualitative data, and helped to verify the interpretation of the data. Next, the codes were compared, reviewed, and organised, for example some codes were clustered together in an attempt to generate themes. The researcher explored the characteristics of the codes by questioning how each segment of data was similar to or different from the others, which allowed for a deeper analysis of the data. This questioning also revealed new codes in the data, for example infrastructure, which included codes related to physical environment and IT. This resulted in a thematic map consisting of main themes and sub-themes. When the final coding framework was completed (**Appendix 5**), the researcher then reviewed and created coding reports for each theme, and labelled each report with the Standard section and the hospital it was taken from.

6.4 Results

A total of 6 hospital accreditation reports were scrutinized for data pertinent to the study aim. **Table 6-4** shows some of the statistics related to the six general hospitals. Of the six, only two general hospitals were granted Substantial Accreditation, three were granted Partial Accreditation with Conditions, and one hospital had a Pre-Accreditation status. The hospitals will be referred to in the chapter as hospitals: A, B, C, D, E, and F, in no particular order, to keep their identity confidential.

Table 6-4 Selected health services and manpower data in Kuwait General hospitals

Hospitals	Beds	Outpatients No.	Emergency Admissions No.	Doctors	Nurses
A	857	430181	809647	630	1735
B	756	193149	679757	439	1583
C	409	160287	151235	523	1134
D	503	216976	412568	458	1326
E	806	261273	758254	625	1534
F	682	298226	454344	680	1090

Source: (Ministry of Health, 2013a)

Two main themes and seven sub-themes were identified relating to the process of accreditation implementation as shown in **Table 6-5** and will be presented in the following sections.

Table 6-5 The final two main themes with sub-themes

Main theme	Sub-themes
Engagement with accreditation	Good-working relationships
	Engagement and participation in the process
Work of accreditation	Adaptation of Standards
	Infra-structure
	Training and education
	Resources
	Administrative system

6.4.1 Engagement with accreditation

A small number of codes were identified under this theme, while the majority fell within the theme work of accreditation, which is reported in Section 6.4.2. Recommendations from the surveyors that related to this theme surfaced mainly in relation to good-working relationships and engagement and participation in the process.

6.4.1.1 Good-working relationships

Similar to the findings in the systematic review, surveyors identified good working practices like communication and teamwork as important factors in the process of implementation. Surveyors reported some organisational and inter-departmental communication failures in all six hospitals, regardless of their final accreditation status. While organisational-wide communication was noted as missing in some reports, other reports highlighted specific areas showing lack of communication. For example, some reports explicitly referred to the need for clinical support services, like laboratory, pharmacy and diagnostic services to better communicate results obtained to other clinical departments, as noted in the recommendations below:

> Recommend better communication with the clinical services to provide blood packs needed in timely manner. (Laboratory services, hospital C)

> Poor communication of the important laboratory and pathology results with the treating physician. (Medical care, hospital D)

> Improve communication with medical staff regarding prescription errors by promoting reporting and education. (Pharmacy services, hospital D)

> Better communication with other caregivers. (Diagnostic imaging services, hospital E)

In all six reports it was recognised from the recommendations that while departments succeeded in writing and documenting plans, they failed to communicate them within staff in their department and across the hospital. This reflected a general concern across all the sites that communication needed to be addressed.

All of the pharmacy accreditation team should be aware of the Quality Improvement plan. (Pharmacy services, hospital D)

Policies, protocols and guidelines have to be documented and distributed to staff to be well familiar with them. (Emergency services, hospital F)

The service has established a Quality and Safety plan that needs to be implemented and communicated to all members of the team. (Specialised/Intensive care, hospital C)

The Accreditation Standards of the NAP address many themes and one is: 'the patient is the core of care, and teamwork is the method for providing that care' (Ministry of Health, 2011b). However, a finding, in three reports, was how communication with patients should be improved. The reports recommended involving patients and their families in the plan of care.

Encourage better communication with patients since it was noted that most patients would not know or understand their plan of care, physicians may benefit from training on patient communication skills in order to improve delivery of information to their patients. (Emergency services, hospital B)

The patient and family need to be informed about approximate waiting times. (Emergency services, hospital D)

It was found that some patients were not introduced to the service properly. (Specialised/Intensive care, hospital C)

This also fits with the need for strong teamwork. Findings from the systematic review in this research identified the value of good-working relationships in creating a positive organisational culture where employees can share experiences and responsibilities. Issues related to teamwork were particularly prominent in the data from all six reports. There were recommendations about the need for multidisciplinary care and that different departments should collaborate in providing an integrated plan to care for patients as the recommendations below illustrate:

Interdisciplinary team should be developed to formulate a plan of care. (Medical care, hospital F)

Multidisciplinary patient care needs to be developed in a better way and documented, and the care plan conveyed to all members involved. (Surgical care, hospital F)

There is an opportunity for the nuclear medicine service to be more involved in the development of the care plan as a means to educate the interdisciplinary team in the appropriate utilization of nuclear medicine. (Diagnostic imaging services, hospital B)

It is strongly recommended to immediately establish a multidisciplinary team (including social workers) to work on the care plan. (Specialised/Intensive care, hospital C)

Recommendations for the increased involvement of Pharmacy services were also identified, where surveyors recommended the importance of pharmacy participation in the plan of care by involving clinical pharmacists, as stated below:

Recommend adding clinical pharmacists to the team to enable proper integration of pharmacy in the plan of care. (Pharmacy services, hospital B)

The pharmacy should get involved in patient information transfer. (Pharmacy services, Hospital A)

The service [pharmacy] does not contribute to patient care neither directly nor at transfer between clinical areas. (Pharmacy services, hospital E)

Skill mix, and developing appropriate multi-professional teams, were frequently identified in the recommendations. The Standards' sections address different services in the hospital, as explained previously in Chapter 3, and a total of 12 domains are included in the National Accreditation Standards for Hospitals. Even if the Standards were about a single discipline, for example Medical care, a multi-disciplinary self-assessment team was seen to be necessary to fully understand and implement the Standards. For example, a Medical care self-assessment team was recommended to include, beside physicians, representatives from nursing, social services, pharmacy, and any specialty or service that influences this care. Other recommendations included:

The self-assessment team members did not involve members from CSSD, ICU or anaesthesia. (Surgical care, hospital F)

It is recommended to revise the team members for the environment standards (i.e. to include quality control officer, fire safety department, etc.). (Environment, hospital C)

The self-assessment team was not a multidisciplinary team. (Medical care, hospital C)

6.4.1.2 Engagement and participation in the process

Few data were coded under this sub-theme and all were from one report. This raises the probability that the team of surveyors visiting this hospital was more interested in exploring this factor than other teams rather than it being a true difference. Recommendations from this one report are listed below:

Involvement of more people in the quality and safety plan. (Medical care, hospital C)

More involvement of specialist/consultant in patient care with documentation. (Medical care, hospital C)

More involvement of staff in risk assessment and patient safety. (Pharmacy services, hospital C)

6.4.2 Work of accreditation

A strong theme emerged from the data coded to the work of accreditation. Work of accreditation meant the implementation of the Standards, and what facilitated or inhibited successful implementation. It related to the daily activities employees need to do for the intervention to be embedded within their routine work. This theme included the subthemes: adaptation of Standards; infrastructure; training and education; resources; and administrative system. These are discussed in turn.

6.4.2.1 Adaptation of Standards

This sub theme had the highest number of codes. Having reviewed the data, plans and strategies related to leadership, departments (clinical and supportive), and quality and safety aspects were identified. The surveyors recommended that the departmental plans must be updated and complete, and further emphasized how to address this gap by providing general guidance like, incorporating standards of practice in the operational policy, and including goals and objectives in communication plans. This was evident across all the services in all the sites as the recommendations below indicate:

> It is recommended that the department develop a specific policy for diagnostic contrast administration (oral and intravenous). (Diagnostic imaging, hospital B)
>
> To develop the inter & intra departmental communication policy. (Medical care, hospital C)
>
> Information management plan need to be developed in collaboration with other clinical and professional departments. (Information management, hospital E)
>
> Policies, protocols and guidelines have to be documented and applied, and for the applications to be later monitored. (Emergency services, hospital F)
>
> The team should produce more effort to document policies, protocols and guidelines. (Surgical care, hospital F)

The reports further addressed how some plans, even if available, required reviewing and amending in certain areas as one recommendation put it:

> Equipment disinfection policies require better documentation and training, specifically for portable X-rays and similar equipment. (Environment, hospital B)

Other recommendations stated:

> Guidelines and protocols should be referenced and dated. (Maternal/child care, hospital, hospital A)

> The patient rights and responsibilities do not exist in the department operational policy. (Medical care, hospital C)

There was a general consensus in the reports from all six hospitals about deficiencies in the plans and documents relating to the quality and safety domains. The reports revealed a major gap in implementing this part of the Standards, and urged the hospitals to address it as a priority. Quality and patient safety criteria represent a key aspect of the Standards and include 7 criteria that aim to assess and improve the quality and safety of the service. The criteria indicate that a service must have a quality improvement and patient safety plan that identifies areas for improvement, actions to be taken, results of actions, and follow-up to be done, and that this plan must be communicated among the staff. The criteria also assert that the staff must receive training in methods to assess quality and patient safety and participate in related activities. Also, they indicate that the service identify and implement appropriate performance indicators for quality improvement and patient safety. The last criterion addresses compliance with patient safety required areas.

The reports, on the whole, identified the absence of several key, hospital-wide, plans. For instance, some recommendations highlighted the need to establish a hospital-wide occupational health and safety programmes.

> Occupational health and safety programme needs to be established with assigned responsibilities for the programme. (Leadership, hospital E)

Other recommendations urged the hospitals to develop plans for disaster management and emergencies. Areas identified included first identifying what constituted a disaster or an emergency. Second, there was a recommendation to assign responsibility for managing and coordinating a response to an emergency. Third, in the event of an emergency, it was recognised that there was a need to describe the process to notify employees.

Many reports mentioned the lack of compliance of many departments in developing quality improvement and patient safety plans specific to their area. Criterion 7.1 in the Standards states that 'the service has a quality improvement and patient safety plan which

covers both inpatient and ambulatory care'. This plan identifies areas for improvement, actions to be taken, results of those actions and follow-up for monitoring. Recommendations in this regard are listed below:

> Quality improvement and safety plan should be developed, implemented and monitored. (Pharmacy service, hospital F)

> The Department is encouraged to continue work on implementing the Quality Improvement Plan, which will include analysis of outcomes; development of action plans; and follow-up to ensure the desired improvement is achieved. (Diagnostic Imaging services, hospital B)

> Quality improvement plan and performance indicator should be done. (Emergency services, hospital E)

> Quality improvement plan, patient safety and performance indicators should be developed. (Surgical care, hospital E)

Another reported problem in all six hospitals was the need to develop performance indicators in some of the services where these were missing. This addresses criterion 7.6 that states 'indicators of performance for quality and patient safety are identified for the service/unit and are monitored as part of the quality improvement and patient safety activities'. Performance indicators are defined as 'measures that a sector or organisation uses to define success and track progress in meeting its strategic goals'(Rozner, 2013). The surveyors recommended:

> Continue to enhance the quality programme by expanding indicator use, analysing trends and benchmarking performance with standards and organisations that are considered best in class. (Diagnostic imaging services, hospital B)

> The general medical service is encouraged to develop more quality indicators appropriate for their service. (Medical care, hospital B)

> The team has managed to accumulate a good number of performance indicators. They need however to concentrate on 2 to 3 of these to start methodology for collecting data, analysis and possible decision-making process for those. (Human resources, hospital F)

> Performance indicators need to be adopted and studied to help the activities of the department. Performance improvement initiatives need also to be looked at more carefully. (Laboratory services, hospital F)

The second matter which emerged regarding Standards adaptation was mainly concerned with implementation of patient safety required areas and process of care related Standards. Reports identified a gap in implementing patient safety required areas, which are a key issue in the NAP Standards in both the Patient Care Standards and Clinical Support Service. Findings from the systematic review did not address this matter. The patient safety required areas aim to reduce healthcare related errors – a problem that affects millions of patients worldwide. See **Table 6-6** for more detail.

The process of implementing all the safety areas appeared to be challenging for most of the departments in all the six hospitals. Some recommendations addressed a general failure in implementing those safety areas,

> The team is encouraged to implement all the patient safety required areas according to the standard. (Emergency services, hospital D)

> The team is encouraged to fully establish and implement all policies regarding patient safety required areas. (Specialised/Intensive care, hospital D)

> Ensure compliance of all staff to patient safety required areas by developing indicators that monitors compliance. (Diagnostic Imaging services, hospital F)

> Implement patient safety required area. (Medical care, hospital E)

Other recommendations identified incomplete compliance, where the departments succeeded in implementing only some of the patient safety required areas and failed in others. This matter is understandably challenging and probably requires more education and training as well as more time to adapt.

Table 6-6 The patient safety required areas in the NAP Standards

Patient verification	Implement a patient identification protocol for the service. The protocol may be standardised across all services in the hospital (for example, wrist band, photo identification).
Transfer of client information at transition points	The service transfers information effectively among providers at transition points to include, patient status, medications, treatment plans, and significant status changes.
Medication reconciliation	Reconcile the patients' medications upon admission to the hospital including emergency department or inpatient units.
Safe surgical practice	Develop a process and written protocol for safe surgery that complies with the WHO Surgical Safety Checklist.
Control of concentrated electrolytes	Remove concentrated electrolytes from client service areas.
Training on patient safety	Deliver training and education on patient safety at least annually to senior leaders, staff, and service providers.
Timely administration of prophylactic antibiotics	Administer prophylactic antibiotic to prevent surgical site infections.
Safe injection practices	Develop safe injection protocols and practices in order to prevent harm to patients and hospital staff.
Avoiding catheter and tubing misconnections	Develop systems and procedures to prevent catheter and tubing misconnections.
Performance of correct procedure at correct body site	Develop a process and written protocol for ensuring correct procedure at correct body site prior to any invasive intervention.
Look Alike, Sound Alike (LASA medication names	Identify and manage risks associated with look-Alike, Sound-Alike medications.
Hand hygiene	Provide easy access and resources for staff to comply with recommended hand hygiene.

Source: (Ministry of Health, 2011b)

Many recommendations reflected difficulties in implementing medication reconciliation, which is a process designed to prevent medication errors at patient transition points by creating an accurate list of all medications a patient is currently taking and comparing that list against the physicians' medication orders (Wong et al., 2008). However, as the following recommendations show, this was proving to be a particular barrier:

Medication reconciliation needs to be fully implemented. (Specialised/Intensive care, hospital A)

The service is strongly encouraged to fully implement a policy on medication reconciliation. (Surgical care, hospital A)

Medication reconciliation requires special attention, in terms of definition and implementation. (Emergency services, hospital B)

Recommend implementing the medication reconciliation process. (Surgical care, hospital C)

Development and implementation of patient safety required area medication reconciliation. (Specialised/Intensive care, hospital E)

Recommendations about the control of concentrated electrolyte solutions were also common in the surveyors' reports. This recommendation aims to remove concentrated electrolytes from patient service areas (Abdellatif et al., 2007). The reports identified a lack of implementation of this safety solution in three hospitals, and the recommendations are listed below:

Concentrated electrolytes presence in the ward should be re-evaluated. (Surgery, hospital B)

The medical service is encouraged to monitor the implementation of the concentrated electrolytes policy in all the required areas. (Medical care, hospital A)

The amount of concentrated KCl (Potassium Chloride) available in some locations is large compared to consumption rates, and The service is encouraged to review with Pharmacy levels of stock to be kept in these areas. (Surgical care, hospital A)

Develop policy and guidelines for patient concentrated electrolytes. (Maternal/Child care, hospital E)

Another area of identified concern was in relation to hand hygiene. Hand hygiene is an easy, yet effective practice in reducing infections. Three of the hospitals were identified as having issues in this area, with the surveyors making a number of recommendations in relation to monitoring and the provision of hand sanitizers.

The hospital is encouraged to conduct audits to ensure hand hygiene compliance. (Hospital A)

It is strongly recommended to implement and monitor the practice of hand hygiene across the hospital in a more strict way. (Hospital C)

There is limited access to hand sanitizers throughout the hospital especially in-patient service area. (Hospital F)

The remaining patient safety required areas were coded less frequently in the reports, which could imply that the hospitals had worked harder on those solutions and implementation is almost completed. The surveyors recommended the following about patient identification:

Patient verification should be implemented in all clinical notes and records. (Medical care, hospital F)

Clear policy regarding patient verification has to be implemented. (Medical care, hospital E)

They also mentioned, in a few recommendations, addressing and implementing the catheter and tubing misconnection, practicing the single use of injection devices, and finally implementing the Look-Alike, Sound-Alike medication names policy.

The implementation of catheter misconnection policy in all critical area. (Specialised/Intensive care, hospital F)

Clear policy for tube misconnection. (Medical care, hospital E)

Develop policy and guidelines for patient safe injection. (Maternal/Child care, hospital E)

Policy related LASA has to be fully developed, implemented and monitored. (Pharmacy services, hospital F)

Another reported problem in adaptation of Standards was concerned with the process of care. This seemed to be a particular problem in some of the emergency departments, where triage systems, or rather the lack of triage systems, were noted. This is an important feature

of any emergency service that helps in categorising patients according to their need. Surveyors recommended implementing this system in two hospitals as stated below:

> Triage system needs to be reviewed and standardised among all casualty areas. (Emergency services, hospital D)

> Triage is a major component in emergency care services and has to be developed in the hospital. (Emergency services, hospital F)

Finally, other recommendations were about the diagnostic imaging department in one of the hospitals. It suggested including radiological interventional services and therapeutic services in the plan of care. The surveyors also made recommendations about various aspects of the care in some sites, for instance the use of checklists in some procedures, and the need to review and organise 'crash carts' in some departments.

6.4.2.2 Infrastructure

Infrastructure refers to the structure of an organisation, the systems, and facilities needed for it to function. The Standards of accreditation demand that certain structures and facilities are available within the hospitals. This might be related directly to the criteria, for example safety requirements, or indirectly, for example space issues. This sub-theme addressed three main domains: the physical environment, workplace safety, and information systems.

It was evident that space problems affected the provision and organisation of services on many levels. In the reports, there were concerns about the general lack of space in all of the six hospitals and recommendations to many departments to improve their physical environment were made:

> The team is encouraged to continue to review their physical facility while they are waiting for the new hospital. (Emergency services, hospital D)

> The physical facility of the department is very limited. Expansion is needed. Accommodating diagnostic services in the new building is recommended. (Diagnostic imaging services, hospital F)

There is a lack of lounge space for families who require privacy when visiting family members or require private conversations over difficult conversations with clinicians. (Specialised/Intensive care, Hospital B)

The department is encouraged to explore ways to improve the problem of space limitations. For example lack of space in the stress test room is an issue in that it affects optimal workflow and the multi functioning of the Thyroid Scan Room may need to be addressed in the future. (Diagnostic imaging services, hospital, B)

In two hospitals, surveyors recommended the need for a central warehouse for medical waste. Other recommendations focused on the lack of storage space in some of the services:

Increase storage facility for flammable and biohazard waste mostly in the laboratory section. (Laboratory services, hospital F)

The team is encouraged to review space for storage. (Emergency services, hospital A)

Improve the pharmacy physical space especially the storage and working space. (Pharmacy service, hospital E)

In three hospitals, there appeared to be issues related to staff safety, especially in the emergency department. The surveyors made several recommendations, particularly in relation to improved security:

Safety is a major issue in regards to staff work environment and patient interaction. (Emergency services, hospital F)

Improve security services especially with high incidence of aggression towards medical staff in the hospital. (Emergency services, hospital B)

The team identified security in the department as a concern particularly for those clients both adult and paediatric presenting with mental health issues. A number of suggestions have been made by the team to better address this safety concern; more presence of security/police within the department, training of staff in managing violent patients and better accommodation of these patients. (Emergency services, hospital A)

The third strand of infrastructure related to the information systems of the hospitals. Surveyors were, in the reports, particularly critical of the lack of a hospital-wide information system across all the sites. Healthcare is a multidisciplinary and integrated service and a hospital information system is a computerised system that attempts to record and manage all patient related data, which allows the healthcare providers to practice their job in a more effective way (Mair et al., 2012). However, systems, if available, were not connected to each other due to a range of technical issues.

Most of the recommendations referred to this obstacle:

> A summary of the patient's care in the emergency department should either be maintained in a file in the emergency department or added to the patient's record at the time of discharge. This will facilitate and promote continuity of care should the patient return to the department. The establishment of an electronic database may of assistance in this regard. (Emergency services, hospital B)

> Management should create and establish a system where they can keep and retrieve the patient's ER records in an electronic fashion. (Emergency services, hospital C)

> No comprehensive computerised hospital wide system yet, although there is a limited electronic laboratory reporting managed separately by the lab through the vendor. (Information management, Hospital C)

> Electronic data management needs to be implemented to improve acquisition of data. (Information management, hospital, E)

A couple of recommendations mentioned the need for Internet access within the hospital premises that could be used for educational purposes by the employees.

6.4.2.3 Training and education

Education is an integral component of any newly introduced intervention and is directly linked to the success of an organisation's accreditation and survey experience. In the systematic review, training staff in quality improvement was found to be a key factor in successfully implementing accreditation programmes. Most of the recommendations in the reports addressed the defect in knowledge in issues that were directly related to the quality and safety aspects of the Standards, like those stated below:

Involve staff members of the team "at all levels" to participate in training for patient safety. (Diagnostic imaging services, hospital D)

Staff should receive training related to patient safety especially to drug adverse events. (Pharmacy services, hospital F)

Recommend training to identify proper indicators of performance for assessment. (Pharmacy services, hospital C)

Many recommendations urged organisations to practice fire safety and evacuation drills, by offering training to their staff, and thus also complying with the disasters and emergencies section of the Standards in the Environment domain. Criterion 10.2 states, 'there are regular simulations and drills to practice the plan' and criterion 12.5 says, 'there is a hospital-wide education programme for fire prevention and safety'. This issue was evident in all six reports.

