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CCHSA: Accreditation: An Instigator for Change and a Motivator for Health Human Resources

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CCHSA ACCREDITATION: AN INSTIGATOR FOR CHANGE AND A MOTIVATOR FOR HEALTH HUMAN RESOURCES

A Case Study of a Health Region in Alberta

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Thesis submitted to the
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In partial fulfillment of the requirements
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LIST OF ABBREVIATIONS

AIM	Achieving Improved Measurement (CCHSA Standards)
AHR	Alberta Health Region
CCHSA	Canadian Council on Health Services Accreditation
CQI	Continuous Quality Improvement
FG	Focus Group
HCOs	Healthcare Organizations
JCAHO	Joint Commission on the Accreditation of Health Organizations
MHA	Masters of Health Administration
QA	Quality Assurance
QI	Quality Improvement
TQM	Total Quality Management

EXECUTIVE SUMMARY

There are many unanswered questions regarding the influence and effectiveness of accreditation programs on healthcare services. Many participants advocate the value of the process and site reform and success experienced as a result of sharing in a program. However, there are many health service providers who have not chosen to participate. This single case study has been initiated as an opportunity to investigate the impact of an accreditation program on a health region and examine the consequences and results of the process on that organization. This study specifically focuses on the impact the process has on teams within the health organization. This report will be used in a broader multi-case study comparison to view similarities and differences in the results of accreditation.

The site of this specific case study was an Alberta Health Region. The accreditation process was undertaken in this region for the first time in the history of the organization under the regional model.

The conceptual framework, which studies the factors that favour change as well as the characteristics of change, was implemented to examine the changes that resulted in the health region as a result of the accreditation process. The methodological triangulation was composed of both quantitative and qualitative data which were collected during the study. Tools used to abstract the data were questionnaires: one to explore and aid in determining the dominant culture in the organization and the other questionnaire to assess the perception of participants regarding the impact of accreditation and the resulting development of a quality improvement program. In addition to these tools, focus groups and interviews were facilitated on site and transcripts of these events were analyzed using qualitative software.

Some of the data collected draws very close ties between the accreditation process and the initiation of new activities in the organization that supports quality improvement. There are references to CCHSA process and its relation to hospital accreditation versus a community based health service. As originally planned, data focuses on the team

approaches involved in the accreditation process and validates previous research findings that support the value of teamwork and a heterogeneous team approach.

As well, information is also reported on the views and opinions of participants in the process and the stage in the accreditation process found to be the most productive.

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FOREWARD

In 2004, students in the Masters of Health Administration (MHA) Program were invited to participate in a multiple case study by a professor in the program who was the lead researcher in the project. These students would write theses, which would contribute to the completion of their MHA Programs. This research project was funded by the Canadian Institutes for Health Research (CIHR), lead by one of the professors on faculty at the University of Ottawa, Marie Pascal Pomey. The results of the research will be used as part of the larger multiple-case study.

CHAPTER I - INTRODUCTION

Over the last decade, more and more Canadians have been receiving devastating reports released by the Auditor General on the mishandling of Canadian funds in the system. Most recently, the sponsorship scandal (which was unveiled in March 2005 in the Gomery inquiry) created quite the uproar with millions of taxpayers dollars unaccounted for (Gomery Commission Website, 2005). As a result, Canadian citizens are taking a more proactive approach and demanding increased accountability of where and how the Canadian taxpayers' money is being spent.

An area that is receiving particular attention is the healthcare system. It is a widely known fact that healthcare is one of the cost drivers in the system. For example, approximately half of the Government of Ontario's budget is channelled to healthcare expenditures. Adding to the already heightened uncertainty of taxpayers, the healthcare system itself has received much negative publicity and attacks regarding patient safety, patient rights, medication errors and adverse events to name a few. Today, Canadians are looking for more than just a certificate, which shows that a certain standard of quality has been achieved (e.g. the Accreditation Certificate). They want **evidence** of good clinical performance, efficiency and safety practices.

Does the accreditation process meet the needs of healthcare organizations? How does it impact an organization's ability to react to change? What are the characteristics of change? Are quality teams really useful? These are some of the questions that will be addressed in this case study on the *CCHSA Accreditation: An Investigator for Change and a Motivator for Health Human Resources.*

The following chapters will provide an overview of the CCHSA accreditation process, a highlight of the overall research study, a review of the relevant research on continuous quality improvement and the usage of teams, and then exploration into the notion that the accreditation process motivates **teams** to develop or to enrich the quality improvement

process in the organization. Finally, linkages will be made back to the overall research project in the discussion section and study limitations outlined.

CHAPTER II - BACKGROUND: THE ACCREDITATION PROCESS IN CANADA

1. THE CANADIAN COUNCIL ON HEALTH SERVICES ACCREDITATION

The Canadian Council on Health Services Accreditation (CCHSA) is a national, non-profit, independent organization whose role is to help health services organizations, across Canada and internationally, examine and improve the quality of care and service they provide to their clients. The CCHSA is founded on the belief that accreditation makes a difference in improving the quality of healthcare in Canada. The mission of CCHSA is "to promote excellence in healthcare and the effective use of resources in health services organizations nationally and internationally in order to improve the delivery of health services" (CCHSA Website, 2005).

CCHSA accredits a wide range of healthcare organizations and has developed different standards and accreditation programs for different healthcare services. They have developed a principle accreditation program and they have some specialty programs for specific types of organizations. Being accredited is a voluntary process in Canada, except for university hospitals and for all hospitals in Québec or in the territories. There is no mandate by the government to be accredited and there is no link to funding for organizations that have been accredited (except for university hospitals, which must have accredited medical programs but the amount is not linked to the accreditation). As at the end of 2001, there were some 1,000 organizations with CCHSA certificates. CCHSA receives its funding through payments made by healthcare organizations participating in the accreditation program. The cost of CCHSA accreditation varies depending on the type and size of the healthcare facility seeking accreditation (CCHSA Website, Safety and Quality Standards 2003). Thus, healthcare organizations voluntarily apply for accreditation and pay a fee for this participation.

There are three parts to the accreditation process: the self assessment, the peer review and the report. The first part involves self assessment. The organization seeking accreditation

measures its own compliance against national standards by forming self assessment teams where participation by frontline staff is encouraged. The team may pre-exist within the organization or they may be assembled to prepare for the survey. Three independent types of teams will be evaluated during the survey including client/patient care teams, teams supporting client/patient care and leadership teams. The key areas that are examined during the accreditation process include client/patient care and the delivery of service, information management practices, human resources development and management, the organization's governance, the management of the environment and the coordination and involvement with the community. The national standards, which all health services organizations are measured against, are developed through consultation with health professionals from across the country and are continually evolving, like organizations involved in quality improvement efforts, to adapt and improve to meet the highest standards of quality.

The second part of the process is the peer review. Once the accreditation self assessment is completed, surveyors from outside the organization undertake the accreditation survey and use the same national standards to independently measure the organization through an on-site survey. This survey offers health organizations the opportunity to have their performance measured by external, objective reviewers. During the on-site visit, the surveyors meet with a broad spectrum of individuals from the organization' environment, including the self assessment teams. Participants are to include, where possible, board members and administrative staff, physicians, human resources people, information management specialists, patients/clients and family members, caregivers and community partners. They all speak with the survey team to discuss their experiences, perceptions and expectations. The surveyors involved in the assessment are from the health field and come from provinces from all across Canada, which brings a wealth of knowledge and experience to the process. The surveyors chosen to evaluate the different health organizations usually are involved in their professional lives in similar health services as those that are undergoing the assessment. As well, it is a requirement that surveyors are involved in ongoing education and evaluation programs to learn and upgrade their skills and knowledge base. Most of the time, the team is composed of an administrator, a doctor

and a clinician. The number of surveyors assigned to each site depends on the size and scope of the organization to be surveyed.

Once the survey is complete, the final part is when the findings are summarized by the surveyors in a written report, which is distributed post accreditation visit. The report focuses on the organization's strengths and weaknesses including ratings against criteria and recommendations for action. Recommendations are made to help the organization develop plans to improve areas which are weak and maintain areas which are strong. There are different levels of standing that can be received, which will determine when the organization has to go through the process again. The longest an organization can go without undergoing another accreditation review is three years (CCHSA Website, 2005), unless granted an extension under special circumstances.

2. Origins of Accreditation: History of Healthcare Accreditation in North America

A system for healthcare accreditation has been in existence in North American for over 50 years. Health services accreditation all originated in the early 1900s when concepts were developed for hospital accreditation by the Clinical Congress of Surgeons of North America. These concepts formed the basis for the Hospital Standardization Program, which was established by the American College of Surgeons (ACS) in 1917 (CCHA, 1967). This set the first minimum standard for hospitals where the requirements filled just one page. Soon thereafter, the ACS began on-site inspections of hospitals. The first manual of hospital standards was published in 1926.

The program began to generate support throughout the United States, and subsequently Canada. In the early 1950's, the American College of Surgeons began negotiating with the American Hospital Association for the takeover of the program because it became too large and complex, with serious financial burden on the College of Surgeons. As negotiations proceeded, more interested parties expressed their desire to participate. Thus, in 1951, the American College of Physicians, the American Hospital Association,

the American College of Surgeons, the American Medical Association and the Canadian Medical Association (representing CCHA) joined to create the Joint Commission on Accreditation of Hospitals (JCAH). The Canadians participated since, at the time, they could not enlist sufficient funds to subsidize a wholly Canadian program and since there had been relationships between the medical and hospital organizations in Canada and United States of America. Thus, JCAH was an independent, not-for-profit organization whose purpose was to provide voluntary accreditation for hospitals in North America. On January 1, 1953, JCAH officially began the task of reviewing hospital reports and granting accreditation (CCHA, 1967). Responsibility for the Hospital Standardization Program was formally transferred to JCAH on December 6, 1952. Back in the 1950s, the accreditation program was designed to ensure a minimum standard of achievement. In 1953, JCAH published its Standards for Hospital Accreditation.

A concurrent process was being adopted in Canada. The Canadian Medical Association had created the Canadian Committee on Hospital Accreditation to develop a similar standardization program for Canada. In 1953, the name was changed to the Canadian Commission on Hospital Accreditation (CCHA), which comprised the Canadian Hospital Association, the Canadian Medical Association, the Royal College of Physicians and Surgeons of Canada and l'Association des médecins de langue française du Canada (CCHA, 1972).

To generate more support of accreditation in Canada, in 1954, it was decided that the CCHA would conduct and finance the majority of Canadian surveys using the Joint Commission standards and survey procedures. As a result, from 1954 to 1958, the number of participating hospitals in accreditation raised seven fold (from 43 to 302). Compared to the United States on a whole, however, the participation of Canadian hospitals in accreditation was low, especially by the smaller Canadian hospitals. As well, JCAH had no standards in the French language and the documentation was becoming inconsistent with the Canadian scene. Thus, an all-Canadian program was still a requirement and the steps were set in motion to create an independent accrediting body in Canada (CCHA, 1972).

In 1958, CCHA was incorporated under federal law. Terms of separation from the Joint Commission were agreed upon in the fall of 1958 and CCHA assumed full responsibility for accrediting hospitals in Canada as of January 1959. At the time, the Council's purpose was to "set standards for Canadian hospitals and evaluate their compliance. The accreditation program was voluntary, free from government intervention, national, bilingual, and not-for-profit" (CCHA, 1972). Upon separation, a decision was made to accept the basic principles for accreditation of a hospital as they were stated in 1958 by JCAH. Council also agreed, in principle, to the Joint Commission's methods of procedure, with the reservations that changes could be made where required for adaptation to the Canadian environment. The Canadian Council agreed that it would recognize the certificates issued by the JC until such time the hospital was reassessed by the Canadian program. As a result of the new Canadian accreditation body, the Canadian Medical Association withdrew its seat on the Joint Commission.

Since separation, JCAH and CCHA proceeded independently but have maintained close relationship. In 1971, JCAH implemented a new set of standards based on an "optimal" concept rather than a minimal concept. Thus, in 1972, the CCHA also adopted its accreditation process with a similar concept. In August 1973, the name was official changed to the Canadian Council on Hospital Accreditation (CCHA, 1977).

Between 1960 and 1988, the healthcare environment increased in specialization and diversification between types of care, thus, CCHA also had to evolve. In 1988, the Council changed its name to the Canadian Council on Health Facilities Accreditation (CCHFA). Also, in 1990, standards documents were revised to focus on structure and process, and begin to look at outcomes and away from only structure. These standards were policy oriented (CCHA, 1986).

As the adoption of quality models became more prevalent, again CCHFA had to evolve to reflect the new approaches to delivery of healthcare. Accreditation systems were accommodating to the broadening of quality models, as the principles went hand in hand with continuous quality improvement (CQI) (Scrivens, 1997). Further movement towards

outcomes was still required. Thus, in 1995, the standards took another shift towards being more client centered (known as CCAP). The revised accreditation program focused on an organization's patient care processes. The philosophy of continuously improving the quality of care and service was also incorporated and organizations were asked to begin developing and using performance indicators, based on the industrial model of quality improvement of the Malcolm Baldrige Quality Award. Also, the Council programs had expanded to a broad range of health services (e.g. encompassing ambulatory, mental health, and even evaluations for comprehensive regional health services). Thus, to more accurately reflect its clients and customers, the Council, once again, changed its name to the Canadian Council on Health Services Accreditation (CCHSA). This new model encompassing CQI put emphasis on teamwork to remove the barriers of structure and the creation of an environment where a team could be fostered (Scrivens, 1997).

3. Accreditation Today in North America

In 1997, once again, CCHSA began working on the development of new standards to emphasize better measurement. In 2001, this resulted in the introduction of a model based on population needs for quality improvement called Achieving Improved Measurement (AIM). CCHSA defines quality in terms of its dimensions or properties. This definition of quality underpins every aspect of accreditation. Each criterion evaluated is linked to one of four quality dimensions, which are responsiveness, system competency, client/community focus and worklife.

The AIM Program is an improved measurement system that enables organizations to measure their clinical and operational performance more accurately, giving them a clearer picture of their strengths and areas where they need to improve. Among other things, the new AIM standards (CCHSA Website, 2005):

- Are expressed as goal or outcome statements. In addition, the criteria under each standard now contain structure, process and outcome requirements, and better enable goals to be met;

- Have a population health focus built into the standards to indicate that all health services organizations bear some responsibility for the health of the populations they serve;
- Use a seven-point numerical compliance scale that has been developed to measure compliance with CCHSA's standards. This is a more consistent and accurate form of measurement that will greatly improve future comparisons between responses and sites;
- Have introduced three focus groups, where surveyors now meet with staff, clients/patients and the organization's community stakeholders;
- Use a risk rating scale, which allows surveyors to make recommendations to an organization in order of priority, helping organizations identify and respond to the most important needs first.

In the United States of America, the Joint Commission on Accreditation of Healthcare Organizations' (changed name in 1987 to reflect the expanded scope of activities) continues to 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 organizations, not just hospitals" (JCAHO, 2005 website). Its purpose remains to act as an independent, not-for-profit organization accrediting body in healthcare in the USA.

The standards used by the Joint Commission address the organization's level of performance in key functional areas, such as patient rights, patient treatment, and infection control, and the standards focus not simply on an organization's ability to provide safe, high quality care, but on its actual performance. Standards set forth performance expectations for activities that affect the safety and quality of patient care.

JCAHO's most recent standards, initiated in February 1997, are part of the ORYX® initiative, which integrate outcomes and other performance measurement data into the accreditation process. It is intended to be a flexible and affordable approach for supporting quality improvement efforts in Joint Commission accredited organizations and

for increasing the value of accreditation. This is still being used and improved today (JCAHO, 2005 website).

As the healthcare industry and quality concepts continue to evolve, so too the accreditation process will have to evolve to provide a framework for measurement of quality improvement. The traditional means of providing healthcare is continually changing as new ideas for patient care are spanning across healthcare systems, not limited anymore to organizational boundaries. A perfect example is the introduction of Local Health Integration Networks, which will facilitate service delivery within regions in Ontario, known as a 'made in Ontario' solution. As will be discussed later, Alberta moved to a regional model in 1995 with the introduction of Regional Health Authorities (RHA). This will continue to present challenges for accrediting bodies to incorporate the philosophy of continuous quality improvement in unique new methods of care provision across the board (Scrivens, 1997). CCHSA is already working on a new version of standards, to be released in the next two years.

4. Benefits of Accreditation in Canada

Studies have already shown that there are many benefits of accreditation. First, accreditation allows organizations to accurately assess their level of performance against a national standard (set by CCHSA and the healthcare industry) to determine where they are in accordance with peers (CCHSA Website, 2005). Pomey et al. (2004) state that accreditation is a means of publicly recognizing that a healthcare organization meets predetermined national standards of operation. Since it is a national standard, it can increase credibility and accountability within an organization since accreditations actually meet a certain standard of quality. As well, having accreditation status can improve public and client recognition of an organization since receiving designation provides a tangible element of a certificate that can be posted on the wall, signifying that a certain standard of quality is met.

Secondly, assessment and validation is performed by external third party reviewers, allowing organizations to obtain valuable advice from peers to improve processes. It also

allows for external surveyors to share best practices and exchange information to improve the processes received by the end client.

Another benefit of accreditation is that recommendations from accreditation reviews are consistently used to make improvements. Evidence illustrates that organizations that participate in the accreditation program over time are increasingly able to mobilize their teams to implement recommendations and adopt a philosophy of continuous quality improvement (CCHSA Annual Report, 2002). "On a perception level, out of the 423 CCHSA accredited organizations surveyed in 2002, sixty four percent (64%) believed that recommendations are important change agents. In more concrete terms, eighty three percent (83%) implemented their report recommendations either fully or partially. In the same 2002 survey, sixty seven (67%) of organizations reported finding deficiencies while comparing themselves to standards during the self assessment process (Beaumont, 2002; CCHSA, 2002)". This same study found that "healthcare organizations with a past in accreditation greater than 10 years had a slightly more developed CQI program than organizations joining the program (Beaumont, 2002)."

Another important study assessing the impact of accreditation on quality of hospital care was performed in KwaZulu-Natal Province in the Republic of South Africa, released October 2003. This study is noteworthy because it represents one of the first randomized control trials conducted to assess the impact of an accreditation process (Shaw, 2001). The study prospectively measured the effects of the COHSASA hospital accreditation program on various indicators of hospital care. The investigators compared the performance of the ten hospitals participating in the accreditation program (intervention hospitals) with ten not yet participating (control hospitals). Results showed that "about two years after accreditation began, the study found that intervention hospitals significantly improved their average compliance with COHSASA accreditation standards from 38 percent to 76 percent, while no appreciable increase was observed in the control hospitals (from 37 percent to 38 percent). This improvement of the intervention hospitals relative to the controls was statistically significant and seems likely to have been due to the accreditation program" (Salmon et al., 2003).

Finally, accreditation is a means (or tool) for influencing the behavior of healthcare staff to bring about change (or reform) in an organization (CCHSA Website, 2005; Duckett, 1983).

Even though there are some findings that have shown some benefits of accreditation, there are still many unanswered questions about the true impacts and value of using the accreditation process as a mobilizer of change. This will be the focus of the overall research study using the Canadian healthcare system as the country under study.

CHAPTER III – TEAMS AND ACCREDITATION: A LITERATURE REVIEW

1. INTRODUCTION

CCHSA defines quality of care as "the degree of excellence; the extent to which an organization meets clients' needs and exceeds their expectations" (National Health Accreditation Results, 2002).

Quality improvement is fundamental to CCHSA's accreditation program. It is defined as "an organizational philosophy that seeks to meet clients' needs and exceed their expectations by using a structured process that selectively identifies and improves all aspects of service" (National Health Accreditation Results, 2002). Quality improvement (QI) continues to be a key principle of the AIM accreditation process. How QI is operationalized at the organizational level is a major component of the literary review which follows, with a focus placed on continuous quality improvement and the use of teams.

2. HISTORY OF QUALITY IMPROVEMENT

When we hear of quality and programming, many different names come to mind: Quality Assurance (QA), Total Quality Management (TQM), Continuous quality improvement (CQI), ISO 9001, the Baldrige process or Six Sigma to name a few.

It has been said that modern quality of care is rooted in the intellectual work of Avedis Donabedian (Donabedian, 1966) who defined quality of care as "a combination of structure, process and outcome". Donabedian proposed this framework to better understand the process of health delivery. This has become the dominant paradigm for the evaluation of quality of care. Structure refers to the organizational structures put in place, such as building, facilities, integration of services and human resources. Processes are the activities that constitute care and management, such as case management and admission and discharge practices; and outcomes are the consequences to health such as morbidity rates and consumer satisfaction (Donabedian, 1982). He also stated that the

degree of quality is the extent to which care provided is expected to achieve the most desirable balance of risks and benefits.

The quality assurance (QA) movement started in the 1970s. QA is defined as "an effort to change or improve the level of care based upon measure of quality" (Larson & Muller, 2003). It began as a management strategy in the business and industry fields, but was soon adopted by healthcare services and in the 1980's became the quality option favored by healthcare organizations and standards agencies (Crawford, 1994). In the 1990s, the trend has been towards CQI or TQM.

The main difference between QA and CQI is that QA aims at conformance with a predetermined standard while CQI is a continually evolving standard. "Using a metaphor from sport, CQI involves raising the bar after each successful jump" (Agyepong et al., 2001). Anita Skok et al. (2000) stated that "an accreditation survey on its own is a good example of QA. An assessment is undertaken and the organization is rated on various service areas. At this stage, recommendations may also be made and the agency re-assessed (e.g., 1 year or 3 years later) against the recommendations. This process provides an assurance (at that point time) of service quality."

CQI expands on the QA concept, containing within it QA activities such accreditation. CQI works at improving quality, however, by continually revising standards against which quality is assessed. It aims to improve the quality of service, not just for the accreditation review but to continually strive towards best practice (Skok & MacMillan, 2000).

Since there are many names of models for quality improvement, for the purposes of this literature review, the focus will be placed on CQI, which is the model and terminology endorsed by the CCHSA.

3. CONTINUOUS QUALITY IMPROVEMENT

The quality of healthcare is a concern for both practitioners and patients alike. Although there is consensus about the need to assure that quality services are delivered, there is much less agreement on how this should be attained. The overall agreement on the characteristics of CQI are similar, however, the translation of these into practice and implementation differ. "The most studied sub-category of quality programs is healthcare programs, particularly TQM and CQI programs. The problem, however, that one can make is that the label of the program is no guide as to what is carried out. Programs with the same names are implemented very differently at different rates, coverage, and depth in the organization" (Øvretveit and Gustafson, 2002).

CQI is one of the most well known quality concepts in healthcare today. CQI is described as "a continuous effort by all members of an organization to meet the needs and expectations of the customer" (Graham, 1995). It was first introduced by W. Edward Deming in Japan after WWII to help the recovery of industries. Another proponent was Joseph Juran who developed a trilogy known as quality planning, quality control and quality improvement. CQI really emerged and was adopted widely throughout Japan in the 1940s and 1950s, where Japanese staff were working continuously to improve quality with the end goal that everyone would benefit. American industry observed its effectiveness and started implementing it in the 1970s and it became a requirement of health accreditations across North America in the 1980s. Now, decades later, the 21st century is being described as the "Century of Quality" (Agyepong et al., 2001).

With CQI, there is a constant pursuit of meeting customer needs and the evaluation of work. This is where the popular slogan "quality begins with the customer" originates. It is a management philosophy targeted at changing the management culture of an organization to achieve quality of service that attains and exceeds the expectation of clients. The philosophy is that QI is the responsibility of everyone in the organization - from top management through to professionals and down to auxiliary and support staff. In essence, CQI emphasizes practical value of ideas which originate from front-level employees and/or direct care providers.

The latest discovery in the health environment related to quality improvement is that the system and processes are seen as the problem and not the people involved. Focus has shifted to finding the root causes and improving the work processes continuously. Very rarely are problems attributed to lack of will, skill or intention of employees in the process. Thus, CQI puts emphasis on the 'process part' instead of the 'people part' (McLaughlin and Kaluzny, 1999).

In the CQI process, participants are encouraged to express opinions to improve the system through innovation/creativity and questioning for clarity. In addition, the CQI process removes barriers between departments to ensure improvement through integration and teamwork. Thus, CQI is considered as a learning system and a model for improvement, not only for organizations but also for individuals.

It is very easy to formulate areas to improve but the difficult part is putting ideas into action. Improvement comes from the application of knowledge. Thus, any approach to improvement must be based on building and applying knowledge. Every process can be improved and the goal is that the whole organization is continuously considering processes and outcomes that require further improvement (McLaughlin and Kaluzny, 1999).

3.1. Is there Evidence that CQI Works?

Not all are proponents of CQI as a method for system-wide change. According to A.R. Benedetto (2003), an MD from the University of Texas, performance methods can be grouped into two broad categories based on the problem to be addressed. He states that "when the problem is relatively minor and localized, 'evolutionary' methods may be suitable (e.g. quality circles, problem-solving staff meeting, CQI, TQM). These tools work best when modest incremental improvement are sought, when major process redesign is not thought to be necessary, and when avoidance of workplace disruption is desired. Reengineering and Six Sigma are the best known examples of 'revolutionary' performance improvement methods when major improvements are necessary" (Benedetto, 2003).

Another report was produced in 1993 by the University of Toronto, which had created a survey to measure the adoption of CQI philosophy, methods and potential barriers to implementation. Results show that almost half of respondents (approx. 400 HCOs) had adopted a CQI philosophy as defined in the survey. The major obstacles to implementing CQI listed were difficulties changing the management style in a rapidly changing environment, lack of time, lack of resources (Baker, Barnsley and Murray, 1995) and lack of a supportive work climate and organizational culture (Brown et al., 1993). Other critics have stated that because CQI does not appear to produce immediate results, it is abandoned for the next big 'change program' (Rondeau and Wagar, 2002). More often than not, these disappointments are rooted in the slow pace of progress seen with improvement initiatives.

Similar to accreditation studies, there is little evidence that any large scale quality programs bring significant benefit or are worth the cost. Conversely, neither is their strong evidence to prove the opposite that there are no benefits or that resources are being wasted (Øvretveit and Gustafson, 2002). However, there is research evidence that some discrete quality team projects are effective. This was a main finding by a study by Shortell et al. that reviewed the literature and research on TQM/CQI in both health and non-healthcare settings (1995). Broad-based, large scale surveys generally revealed dissatisfaction with the results of CQI whereas the smaller samples or single case studies tend to provide some preliminary evidence of a positive impact (Shortell et al., 1995).

3.2. Characteristics Required

There is evidence from some studies that certain factors appear to be necessary to motivate and sustain implementation and to create conditions likely to produce results. A recent study by Øvretveit and Gustafson in 2002, states that the characteristics that are required for effective implementation of CQI are as follows: senior management commitment, a team approach, a focus on customer needs, sufficient resources, practical and relevant training which personnel can use immediately and the right culture.

Based on a combination of findings from studies by Øvretveit (1999), Kennedy et al. (1992) and Berwick (1989), the commonly reported criteria below, when followed and maintained, result in effective quality programs. The fewer of these criteria that are met, the less successful the program is likely to be in spreading the methods and motivation for quality improvement.

1. Build on existing methods for effectiveness and give it constant attention;
2. Professionals and managers to work together to improve quality, which leads to knowing responsibilities of one another, understanding roles which foster trust and respect and enables managers to empower other because they better know the strengths and potentials;
3. Build and extend professional skills – teachers and learners; not just competencies;
4. Program is realistic about time and change demands so it can be carried out and run over a long time span;
5. Provide training in quality methods using established methods as well as new tools that are available;
6. Combine training for all – frontline and physician buy-in;
7. Allow for flexible working arrangements that tolerate and make allowances for chaos that may exist or develop during change;
8. Avoid different quality language. Create terms of reference so all can understand. Keep communication clean and open dialogue;
9. Ensure the plan is organized and structured so approaches can be measured and success assessed so that competence of professionals is not the only guideline;
10. Leadership must demonstrate interest and support and act as a role model, following a top-down approach;
11. Investments of time, money people (resources) are necessary to develop and maintain an effective quality program.

4. QUALITY STRUCTURE AND TEAMS

The use of teams has expanded dramatically in response to competitive challenges. More and more, multidisciplinary teams are becoming the common work unit for managing change (Jackson, 1996).

4.1. Purpose and Definitions of Teams

There are many definitions for teams. A team can be defined as "a collection of individuals, who possess individual expertise, who are interdependent in their tasks, who share responsibility for outcomes, who see themselves and who are seen by others as an intact social entity embedded in one or more larger social systems and who manage their relationships across organizational boundaries" (Alderfer, 1977; Gizzo and Dickson, 1996; Cohen and Bailey, 1997). The word team comes from *duek*, meaning "to pull". Team literally means "pulling together". Thus, a team is a group of people pulling together in the same direction. It has also been defined as "a dynamic group of diverse people with common objectives but different responsibilities that is chartered with improving a process, a product or a service" (Ketelhut, 1999). The word is sometimes used interchangeably with group.

Teams are collections of people who must rely on group collaboration if each member is to experience the optimum of success and goal achievement. It is a blending of team dynamics with partnership. The idea is that teams perform tasks better than individuals or other ways of organizing people and the result is that the sum is greater than its parts, creating synergy. Teamwork offers the potential to achieve outcomes that could not be achieved by individuals working in isolation (Zahavy and Somech, 2001). Jon Katzenbach (1998) describes true teams as "a powerful and creative link between the team as an entity and the individual members. This tension enhances the intelligence, creativity and ability of the individual members while building team intelligence and team capability. It's an environment, a context, an occasion and an ongoing human event of great energy and force – with an existence and a mind of its own".

Teams come in a variety of types and it is important to understand some distinctions among them. Teams can be either permanent work groups or temporary organizations focused on a limited task. Teams can be a part of the organization's operation or they can be used as a mechanism for changing an organization such as quality circles or quality improvement teams (Lawler, 1986). Teams do not necessarily have to be located in the same place but they must have some interaction to perform a common task. Finally, the way teams make decisions differ. Some teams value the consensus building approach to decision making whereas traditional teams favour a more managerial role with a leader facilitating consultative decision making.

Teams have a reason or purpose for working together. They are usually comprised of people with complementary skills, where members contribute to the success of the team by using their unique skills and talents. A team pulls together through a common approach, known as teamwork. A team holds itself accountable for achieving its goals. The team is successful as a whole. If one member of the team achieves his or her goals but the team does not achieve the team goal, then neither the team nor the individual has succeeded. Finally, teams believe that working together will lead to more effective results than working alone (Bragg, 1999).

For the purposes of this study on quality improvement teams, the definition by Ketelhut will be used, where a team is defined as "a dynamic group of diverse people with common objectives but different responsibilities that is chartered with improving a process, a product or a service" (1999).

4.1.1. Why Teams?

Increasingly, organizations are making teams the primary unit of performance. Managers cannot master the opportunities and challenges now confronting them without emphasizing teams far more than ever before. Thus, the use of teams has expanded dramatically in response to competitive challenges.

Teams have evolved as markets and industry have become more competitive. It is a normal facet of society that organizations and business are trying to do more with less. In the 1980s, teamwork was seen as a new way to organize work, which helped to empower the employees and shift the decision-making control to the people actually performing the task (Safizadeh, 1991). In the 1990s, teams went through another phase of evolvement when companies tried to make teams more self-managing (Manz, 1992), shifting management and supervisory functions to the team, thereby reducing the need for supervisors and middle managers. Likert's (1961) linking pin theory see its expression in the ideas that everyone is part of one or more teams, whether production or service orientated or part of the management structure of the organization. The performance of teams within organizations is, thus, an important variable in the performance of the organization as a whole.

Evidence shows that one of the most effective ways to improve quality in health services is through the use of teams, often multidisciplinary ones (Kratzenbach, 1998). One reason for this is that teams are generally an effective means of doing work in professional services as long as they have strong leadership. As well, the contribution of different professionals and perspectives are needed to identify possible causes of problems and to implement solutions. Participating on a team should improve an individual's skills including social/interactive skills, broadening knowledge and perspective (Kratzenbach and Smith, 1993). With several minds focused on the same mission and deeply committed to the success of the organization, the team develops a lively mind of its own that is constantly accessible to each individual mind – more perspectives, more information, more probing questions, more capacity to sort out the complexities to make good judgement and avoid costly errors.

Group tasks motivate members by allowing them to use different skills, thereby reducing boredom and monotony (Hackman, 2002). People are motivated and encouraged when there is a collective responsibility for completing work and when members feel that work is significant.

Finally, team opportunities exist in all parts of organizations from teams that recommend things (i.e. task forces), to teams that make or do things and teams that run things (management teams at various levels).

4.1.2. Factors that Contribute to the Effectiveness of Teams

An enormous amount of research regarding teams, teamwork and team leadership has been undertaken and is ongoing. Each project has its own focus such as Hackman (2002) who studied team formation, Kratzenbach and Smith (1994) considered motivation, Manz and Sims (1987) isolated the leadership role, Safizadeh (1991) discusses teamwork, etc. Although each has its own unique focus and perspective, there are common themes and findings that are consistently shared in the research presented and considered in this particular literature review.

Some commonalities in existing research findings were compiled and outline the factors that contribute to team effectiveness:

1) Teams require clear direction, common goals and shared vision to focus efforts challenging assignment which foster motivation;
2) Teams require leadership with the ability to manage and orient the team towards its goals;
3) Teams need teamwork activities which are complex, challenging, important and significant to the organization and trigger interaction and interdependence of team members;
4) Necessary resources must always be available – time, training, overtime pay, materials and supplies and the understanding that some projects are long term;
5) The organization must be prepared to readily implement decisions, changes and activities formulated by the group. Unimplemented actions indicate disinterest and marginalization of the group by the organization;
6) Team members may be and should be diverse and heterogeneous in nature but all must be willing to communicate openly and must be flexible enough to cover one another;

7) The performance of the team as well as the external environment must be monitored as both effect productivity and satisfaction;
8) Team members must be personally committed, accountable, sensitive to needs and reactions of others and demonstrate a willingness to share;
9) Decision making cannot take place in a team unless there is trust, interdependence, a process for team formation and development, and time together to share experience and successes and failures;
10) Team members must work cohesively and the corporate culture must foster involvement and participation.

These qualities and factors are the cumulative results of findings by: Rabey (2001); Bragg (1999); Cohen and Bailey (1997); Levi and Stem (1995); Katzenbach and Smith (1994); HarperBusiness (1994); Liden, Wayne, Bradway & Sparrowe (1994); Irwin and Racine (1994); Jackson (1993); Salas et al. (1992); Campion and Medsker (1992); Safizadeh (1991); Moran and Musselwhite (1990); Sundstorm et al. (1990); Pearce & Ravlin (1987); Manz and Sims (1987, 1990); Shea and Guzzo (1987, 1992); Hackman (1987); Gladstein (1984); Dyer (1984); Hackman & Oldham (1980); Goodman, (1979); Cummings (1978); McGrath (1964).

4.1.3. Why Teams Fail: Barriers to Effectiveness

Failing to consider or implement these measures will have an impact on team effectiveness. The more factors are present, the greater the opportunity for success. As well, there are additional factors to be considered for certain fields. For example, in healthcare, one must consider that bringing a healthcare team together is a costly use of professionals' time and not needed for all problems and a recognition that pay-off is usually in the long-term. Finally, "not every group is a team and not every team is effective" (Parker, 1990). Using teams are not always the most appropriate method for work. There is a distinction between what a real team activity is and what it is not; thus, before forming a team for a task, the organization must decide if it is indeed an activity appropriate for a team role versus an individual role. Other barriers include employee's mistrust of management's motives, a lack of clarity of what is expected, resistance,

management lack of participative skills and lack of top management commitment (Hitchcock, 1992).

4.2. Purpose and Definition of Quality Improvement Teams

The use of cross-functional and cross-departmental teams are the major mechanism for introducing improvement work (Shortell et al., 1995). Some studies have found that TQM and CQI do not work well in healthcare (Motwani et al., 1996; Bigelow and Arndt, 1995). Yet, there are an increasing number of **teams** that have successfully used CQI/TQM methods which are reported in scientific and quality journals.

Quality improvement teams are formed for a specific purpose related to quality improvement. When an improvement opportunity is recognized at the organizational, program, service or client level, a quality improvement team might be formed and focus on this opportunity to achieve a goal in a timely fashion. Improvement teams are designed to dissect the organizational issue and suggest processes that will improve the way it functions. These quality issues can be identified by any stakeholders such as staff, clients, and other quality teams. Ideas for projects often arise from staff identifying opportunities to improve a process. Ideas can also come from a management review, external pressures or from accreditation recommendations.

Quality improvement teams generally need to be small enough in order for the team to be able to identify problems and create solutions. They are generally comprised of five to ten members that all have a vested interest in the problem or incident at hand. Each member of the team must bring some distinct value to the table for consideration, which is why these teams are often cross-functional or multidisciplinary.

4.2.1. Benefits of Quality Improvement Teams

In healthcare, attaining quality means satisfying the expectations of the patient (consumer). In order to do this, the wishes and needs of patients must become the focus for every decision. This means that organizations require an environment that clarifies expectations.

Quality improvement teams help organizations to cultivate the belief that people are a valuable resource. This is done through empowerment of the workforce, decision-making by the front line, and active employee involvement in the organization's advancement. The traditionally high-level management prerogatives are distributed throughout the entire workforce, which helps to develop talent and stimulate interest at all levels of the organization. Employees learn how to analyze problems, present solutions, make decisions, and implement and evaluate change. An environment is created in which employees not only see problems, but take action to resolve them.

4.2.2. Formation of Quality Improvement Teams

A quality improvement team is designed to involve all stakeholders in the quality process in order to help improve quality for an organization. It is not designed to create more work for employees on top of their regular duties, but to provide them with an opportunity to make a difference in their workplace while improving some aspect of the organization.

Quality improvement teams are often multidisciplinary in order to maximize the technical expertise of the team. This means that there must be variations among the team members who must complement each other's skills and competencies. The variety of disciplines contributes their successes and challenges with an initiative ensuring that all stakeholders' needs are met with the initiative. It is also important to incorporate various perspectives into the team, i.e. front line perspective, administrative perspective, management perspective and the perspectives of different units. Outside consultants, clients and community stakeholders might also be involved. The idea is that through the process of working with people from other parts of the organization or externally, you learn about their positions and increase your own skill set, creating a learning environment through work teams (IHI, 2004).

However, members must be committed to improving quality within their organization and possess knowledge of the quality issue at hand. Members of quality improvement teams are usually people in an organization affected by the quality process and have a

good understanding of the customers'/staffs' issues, concerns and experience of the service. Others have indicated an interest in working on the team.

As well, members chosen are those willing and able to increase their skills by participating in meetings and working collaboratively with others. Individual members are able to reflect on their own behaviour and contribution to the team and have the ability to learn from feedback provided by others in the group.

5. ACCREDITATION AND QUALITY IMPROVEMENT

The notion of standards implies clear-cut criteria and fixed definitions of quality. The notion of CQI implies a continual process of self-examination, a never-ending search for improvement without a fixed destination. There is tension between these two concepts since standards require certainty and CQI continual revision (Scrivens, Klein and Steiner, 1995). This tension is being reconciled by the development of more flexible and less prescriptive standards by standards agencies. Health organizations are encouraged to improve quality and performance by following their own quality journey to improve quality and performance, to meet standards, and to review the quality of care they provide. Standards are also being fitted into the CQI approach by reviewing and updating them regularly, as such is the case with CCHSA, which is continually looking for ways to improve its standards.

There are some practical examples in the healthcare field where teams were used in a quality process and positive results ensued. St. Joseph's Health Centre in London, Ontario and the Brome-Missisquio-Perkins Hospital in Cowansville, Quebec used teams in the quality process that resulted in cost containment, increased patient satisfaction, increased employee autonomy and job satisfaction (Pavelich, 1997).

5.1. Outcomes of Accreditation on Quality Improvement

There have been some studies that have looked at the impact of accreditation and the power of recommendations. Research evidence, by Martin Beaumont (2002), shows that recommendations from accreditation reviews are used consistently to make

improvements. Findings also show that the longer an organization is involved in accreditation, the more it has the ability to mobilize their teams to implement recommendations and adopt a philosophy of CQI. However, the problem with these studies is that it was not clear whether they were performed by CCHSA, and if they were, this creates a certain bias to the results (National Health Report, 2002).

However, one of the studies examined the perception of the effectiveness (defined as the ability to effect change within organizations participating in the accreditation program) of accreditation (Beaumont, 2002). Three additional studies were conducted in 1993, 1997 and 2001 to examine the progress of accredited organizations in implementing quality improvement processes. All of the studies defined were carried out through surveys and the findings from these studies were combined. The results showed that the perception regarding the effectiveness of accreditation is high. Interestingly, organizations rated the self assessment phase as the least effective aspect of the accreditation and the peer review as the most effective aspect. Also, those who had been involved in accreditation for many years had rated effectiveness higher than those more recently accredited. Finally, those that had been accredited for many years had more mobilization of teams and adoption of a QI program (National Health Report, 2002).

In a study by S.J. Duckett of 23 hospitals on *The Role of Hospital Accreditation*, he found that "in general, the changes which were due to accreditation were all initiated prior to the survey and, not surprisingly, this preparatory period before the survey was said to have seen the most work and change" (Duckett, 1983). Another particularly interesting finding from this study was how it was seen as a useful tool for management. Duckett said that "in the hands of an able and motivated administrator, accreditation became a potent weapon, to be used for the completion of various tasks which are overlooked in the routine day-to-day tasks" (Duckett, 1983).

Finally, a study by MP Pomey (2004) conducted in France showed that, following the implementation of a mandatory accreditation program across the country, 69% of respondents indicated that "irreversible changes occurred at the level of the hospital."

6. ORGANIZATIONAL CULTURE

An evaluation of the culture is an important component to address since it has been proven that certain cultures are more conducive for implementation of quality improvement and change. Quality is defined as "the values, beliefs and norms of an organization that shape its behaviour" (Shortell et al, 1995). It is commonly believed that successful implementation of CQI/TQM, which is the basis for the Canadian accreditation program, requires a significant commitment to a culture emphasizing empowerment, autonomy and risk taking (Gaucher and Coffey 1993; Heilpern and Nadler 1992; O'Connor, Boerstler and Foster 1994; McLaughlin and Kaluzny 1990; Shortell et al 1995).

"Organizational culture has been defined as "shared basic assumptions" (Schein, 1992). Culture conveys a sense of what is valued and how things should be done within the organization and includes the norms, values and rituals that characterize a group or organization. Culture serves as a social control mechanism that sets expectations about appropriate attitudes and behaviors of group members, thus guiding and constraining their behavior. Organizational culture is transmitted to organizational members and subsequently reinforced through stories, rituals and language" (Quinn and Kimberly, 1984; Zboril-Benson and Magee, 2005).

7. CONCLUSION

Often survey recommendations serve as validation of the self-identified opportunities for improvement and may not be perceived as the key element in effecting change. An organization will benefit when it is able to mobilize its teams to implement the recommendations put forth.

Thus, this thesis will investigate whether the accreditation process motivates **teams** to develop or to enrich the quality improvement process in the organization.

CHAPTER IV - THE OVERALL RESEARCH STUDY

1. PURPOSE AND DESCRIPTION

Since 1958, the CCHSA has offered healthcare organizations (HCO) in Canada the opportunity to be accredited. Currently in Canada, 3600 (934 parent organizations) HCOs are involved in this voluntary process (CCHSA Annual Report, 2004).

In recent years, there has been increasing attention paid to evaluating the regulatory mechanism in healthcare accreditation. Generally, academic studies of accreditation have "concentrated on its role as an agent of social control rather than analyzing accreditation's impact on participating hospitals (or HCOs)" (Duckett, 1983). Few studies have measured accreditations impact on HCOs and on the health system where it is implemented. Recent published reports state that the quality of care in Canadian HCOs is not improving and that the accreditation process should be compulsory instead of voluntary (Kirby, 2002). Other reasons for the lack of evaluation research include methodological challenges of attributing causality between accreditation and change, since HCOs themselves are complex and ever-changing and the system in which they operate is also in constant flux.

Thus, the research objective for the overall study is to evaluate the impact of the CCHSA accreditation program on Canadian HCOs in terms of organizational changes and quality. An analyses framework is being used to analyze each of the dynamics of change.

Accreditation is only one of the many factors which might cause change in HCOs. However, it is promoted as a substantial vehicle for change (Pomey, 2002). Accreditation can be considered as an intervention in the Canadian healthcare system, leading to change and continuous quality improvement. As such, the accreditation process is likely to bring changes at different levels and at different points in time. However, as stated above, this fact has not been evaluated and it is time that the effects of the program are identified.

Therefore, the objective of this study is to analyze the characteristics of change and the dynamics of change at different points in the accreditation cycle.

Another area this research will explore is the accreditation process and the general perceptions of HCOs for improvement since there have been documented dissatisfactions with the process. For example, American hospitals criticize JCAHO regarding the accreditation process related to the surveyor competency, subjectively applied standards and some state that the costs were too high for what HCOs would get out of the accreditation, dating back to 1994 (JCAHO, 2005). More recently, JACHO has experienced declining survey volumes of hospitals opting out every year forcing JACHO to radically reformulate the process to bring more value and meaningful measurement. JACHO is not the only accrediting body in the USA. There is increased competition and specialization in the field i.e. accreditations are available specifically for LTC, mental health and health education programs to name a few or just other accrediting bodies that want to penetrate the health market. Thus, there is a lot of competition forcing JCAHO to continually ensure that their standards are up-to-date and appropriate given the current health environment.

The Canadian scene is very different since the American system operates under a private, for profit model. However, even the Canadian health ministries perform their own accreditations of health organizations under their jurisdictions. As well, there are specialized accreditations for health promotion and education programs that are starting to emerge. Thus, another objective of this study is to look at the Canadian accreditation process and will determine what improvement may be had on its process (Morrissey, 2002). Within the last 2 years, the Canadian accreditation process was completely reviewed and revamped. The tools that are used to gather information were updated and were designed to be user-friendly. The revisions also included removing several of the redundancies when documenting information. Overall, the revisions improved the accreditation process and many organizations have found the revised process more favourable. However, this factor must be taken into consideration when comparing the organizations that had been evaluated over the last 10 years and the newly accredited

organizations. Thus, this is considered a factor in the study but it is very small. The reasoning is that the study is not comparing the accreditation process over the last 10 years and the process used but instead is focusing on the quality related outcomes received by the accredited organizations.

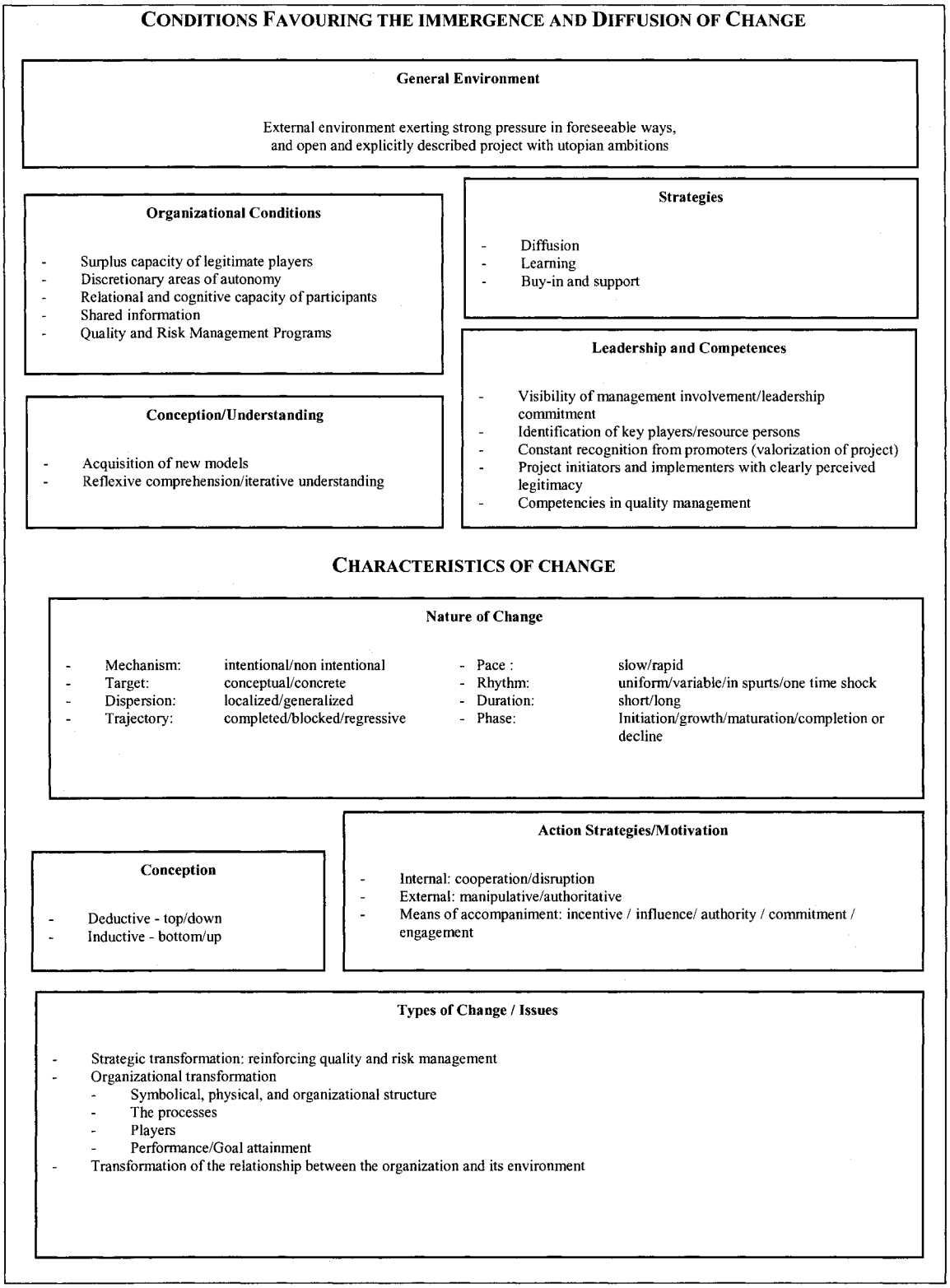
The results of this study will help to better understand how healthcare organizations in Canada use accreditation over time, what they learn and how accreditation helps them to be innovative and to acquire capacity of change, in particular through the implementation of continuous quality improvement programs and risk management.

2. THE CONCEPTUAL FRAMEWORK

The conceptual framework for this study was developed to monitor change and is the basis for the entire research project. The model is a synthesis of various sources and was originally developed for Marie Pascal Pomey's Masters' thesis (2002) and then used as the underlying framework for this research study.

The conceptual framework for this study was developed to monitor change and is a synthesis of many different sources. Change dynamics will be analyzed while taking into consideration the favourable conditions of the implementation of organizational change and also the characteristics of these changes. Please see below an outline of the conceptual model for the overall research study and an explanation of each component. The top of the conceptual model outlines where an organization is at currently (outlining factors that an organization demonstrates that favour change) and the bottom outlines the change that occurs according to different characteristics. It was proposed as the model to work with when the thesis option was provided to me, as the thesis is a single case study part of a multiple case study. This model was also presented as the framework to CIHR in the submission for funding for the study and it was used in a similar study in France.

Figure 1: The Dimensions of Change (Pomey, 2002)



The purpose of the framework is to use this model to characterize the changes that occur in relation to the HCO under study as a result of accreditation.

2.1. Conditions Favouring the Emergence and Distribution of Change

The conditions favouring the emergence and distribution of change are: (1) an environment that puts external pressure and allows the development of a utopia, (2) pre-existing organizational conditions, (3) an appropriate ability to conceptualize, (4) specific strategies to actualise the changes, and finally, (5) presence of leadership and competency.

2.1.1. General Environment

Changes are facilitated by an external environment exerting strong and predictable pressures (Shaw, 2000) allowing, at the same time, the development of an awareness that the situation can improve and solutions are available.

2.1.2. Organizational Conditions

One of the elements necessary to induce change is a discretionary area of autonomy where individuals can express themselves (Crozier, 1973) and try out new projects. If people judge their situation as unsatisfactory, they will more readily seek ways of changing or improving the situation.

2.1.3. Conception/Comprehension

Individuals need to understand upcoming changes within their own context, hence acquire new intellectual models (Kleiber, 1997), which requires a reflexive comprehension.

2.1.4. Strategies

Implementing changes requires specific planned strategies and the diffusion of change requires time (Mintzberg, Ahlstrand and Lambel, 1999). To facilitate change, learning environments must be created to allow for debates, information exchange, and training (Crozier and Friedberg 1997; Mintzberg et al., 1999). The purpose of these strategies is to

get buy-in and support from the professionals and, particularly, from physicians who have been identified as essential for the success of change in the realm of quality improvement, as well as potentially resistant to their implementation (Shortell, 1983; Giraux and Joly, 1992; Berwick and Nolan, 1998).

2.1.5. Leadership and Competency

The importance of leadership in the process of change is stressed throughout the literature (Conger and Kanungo, 1998), as well as the competencies in quality improvement (Weiner, Alexander and Shortell, 1996). The involvement of the highest level of administration in the organization, more specifically the CEO, is essential (Juran, 1989 & 1994; Berwick, Blanton and Roessner, 1990) but not sufficient. Complementary players in a variety of fields acting together are also required to make change possible (Denis, Lamothe and Langley, 2001). For quality improvement programs, a few leaders with competencies in quality management and abilities to promote quality improvement values is key.

2.2. Characteristics of Change

Each change occurring in the organization can be described using four categories of characteristics: 1) the nature of change, 2) its conception, 3) the motivation, which led to the change, and 4) the type of change involved.

2.2.1. Nature of Change

Characteristics of change can be described according to their nature (Ford and Ford, 1995; Hinings and Greenwood, 1988, Vandangeon-Derumez, 1998; Mintzberg, Ahlstrand and Lambel, 1999), such as:

- the mechanism of change, intentional or non intentional;
- the target, whether the change is conceptual or concrete;
- the dispersion, whether the change is localized to a unit or group or generalized across the organization;
- the pace, whether the change is occurring slowly or rapidly;

- the rhythm, whether the change is occurring in uniform, variable, in spurts or one time;
- the duration, whether the change is spread over a short or long period of time;
- the trajectory, whether at the time of the study the change has been completed, stagnant, blocked or regressive; and
- the phase of the change, initiation, maturation, completion or decline.

2.2.2. Conception

The conception for change can be inductive, coming from staff to management, or deductive, from the top down (Rocher, 2000).

2.2.3. Motivation for Change

Motivation for change within an organization can be internally or externally driven (Benson, 1975). Internally, motivation can come from cooperation or from conflict. Externally, motivation for change can come from the authority of an external body (e.g. politicians) or through manipulation. Other strategies to motivate change include acquiring commitment from people involved, setting up incentives, using influence internally or externally or using authority (Mintzberg, 1983; Longest, Rakich and Darr, 2000; Firth-Cozens and Mowray, 2001).

2.2.4. Types of Change

Change can affect organizations at different levels: the strategic level, the organizational level, and relationship level, which is the relation between the organization and other players.

3. THE OVERALL RESEARCH QUESTIONS

The main questions to be answered in the overall research study are as follows:

> Question 1: As accreditation can be considered as an intervention in the Canadian healthcare system, can accreditation be a mobilizer for change at different levels of the organization, according to the characteristics of the overall framework?

> Question 2: Are organizations that have been in the accreditation process for a long time (more than 10 years) able to implement change more easily than organizations that have not? Are organizations that have been involved in the accreditation process longer more reactive to change and flexible?

> Question 3: Do organizations which received recommendations in the accreditation report implement more changes than organizations that do not receive any/many recommendations?

4. RESEARCH DESIGN

As the HCO accreditation process is voluntary, it is not possible to develop a randomized, experimental design for evaluation. Thus, the overall research project is designed as a comparative, explanatory case study with three embedded units of analysis (at the individual, team and organizational level). Seven healthcare organizations were selected to participate. The HCOs selected differ in many aspects: the number of accreditation surveys performed, the accreditation status, the size of the HCO, the type of organization (e.g. hospitals and health regions), the academic standing (e.g. teaching designation), the

geographical location (urban/ rural) and the distribution in Canada (Ontario, Quebec, Alberta and New Brunswick).

Multiple sources of information will be used to draw conclusions. They are as follows:

- Interviews with key stakeholders;
- Focus groups with employees who have been involved in the self assessment teams during the accreditation process;
- An organizational-wide culture questionnaire with selection of respondents through a random sample distribution;
- A questionnaire specifically designed for managers and directors;
- Information about accreditation, organizational change, continuous quality improvement and safety programs.

When all of the data from each of the survey sites has been reviewed and analyzed, the data will be combined and overall findings will result. It is important to note that these are the questions to be answered in the bigger research study. In my case study, as outlined in Chapter 5, the result from this thesis will focus on the usage of teams in the accreditation process and will only address general findings for the overall study, not these questions in particular.

5. THE RESEARCH TEAM

This research project has been funded by the Canadian Institutes for Health Research (CIHR). The research team comprises of professors and students from universities in Ontario and Québec, including the University of Toronto (Louise Lemieux-Charles), l'Université de Montréal (François Champagne and A-Pierre Contandriopoulos) and University of Ottawa (Doug Angus and M-Pascale Pomey). As well, other stakeholders are represented such as the CCHSA. The budget associated with this project is approximately $160,000 over a 3-year period starting Fall 2003.

CHAPTER V - A CASE STUDY FOR TEAMS AND ACCREDITATION

1. Research Questions

The focus of my thesis is to determine the linkages between accreditation and the usage of teams as a method for enabling quality improvement. The data will confirm that one of the outcomes of the accreditation process is that Quality Improvement is enabled through the development (or improvement) of QI teams and process. Therefore, the questions to be addressed through this case study are:

Question 1: Since accreditation can be considered an intervention in the Canadian healthcare system, is it able to introduce process or influence changes within an organization according to the characteristics of the framework?

Question 2: In the accreditation process, is the accreditation preparation phase (also known as the self assessment) the source of change?

Questions 3: Does the accreditation process motivate teams to develop or to enrich the quality improvement process in the organization?

2. THE CONCEPTUAL MODEL

This model was created to visually depict what the three thesis students on this project were studying as part of the larger research project.

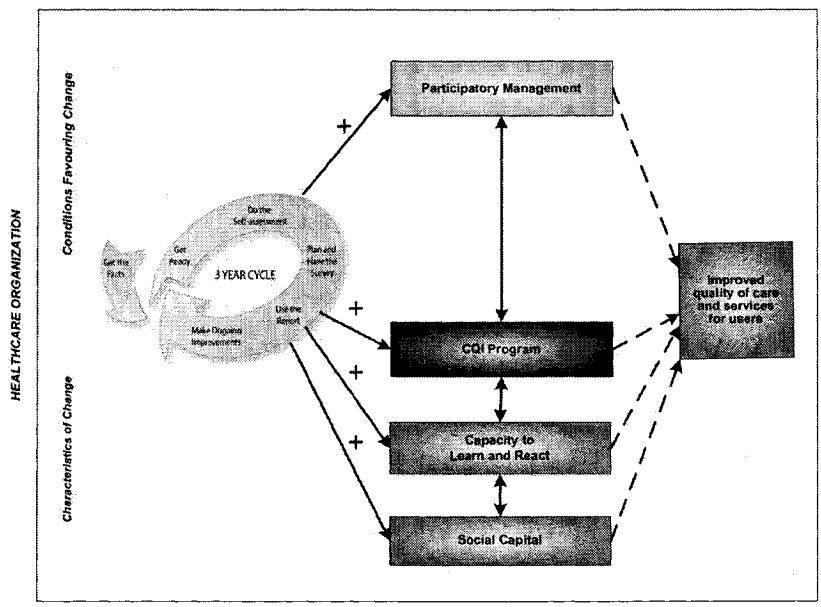
This model outlines that the proposed outcomes of accreditation are:

1) more participatory management,
2) the formation of QI teams and process (which is the focus of this project)
3) improved capacity to learn and react when faced with challenges, and
4) increased social capital.

Each outcome feeds into one and another and, ultimately, should lead to improved quality of care for the users. These feed back into the general environment of the healthcare organizations and contributes to conditions for change. The more an organization has experience with accreditation, i.e. has gone through the loop, the more favourable the conditions are to affect positive change. See Figure 2 below.

The hope is that this visual model will be incorporated into the larger research study when the results from the three theses are combined – either supporting it or refuting it.

Figure 2: Conceptual Model on the Impact of Accreditation



3. CONTEXT FOR THE CASE STUDY

3.1 Alberta: The Province

Alberta is comprised of approx. 3.2 million people over 661,190km^2. The capital city of Alberta is Edmonton. The prime industries in Alberta are farming (grain, canola and vegetables, beef cattle and meat processing), oil and gas production, finance, light manufacturing, mining and forestry, telecommunications and tourism (Statistics Canada, 2005).

According to the 2001 Census, Alberta had Canada's highest census-to-census growth rate in population from 1991-2001. It is also the nation's youngest province. Alberta was also the only province where the ratio of men to women was virtually equal. According to Statistics Canada, Calgary replaced the census metropolitan area of St. John's in Newfoundland and Labrador as the nation's second youngest metropolitan area (Statistics Canada, 2005).

3.2 The Alberta Healthcare System

In 1992-93, Alberta was faced with serious financial problems, with an overall deficit of over $3 billion and mounting debts. The government of Alberta realized that this was not sustainable and had to make some changes. To reduce healthcare expenses, it expected a more integrated and fiscally responsible health system and this could be achieved through restructuring and stability in funding.

Thus, in 1994, the Government of Alberta passed the Regional Health Authorities Act, making 17 Regional Health Authorities across the province. Regional health authorities are defined as "autonomous healthcare organizations with responsibility for health administration within a defined geographic region within a province or territory. They have appointed or elected boards of governance and are responsible for funding and delivering community and institutional health services within their regions" (CCARH Website).