The organisation is highly recommended to practice evacuation drills and fire safety training for the staff in all areas of the organisation. (Environment, Hospital D)

Although regularly practiced drills are reported, it is advised that a comprehensive evacuation and emergency plan be practiced with more comprehensive structure involving the entire hospital and community partners like the Kuwait Fire Department is crucial. (Environment, hospital B)

More training on emergency drills in all areas of the hospital is needed. (Environment, hospital A)

It is strongly recommended that the hospital emergency plan is updated on regular basis with consistent training of all staff members in the hospital. This should include (at least) an annual emergency preparedness drill involving all departments, clinical and non clinical. (Environment, hospital C)

A small number of recommendations called for the need to train staff in Basic Life Support (BLS), which is indirectly related to implementing the Standards.

While the above-mentioned training needs were mainly addressing safety matters, other educational needs surfaced during the surveyors' evaluation, which can be categorised into staff development requirements. These were more specialty specific. For example, in two of the hospitals, surveyors indicated the need for more training in information management

and technology, and another recommendation was about training in specific surgical procedures as indicated below:

> More training for the Information management staff on data and technology. (Information management, hospital D)

> Formal training for staff in the main theatre. Further staff would welcome training (cleaning and disinfection, handling of surgical equipment, CPR, and emergency procedure). (Surgical care, hospital D)

Another one noted,

> The Radiation Safety Officer is encouraged to provide support and education to all staff that are involved with the management of patient care. (Diagnostic imaging services, hospital B)

6.4.2.4 Resources

Resources can include human, time, and financial aspects, which are all equally important in the success of any newly introduced programme. This emerged in the systematic review, where lack of financial resources, staff shortages, and time constraints were identified as a barrier in the process of implementation. Surveyors recommended the need for more staff in three of the hospitals:

> Staff to patient ratio has to be improved. (Emergency services, hospital F)

> The department is understaffed and needs recruitment of more qualified staff to face the continuously increasing workload. (Medical services, hospital B)

> Increase the number of emergency physicians in the department, many shifts are short staffed. (Emergency services, hospital B)

> To increase the manpower in the nuclear medicine department. (Diagnostic services, hospital C)

A couple of recommendations, in two of the hospitals, stressed the need to establish a dialysis unit, and one reference was made regarding the lack of time given to staff for development:

More time should be allocated for the self-assessment. (Surgical care, hospital E)

6.4.2.5 Administrative system

The last sub-theme was related to the administrative system that led to complex and un-necessarily lengthy procedures. Although there were not many recommendations in this area, it is likely that burdensome bureaucracy could be a barrier to implementation, as reported in the implementation of the Quality and Outcomes framework in UK general Practice (Greenhalgh et al., 2014). In one report, an increase in referrals from primary care centres was noted to cause a problem in the hospital because it was suggested that many of the cases could be addressed in the primary care clinics:

The service is encouraged to continue to collaborate with primary care to reduce the self-referral cases. (Hospital A)

To encourage collaboration with the primary care to establish more comprehensive services, which will help prevent overuse hospital services. (Hospital A)

6.5 Discussion

6.5.1 Overview of the findings

The results described in this chapter provided information about the barriers and enablers that affected the NAP implementation in Kuwait Government hospitals. The data used in this chapter were thematically coded from the accreditation reports and mainly address the areas of improvement recommended by the surveyors following their accreditation visits to the hospitals.

Unlike the systematic review, which identified 5 main themes related to the process of accreditation implementation, only 2 main themes were generated from data analysis of the reports: engagement with the accreditation process; and work of accreditation. This might be due to the focus of the surveyors during the visit, where evaluating the degree of compliance with the Standards means they were looking for evidence in relation to the

work being done to implement the Standards, rather than thinking about wider issues such as staff understanding of the process.

As discussed in Chapter 5, the systematic review identified engagement and involvement of the employees as a facilitator for successful implementation. This was not a strong feature of the reports, however; this may be explained by the professional perspective of those writing the accreditation reports. Thus, the surveyors might not be in the best position to evaluate the employees' engagement based on their five days visit, so their assessment was about what could be evaluated during an on-site visit, rather than what should be evaluated. Thus, the internal self-assessment team members, who worked very closely with implementing the Standards and had the opportunity to notice the degree of engagement of the employees, might better evaluate this factor within the hospital.

It was clear that the process of evaluation was focused on the work of accreditation, probably because elements of this theme are tangible and easier to evaluate during an on-site visit. This gives an opportunity to improve the surveying process in the future, by highlighting the key areas that need more exploring and developing a system for evaluating those areas. Two sub-themes emerged in the reports' analysis under the work of accreditation that were not identified in the systematic review of the international literature, and those were: infrastructure and administrative system. All six reports provided strong evidence of a gap in the development of plans and policies to support the NAP in each hospital site. Looking through the Accreditation Standards, the high frequency of coding is explained, because all the 12 domains of the Standards have criteria about developing plans. For example, in Leadership Standards, there are criteria about strategic planning and operational planning demanding the writing of such plans, and the same applies on the clinical and clinical-support domains Standards, as some criteria state the availability of operational plans and quality and safety plans.

Data from the systematic review identified financial resources and lack of time as the main obstacles identified in the process of implementation. In the reports the surveyors also identified lack of manpower as a major barrier.

6.5.2 Limitations and strength

The limited scope of the results was expected and they helped in answering only part of the overall aim of this PhD. This is because: first; the accreditation reports were generated for an entirely separate purpose than this research, thus, selecting information from it that is relevant to the study aim generated less data than other qualitative methods such as interviews, second; the main method of evaluation implemented in the report is a scale system that assessed the degree of compliance with the Standards (explained in detail in Section 6.2.2.), while the section with the recommendations used in this analysis represented only part of the report.

Another weakness identified in the data is the inconsistent judgment of the surveyors and perceived subjectivity, with what appeared to be 'over reliance on the value judgment of the programmes' surveyors' as described by others (Jaafaripooyan, 2014). The surveyors in the NAP undertook an extensive course of training when they joined, attending theoretical and practical workshops. The scope of training includes standards knowledge, surveying technique, teamwork and communication skills, and writing the report. However, some degree of inconsistency was perceived among the surveyors, which could be expected due to their different professional backgrounds and experience (Hurst, 1997, Pongpirul et al., 2006).

Despite the limited data generated, the reports provided several important additions to this research. First, they expressed the opinion of a different group of professionals than the self- assessment teams interviewed and reported on in Chapter 7. The surveyors were educated and trained both locally and abroad about accreditation in general and the evaluation of the process in particular, and so bring an external perspective to the work. Another strength to this method is in helping to triangulate the data from both the systematic review and the interviews to increase the credibility of the findings, thus reducing potential bias that can happen in a single study (Bowen, 2009).

Data collection can be a very time consuming part of research. Other qualitative methods such as observation and interviews demand a lot of time from the researcher to collect and prepare the data for analysis. This approach made use of already available data and was,

thus, much less time consuming and costly but had the drawback of not fully addressing the research question because the data were collected for another purpose.

6.6 Summary

This chapter presented the second study of this research, a documentary analysis of the accreditation reports written for the six general hospitals in Kuwait. This study identified two main themes affecting the process of implementation as viewed by the surveyors: 1) engagement with accreditation and 2) the work of accreditation. Data collected provided less insight into the process of implementation, as compared to the systematic review (the first study). Further exploration of the implementation factors were therefore pursued through the final part of this research, the semi-structured interviews with the self-assessment team members.

Chapter 7- Interviews

7.1 Introduction

This chapter reports on the final phase of research in this study - semi-structured interviews with professionals involved in the accreditation programme within Governmental hospitals in Kuwait. Data generated by the interviews provided a rich description of the accreditation experience; these are reported here and synthesised with the findings of the other phases in Chapter 8.

7.1.1 Rationale

In this study accreditation was defined as 'a self-assessment and external peer review used by healthcare organisations to accurately assess their level of performance in relation to established standards, and to implement ways to continuously improve the healthcare system'(ISQUA, 1998). This lays out the course of the process as first a self-assessment against pre-established standards, second, an evaluation mechanism performed by external surveyors, and third, implementation of approaches to monitor progress. Having already explored the comments of the surveyors and their identification of barriers and challenges to implementation (Chapter 6); this chapter focuses on the views of the self-assessment teams. In order to do this, the method of data collection employed was that of semi-structured interviews.

7.1.2 Research questions

- How did the accreditation process impact on healthcare professionals and what was their view of its organisational impact in Kuwaiti hospital settings?
- What were the facilitators and barriers affecting the implementation of the NAP in Kuwait from the self-assessment teams' perspective?

7.2 Methods

As described in Chapter 4, different approaches can be taken to assess and evaluate the implementation of a complex intervention such as accreditation. Scrivens suggests that such evaluation can utilize quantitative approaches, such as the collection and analysis of accreditation data; qualitative approaches, which explore the views, perceptions and understanding of those involved in the process; or a combination of both (Scrivens, 1997a). A qualitative approach using semi-structured interviews was selected as the study design for this work because it enabled the participants to provide a full description of their experience including the facilitators and barriers they encountered, and how they learned and developed personally from the process.

7.2.1 Selection of hospitals

This in-depth qualitative work was set in two of the six general hospitals described in Chapter 6. The selection of the two hospitals was based on several criteria:

- The hospitals were similar in the services they provided and had a similar number of self-assessment teams.
- Hospitals had to provide a range of services, as opposed to being specialist hospital (e.g. Orthopaedic hospital).
- Included hospitals had to have completed the first survey and received their final report from the higher committee of accreditation.

Two general hospitals were identified and selected and these will be referred to as hospital A and hospital B, which is the same reference to the same hospitals in Chapter 6. This decision was made after several meetings with key personnel in the Quality and Accreditation Directorate, to explain the selection criteria stated above to find the appropriate match. Four sites were primarily selected that fulfilled the selection criteria. After contacting those hospitals, three agreed to participate. However, due to the limited resources and the time frame of the PhD, two were chosen as final candidates to participate in the study. Both hospitals had received their final accreditation report based on the on-site survey visit. For hospital A, the accreditation decision granted was Substantial Accreditation, while for hospital B the accreditation decision was Partial Accreditation with Conditions (the process is explained in detail in Chapter 3).

7.2.2 Participant recruitment

Once the hospitals were recruited, the main participants for the interviews were selected. A purposive sampling technique was used to select key informants, who had the knowledge and experience of the accreditation process in each hospital, and who operated at different levels within the hospital (e.g. doctors, nurses and technicians) and who were thought to have knowledge pertinent to the aims of this phase of the study (Teddlie and Yu, 2007, Tongco, 2007).

Gaining access to a site for the purpose of research is one of the most challenging obstacles to overcome. However, the professional background of the researcher (having been employed in the Quality and Accreditation Directorate) had led to well-established contacts with most of the quality physicians in the hospitals, which facilitated access to both the hospitals and personnel. The researcher contacted the Quality Physician (QP) within each hospital, who acted as the liaison person for the study. These people were chosen due to their knowledge of the programme, access to the site, and their well-established communication with the hospital management and the staff. The research was discussed with both Quality Physicians, outlining the aims and objectives, and explaining how it would be conducted. This engaged them in the study and ensured their on-going help and support throughout the process.

The QP, in both sites, drew up a list of potential participants ensuring representation of most of the self-assessment teams (a description of the self-assessment team is given in Chapter 3). The researcher discussed with the QP which employees were familiar with, and involved in, the accreditation and implementation processes in the hospital, as they were considered to be the best people to provide information about accreditation in each hospital. This also ensured that different specialties and backgrounds were approached, and that people operating at different levels were also included. Potential participants were approached by the QP in each hospital and given the information about the study verbally. The QP then provided interested individuals with the researchers' contact details for any inquiries. Those who agreed to participate responded verbally to the QP and participant information sheets (**Appendix 6**) were sent to both sites and handed to all potential participants in advance, explaining briefly the aim and objectives of the study, and focusing on their right to decide to join the study or withdraw at any time. Furthermore, the

participant information sheet emphasized the importance of confidentiality and described all the measures taken into account to protect their identity. The QP arranged the time for the interviews and the schedule was emailed to the researcher.

The potential participants in hospital A initially totalled 15 individuals. However, the final number of participants who were interviewed was 13 because two of the selected people were on leave during the time of the data collection. In hospital B, the list of participants totalled 13. Eventually, 12 interviews were conducted on this site because one individual changed his mind and withdrew from participating in the study. After obtaining their written consent, see **Appendix 7**, all the interviews were conducted within their work premises.

7.2.3 Interview schedule and piloting

The interview schedule used in this study was developed by drawing on both the conceptual framework (NPT) and findings from the systematic review and accreditation reports, to explore the accreditation experience in more depth. For example, the interview schedule included questions designed to explore respondents' understanding of accreditation (coherence) and the way in which they engaged, and engaged others, in the process (cognitive participation). Also the questions focused on more exploration of the understanding of participants of the process of accreditation implementation due to the limited coverage of this aspect within the systematic review findings. In addition, reflecting on the reports' findings, the researcher wished to explore why some of the Standards were not fully implemented. The semi-structured interview schedule was helpful in providing a structured approach to the data collection but also allowed the researcher to respond to, and explore, the participants' experiences individually. A copy of the interview schedule is attached in **Appendix 8**.

After gaining ethical committee approval, the researcher piloted the interview schedule with five members of the self-assessment team in one of the selected hospitals without audio recording, however, hand written notes were taken. The aim of this pilot was to evaluate the time and flow of the interview; the language of the questions; and the interviewing skills of the researcher. This step was crucial because English was not the first language of either the researcher or the participants.

As a result, minor refinements were made regarding some vocabulary, and some adjustments were made to the content, type and order of some of the questions. Data from these interviews were not included in the analysis of the interviews because the main concern of the researcher was focused on feedback about the interview schedule itself rather than the answer to the questions.

7.2.4 The interview process

Before beginning each interview, the participant information sheet was discussed with each participant, emphasizing the confidentiality, anonymity and the freedom to participate or not. The interview then began with an introduction between the researcher and the participant, and a brief summary of the research.

The questions for the interview started with a general inquiry about their understanding of accreditation and their overall experience. Then, moving on to the main body of questions, the researcher focused on the participants' involvement in the process of accreditation, emphasizing their understanding of the programme concept and their role in it. These questions also aimed at eliciting their opinion of the impact of accreditation on the quality and safety of the services, and whether the process affected them as participants. The remaining questions aimed to find out what they perceived to be the main barriers and facilitators they encountered during the implementation journey, their view of the Accreditation Standards to their everyday working life and whether they could embed these processes into their normal routine.

The time of the interviews ranged from 30 to 40 minutes in length, and a total of 25 interviews were completed over both sites. All the interviews were recorded using a digital recorder after obtaining the participants' approval, along with brief field notes the researcher wrote during each session. All the audio files were transferred into a password protected computer and transcribed by a professional transcription service; following checking, the recordings in the digital recorder were deleted.

7.3 Data analysis

Data from the interviews were analysed using the same approach as the documents i.e. thematic analysis. The researcher first began by organising and preparing the data for analysis. Audio recordings were transcribed verbatim using a professional transcribing company, and all field notes and memos collected during the fieldwork were sorted and organised. The transcripts were then checked for accuracy and any missing words added in from the recording (Braun and Clarke, 2006). Once this step was completed, data familiarization was reached by reading and re-reading through all the material from the interviews and the field notes. This process established a general sense of the data to understand it as a whole before dividing it into codes (Ritchie et al., 2013, Creswell, 2013a). During this phase, the researcher also noted initial patterns identified within the material, as well as general thoughts and inquiries in relation to them.

Having reviewed the data, the next step consisted of coding the material into small segments of information. The process of coding in this study was data-driven, drawing upon emerging issues and patterns within the data. However, the researcher also approached the analysis with prior knowledge from the previous findings within the systematic literature as well as the documents, and drew upon the aim and objectives of this study to help guide the emergence of themes (Fereday and Muir-Cochrane, 2006, Joffe, 2012).

First, the researcher and both supervisors read through four transcripts and applied preliminary codes to the data. These were then discussed in a coding clinic to determine the degree of consistency of coding across the three coders and the interpretations being applied to the data. Following this, the codes were then organised into themes, again following discussion with supervisors, to develop an initial coding framework, see **Table 7-1**. This process of multiple coding can improve the reliability of the analysis and help to avoid any bias that might arise if only a single researcher conducted the coding.

Table 7-1 Example of initial coding framework for the interviews

Interview transcript	Code
Shortage of space is a problem, storing is a big problem	- Lack of space - Storage problem
We try just to fill papers, have files, we talk to other departments but at the end of the day it's only paperwork	- Only documentation - Paperwork
Yeah structure wise I think these are the most issues and you know there are some psychological issues you know the resistance of changes because people still, it's part of their education and awareness because they don't understand what is the benefit out of this, some of them they are thinking it's extra work.	- Resistance to change - Don't know the benefit of accreditation - Workload

The researcher then worked systematically through the remaining transcripts using the coding framework. This process is known as open coding, and can produce a start list of a large number of codes (Burnard et al., 2008, Miles et al., 2013). New codes incorporated into the initial coding framework, for example, personal effort and resistance to change were merged into professional attitude. The coding framework was further reviewed and developed and the structure of the themes revised. During this process, attention was paid to the constant comparative method by revisiting the codes and comparing texts to each other within the same interview or with other transcripts until no further changes were made and no new codes were identified (Hewitt-Taylor, 2001, Fram, 2013).

The next step involved arranging the codes into themes by merging together codes sharing common elements and assigning them to the corresponding themes and eventually developing a coding framework, see **Appendix 9**. Once the coding was completed, coding reports were created for each theme. To do this, a Word file was created for each theme, with all the codes relevant to the theme copied and pasted into the theme coding report. Each section of coded text was tagged with the participant identification number, allowing the text to be traced back to the original transcripts if any contextual details were needed. This allowed easy comparison of codes and themes across all the participants. Even though there was no pre-determined coding framework to guide the data analysis and the method was more inductive in nature, the experience of the researcher and her prior knowledge in this field, as well as drawing on the concepts formed during the systematic review influenced the final interpretation of the results. So codes were categorised into different aspects of the programme, like understanding, engagement, work and impact, to enable a

better understanding of the process and identify areas of weaknesses and obstacles. This, in a way, correlated with the different constructs of NPT.

7.4 Ethical consideration governing the research process

Before starting the data collection, the relevant documents were prepared by the researcher and submitted to the Ministry of Health Ethical Committee in Kuwait on December 31st, 2014. Among the documents presented were the following:

• The study protocol
• The interview schedule
• The participant information sheet
• The consent from
• The application form

The participant information sheet gave a brief statement of the research aim and objectives, focusing on the participants' right of choice to cooperate or withhold participation. Also, confidentiality was assured to them, with the right to withdraw or stop anytime during the interview. Approval was granted by mid-January 2015, and all the documents were further forwarded to the Medical, Veterinary and Life Science (MVLS) College Ethics Committee who considered the whole application and also granted the approval for the study based on the documents submitted on February 20th 2014. See **Appendix 10**.

7.5 Results

Participants were recruited from two general hospitals. The first site (hospital A) is a general hospital that serves around 950,000 people and employs 630 physicians and 1700 nursing staff. This hospital was granted 'Substantial Accreditation'. The second site (hospital B) is also a general hospital but serves half the population of hospital A. The number of physicians in hospital B is around 430 and there are about 1500 nurses. This hospitals' accreditation decision was 'Partial accreditation with conditions'.

A total of 25 participants were interviewed in the study. All were healthcare providers, and part of the self-assessment teams. Most were doctors, although working in a range of medical, surgical and diagnostic areas as outlined in **Table 7-2**.

Table 7-2 Description of participants in the interviews

No	Specialty	Position
Hospital A		
1	Nursing	Senior nurse
2	Diagnostic imaging	Radiologist registrar
3	Nursing	Senior nurse
4	Surgery (ENT)	Registrar
5	Pharmacy	Pharmacist
6	Obstetric and gynaecology	Senior registrar
7	Surgery (orthopaedic)	Registrar
8	Diagnostic imaging	Consultant
9	Medicine	Consultant
10	Paediatrics	Senior registrar
11	Laboratory	Technician
12	Cardiology	Registrar
13	PICU	Specialist
Hospital B		
14	Paediatrics	Registrar
15	Surgery (Orthopaedic)	Senior Registrar
16	Obstetric and gynaecology	Senior Registrar
17	Medical records	Senior administrator
18	Pharmacy	Pharmacist
19	Diagnostic imaging	Consultant
20	Surgery (ENT)	Registrar
21	Emergency	Registrar
22	PICU	Consultant
23	Diagnostic imaging	Senior Registrar
24	Laboratory	Consultant
25	Laboratory	Senior Registrar

(The number assigned to each participant does not reflect the number in the quotes to preserve anonymity of the participants)

Analysis of the 25 interviews identified five broad themes: accreditation meaning; understanding of the accreditation process; engagement with the accreditation process; the

work of accreditation; and the impact of accreditation. These will be discussed in the following sections.

7.5.1 Accreditation meaning

Similar to findings from the systematic review, the interviewees interpreted this in different ways. For many, accreditation was seen as a tool to evaluate and improve services. The majority of participants, from both hospitals, held that view and used words like 'evaluate', 'audit', 'measure', 'improve' and 'highest performance'. One interviewee explained it as:

> Accreditation is a system of audit to put it in a very short statement. Accreditation aim was to review the hospital policy, hospital structures and hospital interaction between departments according to standards. (P6, hospital A)

The value of accreditation as a tool for evaluation and quality improvement was very evident among the responses, as explained by this participant:

> Accreditation is [a] very important tool to evaluate the quality of the services provided in hospitals and to evaluate the advantages or disadvantage, limitation and weaknesses of all the services provided. (P16, hospital B)

Another participant said:

> I think it's all about improving the service, it's all in a concise way, improving service, how to improve your service, how to discover your problems and try to improve. (P14, hospital B)

Some participants believed that the main focus of the Accreditation Standards was on the quality and safety of the entire services of the hospital. One senior administrator described it as follows:

> There are many conceptions of accreditation but to me it is like you have to take care of each quality input you put into your process. (P22, hospital B)

The interviews also revealed how some considered accreditation from other angles, focusing more on the individual components of the programme. They felt that accreditation as a tool helped in standardising the service within the organisation, for example by ensuring better compliance with protocols and pre-set standards. However, they also reported some frustrations due to the struggle they encountered when trying to introduce some practices, like the handover routine. Nevertheless, they viewed accreditation as leverage for implementing best practice. One participant, a paediatric doctor, best described it:

> Sure that I started the accreditation team only in late 2013 so maybe a year and a half, overall I think, I think there are some advantages and opportunities some disadvantages as well. Advantages are really to unify the care of patients across the services, meet certain standards, increase the basic ones and improve on the existing services. (P4, hospital A)

Some participants also expressed the view that accreditation programmes were a '*brand name*' indicating the good job an organisation had accomplished to improve the quality and safety of the services it provided. Recognition is a significant aspect of accreditation and part of its definition stated by Shaw (2004) as 'Accreditation is a public recognition of the achievement of Accreditation Standards by a healthcare organisation, demonstrated through an independent external peer assessment of that organisation's level of performance in relation to the Standards'.

A couple of participants in hospital A felt that, through accreditation, their work was recognised and appreciated, as one said:

> It gives us a privilege of accreditation, and being recognised among people about our job and what are the areas that we are good in. (P5, hospital A)

However, some viewed accreditation to be only about documentation. One participant felt particularly burdened by the demanding process of Standards implementation, as he explained:

> Everybody here is trying to get their certificate but not trying to get actually the value or the action itself, meaning everybody is trying to do the paperwork. Okay so what are we doing? Nothing. We try just to fill papers, have files, we

talk to other departments but at the end of the day it's only paperwork. (P15, hospital B)

Another participant agreed with this concept of accreditation, namely being strongly connected to documentation. From her position in the diagnostic imaging department, she claimed that all the relevant Standards had been implemented before the introduction of accreditation. Thus, she felt that accreditation only helped in organising their files and documenting their work.

Accreditation is a way of standardising the work and documentation. And I always say a synonymous of accreditation is documentation. And honestly I believe what we were lacking before starting accreditation was the documentation, nothing else. (P6, hospital A)

Despite a few comments where participants thought accreditation was merely about paperwork and filing, there was a consensus among most participants regarding their perception of accreditation as an evaluation tool that measures the service against pre-determined standards and promotes quality and safety within the organisation.

7.5.2 Understanding the accreditation process

Analysis identified understanding the accreditation process as a theme, with knowledge and skills, understanding the Standards, and prior experience in accreditation as sub-themes.

7.5.2.1 Knowledge and skills

Having knowledge about the programme and the skills required to implement the process of accreditation appeared to be a corner stone in terms of facilitating the successful delivery of accreditation. Reflecting the findings from the systematic review, most interviewees felt that they faced a challenge in clarifying what accreditation meant, and how the process of implementation worked. There was evidence from both hospitals that participants struggled in understanding accreditation and its components. The self-assessment team members described the programme as strange and unknown, especially in the beginning, as one participant said:

> Especially in the beginning it was not clear. We struggled a lot to understand you know, I remember we went for maybe the first 3 – 4 years just to know what is accreditation. (P21, hospital B)

Another one commented:

> At the beginning I definitely had lots of struggles, especially when it comes to risk management analysis and stuff like that sort of deep specialty. Or the quality control, and what's required from me. (P4, hospital A)

While participants mostly expressed their lack of knowledge of the programme as a whole and their role in the process, some were more specific in identifying particular areas they felt were challenging, like writing up the policies or implementing the safety required areas, which were both identified in the documentary analysis as a major implementation gap by the surveyors.

With time, and as the programme became part of their daily activities, many participants, especially in hospital A, came to be familiar with accreditation and understood their role as self-assessment team members in implementing the Standards, as illustrated in the following quote:

> After we read the policies and we follow it and we implement these instructions the vision became clear for all the staff and became highly organised. (P 7, hospital A)

> Over the first one and a half to two years we were all like, we didn't know what was happening, it was only towards the end you know when the Mock survey started that is when we actually got to understand what's happening and when we got more involved. (P8, hospital A)

However, some interviewees in hospital A insisted that they still didn't fully understand what accreditation was and what the processes were.

> It's not easy okay, and I think because there is no definite process how to implement the standards here in the hospital it's not clear to me until now. (P2, hospital A)

I think I still don't fully understand it unfortunately to be honest but I'm getting there I think yeah I'm getting there. (P4, hospital A)

Participants from both hospitals expressed the need to have a detailed protocol for the right way to implement Standards both within, and across, departments due to the apparent inconsistency in interpreting what each Standard was about and how it should be acted upon. This led to a lack of consistency across the hospital in implementing departmental Standards by the teams due to differences in understanding. One interviewee said:

We don't have any idea on earth what accreditation is and it was our own interpretation so everybody is interpreting the guidelines from his point of view. (P14, hospital B)

Another one commented:

We tried to educate the staff and the department but different people would have different understanding of things so we needed to really reinforce the ideas several times. (P4, hospital A)

The views of staff in both hospitals were quite similar regarding the lack of understanding of the aim of accreditation and how to implement the Standards, especially at the start of the accreditation programme; however, there appeared to be a difference developing between hospitals with respect to individuals knowing their part and what was expected from them. This appeared to be more of an obstacle in hospital B than hospital A.

7.5.2.2 Understanding the Standards

Standards are considered the core of the accreditation programme as explained in more detail in Chapter 3. The self-assessment team members needed to understand what the Standards meant for them to implement them correctly. Some interviewees suggested that there was no absolute guidance defining how the Standards should be achieved. This created a state of confusion among the participants about the correct way of implementing the Standards. Participants also recognised the need for a clearer definition of the Standards and their terminology. One interviewee described it as Chinese when he first

read them, in an attempt to explain how foreign it felt, although he did then state that they became clearer with time as they started to enact them. One participant said:

> Some was easy because this is normal life, we are doing this daily. Some was more difficult. As I told you the new things that we just knew that we have to do this and we have to do that, it was difficult at the beginning but it is familiar now. Yeah and with practice everything will be easy. (P3, hospital A)

Another one explained:

> I had a problem, they were certain issues, of course when they, at the end they give some notes which made things much more easier to understand but some of them were not easy to understand, in fact we had to go to the coordinator to ask what do you mean by it? By this standard what is expected? (P24, hospital B)

This issue was more prominent in hospital A and many interviewees suggested they needed proper training by key personnel at the beginning of the programme, in an attempt to clarify the Standards and try to ensure a common understanding as much as possible among the different teams.

> Some of them really could mean several things so I had to always go back and ask about them because they can mean several things and some of the terminology. I wish there was meetings just to explain each point thoroughly that would be very helpful I think instead of going back and forth to the quality physician. (P4, hospital A)

On the other hand, some participants, from both hospitals, described the Standards as very clear and easy to understand. In general, these participants had prior experience in accreditation (explained more in the next section), which might have acted as a factor in their understanding of the Standards. A couple of them held the view that the National Accreditation Standards for Hospitals book provided a clear description of each Standard, which was very helpful in the process of understanding and implementation. An employee in the diagnostic imaging described it as follows:

> We were given the National Accreditation Standard for Hospitals book, that's helped to some extent to clear up what is accreditation, how to implement it, what's the practical steps required. There will be in the standards on top and then there will be explanation what do they mean by it, how to implement it, what's the required document to be issued to meet the standard, and I will have to say that most of the time that will be helpful. (P16, hospital B)

7.5.2.3 Prior experience in accreditation

The role of prior experience in the accreditation implementation process was explored in the interviews, to identify if any relationship existed between prior experience and current understanding of the process. This was evident equally in both hospitals, with participants expressing the view that being exposed to accreditation in the past facilitated their understanding of it. In the discussion about how they gained such experience, most of them referred to their involvement in the first phase of the programme in Kuwait, which started in 2001 (the phase is explained in more detail in Chapter 3). This involvement mainly comprised establishing the organisational structure of the programme; preparing the accreditation documents; and implementing the basic requirements of accreditation in hospitals. Their involvement is encapsulated in the following comments:

> Ok, I experienced the first implementation, the local one, which was in 2003/2004; it was very basic and thought it was ok, we have to introduce it slowly gradually to the audience. We all just studied this in our practices. (P22, hospital B)

> It's more than ten years and we have been, we've been asked for the accreditation before 2003 to be involved and I remember attending lectures and taking an exam in 2003. (P5, hospital A)

A couple of participants attributed their understanding to being exposed to other accrediting bodies in the past, which helped them to be more familiar with accreditation. One other interviewee revealed an educational background in quality, which helped him in understanding accreditation, as he explained:

> Firstly I have a diploma from AUC (American University in Cairo) in Egypt in quality, so and I work for one year and a half in my hospital in Egypt so I have a good idea about quality and its implementation on medical service. Our Head

> of Department came and she knows, so she chooses me to complete the mission and in a short time we made the 16 files. (P12, hospital A)

As a result of this prior experience, he was appointed as leader of his self-assessment team. These views thus identify a positive relationship between prior experience of accreditation and the understanding of it, which appeared to facilitate the implementation process.

The views reported here indicate that there were two broad responses to the question of comprehension of accreditation and its Standards, with some participants finding the Standards more understandable than others. This might be related to several issues; first their English language capability. The National Accreditation Standards for Hospitals was written in English. However, English was the second language for all participants and a few expressed difficulty with the language used in the Standards; second, their prior experience of accreditation appeared to play a key role in understanding accreditation and its components; third, the training and education they received as part of the implementation process, where many commented on the need for more extensive training programme to facilitate understanding of the accreditation process and the Standards.

7.5.3 Engagement with the accreditation process

A range of issues were identified that related to participants' engagement with the accreditation process. These were: professional attitude, engagement and participation in the accreditation process, good working-relationships, and leadership. These findings are now presented in the following sections.

7.5.3.1 Professional attitude

Findings from the systematic review had reported professional attitude as a barrier in implementing accreditation. At an individual level, interviewees reflected a mixed range of attitudes towards accreditation. Some were clearly positive and enthusiastic – this could be observed in both hospital sites. These interviewees felt accreditation was needed and the right thing to do, often using the terms 'motivation' and 'encouragement' to describe their view point:

> We felt that the hospital has been chosen for a pilot as one of the general hospitals. It was an honour for us; in fact it gave encouragement to work you know and find out, to prove to ourselves that we do have quality service in this hospital. It is usually recognised as a village on the northern side of Kuwait, but we could prove that we do have quality service. (P17, hospital B)

> We had to show that now we are the best, our department is doing best so it becomes a sort of a motivation for us. (P10, hospital A)

This positive attitude wasn't limited to the participants but they suggested it was also the view of others in the programme, who then spent time encouraging other members of staff. As one participant stated:

> Other employees convince them [other staff] that what they are doing is not a waste of time, it has tangible results. (P24, hospital B)

The self-assessment team members discussed how they tried to achieve the tasks set for them, for example reviewing and revising the admission and discharge policies, and writing a quality improvement and patient safety plan. In particular, they stressed the benefits of accreditation to their own work and to the hospital. Some admitted to a high level of competition either with other departments in their own hospital or between hospitals, which they believe gave them the motive to engage in the programme, as encapsulated in the comments below:

> People were also motivated when they saw the standard and yes it's geared toward whatever they are doing and to show how good they are. That will help the department in front of the director of the hospital and the ministry, and in comparison with other departments how well they want to implement the accreditation process. (P16, hospital B)

> We had to show that now we are the best, our department is doing best so it becomes a sort of a motivation for us. (P10, hospital A)

Many interviewees, from both hospitals, also invested their own time in the process, for example by researching for appropriate material through the internet, the Ministry of Health records, the University library, and other hospitals, to help them with some of the

required documents like policies and plans. This reflected a positive professional attitude and willingness to be personally involved in the process, as one paediatric doctor explained:

> I had to do lots of research myself because I was required to come up with the risk management plan and I had no idea whatsoever how to do it. I had to really take it through the net for resources and how to do things and that took me lots of time and effort. Most of it I did in my own time, so I had to do it in the afternoon usually. (P4, hospital A)

Another participant sought help internationally by contacting a colleague:

> We asked for help from some other public leads outside, where like one of my colleagues in Uganda I asked him also please can you help me with such things. (P10, hospital A)

Those involved in implementing accreditation also committed to attending and participating in the self-assessment meetings, which were held during working hours. In hospital A, interviewees talked about peoples' commitment to their teams, translated in their regular attendance and participation in the meetings required by accreditation. This positive professional attitude is stated in the comments below:

> Most of the people of course are consistent from our department, there are people who were involved in the beginning, and they are still involved in accreditation. (P10, hospital A)

> At the beginning there were changes but for last two year or more than one and a half years we are consistent. (P2, hospital A)

The process of implementing accreditation programmes thus demand a high degree of commitment from people. Being a continuous cycle, accreditation is not finished once the survey is completed; instead, the expectation is that it becomes part of everyday routine and work. One respondent explained:

> We need to practice every day because it is a continuous process. You cannot say ah we have got accredited now so we got the full mark so we will stop there because we will miss; you have to follow up with the development whenever anything new. (P3, hospital A)

In contrast, views about commitment were inconsistent in hospital B, where there were two differing opinions. About half the participants indicated that team membership was consistent and that participating staff were committed to attending the meetings:

> Yes we meet almost every two weeks. (P15, hospital B)

> Yeah to some extent we are meeting regularly by either every week or every two weeks. (P16, hospital B)

> We used to meet fairly regularly, of course sometimes one of us could not make it because he was in OT. (P24, hospital B)

However others in hospital B felt there was a lack of commitment among their team members; their responses shed light on the reasons for such an attitude. Some explained that, within a self-assessment team, many members would simply not participate, because they were told to participate in the process even though they were not interested. Eventually, the work fell to just a few members.

> The problem is that you are putting so many names in the team and you find two persons working. I'm talking about me [my self assessment team] but I think this applies for all the other teams. (P14, hospital B)

Others felt this lack of commitment was a natural response, since the staff were already busy doing their clinical work – this limited their ability to meet regularly.

> Not that regularly they [self-assessment team members] were clinical workers. (P20, hospital B)

> We are supposed to meet at least once or twice a month. And sometimes we don't because I am every busy and they are very busy [so] we stop for a time. (P21, hospital B)

Not all of the interviewees were supportive of the accreditation programme, as mentioned above regarding the lack of commitment witnessed to some extent in hospital B. Furthermore, several participants reported a negative attitude, which could have hindered

the accreditation implementation process. These negative attitudes were found amongst interviewees in both hospitals and can be summarised in the following statements:

> I have no benefit from accreditation. (P2, hospital A)

> The major barrier was the attitude of the people in my department basically. (P6, hospital A)

> To tell you the truth some members they don't even offer to attend. (P25, hospital B)

> Lots of people are not interested. (P25, hospital B)

In hospital A there were clearly concerns about this resistance to change. It was evident that the attitude of professionals was a barrier to the process of implementation, and worries were expressed about the difficulty of trying to convince staff to be part of it. As one specialist explained:

> It's easy to change constructions; it's very difficult to change minds. (P1, hospital A)

Interviewees complained that people refused to do the work of accreditation because they thought it was a waste of time and could not see the benefit of it: they either refused directly, or they would just indirectly avoid the responsibilities.

> Avoiding doing the work. This was really and maybe this is the first time I talk about it, honestly this was my main disappointment because some believe that they should only do what they are supposed to do. The rest of things like documentation, meeting, lecturing understanding things they would start avoiding, maybe this, I think, was a bad experience with accreditation. (P6, hospital A)

> The worst point as I said before, some staff they are not interested. (P9, hospital A)

In hospital B there were similar reactions, where some interviewees felt that staff were not motivated. For many, accreditation was not seen as part of their actual work, which was patient care. For example, a doctor would say that he didn't need to participate in the

implementation, because it would not add to their medical knowledge. Another argued that he needed to finish his clinical work first before thinking about taking on the extra burden of accreditation work.

> I would say frankly the majority they were not motivated. They found it an extra burden. (P24, hospital B)

Many suggested that the attitude of the senior staff was discouraging others. While accreditation acceptance required support and leadership, this was less forthcoming in hospital B. Several respondents commented on this and one, in particular, was straightforward in his response when he admitted that Heads of Departments usually didn't participate.

> Sometimes I ask one doctor to come, he is senior and he refuses because this is extra work. His boss say let my doctor finish his job. But this is another job so important …yes from your side it is not so important. But he's a senior and he feels like that. What to do? (P25, hospital B)

Thus, professional attitude towards accreditation was an important factor in implementing accreditation.

7.5.3.2 Engagement and participation in the accreditation process

The issue of the readiness of employees to become engaged and participate in the self-assessment teams was explored in the interviews. In the systematic review, the importance of engaging people in the process was acknowledged. Interviews identified that, for most in both hospitals, their participation was a result of being nominated by others, mostly the Head of their Department. They added that for them, being involved was not a choice and their acceptance was taken for granted:

> It's not voluntary, I remember very clearly we were called to a meeting and he [Head of Department] said we have to go through this accreditation and he said I remember clearly saying this thing we have to go through and I believe we will pass because he said I believe we are the best hospital in Kuwait. (P6, hospital A)

> Our director chose me and that's all. (P14, hospital B)

> Basically I was kind of roped in by the Head of the Department and I got involved in it. (P8, hospital A)

A small number (two from each site) were particularly enthusiastic and took on the tasks required immediately. Two of them attributed their willingness to participate in the self-assessment teams to their previous experience in the field of accreditation, making them more familiar with the process. Another participant commented that her acceptance was because her Head of Department was *'a very good person'*, which made it difficult to refuse the request. This point, even though only one interviewee mentioned it, seemed to emphasize the vital role of leadership and how the personal qualities of the leader either encouraged or discouraged the employees' participation.

> Actually our chief of laboratory chose some people and she asked would I take part in accreditation? And I said yes. You cannot say no to her she is so nice so helpful, whenever you need anything you can go directly to her you don't feel like she is a doctor she is your friend. (P3, hospital A)

> The Head of the Department told me I should be in charge of it, and I have the current teachings of quality assurance through our faculty of health, so it was very easy for me. (P22, hospital B)

Others volunteered as a self-assessment member in the process. Four participants from hospital B and two from hospital A said that they had willingly volunteered in the programme. Some explained their decision was based on the fact that they thought the elements of accreditation were embedded in their everyday work and it was a way to organise and improve their practice. Others reported that their prior involvement in the programme from the first phase (Accreditation phases were explained in Chapter 3) led them to believe in its potential and importance. This suggested that among the factors that influence the willingness to enrol in accreditation, knowledge and belief in its value are especially significant. One senior registrar explained it as:

> When I came in I guess I had lots of energy just coming from abroad. And when I came in I started shouting that we need to implement this and that without knowing about the accreditation yet. I heard that there is an accreditation process going on and then I guess the Head of Department invited me to join the group.

Interviewer: So it was willingly?
Yeah yeah definitely willingly and enthusiastic about it as well yeah. (P4, hospital A)

Another one said:

> This is part of everybody's job in the hospital. To be part of the accreditation process, either directly by reviewing the documents and making sure that the department has the standard implemented and supply all documents, or being part of the attendance of the meetings that are held every now and then. Being part of the process sometimes I have to make a checklist and I have to fill those checklists as either, as a physician or as administrative work. So I have to say it's both, as part of my job and some task yeah I was voluntarily involved in those processes. (P16, hospital B)

In relation to making an effort to involve others in the programme, the interviews presented evidence, especially in hospital A, which supports the influence of some team members in engaging others in the process. One interviewee elaborated on how, by involving the staff in writing guidelines and operational policies, this facilitated the participation of the majority of staff. Another respondent revealed how she repeatedly replaced the team members to ultimately get everyone exposed to the process during one phase or another:

> In my department every six months I'll take out one of the self-assessment, the good one and I'll put one of the departments in her or his place, so maybe during two years we have changed maybe five times our self-assessment [team], it's for the sake that I want to involve as much as I can from the staff in the department so I believe this was my main challenge in my department is that everybody knows. (P6, hospital A)

Another also stressed the importance of involving as many staff as possible, in an effort to make the implementation successful:

> We are involving more and more colleagues, I don't want to work alone so I have three, four doctors who make up the sub team to involve as maximum people. (P20, hospital B)

However, the challenge of getting people interested and involved also surfaced during the interviews. This was observed in both hospitals, and was clearly a barrier to the process of implementation. Several team members expressed concern about this, and they commented on how it was very hard to stimulate and engage people to participate, because, as one participant explained, the entire hospital must become involved, not only the self-assessment team members:

> We have to really stimulate people to come and join and it's hard work. (P4, hospital A)

> The process itself involved almost most of the people in the department but unfortunately there are people who are not willing to participate and there are people who are not willing to take an active part in the accreditation, they say I will do just my work and that's it. (P5, hospital A)

> The major thing was how much would you get the people interested and motivated. (P17, hospital B)

7.5.3.3 Good working-relationships

Good working-relationships in the hospital was another sub-theme of engagement. The key role of communication and teamwork was highlighted in both the systematic review and the documentary analysis. In the interviews this was discussed more in hospital A and proved to be a key issue in supporting accreditation implementation. The responses offered by the participants in hospital A emphasized the role of friendly relationships, teamwork, and information sharing as facilitating factors to successfully engage with the programme. One respondent described how the hospitals' atmosphere projected a *'family spirit'* during the survey visit.