The new Regional Health Authorities Act gave regions extensive responsibility to assess health needs, establish priorities and allocate resources. The new Alberta legislation required health authorities to act as the health-system manager for residents of the region it serves. Services to be provided by the health region range from prevention and promotion to home care and long-term care. However, separate provincial health authorities were created to take responsibility for managing mental health and cancer services. Local municipalities maintained responsibility for ambulance services.

As a result of the restructuring, Alberta went from being one of the highest per capita spending provinces for health services in the mid-1980s, to one of the lowest. According to the Globe and Mail, between 1991 and 1998 Alberta has had the lowest percentage increase in provincial health spending of any province.

However, Alberta did not stop at restructuring. On April 1, 2003, the 17 previous RHAs were reduced to 9. Also, the new RHAs took on the responsibility of Mental Health services as part of the new restructuring. The size of the RHAs now ranges anywhere from 61K to 1.1M people. Currently, cancer and ambulance services are also being included, making the health regions truly responsible for all health-related activities within their designated boundaries.

3.3 The AHR and Accreditation

In the recent restructuring, the new health region combined four of the previous 17 health authorities. This new and expanded region includes mental health services as part of the service mix. They have over 50 sites of service. Currently, the third largest region in Alberta by population, the AHR serves nearly 300,000 residents, covers 60 thousand sq. km of territory and employs over 8,000 staff with over 350 practising physicians.

When accreditation was performed, the RHA under study had 35 sites with over 1300 beds. Services offered at the time included ambulatory care, community care, continuing care, maternal/child care, medical care, mental health, palliative care, public health, rehabilitation, surgical care and critical care.

In regards to accreditation, the health region as it is currently known had never been accredited before. Its first accreditation was in 2002 and the number of teams that participated in the last accreditation was 19. They received accreditation with 2 Key Recommendations and 6 Total Recommendations. Before regionalization, some of the individual sites had been exposed to accreditation but nothing had been documented since there are so many facilities within the health region.

4. RESEARCH METHODOLOGY

This section outlines the research design, the data collection and materials used and the timeframe for data collection.

4.1. Design

The overall purpose of this case study is to better understand how accreditation affects change, where accreditation is perceived as an intervention. This thesis is based on an explanatory single-case study (Yin, 2003), where both quantitative and qualitative information was collected to enable triangulation. Four levels of analysis were identified relative to the study: 1) the individual level, 2) the group level, 3) the organizational level and 4) the community level.

4.2. Data Collection and Materials

As mentioned, several methods and materials were used to gather data for the purpose of analysis and to enable triangulation of the results. Primary data was collected from an AHR using interviews, focus groups and questionnaires. Secondary sources included the AHR's accreditation report, pertinent information about the AHR and their quality programs and various sources and studies regarding the accreditation process, CQI and the teaming concept.

4.2.1. Quantitative Data

The quantitative data collected were in the form of two questionnaires. The information below will outline the data collection tools and the content. The quantitative data comes from other questionnaires previously tested for validity in other studies related to quality

improvement and organizational change. All questionnaires were used with prior approval of the initial researchers.

4.2.1.1.Organizational Culture Questionnaire

The first questionnaire was designed to assess the organizational culture of the Alberta health region in terms of beliefs, norms, values, and behaviours relative to how work is approached or conducted. The 20-point instrument used was developed by Zammuto and Kralower in 1991 based on Quinn and Kimberly research and typology in 1984. This tool has been previously validated in several studies (Shortell 1995, 1998 and 2001 and Pomey, 2002) related to quality improvement in both healthcare and non-healthcare organizations, such as '*Assessing the Impact of Continuous Quality Improvement/Total Quality Management: Concept versus Implementation*' by Shortell et al. (June 1995) and '*Implementing Evidence Based Medicine*' by Shortell et al. (2001) to name a few.

The purpose of the culture survey was to "probe" the organization. This was not the main focus of the research. Please see Appendix A for a copy of the Organizational Culture Questionnaire.

4.2.1.2.Perception of Quality Improvement Implementation and Professional Implication in AHR Questionnaire

The second questionnaire refers to the perception of implementation of quality management and the implication on professionals, aimed at managers and executives (therefore, it is also described as the Questionnaire for Managers or the Management Questionnaire). It was made up of four sections: A) Quality of Care, B) Professional Participation, C) Accreditation Impact and D) Respondent Characteristics.

Section A used a 56-item instrument based on the Baldrige National Quality Award Criteria. These criteria have been used to successfully differentiate between high and low performing organizations in the USA and abroad and have been used in various studies (Blackburn and Rosen, 1993; Little, 1992; Shortell et al, 1995 and 2000). This tool assessed 7 major areas of quality management work:

1) Leadership, which measured the extent to which senior executives' personal leadership and involvement creates and sustains a customer focus and clear, visible quality values and the extent to which these quality values are integrated in the HCOs management system;

2) Information and analysis, which measured the extent to which the scope, management and the use of data and information maintain a customer focus, drive for quality excellence and improve operational and competitive performance;

3) Quality strategic planning, which measured the extent to which HCO employees are involved and empowered to be involved in the HCO's quality planning efforts;

4) Human resources utilization, which measured the extent to which HCO employees are provided adequate education and training for quality improvement efforts;

5) Quality management, which measured the extent to which all work contributes to overall quality and operational performance requirements. The criteria examined the key elements of process management including design, management of day-to-day activities, improvement of quality and operational performance and operational assessment;

6) Quality results, which measured the extent to which the HCO has shown measurable improvement in quality, operational performance and supplier quality;

7) Customer satisfaction, which measured the extent to which the HCO effectively assesses and meets customers' requirements and expectations.

All items are measured on a 5-point Likert scale (1 = low or strongly disagree to 5 = high or strongly agree where 9 = don't know). Please see Appendix G for a copy of the Baldrige National Quality Award Criteria.

Section B examined the perceptions of the degree of professional participation of the AHR's administration and the perceptions that professionals have of being consulted in the administrative decision-making processes as well as their degree of influence in the decision making process. This tool was also developed and validated by Shortell (1995, 2000). This section used a 5-point Likert scale (1 = never or none to 5 = always or very high).

Section C on the accreditation impact was derived from work done by Marie Pascal Pomey (Pomey, 2002) for her Masters' thesis on the impact of accreditation preparation in France. The original questions were adapted to meet the needs of this study. This section addresses the perceptions of respondents of the impact of accreditation in terms of the dynamics of change at the AHR. Section C used the same Likert scale as Section A (1 = low or strongly disagree to 5 = high or strongly agree where 9 = don't know).

Finally, Section D of the questionnaire was comprised of independent variables, outlining respondent's characteristics to enable analysis. This included age, gender, clinical background, occupation, length of employment with the organization, involvement on a self assessment team, involvement with quality, and involvement in the accreditation process. Please see Appendix B for a copy of the Perception of Quality Improvement Implementation and Professional Implication in AHR Questionnaire.

4.2.2. Qualitative Data

For the qualitative analysis, there were two different methods used to gather information - semi structured interviews and focus groups - with three different tools. The following sections describe the tools used and the content of the tools.

4.2.2.1.Interviews

For the interviews, a semi-structured format was used. The first interview guide adopted for the project was developed by the research team based on previous research by Marie

Pascal Pomey (2002). The interview guide was divided into 6 categories:

1. General Information (about the interviewee)
2. Factors of Change
3. Accreditation Preparation and in General
4. Accreditation and Changes in line with the Latest Survey
5. Changes in the relationship between the AHR and the Community
6. Conclusion (the Accreditation Process)

All of these subjects are included as components in the conceptual model, developed by the main researcher and research team (Pomey, 2002). In summary, the interviews gathered input on the factors of change, the changes in line with accreditation at different stages of the accreditation process, linkages with the community and the accreditation process itself.

The interview questions were translated from French to English and then tested at a bilingual pilot site in Montreal in both English and French before they were used for the study. The information collected at the AHR was all in English at the choice of the organization. Please see Appendix C for a copy of the interview questions.

The second interview tool was geared to get input about the self assessment teams and the 'teaming' concept. The questions included were revised from the focus group questions discussed below and developed by the research team based on previous research by Pomey (2002). This interview was designed to get specific input on work by the self assessment team related to its purpose, composition, leadership, impact, relationships formed and value added. When the questionnaire was developed, the information gathered for the literature review was also considered and used to develop the questions. Please see Appendix D for a copy of the teaming interview questions.

4.2.2.2.Focus Groups

For the focus groups, a semi-structured format was used. The focus group guide adopted for the project was developed by the primary researcher. The focus group question guide included questions related to:

1. Accreditation Preparation
2. Accreditation Report
3. Characteristics of Change
4. Impact of Changes
5. The Self assessment Teams
6. The Survey Tools

As with the interview questions, the subjects outlined above were components linked to the conceptual model developed by the research team. Also, the focus group questions were tested at the same English and French pilot sites before they could be used for research purposes. The focus groups were conducted in English. Please see Appendix E for a copy of the focus group questions.

4.2.3. Timeframe for Data Collection

The two visiting researchers to the AHR were a Masters of Health Administration student and myself. The data collection period for the visit consisting of the interviews and focus groups and collection of the culture questionnaires was November 1 and 2, 2004. On November 1, both focus groups were conducted as well as the Quality Improvement Team Interview, which was a one-on-one interview. On November 2, all of the remaining interviews were conducted. On both days over the lunch period, culture surveys were distributed and collected.

4.3. Data Analysis

The following section outlines how the data were collected and how they were analyzed.

4.3.1. Quantitative Data

Once all of the questionnaires were received, they were reviewed for completion and entered into SPSS. The culture data and the management data were separated into two different files. The data inputted into SPSS were reviewed twice to eliminate recording/input mistakes. Also, spot checks were performed randomly to ensure that the data was entered accurately. Each questionnaire was assigned a number, which was recorded on the front of each questionnaire. The number corresponded to the line in which the data appeared in the associated SPSS document. Thus, every survey can be cross-checked at any time to ensure that the data were inputted correctly but cannot be linked to any one respondent.

The data from the culture and management questionnaires were all analyzed using SPSS version 12. Standard statistical tests conducted on the quantitative data included means, frequency, range, standard deviation, correlation, paired comparison t-tests, Levene's Test for Equality of Variances, and ANOVAs.

4.3.1.1.Organizational Culture Questionnaire

Section A: The Culture Types

Quinn and Kimberly (1984) defined four cultural types: group culture, developmental culture, hierarchical culture and rational culture. These four culture types were built into the culture questionnaire and each question was associated with a culture type. If the respondent assigned higher values to A in any of the questions, the responses were associated with a group culture emphasizing affiliation, teamwork, coordination and participation. If the respondent assigned higher values to B in any of the questions, it was associated with a developmental culture emphasizing risk taking, innovation and change. If the respondent assigning values to C, it was associated with a hierarchical culture, emphasizing rules, regulations and reporting relationships. If the respondent assigned higher values to D, it was associated with a rational culture, emphasizing efficiency and achievement.

To determine the most prevalent culture(s), the means, range and standard deviations were calculated for each of the four cultures. T-test were performed on all of the means to determine if there were any significant differences between different variables e.g. gender or years with organization, at 0.05 level of significance. Equal variance was assumed when alpha is greater than 0.05. Unequal variance was assumed when the alpha is less than 0.05. The hypothesis of equal variance is rejected when the confidence interval does not include zero.

Finally, Spearman's Rho, a non-parametric test for correlation, was performed, which is a measure of association between rank orders. It assesses reliability of the data since it assessed the correlation of the answers within each culture type. A lower correlation indicates a lower reliability of the result, since there is a weaker link among the answers for each question.

Section B: Respondent Characteristics

The same statistical tests were performed on the data as were outlined for Section A of the culture questionnaire. However, for the occupations groups, the analysis of variance (ANOVA) test was used to determine whether the means are equal for the different variables. The level of significance used was 0.05. When the p-value was less than 0.05, the hypothesis for equal variance was rejected indicating that there is a significant difference in at least two of the means in the occupational categories for each culture type. If the p-value was larger than 0.05, the hypothesis was accepted, indicating that there was no significant difference between any of the culture means for the occupational categories.

For analysis, in Section B, Question 2, in question related to age, there were 4 options for respondents: below 30 years, between 30 to 45 years, between 46 to 55 years and over 5 years. For the purposes of the analysis, those below 30 years and between 30 and 45 years were combined into one category and those between 46 and 55 years and 55 plus were combined into another category.

To calculate the length of time worked or associated with the organization, the data was converted from months to years and categorized as with 'less than 10 years' or 'more than 10 years' (Section B, Question 4).

Finally, when looking at the occupational category responses (Section B, Question 5), for analysis, the medical doctor responses were included with administration and volunteer responses since there were so few in these occupational categories.

4.3.1.2.Perception of Quality Improvement Implementation and Professional Implication in AHR Questionnaire

Section A: Quality of Care

As mentioned in the methodology, Section A is based on the Baldrige National Quality Award Criteria. The seven sections in Part A correspond to the seven criteria for the Baldrige Award (Quality Improvement Implementation Survey: QI Implementation II). To determine the values for each section, the means, range and standard deviations were calculated for each of the seven criteria. T-tests were performed on all of the means to determine if there were any significant difference between different variables e.g. gender or years with organization, at 0.05 level of significance. As with the culture questionnaire, equal variance was assumed when the alpha was greater than 0.05. Unequal variance was assumed when the alpha was less than 0.05. The hypothesis of equal variance will be rejected when the confidence interval does not include zero.

Inter-Item Correlation Matrixes will also be used to analyze the degree of correlation between the responses of each criteria indicating whether the responses were reliable or not. The general rule used will be that if the correlation is higher than 0.6, it indicates that there is good correlation between the responses for each criteria.

Finally, the Cronbach's Alpha test is used to test the internal consistency of the results for each criteria expecting patterned responses. The Cronbach's Alpha test is also known as the scale reliability coefficient. The closer the Cronbach Alpha is to 1.00, the higher the internal consistency of the responses for each criterias and the more consistent and reliable the instrument used is measuring what it is intended to. The general rule used is

that if the Cronbach's Alpha is less than 0.6, the reliability of the data is low. Also, the larger the number of items and the larger the sample size, the easier it is to prove internal consistency.

Section B: Professional Participation to Organizational Management

Section B on Professional Participation was designed to assess the extent staff are involved in decision making. The same statistical tests were performed on the data as were outlined for Section A of the management questionnaire.

Section C: Accreditation Impact

This section examined the perceptions of the impact of the accreditation in terms of the dynamics of change at the AHR. For the analysis, questions were combined since the underlying purposes of different questions were similar. The results were combined as follows:

Results for Questions 1 and 2 (related to preparation)
Results for Questions 3, 5 and 5 (related to recommendations)
Results for Questions 6, 7 and 8 (related to quality of care)
Results for Question 9, 10 and 11 (related to response to environment)
Results for Questions 12 and 13 (related to accreditation as a tool)

The same statistical tests were performed on the data as were outlined for Section A of the management questionnaire.

Section D: Respondent Characteristics

Depending on the amount of questionnaires received, combinations may be required. The same statistical tests were performed on the data as were outlined for Section B of the culture questionnaire.

In this section at the end of the survey, there is a scale that measures the level of involvement in accreditation. When the person wrote the number out of 10 down, that was the number taken. If the person did not write the number down, the scale was

measured (10 cm long) and where the line was marked was where the measurement was taken.

4.3.1.3.Summary

The final triangulation is based on a theoretical framework (Pomey 2002; Yin 2003) which includes the analysis of favourable conditions in the implementation of organizational change and actual change in the AHR.

4.3.2. Qualitative Data

At the site visit, each interview and focus group were audio taped. One of the researchers was responsible for asking the questions while the other researcher took notes. Each of the interviews and focus groups were transcribed by the same transcriber and then checked for accuracy by the primary researcher of the survey site. In the case of the first focus group, because it was the first time the researchers performed a taping of the session, only half of the focus group was captured on tape. Thus, in order to compensate, the notes that were taken by the second researcher were used as the primary data set. The notes were considered the more valuable source of information since when checks were made with the other data, the two information sources matched. If there were discrepancies, changes were made to the transcribed version, not the notes.

All of the qualitative data, including the interviews, the focus groups and the documentation, were analysed using N-Vivo 2.0 software. The research team used pre-established codes based on the conceptual framework used for the overall research study and previously used in Marie Pascal Pomey's study on the impact of accreditation preparation in France (Pomey, 2002). The information was coded by recurring themes and all researchers involved used a common coding framework. The coding was originally tested on the data from the pilot study. Each surveyor was asked to code the data and convene to compare coding. During the process, the codes were revisited by the survey team and definitions were attached to each so that there would be no confusion on the usage of the codes. This facilitated better understanding and consistency between sites, which is critical for the overall research project. The codes went through multiple

revisions. As the surveyors coded the qualitative data, updates were required to the codes so each researcher would receive an updated version if any changes were made. Another step that was taken to aid in coding was that questions from the interviews and focus groups were tied to specific codes but this was only used as a guide.

Additional codes were added which were related specifically to continuous quality improvement and the team concept. These were used throughout the coding of all of the qualitative data collected. Please see Appendix F for a copy of the codes, definitions and any of the coding tools used.

Once the focus groups and interviews were coded, they had to be checked by another researcher to verify the coding. One interview and one focus group were coded by the primary researcher, Marie Pascal Pomey. The coding was compared to that of the writer and any discrepancies were discussed and a conclusion drawn. If the discussion of the discrepancy was worth mentioning to the other researchers, the information was passed on. If additional codes were required, each of the surveyors were consulted on the addition of the code and the meaning so that there could be consistency in the coding.

Finally, an excel template was developed to capture the different types of changes being studied (assessment, visit, report, other changes) compared to the levels of analysis (individual, group, organization, partners).

4.4. Data Quality

The data used was primarily the qualitative data supported by the information provided from the culture and management surveys. Studying the culture and the perceptions of management regarding accreditation are to give a general idea of the environment. The results should not be considered alone. They are only a probe and to be used to give a sense of the setting and provides opportunity to review these results in the context of the overall case study through triangulation.

CHAPTER VI – QUANTITATIVE RESULTS AND ANALYSIS

Table 1: Questionnaire Response Summary

	Cultural Questionnaires	*Management Questionnaires*
Number of Sites Covered	5	Across all sites
Total Completed	259	21
Number Rejected	14	1
Number of questionnaires sent	Approx. 350	45
Response Rate	Approx. 74.0%	46.6%

1. Organizational Culture Questionnaire Results

For the culture questionnaire, since the health region under study was so large, five sites were used as survey sites (out of 50 sites). These sites were dispersed throughout the region with the goal of having a more representative sample of the culture across the entire region. Also, the sites chosen were the larger centres with more traffic.

Surveys were distributed to any person working in the organization such as nursing staff, support staff, doctors, administration, volunteers, etc. All of the culture surveys were collected over lunch period using the same process. Half of the culture questionnaires were collected over the lunch period on November 1st and 2nd when the site visit was made. The remaining questionnaires were collected at four other sites across the AHR over the lunch period using the same process by members of the Quality and Planning Department.

Respondents had the opportunity to participate on a voluntary basis. A booth was set up outside of the main food area at each of the five sites and was manned by two people. One person distributed questionnaires as people entered the food establishment (usually the cafeteria). The other person solicited the participation of all professionals at the survey site in the food establishment encouraging people to complete the survey and providing feedback. As an added incentive, respondents could enter a contest to win a $50 gift certificate to a local eating establishment. The only way they could enter the

draw was if they returned the completed survey to the booth and filled out a contest voucher, thus removing any possibility that any survey could be associated with any particular individual in the organization. This incentive was considered minimal enough not to introduce any bias in the results.

Respondents were asked to complete the survey and assign 100 total points to each section. The completion of the questionnaire took less than five minutes. For each part, respondents were to assign different values representative of the culture depending on how similar the description was to the organization.

In total, 273 questionnaires were returned and 14 were removed from the analysis due to incomplete information. Thus, the number of questionnaires eligible for analysis was 259. However, one culture questionnaire was missing a response for one variable (whether or not the respondent was a manager) in Section B 'general information' which excluded it from analysis of that variable (making the sample size 258). Being a novice researcher, the number of culture questionnaires that were sent passed out were not tracked and when the error was realized, it was too late to correct. My estimate would be 350 sent out in total but this cannot be validated, making the response rate 74%.

1.1. Respondent Characteristics

89.96% of respondents were female (233 people) and 10.03% were male (26 people). This is consistent with the breakdown of the organization where a majority of staff are female. There was an even distribution between those above and below the age of 45. Also, there was equal representation of those working or associated with the organization for less than 10 years (129 respondents) or more than 10 years (130 respondents). A majority of respondents were not at the management level (89.15% or 230 respondents), which also is indicative of the organizational structure since there are limited individuals in senior level management positions.

There was a good mix in the distribution in occupational categories. The largest category of respondents was nurses, accounting for 29.73% of respondents (77 out of 259). Next,

support workers comprised of 26.25% of respondents (68 people). The following category was allied health professionals at 22.77% of respondents (or 59 people). Only 6.95% of respondents were from administration/MD (or 18 people). Out of 259 responses, there was only one physician response. Finally, there were 37 people who did not fit in any of the set categories above. The types of individuals in this category included clerical staff and volunteers.

Table 2: Description of the Sample for the Culture Questionnaire

CATEGORIES	*Variable*	N	%	*Variable*	N	%	Total
Gender	*Female*	233	89.97	*Male*	26	10.03	259
Age	*<= 45*	132	51	*>45*	127	49	259
Years with organization	*<10 years*	129	50	*>= 10 years*	130	50	259
Manager	*Yes*	28	10.85	*No*	230	89.15	258

Occupation Variables	N	%
Nurses	77	29.73
Allied Health Professional	59	22.77
Support	68	26.25
Administration + MD	18	6.9
Others	37	14.28
TOTAL	**259**	**100**

1.2. General Findings

As previously mentioned, this questionnaire is based on four basic culture types that correspond with the questions in the organizational culture questionnaire. At the organizational level, no organization is likely to be totally characterized as only one type of culture. Thus, an organization is likely to be a combination of culture types. The crucial factor for QI implementation is the distribution of these culture types.

Based on the means of the percentage distribution in the culture questionnaire, the AHR presents two dominant cultures: a ***'hierarchical' culture*** at 35.49% and a ***'rational'***

culture at 25.61% (see Table 3). Group culture was next at 21.81% and the least favourable characteristic of culture was a developmental culture.

Hence, the perception of the respondents is that the culture in the AHR is that the values and norms are associated with bureaucracy such as following the rules, uniformity and coordination. The culture also emphasizes efficiency, productivity and achievement. Leadership styles tend to be more conservative, cautious, detail oriented, directive and goal oriented. The organization would also have a tendency to value stability, as shown in Figure 4 below (Quinn and Kimberly, 1984).

Table 3: Organizational Culture Scores

Culture for the AHR	Means	Range	Standard Deviation
Group (A)	21.81	0 – 90	12.753
Developmental (B)	17.09	0 – 43	8.485
Hierarchical (C)	35.49	0 – 100	15.981
Rational (D)	25.61	0 – 75	10.221
TOTAL	100	-	-

Figure 3: Organizational Culture Profile

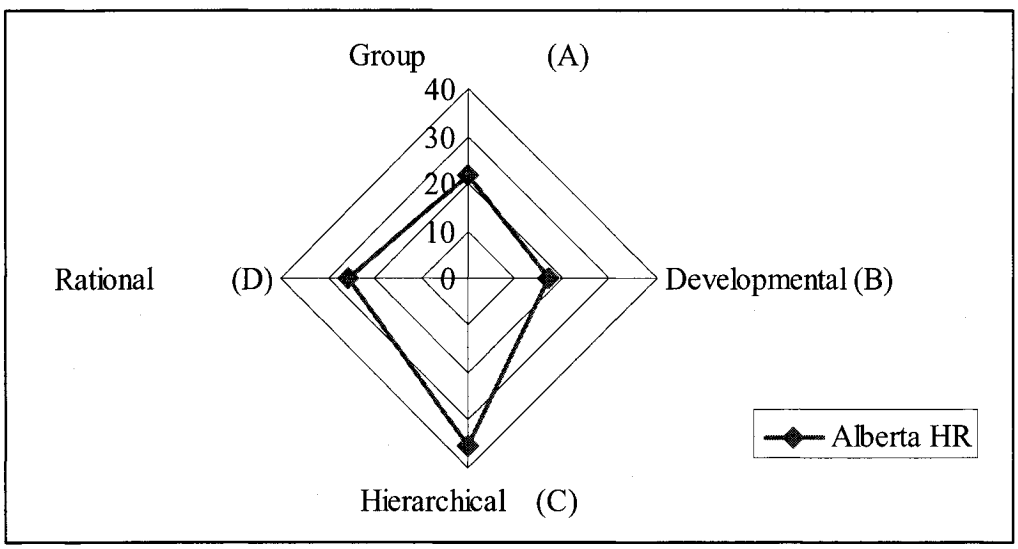
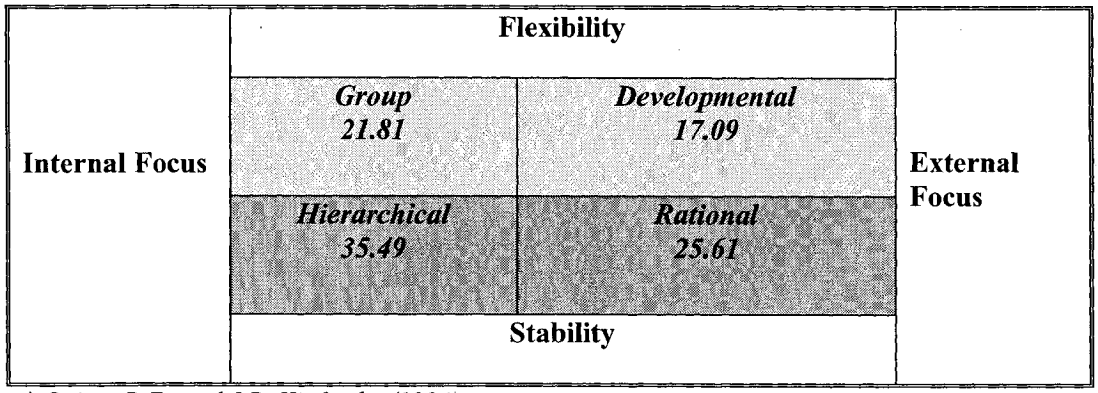


Figure 4: Relational Diagram of the Organizational Culture Dimensions



* *Quinn, R.E., and J.R. Kimberly. (1984)*

1.2.1. Findings in Relation to Independent Variables

The table below indicates in detail the data for each variable, with the shaded areas representing the statistically significant different means. There were no statistically significant differences in the means between males of females at a 0.05 level of significance. Thus, males and females had the same perceptions on the culture within the AHR.

However, there were statistically significant difference in the mean between those under the age of 45 and those above 45 at a 0.05 level of significance. Those above the age of 45 felt that the culture was more representative of a developmental culture and less representative of a hierarchical culture as compared to those under or equal to 45. Thus, the older group's perception was that the culture was based more on risk taking and innovation rather than bureaucracy.

Conversely, there were also differences in the means between those who have worked for more than 10 years in the organization and those working less than 10 years at a 0.05 level of significance. Those in the organization for a long time perceived the culture as more hierarchical and less group oriented versus those working for the organization less than 10 years.

With the occupation variables, there is evidence that the means are significantly different for at least 2 of the occupational groups. In the questions related to group culture, the mean for administration/MD was significantly higher than the mean for the allied health professionals and nurses. Conversely, in the questions associated with hierarchical culture, the mean from the administrative, support and other respondents are significantly lower than the mean for allied health professionals.

Overall, the perceptions of respondents were fairly consistent throughout the questionnaire. Most correlations between the different questions were significant at the 0.05 level. The details are as follows:

- The correlations were all significant for responses related to group culture at the 0.05 level.
- In the developmental related questions, there was no correlation between the perception that AHR is 'risk takers' and 'ready to meet new challenges'. The correlation was significant between the perception that the AHR is 'dynamic and entrepreneurial' and 'ready to meet new challenges' at the 0.05 level.
- The hierarchical correlations were all significant at the 0.05 level except for the perception that 'managers are rule enforcers' and 'permanence and stability' in which there was no significant correlation.
- Finally, in the questions related to rational culture, most of the correlations were significant at the 0.05 level. The correlation that was not significant was that the AHR is 'very production oriented' and 'managers are coordinators and coaches'. There was also no significant correlation between the responses related to 'managers are coordinators and coaches' and 'the organization emphasizes competitive actions and achievement'.

Table 4: Means for the Different Culture Groupings by Independent Variable

SCALES	Gender (N=259)		Age (N=259)		Manager (N=258)		Years with Organization (N=259)	
	Female	Male	<=45	>45	Yes	No	<10 years	>=10 years
Group (A)	21.64	23.31	21.78	21.83	23.26	21.59	23.48	20.14
Developmental (B)	17.18	16.34	16.03	18.20	18.44	16.92	16.81	17.38
Hierarchical (C)	35.57	34.70	37.63	33.26	31.65	35.97	33.74	37.22
Rational (D)	25.61	25.65	24.56	26.71	26.66	25.51	25.97	25.26
TOTAL Different	0		2		N/A		1	

Other interesting findings in the means for the hierarchal questions show an opposite phenomenon between the age and length of time with the organization. As mentioned, there are significant differences in the means for these variables: those who are above or below the age of 45 and those who have worked for the AHR for more or less than 10 years.

The element of studying the culture of the organization is to give a general idea of the environment at the AHR and the results should not be considered alone. They are only a probe and to be used to give a sense of the setting. The low response rate prevents broader generalization but it does provide opportunity to review these results in the context of the overall case study through triangulation.

2. Perception of Quality Improvement Implementation and Professional Implication Questionnaire Results

The second questionnaire refers to the perception of implementation of quality management and the implication on professionals, aimed at managers and executives.

The management questionnaire was collected over a three week period from October 25 to November 12, 2004. It was first distributed electronically via email by the Manager of the Quality Department at the AHR and distributed to all managers and directors in the organization. Respondents had the option to complete the survey online or to print the

survey and fax or mail the results to the Quality Department. The management questionnaire was lengthy, thus it was decided that at least 3 weeks were required to complete it. It takes approximately 15-30 minutes to complete from start to finish. Thus, the completed questionnaires were sent to the research team in Ottawa once the date for completion arrived.

There are 48 Directors and Senior Management staff within the AHR. The questionnaire for managers was sent to all Accreditation Team Leaders and AHR Directors. 45 people in total received the questionnaire and 22 were returned. Unfortunately, one of the questionnaires was incomplete and had to be removed from the sample. Thus, the response rate was 46.67% (or 21 questionnaires). However, two of the management questionnaires were missing a response for one variable (length of time with the organization) in Section D 'general information' which excluded them from analysis of that variable. Another questionnaire was missing a response for the question regarding the involvement in the last accreditation process, also in Section D 'general information'. Thus, this question was a sample of 20.