Several participants in hospital A explicitly acknowledged the role of teamwork among the hospital staff, and claimed this helped in the distribution of the workload of accreditation, and helped in addressing the problems and difficulties encountered during the process by trying to solve it as a team.

> You know there were difficulties, but these difficulties that we have gone through are solved by the teamwork. (P1, hospital A)

A few respondents spoke about the positive effect of friendly relationships among the team members, their leaders, and even the surveyors. This helped people work in harmony, crossed professional boundaries, and facilitated staff involvement.

> I think it's very important for any leader who is going to recruit people for accreditation to make sure that there is good relationship. (P1, hospital A)

Another respondent expressed a similar attitude, and thought this helped engage the surveyors when they wanted to gain from their knowledge and experience in the field of accreditation and Standards' implementation.

> In one of the meetings I have suggested that we have a couple of surveyors from other hospitals and sure they can help us. And they said why not to invite them for a cup of coffee and then we will come and listen to their comments. (P6, hospital A)

Respondents also suggested how the inter and intra-departmental cooperation generated a general sense of sharing and communication.

> One of the missed points in the past is the inter department communications and during our meetings we stress at this point and we start to achieve really better communication between the departments through interrelation between the policies. (P7, hospital A)

> In fact, in accreditation we had good inter-departmental cooperation as well. (P10, hospital A)

These views were, however, expressed less frequently in hospital B, where the issues of inter-departmental cooperation and friendly relationships were mentioned only twice. The same applied to teamwork spirit; in hospital B there was no emphasis on this issue. The main comments relating to co-operation focused on the sharing of information about accreditation among the staff, with several participants in hospital B discussing the benefits of displaying their work to others and sharing their experience.

> We learnt and we tried to share that knowledge with our colleagues. (P20, hospital B)

> We receive some people coming from other hospitals, we show them everything we have and they were impressed. And we told them about the issues so we have no problem at all you know we see the people we sit with them and we show them how it will work. (P15, hospital B)

When considering the role of good working relationships as a facilitator in the process of accreditation implementation, the results identified inconsistency between the two sites. Almost all the participants in hospital A agreed about the positive effect of good working relationships, expressed in different ways, as a contributing factor to a successful implementation. However, interviewees from hospital B did not express a strong opinion about this issue, instead focusing on the value of sharing their own experience with others in their hospital or across other hospitals.

7.5.3.4 Leadership

Over the course of the interviews, leadership appeared to be an important facilitator, helping people engage with the process of accreditation implementation. This resonated with findings from the systematic review. In both hospitals, the Quality Physician - who was the Head of the Quality and Accreditation Office in each hospital – was seen as having the central leadership role. Their role was providing guidance and support to the team members as part of their job description as a quality physician. There was evidence that both quality physicians offered motivation and encouragement to the hospital staff through regular meetings, and helped more specifically in clarifying the meaning of Standards; giving advice on how to comply with Standards' requirements; and helping with the documents and plans as they were developed. One interviewee said:

> I have to acknowledge the role of quality officer in the hospital because he has a background experience of dealing with accreditation. He helped a lot in how to implement. I will tell him how can I, he will tell me. Safety measures or safety standards, safety plan, safety solution for example for the patient I will ask him what does that include, he has more explanation for that. (P16, hospital B)

Another said:

I think the Quality Physician I believe, it's not the biggest role in accreditation but it's the most vital, because she is like an orchestra leader, she is the one who would make everybody work in harmony and everybody should know his exact role. I really, I really believe the accreditation people should have the gratitude for their work. (P6, hospital A)

Participants also spoke about the role of the Heads of Departments in relation to demonstrating leadership and involvement in the programme. Many acknowledged their role, with words like 'help', 'support', and 'involved' used to describe their part.

It was not so easy, but with the practice, the co-operation of our people and like we had a team together we used to discuss and then when it came to us we tried our best and even our Head of the Department Dr (-----) really he helped us. (P11, hospital, A)

I think our Head of Department is the best one in the hospital for this accreditation. All of them come and take his ideas. (P19, hospital B)

We are lucky that our Head of Department is supportive. (P20, hospital B)

However, two respondents presented another view regarding the involvement of the Heads of Departments, where they felt less optimistic about their contribution in the process. This view might reflect their particular departments, and asserted the importance of the leadership role of the Heads of Departments.

For the leadership self-assessment team we need to get more involvement from the Heads of the Departments. (P17, hospital B)

And I think maybe if the Head of Departments says something then it has much more weight than say somebody else. (P24, hospital B)

Participants from both hospitals also discussed the supportive part played by the hospital management, represented by the hospitals' Directors. They believed the Directors were supportive and committed to achieving accreditation. Being in overall charge of the hospital, the Director's influence was inevitably crucial, and recognised as a key facilitator

in encouraging employees to engage and participate in accreditation. These feelings are encapsulated in the comments below:

> As long as they have a good support from the administration and a good support from the local quality team I think it has been a pleasant experience. (P4, hospital A)

> I think it's always that our director is helpful to us and he don't mind if you want to introduce anything. (P14, hospital B)

> Communicating with them with the involvement of the hospital director and with the quality physician and then our help so they started to involve. These are the main barriers that nobody wanted to. Then gradually the whole department with the communication and with the involvement of the senior participated. (P19, hospital B)

Examining the role of leadership on the accreditation process highlighted the key role of the Quality Physician, in both hospitals, in providing help and support related to the specifics of the programme. The involvement of the Heads of Departments was acknowledged as a facilitator in both hospitals although less so than the Quality Physician.

7.5.4 Work of accreditation

Analysis identified five sub-themes: training and education, resources, infrastructure, bureaucracy, and Standards adaptation.

7.5.4.1 Training and education

Similar to findings from both the systematic review and the documentary analysis, training was considered a crucial factor in improving the understanding of the accreditation process. As described earlier, staff struggled to grasp the meaning of accreditation in general and the interpretation of the Standards in particular, highlighting the importance of meeting their training needs. Comments included:

> You know, training, you have to train, always we need training and if you ask me now we need training I would say yes. (P1, hospital A)

> If somebody is having their training it would be easy for him, but somebody who is starting as new it would be a bit difficult. (P10, hospital A)

The training process introduced to the hospitals embarking on accreditation was from multiple sources. The main source was from Accreditation Canada, because it was included in the second agreement with the Ministry as a contractual deliverable. Initial plans were for training delivered four times per year for the first two years (in 2011 and 2012), and twice per year for the remaining three years (2013-2015). However, due to the large number of self-assessment team members in all the hospitals, this was not enough to cover the entire population. Therefore, the Quality and Accreditation directorate also scheduled training sessions delivered by the accreditation department upon request. In addition, a few surveyors volunteered to share their experience and knowledge with accreditation staff in the hospitals on an informal basis.

The interviews identified a difference in perspectives between the two sites towards training. In hospital A there was near consensus amongst participants about training being an integral part of the programme. Most of the interviewees had attended training lectures and workshops, outside and inside their hospitals, although they were less clear about how such training had benefited them.

> We attended couple of lectures about accreditation, I believe presented by the accreditation department in the ministry. (P6, hospital A)

> We did have a lot of them like we had people coming and talking to us in our department and we would be nominated to go outside and attend the courses. (P8, hospital A)

A few participants in hospital A described attending workshops in the areas of risk management and performance indicators.

> Definitely they are useful we've been involved with the, one of things for example we've been involved is the risk analysis and that helped us a lot. (P5, hospital A)

> There was training especially you know I am mostly involved with the indicators so I had a little indicator training then there was a safety and risk management training also which I did attend. (P8, hospital A)

Some interviewees also acknowledged the role of local training, conducted mostly within their departments. This was also recognised as worthwhile and having an important role in developing knowledge and engaging staff:

> Because during all that time we give lectures and we try to make them understand what accreditation is, and you can do what is on your mind. In the hospital there are maybe nine pharmacies and each pharmacy has maybe more than 12 pharmacists so, the number is very good. So yeah we took maybe two or three weeks, every day we are taking some of the pharmacist to give the lectures. (P9, hospital A)

> You educate within your department, within your clinical department this kind of direction with kind of prepared lectures, which improve the awareness of the staff. (P20, hospital B)

However, one participant did raise the problem of a language barrier during those in-house educational lectures as training sessions were conducted mostly in Arabic, which was a problem for her to follow and understand:

> It is good but one point is that mostly they are speaking in Arabic and how many times I told please to speak in English, one word, two sentences, then I need somebody to translate, this is very difficult for me. (P13, hospital A)

In contrast, in hospital B half the participants reported a lack of training in accreditation, with one interviewee suggesting the need for 'a proper systematic training' for staff. They argued that even though they had attended some training sessions, it was not enough due to the huge scope of the subject. One participant commented:

> But the problem I told you there was no training courses, it still not done, some training lectures, one day lectures, something like that which is not enough, which is not enough at all like they were arranging in one of the hotels. But maybe to tell you I attended two times only in this six years or seven years just two times or something like that, it wasn't enough at all. (P14, hospital B)

Another felt that even though his knowledge of accreditation was fairly good, his colleagues definitely needed training and education:

> I think my knowledge in this practice I am, evaluate myself, my knowledge in accreditation as a whole about 60% this is in my own evaluating myself but I

> think my colleagues need, if I'm 60% my colleagues maybe 10% or nothing but we need more workshops. (P18, hospital B)

This rather negative opinion was not shared by all the interviewees in hospital B. Others reported that attending training sessions had a positive impact on their knowledge about quality and accreditation, as illustrated in the following comments:

> Yes, I went to workshop for quality, they were very helpful. (P22, hospital B)

> Yeah I attend many lectures outside and inside hospital, start to make me know more about the accreditation. (P25, hospital B)

This identified a difference in views between the two sites on the usefulness of the training programmes delivered to them. While there was a general consensus in hospital A, acknowledging the benefit of training in general, delivered either locally or more centrally, the evidence was inconsistent in hospital B, with many noting the need for more extensive training programmes.

7.5.4.2 Resources

Resources are key to any newly introduced programme and include human and financial resources, as well as time. In the interviews, similar to findings of the systematic review, it was clearly evident in both hospitals that time was the most challenging factor the team members encountered during the process of implementation. These professionals already had their day arranged to attend to their routine clinical duties, so it was particularly challenging to find the time for accreditation activities on top of this. One of the participants explained how they relied on colleagues who were on call to complete some accreditation tasks:

> Honestly I believe the time, the time work from 7.30 to 1.30 does not allow us to do lots of work, I always say if you have something extra research, if you want to write protocols if you want to prepare for presentation you have to do it in the afternoon. So part of the work of the accreditation at the beginning was done in the afternoon. We made use of the people who were on call, so the first few months we made use of these people to prepare things then to put things in order. (P6, hospital A)

As discussed previously, some took the work of accreditation home, once they finished their shifts, in order to complete it. For them it was the only solution they saw to overcome the lack of time, even if it affected their personal work-life balance:

> In fact at my home I was not getting the time for family, they were all the time telling me that I'm busy with hospital work. I don't think they can understand it's something which I need time and I need myself to be relaxed, I cannot do it at hospital. (P10, hospital A)

> We are all very busy; our main work is our main work, so there is always a conflict between the accreditation work and the main work. I am doing a lot of my work out of the hospital at home. (P24, hospital B)

There was consensus from most interviewees regarding the workload of the process; accreditation work was time consuming, as the following comments show:

> It's time consuming and effort consuming, it's lots of work and we don't have to take time and personnel always for the process. (P4, hospital A)

> When we are doing this properly it takes time and effort, and we have to combine to our normal work. (P20, hospital B)

One interviewee from hospital B suggested relieving the teams partially from their daily responsibilities in order to focus on the programme. This individual felt it would encourage people to complete their accreditation related tasks, because they would have the advantage of dedicated time for accreditation. Indeed, for this participant allocating the time was better than giving financial rewards:

> For me money will not be ok, because unless you specify the time even if you give them extra money, if he does not have the time during working hours, he will not do it properly, even if you give him very good money. For me time is more important than money. (P22, hospital B)

However, many participants didn't share this view and believed a financial incentive would influence the participants in overcoming the obstacle of time. This led to an exploration of the second type of resource need discussed in interviews.

Similar to findings of the systematic review, financial resources were discussed in terms of the budget allocated to fund the requirements and activities of accreditation and also financial incentives to encourage staff to take part in the self-assessment teams. The issue of incentives for individuals was more evident in hospital B where half the participants expressed concerns about how people needed incentives and rewards to encourage them to participate. Accreditation work was viewed as highly demanding and participants felt that the absence of financial recognition for individuals giving their time was a key barrier:

> Why there is no budget or nothing we don't know. If there is a recommendation to the ministry I think you should request the incentive for people who are involved. (P20, hospital B)

> We need support in a financial way and we don't get it. (P21, hospital B)

This related to the issue of personal time and commitment, already discussed in Section 7.5.3.1. As previously reported, self-assessment teams had to stay after working hours specifically to accomplish accreditation requirements and related activities; this led one participant to suggest that participants should be able to consider it as overtime and get paid for it.

Financial resources were discussed to a lesser extent in hospital A, but the financial incentive was still recognised as a barrier for the process of implementation. Again, interviewees discussed the need to allocate a budget for the process.

> Because there is no reward, no incentives and no, I am here not talking about punishment but I don't know how it will go okay, how to give incentives or encourage the doctors to follow the recommendations or standards. (P2, hospital A)

> There are no financial benefits, maybe that is why some people were hesitant. (P4, hospital A)

These calls for assigning a budget for the programme to the hospitals was not entirely for the purpose of reward but as recompense for work being done. For example, a couple of participants in hospital A cited other reasons for their financial demands, reporting that

some team members were contributing from their own pocket to carry out accreditation-related activities, such as photocopying documents and forms. From hospital B they stressed the need for a budget to comply with the Standards' requirements in providing Internet access and establishing a Library.

> Actually part of the accreditation team [members] were paying from themselves, the accreditation process in order to meet and to reach you know. (P1, hospital A)

> We are struggling now with the printing forms, because lack of resources basically, lack of financial resources. (P4, hospital A)

> Actually library is part of accreditation, we tried to improve but it still really lacked. (P19, hospital B)

Another important resource constraint, in both hospitals, was the deficiency in staffing levels, for both clinical and administrative staff. This was identified as a barrier in the documentary analysis, and affected the team members' ability to fully participate. Interviewees explained how the highly demanding accreditation implementation process was overwhelming; recruiting more staff would ease this and facilitate the process.

> To go through accreditation first in the hospital, in such a big hospital definitely needs more personnel and manpower. (P1, hospital A)

> The problem that we are short of staff to start with. So we give each one member of the staff specific task so it will be evenly distributed. (P16, hospital B)

The lack of equipment and software was occasionally raised, for example one participant commented how they were not dealing properly with the chemical waste generated in their laboratory:

> The bad issue is, it is environmental pollution we don't have a machine to get rid of chemical waste that are coming directly from the machines. (P3, hospital B)

Another acknowledged that the purchase and instalment of a new computerised system to be used in registering the patients visiting the emergency department would improve the process instead of the manual approach, with the added benefit of helping the department meet accreditation criteria:

> But this problem for us if computerised we can see the patient if the patient came two times per day we can see if they complain or not of the same, especially we register this data in the computer. (P18, hospital B)

Only one interviewee referred to the problem of getting Internet access, which was a required criterion in the Information Management Standards:

> But they still really lack the Internet and there are still certain things we have to improve, they still really lack. (P19, hospital B)

The data presented here shows that adequate resources were inevitably important in facilitating the accreditation implementation process. However, respondents' views were mostly negative and the lack of different resources, in their opinion, hindered the work of accreditation. Time and financial resources were cited as major barriers in both hospitals, although support for financial incentives as a facilitator was more pronounced in hospital B. Although not raised by the interviewees', solutions for these barriers will rest at the level of the hospitals themselves or with the Ministry.

7.5.4.3 Infrastructure

Infrastructure is closely aligned to resources but, as explained in Chapter 6, refers to the structure of an organisation, the systems, and facilities needed for it to function. Participants from both hospitals described obstacles related to infrastructure but there was a difference between them about the main problems. Many argued in hospital A that the physical environment of the hospital was a barrier; this was also identified in the hospitals' accreditation report. For example, one interviewee explained how they sought the help and advice of the Kuwait Fire Administration when developing a safety and evacuation plan for their department. However, the advice given was that the department must be properly ventilated to avoid suffocation in case of fire or any chemical emergency - this was difficult to implement due to problems in the physical environment of the department.

Actually we bring fire marshals, then they tell us this one is completely wrong, because we have an open duct we do not have ventilation, you have to fix it. So we went to the engineering department, but you know this is part of the challenge because they cannot fix it. (P3, hospital A)

Responsibility for addressing issues of infrastructure often lay outside the control of the hospitals' administration. In addition, interviewees in both hospitals expressed concerns about the general lack of space. A few participants noted how clinical service were affected due to structural capabilities as explained in the following comments:

There are barriers we cannot overcome very easily. Number one is the space; we have a big problem in our space, our capacity. For example this hospital was established in 1979 or 1980, the population at that time was almost 150 to 200 000 people. Now the official number from the Civil Id is more than 1 million 70 thousand and this is five times almost the number from before. (P5, hospital A)

There was objection of the casualty because it is one room, there is no space and they want to [have a] triage room. (P23, hospital B)

We are having a problem with operation theatres. We have lack of operation theatres I do not know how we are going to fix this one. It is going to be a big issue and only when the new hospital finish, that is the time it will get solved. (P24, hospital B)

A second infrastructure issue was IT. Similar to findings from the documentary analysis, where this issue was evident in data from all six hospitals, two responses from hospital B serve to illustrate what was viewed as the main problem with the hospital Information System, namely recognised incompatibilities due to the different information systems that had been installed across the hospital.

Other great problem, which we faced, was the computerisation. Hospital information system, we change that, is not completely compatible. Well recently we have had the information system from the radiology that is fitting with ours. (P17, hospital B)

So I am reporting my images here. Now these images should go to the clinical department. So what happened is that writing is still by hand and they cannot view in their department. Which we are very concerned about it. I think it is now in process to being fixed. (P20, hospital B)

Different companies provided the information technology systems, and unfortunately, in the view of the participants, the hospital board had not participated in the decision of the most appropriate contract because it was not within their authority. As a result, the two hospitals ended up with different systems installed in different departments, and it was difficult to try to connect them together. Centralisation in healthcare was, therefore, perceived as having many downsides in relation to developing infrastructure. This is further discussed in the next section.

7.5.4.4 Bureaucracy

The Accreditation Standards represent the core of the programme, and within them are certain demands that needed to be fulfilled. For example, in the human resources section, the second Standard states, 'the hospital council has a policy that requires all categories of staff to have a clearly written job description'. This Standard was a challenge to many professional groups for several reasons; some claimed that there was no official job description provided for them by the Ministry of Health. Others had a job description, however, it was so old and out-dated it was as if it didn't exist at all. One participant commented:

> There are problems [which] also act as barriers. There are a lot of things that they are central and we don't have the real answer for them. We don't have a real job description even that what we have in 1993 what we called the job description but it's not real job description for the people. I don't know what's the job description I haven't seen a job description for the Director of the hospital, the Head of the Department, the Minister and all these things. Even the ones that they are speaking about the job description I think this, I think it needs to be reissued again and what's the job description of the secretary? What's the job description of a technician? (P5, hospital A)

It was evident from several interviews that communication channels between the different levels of authority in the healthcare system were slow, for example, between a hospital and the Regional Health Office or the Ministry. The participants generally reported that they were frustrated and discouraged with the long period of time, sometimes extending to years, for things to be approved and established, whether it was a consent form, patients' rights, or even an infrastructure related matter. Different experiences were reported as follows,

To approve the consent form you know we tried for two years, we tried for two years. (P1, hospital, A)

All the instructions were coming through channels, so it took too much time. For example if they sent a request that these are what we want implemented, then we have to get approval through the proper channels so it took much longer. (P19, hospital B)

Bureaucracy. You know what I mean by bureaucracy? For example I want to make like a connection between the new hospital here and the old one as regards to the sound alarm, do you know how long it takes? … More than one year. (P25, hospital B)

The above accounts from participants from both hospitals suggested a critical barrier in accreditation implementation. One participant suggested that frequent changes in central administration and the Ministry might be to blame:

There was a frequent change of ministers okay, so it was a ministerial problem at that particular point in time. At least I think there were four different or five different leaders with whom I had to work with or exchange ideas with, but two or three of them were very supportive. (P17, hospital B)

Another attributed the slow feedback from the Ministry, if any at all, to the priorities of their agenda:

I think the ministry have to consider accreditation as a priority point on other things, because it covers everything, if it's not a big issue for them it will be a waste of time. (P21, hospital B)

Many important decisions were kept within the authority of certain Directorates and Administrations at the Ministry of Health, keeping the hospitals from participating in key decisions. The channels of communication between the hospital and those centralised authorities were very slow, which appeared to delay the work needed for accreditation, as one participant explained:

> Centralisation in health in this system is not of benefit to the service so again the process was too long to reach the decision point and turn back. So again centralisation of the system in Kuwait was part of delay, so if you have your decision in the hospital its much better. (P1, hospital A)

Thus problems arising from the bureaucratic system in the Ministry of Health appeared to be a common issue in both hospitals. Addressing this problem might be a way to remove obstacles encountered in resources or infrastructure.