In terms of data analysis, since only 21 questionnaires were received, combining data was required in the respondent characteristics to make the results more significant.

In Section D, Question 2, in question related to age, again there were 4 options for respondents: below 30 years, between 30 to 45 years, between 46 to 55 years and over 5 years. For the purposes of the analysis, those below 30 years, between 30 and 45 years and between 46 and 55 were combined into one category and those greater than or equal to 55 years was the other category.

Similar to the culture questionnaire, to calculate the length of time worked or associated with the organization, the data was converted from months to years and categorized as with 'less than 10 years' or 'more than 10 years' (Section D, Question 3).

In the occupational category question (Section D, Question 5), there were no medical doctors that completed the management questionnaire. Thus, the only categories that were used in analysis were 'allied health', 'nurse' and 'other'.

Finally, the results were combined for Section D, Question 8, which asked respondents to indicate on a scale from 1 to 10 their involvement in accreditation. Those scoring their involvement under 7 were all combined. Thus, those scoring their involvement as 7 or higher were also combined.

No analysis was done with the occupational variable since the sample size was too small (N=21) and since there were only 3 categories identified. There would be little validity if any test of significance was run. However, these answers will be taken into consideration when all of the data is combined as part of the larger research study.

2.1. Respondent Characteristics

See the table below for a summary of the respondent characteristics. 85.71% of respondents were female (18 people) and 14.29% were male (3 people). For the purposes of the analysis, those below 30 years and between 30 and 45 years and between 46 and 55 years were combined into one category. The age cut-off was chosen at 55 because of considerations for other sites in the larger research study. Thus, the 55 plus was another category. There was not an even distribution between those above and below the age of 55. 61.90% of respondents (or 13 people) were less than 55 years of age. 38.10% of respondents (or 8 people) were 55 years of age or older. As mentioned, only 19 people responded to the length of period working with the AHR where 57.90% of respondents (11) have worked or been associated with the organization for less than 10 years and 42.10% of respondents have been working or associated with the organization for more than 10 years (8 respondents).

A majority of respondents had a clinical background (80.95% or 17 respondents). Only 19.04% (or 4) of respondents were non-clinical management staff. There was a good mix in the distribution of the occupational category. The largest category of respondents was

nurses. 47.60% of respondents were nurses (10 out of 21). The next biggest category was allied health professionals at 28.60% of respondents (or 6 people). Finally, 23.80% of respondents were from the other category (or 5 people). For the purposes of the analysis, the types of people in the 'other' category included 2 directors, 1 person in HR, 1 person in management and 1 person in support service. There were no medical doctors included in this sample.

Two-thirds of respondents were participants in the completion of the accreditation manual in the last accreditation (66.67% or 14 respondents). 33.33% (or 7) of management questionnaire respondents were not involved in this process. Two-thirds of respondents were members of an organizational wide quality assurance or quality improvement steering council (or equivalent body) (61.90% or 13 respondents). 38.10% (or 8 respondents) were not involved at all. Thus, there is a good mix in responses between those actively involved in quality improvement as part of their management role and those that are not.

Only 20 people answered the final question regarding the involvement in the last accreditation process. Out of all of the respondents, 25% (or 5 people) rated their involvement less than 7 on a 10 point scale. The remaining amount, 75%, rated their involvement in the accreditation process equal or above 7 out of 10 point scale. This is similar to the results found from question 6 regarding the involvement in the completion of the accreditation manual.

Table 5: Description of the Sample for the Management Questionnaires

CATEGORIES	*Variable*	N	%	*Variable*	N	%	Total
Gender (N=21)	*Female*	18	85.71	*Male*	3	14.29	21
Age (N=21)	*< 55*	13	61.90	*>=55*	8	38.10	21
Years with organization (N=19)	*<=10 years*	11	57.90	*> 10 years*	8	42.10	19
Clinical background (N=21)	*Yes*	17	80.95	*No*	4	14.95	21
Member of Self assessment (N=21)	*Yes*	14	66.67	*No*	7	33.33	21
Member of Quality Body (N=21)	*Yes*	13	61.90	*No*	8	38.10	21
Involved in last accreditation (N=20)	*Scale<7*	5	25.00	*Scale 7-10*	15	75.00	20

Occupation Variables*	N	%
Nurses	10	47.60
Allied Health Professional	6	28.60
MD + Other	5	23.80
TOTAL	**21**	**100**

** The occupational categories differed in the management questionnaire as compared to the culture questionnaire.*

2.2. General Findings

In the subsequent sections, each will include tables, indicating in detail the means associated with each independent variable, with the shaded areas representing the statistically significant different means. Also, because of the low response rate, the following results are more of an indication of tendencies and should be validated through other means.

2.2.1. Section A: The Baldrige National Quality Award Criteria

As represented in the Table 6 below, results show that the scale with the highest mean is the information and analysis scale followed by customer satisfaction and quality management. The scale with the lowest total mean score is the Human Resources Utilization (a.k.a. Employee Quality Training) followed closely by Strategic Quality Planning (Employee Quality Planning Involvement) and Quality Results. This indicates

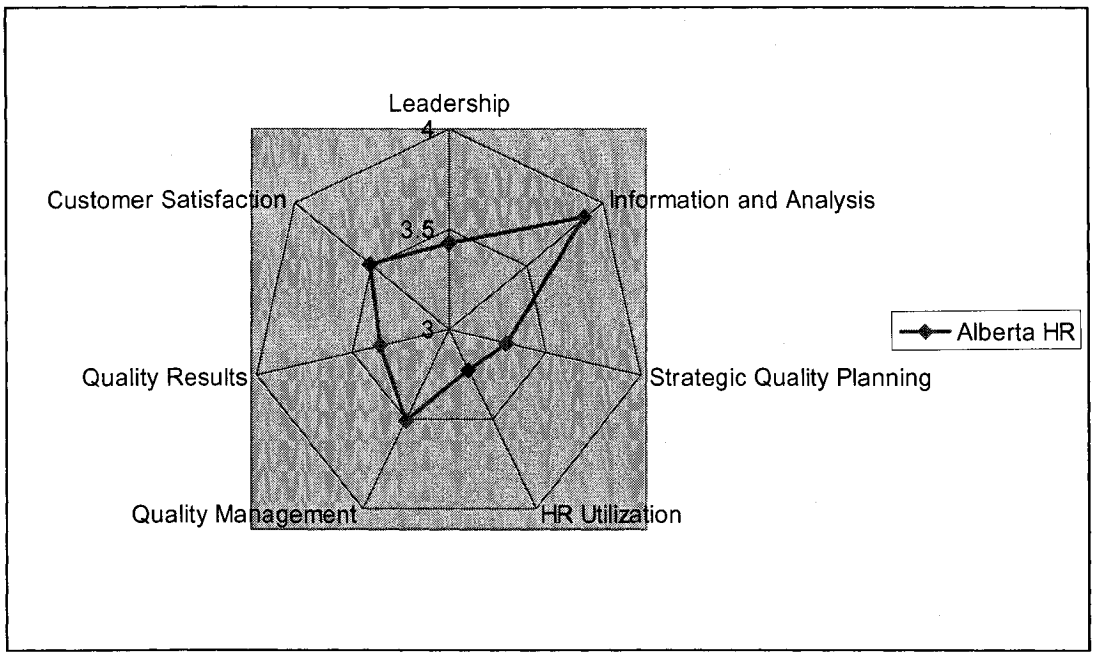
that the strengths of the organization lie in the use of data and information to drive decisions (3.89), meeting the customer expectations (3.52) and having work that contributes to overall quality and operational performance requirements (3.51). This is well evidenced by the implementation of QI teams and increased use of indicators through the use of a corporate balanced scorecard. Also, with the institution of a new Quality and Planning Department, there is more support for ensuring quality and operational performance.

However, the results identify lower ratings related to issues of employees not feeling educated and trained enough in quality improvement efforts (3.23). It was identified in the interview and focus groups that each member of the self assessment teams went through introductory training on the accreditation process but this has not penetrated the entire organization (solutions for those not involved). Also, the lower results in the involvement in strategic planning (3.30) indicate that employees do no feel as involved in the region's quality planning efforts or as empowered as they want to be. This is contradictory to the demographics of respondents of this survey since most indicated that they were involved in accreditation and quality efforts. Finally, the lower mean in quality results (3.36) indicates that respondents felt that the hospital was weaker at showing measurable improvement in quality and performance. This is not surprising since the institution of an official quality program was only attained post accreditation and wide-spread recognition of quality efforts was never mentioned as something to be highlighted throughout the entire site visit. Generally, it takes long to see the value of quality improvement and this often occurs over the long run.

Table 6: Section A Means

Scales	Mean	Range	Standard Deviation	Rank	Cronbach's Alpha
1. Leadership (N=21)	**3.43**	**2.1 – 4.6**	0.67685	4	0.914
2. Information and Analysis (N=21)	**3.89**	**1.6 – 5.0**	0.85413	1	0.953
3. Strategic Quality Planning (N=21)	**3.30**	**1.0 – 4.9**	0.80274	6	0.899
4. HR Utilization (N=21)	**3.23**	**1.9 – 4.9**	0.66648	7	0.812
5. Quality Management (N=21)	**3.51**	**2.3 – 4.3**	0.56173	3	0.832
6. Quality Results (N=21)	**3.36**	**2.2 – 4.0**	0.54918	5	0.860
7. Customer Satisfaction (N=20)	**3.52**	**2.4 – 4.4**	0.55727	2	0.809

Figure 5: Results of Management Perceptions of Quality Improvement, Section A



The reliability test using the Cronbach's Alpha is not the most statistically significant test in this aspect of the case study since the sample size small. Thus, variations will have more of an effect in a smaller group versus a sample size of 100. In a larger sample size, variations would be absorbed. However, in this case, the results for this section all can be considered reliable since the Cronbach Alpha scores are all above 0.6.

2.2.1.1.Findings in Relation to Independent Variables

There were statistically significant differences in the means between a few of the independent variables. In particular, the following were identified:

- Those above the age of 55 perceive quality management more favourably than those under 55 at a 0.05 level of significance;
- Those managers involved in accreditation report a higher degree of involvement and empowerment in quality planning efforts at a 0.05 level of significance.

Table 7: Section A Means related to Independent Variables, 0.05 Level of Significance

Scales	Gender N=21		Age N=21		Years in organization N=19		Clinical background N=21	
	Female	Male	<55	>=55	<=10 years	>10 years	Yes	No
1. Leadership (N=21)	3.45	3.33	3.30	3.65	3.50	3.50	3.47	3.27
2. Information and Analysis (N=21)	3.87	4.00	4.01	3.70	4.13	4.04	3.83	4.14
3. Strategic Quality Planning (N=21)	3.35	3.05	3.18	3.50	3.30	3.67	3.39	2.93
4. HR Utilization (N=21)	3.20	3.42	3.15	3.36	3.24	3.42	3.23	3.24
5. Quality Management (N=21)	3.55	3.26	3.29	3.87	3.58	3.59	3.53	3.40
6. Quality Results (N=21)	3.35	3.38	3.18	3.64	3.40	3.36	3.33	3.47
7. Customer Satisfaction (N=20)	3.52	3.54	3.44	3.65	3.59	3.62	3.52	3.49
Total # of variables with significantly different means	0	0	1	1	0	0	0	0

SCALES	Member of Self assessment Team (N=21)		Member of Quality Body (N=21)		Involvement in last Accreditation (N=20)	
	Yes	No	Yes	No	<7	7-10
1. Leadership (N=21)	3.50	3.29	3.58	3.18	2.96	3.58
2. Information and Analysis (N=21)	3.89	3.90	3.96	3.79	3.43	4.03
3. Strategic Quality Planning (N=21)	3.45	3.00	3.50	2.99	2.69	3.52
4. HR Utilization (N=21)	3.17	3.36	3.40	2.95	3.05	3.30
5. Quality Management (N=21)	3.54	3.43	3.63	3.31	3.37	3.56
6. Quality Results (N=21)	3.35	3.37	3.43	3.24	3.31	3.42
7. Customer Satisfaction (N=20)	3.51	3.53	3.61	3.37	3.23	3.62
Total # of variables with significantly different means	0	0	0	0	1	1

2.2.2. Section B: Professional Participation

Section B on professional participation was designed to assess the extent staff are involved in decision making. Overall, the mean was high overall at 3.74, indicating that respondents feel that they are 'almost always' involved or have influence on the decision making process. The results of this section indicate a high Cronbach's Alpha (0.927 > 0.6), which may suggest a high level of item redundancy; that is, a number of items asking the same question in slightly different ways. Thus, the Cronbach's Alpha cannot be used alone as a test of consistency and reliability. However, looking at the inter-item correlation matrix shows that all the variables are highly correlated (>0.5), which means that each variable contains the same information about professional participation and perceptions.

Table 8: Section B Means

SCALES	Mean	Range	Standard Deviation	Cronbach's Alpha
Professional Participation (N=21)	3.74	1.00 – 5.00	0.8596	0.927

Respondents feel that they are involved in administrative decisions, consulted in decision making and that participation by professionals in the organization's management is relatively similar as the others. However, the level of participation in the organization's management is not as highly correlated. This indicates that respondents perceive that they are involved in administrative decisions and consulted but that they are not as active in the organization's management as they would like to be.

2.2.2.1.Findings in Relation to Independent Variables

Overall, there are no statistically significant differences related to professional participation at a 0.05 level of significance.

Table 9: Section B Means related to Independent Variables, 0.05 Level of Significance

SCALES	Gender N=21		Age N=21		Years in organization N=19		Clinical background N=21	
	Female	Male	<55	>55	<10 years	>10 years	Yes	No
Professional Participation	3.72	3.88	3.57	4.00	3.82	3.93	3.72	3.81

SCALES	Member of Self assessment Team (N=21)		Member of Quality Body (N=21)		Involvement in last Accreditation (N=20)	
	Yes	No	Yes	No	Yes	No
Professional Participation	3.86	3.50	3.95	3.40	3.08	3.94

2.2.3. Section C: Impact of Accreditation

Section C addresses the perceptions of respondents on the impact of accreditation within their organizations. The questions in this section focus around the preparatory phase of accreditation, the recommendations, the intern

al changes, responsiveness and collaboration and accreditation as a valuable tool. Please see Table 10 for a comparison of responses.

Table 10: Section C Means

SCALES	Mean	Range	Standard Deviation	Cronbach's Alpha
Preparation Phase Q1 to Q2 (N=19)	3.76	2.00-5.00	0.82274	0.734
Recommendations Q3 to Q5 (N=21)	3.95	2.67-5.00	0.77664	0.796
Internal Changes Q6 to Q8 (N=20)	4.18	3.00-5.00	0.76753	0.803
Responsiveness and Collaboration Q9 to Q11 (N=20)	4.08	2.67-5.00	0.80840	0.881
Valuable Tool Q12 to Q13 (N=20)	4.25	3.00-5.00	0.55012	0.861

The means presented in the table suggest that respondents 'agree' in general that accreditation made an impact internally and on the relationships with external partners. Overall, the responses indicate that people felt that accreditation has an impact in the preparation phase, that recommendations were an opportunity to implement change, that accreditation enhances responsiveness and collaboration and that accreditation enables the improvement of care, development of values and better use of resources. Most respondents were in favour of the statements that accreditation is a valuable tool for the organization to implement changes and that it enables an organization to be more responsive to change.

In terms of reliability, since all of the Cronbach's Alpha's were greater than 0.6, the scales are considered highly consistent and reliable. However, when looking at the inter-item correlation matrix, they indicated that the degree of correlation between some of the grouped responses were not always well correlated since the correlation was less than 0.6. For example, in the questions related to accreditation preparation, there was limited correlation between the perception that changes were implemented in the preparation phase and the responses related to actually being involved in the changes. In the questions related to the recommendations, there was limited correlation between people's perceptions that recommendations were communicated about the last survey versus recommendations were an opportunity for improvement and participation in the changes. Finally, in the questions related to internal changes, there was limited correlation between people's perceptions that accreditation enables the improvement of patient care and accreditation enables organizations to use resources better. However, all of the inter-item correlations were above 0.5.

When looking more closely at the ranges in responses, they indicate that no one responded that they strongly disagreed with any of the statements in the accreditation impact section.

2.2.3.1.Findings in Relation to Independent Variables

There were statistically significant differences in some of the independent variables, which are highlighted in grey in the table below (at a 0.05 level of significance). Related to internal changes, females respondents agreed that accreditation has impact where male respondents neither agreed nor disagreed. There were differences in responses between those above and below 55 years of age. Those above 55 did not see as much value in the preparatory phase of accreditation as those under 55. This could be explained since, more likely, those under 55 are not as familiar with the organization as the longer standing employees, who could see more value in the preparatory phase and connecting with others.

Table 11: Section C Means related to Independent Variables, 0.05 Level of Significance

SCALES	Gender		Age		Years in Organization		Clinical Background	
	Female	Male	<=55	>55	<=10 years	>10 years	Yes	No
Preparation Phase Q1 to Q2 (N=19)	3.72	4.00	3.41	4.25	3.61	3.88	3.72	4.00
Recommendations Q3 to Q5 (N=21)	3.85	4.56	3.92	4.00	3.85	4.08	3.84	4.42
Internal Changes Q6 to Q8 (N=20)	4.25	3.50	4.22	4.10	4.00	4.40	4.21	4.00
Responsiveness and Collaboration Q9 to Q11 (N=20)	4.13	3.67	4.08	4.08	3.93	4.17	4.08	4.11
Valuable Tool Q12 to Q13 (N=20)	4.25	4.25	4.42	4.00	4.10	4.38	4.21	4.50

SCALES	Member of Self assessment Team		Member of Quality Body		Involvement in last Accreditation	
	Yes	No	Yes	No	Yes	No
Preparation Phase Q1 to Q2 (N=19)	3.89	3.40	3.91	3.56	3.5	3.86
Recommendations Q3 to Q5 (N=21)	4.12	3.62	4.21	3.54	3.33	4.13
Internal Changes Q6 to Q8 (N=20)	4.17	4.19	4.11	4.27	4.27	4.23
Responsiveness Q9 to Q11 (N=20)	4.08	4.10	4.28	3.79	3.93	4.21
Valuable Tool Q12 to Q13 (N=20)	4.19	4.36	4.25	4.25	4.20	4.29

2.3. Analysis

The results from the management questionnaire related to a tendency around the use of information and analysis for improving care which aligns well with results from the culture questionnaire, which indicate a culture of efficiency, productivity and achievement orientation. However, it is surprising that the management questionnaire did not show a higher mean for quality results but instead, 'quality results' was one of the least favourable values. This further indicates that managers and directors want more of an assessment of hospital efforts to improve quality and want to be involved in the development of plans to improve quality.

The interesting result is that those who completed this questionnaire were really the ones pioneering or involved in changes related to accreditation and QI since a majority of responses (two thirds) indicate this fact. Conversely, when rating involvement in the accreditation process, 75% of respondents indicated that they were very involved. Thus, the opinions represented in this survey truly show the perceptions of those key players in the QI process.

It is important to note that all the means fall around the same point on the scale (between 3 and 4; between neither disagree nor agree and agree), indicating that the differences between items is not very significant. This suggests some issues related to use of the Likert scales since the answers seem to gravitate to the "centre". Even though this is the case, it does still provide some sort of ranking in terms of area of importance.

CHAPTER VII – QUALITATIVE RESULTS AND ANALYSIS

1. RESPONDENT CHARACTERISTICS

In preparation for the visit to the AHR, the recommendations and areas to improve as outlined in the Accreditation report were reviewed and outlined. This information was used as an aid for the researchers in order to probe and to give context for the research.

1.1. Focus Groups Summary

The following is a summary table of the participation in the focus groups. The number of clinical teams and support teams represented were for the accreditation year 2002.

Table 12: Focus Group Participants Summary

	Number of Participants	*Type of Group*
Focus Group #1 (FG#1)	8	Non-Clinical (Leadership & Partnerships, Information Management, Human Resources, Environment, Pharmacy and Lab)
Focus Group #2 (FG#2)	10	Clinical (Palliative Care, Rehabilitation, Public Health, Community Care, Continuing Care, Critical Care, Ambulatory Care, Medical Care, Surgical Care, Maternal Child Care)

As indicated, two focus groups were established, where the meetings lasted approximately an hour and a half. The first focus group represented the non-clinical teams a.k.a. the support teams (i.e. the Leadership and Partnership Team, Environment Team, Information Management Team and the Human Resources Team). Of the participants, two were from Pharmacy and Lab Services, represented on the Information Management Team, adding an interesting dynamic and perspective to the conversations. The second team was comprised of only clinical representatives. Out of the nineteen

accreditation self assessment teams, 14 were represented over the two focus groups, which is a fairly good representation of the teams. The teams that were not represented were Mental Healthcare Team and the support teams for a specific site in the AHR. The specific site was surveyed separately since the representatives from that site were not included in the other teams.

There was a mix-up in the start time of the focus groups so some people arrived late. In the first focus group, two participants entered after the first question was answered. In the second focus group, only one person was late and they entered halfway through the focus group. Thus, by the end of the session, all representatives scheduled to participate had provided some degree of input. This was not a hindrance since the members were able to still contribute to the main aspects of the conversation.

On the first day in the first focus group, only one half of the focus group was taped because the researchers were not familiar with its functioning and only realized it stopped when the focus group was complete. Thus, for the first half of the focus group with administrative staff, the transcribed version was coded. For the second half of the first focus group that was not taped, the notes from the focus group were used to capture the essence of the conversation. The notes taken were satisfactory throughout the entire site visit. Most of the conversations were captured verbatim. This can be qualified since after the transcriptions of the interview and focus groups were completed, they were compared against the notes and they were very accurate. Thus, no key information gathered from the focus group was missing, even though the focus group was not all taped. Subsequently, all interview and focus groups were compared against the notes to ensure consistency.

1.2. Interview Summary

Originally, there were to be six interviews, where five interviews were gathering input using the original interview questions and the last interview was receiving input on a specific quality improvement initiative. However, due to time constraints, the CEO and COO did an interview together, resulting in only five interviews in total. These

interviews lasted up to an hour and a half, with the longest interview being with the CEO and the COO. Also, one team leader responded to the QIT interview questions in written form.

Initially, it was requested that the CEO, the Director of Quality, the Director of Professional Services, a Physician and the Chief Nursing Officer/Director of Nursing be interviewed. The people who actually participated held the following positions:

1. Executive Director, Workforce Services (INT #1)
2. Chief Executive Officer and Chief Operating Officer (INT #2)
3. Executive Director, Mental Health Services (INT #3)
4. Executive Director, Patient Care Services (with background in quality management) (INT #4)
5. Team Leader, Palliative Care (INT #5)
6. Team Leader, Maternal Child (INT#6) Note: This team lead participated by answering the QIT interview questions in written form

2. Conditions Favouring Change

The conditions favouring the emergence and distribution of change will be reviewed in the context of the findings from the interviews and focus groups.

2.1. General Environment

The Healthcare system within the Province of Alberta has experienced significant change and reorganization over the past decade. Merging of regions, reduced spending and reassignment of governance structures have all contributed to the sense of uncertainty and frustration amongst the populace. Now that change has been implemented and major adjustments made, growth and progress can be realized; but the milestones of that journey cannot be forgotten nor can the impact of that change on healthcare be ignored:

- 1992-93: Serious financial problems are identified and healthcare cuts must be made. Reductions require a more integrated healthcare model with reduced spending and stability in funding;

- 1994: Regional Health Authorities Act established. 17 health regions created that practice autonomously;
- 1998: Per capita health spending dropped to the point where Alberta is lowest in Canada;
- 2003: The 17 existing regions are reduced to 9 and the Mental Health Boards are included with the new regions. The Alberta region under study was created when 4 former regions were combined and the mental health board integrated to form a single region.

These milestones clearly confirm the feedback received during the interviews and focus groups. The one consistent factor in healthcare in Alberta has been the ongoing change process.

> *"So change has actually been the consistent thing in our health region anyway. A lot of regions did not go through that this last time. So we were probably, along with one other region, impacted in the greatest way when we went from 17 to 9 regions in this province." (INT #2)*

With the change has come pressure to adapt and conform and, in many instances before that occurs, more change is initiated. Those employed in healthcare have, for the most part, survived and learned from these experiences but the real motivation has been initiated by the strong population health component that exists in the region. Healthcare delivery in the region is accountable to the provincial government but also to the citizens. Services then can be determined by the region to meet the needs identified through demographic and population based data. Perceptions exists that all Albertans are receiving equitable services and individual regions respond to specific needs of their communities.

> *"Since 1995, things have been standardized across Alberta – equitable access to services needed."(FG#2)*

There are some factors, however, that have been stabilized in spite of all the changes. The management structure and the individuals in leadership roles have not varied

significantly over the decade. New middle managers and new position may have been created but there has been stability at the senior management level.

> *"With the integration of the four health regions and the Mental Health Board, I think there's been a fair amount of movement in sort of the middle management area. There's been a little movement at the senior management level, but not as much as at the middle management level, and that was during the last 5 years. Yeah that was 2003 we integrated." (INT#3)*

As well, the decision making process has varied very little. Strategic plans are set and operational plans of action follow. Those involved in the process know what to expect and rely on this stable, secure process that is based on facts and evidence. However, before accreditation, QI was not identified as part of this process but this has since changed.

> *"We have a strategic plan, and each one of the departments has developed operational plans as a result of that strategic plan. So we normally go back and double check the strategies in our strategic plan to ensure that we're still moving towards the goals of the organization as a whole. So that would probably be the first step, looking at the important decisions. And then the strategies that are implemented, we look at the most efficient, effective and holistic. We look at collaborative means for implementation. So we look to other departments. Who should be involved? Who is this going to impact most? How do we get them involved? That's kind of how we work with the strategies that need to be implemented, and then we can communicate that."(INT#1)*

In addition, the philosophy of need focused, improvement oriented service delivery, accreditation is a priority for which, inevitably, might stabilize the constant changes that occur on an ongoing basis; and instead, lead to continuous quality improvements where change occurs on a more subtle but ongoing basis. This fosters creativity and innovation where many can be involved and realize success. Of course, the needs of the clients are considered utmost but this goes without saying.

"And so that speaks to having freedom to express opinions, and to make recommendations or take action. However, always within the constraints of good judgment in the sense that you know the other side of that balance is making sure that the patient and the public is safeguarded in terms of opinion expressing, and in terms of acting independently, that there is a greater good that needs to be considered, both for the patient and the organization. If it's a decision that is going to impact financial resources, if you need more money for it, then you have to present a business case saying this is what we need to do. In terms of decision making, our management philosophy is quite clear in terms of our accountability and we're expected to make decisions within our scope of responsibility." (INT#2)

"Certainly, within any organization as large as this, there are certain things that need senior management and board authority approval, but I would say that probably those are the minority. Mostly a department is expected to manage. You know what your resources are. You have the freedom to use your resources, to meet the mandate of your department. E.g. I'm responsible for Child & Adolescent Mental Health, and you know the expectation is that I'll make the decisions about Child and Adolescent Mental Health. I mean I do that in cooperation with other people, but the bottom line is I sign for the money." (INT#4)

2.2. Organizational Conditions

During the interview process, representatives from teams across the region were asked to identify the important values that were evidenced in the healthcare system. Consistently, comments praising the quality of care and the client-centred focus were expressed. The care providers, of course, accepted credit for the care and pride themselves on excellent skills and abilities.

"We need to be a learning organization and environment, and we need to be sensitive to the needs of our clients, and we need to be sensitive to the needs of

our communities, both rural and urban."(INT#1)

"Client centered, patient safety clients come first; patients come first. It's all about the care we provide. Ultimately (the AHR's) goals, in my view, are to ensure that we're providing quality patient, client care throughout the entire region."(INT#2)

Values then that are important to them include ethical behaviour; being responsible and accountable to client, to the organization and to oneself; seeking opportunities for learning and acquisition of new knowledge and skills so each individual might be challenged to be the best he/she can be; working as an individual but working in a team; communication that is open and honest; and cooperation and commitment to the organization and to the teams. Many respondents made it clear that there is diversity and uniqueness throughout the region; but collectively, innovation and creativity are encouraged. Individuals can think and act independently but quality care emerges when there is teamwork and cooperation.

"There is a sense of teamwork at the senior management level. I think we do things collectively, and we do have input obviously, at some point, there's always somebody has to make a decision, but I think normally it's reached by consensus and so on. So I think openness". (INT#2)

In coding the responses and considering the comments, there was no obvious evidence of dissatisfaction with the AHR. The situation was not at any point described as unsatisfactory.

"There is lots of corporate spirit. I think people within (AHR) are very committed to (AHR) and very long service employees."(INT#3)

Based on the assumption that dissatisfaction evokes the desire to change and satisfaction maintains the status quo, the expectation would be that these teams would not be interested in change or improvement. However, they were willing to embrace the accreditation process and accepted the challenges of the new undertaking.

2.3. Strategies for Exchanging Ideas, Learning, Participation and Diffusing Information

The self assessment team representatives readily identified the communication strategies that are available to them so there is exchange of ideas and opportunity for brainstorming and decision making as a team. Some of the formal structured venues included:

- departmental meetings;
- elected representation on decision-making committees that are functional based on mandates within collective agreements; and
- leadership seeks input from all staff and forums are established for this purpose.

It was also significant to hear that a usual practice is to form an investigative research/information gathering team when a quick decision must be made regarding an issue affecting healthcare in the region. Recommendations are finalized and decisions are then made.

> *"Another thing that the (AHR) does when we have to make a quick decision, we put together a team quickly to do a review, obtain the information required and put forth recommendations." (INT#2)*

Formal and informal committees convene at the upper management level right down to frontline team meetings. In some instances, outsiders from the community are a part of the process. Generally, there is a sense of openness and sharing and the expectation is that all will feel free to share exists and is understood.

In addition to the verbal exchange of information, modern technology allows sharing through an IntraWeb connection and chat rooms. Information can also be readily shared through newsletters that are available online and via hard copy. Divisions within the region then share information on a regular basis. Communication across this big region might be less effective but the methods exist for those that seek them out.

> *"The (AHR) has an online chat line that they encourage people to use to discuss current issues and topics. It's called IntraWeb, where there's information constantly as to what's going on in the region. There aren't really chat rooms but*

there's ability to do some interactive things on the internet in terms of getting people's input."(INT#2)

"We've got several newsletters, weekly ones, and then we've got the every couple of months one. We've got the one's that the public gets called "Health Facts". We have every newsletter in the world imaginable going out and we also do annual reports to the community. We do mid year reports. So I think the fact of being transparent, I think, is an overused word, but where it makes sense."(INT#4)

Knowing this openness and communication exists helps explain the success evidenced during the accreditation process. To facilitate change, environments must be created to allow for debates, information exchange and training (Crozier and Freidberg, 1997; Mintberg et al., 1999). Across management and staff, all personnel are comfortable relating because of previously established strategies. Accreditation, then, was a new process but teamwork with open communication was not a new experience.

2.4. Leadership and Competencies

2.4.1. Visibility of Leadership Commitment

The general consensus from all the comments and feedback gathered from participants indicate that leadership is strong and a priority at the AHR.

"Leadership is seen as a strength at the (AHR)." (FG#2)

Interestingly, leadership refers not only to the CEO but also to management at all levels of service.

"We have a fairly strong CEO with strong leadership skills."(INT#1)

"The CEO values the effective leadership that is provided by the people he works with."(INT#4)

"We've got people who have been involved clinicians at high levels that have been involved in healthcare for years. These people add clinical excellence, expertise and value. They have participated in important changes that occurred at the (AHR). They are very experienced managers, very skilled, and we have some new managers, because you need to be bringing new people in to build your bench straight for the future. At the clinical level, I would say we're a very strong region management-wide and leadership-wide. Like any organization, we have issues. But I would not say that our management team is one of our weaknesses, and even at the clinical level, we have very long service employees, even on the frontlines." (INT#1)

There were several comments that referred to the strength in leadership from the medical staff. This strength seemed to have come as the reorganization evolved. Interesting also were the comments that referred to the informal leadership, those not recognized as official administrators.

"There are times when there are people that you know are key people, and maybe further down, by down I don't mean in the organizational structure. I think there are key leaders, who may not have a position necessarily, but who you know are the informal key leaders in their own peer group. That is important to know as well. We talked about that in looking at service planning, where there will be certain people that will be there to represent certain groups, just to ensure that everybody perceives that it's an all inclusive process." (INT#2)

In compelling comments and data regarding leadership, participants consistently link leadership with the number of years an individual has been with the organization and the number of years of service in a particular position. Although there are references to new managers recently hired, they are not labeled "leaders".

"Very experienced managers, very skilled, and we have some new managers, because you need to be bringing new people in to build your bench straight for the future." (INT#1)

2.4.2. Identification of Resource People

Prior to accreditation, it was generally accepted that the leaders within the organization were also available as a resource to others. The slogan at the AHR has been:

> *"Quality is everybody's responsibility." (INT#2)*

Therefore, everyone was thought to be answerable. This notion, however, seems to have shifted since the experience of the accreditation process. The Quality Department and Quality Improvement Teams have been established in the last 18 months.

> *"These people are seen as a resource, and the people that have the expertise that assist all of the departments and the staff in dealing with quality improvement." (FG#1)*

After accreditation, there now exists more of an environmental sensitivity to quality. The comments regarding this newly organized department confirm the value of this leadership.

> *"Thus, the Quality Improvement and Planning Group have formal responsibilities are quality planning, those kinds of things. There is good leadership with our quality management area. They facilitate quality, and so quality management is built into what we do, and hopefully it interweaves or is the foundation for our strategic planning, for our operational plans. I think it's quite strong when you look at our balanced scorecard that everything really does have the output of being a quality service. So I would say that all management is involved in quality improvement."(INT#1)*

2.4.3.Project Initiators and Implementers with Clearly Perceived Legitimacy

The interviewees identified several individuals and groups as initiators and implementers for improvements. Naturally, those first recognized as leaders within the organization were mentioned again.

The Chief Executive Officer

"The CEO is involved to the degree where he supports and endorses quality improvement processes, and he's interested in knowing the results. He drives through his leadership and vision but he professes and lives that philosophy. And I think that's demonstrated by the initiatives that he's supported going forward."(INT#1)

The Chief Operating Officer

"The COO provides regular monthly updates to senior management on our operational plan. So we've identified all of the goals and strategies in our operational plan, and as we implement actions, timelines, leads and dates, the COO provides a monthly report on progress." (INT#2)

Employee Health and Safety Groups

"In terms of safety, there is an Employee Health and Safety Group, and they have formal responsibilities for disability management, occupational health and safety and employee health. So the immunization program, safety as far as environmental safety. They establish, orient, educate, train and work through with the various departments with respect to policy development, and procedures for implementing safety in their own areas."(INT#1)

2.4.4. Ongoing Valorization of Project

As previously mentioned, following the accreditation process, the organization created the Quality Improvement and Planning Group. Naturally, part of their responsibility would be to promote and maintain CQI. The comments regarding the work of the department were positive.

"I think it's quite strong when you look at our balanced scorecard that everything really does have the output of being a quality service. So I would say that all management is involved in quality improvement."(INT#4)

The expectation of course would be that this department be connected and integrated in all areas of the organization to assist with identification of issues of concern and to motivate others to assist with the CQI process. However, it does not seem that this process has been established yet.

> *"The challenge becomes when QI is a separate area, it's really hard to then weave the thread of quality improvement through daily activities when we have a separate areas whose job that is, or whose focus that is. So it's a bit of a balancing act."(INT#2)*

2.4.5. Competencies in Quality Improvement

When asked about representatives within the organization that possess good knowledge and skills in the area of QI, responses from focus and interview participants link the accreditation experience with QI. Consistently, individuals who had previous experience with accreditation or as an accreditor were also identified as individuals within the organization who had competencies in QI.

> *"Some members of Senior Management, some physicians and a few in the Quality Planning group are surveyors for CCHSA. Other members of the Quality Planning group have QI as their background or area of study. They demonstrate the ability in that area to facilitate". Also there are "various managers involved in other accreditations throughout their lives that bring that experience to the process."(FG#2)*

The comments, however, also indicated that the accreditation process was an educational experience and many employees are interested in leaning more and being more involved.

> *"Where staff do not have the background, they learn. They build that capacity within our people, or we may bring in experts. For example, we're learning root cause analysis, so we needed to bring some people in to help us learn the specifics of root cause analysis. But I'm not sure that we need people who have experience in quality improvement. You just need people with really good analytical skills and understanding quality improvement. Another example is*

that with the last round of accreditation, a lot of education was offered to people in the organization and the coordinator was very supportive."(INT#4)

2.5. Conception and Comprehension

In reviewing the changes faced by this health region, it is obvious that the biggest factor the staff, both administration and frontline, had to cope with was change; change that came unexpectedly, change that was economically driven and change that was politically motivated. This has all been explained in the previous sections. The participants in our focus groups and the interviewees frequently mentioned this constant evolution of change. Notable, however, there are strengths that they identify, perhaps unknowingly; themes that consistently appeared in their recounting of the "journey" of the organization had traveled since 1992. The behaviours, the models, the "knowing" that emerged as a result of the process include:

a) A sense of confidence and security remained unchanged in the organization because the administration and management right down to frontline staff remained. The organization grew and expanded but the "workers" and "knowledge of history" remained, giving stability and sense of sameness.

"There have been a number of changes on the corporate side certainly, and I suspect on the professional side as well. On the corporate side, 18 months ago actually we ended up bringing five organizations together. The (AHR) became the going concern, if you will, but added to us was another health region, a smaller rural region, parts of two others, and a significant part of the Alberta Mental Health Board. So that was all brought together, and we have been through significant changes prior to that as well."(INT#2)

"Senior executive roles have been filled by the same or similar people for a number of years. And some of the managerial roles, up to and including the director role are filled by people, who have been in the health system for years,

although like me through restructuring have ended in a different spot from where they started."(INT#1)

b) Although the initial change was unexpected and disruptive, over time, it became expected.

"Change has actually been the consistent thing in our health region anyway."(INT#2)

c) Because of the changes and because of the leadership stability, this organization has developed a confident and accountable method of decision making. This process has developed because of necessity. Business must continue, even in turmoil, and being able to look back and learn from it is a strength and, if done well, it allows an organization to move forward.

"Underpinning philosophy is to enable people to be the best that they can within our organization. And so that speaks to having freedom to express opinions, and to make recommendations or take action. However, always within the constraints of good judgment in the sense that you know the other side of that balance is making sure that the patient and the public is safeguarded in terms of opinion expressing, and in terms of acting independently, that there is a greater good that needs to be considered, both for the patient and the organization. They do not have the freedom to put the organization at risk in order to exercise their independence."(INT#2)

"Departments across the continuum are constantly developing new programs, taking new approaches; you know applying best practices, freedom, certainly to bring forth ideas. Strategies are implemented they've really attempted, not always successfully to have a communication plan attached to the strategy."(INT#4)

"There really is a sense of teamwork at the senior management level. I think we do things collectively, and we do have input obviously at some point there's always somebody has to make a decision, but I think normally it's reached by consensus and so on. So I think openness. I think communication is another thing that we value greatly within our organization."(INT#2)

"The (AHR) is using a number of focus groups to get at the important, key issues to enable us to make a decision ultimately e.g. used in service planning. And that's a model that we use fairly consistently in trying to get the information that we need to make decisions...Another practice used is that it is a lot easier to get people's input if it isn't senior management running the focus group. So we have somebody actually independently running those focus groups."(INT#2)

The behaviours outlined, verbally confirmed in the qualitative data, validate the findings of Kleiber (1997) which states that "individuals need to understand upcoming changes within their own context, hence acquire new intellectual models, which requires a reflexive comprehension". In today's vernacular "been there, done that", we have learned a lesson that we can now use to move forward!

3. CHARACTERISTICS OF CHANGE

Each change identified in the organization can be described using four categories of characteristics which are as follows: (1) the nature of change, (2) its conception, (3) the motivation, which led to the change and (4) the type of change involved. Each change are reviewed in the context of the findings from the interviews and focus groups. Overall, 26 changes were listed in total: 3 occurred in preparatory phase, 2 in the survey phase, 15 after the report and 6 general changes not linked to any particular phase. There were other change identified not tied to accreditation as well

However, for the purposes of this section, particular changes identified in the study have been selected and evaluated in order to make some generalizations on the findings related to characteristics of change. The changes selected are as follows:

- two changes as a result of the key recommendations from the 2002 accreditation survey
- three changes as a results of the general recommendations from the 2002 accreditation survey
- two changes identified for improvement by self assessment teams
- one structural change.

Table 13: Characteristics of Change

Characteristic of Change	*Enhancement of the Special Care Nursery Structure and Environment*	*Implementation of process for fire drills across the region*	*Creation of a QI Plan for Information Management*	*Implementation of an Ethics Committee to help staff and clients resolve ethical dilemmas*
Nature of Change				
Mechanism	Intentional	Intentional	Intentional	Intentional
Target	Concrete	Concrete	Concrete	Concrete
Pace	Rapid	Rapid	Slow	Slow
Rhythm	One time	Variable	By increments	One time
Dispersion	Localized	Generalized	Generalized	Generalized
Trajectory	Completed	Completed	Blocked	Completed
Phase	Completed	Growth	Initiation/Growth	Growth
Duration	Short	Long	Long	Long
Conception	Deductive	Deductive	Deductive	Deductive
Motivation	Authority of Accreditation	Authority of Accreditation	Influence of Accreditation	Influence of Accreditation
Type of Change	Physical Structure	Process	Process	Organizational Structure
Level of Change	Organizational	Organizational	Organizational	Organizational

Characteristic of Change	*Creation of a process for performance appraisals*	*Development of a QI Team for Maternal Child*	*Connection of 11 immunization registries*	*Director of HR and Education merged into one position*
Nature of Change				
Mechanism	Intent	Intent	Intent	Intent
Target	Concrete	Concrete	Concrete	Concrete
Pace	Slow	Rapid	Slow	Rapid
Rhythm	Incremental	One time	Incremental	One time
Dispersion	Localized	Localized	Generalized	Localized
Trajectory	Blocked	Completed	Blocked	Completed
Phase	Growth	Growth	Initiation	Growth
Duration	Long	Short	Long	Short
Conception	Deductive	Inductive	Deductive	Deductive
Motivation	Influence of Accreditation	Influence of Accreditation	Influence of Accreditation	Influence of Accreditation
Type of Change	Process	Strategic Transformation	Risk Mgmt and Process	Organizational Structure
Level of Change	Organizational	Group	Organizational	Organizational

3.1. Nature of Change

Looking at Table 13, we notice that all of the changes that occurred were intentional, concrete and inductive, except for the change that was implemented by the Maternal Child Team, which advocated for the creation of a QI Team for this area. Most of the changes identified were in the initiation or in the growth phase. Since accreditation was a new process for the AHR, this would make sense that that many of the recommendations and changes are still in the process of being initiated or are in the growth phase. Only one change was completed fully, which was the enhancements to the special care nursery. In terms of trajectory, many of the changes have been worked on. Only some have faced issues with implementation. Depending on the change, the dispersion, the pace, the rhythm and the duration would vary. A common theme that resulted, however, was that if the change was generalized and the motivation was top down, the change process was slower since it would impact more people and require more coordination for the change to take place. When the change was more localized, the pace of change was more rapid, most likely due to the smaller scale and the ability to react and implement change would be much quicker.

3.2. Conception of Change

One interesting finding from the changes that were implemented was that most changes were deductive, from the top down (Rocher, 2000) instead of inductive, coming from staff to management. Many of the changes that were suggested in the self assessments were inductive in nature in that the self assessment teams put forth strengths and areas to improve as part of the first phase of accreditation. However, the movement of those areas for improvement to action was as a result of management realizing the importance of the changes required and endorsing those.

> *"At the senior management level, they took the report, and they assigned different recommendations to different senior managers according to their portfolio, and they were responsible for making sure that there was action taken, and that those recommendations were followed through on, and there was some closure. And in some cases, because the recommendations were fairly large, and fairly broad, it involved a lot, like the Special Care Nursery, which was one of the*

recommendations that we got which was very complex. There was a plan that had to be put in place, and COO was responsible for making sure that that was carried through, and those were revisited on a regular basis to make sure that they were making it happen."(FG#1)

Also, when the risk of an issue was high, it resulted in more rapid change versus an issue that was not as much of a risk to the AHR i.e. the special care nursery space issue and the dangers associated with lack of space or the fire safety and preparedness.

3.3. Motivation for Change

Special cases in point worth mentioning are the first two changes that were identified, which were the changes to the special care nursery and the implementation of a process for fire drills across the region. Since these two changes were mandated by the accreditation process, there was a requirement that the AHR do something about them within one year. This was a requirement by CCHSA since they received accreditation with report. Thus, one could generalize and say that when there is a key recommendation by CCHSA to complete a change within a short time frame, it is inevitable that the change would be more rapid.

When looking back to the accreditation report, most of the recommendations from the accreditation process were items that were put forth as areas requiring improvement from the self assessment teams. Thus, there is support and some inherent motivation to see the process or issue become resolved since they were identified by the self assessment groups.

"I think sometimes the suggestions from the surveyors are a recording of what has already been highlighted by your own self assessment team. So I think that you know we talked about every way to try and fix the issues. I think the teams already know through the process which areas that they want to work on and improve, which we would incorporate into our goals."(INT#2)

Another interesting finding was one case where the palliative care area was highly commended and considered an area of strength for the organization in the accreditation report. This was to its detriment, according to some respondents. Since palliative care had received such high recognition for their work, the self assessment team was not supported as much as the areas that received recommendations post accreditation. When issues were brought forth to senior management from the palliative care area, they were not deemed as important since there were other things to address. It was also stated that is not known whether in the next accreditation process, there will even be a palliative care team. Thus, one could caution organizations to address the areas outlined for improvement but to also continue to support the areas identified as strengths.

3.4. Types of Change

Change can affect organizations at different levels: the strategic level, the organizational level, and the individual level and the relationship level, which is the relation between the organization and other players. A commonality amongst the results was that most changes that resulted from the accreditation process were at the organizational level versus the group or individual level. There were no changes that were identified at the relational level. Thus, most of the changes identified crossed the entire organization and were not focused on any particular area. These changes will be explored in detail in the following section.

4. Changes in Line With Accreditation

It was very difficult for respondents to delineate the changes that resulted because of the accreditation process and the changes that occurred because of other events or interventions, such as regionalization.

> *"I don't know if there was change as a result of the self assessment, because of course, once the survey was done, things went right into transition and restructuring and now we're twice the size we were."(INT#1)*

However, the changes that are presented in this section are a direct result of the accreditation process for the AHR, which aid in drawing conclusions on the impact of

accreditation on health organizations. Please see Table 14 for a complete list of these changes with additional details.

Since the accreditation process is likely to bring about change at different levels at different points in time throughout the process, the changes have been categorized into the various stages of the accreditation process (i.e. self assessment, accreditation survey and accreditation report) and the level at which the change occurred (i.e. individual level, group level, organizational level and external partnership level).

4.1. Changes Implemented during the Self Assessment Phase

There were not many changes attributed to the self assessment phase of the accreditation process but the changes that were implemented were substantial. There were obvious things that had to be addressed. The AHR refused to wait until the self assessment was over to rectify the areas needing immediate attention.

> *"I think often the assessment teams found problems, and they try to fix them, and I think there was some of that going on with some minor things that had been changed."(INT#2)*

> *"Well we can't wait until this process is over to do something."(INT#4)*

One of the key recommendations that came out of the accreditation process was related to the tracking and documentation of fire drills across the region. This is characterized as a process change at the organizational level since it would affect each and every facility within the AHR (at the time 35 sites). Prior to the self assessment phase, it had not been given full attention. Nobody took ownership of the issue and took for granted that each facility was adhering to fire and safety standards when that was not the case. In the past, it was recognized that fire drills and documentation needed to be done, but it was never decided under whose responsibility this would fall. Thus, in the self assessment phase, when it was identified, it became an instant priority. This was identified as one thing that the accreditation very positively ended up making an impact across the whole region.

"I personally was not aware of how serious those gaps were, and may not have been for some time."(INT#2)

"There were major issues that my team identified. None of them were sort of overlapped into each other as well, and one of them was the lack of tracking, and documentation on fire drills across the region. There were no documented standards at which they should occur, and there was no documentation to identify. I noticed that was a big one amongst other things. So actually once it was identified, there had been, before the surveyors even came, there was some work being done on trying to correct that problem."(FG#1)

Another change that started during the self assessment phase was specific to the obstetrics department. It is categorized as a change that occurred at the group level. As the Maternal Child self assessment team went through the accreditation standards, they identified that the obstetric department had very outdated equipment that did not meet the best practices for the physical environment for both staff and clients. Thus, before submitting the report, they began to put in motion the process for updating the equipment, even before it became a key recommendation.

"The obstetrical team found that they had some really outdated equipment, and weren't really meeting best practices in some areas. Well we didn't wait for someone to tell us in that report. We immediately got those items on the capital equipment list, because life goes on, and there's other processes happening parallel to this. So we got those things on the capital equipment list so there were equipment things."(INT#6)

The final change that was identified as part of the self assessment phase was the creation of the required policies in line with the accreditation standards. Since many of the policies would affect the entire organization, the creation of policies is considered a change at the organizational level. Before the accreditation process began, there had been an identification of certain policies that needed to be put in place. However, it only became a priority and a deliverable when these were standards outlined in the self

assessment phase. The process, thus, enabled the AHR to implement the policies and procedures right away when they were not a main concern in the past.

> *"The report almost coincided with having a number of policies in place that we'd been sort of trying to get into place, and we were having difficulty with. We finally got them into place and part of the reason of getting that work done I'm sure was the accreditation process."(INT#3)*

4.2. Changes Implemented during the Accreditation Survey

There was little indication of changes occurring during the accreditation survey and visit from the information gathered from the interviews and focus groups. However, some changes were initiated after the submission of the report to CCHSA. Once the self assessment phase was completed, the Quality Steering Committee requested from each self assessment team their top 3 priorities as identified in their areas. From these, the Steering Committee identified 8-10 regional priority areas for the entire organization to start working on before the surveyors arrived and before the final report was received. Thus, even though these regional priorities were not identified specifically in the information received from the interviews and focus groups, these changes can be characterized as changes at the organizational level since they were regional in nature. It was indicated in multiple occasions that if these priorities had not been identified, then they would not have resulted in any change.

> *"One of the things that we did is towards the end of the self assessment process, you could have a massive list of things that people wanted to do, and there was. The lists were massive, but we asked each team to develop three areas of priority of everything that they did, and then we took that, and we came up with I think it was eight, or nine, or ten priorities for the organization that we found that we would begin working on right away."(INT#4)*

> *"We identified our own regional priorities for action arising from the self assessment, and I think there has been some movement on those regional priorities that probably wouldn't have occurred had it not been for the accreditation."(INT#2)*

Many of the items that were identified in the self assessment phase that were not categorized as regional priorities were often turned back to departments to incorporate into operational plans. Again, the items were not specifically mentioned as part of the qualitative data collected but it was mentioned that many of the areas to improve identified during the self assessment phase were delegated back to specific departments to implement within their areas. Thus, most probably, these changes would have occurred at the group level since they were program specific.

A possible explanation for the lack of change during this period of the accreditation process is that this was the first time the region as a whole underwent an accreditation and perhaps, were waiting to see what kind of results would be highlighted in the accreditation report as areas requiring improvement before the next accreditation survey visit. Another possible explanation is related to the immense amount of change that the AHR was already undergoing as a result of the general environment. The one consistent factor in healthcare in Alberta has been the ongoing change process. Thus, the AHR could have been undergoing change overload.

4.3. Changes Implemented as a Result of the Accreditation Survey Report

4.3.1. Dissemination of the Accreditation Survey Report

When the accreditation report was received, every self assessment team lead received a portion of the report pertinent to the team, but not the whole report. Although people didn't see the whole report, everybody was well aware of the key issues and priorities and what the hospital requirements were for dealing with the priorities. All those people who were involved knew the priorities that were identified. This can be attributed to a very good briefing done once the report was received.

It was unclear what the actual process for dissemination of the report actually was. Some said that there was a very specific plan for the risk areas and top priorities, and then the teams were asked to review the recommendations after the survey. Some indicated that the team lead sent out information identifying some of the results and let team members

know that the report was there. Other indicated that they couldn't remember management asking the teams to review the reports but they indicated that that was just a given.

> *"It was automatic that we would review them, and look for areas of improvement, because I think we knew what the purpose of the accreditation was."(FG#2)*

Each team had the opportunity to see the results from the other self assessment teams but many did not choose that option.

> *"From our point of view, I think that we probably had just so much on our plate that we weren't inquisitive enough to ask for any reports outside of our own area."(FG#2)*

4.3.2. Changes at the Group and Organizational Level

Most of the changes implemented within the AHR are as a result of the accreditation report, occurring at either the group (7) or organizational (8) level. There were no changes identified at the individual or relationship level. Please see below for the specific changes and details.

Changes at the Group Level

In Public Health, there were risk issues identified with the immunization registry as the 11 registries were not connected. This was identified as an area to improve in the accreditation report. There were major risk issues with not knowing an immunization history and there was also the risk of repeating immunizations or missing immunizations. Thus, it was identified as a priority and was funded shortly after the accreditation report was received. An information system was initiated and is currently in the growth stage of development.

As discussed above, a key recommendation from the accreditation report was the required improvements to the special care nursery. It had long been known that the equipment and space was an issue but nothing had been done to bring the special care nursery to best practice standards. This department was addressing the issue almost

immediately after it was identified in the self assessment but it wasn't until after the report was received that the changes were in fact made. The special care nursery structure and environment was updated within one year of receiving the report.

> *"We didn't have enough space to meet what appeared to be national standards. We were just going through a planning process. We had to add significant dollars to our budget for planning, but that might have taken a lot longer to be identified. So that was one that perhaps we may have come upon later, but it certainly its result has been wonderful"(INT#2)*

> *"We knew that was an issue, and it was an impetus to move forward and change it. So it supported where we wanted to go, but the accreditation report really did profile it, because it came back as a major recommendation for the region to move forward." (FG#1)*

Thus, it is evident that a key self assessment group in the whole accreditation process at the AHR was Maternal Child. They were the pioneers in the development of a quality improvement team, designed to follow up on the recommendations received in the accreditation report. Soon thereafter, the region adopted best practice teams from all of the clinical self assessment teams to follow a similar process.

> *"One of the major issues that we identified as a problem area is the integration evolved in Maternal Child, where it was very fragmented and people were doing different things. We did actually start Maternal Child QI Team. We started as soon as we had identified it."(INT#6)*

> *"In Maternal Child group, the results of the survey formed the initial foundation for prioritizing projects and have led the way for the QI projects undertaken by this committee." (INT#6)*

Another change that resulted at the group level was new programming set up in continuing care. As with the Maternal Child Team, the Continuing Care Team evolved into a best practice team and addressed the areas to improve for their area.

"I think another area that we have done well on is the continuous care and home case management. A lot of programs have been set up because this was an area that we identified in accreditation."(FG#2)

"So with the Continuing Care Team, the best practice team had developed and also then the priorities were incorporated into our operational plan wherever they needed to be."(FG#2)

A particular self assessment team that was unique was the Palliative Care Team. Instead of just working on the standards laid out in the accreditation process, they developed a definition for palliative care and clinical guidelines. In a regional setting, palliative care can occur in multiple settings so there needed to be some guide for care that would transcend sections instead of each area providing different types and levels of end-of-life care.

"In Palliative Care, defining the population for a fairly new program was key and mainly because it was a challenge in the Palliative Care discipline to define that population. So what we identified instead was criteria for different settings as general guidelines, and that was put in place."(FG#2)

"With the Palliative Care Team, they really wanted something concrete and a lot of the members or most of the members were frontline staff, and so the program development piece was suggested but they were not particularly interested. They wanted concrete so they chose to do a clinical issue, which was looking at hydration and developing clinical pathways."(INT#5)

During the accreditation process, the AHR was in the process of redevelopment of Ambulatory and Emergency Services in terms of capital planning and building. Thus, the Ambulatory and Emergency Team took the opportunity to incorporate some of the areas to improve that were identified through the self assessment and to report into the redevelopment process.

"I think from our perspective in Ambulatory and Emergency, the redevelopment in Red Deer assisted with addressing the recommendations and weaknesses by incorporating them into the re-development and helped areas in areas where structure. It is fortunate that we had that going on at the same time because we were able to incorporate it, especially in the new inpatient unit."(FG#1)

Finally, following the report, the Community Care best practice team decided to develop a client map in community care, which was identified in the report as an area to improve. They now have client maps for several different clientele who access their services, to the point where clients are truly involved in the care planning and must agree to the treatment goals. This builds on the heart and philosophy of quality improvement which is putting the client first and involving them in their care.

"Community Care has done quite a bit. The best practice team chose to start working on the development of a client map, just so that there would be some logical order for addressing things. The very first item addressed was intake and looked at business processes within the department. They have subsequently done that with the new larger region that came about in 2003. They put in place new processes and the tools for several initiatives starting with intake. Now one of the standards is that the client signs their care plan. The clients are aware and agree with the care plan, and so they've now got to that which was service, you know in our client map is sort of the service plan development."(FG#2)

Changes at the Organizational Level

The changes that are presented in this section affect the entire region under study and can be linked to the recommendations and areas to improve identified in the accreditation report. As discussed, as a result of the report, the AHR developed areas of priorities for the entire region to work on and many of those priority areas are identified below. The priorities were identified using a nominal group approach to all the issues. When the report was received, there was a meeting with all the team leaders and the steering

committee. The group worked together to distil those issues down to something manageable and something that could be initiated immediately.

As mentioned, at the Senior Management level, they took the report, and they assigned different recommendations to different senior managers according to their portfolio. Those managers were responsible for making sure that there was action taken and that those recommendations were followed through and that there was some closure. There was a plan that had to be put in place and the COO was responsible for making sure that that was carried through, and those were revisited on a regular basis to make sure that they were making it happen.

An obvious change required was related to information management and the use of information technology in service delivery. This was not externally imposed but something that the AHR decided to embark upon to improve coordination, integration and communication. More specifically, standardization of documentation was of utmost concern. The organization addressed the fragmentation as a corporate priority through the development of an information plan, to be completed and implemented by 2006. This work is still in progress and occurring in increments.

> *"We didn't have an information management plan or strategy."(INT#4)*

> *"Our decision making was intuitive and we still don't have an information system. We are in the process of developing one, and should have one by 2006." (INT#4)*

> *"When I look at the Information Teams' recommendations, I see that they moved have moved on them. So obviously they did put a plan in place, and I think have been quite aggressive about it. It was about integration of systems and what not, and as we heard today, they're still struggling with that. But they've got an active plan, and that's only been 2 years."(FG#1)*

Another large priority area identified through the accreditation report was for Human Resources to look for ways to improve education for all staff, both mandatory and

specialty (i.e. disability management, WHMIS training). This was a corporate priority since staff work across the entire region all had different education needs. Change has been made to get input into the actual education needs of staff such as tracking what the employees' basic level of education required to work in the different departments from the start. Also, the HR team learned, through the self assessment phase, the valuable lesson that it is important to have input from the grass roots people requiring the education. More specifically, in the recommendations made in the last round of accreditation, an area to improve was enhanced focus on some of the specialized skills required for care delivery. A good example is obstetrics.

> *"The HR team looked at the training of Obstetrics nurses on one of the four Obstetrics wings. So certainly that influenced the hiring of a manager 0.5 with 0.5 education designation and training experience in Obstetrics. The AHR have utilized that skill to enhance the standard of our Obstetrics training." (INT#1)*

This is one example of where the more specific training of those professionals was influenced by the accreditation review.

A subsequent change that occurred in the HR arena was the development of a performance appraisal process. This had been an area of concern for a long time (i.e. the length of the Performance appraisals) and it had been an issue to get buy in for changing the process. Thus, the HR team used the accreditation report as an opportunity to highlight this as an issue and change it to make some improvements.

A structural change that occurred impacting the organization was that the Director of HR and Education merged into one position. Before accreditation, these two positions existed independent of one another. In fact, when accreditation happened, those two roles and subsequently departments were very separate. Following the accreditation survey and in consideration of one of the recommendations that came out of HR plus a review of the HR portfolio, these two departments were combined. Other recommendations from HR were incorporated into the operational plans.

Another recommendation from the accreditation report was the clarification of ethical processes. It was noted in both the interviews and focus groups that post accreditation, there had been an implementation of an Ethics Committee Support Team to help staff and clients (including their families) resolve ethical dilemmas, which was an organizational structure change.

Next, a substantial change that has occurred is the development of a regional initiative for risk management, tracking and reporting incidents. This has been a slow process since the initiative requires working through an electronic solution.

> *"We identified that there wasn't a good process for reporting the tracking of incidents and there has been a regional initiative to address that and that's been in place."(FG#2)*

It was mentioned by one of the focus group participants that a regional research and approval process had been developed, which was a recommendation to the Leadership and Partnership Team as an area to improve. It was designed to encourage staff participation in research and would be classified as a process change.

Finally, a change in leadership resulted in the area of safety and security since accreditation, which could be linked to the enhanced priority of organization of fire drills and safety.

It was indicated that most, if not all, of these changes would have probably occurred in due time but highlighting the areas to improve and providing recommendations helped speed up the process in terms of prioritizing areas for change.

> *"I think the changes would have happened over time. I'm not sure that they would have got to the top of the list as quickly as they would with the process that we did in terms of prioritizing." (INT#4)*

> *"Priority issues were identified so that senior administration could make decisions as to what needed to happen now, and what needs to be planned on*

kind of thing. So I think accreditation has been beneficial. A lot of things may have happened eventually, but I don't know how long it would have taken."(FG#1)

5. Changes that Occurred because of Other Events or Interventions

The region was influenced by things above and beyond its direct control and these changes occurred outside of the accreditation process. Many of these changes have been mentioned already in the sections above but some are worth reviewing again in this context. All of the changes identified in the interviews and focus groups were at the organizational/corporate level and not at the individual or group levels. This is not to say that changes did not occur at the individual and group levels but these were not highlighted as part of the research findings.