7.5.4.5 Adaptation of Standards

Participants were asked to indicate whether it was easy or difficult to implement the Standards. The majority, from both hospitals, commented that they faced difficulty in implementing the Standards.

> It was not easy to implement standards! I can say that. (P4, hospital A)

> It's not easy definitely, we are still you know we are still in the process. Some things just work on paper they don't work in reality. (P8, hospital A)

> It was difficult to implement standards, it is still difficult. (P24, hospital B)

A number of issues were identified that hindered the Standards' implementation. Concerns regarding the full implementation of incident reporting surfaced in hospital A. A few interviewees described how some employees were hesitant to report any incidents or near misses related to patient or even their own safety, because they feared punishment from the hospital administration. Efforts were made to convince staff that the incident reports aimed to identify harmful incidents that occurred or even nearly happened, so they could be corrected and avoided in the future. However, the organisational culture was still not accepting of this kind of honesty and openness regarding admitting mistakes.

Another problem was specifically related to the diagnostic imaging departments in both sites, with departments facing particular challenges while implementing the Standards. The Diagnostic Imaging section in the National Accreditation Standards comprises both the Radiology Department and the Nuclear Medicine Department, which meant they had to work together as one team in addressing the Standards, and were assessed as a single entity. One interviewee thought there was a difference in practice between the two

departments, which was apparent during the process of implementation. Another interviewee illustrated this issue as follows:

> Now the standards when you go through them it's for the diagnostic services, nothing for nuclear medicine so some of the standards are not applicable to us. When you come to MRI when you come to contrast media, when you come to ultrasound. And again there is part of our work is missing in the standards like we have a lot of radio pharmaceuticals part work that is not involved in the standards. We have a therapeutic service we give to the patient it's not involved in the standard but again I think, not I think I believe the standard where kind of not justice let's say, not right to us because most of the standards apply to the radiology, the diagnostic radiology but not to our work. (P6, hospital A)

It was suggested by this participant that the solution was to amend this by separating the departments into two, making the Standards more applicable to each specialty.

Some also felt that some Standards were not responsive to local or to patients' culture. As one participant put it:

> For example, religious preference to be part of the admission process, many people I guess locally or even doctors might think that it's a little bit offensive to ask somebody what's your religious preference or sort of thing but I think it's still relative because different people have different opinions, even like patients will have different opinions whether they want to be asked about their religious. (P4, hospital A)

Another individual stated that:

> Some points are not applicable to our community, I think we need to find our own items, our own points which is applicable to the local community. (P23, hospital B)

However, a few interviewees, from both sites, remarked that most of the required Standards already existed as part of their job, and they needed only some re-organisation and documentation to be fully compliant with the Standards,

> The system was already in place but it's just that you know we had to present it the way it was expected of us that's all. (P8, hospital A)

> It was a part of the job already and we were doing it and I think it was not documented. (P17, hospital B)

> And some of the things that we used to do we do it on a regular basis but we did not document it. And this is one of them main issues we had so the during the process of implementation it taught us how to document things. (P22, hospital B)

This view was echoed by other participants, who felt that many of the documents required by the Standards were already available, but they needed updating and/or organising. One participant admitted that she didn't realise the value of some available documents within the hospital until the accreditation process started.

Whilst a minority felt that some Standards were not related to their daily work, most agreed that the Standards were highly relevant to their job and basically translated what they did routinely every day. This consensus was expressed equally in both hospitals. A recurrent issue in the interviews was a sense amongst the interviewees about the challenges they encountered during the process of implementation, even though, most agreed that the Standards represent an integral part of their daily work.

7.5.5 Impact of accreditation

The accreditation programme is a demanding process for any organisation, requiring financial support and the dedication of staff, who are already busy with their daily work (Shaw, 2003, Brubakk et al., 2015). Given the time, effort and resources required, it is important to measure the outcome of the programme and evaluate the impact as perceived by the professionals, in order to establish the value of the programme. This section reports the views of the interviewees with respect to organisational impact, as well as personal impact.

7.5.5.1 Organisational impact

The majority of interviewees from both hospitals indicated that they definitely felt a positive impact on the organisation, as the following comments illustrate:

I've seen things being changed for the better and being implemented and actual results on the ground. So definitely I would recommend it. (P4, hospital A)

The accreditation I have seen it has improved a lot of services while we are doing here. (P5, hospital A)

There has been a difference yes and as a continuous exercise it will even get better. (P20, hospital B)

To be honest we have a large improvement in some areas and we have some drops in some areas. (P21, hospital B)

Additionally, several interviewees reported a marked improvement in the process of healthcare delivery. One participant explained how many practices were now routinely embedded in everyday activities and that now 'I don't have to tell anybody to bring the checklist. When I enter the OT I start the case, it is already there so this is what we wanted initially, we wanted that it should become a routine we should not tell somebody that doing this thing and that thing, it should be a routine, they should already understand that this is a part of the procedure' (P10, hospital A). This contrasted with practice in the past where, he said, he needed to remind them constantly about the checklist.

Similar to findings from the systematic review, some participants mentioned that they detected an improvement in different processes, including the appointment system, admission and discharge procedures, and referral processes. Furthermore, a few noted a direct influence of accreditation on clinical care:

We have managed some improvements that happened and people who need catheterisation, we have new system now that's working from 8 am until 4 pm. If you need an urgent catheterisation the people are sent from here directly to the chest hospital and the time has decreased from almost 120 minutes to less than 70 minutes. (P5, hospital A)

Changes within working areas and the hospital premises were also highlighted as a beneficial outcome from accreditation:

One of the surveyors who came to us was really impressed. Our main aim is to give a safe and a good service to the patients so our waiting area is full of instruction with animation and everything so after we finish he said I would like to have copies of this because it's a good effort you could distribute it to

other departments. I think we were really thrilled and when we were asked about the instruction I told them we are living in an area with multi-nationalities so have our instruction for the difference in languages, and they were really impressed this was a fruitful experience to us. (P6, hospital A)

One of my best experience in this issue I think we got more extension for our casualty after many committees and we increased the number of rooms in general casualty, and this decreased the load on our doctors and nurses staff. (P7, hospital A)

With the process of accreditation the hospital is properly marked entrance, exit. (P19, hospital B)

An improvement in workplace safety was also noticed by a small number of participants in both hospitals. The Environment section of the Standards has disasters and emergencies Standards and fire prevention Standards - in both parts criteria clearly state the need for a plan in each event. A couple of interviewees commented on developments in these areas:

Actually we did the drill as part of safety, we just sent the letter in December 2013 and we did our drill in 2014 June but it was very successful. It was very helpful and they gave us so many instructions and according to those instructions we did so many things, you know. All the employees now they have an idea above the main exits, what to do in case of fire, what to do in case of any spillage, chemical, blood or anything which will keep them safe first then the others. (P3, hospital A)

Like people in radiology we are concerned with fire regulations, then immediate reaction because of contrast media so we made an arrangement, and because of the contrast reaction communicated really well so nobody died so far with the contrast. So this is a major achievement. Now everybody know of the exit and some got fire practice but these are the things at the level of safety like mechanical, electrical fire. (P20, hospital B)

When participants were asked whether they thought that accreditation had enabled the hospital to better use its resources, some agreed and volunteered positive views, for example in relation to human resources:

Yes for me, I was just thinking human resources yes I think they have been better utilized. (P24, hospital B)

Better use of resources was also noted in relation to finances, time, space and diagnostic procedures:

> Yes, we save time, we save consumption of examination. (P12, hospital A)

> We tried to create a healthy and comfortable environment for the staff regarding space like break room and the toilets. (P15, hospital B)

One interviewee emphasized this point by attributing the Clinical Pharmacy service they established to accreditation, enabling the Department to use its resources the best way possible in offering their expertise to the clinical team.

> Well I can tell you now for example, before we don't have clinical pharmacy service. Okay now we started a clinical pharmacy service and this service you know the pharmacists interfere with the selection of medication. So it will impact on the cost of the medication selected for patients, it will impact on the end results also. Okay because you know some of the doctors they have no information about the drug use so the pharmacist will support them to improve the patient's safety and patient treatment plan. (P21, hospital B)

However, others, in both hospitals, were more negative, and this is reflected in the comments from three different self-assessment team members:

> To tell you the truth I don't think there is a lot produced or has been changed from the accreditation. (P6, hospital A)

> But it's a disappointment to me. All this effort, I mean all this money, time, manpower it's not really giving you the results you expect. (P15, hospital B)

> For example for the filing system this is zero, there is no improvement in the filing system. (P23, hospital B)

One thought that the service they provided as a department had always been good, not just as a result of accreditation. He explained that employees 'Who are keen on their work regardless of the accreditation or the surveys. And people who are careless they remain careless, they don't care if the lab pass, not pass what happens, I am just coming even doing my work and less than my work' (P14, hospital, B).

Safety was a very important element in all the clinical and clinical-support services. These criteria were challenging for the hospitals and their implementation happened over a long period of time, with some departments failing to fulfil all the required patient safety criteria and needing more time to fully comply. This gap was identified in the findings from the documentary analysis. Nevertheless, many participants commented that they had worked hard on these Standards, with tangible results.

> In terms of safety now there is the safety solutions all of them are implemented by now and so whether it's, whether it's communication, drug safety, tube connections, LASA they have all been implemented one way or another and I believe this must have played a huge part in the patient safety. (P4, hospital A)

It was evident in the interviews that the requirements of accreditation had contributed to the implementation of many safety initiatives, which the staff saw as an integral part of the service, which resonates with findings from the systematic review. This is encapsulated in the extract below:

> Regarding the safety the most important part of us now was that we are more documenting what we are doing, we are looking and things that we were not paying attention to we were involved in initially, initial part of patient identification, we have worked with lookalike, sound-alike medication, the hospital infection control was focussing on hand hygiene, we had several lectures regarding these things and in fact I was involved also in surveying the hospital or looking at the initial part of lookalike, sound-alike medication I was searching the hospitals and finding some of the medications that they were for example we were finding a drug for, two drugs they are similar but they are different mechanism of action almost in the same place and since that time we've taken them away from each other. (P5, hospital A)

> I can tell that hand washing, everybody knows this is a basic, in medical school they teach us how to wash the hands but frankly speaking I was not like following the same protocol anywhere else seeing the patients, I was not washing the hands every time so now when I started accreditation the things have changed. People are following of course I can tell you. (P10, hospital A)

> For pharmacist when we dispensed we rarely called the patient's name okay so we had many problems of patient id. Now this has changed because we start calling the patient names, start to check the patient id, not in all areas but at

least in some of the areas which made a difference to reduce the patient errors. (P21, hospital B)

Overall, these results indicated a positive outcome of accreditation on many organisational areas as perceived by the participants from both hospitals. However, it is important to acknowledge that this was based on the participants' views; quantitative evidence on impact was not collected or available within the two hospitals.

7.5.5.2 Individual and interpersonal impact

The process of working towards accreditation was a positive experience for most participants. The self-assessment team members experienced many benefits, at a personal level, which they attributed to the process of accreditation. Interviewees, mostly from hospital A, confirmed how participating in the process had furthered their personal development. Many emphasized how being involved in accreditation encouraged them to read and increased their knowledge and understanding in many ways.

> For my personal benefit I gained much knowledge about accreditation itself I think and about its importance. (P2, hospital A)

> For me yes definitely it's been a tremendous learning experience for me personally yes. (P8, hospital A)

> As I said the highest point I get a new experience in field I don't know before. I never studied before, I studied my qualification in US, and UK and Egypt, 3 areas, I never expected this point. (P25, hospital B)

As described earlier, teamwork was an important feature of the process and was acknowledge positively by the interviewees.

> The part of collaboration was excellent I think the teamwork was very good. (P4, hospital A)

> I believe it is a positive experience and I believe there was some teamwork among departments I felt during accreditation. (P6, hospital A)

7.6 Discussion

7.6.1 Overview of the findings

The results presented here, collected from interviews with members of the self-assessment teams, provide important insights into the facilitators and barriers encountered during accreditation implementation in Kuwait Governmental hospitals. Three broad themes were identified: understanding the accreditation process, engagement with the accreditation process, and the work of accreditation. The issues identified by the participants operate at different levels of the healthcare system. For example, human and financial factors were identified as barriers to implementation. In the Kuwait health system context, these are controlled centrally by the Ministry, through its Regional Health Offices. However, the issue of time management-which was also identified as a barrier - can be addressed at an organisational level between the hospital management and the staff.

In this study, only the views of members of the self-assessment teams were sought; frontline staff was not included in the interviews. However, the self-assessment stage of an accreditation cycle is a crucial step that enables the organisation to evaluate its performance, identify its strengths and weaknesses, and follow that by implementing improvement strategies. The self-assessment team members are central to this process, so it was appropriate to focus on their views and experience. It was evident, however, in this study that the teams were not fully prepared or appropriately equipped to accomplish their tasks successfully.

Despite the complexity of the intervention, there appears to be a general consensus of its meaning among the interviewees, from both hospitals, even if the words used for describing the meaning of the programme varied. This was true also in the literature, where different descriptions for accreditation are used. However, many recognised it as a tool for assessing healthcare organisations' performance, and improving the quality and safety of services (Hirose et al., 2003, Montagu, 2003).

With a newly introduced programme, the organisation as a whole needs to be connected and engaged with it. The semi-structured interviews offered the opportunity to explore this

issue in more depth. Self-assessment team members, as mentioned previously, were key in the process of implementation, which means their attitude and input could either facilitate or hinder the embedding of accreditation. The professionals participating in accreditation as self-assessment team members were exposed to a new pattern of work that was different from their usual routine, and this change took them out of their comfort zone, with some expressing a lack of understanding. As a result, the reaction of those professionals to the programme varied from embracing it to resistance and rejection. The key role of leadership was identified as a driver for implementing the programme, and also an influential factor in engaging people to be part of the accreditation process.

Recognising that the actual work and implementation of Accreditation Standards requires more than simply engaging people in the process, the interviews explored what enabled or hindered the work of accreditation as viewed by the self-assessment teams. Interviewees talked more about barriers than facilitators, and the interviews revealed a general frustration concerning the actual work of accreditation. The issues raised concerning the work of accreditation are mainly controlled by the Ministry of Health, suggesting that many of these issues were out with the direct control of the hospital-based self-assessment teams.

In addition, the interviews explored the impact of implementing the accreditation programme at both an organisational and individual level, as perceived by the professionals involved. The organisational benefits highlighted in the interviews included improving care delivery, developing an organised documentation system, evaluating and improving the work area, and formulating policies and plans needed for the service. On the personal level, many participants felt the process helped in their development academically and socially. They increased their knowledge about many subjects related to accreditation; also they appreciated the teamwork spirit within their organisation enabling them to work towards a unified goal.

Some variation was identified between the two hospitals as illustrated in **Table 7-3**. Self-assessment team members from hospital A (substantial accreditation) were more positive in their feedback about four areas: commitment; good working relationships; training and

education; and personal benefit. Participants from hospital B (partial accreditation with conditions) reflected more negative views of the same four areas.

Table 7-3 Difference in findings between the two hospitals

Area	Hospital A	Hospital B
Understand Standards	-ve	+ve
Commitment in attending meetings	+ve	-ve
Good-working relationships	+ve	-ve
Financial incentives	-ve	-ve
Training and education	+ve	-ve
Organisational benefit	+ve	+ve
Personal benefit	+ve	-ve

7.6.2 Limitations and strengths

One limitation was the language barrier. All the interviews were conducted in English, which was not the first language of the participants. This might have affected the quality of their opinion and views, which might have been better expressed in their own language. However, given the time and resource constraints of the PhD, it was not feasible to conduct the interviews in Arabic and then have them translated for later transcription.

Another problem was related to the data collection process, as some participants hesitated to participate in this research because they felt they were exposing themselves to external scrutiny or that it was not beneficial to them. The researcher addressed this issue by reassuring them the data would be reported in a way that fully ensures anonymity, and is used for academic purposes. Another matter is the relatively small sample size (25 participants). Nevertheless, there appeared to be data saturation, in that eventually there were no new issues emerging during the interviews; respondent talk about very similar issues and no new themes were identified. One reason for this might be that the sample was fairly homogenous (Guest et al., 2006). In future, a larger interview study might help in exploring the subject in more depth.

Also another possible limitation was the focus of the research on self-assessment team members only. Exploring the views of other groups, such as surveyors, hospital directors, healthcare policy makers, could have shed light on other aspects of the implementation process from different levels of the healthcare system.

A clear strength of this phase of the work was the fact it was the first study of its kind to be conducted in Kuwait exploring this field in particular, and also managed to get people to participate willingly. In addition, the interviews also helped to elaborate on issues that were not very clear in the systematic review or the accreditation reports. It enabled the researcher to explore more deeply possible links among the different implementation factors, for example between leadership and engagement with the process.

7.7 Summary

This chapter presented a detailed account of the self-assessment teams' perspective and attitude towards the implementation of accreditation in their organisations. A number of themes emerged during data analysis related to the factors influencing the implementation process and the potential impact of the programme: 1) accreditation meaning, 2) understanding the accreditation process, 3) engagement with the accreditation process, 4) the work of accreditation, and 5) the impact of accreditation. The final chapter will now integrate the findings from the three studies to generate a robust discussion of the barriers and facilitators to accreditation in Kuwaiti general hospitals.

Chapter 8- Synthesis of Findings and Discussion

8.1 Introduction

This chapter aims to integrate the research results obtained from the systematic review, documentary analysis, and the interviews, addressing the aim and research questions, and highlighting the major findings. It is followed by a discussion on the possible changes required to the health system in Kuwait to support the implementation of accreditation. Then the limitations and strengths of the research design are presented, followed by how the findings fit with current knowledge and, finally, recommendations for future research and policy.

8.1.1 Rationale

This research aimed to contribute to a better understanding of the implementation of the accreditation programme in Kuwait's general hospitals from the multiple perspectives of the healthcare professionals involved. Accreditation is defined as a self-assessment and external peer review used by healthcare organisations to accurately assess their level of performance in relation to established standards, and to implement ways to continuously improve the healthcare system (ISQUA, 1998). In this research three studies were conducted: a systematic review of the literature to explore the factors affecting the accreditation implementation process, and how accreditation impacts services; a documentary analysis of the accreditation reports of six general hospitals in Kuwait to assess the implementation process from the surveyors' perspective; and an interview study exploring the implementation of accreditation in two general hospitals from the perspective of self-assessment team members. Underpinning all of this work, and discussed in greater detail here, was the use of a theoretical framework for implementation – Normalisation Process Theory.

8.2 Synthesis of findings and mapping to NPT

This work has identified key factors that influence the implementation process, as identified across five main themes: accreditation meaning; understanding the accreditation process; engagement with the accreditation process; the work of accreditation; and perceptions of accreditation impact. This section will show how the key findings from each individual study map onto the project's underpinning theoretical framework of NPT and, in doing so, will help to develop a conceptual model of the process of implementing accreditation in a complex setting such as hospitals. The key findings from the three studies are illustrated according to the related NPT constructs in the Tables 8.1, 8.2, 8.3, and 8.4.

To do this, the key results from each study were summarised and reviewed by the researcher and primary supervisor (COD). Each finding was mapped to the most appropriate NPT construct (for example, if about understanding of the process, then mapped to coherence). However, some findings mapped to more than one construct – where this occurred, a note was made of the second construct (see Tables 8.1-8.4). These relationships were then reviewed and the linkages discussed in the following sections. In this way, it was possible to see how the constructs of NPT can interact with each other in a way that is fluid and dynamic, as previously suggested (May et al., 2009, May and Finch, 2009).

Table 8-1 Mapping the key findings of the three studies into NPT construct 1: Understanding and sense-making work (Coherence)

Systematic Review	Qualitative analysis of the accreditation reports	Interviews
1- There were different definitions of accreditation. 2- Accreditation is seen to be linked strongly to other existing quality initiatives in an organisation, which provided the foundation for implementing accreditation. (**This cross-maps to availability of resources and policies that support the implementation/** *Collective Action*). 3- The papers focused only on organisational and departmental understanding, but not the individuals within the organisation. 4- Stakeholders are interested because they believe it will improve quality of care. (**This relates to understanding of accreditation, but also maps to the stakeholders' assessment of the benefits of accreditation/** *Reflexive Monitoring*). 5- Shared understanding of the aims, and benefits of accreditation is an important element in the process and encourages engagement. 6- Understanding the Standards is a key factor in a successful implementation (**5 and 6 relate to shared understanding of accreditation components but also cross-maps to participation and engagement/** *Cognitive Participation,* **as participating can lead to better understanding**).	No data related to understanding was extracted from the accreditation reports.	1- There were different interpretations of accreditation. 2- Most saw it as a tool to evaluate and improve services. 3- Others viewed it as only a brand name, leverage for implementing best practice, or only about documentation. 4- Many expressed a general lack of knowledge of the programme and their role in it. (**This cross-maps with having the correct skills and training to implement accreditation/** *Collective Action*). 5- Some became more familiar with accreditation because they became more involved in its implementation (**This cross-maps to engagement and participation in the programme/** *Cognitive Participation,* **and also to actually doing the work/** *Collective Action*). 6- For many, there was no shared understanding of the process and the Standards among the teams, leading to variation in implementation (**this cross-maps with having the correct skills and training to implement accreditation/** *Collective Action*) 7- Some reported that their prior experience in accreditation helped them in understanding the programme and the Standards and also encouraged them to engage with the implementation (**This cross-maps to having the skills and training to implement accreditation/** *Collective Action,* **and also relates to them believing its appropriate for them to get involved/** *Cognitive Participation*).