The main event which created much change was the further standardization and realignment of the region towards regionalization merging four entities together including the mental health board. This brought about new blood in the organization with experiences from different backgrounds and areas, bringing four different organizational cultures together. This also included various structural changes in service delivery, enabling a critical mass for specialty services.

> *"There have been changes that happened independent of accreditation, for example, the structure that human resources came up with to provide services to the region really wasn't meeting mental health needs. Services were consolidated down so that we have one HR contact instead of multiple. Also, they just revamped the whole recruitment process so that we now have one recruitment center for the whole region so we don't have sort of zones of recruitment happening so that the processes are all the same, standardized, which is very, very helpful when you're trying to manage such you know, you know a few staff in one area." (INT#1)*

The management group itself remained consistent and mature but when the regional structure expanded, it added more management staff and more responsibilities to each manager. Where the main change occurred, however, was that senior level managers historically had held a considerable amount of control. Since this last round of restructuring, it was noted that the control was starting to be dispersed amongst those management professionals throughout the organization and they were starting to take the opportunity to make those decisions.

There was also a change in demographics of the population served. The larger region brought in a whole new realm of service delivery to aboriginals, which is typically a federal health jurisdiction. This is an important challenge because this is a new mandate and will be a learning experience for many.

Another area that resulted in change was the financial arena. It was mentioned, on numerous occasions, that there had not been any official cuts in the budget but that there was a freeze on funds, which in essence is a cut when the cost of living continues to increase and there is no compensation from the government for the increases. Thus, this was a change that the AHR had to endure and adjust delivery to operate within limited resources.

> *"We've certainly had the same challenges as organizations across the country in terms of budget restraints. I wouldn't say in the last 5 years we've had budget cuts, but we've had sort of holding the budget, which in effect I guess is a budget cut when you factor in inflation, and so we've had to look at how we use our resources." (INT#1)*

There were also legislative changes that the new region had to endure. In particular, a new Bill to reduce the amount of union representation was introduced and this brought about a sense of anxiety and stress, requiring better management of relationships with staff.

> *"There's also Bill 27. You know I think at the point where while we were integrating the region, I think we had like 94 union certificates held by (AHR)*

or the various groups that made up the (AHR) and it really is a very lengthy process to try and integrate those collective agreements and narrow it down to a number that's manageable. Now there are only 4." (INT#3)

Finally, another legislation change imposed was around changing requirements for training of staff towards enhanced safety. For example, there was the institution of a legislation covering standards about working alone safely that had to be followed.

Thus, many of the items identified influenced the AHR but they were above and beyond the region's direct control and these changes occurred outside of the accreditation process. This must be taken into consideration when trying to truly determine the impact of accreditation on the organization's ability to react to change. These changes were clearly not linked to the accreditation process.

5.1. Changes that Occurred at the External Partnership Level

Partnerships have always been a strong point of the AHR and tend to exist based on the identified needs throughout the community served. The primary focus of partnerships was to avoid duplication and increase innovation, especially within the private sector. However, it was recognized that the accreditation process was an opportunity to further enhance the current relationships, bringing partners together and was another avenue to create common ground or standards as part of the self assessment phase.

5.2. Overall Changes as a Result of Accreditation in General

There were changes identified in the interview and focus groups that resulted from the accreditation process on a whole that were not directly linked to a particular phase of the process. All of the changes outlined in this section impact the organization as a whole and are related to process and direction.

The first important change was the heightened awareness of ensuring that best practices are in place and that practices are evidence-based. Many people indicated that this was highlighted by the self assessment process. Furthermore, accreditation provided the

opportunity for the region to highlight the current best practices in place and identify others that still needed improvement.

> *"I think the whole evidenced-based practice was highlighted by the self assessment process, and certainly we started paying much more attention to what is the best practice? What are they doing in other areas? It really gave us an opportunity to look at how we do things, like where we excel and where we don't. It helped us have the benchmark where we were, where the benchmark is, and what we need to do to reach the standard for service."(INT#3)*

> *"I know for myself when I get involved with working on projects now, one of the first things that comes to mind is, I wonder what's in the accreditation standards? I get the standards so that when I propose a policy, we're in line with the standards."(INT#5)*

> *"It really gave us an opportunity to share our best practices, and learn about best practices from other organizations, or regions as well." (INT#1)*

In general, a whole new language around quality, improvement, standards, accreditation and indicators was developed throughout the organization, which would not have happened without the accreditation process. Also, ensuring quality became an expectation of all employees, not just the staff who were involved in QI teams or part of the accreditation process.

> *"I think there has been an organizational adoption of terminology around accreditation, and that's made a difference in moving things forward."(FG#2)*

> *"One of the things that is important to know is that one of our slogans within the region is "Quality is everybody's responsibility", and so we don't have a pocket of people that are the only ones that are responsible for it. We really expect everybody in the organization to be involved in quality improvement."(INT#2)*

"We were such a new region in the way that we communicated, and there wasn't a basic understanding out there of what accreditation was, and what it would do for us. Accreditations had been carried out differently in the different organizations that had come together as one health region. So that was a challenge. I can't say that we did anything extremely different before the survey. We tapped into some of the communication channels that we already had set up, but one thing that we did do was we developed a vision for accreditation that helped us describe to people when we were going forward, and that was "Achieving excellence, everyone, everyday". We continue to use that now, and we found that staff bought into it big time and they like it a lot better than our region vision."(FG#1)

Subsequent to the accreditation report, many of the self assessment teams continued to meet to address the areas outlined in their sections of the report. Management recognized the value of these teams and formally development best practice teams as part of the organizational structure (which subsequently changed to QI teams in 2003 after the merger). This will be explored in more depth in Chapter VII, Section 6.

"I think the development of the QI interdisciplinary teams probably wouldn't have happened in the past culture. It might have happened over time, but I think it really made us aware of how valuable that was in the accreditation process."

"I think what it did for us was enable us to create a foundation for our QI structure, and more formal structure for our QI structure. Now we've got a ton of QI. The teams are cross functional in their composition, and really reflect the accreditation or structure of QI."(INT#2)

Another change that occurred as a result of the process was enhanced integration across the region and programs. The accreditation process helped to identify shared weaknesses and areas to work together. A tangible example of this happening was when the Steering Committee and self assessment team leads came together to identify priorities for the region to work on collectively.

"Since accreditation, I think people are looking at things more program-based rather than facility-based. They are keen to find out what they should be doing as opposed to what they are doing. They have a broader perspective of what's going on in the area and a renewed appreciation for what everybody was doing. Thinking outside of the box more, and have bigger picture."(FG#1)

"I think it created awareness from the inter-disciplinary perspective and highlighted what were the priorities, and where we needed to put our energies into understanding since there were a lot of similarities between sites."(FG#2)

"It showed the similarities as well between areas, and you know, although standards for Continuing Care focused on the Continuing Care residents, you're looking for the same thing when you're looking at Child or you're looking at Surgery. But there are still some of the same issues they're facing. There's still the focus on quality and on improving areas, and you know that kind of language. You use the same kind of language even though you may be identifying different priorities."(FG#2)

The final two items identified were additional benefits that resulted from accreditation and could be classified as intangible changes that cannot really be measured. The first was that the accreditation process brought people together, often for the first time. It helped people get connected.

"I think it helped get people contacted. You know having this hospital and this hospital, it actually put faces to names so that if one of the outlying areas was having problems, they actually knew somebody, "Oh, I can email this person and maybe they can help me with this". It brought people together rather than everybody kind of going "Oh no where do I go?" It helped very much. It brought staff from different sites together."(FG#2)

Second, for many, it provided a better understanding of the region. Many indicated that it helped them to understand the overall system and all of the players involved.

Table 14: Changes Recorded in the AHR

Change	At which Level? IND = individual; GROUP = group practice level; ORG = organizational level; EXT = external partnership level	Type of Change	Linked to a Recommendation (ATI=area to improve)
CHANGES DURING THE ACCREDITATION PREPARATION			
lack of tracking, and documentation on fire drills across the region	ORG	Process	Key R (Within 1 year)
Updating equipment in obstetrics	GROUP	Physical Structure	ATI
Creation of policies required	ORG	Process	
CHANGES DURING THE ACCREDITATION VISIT			
Identified 8-10 regional priority areas for the entire organization to start working on	ORG		
Some items turned back to departments to incorporate into operational plans	ORG		
CHANGES AFTER THE ACCREDITATION REPORT			
Implementation of an information system of immunizations as there were risk issues with the current 11 immunization registries as they were not connected	GROUP	Risk Management and process	ATI
Changes made special care nursery structure and environment	GROUP	Physical Structure	Key R (Within 1 year)
Development of a QI Team for Maternal child	GROUP	Strategic direction	ATI
Program set up in continuing care	GROUP	Process	ATI
Development of general guidelines for PC	GROUP	Clinical Guidelines	
Incorporation of recommendations in ambulatory and Emergency into the redevelopment	GROUP	Physical Structure and Process	ATI
Development of a client map in community care	GROUP	Process	ATI
Addressing the fragmentation in documentation as a corporate priority through the development of an information plan	ORG	Process	R
Continue to look for ways to improve education, both mandatory and specialty i.e. disability management, WHMIS training	ORG	Process	ATI
Director of HR and Education merged into one position	ORG	Organizational Structure	ATI
Implementation of an Ethics Committee to help staff and clients (including their families) resolve ethical dilemmas	ORG	Organizational Structure	R
Development of a regional initiative for risk management, tracking and reporting incidents	ORG	Risk Management	ATI

Change	At which Level? IND = individual; GROUP = group practice level; ORG = organizational level; EXT = external partnership level	Type of Change	Linked to a Recommendation (ATI=area to improve)
Development of a regional research and approval process	ORG	Process	ATI
Development of a performance appraisal process	ORG	Process	R
Leadership change in safety and security	ORG	Organizational Structure	ATI
CHANGES IN GENERAL			
Evidenced-based practice was highlighted by the self assessment process	ORG	Process	ATI
New language around quality and improvement	ORG		
Development of best practice teams (to QI teams)	ORG	Structure	
More integration across the region/programs; shared weaknesses and identified areas to work together	ORG	Process	
Connecting people	ORG		
Understanding the region	ORG		

6. The Team Concept and the Accreditation Process

6.1. The Team Concept at the AHR

In considering the question, "does the accreditation process motivate teams to develop or to enrich the quality improvement process within the organization?", a total of fifteen separate teams were considered (at the time accreditation was performed). Eleven of the fifteen were recognized as clinical teams while the remaining four were corporate teams (Information Management, HR, Environment and Leadership and Partnerships). Initially, all fifteen teams were called "self assessment teams" and were formed about a year before accreditation began. The teams remained intact, even after the process was completed.

> *"After accreditation, I think one of the things that occurred is that most of the self-evaluation teams did not disband, in fact, some of them went onto bigger and better things, and became quality improvement teams. They started out as best practice teams, and we have since renamed those as quality improvement teams. The QI teams could carry on the work that had been done by the accreditation team. And all the team members were pretty enthusiastic at that point, really interested, and wanted to carry on. They didn't want it to stop. So we put the teams together to carry on. So they never stopped meeting. Some of the membership dropped off, and I would say some of the community partners, probably in all cases, did not sustain. The physician participation at the self-evaluation process probably dwindled off, but those same physicians have retained a connection with those teams by reviewing minutes and providing input, maybe not by their presence but by written material. So I think we learned a lot." (INT#4)*

In reviewing the CCHSA guideline for accreditation, it is clear that this nomenclature and suggested time frame be followed. It is interesting, however, that although formed one year prior to the actual survey process, these teams did not start meeting formally until three months later, leaving nine months for the actual teamwork and completion of the assessment. This would lead to the assumption that outside of normal circumstances,

such as trouble finding a meeting space, unexpected interruptions or conflicting schedules, there was some reluctance and slowness initially. From comments collected in interviews and focus groups, team members did not know one another, had not been a part of the accreditation process, and had not participated in formal group activities with others in the defined community.

> *"We needed to invest extra effort, because as we said we were fairly new as AHR and we had only just envisioned a quality improvement framework, and so we hadn't lived that framework, and so this was a new way of doing things, and so there was several months of preparation, team member orientation, understanding what the AIM standards were all about, and how we would proceed. So there was extra effort understanding certainly what an indicator was. There were performance indicator workshops for team members, and certainly for the team leaders. So, although it fit with our framework, we hadn't had an opportunity to actually implement that framework at the time." (INT#4)*

> *"It took awhile to kind of figure out what was the best way of doing it. You know were half days good, meeting more often, or do you meet all at once."(INT#4)*

Efforts had been made, however, to keep the groups a manageable size so interaction and decision-making could be facilitated. There were then approximately 15 team members per group and the deliberate composition was interdisciplinary from a broad cross section of the organization as a whole. Initially, members were directed to participate. There was a steering committee that looked at trying to get a cross representation on all teams from all levels from various departments. The teams had to be manageable and when in the formation stage, the steering committee tried to minimize travel as much as possible. Thus, there was a lot of input to how the teams were formed since they did not exist before. Even still, the consensus from interviews indicated all were there on the teams because they wanted to be. An overview of team participation would include a mix of frontline staff, management, pharmacists, volunteers, respiratory therapists, psychologists, social workers, dieticians, pastors, physicians, researchers, nurses from surgery, medicine, palliative, paediatrics, urban, and representatives from the community

as well as rural populations. Initially, since this was the first accreditation visit as a health region, they had to expend a lot of extra effort because the organizational structure did not lend itself well to doing things the way the accreditation survey and process dictated in terms of the use of cross functional teams. Thus, expanded efforts and resources were distributed up to 9 months before that survey took place.

The team facilitators had been pre-selected and prepared using CCHSA guidelines for the team leader roles. Upon questioning, informants repeatedly indicated the importance and responsibility of the leaders to keep team activity on topic, focused and moving forward. Leaders were described as being committed, strict and organized coordinators. Obviously, the mix then was notable and confirmed the diversity and unfamiliarity of members to one another.

The critical team activity focused on education and preparation that clarified the accreditation process and expectations. This directed the thinking of all participants towards accreditation and the task at hand. In referring to the Ketelhut definition of team, *"a dynamic group of diverse people with common objectives but different responsibilities that is chartered with improving a process, a product or a service* (1999)", it is clear that the fifteen teams designated fell within this criteria and as Gizzo and Dickenson (1996), along with many others studying teams, an almost automatic "pulling together" in one direction emerged.

The representatives interviewed from the original self assessment teams used words like "interactive, good participation, understanding, unified and respect" to describe the interaction and dynamic that took place within the groups. Overall, each team completed their assignment during the 9 months of meetings by investing approximately 50 hours in team meetings. Some teams met once month for a day at a time, others met bi-monthly for half day time slots via teleconference depending on location. Each established its own pattern which was not prescribed but in the end, all had invested around the same number of hours on the process (expect for some team leaders who expressed that they put in additional time).

From the beginning of team selection and initial meetings, each member and each team clearly understood the purpose for the team and its activity was preparation for the accreditation survey visit. Although CCHSA guidelines addressed process, the name of the teams as "self assessment" bodies notified each of the expectation that a self evaluation would occur during the process and something – change – would result. Interview and focus group comments then indicated that the teams realized people with diversity had been brought together, to consider the issues in the same way and formulate action. There were diverse perspectives, common concerns, consensus and single solutions.

Initially then, accreditation impacted these fifteen teams by bringing them together and giving them purpose and focus. Because a critical path with clear guidelines was established early, in spite of being unacquainted and diverse, the team overcame these barriers and formed relationships early in the process. The single purpose of the self assessment of certain standards and demonstration through indicators kept them moving forward and pulling together in the same direction rather than moving off on tangents and self interest pathways. Interview and focus group respondents noted that the whole process leading up to the survey visit was very well mapped out with a clear schedule. Activities were well designed to build one upon one another. There was a critical path so that everybody knew from the outset what the goals for completion were each month. Thus, it was very well planned out. "It's very easy for time to slip by" (INT#2) so timelines were set to keep everyone on track.

As the members became more familiar with one another, accreditation and the self assessment process lead them to new discoveries and insights, outlining strengths and areas to improve.

6.2. Effective Accreditation during the Team Process

Following the initial impact of forming a new group and focusing on a demanding purpose, self assessment kept the team on its critical path. This intensity enhanced the natural synergy that was becoming evident in the groups as bonding occurred and

friendships with better awareness of each member's role and responsibility in the organization occurred. It seemed, from comments shared by group members, the more the group met, the stronger the links became within the groups. Diversity remained in terms of individuality, workplace site and job responsibility but unity of purpose drove the team more closely together. It would seem then that during this formative, intense time in the team process, the synergy and dynamic emerging from the process validates Kratzenback and Smith's findings that participating on a team increases participants' social/interactive skills, broadening knowledge and perspective. Thus, findings from these fifteen groups indicate that the longer the group was together, with the inclusion of another meeting to the total, the more the team was able to recognize its potential and be aware of what might be accomplished.

> *"The team really expressed, more than anything else, that they just found it amazing to listen to people from other departments, other sites and hear how things go on in their area of work. It was a huge benefit, particularly for the frontline people."(FG#2)*

Each time the self assessment teams met, strengths and abilities of individual teams members was recognized. Team members understood that using everyone's strength contributed to the synergy within the group and as a unit, they could be more effective than as a single individual. The more they accomplished, the more motivated they were to continue. This confirms findings from Zahavy and Somech (2001) that teams perform tasks better than an individual working alone and the result is that the sum is greater than its parts, creating synergy. In summary, each team recognized the impact and change it could affect in the organization.

6.3. The Accreditation Site Visit

As the accreditation process came closer to conclusion and the activity of each group would have been expected to be "winding down", interviewees indicated interesting events were occurring within each team. As previously explained, when asked how accreditation had effected the team, comments including "lead to synergy in the team, friendships/relationships formed, team members learned a lot about the formal team

process and how teamwork, awareness and bonding has taken place" were all feelings shared by most team representatives that were interviewed. However, it was also interesting that during the team process, members gained confidence and an openness in self assessing and ensuring that the best processes were in place. This lead to the setting of priorities by each team, outlining key areas requiring improvement. Not all of the teams set the same priorities but all did recognize that the need to improve and that change did not terminate with the conclusion of accreditation. Defining areas requiring change, setting priorities, determining actions and implementation of the plan were behaviours learned as well during the team process. Team members indicated that they felt valued and respected as they worked together and saw their suggestions considered for change within the organization (sometimes even implemented).

In reviewing the data collected from these groups, one reported some internal dysfunction within the group where many suggestions were not shared or implemented because of weak leadership. Team members expressed disinterest and loss of motivation as a result of the accreditation process because they witnessed no change and felt devalued and uninvolved. The conclusion then was groups needed to be diverse but effectiveness of the group was linked to leadership that possessed the authority to implement change. This activity was seen as a motivator as well as an indicator for success.

At the conclusion of the accreditation process, the teams reported the following occurrences had taken place on a personal as well as team level:

- Better understanding of self, one another and the organization;
- Relationships formed, leading to linkages across the organization;
- A clearer understanding of the region (health), its currency as related to practice and the common culture within the workplace;
- An eye opener and insightful when considering urban and rural implications;
- The benefit for the future as individuals now better informed continue to work together with a better knowledge of one another;
- More integrated with stronger internal links amongst services and external links to the community;

- Success leads to confidence to think outside the box;
- Enhanced awareness of the complexities of the organization as a whole;
- Learning to see more than just implications by site/service but instead regionally;
- Respect and appreciation for the broad health human resource available to all in the organization;
- Same issues identified even though different groups came together with different criteria. Thus, there were similarities across the entire structure.

6.4. After the Accreditation Visit and Report

Following the completion of the formal accreditation process, many of the groups did not want to disband. The work had been intense over a short period of time but success and the feeling of accomplishment as well as the social aspect of the group motivated ongoing group activity.

> *"We never really quit. We took the self assessment tool into our best practice team, and it was brought up at our last meeting, that you know that we'll be looking at accreditation, and start doing the self assessment as early next spring. And we, I mean, one of the major things that we have done is we have kept on working on the things from our first assessment."(FG#2)*

For the most part, each group had identified issues of interest and priority that needed attention and change. Even though accreditation was complete, these outstanding, unfinished tasks held some of the groups together. Recognizing these factors, the organization directed the formation of "best practice" teams. This transition period following accreditation then saw some changes in the groups. Membership dropped to 12-15 members and some groups became less active, especially those where leadership had been an issue and few effective changes had been initiated by the group. During this transition period, Alberta further regionalized its health services, expanding this health region once again, making it even larger than before. But the end result saw the original teams remaining functional and evolving to what is known today as QI teams. This project investigated fifteen self assessment teams – eleven which were clinical. During this post accreditation period, these were the most active teams remaining.

Shortell et al. (1995) defined QI teams as ones where the major mechanism of action is to introduce improvement work. As well, his findings indicated that the effective teams were cross-functional and cross-departmental. Based on these indicators, the interviewees for this present study fell naturally into these categories. Because they were selected and formed originally as inter-disciplinary from cross sections of the region, the membership mix fit the QI criteria. Also, during the accreditation process, priorities were set. When the process concluded, the unmet or unfinished priorities provided a focus and goal for the teams and gave them a specific purpose to focus on for quality improvement. All were directed toward improvement work in one way or another. Contrary then to Motwani et al. (1996), which found indicators that healthcare teams do not work well with QI, the teams providing evidence for this study experienced an above average level of success and were so motivated that they continued to function as QI teams, even after accreditation was complete.

> *"A lot of the QI Teams are based on the self assessment teams. Those groups of people are moving towards doing the next self assessment." (INT#1)*

> *"It was the clinical teams that kept on going (e.g. maternal child team). Non-clinical teams are going to evolve very soon so they can start working on self assessment and preparation for 2006 accreditation."(FG#1)*

Follow up data indicated that the regional organization recognized the synergy and group dynamics that were being generated and the continued momentum. Rather than discouraging further meeting and team activities, the administration encouraged ongoing QI. Team priorities were categorized and improvements for the entire organization to focus on were identified.

> *"And I can't recall the timing, but we all had implemented best practice teams. I would say that the improvement efforts, based on what we had identified in self assessment, were underway regardless of report."(FG#2)*

Some community involvement dwindled, physician participation decreased but those who were truly interested in quality improvement continued on and maintained activities.

After regionalization in 2003, some teams may have inherited new members due to the expansion.

> *"Well I think one of the things that occurred is that most of the self-evaluation teams did not disband, in fact, some of them went onto bigger and better things, and became quality improvement teams. They started out as best practice teams, and we have since renamed those as quality improvement teams. So they never stopped meeting. Some of the membership dropped off, and I would say some of the community partners, probably in all cases, did not sustain. The physician participation after the self-evaluation process probably dwindled off, but those same physicians have retained a connection with those teams by reviewing minutes and providing input, maybe not by their presence but by written material." (INT#4)*

Now, post accreditation, QI teams are still functioning.

> *"We have a number of QI Teams, whose intent is to review, discuss best practices and to make recommendations about new initiatives or new best practices that ought to be incorporated." (INT#2)*

A Quality Improvement and Planning Group has been formed, an 11-step QI methodology and process outlined and an adoption regionally of the use of the Balanced Scorecard for quality measurement. Most notably, many team members learned from the process. They felt empowered, which motivated them far beyond the accreditation period; they better recognized best practices outside the organization and were willing to bring these practices into the workplace; and a sharing of their own best practices with others helped validate these changes.

7. THE ACCREDITATION PROCESS

7.1. General Opinions and Expectations

The accreditation process is perceived and evaluated differently by each individual who has participated in the research. In this section, we will discuss the various responses and consider the value and impact of accreditation in this particular health organization.

Some of the responses focused on the process alone. The consensus was that it had proven itself beneficial to the organization.

> *"I think the advantage of the accreditation process is the process itself."(INT#4)*

> *"It is a validating process and mechanism with external review."(INT#1)*

Others considered the only value being in the certificate awarded at the conclusion of the process.

> *"It is prestigious to hang an accreditation certificate." (INT#4)*

> *"We were the only region not accredited." (INT#2)*

As well, some participants that were interviewed looked at the outcomes of the process as being valuable.

> *"Enhanced the credibility, which shows that the organization has vision about quality and standards of service."(INT#3)*

> *"Demonstrates to others that a certain level of quality and national standards has been met."(INT#2)*

> *"Independent assessment in line with best practices."(FG#1)*

Others saw the real value of accreditation as being the self awareness and self evaluation that took place within the organization.

> *"...to go through that process collectively, it created some very good understanding or the entire organization..."(INT#2)*

> *"Allowed the organization to increase awareness of the various quality activities that were being undertaken that may not have been previously exposed."(INT#1)*

> *"I knew that we were probably still working within departmental silos and we needed sort of a catalyst or an impetus to bridge that."(INT#4)*

> *"Helped to understand the bigger (AHR) system and to build relationships with other players within the system, which was really important, and has continued to be important." (INT#3)*

The final group of comments related to the impact accreditation had on future activities associated with quality improvement.

> *"...it allowed for the formation of a quality program with formal quality teams."(INT#5)*

> *"Helped develop the QI teams and Quality Philosophy"(INT#4)*

> *"Starting to adopt certain language around quality improvement and accreditation. for example, I think there has been an organizational adoption of terminology around accreditation, and that's made a difference in moving things forward, I think. Also, there is now more reference and thought given to the accreditation standards in planning, and using the standards as a reference. (FG#2)*

It was interesting to observe that there was a much more positive perception of the accreditation process and self assessment expressed from those who participated in the focus groups than the senior staff. This can be attributed to the fact that the focus groups

were comprised of individuals who were implicated and saw the value of the process first hand versus the senior staff. Although the comments were varied, they all did indicate a positive impact perceived as a result of the overall process.

7.2. Accreditation Preparation

In considering the entire accreditation process, focus group members identified parts of this process that they felt to be the most favourable stage in the accreditation process to implement change. These were numerous comments and most referred to the self assessment process. The comments support the notion that the self assessment phase was considered the portion of the accreditation process that most influenced the implementation of change in this organization.

> *"I think the self assessment process really is a tool that although you do these self assessments with the accreditation process, it really helps you wear that self assessment hat more often, and ask questions like, "What would somebody who accessing our service think of this? You know what would somebody who's accessing our service think of the flow of information?"(INT#3)*

> *"I think it was worth the effort to really have that really good look at yourself, and the self assessment part really was the most important part..." (INT#3)*

> *"I really think self assessment is the most important piece, because you're doing it because you want to do it, and you're doing, I think the process that we used was to set priorities, and determining what we would do first, or what we would focus our energies and resources on was a good process, and we did that before the report. We did that in advance, documents that we actually prepared for the surveyors to show that we were taking it seriously. Those building blocks became part of our strategic planning over the next subsequent years."(INT#4)*

There were a few participants that valued the self assessment phase as it enabled the organization to measure itself against an established standard and benchmark.

"I think when you do that self assessment, and you go, "Oh this is the standard. This is where we're at. It's not congruent. We need to do something." I think it's much easier to implement change when its staff driven than when you get a report back saying, "You ought not to be doing it that way or whatever.""" (INT#3)

7.3. The Surveyors

In commenting on the value of the accreditation process and identifying the most valuable phase, participants were invited to share their impressions of the surveyors themselves. In general, the comments were most complimentary and indicated an appreciation for the sharing and learning that took place. Most agreed that the survey teams were great and were a valuable resource. They brought with them many skills and added a connection or link to the rest of the real work. They shared certain experiences and best practices. Also, they had sufficient background to be able to evaluate a larger region. In comments from other participants, they pointed out that in their team there was a good cross section of administrative, clinical support and diagnostic representation. A few of the respondents indicated they felt some of the surveyors' comments were superficial and more work could have been done to uncover what the real organizational issues were.

Suggestions were directed as to the role of the surveyors.

"Have someone appointed to work with the health region in developing the plan and to work through the process, partnering with one of the actual surveyors helps the surveyors understand the depth and the breadth of the region and the scope."(INT#3)

"If you look at the survey as a tool, it was a lot of work in terms of self assessment, with involvement from people from all 33 sites, and then the surveyors only looked at six sites." (FG#1)

7.4. Overall Disadvantages

Naturally, all comments were not positive. Many were able to clearly identify advantages and disadvantages of the accreditation process. Understanding the participants in the focus groups and interviews are employed by a large regional health organization, the greatest disadvantage identified was the time taken from their busy schedules to share in the process for the amount of feedback received.

> *"This was very labour intensive process. There needs to be some support and dedicated time..." (FG#2)*

> *"A lot of repetition and overlap in the standards."(INT#4)*

As well, participants were clear in their criticism of the process, pointing out surveys and questions clearly related to the acute care environment and institutional care.

> *"Tools were inadequate since we have a focus on direct patient care which (the accreditation) tools did not take into account." (FG#2)*

> *"Questions were very much from an acute care focus" (FG#2)*

There were additional comments that confirmed dissatisfaction with the process.

> *"Not a lot of support from the CCHSA resource in terms of answering questions on the standards and meaning, however there were clear guidelines."(FG#2)*

> *"Standards were too wordy and the scoring system was not adequate."(FG#2)*

> *"In a health region, it's not as appropriate to use the surveyors' time to go visit the various different sites. Thus, it must be determined what the value is of this from CCHSA's perspective."(FG#2)*

7.5. Standards

Participants were asked to comment on the CCHSA standards which have changed and evolved over time. Some comments indicated that the standards were "more collaborative versus just meeting a standard." Some participants referred to the new standards, AIM, and pointed out that these were "much more valuable, a big improvement and a good learning opportunity." As well, a few of the participants had been a part of accreditations in the past that had occurred at other work sites but not in this organization. Their comments pointed out, "(the standards) foster much more learning and are non-punitive, where in the past, and things were either right or wrong." (INT#3)

7.6. Capacity to React when Faced with Change

There were mixed opinions from participants about whether or not accreditation helps an organization improve their capacity to react in the face of change.

Some felt that accreditation provides opportunity to really team build and bring people together to problem solve. It was also shared that it provides an opportunity to share best practices, and learn about new models from other organizations or regions. As well, it was indicated that accreditation sets a certain standard that must be achieved at the least and provides guidance on what needs to be attained.

Others felt that accreditation may help an organization to be more responsive but not reactive. They felt that managing change is part of the organizational philosophy, with or without accreditation. The goal would be to be more proactive. It was felt that the AHR was leading the process and not just reacting to it.

CHAPTER VIII - DISCUSSION

In discussing the findings that were compiled following the undertaking of this case study, it is first important to reiterate the basic assumptions that were formulated before the research process began.

> **Question 1:** Since accreditation can be considered an intervention in the Canadian healthcare system, is it able to introduce process or influence changes within an organization according to the characteristics of the framework?

Before examining the influence of accreditation on this health region, the organizational culture, leadership and attitudes of the staff working with the AHR should be considered and some assumptions made.

Organizational Culture

Research indicates that cultures emphasizing group and developmental components (at least a combined score of 50) help promote QI implementation of CQI/TQM (Shortell et al., 1995) and are important for integration efforts (Shortell et al., 1996). These types of cultures emphasize empowerment, autonomy, and risk-taking. This was not the case at the AHR since the dominant cultures are more indicative of hierarchal and rational cultures, such as a tendency towards efficiency and achievement orientations. The cultural characteristics identified are not surprising considering the changes that have taken place in Alberta over the last decade. Much emphasis has been place on improving the bottom line, increasing efficiency and standardizing operations.

There seems to be some difference of opinions amongst the administrative staff and the front line teams regarding the culture of the organization. More than half of respondents were nurses and allied health staff, whose perception of the culture is more bureaucratic whereas administration perceived that the culture is more participative and team based.

Also, those in the organization for a long time perceived the culture as more hierarchical and less group oriented versus those working for the organization less than 10 years. This could indicate that the newer employees have different cultural perspectives and are more open to teamwork and participation than long standing employees.

In spite of the differing opinions, however, all agreed that the focus of their organization was the patient and AHR systems' supports were built around these individuals. One of the perceived strengths outlined in the management questionnaire is meeting customer expectations (u=3.52). This common goal and understanding united them and as an organization, they were willing to embrace accreditation and accept the challenge of the new undertaking.

Leadership

In considering the impact of accreditation in the AHR, the evidence of change that occurred in the organization following the accreditation process would lead one to believe that the change resulted from the influence of accreditation. QI did emerge at the AHR as participants noted issues of concern, strategized and planned corrective measures, acted on the plan and realized success in several areas.

One of the founding principles for QI is key leadership. The comments and insights gathered from respondents seem to indicate that a strong sense of leadership and responsibility exists within this organization. This is corroborated between the quantitative and qualitative data. Although an awareness of QI has been in place for quite some time, it has perhaps been part of the philosophy but not part of the activity. Now, it seems, as a result of the accreditation process, QI is readily associated with the result of the process and an activity that needs to be ongoing. In fact, it is important enough to be given a department within the organization to facilitate this activity. Only time will determine the effectiveness of these efforts in the change process.

In looking back over comments of participants regarding the administration and leadership at AHR, it is consistently evident that most of the staff felt confident and

secure with the leaders and department heads to who they report. A sense of confidence and security remained unchanged in the organization because the administration and management right down to frontline staff remained in tact. The organization grew and expanded but the "workers" and "knowledge of history" remained, giving stability and a sense of sameness.

This leadership also effected accreditation and the change it triggered. One of the greatest factors to help achieve culture change is total commitment of top leadership to the effort. The more hierarchical the original culture, the more important it is that the leadership's commitment to quality improvement be visible.

It appears then that leadership has been strong in the past and remains strong in the present. Therefore, based on the previous findings regarding leadership, change and QI, it does appear this organization has the human resources and operational plans in place for success since they have the involvement of the highest level of administration in the organization (Juran, 1989 & 1994; Berwick, Blanton and Roessner, 1990) with complementary players in a variety of areas (Denis, Lamothe and Langley, 2001). They also have competencies in QI, which is key (Weiner, Alexander and Shortell, 1996).

Attitude

In fully understanding the influence of accreditation on organizational change, the attitude of staff at the AHR must be considered. Consistently throughout the questionnaire, interview and focus groups, participants openly shared the fact that change was an accepted norm for the AHR. It seemed that an attitude of acceptance had developed as a result of the many changes the organization had undergone over the last 10 years. A few expressed frustration because change was a constant and a consistent pattern was never established. However, no one seemed threatened or expressed apprehension when discussing the possibility of change. Therefore, when the AHR embarked upon the accreditation process, participants engaged willingly without fear that the process would lead to more changes. They were accepting of change and not

intimidated by it. It is important, then, to understand this attitude existed prior to the accreditation process.

The staff would not be apprehensive about accreditation leading to change as they have to learn to cope with and embrace the challenges change brings. Most of the participants were very engaged in the process, feeling that the management team at the AHR is strong and sustainable.

Considering all the change prior to the accreditation exercise and organizational changes that followed the process but were unrelated to it, it is interesting to consider that accreditation was not only a motivator that fostered CQI but perhaps it was also a stabilizer for the ongoing change that pervaded this organization. Without question, the staff from the AHR, from top to bottom, all understand change and have learned to use it effectively rather than allowing it to be destructive.

In conclusion, accreditation did act as an intervention at the AHR and it initiated change and had an ongoing effect on the organization. The culture within the organization supported this effect that accreditation exerted but the existing attitude of staff towards changes likely was a contributing factor in the positive activity that resulted from accreditation.

Question 2: In the accreditation process, is the accreditation preparation phase (also known as the self assessment) the source of change?

In considering the entire accreditation process, focus group members identified parts of this process that they felt to be the most favorable stage in the accreditation process to implement change. These were numerous comments and most referred to the self assessment phase of the process. The comments support the notion that self assessment phase was considered the portion of the accreditation process that most influenced the

implementation of change in this organization. Others saw the real value of accreditation as being the self awareness and self evaluation that took place. Interesting to note was the reported enthusiasm and synergy within the teams as they evaluated the issues and determined positive actions that might correct the problems. Results from the management questionnaire also indicated that accreditation has an impact in the preparation phase.

There were obvious things that had to be addressed. The AHR refused to wait until the self assessment was over to rectify the areas needing immediate attention. They literally corrected issues before the accreditation report was even presented. Knowing this, it is easy to understand that the AHR saw accreditation as an educational experience that they could learn from and as a result an environmental sensitivity to quality developed and continued to be nurtured as the identified changes were initiated and deployed successfully.

Finally, what is most interesting is that the majority of people involved in the interviews and focus group indicated that the preparation phase was an opportunity to implement changes, however, when you actually look at the examples of changes that occurred in the self assessment phase, there was little mentioned. This could be due to the lack of experience of the researchers in probing for more examples of changes but this is an interesting paradigm.

Changes

The interesting facts were compiled in relation to the change process at the AHR. One notable finding from the changes that were implemented was that most changes were deductive, from the top down (Rocher, 2000) instead of inductive, coming from staff to management. Many of the changes that were suggested in the self assessments were inductive in nature in that the self assessment teams put forth strengths and areas to improve as part of the first phase of accreditation. However, the movement of those areas for improvement to action was as a result of management realizing the importance of the changes required and endorsing those. The management questionnaire also indicated that the recommendations were an opportunity to implement change.

A common theme that resulted was that if the change was generalized and the motivation was top down, the change process was slower since it would impact more people and require further coordination for the change to take place. When the change was localized, the pace of change was more rapid, most likely due to the smaller scale and the ability to react and implement change would be much quicker.

Another finding is the realization that when the risk of an issue was high, it resulted in more rapid change versus an issue that was not as much of a risk to the AHR i.e. the special care nursery space issue and the dangers associated with lack of space or the fire safety and preparedness. In addition, when a strength was identified, it was not continually supported as attention was given to the areas to improve.

No matter what phase of the accreditation cycle, a commonality amongst the results was that most changes that resulted from the accreditation process were at the organizational level versus the group or individual level. There were no changes that were identified at the relational level. Thus, most of the changes identified crossed the entire organization and were not focused on any particular area.

Questions 3: Does the accreditation process motivate teams to develop or to enrich the quality improvement process in the organization?

Team Composition and Focus

When accreditation was undertaken at the AHR, staff were selected across the organization and directed to participate in various groups that were being organized. The groups then were formed with a heterogeneous mix of staff with different positions working in different areas of the organization and they all came together with their

different experiences and opinions. The commonality that existed was the goal they shared. This focus began during the preparation sessions.

The critical team activity focused on education and preparation that clarified the accreditation process and expectations. This directed the thinking of all participants towards accreditation and the task at hand. In referring to the Ketelhut definition of team, it is clear that the fifteen teams designated fell within this criteria and as Gizzo and Dickenson (1996) along with many others studying teams, an almost automatic "pulling together" in one direction emerged. This was supported by results from the management questionnaire which indicate that accreditation enhances responsiveness and collaboration.

There were diverse perspectives, common concerns, consensus and solutions. It seemed, from comments shared by group members, the more the group met, the stronger the links became within the groups. Diversity remained in terms of individuality, workplace site and job responsibility but unity of purpose drove the team more closely together. As the members became more familiar with one another, accreditation and the self assessment process led them to new discoveries and insights, outlining strengths and areas to improve. The longer the group was together, with the inclusion of another meeting to the total, the more the team was able to recognize its potential and be aware of what might be accomplished.

Each team recognized the impact and change it could affect in the organization.
As previously explained, when asked how accreditation had effected the team, comments including "lead to synergy in the team, friendships/relationships formed, team members learned a lot about the formal team process and how teamwork, awareness and bonding has taken place" were all feelings shared by most team representatives that were interviewed.

Not all of the teams set the same priorities but all did recognize that the need to improve and that change did not terminate with the conclusion of accreditation.

Team Communication and Decision Making

The effectiveness then of the team unexpectedly was in its diversity which brought a breadth of experience and depth of knowledge. This was enhanced by the communication that flowed within the groups. Knowing this openness and communication exists explains the success evidenced during the accreditation process. To facilitate change, environments must be created to allow for debates, information exchange and training (Crozier and Friedberg, 1997; Mintzberg et al., 1999). Across management and staff, all personnel are comfortable relating because of previously established strategies. Accreditation, then, was a new process but the teamwork with the open communication was not a new experience.

Part of this openness must be linked back to the influence of leadership in the organization. Because of changes and because of the leadership stability, this organization has developed a confident and accountable method of decision making. This process has developed because of necessity. From the management questionnaire, respondents felt that they are involved in administrative decisions, consulted in decision making and that participation by professionals in the organization's management is relatively similar as the others. Because of the comfortable supportive relationship between management and staff, the groups' effectiveness was linked to leadership that possessed authority to implement the changes that were identified by each group. This activity was seen as a motivator, as well as an indicator for success.

In summary, from the analysis of the changes, a generalization is that the groups needing to make the most changes and likely to gain the most took greatest interest in quality improvement. They embraced the process; they weren't intimidated by the changes required but rather motivated, especially after change was initiated and benefits recognized.

Before accreditation, QI was not identified as part of this process but this has since changed. In this organization, innovation and creativity are encouraged. Individuals can think and act independently but quality care emerges when there is teamwork and

cooperation. This has been confirmed through the accreditation process. The groups are willing to embrace the accreditation process and accepted the challenges of the new undertaking. After accreditation, there now exists more of an environmental sensitivity to quality.

Subsequent to the accreditation report, many of the self assessment teams continued to meet to address the areas outlined in their sections of the report. Management recognized the value of these teams and formally development best practice teams as part of the organizational structure (which subsequently changed to QI teams in 2003 after the merger).

Now, post accreditation, QI teams are still functioning. A Quality Improvement and Planning Group has been formed, an 11-step QI methodology and process outlined and an adoption regionally of the use of the Balanced Scorecard for quality measurement. Most notably, many team members learned from the process. They felt empowered, which motivated them far beyond the accreditation period; they better recognized best practices outside the organization and willingness to bring these practices into the workplace; and a sharing of own best practice with others validated these changes.

CHAPTER IX - CASE STUDY LIMITATIONS AND FUTURE RESEARCH

1. COMMON LIMITATIONS

Like any other research study, certain tests must be performed to establish the quality of case studies. The four most common tests are reliability, construct validity, internal validity and external validity.

1.1. Reliability

For a study to be considered reliable, the researcher must be able to demonstrate that the operations of a study (e.g. data collection procedures) can be repeated, with the same results (Yin, 2003). This is achieved through the development of case study protocol. Many steps were taken in this study to ensure that the collection of data were reliable. Some of these have already been mentioned in the previous section. The following is a summary of the steps taken to increase reliability:

Overall

- There is a high degree of internal consistency (the extent to which tests or procedures assess the same characteristic, skill or quality, Writing@CSU 2005) since the same versions of the interviews questions, the focus group questions, the culture questionnaires and the management questionnaires were used for all study sites of the overall research study;
- The questionnaire tools used in the study have been used on numerous other occasions and have proven to be reliable in other studies. Similar processes were used in this case study as were used in the studies where the tools have been used before e.g. Shortell 1995, 2000, 2001 and Quinn and Kimberly, 1984;
- Some sections of the management questionnaire and the qualitative methods used in this case study have been previously used by Marie Pascal Pomey in the study of the impact of accreditation in France (Pomey, 2002).

Qualitative Data

- Each of the interviews and focus group transcriptions were reviewed and corrections made to increase accuracy. Also, all notes taken while on the survey visit were compared to the transcriptions to ensure the information is consistent;
- A set of standard codes with definitions was used as a reference tool to ensure all project coders are using the same coding practices;
- In terms of coding of the qualitative data, there were countless revisions to the coding system (process of coding into usable form) associating definitions so that each researcher was using the codes for the same purposes. The pilot findings were all coded by the researchers and discrepancies identified in coding practices. As well, from the more than one transcript was coded by another researcher, discrepancies discussed and conclusions reached resulting in higher interrater reliability, which is the extent to which two of more people agree.

Quantitative Data

- The inputted results for each of the questionnaires were reviewed twice to eliminate data entry errors. Also, random spot checks were performed to ensure that the data is entered accurately. Finally, when entered, each survey was given a number, which can be crosschecked with the SPSS data;
- For the results of the culture questionnaire, ANOVA, Spearman's Rho and correlations were performed on all of the variables and analyzed when there were significant differences. However, the overall response rate for the culture questionnaire was only 3.24% (259 out of 8000), meaning that the survey captured the opinions of only 3% of staff's opinions. However, multiple sites (five different locations) were used to get a more representative sample of the culture at the AHR, increasing the reliability of the results found;
- From the results of the management questionnaire, the Cronbach's Alpha test and correlations were performed on all of the variables and analyzed when there were significant differences, testing for internal consistency. The response rate for the management questionnaire was 46.67% (21 directors and managers out of 45), indicating that almost half of the managers at the AHR had the opportunity to

express their thoughts and opinions, representing a diverse enough perspective that the results are considered reliable and representative.

1.2. Construct Validity

Construct validity seeks agreement between a theoretical concept and a specific measuring device or procedure. It requires establishing correct operational measures for the concept being studied (Yin, 2003). Construct validity is especially problematic in case study research. It has been a source of criticism because of potential investigator subjectivity. Yin (1994) proposed three remedies to counteract this: using multiple sources of evidence, establishing a chain of evidence, and having a draft case study report reviewed by key informants.

In this case study, multiple sources of evidence, gathered independently, were used to link certain findings together related to looking at the changes occurring within the healthcare organization, internally and externally. There was a triangulation of the theoretical framework and the multiple sources of evidence such as internal documents and the qualitative and quantitative data received, resulting in a chain of evidence (Pomey, 2002). Also important was the linking of the focus group and interview questions to codes and quantitative data.

As well, to compensate for any bias, once the case study is completed, the results will be shared with the participants in the study from the AHR to confirm that all of the information collected was correct and that the analysis and results reflect reality. The AHR must agree with the material, which will increase the construct validity and will be taken into consideration of the larger research study.

1.3. Internal Validity

Proving that the results are internally valid is required since an explanatory case study was performed. Ensuring that the results are internally valid means measuring how well one can confidently conclude that the changes in the dependant variable were produced by the independent variable and not external factors. This is evidenced in this case study

when conclusions are drawn regarding the changes that occurred as a result of accreditation. Since a focus of this case study is placed on the qualitative results, there was a section in the data addressing other external factors resulting in changes. Thus, if there were rival explanations, they were considered in the analysis. In this case study, many of the changes that were valid were those that occurred in the preparation phase and during the actual survey because it was hard to link changes after the report was received to just accreditation since the AHR underwent another round of regionalization.

As with construct validity, the use of the triangulation technique permits the researcher to enforce internal validity of a case study since common threads may be linked between the results, reinforcing certain changes.

1.4. External Validity

External validity refers to establishing the domain to which the study findings can be generalized (Yin, 2003) and transferred to other contexts. Since this is a single case study, the generalizability of the results to a broader population is minimal. However, since the results from this single case study will be compiled as part of the larger research study, it will provide the opportunity to either confirm or refute the case study findings. The combination of the results from the seven different sites will allow for more generalizations of the results to a broader population since multiple case studies increase external validity. As well, since the overall study has a similar design and findings to the France study on the impact of accreditation preparation in France (Pomey, 2002) and some studies by Shortell et al. (1995), the findings can be compared to see if there are any similarities to build on the prior case studies in the same areas of research. Please see Chapter IV for a review of the overall research study.

1.5. Qualitative Data Limitations

There are limitations in the qualitative data received. Firstly, there were some issues with the recruitment and selection of people who were included in the case study. People were not chosen randomly for the interviews or focus groups. They were selected by the quality department of the AHR and directed to participate. Those included had

participated to some degree in a previous accreditation although it may not have been at this AHR. Also, two interviewees were not part of the accreditation preparation or the actual accreditation visit, which limited their responses mainly to getting information regarding accreditation in general. They had been with the AHR when the report results were received so they could provide information only on the quality aspects of the region after they became employees in the last phase of accreditation. Also, there were no physicians included; thus, their perspectives were not represented in the qualitative data. This is a limitation since the medical doctor is valued as a key role in the decision making process within the healthcare system.

Another limitation is the data itself was largely self-reported and thus, subject to biases since respondents may have wanted to provide the 'right' answers instead of expressing true reality. Another consideration is that some study participants were better able to articulate their ideas and express themselves, which led to provision of more specific information related to changes that have occurred. For example, some respondents outlined many specific changes and others only commented broadly on the overall accreditation process. Since the emphasis of this case study was on the interview and focus group findings, this is a limitation because the results can only be as good as the responses that are shared and received. It is possible that this limitation could be minimized with better questioning and probing by the researchers.

Finally, this case study investigated team members' assessment of team functioning and changes related to accreditation and not the actual performance of teams. This is a limitation since teams may produce different effective outcomes based on the perception of the respondent. Thus, personal opinions and narratives were reported rather than measurable performance outcomes, which leaves margin for subjectivity.

Therefore, triangulation of the interview and focus groups results with the questionnaires and other materials from the AHR seldom brought about contradictory responses, increasing internal validity.

1.6. Sample Bias for the Quantitative Data and Tool Limitations

There were also limitations with the questionnaire tools used and data collected. For the culture questionnaire, the number of questionnaires completed was limited as compared to the entire population of the AHR (259 out of 8000). Secondly, there were many comments regarding the user friendliness of the culture questionnaire. Many of those surveyed commented on the ambiguity and confusion of the survey format. This is evidenced by the fact that many of the surveys were not completed correctly because the respondents did not follow direction in correctly allocating points to the questions. As well, the data collection methods were biased. People sampled were only those who at in the cafeteria, which is not all staff. In addition, the other, some questionnaires were collected by the QI department which may lead to a bias in the results.

This case study found that the AHR is characterized as having a hierarchical and rational culture. However, many hospital cultures are composed of many subcultures (e.g., departments or programs, patient care units, disciplinary groups) (Coeling and Simms 1993; Deal et al. 1983). Thus, the hierarchical and rational culture for the entire region is an oversimplification that ignores the presence of organizational subcultures. In this case study, only 5 sites across the region were surveyed out of 50 sites. They were all hospitals or health centres since the volume of staff traffic at these sites was predicted to be higher on average than other sites (i.e. continuing care facility) within the AHR. Thus, only the sites surveyed provided input on their perceptions of the culture at the AHR and alternate perceptions may have resulted had more sites been surveyed.

2. Other Case Study Limitations

Overall, a consideration for this study is that people in Alberta may be desensitized to change since change has been such a regular phenomena in this province. Thus, whether the changes that occurred were massive or minor, the notion of change was the only constant. The individual perception of the specific change could differ drastically but all expressed an attitude of acceptance – "change happens here!" The same change, however, in another health region in another province may be described and perceived very differently.

3. Suggestions for Other Studies

3.1. Suggestions for the other sites as part if the Multiple Case Study

There are definitely improvements that can be made to the quantitative data collection methods and tools. Firstly, before surveying the sites, researchers should find out what sample size is required for both the culture and management questionnaire for analysis to ensure that significant results will be achieved. Secondly, in terms of participation, researchers must ensure that physicians are included in the focus group and/or interview to get more data from this perspective. Also, when reviewing those selected to be a part of the research study, some of the people interviewed in Alberta were not part of the last accreditation process which limited the information. Thus, further consideration of the right people to interview is important to maximize information that can be gathered. Practice with the interview questions in simulated scenarios may also better prepare the researchers for possibilities that will occur which the tool is actually used in the setting under study. This may help to eliminate awkwardness and maintain the integrity of the questions and recording of data.

More specifically, in the culture questionnaire, the user friendliness of the tool must be addressed. Direction for use should be precise. Researchers should ensure that the culture questionnaires have the 100% total at the end of each section to enhance clarity of the exercise.

In terms of location for sampling for the culture questionnaire, in this particular case study, we assumed that staff eat in the cafeteria for lunch but this is not the case for all staff. Researchers should consider expanding the locations for getting more surveys completed.

Finally, in all of the materials, the translated documents (i.e. the questionnaires and the interview and focus group questions) listed 'security' instead of 'safety'. This must be corrected since this was an item of confusion for participants.

3.2. Suggestions for Future Studies

The tentative results reported in this case study suggest a promising venue for future research. However, some changes are required to improve upon the methodological inadequacies of this study.

Firstly, more research is required that includes objective measures of performance such as productivity of teams or patient outcomes. Increasing the number of teams involved as well as a higher percentage of individual within the organization participating would also enhance the findings.

Secondly, there was no indication as to what the "ideal" conditions are for effective teams in the healthcare environment. A future study around the use of teams in the accreditation process could be an opportunity to explore this further.
Thirdly, in this study there was an attempt to gather information on costs associated with implementation of accreditation (e.g. costs and ROI). However, this must be expanded since this was really not captured as the information gathered was very broad in nature. Little is known regarding the actual cost of accreditation for organizations, directly and indirectly.

Leadership was considered as one of the important elements under conditions for change in the conceptual model. However, this could be a study in and of itself where the leadership piece is reviewed and the links to accreditation pursued in more depth.

Finally, since this case study was focusing on the teaming concept and accreditation was performed only on one health region, the results must be further corroborated with other sites, in particular health regions to validate the findings.

CHAPTER X – RECOMMENDATIONS FOR THE AHR

Below are some recommendations for the AHR to consider as a result of the analysis completed regarding the impact of accreditation on the organization.

The AHR should:

- Continue to be involved with CCHSA and undergo the survey as planned in 2006. Once the second accreditation cycle is complete, the AHR should evaluate the impacts and determine the value added from being involved;

- Reorganize and promote teamwork by recognizing and reporting team efforts that identify deficits and take action to correct these issues;

- Find new ways to involve all staff in quality improvement. Currently, it is stated that 'quality is everyone's responsibility' but it is difficult to measure this. The organization must find ways to mobilize staff that are neither included in the accreditation process nor on QI teams and to ensure that the QI principles are clearly communicated through different mediums.

- Could consider putting in place a reward program to highlight the QI initiatives that are occurring throughout the organization to increase awareness and potentially increase buy-in for those not formally involved;

- Should use the current staff involved in accreditation as champions of QI and develop an associated plan to highlight the new quality process;

- Clarify the role of the Quality Planning Department for all involved in the organization; clearly outline the linkages between the QI program and the accreditation process across the region.

- Improve in the area of demonstration of quality results and performance;

- Maintain and strengthen relationships with the community. In this case study, it was identified that partnerships have always been a strong point of the AHR that have existed based on the identified needs throughout the community served. It was recognized that the accreditation process was an opportunity to further enhance these existing relationships. Bringing partners together was another avenue to create common ground or standards as part of the self assessment phase. Thus, the organization should continue to look for ways to keep partners and community representatives included, thereby strengthening relationships;

- Over the long term, shift the organizational culture from hierarchical and rational to more group oriented - emphasizing teamwork, support and development of everyone's potential (Shortell et al., 1995);

CHAPTER XI – CONCLUSION

The data and information gathered for this single case study using this provincial health region as the demonstration site supports the questions formulated prior to the initiation of this study. The facts collected confirm that the accreditation process did have an impact on this service provider. The changes were validated through responses to questionnaires, in focus group activity and personal interviews. Initial change actually occurred in the self assessment teams as areas of weakness and issues needing attention were identified. Momentum for change began as predicated during this pre assessment phase, which was considered by the majority of participants as the most productive part of the accreditation process.

In many instances, the resulting QI measures that began with accreditation are ongoing, long after the accreditation process has ended. As well, the process allowed an already strong organization to find unity and added strength in itself by allowing them to unite, work together, share ideas, become acquainted to each others strengths and abilities, and work together to facilitate change. Personal relationships internally within and amongst the staff and management were forged and externally with community partners were encouraged to grow. This group approach, combined with the accreditation process itself, instigated change that expanded to an actual QI department within the organization. During the process, strengths within the organization were identified and participants provided responses that validated the value they perceived in the accreditation process.

As the study came to conclusion, some questions regarding accreditation were answered; however, many questions remain as unconfirmed responses still remain. These unanswered, yet to be assessed areas related to the accreditation program provide the basis for new studies that could be examined and investigated in the future. Recommendations and suggestions for further studies were provided.

APPENDICES

APPENDIX A: ORGANIZATIONAL CULTURE QUESTIONNAIRE

A. The AHR's Culture

The AHR's Character

(Please distribute 100 points)

a. The AHR is a very personal place. It is a lot like an extended family. People seem to share a lot of themselves.

Points for A _____

b. The AHR is a very dynamic and entrepreneurial place. People are willing to stick their necks out and take risks.

Points for B _____

c. It is a very formalized and structured place. Bureaucratic procedures generally govern what people do.

Points for C _____

d. This place is very production oriented. A major concern is with getting the job done. People aren't very personally involved.

Points for D _____

The AHR's Managers

(Please distribute 100 points)

a. Managers are warm and caring. They seek to develop employees' full potential and act as their mentors or guides.

Points for A _____

b. Managers are risk-takers. They encourage employees to take risks and be innovative.

Points for B _____

c. Managers are rule-enforcers. They expect employees to follow established rules, policies, and procedures.

Points for C _____

d. Managers within the AHR are coordinators and coaches. They help employees meet the AHR's goals and objectives.

Points for D _____

The AHR's Cohesion

(Please distribute 100 points)

a. The glue that holds the AHR together is loyalty and tradition. Commitment to this AHR runs high.

Points for A _____

b. The glue that holds the AHR together is commitment to innovation and development. There is an emphasis on being first.

Points for B _____

c. The glue that holds the AHR together is formal rules and policies. Maintaining a smooth running operation is important here.

Points for C _____

d. The glue that holds the AHR together is the emphasis on tasks and goal accomplishment. A production orientation is commonly shared.

Points for D _____

The AHR's Emphasis

(Please distribute 100 points)

a. The AHR emphasizes human resources. High cohesion and morale in the AHR are important.

Points for A _____

b. The AHR emphasizes growth and acquiring new resources. Readiness to meet new challenges is important.

Points for B _____

c. The AHR emphasizes permanence and stability. Efficient, smooth operations are important.

Points for C _____

d. The AHR emphasizes competitive actions and achievement. Measurable goals are important.

Points for D _____

B. GENERAL INFORMATION

1. What is your gender?

Female ☐ Male ☐

2. What is your age?

Below 30 years ☐ Between 30 to 45 years ☐

Between 46 to 55 years ☐ Over 55 years ☐

3. Are you in a manager position?

Yes ☐ No ☐

4. How long have you worked for or been associated with the AHR?

/_____/ year(s) /_____/ month(s)

5. What is your occupational category?

Medical doctor ☐ Nurse ☐

Allied health professionnal ☐ Support ☐

Administration ☐ Volunteers ☐

Other (please specify) ☐

Thank you for your collaboration!

APPENDIX B: Perception of Quality Improvement Implementation and Professional Implication in Healthcare Organization Questionnaire

Université d' University of Ottawa

University of Toronto

Université de Montréal

Perception of Quality Improvement Implementation and Professional Implication in the AHR

QUESTIONNAIRE FOR THE MANAGERS OF THE AHR

Instrument developed by:
S.M. Shortell et al, 1995. "Assessing the Impact of Continuous Quality Improvement/Total Quality Management: Concept versus Implementation." Health Services Research, 30:2 (June 1995), 377-401.

The goal of this questionnaire is to establish the principals of management of quality of services and care as well as the involvement of professionals. Answering this questionnaire does not require any research on your part - answer according to your opinion, perception, and knowledge. All of the answers provided will remain **confidential** and will only be used by members of the research team. Nothing within the results will permit identification of persons or institutions. Please plan to take 15 minutes to complete the survey.

For additional information about this study and more specifically this questionnaire, please contact:
Marie-Pascale Pomey, MD, PhD, School of management, University of Ottawa
Phone: (613) 562-5800 ext. 4734, Fax : (613) 562-5164,
Email: pomey@management.uottawa.ca

Any information about my rights as a research participant may be addressed to:
Protocol Officer for Ethics in Research, University of Ottawa
550, Cumberland Street, Ottawa (ON) K1N 6N5
Phone: (613) 562-5841 or ethics@uottawa.ca

This research has been financed by the Canadian Institutes of Health Research. The co-researchers are: M-P Pomey, Doug Angus (University of Ottawa), Louise Lemieux-Charles (University of Toronto), François Champagne, A-P Contandriopoulos, J-L Denis (University of Montréal)

A. QUALITY OF CARE

In this section, you will evaluate the AHR's involvement in the improvement of customers' quality of care. Read the following sentences and circle the most appropriate answer (1= strongly disagree, 5= strongly agree). When you answer these questions you must think of the AHR at the present time and not how it was or how it will be.