Table 8-2 Mapping the key findings of the three studies into NPT construct 2: Relationship work (Cognitive Participation)

Systematic Review	Qualitative analysis of the accreditation reports	Interviews
1- Professional attitude was seen as a key barrier in implementing accreditation (**This cross-maps with having the knowledge and training to implement accreditation/ *Collective Action*, also maps to understanding the benefit and impact of accreditation on the services/ *Reflexive Monitoring*).	1- Communication problems were reported, both organisational and inter-departmental.	1- Some participants were positive towards implementing accreditation and viewed it as the right thing to do.
2- Engaging others in the programme is important and can be achieved through explaining the benefits of accreditation (**This relates to how individuals are identified and organised, to engage with the individual intervention, but also maps to the benefits of participating in accreditation/ *Reflexive Monitoring*).**	2- Communication with patients and their families should be improved.	2- Many invested their own time in the implementation of Standards (**This related to the participants identifying the tasks and activities required but also cross-maps to the work needed for accreditation implementation/ *Collective Action*).**
3- Those directly involved in the process could create a positive attitude towards driving the implementation forward (**This relates to engaging others in the process but also maps to the work done to implement accreditation/ *Collective Action*)**	3- Recommendations to provide multidisciplinary care for patients included improved communication.	3- Participants, in site A, showed commitment in attending and participating in the accreditation meetings.
4- Good-working relationships by the participants, accountability, and confidence in themselves and accreditation are identified as a key implementation factor (**This cross-maps with developing relationships and building confidence with the newly introduced practice/ *Collective Action*).**	4- The reports identify the importance of involving clinical pharmacy in the plan of care. **These all relate to relational work of accreditation but also map to what needs to be done to make accreditation work/ *Collective Action*).**	4- Participants in site B showed a lower degree of commitment due to them being already busy in daily work (**This cross-maps with time constraint as a barrier/ *Collective Action*).**
5- Communication and teamwork are identified as key implementation factors.		5- Some reported a negative attitude because they didn't understand the benefit of accreditation (**This cross-maps to how individuals assess the effectiveness of accreditation, *Reflexive Monitoring*).**
6- A positive correlation between leadership and accreditation performance was reported.		6- Most participants were nominated to participate.
		7- Some volunteered, due to the perceived benefit of accreditation, and to their prior knowledge (**This cross-maps to understanding the programme/ *Coherence*, and also to the individual assessment of the impact of accreditation / *Reflexive Monitoring*).**
		8- Teamwork spirit and communication were acknowledged more in site A as a contributing factor to successful implementation.
		9- Quality Physicians played a central role in the implementation of accreditation.
		10- Head of Departments involvement was acknowledged as a facilitator, but to a lesser extent than the QP.

Table 8-3 Mapping the key findings of the three studies into NPT construct 3: Enacting work (Collective Action)

Systematic Review	Qualitative analysis of the accreditation reports	Interviews
1- A budget for accreditation activities and financial incentives for participants was identified as fundamental to successful implementation (**This cross-maps to people willingness to engage/** _Cognitive Participation_). 2- Workload was reported as a major barrier to implementation, and some contributed their own time to complete the tasks. 3- Views varied regarding whether accreditation made their job easier or harder, as some reported lack of confidence in accreditation and preferred to focus on their clinical duties. Other studies reported teamwork and involvement in decision-making as a result of accreditation (**This cross-maps with the collective assessment of the effectiveness of accreditation/** _Reflexive Monitoring_). 6- Training and education was reported as an important factor for successful implementation (**This cross-maps with understanding the programme/** _Coherence_, **and also with people willingness to participate and engage/** _Cognitive Participation_). 7- Having the appropriate system, laws, and regulations already existing would assist in standards implementation.	1- The reports addressed the issue of understaffing in some of the services. 2- There appeared to be a major gap in documenting departmental plans, safety and quality plans, and performance indicators. 3- Also there was a gap in implementing the patient safety required areas. (**2 and 3 relate to the work done in implementing the Standards but also cross-maps with having the knowledge to write up such documents/** _Coherence_). 4- There appears to be a defect in training needs, mainly within the safety domain, for the staff (**This cross-maps with the knowledge required to implement standards/** _Coherence_). 5- The reports demonstrated a general lack of space. 6- Staff safety must be addressed, particularly in Emergency departments. 7- There was a problem with the Information Systems, where, if available, they were not connected to each other due to technical issues. 8- Few recommendations were regarding the referral system between the primary care and the hospitals.	1- Workload was reported as a major barrier, and some contributed their own time to complete the tasks. 2- A budget for accreditation activities and financial incentives for participants was reported to be key factor in successful implementation (**This cross-maps to people willingness to engage/** _Cognitive Participation_). 3- The interviews reported understaffing as a barrier, due to the demanding nature of accreditation. 4- Most of participants agreed that the Standards were highly relevant to their daily activities, and few commented on how many of the required documents already exist. 5- There seems to be a need for more structured training programme delivered to the self-assessment teams (**This cross-maps with understanding the programme/** _Coherence_, **and also with people willingness to participate and engage/** _Cognitive Participation_). 6- A general lack of space was reported. 7- Participants in site B reported a problem in the Information System of the hospital. 8- Channels of communication between the hospitals and centralised authorities were reported to be very slow (**This cross-maps to people willingness to engage/** _Cognitive Participation_).

Table 8-4 Mapping the key findings of the three studies into NPT construct 4: Appraisal work (Reflexive Monitoring)

Systematic Review	Qualitative analysis of the accreditation reports	Interviews
1- In general, the evidence of accreditation impact on clinical services was inconclusive. 2- Positive impact of accreditation standards on availability and quality of clinical guidelines (**This cross-maps with the work done to implement the standards/** *Collective action*). 3- Evidence was inconclusive regarding the effect of accreditation on the quality and safety of the service. 4- A positive relationship was found between accreditation implementation and Quality Management Systems (internal audits, risk management, patient safety system). 5- Individuals expressed positive views about accreditation and indicated how they preferred to be employed in an accredited organisation (**This relates to the individual assessment of accreditation and cross-maps to the positive attitude of individuals towards the programme/** *Cognitive Participation*).	No data related to work of accreditation was extracted from the accreditation reports.	1- Participants reported a marked improvement in the process of healthcare delivery, and now many practices are routinely embedded in everyday routine (**This cross-maps with how individuals view it appropriate to be involved/** *Cognitive Participation*, **and also cross-maps with how accreditation made it easier to do their tasks/** *Collective Action*). 2- Some reported improvement on clinical care. 3- A positive impact on the working area, physical facility and workplace safety was reported. 4- A positive relationship was noticed between accreditation and better use of resources (**This relates to resources required to support the implementation/** *Collective Action*). 5- Some reported negative feedback, where they claimed no impact was detected as a result of accreditation (**This cross-maps with the participants attitude towards engagement/** *Cognitive Participation*). 6- A positive relationship was detected between accreditation and safety initiatives. 7- Participants reported a positive impact on their personal development and knowledge (**This relates to individual assessment of accreditation but also maps across their understanding of the process/** *Coherence,* **and their involvement and engagement in the process/** *Cognitive Participation*)

One important finding was how in the systematic review and the documentary analysis of this research, understanding the process of implementing accreditation appeared to have the least focus. While this may not be surprising in the context of the accreditation reports written by the surveyors, it was more surprising in terms of the international literature. As a result, the researcher tried to explore this in more detail during the qualitative interviews. By contrast, the work needed to enact the intervention seemed to dominate the data in all three studies.

Analysis of the accreditation reports identified two major themes: engagement with the accreditation process and the work of accreditation, although most of the recommendations addressed issues related to enacting of the programme.

This result also suggests that the process of surveying may focus more on tangible and measurable aspects, such as the infrastructure, training needs, and human resources, as opposed to softer measures, such as engagement and co-operation across teams. Given the importance of participation and team working, this might be an area that surveyors' also consider in the future.

It is also important to consider the level at which identified barriers and facilitators operate. Many of the implementation factors identified as related to the work of accreditation fall largely within the remit of the Ministry of Health and the Quality and Accreditation Directorate. For example, developing and introducing a well-structured training programme is a higher-level, national responsibility. Financial support, like an allocated budget for accreditation implementation issues and incentives for employees, is also a ministerial decision. However others, such as understanding the accreditation process and engaging others, has been identified by this research to be mostly within the remit of hospitals and their departments.

The following sections discuss the factors identified as affecting the process of accreditation implementation and attempts to establish relationships among those factors. In particular, it draws on the findings reported in Tables 8.1 to 8.4, to consider how these factors map to NPT.

8.3 Influential factors affecting accreditation implementation

8.3.1 Understand accreditation meaning and process (mapping to the NPT construct of coherence)

The systematic review revealed how relatively limited consideration was paid to ensuring that those involved in the implementation of accreditation schemes understood what was being done, and why. This resonates with other work about the implementation of e-health systems (Mair et al., 2012) and the implementation of guidelines in nursing (May et al., 2014). The central role that understanding plays in implementing this organisational wide quality initiative was identified more clearly in the interviews. Here, participants talked about the need to see accreditation as something different from other quality improvement initiatives; this was also found in a recent study exploring the implementation of medical accreditation and revalidation (Tazzyman et al., 2017). This fits with other studies which have also reported on the need to ensure that those involved understand the aim and values of an intervention and understand its components for a successful implementation, for example, Bamford et al. (2012).

Self-assessment team members who were interviewed agreed that they saw accreditation as a tool to evaluate the service and promote quality and safety within the organisation, but they appeared to have difficulty in understanding the implementation process. Even though participants appreciated the guidance contained in the book of National Accreditation Standards for Hospitals, many appeared to have different interpretation of the Standards, which affected how they approached implementation, particularly in hospital A. Pomey et al. (2005) in their review, suggested that even when standards and guidance existed, there should still be scope for discussion and creativity in the implementation process, which fosters the organisational development and creates a connection among different 'territories' with in the hospital.

The findings from the interviews demonstrated that participants with previous experience and exposure to accreditation programmes had an advantage in knowledge, which facilitated their understanding of the NAP. While this can't be directly factored into the implementation process and depends entirely on the potential involvement of participants

with prior accreditation programmes, it does suggest that it would be beneficial to pursue such experienced employees and recruit them into the current programme. It also supports the role of having a good knowledge base as a facilitator of implementation.

Training workshops and educational material were delivered to the self-assessment team members as indicated by the second agreement with Accreditation Canada – this work will be discussed more fully under the NPT construct of collective action. However, the interview findings suggest that such educational programmes didn't always deliver the expected outcome. For example, many interviewees, mostly in hospital B, didn't fully understand their role in the process, and some wondered if they had the right skills to be part of the programme.

This relationship between training and education and understanding clearly outlines the interrelationship between the different constructs of NPT, stressing how these are not linear or sequential but rather interact during the process of embedding a new intervention. Even though training and education are part of the work of accreditation, it links to the aspect of understanding and emphasizes the need for training before starting the programme. This is outlined in Figure 8.1.

8.3.2 Engagement with accreditation process (mapping to the NPT construct of cognitive participation)

Introducing a quality improvement initiative, such as accreditation, requires a change in attitude and behaviour of the staff involved (EMRO, 2003), and their involvement and participation is integral to the successful embedding of the initiative (Black, 1995, Daily and Bishop, 2003). The studies reported in this research sought to address the factors that influenced individual and team engagement in the implementation process.

8.3.2.1 Professional attitude

There was evidence from the systematic review and the interviews that professional attitude is an important factor in the process of implementation. While in the systematic review it was recognised mostly as a barrier, views from the interviews varied. Many participants from both hospitals welcomed the intervention and believed it was beneficial

to their work as well as to the service more widely – in NPT terms, there was both legitimation and activation. Participating in accreditation was believed to increase staff motivation and created a healthy competition environment between departments. A number of participants, mostly from hospital A, further demonstrated their commitment by volunteering their own time to implement the standards, and by their regular attendance and active participation in the accreditation meetings held by their departments, suggesting that they were willing to drive the process of implementation (in NPT terms, the sub-construct of initiation). Others, from both sites, were more negative about accreditation, reasons included: lack of knowledge about the nature of the process; the belief that accreditation had no benefit or impact on them or on the service; and that the work of accreditation was a burden and not part of their contractual work. Findings from the literature support this, with many studies identifying professional attitude, especially from physicians, to be a major barrier to the process (James and Hunt, 1996, Pongpirul et al., 2006, Greenfield et al., 2011, Alkhenizan and Shaw, 2012).

Education plays a key role in changing the attitude of professionals, as Havens and Johnston (2004) demonstrated in their study. In their study of the Magnet accreditation programme, they found that offering educational sessions to physicians about the Magnet programme and its potential benefits resulted in reduction in sceptical views and the development of a more positive attitude. This suggests that the work of accreditation, in terms of providing education and training, will also impact on changing attitudes towards participating in the process.

8.3.2.2 Engagement and participation in the process

Involving staff in implementing accreditation programmes can empower them and enhance their sense of ownership in the programme. This can, ultimately, improve their input into the process (Lovering, 2013), and is recognised as a key feature in accepting and supporting the process of change (Pongpirul et al., 2006, Shaw, 2015). As previously discussed, it is also linked to professional attitude towards the process of change. Chiu et al. (2011) in their study identified the importance of staff engagement, and suggested three strategies that would encourage this engagement: open and frequent communication

channels; ensuring that staff were aware of the value and benefit of accreditation; and recognising their effort and rewarding it.

The findings from the systematic review and the interviews found that directly involving staff in the process and encouraging them to share their ideas and participate in making decisions was related to their willingness to engage in the process of change – in NPT terms taking part in the enacting work of accreditation also improved the relationship work. This resonates with findings from the literature (Cotton et al., 1988, Boon et al., 2006, Keng Boon et al., 2007). However, the interviews conducted in this work also found that many participants were nominated by their head of departments, and they felt coerced and had no choice but to join the self-assessment team. Feeling pressurized to join this work may mean that staff fail to fully understand why they should participate. Others have reported that this can eventually lead to staff avoiding meetings and withdrawing from tasks related to standards implementation (Dickenson et al., 2000, Amar and Mohd Zain, 2002, Subrahmanya Bhat and Rajashekhar, 2009).
Some, however, welcomed this nomination, sometimes because of prior experience of the programme and its perceived benefit, or because of a supportive leadership style.

8.3.2.3 Good-working relationships

Good-working relationships help to create a positive organisational culture, where experiences and responsibilities are shared and distributed. In this research, communication and teamwork were important. For example, the systematic review identified communication and multidisciplinary teams as key factors in implementing quality change initiatives.

Results from documents analysis and the interviews, however, suggested that there were communication failures within the organisations. Effective communication plays an important role during change and quality implementation (Sila and Ebrahimpour, 2003, Gollop et al., 2004, Lanteigne and Bouchard, 2016). The accreditation reports identified communication failures in all six hospitals. Within and between departments there appeared to be evidence of lack of communication indicated by deficiencies in sharing information. Pongpirul et al. (2006) have reported similar findings where communication

among departments was identified as one of six other barriers in implementing quality systems. Also, in some reports in this study, organisational-wide communication issues were noted. The interviews findings supported the findings from the reports; however, this problem appeared more prominent in hospital B, where inter-departmental communication was reported to be weak.

Teams are the basic block in quality management and creating effective self-assessment teams are key step in the accreditation process. Teamwork is necessary to help in identifying and managing quality and safety matters (Joss and Kogan, 1995, Leonard et al., 2004). The accreditation programme is based on the principle that the people who implement the processes are in the best position to understand, assess, and improve them. The findings addressed teamwork from two perspectives. The hospital reports indicated a defect in providing multidisciplinary care for patients, which is reported as a barrier in implementing quality by (Pongpirul et al., 2006). The other perspective was that of the self-assessment teams specifically, who were responsible for implementing the standards and accreditation (Bruchacova, 2001, Jovanovic, 2005). As the standards were service specific, not department specific, teams were made up of staff from different departments, each reflecting their professional discipline. This meant that good working relationships were essential within the teams.

8.3.2.4 Leadership

Findings from the systematic review reported a positive association between leadership support and accreditation performance, which is similar to findings from recent research, where leadership was found to significantly influence the process by providing guidance and support to the staff (Lanteigne and Bouchard, 2016). NPT also draws attention to the importance of good leadership, through the sub-constructs of initiation and enrolment, which highlight the role that key individuals can play in driving the process of implementation. The Total Quality Management (TQM) philosophy states that every person is involved, and emphasizes the essential role of management and leadership in transforming the culture into a quality culture (Parsley and Corrigan, 1999). Any change must be focused first on strong leadership, and to achieve that, leaders must be supported

and trained in specific techniques to enable them to steer employees through the change process (Ennis and Harrington, 1999).

The interviews findings reinforced the evidence from the systematic review by demonstrating a strong link between supportive leadership and staff engagement, which then contributed to more successful implementation. Three levels of leadership were identified from the interviews: the Quality Physician (QP), the Head of Departments and the Hospital Director. The role of the Quality Physician was clearly appreciated in both hospitals and was the most prominent as a key person, providing guidance, support, and motivation to the self-assessment teams throughout the accreditation process. The role the QP adopted is similar to the Situational leadership style proposed by Hersey and Blanchard (1969). Effective management is suggested to result from the way a manager deals with an individual subordinate on a particular task. Accordingly, managers need to provide each subordinate with a different amount of direction on different tasks depending on the subordinate's developmental level. It constitutes four styles, directing, coaching, supporting and delegating (McCleskey, 2014).

The part the Head of Departments played in involving and supporting staff was recognised less frequently than the QP, although interviewees did report that their support helped in completing the tasks related to standards implementation, and balancing the time between their everyday work and preparing for accreditation. Finally the role of the Hospital Directors and their belief in the programme was a key element in motivating the staff and encouraging their participation in the process, which resonates with findings from the literature reporting the importance of the support of higher-level leaders (Scrivens, 1997a, Pomey et al., 2004, Braithwaite et al., 2010, Santana et al., 2012).

8.3.3 The work of accreditation (mapping to the NPT construct of collective action)

The construct of collective action focuses attention on the enacting work that implementation requires, including the skills that staff require, the division of labour and the level of support at local, regional and national levels. There was an official management structure supervising the healthcare accreditation initiative, extending from the Ministry of Health, with the Accreditation Higher Committee, through middle

management, represented by the Quality and Accreditation Directorate, and ending with the Quality and Accreditation Office located in each hospital as explained in more detail in Chapter 3. This office consisted of the Quality Physician and the quality nursing team. This multi-level management was responsible for addressing any challenges encountered during accreditation implementation. As mentioned previously, much of the data identified in the systematic review and report analysis coded to collective action, however it was also important in the interviews.

8.3.3.1 Resources

The literature identified the need for adequate resources to implement a new intervention, especially financial resources, as identified by others (Bukonda et al., 2003, Klefsjö and Eriksson, 2004, Pongpirul et al., 2006, Mair et al., 2012, Aryankhesal et al., 2014). Human resources, including more staff, were also identified as important (Shaw, 2003, Greenfield et al., 2007).

Bruchacova (2001) developed a guideline to help support the successful implementation of accreditation as mentioned previously in Chapter 3, and argued for the importance of providing extra time, money and staff to support the development of quality improvement tasks. The findings from the systematic review and the interviews support this, and demonstrated that allocating a budget for accreditation related activities and for rewarding the staff was fundamental to the success of the programme. A mixed methods study by Davis et al. (2009) also found that respondents agreed on the value of financial incentives to encourage the staff to participate in a National Public Health Accreditation Programme.

The findings reported here identified that a lack of central resources imposed a financial burden on some of the team members, because they personally contributed to assist in facilitating the implementation of standards, for example paying for photocopying. In a study aimed to assess incentives and barriers for implementing accreditation in Uganda, one participant stated 'standards without resources to implement them are useless' (Bateganya et al., 2009). Thus findings from this study are in line with the literature in recognising the importance of financial funding to promote the successful implementation of accreditation (Braithwaite et al., 2012, Saleh et al., 2013, Janamian et al., 2014).

The second challenge, related to resources, identified in each of the three studies reported here is the lack of time to complete the accreditation tasks. This has been reported by others to affect the attitude of professionals in welcoming the change because they think, from their perspective, the work load outweighs the benefit (Fairbrother and Gleeson, 2000). This shift in paradigm from a healthcare service-centred approach towards a quality focus approach was identified by some participants to be more important than the financial barrier and is, again, supported by others (James and Hunt, 1996, Havens and Johnston, 2004, Alkhenizan and Shaw, 2012, Lanteigne and Bouchard, 2016). The suggestion by some that self-assessment teams are given time off from their actual job to focus only on implementing standards has been recognised by the WHO as a key issue. Indeed, the WHO have recommended that organisations should ensure dedicated time for teams to complete accreditation related work (Shaw, 2006).

Findings from the documentary analysis and the interviews suggested human resources to be an important implementation factor. The work of accreditation is highly demanding, and deficiencies in staffing levels were reported as a barrier in many studies (James and Hunt, 1996, Bukonda et al., 2003, Rad, 2005, Pongpirul et al., 2006, Bateganya et al., 2009, El-Jardali et al., 2014). Surveyors in their recommendations acknowledged this factor in three hospitals. The interviews further reported staffing problems are identified in the clinical and administrative parts of the organisation.

Resources, as demonstrated previously, are linked to professional attitude; comparing the findings across the three studies showed that the introduction of financial incentives and dedicated time for participants could, in turn, increase involvement in and understanding of the programme. In NPT terms, a focus on enacting work (collective action) could in turn increase participation (cognitive participation) and understanding (coherence).

8.3.3.2 Training and education

Findings from the systematic review identified training and education of staff involved in implementing accreditation as a key facilitator. Education is an integral component of the accreditation process and is directly linked to the success of an organisation's accreditation

and survey experience (Hurst, 1997, Zhang et al., 2000, Dayton, 2001, Lanteigne and Bouchard, 2016).

One of the main deliverables of the agreement between the Ministry of Health and Accreditation Canada is providing training and workshops for different categories of staff to develop their knowledge and understanding of the process (Ministry of Health, 2011a). In this way, the enacting work of accreditation through training and education could directly impact on individual and collective understanding (the NPT coherence sub-constructs of individual and communal specification), and through joining it enhances cognitive participation. Findings from the documentary analysis identified that the training skills that particularly needed addressing were mostly within the quality and safety domains of the services being delivered, especially in hospital B. The literature also demonstrates the importance of having clear training programmes; single sessions might not deliver the full understanding. Thus, it might be necessary to develop more extensive approaches to help participants acquire the appropriate tools and skills for proper implementation (Motwani et al., 1994, Kennedy, 1998, Thurber and Read, 2008).

The interviews also identified language as an issue. Although the National Accreditation Standards and all the documents related to the programme were in English and also, training was often delivered in Arabic, which was not suitable for all members of staff.

8.3.3.3 Infrastructure

Problems associated with physical environment, work place safety, and information systems were a prominent feature of the findings in the accreditation reports and the interviews. This was not acknowledged in the systematic review however. This might be related to the use of the NPT framework, which might not draw attention specifically to infrastructure as a resource, or may indicate an under-researched area in the implementation process.

Problems associated with infrastructure in this study are all the responsibility of the Ministry of Health and other higher authorities, rather than the hospitals. Even when hospitals tried to fix those issues, they were frustrated with the bureaucratic procedures. The accreditation reports also identified a lack of space in all six hospitals, which was

further reinforced in the interviews, and participants agreed that this affected service delivery (Bateganya et al., 2009). Space issues were detected in waiting areas, storage space, and, in a couple of hospitals, a lack of central warehouses.

Another element of infrastructure is related to information systems, with two issues identified. Effective health information systems have been identified in the literature to be of great value, supporting the delivery of effective services, reducing costs, and improving outcomes (Chiasson et al., 2007, Fichman et al., 2011). Effective information systems will enhance both the enacting work of implementation, but will also make monitoring of process and outcome indicators (key activities of NPT reflexive monitoring) easier. Hospital information system failures have been reported in the literature, and successful implementation can be challenging (Lærum et al., 2001, Berg, 2001, Giuse and Kuhn, 2003).

8.3.3.4 Standards adaptation

A standard is defined as the desired and achievable level of performance against which actual performance can be compared (Ministry of Health, 2011b). The National Accreditation Standards for Hospitals contain twelve sections, explained in more detail in Chapter 3, and divided into four categories: patient care standards; clinical support services standards; non-clinical support services standards; and leadership.

When most of the system is already in place it facilitates implementation, like for example the procedures required by accreditation standards such as policies, guidelines, structural requirements and safety systems (Melo, 2016). Findings from the systematic review identified the importance of having appropriate systems, like existing documents and quality programmes, in place to align standards with. This was echoed in the interviews, with participants discussing how many accreditation requirements already existed in their hospitals. The accreditation reports also identified gaps in plans and policies related to leadership, administration, and quality and safety. Others have identified that although documenting the clinical and administrative work of a service is very important in implementing a quality initiative (Pomey et al., 2004), it can lead to disengagement of

participants, with many finding the work related to documenting quality programmes to be overwhelming (Tang and Kam, 1999, Beskese and Cebeci, 2001, Yahya and Goh, 2001).

Taken together, these results identified ways in which the enacting work of accreditation – the NPT construct of collective action – also linked strongly to that of reflexive monitoring. So, in order to appraise the impact of accreditation and to ensure that standards are maintained, there needs to be consideration of the work to be done and the resources needed to support that work.

8.3.4 Accreditation impacts (mapping to the NPT construct of reflexive monitoring)

This section discusses findings from the systematic review and the interviews and seeks to address the potential organisational and individual impact of implementing accreditation. There was no consideration of monitoring or impact in the accreditation reports.

8.3.4.1 Organisational impact

Both the systematic review and the interviews highlighted a range of organisational impacts as a result of implementing accreditation. Some literature also reports that accreditation programmes could improve quality of care (Montagu, 2003, Hinchcliff et al., 2012b, Yildiz and Kaya, 2014, Devkaran and O'Farrell, 2015, Bogh et al., 2016). El-Jardali and colleagues also demonstrated improvements in the overall organisational culture and quality of care post accreditation (El-Jardali et al., 2008). Keeler et al. (1992) in their study, however, reported that accreditation had no impact on the quality of care delivered. This suggests that there is variation in how both individuals and groups assess the effectiveness of accreditation (in NPT terms, individual and communal appraisal). Scrivens (1997b) suggested that a key feature of ensuring impact was the engagement and support of leaders in the healthcare service, suggesting that appraisal work relies on both clear understanding (coherence) and staff participation (cognitive participation).

Findings from the systematic review demonstrated an inconclusive association between accreditation and clinical efficiency, evaluated mainly by performance indicators. However, evidence from both the systematic review and interviews did demonstrate that

organised documentation systems had a positive impact, because that encouraged staff to develop written practices and procedures, which in turn supported the development of standardised care. In NPT terms, this sits with the sub-construct of reconfiguration, where stakeholders can modify or develop the system being implemented. Documentation was also reported as a positive impact of accreditation leading to consistency in care delivery (Walker and Johnson, 2009, Tabrizi et al., 2011, Melo, 2016), and as Pomey et al. (2004) demonstrate in their study how the organisation learned the importance of 'a writing culture' rather than relying on word of mouth.

Other benefits deemed to have resulted from accreditation were better resource management, and improved safety environment. In terms of resource management, accreditation, as identified in literature, drove organisations toward a better use of its resources (Greenfield and Braithwaite, 2008, Jaafaripooyan, 2014). Hurst (1997) argues that despite the financial obligation linked to accreditation implementation, in the long run, it saves money. Findings from the interviewees support this notion by reporting a noticeable decrease in un-necessary diagnostic tests and procedures.

8.3.4.2 Individual and inter-personal impact

The results from the interviews demonstrated that the main benefit participants acknowledged, as being part of the self-assessment teams, was personal development and learning, which was echoed by findings in the literature (Greenfield and Braithwaite, 2008, Pomey et al., 2010, Tabrizi et al., 2011, Melo, 2016). Consistent to findings from this study, Lanteigne and Bouchard (2016) note how the self-assessment phase fosters knowledge and learning, and this lead to a positive impact on the teams in regards to personal development.

Teamwork was also improved, linking back to the construct of cognitive participation, and fits with results reported by Bukonda et al. (2003), Pomey et al. (2004) , and Tabrizi et al. (2011). They also noted how the process of implementing the standards fostered teamwork and collaboration due to the development of many multidisciplinary teams who worked together and shared many meetings to accomplish the tasks required by accreditation.

The findings from both the systematic review and the interviews have reported to some degree an increased motivation of staff to participate in implementing the programme, which was more evident in hospital A, and Almasabi and Thomas (2016) suggest a possible link between accreditation impact and professional attitude towards the acceptance and involvement with implementing the standards, an association that was concluded also in this study, see **Table 8-4**.

The synthesis of the findings from the three studies has highlighted the way in which the different themes identified lie across multiple constructs of NPT, see **Figure 8.1**. This demonstrates how those different elements are not linear, but rather interrelated and can coexist during the process of implementation. The use of NPT provided a deeper understanding of the implementation process, focusing attention on how individuals think, engage, work and monitor the accreditation programme. It also enabled the identification of barriers and facilitators, highlighting several important associations. First, coherence (understanding the programme) is linked to training and education, which is part of the work of accreditation (collective action). Second, individuals' engagement (cognitive participation) can be influenced by understanding the programme (coherence) and the potential benefit of accreditation (reflexive monitoring), as well as by taking part in training (collective action). Third, the availability of resources and the appropriate infrastructure (collective action) influence the engagement of individuals in the programme (cognitive participation).

This allowed a better understanding of the NAP implementation in general hospitals in Kuwaiti setting, and highlighted the important changes that could be made to enhance a more successful implementation.

Figure 8.1 Conceptual model of accreditation implementation process mapped across NPT constructs

| Understand accreditation process | Engagement with accreditation process | Work of accreditation | Impact of accreditation |

Knowledge and skills / understand standards

Prior experience in accreditation

Professional attitude / engagement and participation

Good-working relationships

Leadership

Resources

Training and education / Adaptation of standards

Infrastructure

Organisational / individual and interpersonal impact

8.4 Strengths and limitations

Strengths and limitations pertinent to each study in this research have been discussed in the results chapters (Chapters 5, 6, 7). In this section, a broader discussion of the research design in relation to adopting a multi-method qualitative approach is presented.

The multi-method qualitative approach, as discussed in Chapter 4, incorporated a systematic review, a qualitative analysis of accreditation reports, and interviews with self-assessment team members. Undertaking this comprehensive research design has been

challenging in many ways to the researcher. It required the researcher to be familiar with all those methods, and to build a good knowledge base to accomplish the research as best as possible.

There are limitations inherent in the qualitative research domain as previously described in Chapter 4, and certain measures are required to establish rigor and comprehensiveness. The validity of the study was enhanced by utilizing multiple sources of evidence and the three study approaches. The findings were triangulated across the three studies and incorporated in the Discussion Chapter. Another way to help enhance the validity is by the use of a robust theoretical framework (O'Donnell et al., 2011). NPT informed the research design and the systematic review analysis, and even though this theory has been applied across a range of healthcare related issues, this is the first study to apply this theory to the implementation of a healthcare accreditation programme in the hospital setting. The use of theory added strength to the findings and aided in identifying and understanding the different influential factors within the Kuwaiti context. However, applying a theoretical framework directly to the analytical process can lead to accusations of data being 'shoe-horned' to fit the theory selected.

To address this potential limitation, the researcher approached documentary analysis and interviews analysis from a different angle, using thematic analysis in these two studies. This was decided to ensure that all the data is captured and to balance the arguments that claim by using a pre-determined theoretical framework the data is shoe horned into the constructs. This analytical triangulation helped to address the different views and enhanced the understanding of accreditation from many perspectives, thus it was a clear strength of the study.

Another possible limitation in this study is the potential bias of the researcher due to her prior knowledge and experience gained from working in accreditation for many years. Careful and meticulous planning throughout the process of research aimed to minimize such effect, but it is an issue to be recognised and acknowledged.

A further limitation of this study was removing observation from the research methods. The initial research protocol at the beginning of the PhD included observation as one of the

data collection methods to be used along side the others. However, as the research progressed, this approach was eventually discarded due to two reasons. First, the timeframe of the PhD did not serve this choice because of the multi method qualitative approach, which was overwhelming and demanded a lot of work. Second, the environment in Kuwait is not familiar with such approach, and so I was hesitant to pursue this because I thought that the participants might feel self-conscious and behave differently.

There were certain difficulties regarding data collection, and the fieldwork experience in Kuwait was a challenge because of the time frame of the interviews. The process of data collection was interrupted by the emergence of the month of Ramadan, and that meant the working environment was slow. This was followed by the summer months where many employees were on vacation. So even though the interviews began in April, the process stopped for three months (June, July, August) and it wasn't until September that the fieldwork resumed. It is also important to note the limited resources (time, manpower) for the research, which made it difficult to pursue further data collection methods or other data sources.

8.5 Implications for policy

The process of accreditation in Kuwait is still a recent intervention. However, one recommendation from this research is to establish a monitoring system within the Ministry of Health to assess the implementation process continuously. Recognising the gaps that affect a successful implementation helps to identify which should be targeted and aids in improving the process. Obtaining the feedback of employees is also important in the evaluation of the programme, because they represent the first line in implementing the Standards and so they can provide helpful insights. The monitoring system, for example, can be in the form of a ministerial committee and the members assigned include representatives across different levels in the ministry, like self-assessment team members; surveyors; quality physicians; middle administration (Quality and Accreditation Directorate); and the head of the Accreditation Higher Committee.

Knowledge of the accreditation programme and its elements is crucial in accepting and engaging with the implementation process. Reassessment of the educational programme is preferred by reviewing the content, timing and outline of training, to ensure the sessions are targeting the audience requirements and needs. More effort must be put towards designing a better educational programme, and due to the large number of participants, one of the ways to help in enhancing the knowledge is to implement *train the trainer* approach, where the participants develop the knowledge and the skills to be able to transfer this knowledge to their organisations.

Leadership is clearly important – this should be emphasized and those leading the programme need to know that they are a role model for the employees, motivating them to believe in the intervention. Targeted efforts to engage the leaders and key personnel in the hospital and elicit their commitment are encouraged. Also educational programmes that address leadership competencies are essential. For example involving them in personalised training sessions, like communication skills, the science of teamwork, and change management could encourage their full participation in the programme.

Further, the programme could benefit from an accreditation agenda that aims to estimate the resources needed for accreditation implementation, like staff and budgets, and develop a plan to reinforce the programme with resources to help the hospitals in implementing the Standards, and to encourage the staff with financial incentives.

8.6 Contribution to knowledge and originality of the research

As noted above, the specific aim of this research was to investigate the implementation of the accreditation programme in Kuwait from the multiple perspectives of the healthcare professionals involved. The research makes the following contributions:

- This study responds to the gaps identified in the literature about accreditation programmes, and the recommendations of researchers who concluded the need for more research in this field (El-Jardali, 2006, Shaw et al., 2010a, Greenfield et al., 2012, Mumford et al., 2013). This is the first study of the kind to be conducted in Kuwait, and so it contributed to the body of knowledge of healthcare accreditation

by bringing to light valuable insights into the process of accreditation implementation and the associated potential impact of the programme within the Kuwaiti context and more specifically the public sector of the healthcare.

- With reference to the specific area of implementation, there is a lack of empirical studies addressing the process of implementing accreditation, and more research is called for with emphasis on the perspective of the people most involved (Braithwaite et al., 2010, Hinchcliff et al., 2013). This study sought to identify the influential factors that promote or hinder the implementation of accreditation by an in-depth and robust methodological and theoretical approach, from the perspective of the self-assessment team members, who are central to the process, thus making significant contribution to knowledge.

- This research has adopted a multiple method qualitative approach, guided by Normalisation Process Theory, which enhanced the understanding of such a complex intervention and investigated the degree of success of implementation by identifying the barriers and facilitators encountered. This research is considered the first to use this approach within the field of healthcare accreditation, and thus, provided a unique insight to the body of knowledge internationally and in particular locally in the Middle East region.

8.7 Opportunities for future research

A number of recommendations are presented for future research in conclusion to this study:

- This research was limited to two sites, clearly there is an opportunity to extend to other similar settings, to investigate if the findings from this study are elicited elsewhere, in Kuwait, the Middle East, and other countries. The replication of this study across multiple sites however, requires a group effort from a number of researchers.

- This research could be repeated in the same sites after another cycle of accreditation in order to investigate any change or development in the process of implementation, and whether the identified barriers in this research are still persisting or have been rectified.

- An important future step in the exploration of accreditation implementation is to conduct observational studies combined with other methods. This was not feasible in this research due to the time limit of the PhD. An on-site observation approach would help the researcher become familiar with the sites, gain knowledge about the physical context of the hospitals, and understand how individuals interact, organise, and act within the hospital setting.

- As this research adopted qualitative approach and reflected professional views and perspectives, further work is required to assess the potential organisational and individual impact of the NAP through a survey, performance indicators, or routine data analysis. However, in attempting to progress research in evaluating the impact, it should be acknowledged that accreditation in Kuwait is still relatively in its early stages, and the effect of accreditation might not be seen directly after implementation. Taking into account that the hospitals completed the second cycle of accreditation in 2017, it might prove useful to assess the impact of accreditation.

- Another area of research is to explore the views and experiences of the QP assigned in all the hospitals, with the particular interest of exploring the implementation process from their perspective. This study has identified the centrality of the QP in terms of leadership, knowledge, and support, thus it comes to reason they would add valuable information relating to accreditation implementation.

- Finally, in order to progress research in this field, addressing the views of the accreditation surveyors might also provide an alternative perspective into the process of implementation. It might also enhance and elaborate on the findings from the accreditation reports, by eliciting their reflection on the recommendations.

8.8 Summary

This research used qualitative multiple methods to explore the implementation of accreditation programme in Kuwaiti hospitals, from multiple professional perspectives. Integrating the findings from those methods revealed a range of conclusions presented in this chapter, related to accreditation implementation process. Built upon those conclusions a number of implications for the policy were presented. It has also listed the limitations inherent in this research design, and also served to highlight the contribution of this research and the possible opportunities for future research.

Personal Reflection

'The cure for ignorance is to question'
Prophet Muhammed

The last four years have been an unprecedented experience for me. I started my PhD journey just days after the New Year in 2014. I embarked on this experience with prior research skills from my Masters Degree, however, those skills were greatly enhanced and new ones were gained as a result of the current research.

Year one-the beginning

'A good beginning makes a good end'
Louis L'Amour

This year represented the most difficult phase in my entire journey. I decided to pursue my dream in higher education by applying for a PhD programme in Public Health at the University of Glasgow. After receiving the final decision from the University that I was accepted, I then applied for a scholarship from the Ministry of Health in Kuwait on October 2013, which was after the deadline. The chances were slim for me, until I got a call from the scholarship department to inform me that my application had been accepted due to one withdrawal from the programme and so, one chair became available. Now everything was on the right path, but this brings me closer to the day when I will have to leave my children, husband, and family to begin this trip to Glasgow. Indeed, from a personal view, this was the most challenging thing I had to overcome.

It took me a couple of months to settle in, and the introductory meetings with my supervisors commenced regularly. The topic of my research was 'healthcare accreditation'. I have chosen to focus on this subject because I have been working in the accreditation department in the Quality and accreditation Directorate since 2003, and I have much interest and experience in this field.

I gained so much from attending lectures in the university about different domains, such as the knowledge and intellectual abilities, personal effectiveness, and research governance and organisation. I was introduced to a wide knowledge of many important theories, and in successful writing workshops, good approaches were demonstrated and helpful tips were pointed out which were useful in writing assignments or constructing the thesis. The qualitative research lectures were useful because I was planning to use the qualitative approach in my research. Useful information was presented in regards to key requirements and procedures of the research process.

Also issues about the ethical approach were discussed and clarified, pinning down the steps and requirements to apply for an ethical approval. Those workshops provided excellent skills in time management, professional involvement, and problem solving. They demonstrated practical solutions and ideas and I have benefited from sharing experiences with others and exchanged valuable knowledge.

Meanwhile, I continued developing the most appropriate research methodology for my PhD, which represented the foundation to build on, through the guidance and support of my supervisors. I revisited my research objectives that I initially started with, and they were refined and slightly changed. This was mainly due to reading a large amount of relevant articles that helped to shape my focus. I started with conducting a systematic review - a first time experience for me, but it helped me to develop a fuller understanding of my topic and illuminated key issues, which then guided my next two studies (documentary analysis and interviews). I had to prepare well for every stage of the systematic review by reading and meeting with the librarian for practical sessions. The critical appraisal lectures were really informative and helped me during the quality appraisal of the articles in the systematic review.

The other important event in this year was to finalize my research protocol and apply for ethical approval from the Ethical Committee in the Ministry of Health in Kuwait. After some corrections to the protocol I received ethical approval just days before the year 2014 ended.

Year two- the adaptation

''No one plows the field just by thinking about it''
Ljupka Cvetanova

I started year two really excited because I had the approval from the University of Glasgow on my Furth of Glasgow application to pursue my data collection in Kuwait. Being away from my family has been difficult on me and also on them, but they have learnt to carry a certain degree of responsibilities and attain personal growth.

I attended training on Good Clinical Practice for non-drug trials before travelling back home, and it outlined several key issues in the principals of good clinical practice. Also it covered many ethical aspects necessary in any research, like the rights and safety of participants, consent forms, confidentiality, and the quality of every aspect of a research study.

Gaining access to both sites was not an obstacle and I received full cooperation from the quality physicians and the hospital Directors. In fact, in the first site and on the first day of interviews, the hospital Director came to introduce himself and offer his full support. I appreciate the tremendous effort from both QP towards helping me in selecting the participants and then organising the time schedule and the appropriate setting to conduct the interviews. In the first site there was a meeting room set up to do all the interviews and this meant I would stay in one place and the participants would arrive according to a schedule. On the second site, however, the process was done the other way around. The interviews were conducted at the participants working environment, which, in my opinion was a better approach than the first and had the following advantages: first, going through the different hospital departments was like a tour for me, which allowed me to observe the working environment from the accreditation perspective; second it was a suitable opportunity for the departments to show some of their effort in implementing the standards and a couple even took me into the ward to illustrate the many initiatives they implemented because of accreditation.

All the participants were employees in the hospitals and had daily duty obligations they were committed to. This made it challenging for the researcher and the QP to arrange time slots for the interviews and to integrate it with their daily activities, especially when they thought that this was an extra burden and they were already very busy with their primary work. Also, some interviews were interrupted a few times because the participant was needed for some urgent matter or quick consultation.

I also had the opportunity to submit an abstract for the Quality and Safety Forum in London in 2015, and I was really thrilled when it was accepted. Attending the Quality and Safety forum enriched my horizon by attending many lectures and workshops that reflected skills and practice from a variety of backgrounds. Presenting my systematic review as a poster in the conference was a positive experience for me. Designing the poster was really interesting and answering queries from the attendants helped me develop good communication skills.