Leadership (*circle the appropriate number)*

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Don't know
1. The senior executives provide highly visible leadership in maintaining an environment that supports quality improvement.	1	2	3	4	5	9
2. Top management is a primary driving force behind quality improvement efforts.	1	2	3	4	5	9
3. The senior executives allocate available AHR resources (e.g., finances, people, time, and equipment) to improving quality.	1	2	3	4	5	9
4. The senior executives consistently participate in activities to improve the quality of care and services	1	2	3	4	5	9
5. The senior executives have articulated a clear vision for improving the quality of care and services.	1	2	3	4	5	9
6. The senior executives have demonstrated an ability to manage the changes (e.g., organizational, technological) needed to improve the quality of care and services.	1	2	3	4	5	9
7. The senior executives act on suggestions to improve the quality of care and services.	1	2	3	4	5	9
8. The senior executive leadership is personally involved in quality improvement efforts.	1	2	3	4	5	9
9. The senior executives have a thorough understanding of how to improve the quality of care and services.	1	2	3	4	5	9
10. The senior executives generate confidence that efforts to improve quality will succeed.	1	2	3	4	5	9
11. The team seeks information on needs and suggestions for quality improvement directly from external customers (e.g., patients, families, and payers).	1	2	3	4	5	9

Information and Analysis (*circle the appropriate number)*

	Strongly	Disagree	Neither	Agree	Strongly	Don't

	disagree		disagree nor agree		agree	know
12. Your team collects a wide range of data and information about the quality of care and services.	1	2	3	4	5	9
13. Your team uses a wide range of data and information about the quality of care and services to make improvements	1	2	3	4	5	9
14. Your team continuously tries to improve how it uses data and information on the quality of care and services.	1	2	3	4	5	9
15. Your team continuously tries to improve the accuracy and relevance of its data on the quality of care and services provided.	1	2	3	4	5	9
16. Your team continuously tries to improve the timeliness of its data on the quality of care and services provided.	1	2	3	4	5	9
17. Your team is actively involved in determining what data are collected for the purpose of improving the quality of care and services.	1	2	3	4	5	9
18. Your team compares its data to data on the quality of care and services at other organizations.	1	2	3	4	5	9

Strategic Quality Planning (*circle the appropriate number)*

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Don't know
19. AHR employees are given adequate time to plan for and test improvements.	1	2	3	4	5	9
20. Each department and work group within this AHR maintains specific goals to improve quality.	1	2	3	4	5	9
21. The AHR 's quality improvement goals are known throughout the region.	1	2	3	4	5	9
22. AHR employees are involved in developing plans for improving quality.	1	2	3	4	5	9
23. Middle managers (e.g., department heads, program directors, and first line supervisors) play a key role in setting priorities for quality improvement.	1	2	3	4	5	9

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Don't know
24. External customers play a key role in setting priorities for quality improvement.	1	2	3	4	5	9
25. Non-managerial employees play a key role in setting priorities for quality improvement.	1	2	3	4	5	9

Human Resources Utilization (*circle the appropriate number)*

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Don't know
26. AHR employees are given education and training in how to identify and act on quality improvement opportunities.	1	2	3	4	5	9
27. AHR employees are given education and training in statistical and other quantitative methods that support quality improvement.	1	2	3	4	5	9
28. AHR employees are given the needed education and training to improve job skills and performance.	1	2	3	4	5	9
29. AHR employees are rewarded and recognized (e.g., financially and/or otherwise) for improving quality.	1	2	3	4	5	9
30. Inter-departmental cooperation to improve the quality of services is supported and encouraged.	1	2	3	4	5	9
31. AHR employees have the authority to correct problems in their area when quality standards are not being met.	1	2	3	4	5	9
32. AHR employees are supported when they take necessary risks to improve quality.	1	2	3	4	5	9
33. The AHR has an effective system for employees to make suggestions to management on how to improve quality.	1	2	3	4	5	9

Quality Management (*circle the appropriate number)*

	Strongly disagree	disagree	Neither disagree nor agree	agree	Strongly agree	Don't know
34. The AHR regularly checks equipment and supplies to make sure they meet quality requirements.	1	2	3	4	5	9
35. The quality assurance staff effectively coordinates its efforts with others to improve the quality of care and services the AHR provides.	1	2	3	4	5	9
36. Data from suppliers are used when developing the AHR 's plan to improve quality.	1	2	3	4	5	9
37. The AHR has effective policies to support improving the quality of care and services.	1	2	3	4	5	9
38. The AHR works closely with suppliers to improve the quality of their products and services.	1	2	3	4	5	9
39. The AHR tries to design quality into new services as they are being developed.	1	2	3	4	5	9
40. The services that the AHR provides are thoroughly tested for quality before they are implemented.	1	2	3	4	5	9
41. The AHR views quality assurance as a continuing search for ways to improve.	1	2	3	4	5	9
42. The AHR encourages employees to keep records of quality measurements.	1	2	3	4	5	9

Quality Results (*circle the appropriate number)*

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Don't know
43. Over the past few years, the AHR has shown steady, measurable improvements in the quality of customer satisfaction	1	2	3	4	5	9
44. Over the past few years, the AHR has shown steady, measurable improvements in the quality of services provided by the administration (finance, human resources, etc.)	1	2	3	4	5	9
45. Over the past few years, the AHR has shown steady, measurable improvements in the quality of care provided to medical, surgical and obstetric patients.	1	2	3	4	5	9

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Don't know
46. Over the past few years, the AHR has shown steady, measurable improvements in the quality of services provided by clinical support departments such as laboratory, pharmacy, and radiology.	1	2	3	4	5	9
47. Over the past few years, the AHR has maintained a high quality despite budget constraints	1	2	3	4	5	9

Customer Satisfaction (*circle the appropriate number)*

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Don't know
48. The AHR does a good job of assessing current patient needs and expectations.	1	2	3	4	5	9
49. The AHR does a good job of assessing future patient needs and expectations.	1	2	3	4	5	9
50. AHR employees promptly resolve patient complaints.	1	2	3	4	5	9
51. Patients' complaints are studied to identify patterns and prevent the same problems from recurring.	1	2	3	4	5	9
52. The AHR uses data from patients to improve services.	1	2	3	4	5	9
53. Data on patient satisfaction are widely communicated to AHR staff.	1	2	3	4	5	9
54. The AHR does a good job of assessing physician satisfaction with organizational services.	1	2	3	4	5	9
55. The AHR uses data on customer expectations and/or satisfaction when designing new services.	1	2	3	4	5	9
56. The AHR does a good job of assessing employee satisfaction with services provided by other employees and departments.	1	2	3	4	5	9

B. PROFESSIONAL PARTICIPATION TO AHR MANAGEMENT

The goal of this section is the examine the degree of participation of the AHR's administration, the perception that professionals have of being consulted in the administrative decision-making processes, as well as their degree of influence in the decision-making process. *For each of the following questions, please circle the appropriate number.*

	Never				Always
1. Are you involved in administrative decisions concerning the following areas:					
a) Budgets	1	2	3	4	5
b) Human resources	1	2	3	4	5
c) Professional practices	1	2	3	4	5
d) Acquisition of new equipment and technologies	1	2	3	4	5
	Never				**Always**
2. Since you are consulted in the decision-making process, do you feel that your opinion is taken into consideration?	1	2	3	4	5
	None				**Very high**
3. How would you rate your level of participation in the AHR's management?	1	2	3	4	5
	None				**Very high**
4. How would you rate the level of participation of professionals in the AHR's management?	1	2	3	4	5

C. ACCREDITATION IMPACT

The goal of this section is to examine the impact of the accreditation in terms of dynamics of change at the AHR. ***For each of the following sentences, please circle the appropriate number.***

	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree	Don't know
1. During the preparation for the last survey, important changes were implemented at the AHR.	1	2	3	4	5	9
2. You participated in the implementation of these changes.	1	2	3	4	5	9
3. You learned of the recommendations made to the AHR since the last survey (if it's the case).	1	2	3	4	5	9
4. These recommendations were an opportunity to implement important changes within the AHR.	1	2	3	4	5	9
5. You participated in these changes.	1	2	3	4	5	9
6. Accreditation enables the improvement of patient care.	1	2	3	4	5	9
7. Accreditation enables the development of values shared by all professionals within the AHR.	1	2	3	4	5	9
8. Accreditation enables the AHR to better use its internal resources.	1	2	3	4	5	9
9. Accreditation enables the AHR to better respond to the populations needs.	1	2	3	4	5	9
10. Accreditation enables the AHR to better respond to its partners (other organizations, diverse organizations, private clinics, etc.)	1	2	3	4	5	9
11. Accreditation contributes to the development collaboration with partners in the healthcare system (other organizations diverse organizations, etc.)	1	2	3	4	5	9
12. Accreditation is a valuable tool for the AHR to implement changes.	1	2	3	4	5	9
13. The AHR's participation in accreditation enables it to be more responsive when changes are to be implemented.	1	2	3	4	5	9

D. INFORMATION ABOUT YOURSELF

1. What is your gender?

Female ☐ Male ☐

2. What is your age?

Below 30 years /___/ Between 30 and 45 years /___/

Between 46 and 55 years /___/ Over 55 years /___/

3. How long have you worked for or been associated with the AHR?

/_____/ years /_____/ months

4. Do you have a clinical background? **Yes** ☐ **No** ☐

5. What is your occupational category?

Medical Doctor /___/ Nurse /___/

Allied Health Professionnals /___/

Other: /___/ Specify:

6. You were member of a self assessment team that participated in the completion of the accreditation manual? Yes ☐ No ☐

7. Are you a member of an organization-wide quality assurance or quality improvement steering council (or equivalent body)? Yes ☐ No ☐

8. How do you judge you involvement into the accreditation process on a scale from 1 to 10?

1 ●——————————————————● 10

Thank you for Your Collaboration

Feel free to write comments on the back of this sheet

APPENDIX C: INTERVIEW GUIDE FOR THE INDIVIDUAL INTERVIEW

The dimensions used to categorize the questions are those proposed in the theoretical framework which takes up the different analytical directions regarding the dynamics of change. The questions relate to the characteristics of an organization that can favour change and the elements that can characterize the changes implemented in line with the accreditation of hospitals.

1. Introduction

1.1 Can you in a few words describe your career? How long have you worked for the AHR and in this position?

2. Factors of Change / The David Thompson Health Region's Characteristics

2.1 Did the professionals working for the AHR change much over the past five years? At the management level, clinical services level, support level and others?

2.2 Could the AHR be characterized as dynamic and enterprising? Give examples.

2.3 Do the professionals have a certain margin of freedom to express their opinion, to make decisions, to act independently? Can you give some examples?

2.4 What are the main values shared by the AHR's professionals? Quality, public service, health, efficacy, efficiency, etc.?

2.5 When important decisions are necessary, which strategies are implemented? How are they implemented? Does one seek professional approval?

- Existence of formal consultation forums involving all of the professionals or informal forums involving administrative and healthcare staff
- Possibilities of prompt consultations
- Existence of representative elected committees that participate

2.6 Do formal or informal discussion forums exist in which new ideas can be exchanged?

2.7 Are people that exert strong leadership present at the management level? At the clinical level? At other levels?

2.8 Did these people participate in important changes within the AHR?

2.9 Is general management involved in quality improvement? Is the CEO also involved in decisions relating to quality improvement and security?

2.10 Are people present within the AHR who are recognized for their competencies in the area of quality improvement and security?

3. Accreditation

3.1 Why did the AHR enter the accreditation process? What are the AHR's goals?

3.2 Did you hesitate before entering the last/first accreditation process? Why?

3.3 Is time recognized and allocated to the professionals that participate in the accreditation's preparation?

3.4 Does a financial estimate exist for the cost of the AHR's accreditation? And the return on investment?

3.5 Over the course of the accreditation cycles in which the AHR participated, are you under the impression that know-how was acquired? For example, is the preparation easier to implement as it has been done before? Why?

4. Accreditation and changes in line with the latest survey

This part of the interview is about the accreditation process and the changes that were able to take place during the self assessment phase and in line with the survey's conclusion.

4.1 Were you able to integrate the preparation for accreditation with your regular quality improvement activities, or was it necessary to invest extra effort and specific resources a couple of months before the accreditation?

4.2 Can you tell me how the preparation for the survey went? How long did the self assessment take? How were the self assessment teams formed? Did they already exist before? If so, through the previous survey? If not, why not? How do you characterize the participation of different groups of professionals in the preparation? (doctors, administrators, nurses, pharmacists, others)?

4.3 Did the implemented changes of standards lead to important changes during the preparation of the accreditation survey?

4.4 Was the accreditation preparation an opportunity to implement any changes? If so, which ones? At which level were they implemented? How were they implemented?

4.5 Did the self assessment teams implement any changes? Give examples.

4.6 Was the submission of the final report occasion to implement changes? If so, which ones? For each of the presented recommendations in the report, could you indicate which ones were implemented following the report? In case there were no recommendations, following the conclusion, which were the changes or actions pursued?

4.7 Did any of these changes, that took place during the self assessment phase or in line with the survey's conclusion (please specify), relate to the AHR's practices? If so, please give examples relating to healthcare services, management, or in other sectors within the AHR.

- Did new functions or jobs appear?
- Can you give me examples of innovative modes of strategic directions or special changes that were implemented within the AHR? In one or more care units? Were they brought to the attention of other professionals who might then be inspired?
- Do you believe that the self assessment was an opportunity to acquire new views on existent practices?
- Were clinical practices modified? Is there a more profound integration of "evidence-based medicine"?
- Were management practices modified? If so, which ones?

4.8 Did other changes during the self assessment or in line with the survey's conclusion (please specify), take place in connection with the AHR's organization?

- Which structures were modified or created?
- Were new organizational charts put in place?
- Did new organizational models get implemented?
- How were the information systems adapted to the accreditation's requirements? (Creation of an intranet, the collection of other data of the AHR, etc.)
- Were hierarchical structures of services modified? If so, please give examples
- Did certain departments acquire a more important authority? If so, please give examples.
- Did the hierarchical relationships at the AHR get modified (for example between the services and management)?

4.9 Which professionals are most involved in these changes? Which are least involved?

4.10 Did people receive leadership roles in the implemented changes? If so, which ones?

4.11 How would you characterize these changes? Were they important? Did they get implemented rapidly? Were the professionals involved?

4.12 Is the training plan for the professionals influenced by the accreditation requirements? If so, since when?

4.13 Did the involvement of patients and their families in quality improvement get modified? If so, how? Give examples.

4.14 Did resistance to change exist? If so, what was its effect?

4.15 Was the AHR's CEO/yourself actively involved in the changes that were implemented?

4.16 Which phase of the accreditation cycle do you consider the most favourable to implement change?
- Self assessment, the visit, after the report? Another time?

4.17 Does a group exist independent of the accreditation process that proposed and implemented changes within the AHR over the past five years? If yes, which and could you give us some examples?

4.18 Where did the most important changes within the AHR originate over the past five years?
- (Hospital closures, mergers, regionalization, reduction of deficits (budgetary cuts), changing demographics, unions, problems of recruitment and retention of personnel, competition with the private sector, alliances with the private sector, patient-centred emphasis, international competition for personnel and/or patients, accountability, technology, others?)

5. Changes of the relationship between the AHR and its network in connection with the accreditation

5.1 In which manner did the accreditation help the AHR to be more responsive to its environment's needs? (for example adaptation to the population's needs or the creation of a new service)

5.2 What are the principal impacts of the accreditation on the connection between the AHR and its other partners? (Other hospitals, community groups, different organizations, private clinics, etc.)

5.3 What are the principal impacts of the accreditation on the connection between the AHR and its administrative and financial structure?

6. Conclusion

6.1 What is your assessment of the CCHSA's accreditation process? Did you appreciate the survey team? Did you appreciate the new norms? Do you agree with the report's conclusion?

6.2 How do you characterize the accreditation experience for the AHR? (Advantages / disadvantages)

6.3 Do you believe that the AHR's participation in the accreditation process helps it to be more reactive to change? If so, why? Give examples.

- Thank you for your cooperation -

APPENDIX D: INTERVIEW GUIDE FOR THE QIT INTERVIEW

QIT Interview, concept is to look at team dynamics and evaluate the impact of teamwork on the accreditation process and on the quality of the organization

Interviewee:

Impact of quality improvement projects on the quality mission

1. What was the Quality Improvement Project? Why was it put together?
2. How many people on the QIT are involved in the self assessment teams?
3. What is the composition of the QIT? Why was it chosen? What was the interest?
4. Who was the chair? Would you say they were effective in achieving the mission or moving it forward?
5. What is the quality improvement process here?
6. Were any significant changes made as a result of the improvement process?
7. How has this project impacted the hospital? The accreditation process?
8. What were the main challenges faced in the implementation of the quality improvement project?
9. How did you feel as a member when the recommendations were put forward?
10. What kind of relationships were formed between team members? What was the impact on the organization from these relationships?
11. Were you able to meet new people and establish new working or personal relationships, and also to better understand what these people do?
12. Were you able to get to know your organization better?
13. Were you able to feel more integrated in your organization?
14. Are you under the impression that you belong to a certain common culture in your group? (Acquisition of vocabulary, certain expectations, work norms, etc.)?

APPENDIX E: INTERVIEW GUIDE FOR THE FOCUS GROUP

Focus Group
Self assessment Team Questions

We are going back to the 2002 Accreditation Survey for the David Thompson Health Region (AHR).

1. When you were preparing the 2002 CCHSA's visit, did you identify any problems inside the AHR?
    a. If so, which ones?
    b. Did you implement any measures to resolve them before the 2002 survey?
        i. If yes, please give examples.
        ii. If no, why not?

2. When the final report was sent to the AHR in 2002, did each of your self assessment teams receive a copy?
    a. If so, did management ask you to review the results or to act on them?
    b. If not, how did you find out about the report?

3. After receiving your report, what did you decide to do? How did you tackle the work on the recommendations or the weaknesses? Give me examples of actions.

4. How do you characterize the changes implemented at the AHR?
    - In line with the weaknesses
    - In line with the recommendations

5. How do you keep track of the changes?

6. Would these changes have taken place without the accreditation? Why or why not?

7. Did the changes made by your self assessment team impact other areas of the AHR? Which ones?

8. Are the 2002 self assessment teams still working as a group? If yes, are they working towards the 2006 survey? Are they using the 2002 report as a working tool?

9. I wish to conclude with a few questions concerning how being part of a self assessment team has benefited you as a person:
    a. Were you able to meet new people and establish new working or personal relationships, and also to better understand what these people do?
    b. Were you able to get to know your organization better?
    c. Were you able to feel more integrated in your organization?

d. Are you under the impression that you belong to a certain common culture in your group? (Acquisition of vocabulary, certain expectations, work norms, etc.)?

10. What do you think of the survey tools?

APPENDIX F: CODING TOOLS

Codes Qualitative Analysis, May 2005

I. Conditions favouring emergence and diffusion of change			
General Environment and fundamentals	GE	environment	Strong external pressures: technology, social, legal, financial, regulatory
		capacity	Surplus capacities of legitimate actors; both internal and external
		autonomy	Capable of making autonomous decisions (2.2)
		relationship	Relationships with external stakeholders (2.7)
		information	Sharing of information
		comparison	Comparison to other organizations and/or benchmarking
		knowledge	Ability to gather knowledge on the environment i.e. population health statistics
Strategies	ST	learning	Any media available for the exchange of ideas E.g. forum, committees, rounds, etc. (2.5/2.6)
		participation	Encouraging participation
		resistance	Resistance to participation
Leadership	LE	diffusion	Project initiators and implementers
		visibility	Visibility of leadership commitment (2.7/2.8/2.9)
		resources	Identification or key resource people (2.9)
		recognition	Ongoing recognition of projects
		competencies	Competencies in quality management: recognition of quality management competency through credentials, training, etc (2.10)
Conception	CO	model	Capacity to acquire new models of thinking, capacity to face complexity.
		critique	Ability to self-assess / critique oneself or ones organization
		intervention	Knowledge of the accreditation as an intervention; e.g. as a merger tool or method of acquiring best practices
Purpose	PU	open	open and explicit knowledge process; communication of purpose of accreditation for everyone.
		future	capacity to see the project in the future

II. Characteristics of change			
Nature	NA	Target	conceptual/concrete
		Intent	intentional/unintentional
		Pace	slow/rapid
		Rhythm	uniform/variable/one-time shock/incremental
		Dispersion	localized/generalized
		Trajectory	completed/blocked/regressed
		Phase	Initiation/growth/maturation/completion or decline
		Duration	Short/long
		Unspecified	Change mentioned
Action	AC	Incentive	
		Influence	
		Authority	
		Commitment	E.g. Putting patient welfare first could be a commitment that comes with an action
Resistance	RE	Indifference	Indifference towards change (4.14)
		Dissent	Dissent / counteracting change (4.14)
		Refusal	Refusal to participate in change (4.14)
		None	No resistance to change
Initiation	IN	Deductive	top/down (4.15)
		Inductive	bottom/up (4.15)
III. Hospital's characteristics			
Hospital's characteristics	HC	Values	values (2.4)
		social climate	Reference to culture of the organization (2.1)
		Budget	Any mention of budget
		accr issues	Issues for the HCO related to the accreditation process
		entrepreneurship	Dynamic and enterprising (2.2)
		Strength	Strength
		Weakness	Weakness
		Stability	Professional stability, turnover (2.1)
		information system	Information system
		Structures	Any indication of a formal structure, e.g. committee
		Organization	Program management has had changes from silos to something new (i.e. from department to program management)
		Team	Evidence of presence or lack of teamwork

IV. Quality programs and interventions			
Quality programs	QP	Structure	Organizational structure of a quality program e.g. quality improvement teams
		Policy	Any policies mentioned related to the quality program
		Accreditation	Relationship between the quality program and the accreditation process (4.1)
		Complaints	Complaints
		Satisfaction	Satisfaction
		risk management	risk management
		Dysfunction	Dysfunction
		clinical practices assessment	Whether the quality program assesses clinical practices
		Cost	Cost
		Participation	Participation
		Protocol	Protocols
		Recognition	Recognition
		balanced scorecard	balanced score card
		Indicators	Indicators
Accreditation's preparation	AP	teams formed	Accreditation teams formed (4.2)
		self assessment	The self assessment work
		Participation	(4.2)
		Physician participation	Physician participation in accreditation
		Standards	Changes of the accreditation standards (4.3)
		Changes	Implementation of changes during the accreditation preparation (4.4/4.5)
		Report	Implementation of changes related to the previous final report (4.6)
		recommendations	Recommendation implemented from the old report (4.6)
		Functions	New jobs, new functions as a result of preparation (4.7)
		Strategic directions	New strategic dimensions
		clinical guidelines	New clinical guidelines
		management practices	New management practices
		Structures	New organizational chart or model or hierarchical structure (4.8)
		information systems	New information systems (4.8)
		Authority	Description of how people are in hierarchical or individual relationships; relationships between people, not structure related eg. Physicians having authority over nurses, without being their superiors. (4.8)
		Risk management	Risk management
Accreditation's visit	AV	Participation	(4.2)
		Standards	Changes of the accreditation standards (4.3)
		Changes	Implementation of changes during the visit (4.4/4.5)

		Report	Implementation of changes related to the experts' feedback (4.6)
		Functions	Functions: new jobs, new functions (4.7)
		Strategic directions	Strategic directions: new strategic dimensions
		Clinical guidelines	Clinical guidelines:
		management practices	Management practices:
		Structures	New organizational chart or model or hierarchical structure (4.8)
		Information systems	Information systems 4.8
		Authority	Description of how people are in hierarchical or individual relationships; relationships between people, not structure related eg. Physicians having authority over nurses, without being their superiors. (4.8)
		risk management	Risk management
Accreditation's report	AR	Report	Implementation of changes related to the final report (4.6)
		Functions	New jobs, new functions (4.7)
		Strategic directions	Strategic directions: new strategic dimensions (4.7)
		clinical guidelines	Clinical guidelines: (4.7)
		Management practices	New management practices: (4.7)
		Structures	New organizational chart or model or hierarchical structure (4.8)
		Information systems	New information systems (4.8)
		Authority	Description of how people are in hierarchical or individual relationships; relationships between people, not structure related eg. Physicians having authority over nurses, without being their superiors. (4.8)
		risk management	Risk management
		Meeting	Meeting after report – no change implemented
Accreditation in general	AG	Cost	Evaluation of the accreditation process cost (3.4)
		Motivation	Reasons to enter into the accreditation process (3.1/3.2)
		Time	Time recognized for the accreditation process (3.3)
		know-how	Accreditation know-how is acquired through the years (3.5)
		Professional	Professionals involved in changes (4.9)
		Leadership	Leadership roles in the implemented changes (4.10)
		Training	Training plan influenced by the acc. Process (4.12)
		Patient	Involvement of patients and families (4.13)
		best phase	Phase of the accreditation cycle to implement change (4.16)
		Hesitation	Hesitated to enter into the accreditation process (3.2)
		Structure	New organizational chart or model or hierarchical structure unrelated to a specific phase (4.8)
		Culture	MP to add definition.

		social capital	Reference to social capital concept (establishing networks, exchange of information, sharing of values, development of a same vocabulary) instead of a completely new category for social capital.
		In the past	Reference to accreditation that happened before the one studied. (not to mix references to the assessment of AIM and prior accreditation programs)
Others changes	OC	five years	Important changes during the past five years (4.18)
		Environment	More responsive to the environment (5.1)
		Partners	Changes concerning the organization's partners (5.2)
		administrative structure	Changes in administrative structure, eg. Mergers, regionalization, organizational charts, unrelated to accreditation (5.3)
Expectations and opinions	EX	Capacity for change	expectation for the capacity for changes related to the accreditation process (6.3)
		advantages and disadvantages	advantages and disadvantages of the accreditation experience (6.2)
		Assessment	assessment of the procedure / process / Surveyors (6.1)
Recognition	RC	Internal	within hospital – recognition received via internal systems within the hospital
		External	via external organization – recognition received from organisations outside of the hospital
		Accreditation	Recognition for work well done received through accreditation
Means	lack of means		lack of means to implement changes, etc.

IV Personal data			
Personal characteristics	PC	Less than 5 years	number of years on the H <5 years (1.1)
		5 to 10 years	number of years on the H between 5 to 10 years (1.1)
		More than 10 years	number of years on the H more than 10 years (1.1)
		Physician	(1.1)
		Pharmacist	(1.1)
		Nurse	(1.1)
		Management	(1.1)
		Proud	proud to work on this institution (1.1)
		Motivated	motivated to work in this institution (1.1)
		Nurse management	PC nurse management: nurse in a management position (1.1)
		Other professional backgrounds	PC other professional backgrounds
Personal involvement	PI	characteristics	Characteristics of involvement in the accreditation process (1.1)
		strategies	(1.1)
		learning	(1.1)
		focus	professional focus
V Quality Improvement Teams			
Quality Improvement Teams	QIT	Commitment	
		Purpose	
		Leadership	
		Integration	
		Composition	
		Relationships	
		Project	Self assessment; QIT to AR Report
		Change	
		Culture	
		Challenges	

NVivo Coding by questions for Interviews, May 2005

Question	NVivo Coding options (but not limited to)
1.1	PC & PI
2.1	HC social climate, HC stability
2.2	GE autonomy, HC entrepreneurship, HC social climate, LE visibility, LE resources
2.3	GE autonomy, HC structures
2.4	HC values
2.5	ST learning, LE visibility
2.6	ST learning
2.7	GE relationship, LE visibility
2.8	LE visibility
2.9	LE visibility, LE resources, QP participation
2.10	LE competencies, RC Internal
3.1	AG motivation
3.2	AG motivation, AG hesitation
3.3	AG time
3.4	AG cost
3.5	AG know-how
4.1	QP accreditation, AG cost
4.2	AP teams formed, AP participation, AV participation, AP self assessment
4.3	AP standards
4.4	AP change, AV change
4.5	AP change, AV change
4.6	AR meeting, AR strategic directions, AP report, AP recommendations, AR report
4.7	AP functions, AV functions, AR functions, AR strategic directions, AR clinical guidelines, AR management practices, QP accreditation, AP clinical guidelines
4.8	AP structure, AP information systems, AP authority, AV structure, AV information systems, AV authority, OC administrative structures
4.9	AG professional
4.10	AG leadership
4.11	NA target, NA intent, NA pace, NA rhythm, NA dispersion, NA trajectory, NA phase, NA duration, IN inductive, IN deductive
4.12	AG training
4.13	AG patients
4.14	RE indifference, RE dissent, RE refusal, RE none, ST resistance
4.15	AG professional, IN deductive, IN inductive
4.16	AG best phase
4.17	IN deductive, IN inductive, OC five years
4.18	OC five years, OC administrative structure, OC environment, OC partners, IN deductive, IN inductive, GE environment
5.1	OC environment, GE comparison, GE environment
5.2	OC partners, GE relationship
5.3	OC administrative structure
6.1	EX assessment
6.2	EX advantages and disadvantages, EX assessment, HC accr issues
6.3	EX capacity for changes

NVivo Coding by questions for Focus Groups, May 2005

Question #	NVivo Coding options (but not limited to)
1.	AP self assessment, AP changes and other AP, NA as appropriate for changes (also CO)
2.	GE information, AR meeting after report,
3.	AR Report, and other AR category depending on the change that occured CO model, critique Characteristics of change section: NA, AC, RE, IN GE information, ST learning, QP section
4.	AR report (two sub groups: weaknesses and recommendations??) NA (EX Section & HC as apply)
5.	QP protocols? (I had a lot of QP balanced Scorecards)
6.	QP accreditation?
7.	NA dispersion (localised/generalised) NA intent, AP change
8. a	QP structure or AP teams
8.b	AP teams
8.c	AP report???, AP recommendations ??
9.	For me: Social Capital: SC relationships, SC Org Knowledge, SC integration, SC common culture,
10.	EX assessment, EX advantages_disadvantages, EX Capacity for change

APPENDIX G: MALCOLM BALDRIGE NATIONAL QUALITY AWARD

Who was Malcolm Baldrige?
Malcolm Baldrige was Secretary of Commerce from 1981 until his death in a rodeo accident in July 1987. Baldrige was a proponent of quality management as a key to this country's prosperity and long-term strength. He took a personal interest in the quality improvement act that was eventually named after him and helped draft one of the early versions. In recognition of his contributions, Congress named the award in his honor.

What is the Malcolm Baldrige National Quality Award?
The Baldrige Award is given by the President of the United States to businesses—manufacturing and service, small and large—and to education and healthcare organizations that apply and are judged to be outstanding in seven areas: leadership; strategic planning; customer and market focus; measurement, analysis, and knowledge management; human resource focus; process management; and results.

What are the Baldrige Criteria?
The Baldrige performance excellence criteria are a framework that any organization can use to improve overall performance. Seven categories make up the award criteria:

Leadership—Examines how senior executives guide the organization and how the organization addresses its responsibilities to the public and practices good citizenship.

Strategic planning—Examines how the organization sets strategic directions and how it determines key action plans.

Customer and market focus—Examines how the organization determines requirements and expectations of customers and markets; builds relationships with customers; and acquires, satisfies, and retains customers.

Measurement, analysis, and knowledge management—Examines the management, effective use, analysis, and improvement of data and information to support key organization processes and the organization's performance management system.

Human resource focus—Examines how the organization enables its workforce to develop its full potential and how the workforce is aligned with the organization's objectives.

Process management—Examines aspects of how key production/delivery and support processes are designed, managed, and improved.

Business results—Examines the organization's performance and improvement in its key business areas: customer satisfaction, financial and marketplace performance, human resources, supplier and partner performance, operational performance, and governance and social responsibility. The category also examines how the organization performs relative to competitors.

The criteria are used by thousands of organizations of all kinds for self assessment and training and as a tool to develop performance and business processes. Several million copies have been distributed since the first edition in 1988, and heavy reproduction and electronic access multiply that number many times.

For many organizations, using the criteria results in better employee relations, higher productivity, greater customer satisfaction, increased market share, and improved profitability. According to a report by the Conference Board, a business membership organization, "A majority of large U.S. firms have used the criteria of the Malcolm Baldrige National Quality Award for self-improvement, and the evidence suggests a long-term link between use of the Baldrige criteria and improved business performance."

Source: The Baldrige Website
URL: http://www.nist.gov/public_affairs/factsheet/baldfaqs.htm

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