Year three- the growing

> *"What ever the mind of man can conceive and believe, it can achieve."*
> *Napolean Hill*

Entering my third year the process of data analysis of the second and third study started, coupled with writing Chapters. The qualitative data was large and messy, but I managed to organise it in files. Theoretical framework analysis for the systematic review and thematic analysis for the documents and interviews was conducted and at the beginning it was a bit confusing to turn those whole and complete interview transcripts and accreditation reports into bits of codes. The data extraction phase was extensive, time consuming and complex, as the amount of text to be coded was significant. The help and support of my supervisor (COD) added strength to data extraction, as she used this theoretical approach previously and all the data were double coded by myself and (COD) to avoid and possible bias and resolve conflicts.

The use of Nvivo software was strength in this study, because it helped to organise the process and provided detailed reports, which proved useful while writing the results. Also the software made it possible to access the data anytime anywhere.

When the data analysis was finally completed I needed to place it all in front of me for clearer view and comparison. I printed out and stuck it on a large piece of poster paper and color-coded each theme and subtheme for more clarity.

I have relished the importance of having time for myself to work alone and focus, but as importantly, share my ideas and progress with others to get a different perspective.

Year four- the end

> ***''Ultimately, education in its real sense is the pursuit of truth. It is an endless journey through knowledge and enlightenment''***
> ***A. P. J. Abdul Kalam***

Entering year four, several drafts of Chapters were already completed and many improvements were done based on the feedback of my supervisors by directing me to some key points and important papers to look through. The writing process was like a brain exercise, where I would have to organise the material in my head and write it the best way I can, especially since English was not my first language. Some days I would end up writing only 250 words, but I would be really satisfied and happy because still it is considered a step forward.

The thesis outline was amended several times by adding or removing sections. I think this was normal or I might even say necessary, because the further I progress in writing the clearer the outline becomes.

Once I completed all the Chapter drafts and combined it in one document I started to feel the journey was almost coming to an end. I was really proud of myself for being able to accomplish all this at my age and despite some inevitable difficult moments I kept on going and never for one moment did I regret my decision to pursue this Degree.

In the end I could say that each aspect and stage of this research has taken me through different challenging experiences and many valuable lessons that, combined together, helped me grow both personally and academically.

'' The important thing in science is not so much to obtain new facts as to discover new ways of thinking about them''

Sir William Bragg

Appendices

Appendix 1 Search strategy for the systematic review

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2. limit 1 to (human and english language and yr="2003 - 2013")

3. Joint Commission on Accreditation of Healthcare Organizations.mp. or *accreditation/

4. limit 3 to (human and english language and yr="2003 - 2013")

5. *health care quality/ or *health care policy/ or health care planning/ or *patient satisfaction/ or *organization and management*/ or *health service/ or primary health care/ or primary health care services.mp. or health care delivery/

6. limit 5 to (human and english language and yr="2003 - 2013")

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9. 8 and "accreditation".sa_suba.

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Final round medline 210 hits

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Meeting with HeatherWA

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1. accredit*.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]
2. limit 1 to (english language and humans and yr="2003 - 2013")
3. Joint Commission on Accreditation of Healthcare Organization.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique Identifier]
4. limit 3 to (english language and humans and yr="2003 - 2013")
5. 2 or 4
6. primary health care.mp. or *Primary Health Care/
7. limit 6 to (english language and humans and yr="2003 - 2013")
8. *Primary Health Care/ or primary health care services.mp. or Health Care Reform/
9. limit 8 to (english language and humans and yr="2003 - 2013")
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Meeting with HeatherWA

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Appendix 2 Scoring sheets used for systematic review papers

a) Systematic review scoring sheet – Prisma

Were the inclusion and exclusion criteria clearly stated and reasonable?	Yes Can't tell No Score	Were all information sources and date last searched clearly described?	Yes Can't tell No Score
Was the full electronic search strategy presented for at least one database?	Yes Can't tell No Score	Was the process for selecting studies clearly stated?	Yes Can't tell No Score
Was there any measure to reduce selection bias?	Yes Can't tell No Score	Was the method of data extraction from articles well described?	Yes Can't tell No Score
Was there duplicate study selection and data extraction? (Two reviewers)	Yes Can't tell No Score	Were the results clearly presented?	Yes Can't tell No Score

b) Qualitative research scoring sheet – CASP

Was there a clear statement of the aims of the research?	Yes Can't tell No Score	Is a qualitative methodology appropriate?	Yes Can't tell No Score
Was the research design appropriate to address the aims of the research?	Yes Can't tell No Score	Was the recruitment strategy appropriate to the aims of the research?	Yes Can't tell No Score
Was the data collected in a way that addressed the research issue?	Yes Can't tell No Score	Have ethical issues been taken into consideration?	Yes Can't tell No Score
Was the data analysis sufficiently rigorous?	Yes Can't tell No Score	Is there a clear statement of findings?	Yes Can't tell No Score

c) **Descriptive research scoring sheet**

Study design Randomizes controlled trials Cohort Case-control Cross-sectional Survey Descriptive analysis Interrupted time series Other, specify	Was the study described as randomized? Yes No	If YES, was the method of randomization described? Yes No Score	Was the research question clearly stated? Yes Can't tell No Score
Was the source of cases identified? Yes Can't tell No score	Are the individuals selected likely to be representative of the target population? Yes Can't tell No Not applicable Score	What percentage of selected individuals agreed to participate? 80-100% 60-79% Less than 60% Can't tell Not applicable Score	Were the numbers of individuals at each stage of study clearly reported and explained? Yes Can't tell No Not applicable Score
Was the duration of study clearly stated? Yes Can't tell No Score	Was there any pilot phase? and changes made were clearly explained? Yes Can't tell No Not applicable Score	Were there any efforts to address potential sources of bias? Yes Can't tell No Score	Was the analysis method described clearly? Yes Can't tell No Score

Appendix 3 Study Protocol

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National Accreditation Program of Health Services in Kuwait, challenges and barriers.

Background:

Accreditation comes from the Latin word credito, meaning trust (ALstete, 2007). Accreditation is a phenomenon which is receiving considerable attention, and It became a wide spread method internationally and has been adopted by many health systems around the globe (Braithwaite et al., 2006).

Hospitals accreditation emerged in Kuwait as a government initiative, by establishing the Quality and Accreditation Directorate (MOH, 2011), that lay it's principals in the ministerial decree 358, of 2001. It was one of the first initiatives in accreditation among other countries in the area, preceded only by Lebanon (Kronfol, 2012). World Health Organization Regional Office the Eastern Mediterranean (EMRO) stressed upon the importance of establishing national systems to support healthcare accreditation in the Middle East (EMRO, 2003).

While mostly considered a voluntary process, healthcare accreditation in Kuwait is a ministerial requirement initiated by the government.

Rationale:

The beginnings of the national accreditation program (NAP) in Kuwait have indeed been basic and low scale (MOH, 2001). Nevertheless, the program became more extensive, gained increased momentum and rose to the international standards starting from 2008 by the signing the first contract with Accreditation Canada for a period of two years. Accreditation Canada (formerly known as The Canadian Council on Health Services Accreditation---CCHSA) is a national, non-profit, independent organization created in 1958 (Touati and Pomey, 2009). The first contract ended successfully in achieving the required objectives, which are, first, the development of customized standards

</div>

specifically for Kuwait, and second, the recruitment and training of 40 surveyors (MOH, 2008). Accordingly, the affiliation was renewed between the ministry of health and Accreditation Canada. However, this contract reflected a wider scope, with larger scale of objectives and runs through a period of six years starting from 2011 (Accreditation Canada, 2011).

Under the umbrella of Accreditation Canada, the National health care standards for hospitals were modified and amended from their original state. Indeed the shaping is inevitable according to the country's needs and limitations, and as Fortes et al., (2011) described it as a political proposal of health service qualification.

It is noteworthy to mention that both contracts have cost a total of 4,134,939 Canadian dollars. Under such circumstances, the outcome of the hospitals who completed the first cycle of accreditation have not been as expected, but rather out of the 9 hospitals surveyed up to this date, only two organizations had the privilege of a substantial accreditation status. Indeed this is rather disappointing.

The first cycle of accreditation ends in the last quarter of 2014, which will be suitable to the timeframe of my study.

In this regard, it would be interesting to identify the reasons for this outcome by exploring the literature and designing the best research method.

Aim:

- To evaluate the impact of accreditation on healthcare services.
- To investigate and identify the challenges and barriers of the NAP, related to Micro, Meso and Macro levels of the system.

Research questions:

1- What are the challenges and barriers affecting the implementation of the (NAP) in Kuwait?

2- How do these challenges and barriers affect the implementation of the (NAP)?

3- Is there a common non-compliance of the standards among the hospitals? And if there is, why it exists?

4- What are the challenges and barriers that are specific to the Kuwaiti environment and system, if any, and why they exist?

Research methods:

- **Systematic review**:

* **Case Study**:

* Empirical inquiry that investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used (Yin, 2014).

* **Tools**: Interviews, Documents review (accreditation reports), observation

* **Sample:** The sample will include: quality physicians and self-assessment teams.

Appendix 4 Word Document organising data extracts for each hospital

Hospital ■■■

Areas for improvement:

Team Name: Emergency

Triage system needs to be reviewed and standardized among all casualty areas.

The patient and family need to be informed about approximate waiting times on ongoing basis.

The team is encouraged to continue to review their physical facility while they are waiting for the new hospital.

The team is encouraged to implement all the patient safety required areas according to the standard.

Team Name: radiology

Recommend better communication of the results to other service areas within the hospital.

Involve staff members of the team "at all levels" to participate in training for patient safety.

Team Name: Environment

The organization is highly recommended to practice evacuation drills and fire safety training for the staff in all areas of the organization.

Central warehouse for medical waste.

Appendix 5 Final coding framework for the documentary analysis

Theme	Sub-theme	Category	Example of codes
Engagement with accreditation process	Good-working relationships	Organizational/interdepartmental communication	Communicate with other departments, better communication with other care givers, Communication between Lab and hospital
		Teamwork	Involve other departments, professional interaction,
	Participation and enrollment		Involvement of more people in the quality and safety plan, more involvement of staff in risk assessment and patient safety
Work of accreditation	Adaptation of standards	Plans policies and guidelines	Job description, develop strategic plan, performance indicators, quality and safety plan
		Patient safety required areas	Hand hygiene, medication reconciliation, concentrated electrolytes, safe injection policy
		Process of care	Organise crash cart, include therapeutic services, establish triage system,
	Infrastructure	Physical environment	Emergency exits, lack of space, Increase storage facility
		Workplace safety	Improve security against aggressive people,
		Information systems	Electronic records, computerized system, need for Hospital Information System
	Training and education		Orientation programme, training and continuing education for staff, train all staff members in patient safety
	Resources	Human	Increase staff, understaffed,
		Financial	Establish dialysis unit
		Time	More time should be allocated for the self assessment,
	Administrative system		Encourage collaboration with the primary care

Appendix 6 Participant Information Sheet

University of Glasgow

Participant Information Sheet (PIS)

Study Title: **Implementing a National Accreditation Programme in Kuwaiti hospitals: Understanding the impact, challenges and barriers using a multiple methods approach**

Researcher: Dr Azari Alhaleel

Please read this information carefully before deciding to take part in this research. If you are happy to participate you will be asked to sign a consent form.

What is the research about?

Given the importance of healthcare accreditation system for ensuring the quality and safety of health care, there has been an elaborate need for the assessment of this external evaluator system in the literature. This study aims to explore the National Accreditation Programme for the hospitals in Kuwait using selected theoretical model. It pursues to enhance our understanding of what impacts this programme conveys and what are the barriers that impedes its' implementation.

Why have I been chosen?

Hospitals' self-assessment teams are the most involved and knowledgeable people in the hospitals towards this National Accreditation Programme.

What will happen to me if I take part?

The data collection will probably take around six/eight months and you will be involved in a few face-to-face interviews, conducted by the researcher. A short introductory session will include explanation of the plan of the interviews and ask about the extent of your involvement in the accreditation of your hospital. Each interview will last about 45 minutes.

Are there any benefits in my taking part?

There is no tangible benefit for your participation; however, the experience of participating in the research process might be useful for you.

Will my participation be confidential?

The gathered data will be kept strictly confidential. Your name and your hospital name will be immediately coded when each interview is transcribed. The audio recordings, if you agree, will be kept only with the researcher in the password protected computers and will be destroyed in compliance with the Data Protection Act and University of Glasgow policy, after the end of the current research. Only the researcher will have the access to data collected during the course of the research.

What happens if I change my mind?

You are completely free to withdraw yourself from the participants of this study whenever you want

In the case of any concern you can find my details below:

Dr Azari Alhaleel
Mobile:
Email: aalhaleel@yahoo.com

Appendix 7 Participant Consent Form

University of Glasgow

Consent Form

Study title:

Implementing a National Accreditation Programme in Kuwaiti hospitals: Understanding the impact, challenges and barriers using a multiple methods approach

Researcher name: Dr Azari Alhaleel

Please tick the box if you agree with the statement(s):

I have read and understood the information sheet and have had the opportunity to ask questions about the study ☐

I agree to take part in this research project and agree for my data to be used for the purpose of this study ☐

I understand my participation is voluntary and I may withdraw at any time without my legal rights being affected ☐

Signature of participant ....

Name of Researcher...
Signature

Date..

Appendix 8 Interview Schedule

Implementing a National Accreditation Programme in Kuwaiti hospitals: Understanding the impact, challenges and barriers using a multiple methods approach

Interview schedule

(The sentences in italic are not part of the conversation or questions)

The interview will be semi-structured in format and will allow the participant to reflect in length about their views and experience of accreditation.
All participants took part of the accreditation self-assessment teams of the hospital.
1-2 members of each self-assessment team chosen.

Introduction:

(In the day of the interview) Thank you for meeting me today. *(Give my complete name and identify my self as a researcher)* Are you still happy and willing to participate in the research? *(Emphasize the following points to them)*
- I would like to record the interview, if it's OK, because it will help me remember more accurately what we talk about today. I assure you the recordings will be confidential and I will not be playing the recordings to anyone else.
- All the materials will be anonymous and no real name of you or your hospital will appear in the context of my research.
- We can stop whenever you like. Please just let me know and we can finish the session.

(They were provided with a consent form before the interview)

General

1- In your own understanding, can you tell briefly what is accreditation?
2- Looking back, what was your overall impression of the accreditation process?
3- What improvement in the quality and safety in the service, if any, do you think accreditation is producing?
4- Do you think there are barriers to implementation of accreditation in your organization?
5- What are these barriers?

Main body

1- What do you think are the main values, mission and vision of the hospital? And how does the accreditation programme meet them?
(Give a brief about the mission and vision of the organization as a reminder)

2- Did you understand the process of accreditation implementation? And was your role in it clearly stated?

3- Are the standards comprehensible to you? *(Probe for difficult standards)*

4- When you needed clarifications about the process or your role in it, did you get help from others? (Quality physician, coordinator, self-assessment team member)

5- How does the accreditation standards meet your daily activities in the hospital? And would you encourage others to participate and be part of the accreditation programme?

6- How did you come to be involved with accreditation?

7- Did you need any training to be part of the accreditation team? And how was it delivered?

8- Do you think the standards are relevant to your daily activities in the hospital?

9- Do others (quality physician, self-assessment member, coordinator) share their learning with the involved groups?

10- How easy/ difficult was it to implement standards?
(PROBE: give some examples of standards difficult to implement)

11- Were all the documents required by the standards available? If not, what was done to provide them?

12- Did the self-assessment team manage to meet according to the planned schedule?
(PROBE: ask about the attendance, the team members consistency)

13- Has the accreditation process enable the organization to better use its' internal resources? *(Financial, time, people, equipment)*

14- In your opinion, did the accreditation process enable the motivation of staff and encourage teamwork and collaboration?

15- Has working with accreditation been a positive experience for you personally?

16- What has been the best and worst experience you encountered during the implementation?

17- Would you recommend other hospitals to participate in the accreditation programme?

Close of interview

I have asked all the questions I wanted to ask you. Are there any issues you would like to mention, which I haven't covered?

The researcher:

- *Thanked the participant*
- *Provided her contact details for any possible questions*

Appendix 9 Final coding framework for the interviews

Theme	Sub-theme	Category	Example of codes
Accreditation meaning	Accreditation meaning		System of audit, tool to evaluate the quality of the services, a privilege.
Understanding the accreditation process	Knowledge and skills		They are not oriented with the benefits of accreditation, still don't fully understand, strange thing for me.
	Understanding the standards		Some of them really could mean several things, Some was more difficult, Some points where hard.
	Prior experience in accreditation		I was involved in the ISO certification, I know about accreditation since ten years
Engagement with the accreditation process	Professional attitude		Difficult to change minds, doctors are the first barrier, this was just extra work.
	Participation and enrolment in the accreditation process		We have to really stimulate people, convincing the people to participate, how much would you get the people interested and motivated.
	Good working-relationships	Organisatonal/interdepartmental communication	We don't have any communication,
		Teamwork	Solved by the team work, The cooperation was very good
	Leadership	Key personnel	Role of quality officer,
		Senior support	More involvement from the Heads of the Departments, support from the administration, our director is helpful
The work of accreditation	Resources	Human	Needs more personnel and manpower, we are short of staff
		Financial	No incentives, no rewards, they should be awarded, there is no budget
		Time	I believe the time does not allow us to do lots, I am doing a lot of my work out of the hospital at home.
	Training and education		I attend many lectures outside and inside hospital, I went to workshop for quality, there were no training courses.
	Infrastructure	Physical environment	Big problem in our space, There was objection of the casualty because it is one room.
		Information systems	Hospital information system is not completely compatible
	Administrative systems		The process above this level was too long, we struggled getting it approved.
	Adaptation of standards		It was not easy to implement standards, some points are not applicable to our community
The impact of accreditation	Organizational impact		we save consumption of examination, create a healthy and comfortable environment, I don't think there is a lot produced.
	Individual and interpersonal impact		A positive experience, The awareness has definitely increased, tremendous learning experience.

Appendix 10 Ethical Approval

a) Ministry of Health, Kuwait (translated to English)

Al-Diwan Translation Ce:

E-mail : diwan_translation@hotmail.co

Date: 13/01/2015

Ref.: 34628

Dear Mr./ Dr. Undersecretary   Respectfully,

After greetings,

Subject: to facilitate task of the researcher Dr. Azari S AL-Haleel, for conducting the research No.(199/2014) under the title " national accreditation program for the hospitals, it's impact challenges and barriers ".

Kindly be informed that according to the recommendation decided by the permanent committee for coordination health and medical researches, formed by the ministerial decree No.207 for year 2012, during it's fifth meeting conducted on Tuesday 25/06/2013, related to the method of checking the requests of researches which not include making any examination, interventions, or giving any medications for the patients, and by studying request and protocol of the research submitted by the researcher Dr. Azari S AL-Haleel, on date 31/12/2014, under title of "national accreditation program for the hospitals, it's impact challenges and barriers ".

As opinion of Mr./ Assistant undersecretary for the legal affairs has been obtained, and he declared by the letter No. ‏وم/ش ق/ 21/31 on date 07/01/2015, that there are some remarks related to the informed decree, as the researcher has amended the decree and then attached the modified decree with her incoming letter under No.26066 on date 12/01/2015.

Which performed by conducting interviews to collect the required information from Doctors, and staff working in the hospitals subject to the national program of accreditation with health care's quality in state of Kuwait.

Consequently, we are recommending with approval to perform the research by conducting the interviews, with the commitment from the researcher's side to maintain the rights of participants in the research, including privacy, confidentiality of information and not use this information for any purpose outside the research's scope, in addition, obtaining the prior informed consent of participants by using the approved form for this purpose.

Kindly be requested to review and decide the suitable procedures to communicate with the concerned authorities

مركز الديــوان للترجمة والطباعة والتصوير

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مترجمون محلفون ومعتمدون من قبل جميع الوزارات والسفارات في الدولة وبكافة اللغات العالمية
SWORN TRANSLATORS SPECIALIZED IN ALL APPROVED LANGUAGES AUTHORIZED BY ALL EMBASSIES & MINISTRIES

related to the research's subject (Messrs./ Managers of healthy regions and hospitals, and Mrs./ Dr. manager of quality and accreditation department) for the purpose related to facilitate the researcher's task to conduct the study according to the procedures regulating that.

Thanks and best regards.

Dr. Gamal Mansour Al-Harbi.

The Assistant Undersecretary for the assistant medical services.

Head of the permanent committee for coordination healthy and medical researches.

b) MVLS Ethics College Committee

University | College of Medical,
of Glasgow | Veterinary & Life Sciences

20 February 2014

Professor Kate O'Donnell
General Practice & Primary Care
Institute of Health and Wellbeing
College of Medical, Veterinary & Life Sciences University of Glasgow
1 Horselethill Road
Glasgow G12 9LX

Dear Professor O'Donnell

MVLS College Ethics Committee

Project Title: **NATIONAL ACCREDITATION PROGRAMME OF HEALTH CARE SERVICES IN KUWAIT; IMPACT, CHALLENGES AND BARRIERS**

Thank you for forwarding to the MVLS Ethics Committee the application documents and letter of ethical approval for the above project from the Kuwaiti Ministry of Health.

It is normal practice for overseas projects to require full ethical review by both local and a University of Glasgow College Ethics Committee. However, having reviewed all the documentation, it is clear that the ethical approval process applied in Kuwait is just as rigorous as the one we employ here. Indeed, the key documents relating to informed consent (participant information sheet and consent form), have been modelled on the MVLS templates and procedures. Accordingly, the MVLS Ethics Committee is satisfied that all the necessary ethical safeguards are in place and you and your colleagues now have approval from us to begin your study.

The MVLS Ethics Committee will retain for its records this letter of approval and the documents you submitted to us.

Yours sincerely

Professor William Martin
College Ethics Officer

ApprovalOdonnell.docx

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