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POSTDOCTORAL STUDIES

Sophia Aurora D. Weber

AUTEUR DE LA THÈSE / AUTHOR OF THESIS

M.H.A.

GRADE / DEGREE

School of Management

FACULTÉ, ÉCOLE, DÉPARTEMENT / FACULTY, SCHOOL, DEPARTMENT

Learning Organization: How does the CCHSA Accreditation Process help Health Care Organizations
to Develop Their Learning Processes?

TITRE DE LA THÈSE / TITLE OF THESIS

Marie-Pascale Pomey

DIRECTEUR (DIRECTRICE) DE LA THÈSE / THESIS SUPERVISOR

Douglas Angus

CO-DIRECTEUR (CO-DIRECTRICE) DE LA THÈSE / THESIS CO-SUPERVISOR

EXAMINATEURS (EXAMINATRICES) DE LA THÈSE / THESIS EXAMINERS

Ian Graham

Laurent Lapierre

Gary W. Slater

LE DOYEN DE LA FACULTÉ DES ÉTUDES SUPÉRIEURES ET POSTDOCTORALES /
DEAN OF THE FACULTY OF GRADUATE AND POSTDOCTORAL STUDIES

*Learning Organization: How does the CCHSA
Accreditation Process help Health Care Organizations
to Develop Their Learning Processes?*

Sophia Aurora D. Weber

Thesis submitted to the
Faculty of Graduate and Postdoctoral Studies
In partial fulfillment of the requirements
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LEGEND

CCHSA:

Canadian Council of Health Services Accreditation

CHE:

Certified Health Executives

CQI:

Continuous Quality Improvement

FTE:

Full-Time Equivalent

HCO:

Health Care Organization

PCA:

Patient Care Assistant

QI:

Quality Improvement

RPN:

Registered Practical Nurse

TQM:

Total Quality Management

VP:

Vice-President

ABSTRACT

Objective: To demonstrate that participation in the CCHSA accreditation process helps HCOs to be more reactive to change, improving quality and safety, and that accreditation also helps health care organizations to develop their organizational learning processes.

Design and Method: This study was conducted in July and August 2004 at an anonymous Ontario hospital, recently merged, but nevertheless with a history of accreditation. This is a single-case study with four embedded units of analysis. The study was based upon a conceptual framework for the dimensions of change. Structured interviews (n=6), structured focus groups (n=2), a questionnaire designed for managers (n=51, 28.8% response rate), a questionnaire designed for all staff (n=171, 1.6% of the population), and provided documentation were used. All quantitative data was analyzed using SPSS and qualitative data using N-Vivo.

Results: The hospital's culture is of a hierarchical nature ($\bar{x} = 36.92$), but with the help of organizational initiatives, strong leadership, and accreditation, it is evolving towards a group culture. The hospital has a high commitment towards information and analysis, however, employees do not always perceive themselves as receiving adequate training and education for quality improvement. Accreditation has helped the hospital through its merger. It has affected the hospital at an individual, group, organizational, and external partnerships level. The self-assessment phase was highly effective in encouraging cohesion and collaboration, the emergence of a multidisciplinary approach to care, community involvement, and the development of organizational learning. The first post-merger accreditation's report encouraged the development of an organization wide quality framework which focuses on quality of care, efficiency, and patient safety.

Conclusion: Most key values and initiatives are in place for the hospital to be a Learning Organization. A shift in organizational culture towards a group and developmental culture, as well as a stronger commitment towards QI education and training, are still necessary.

1. INTRODUCTION

Accreditation in Canada is considered a voluntary process, and as such, a hospital has to decide whether the benefits that the accreditation process can bring outweigh the costs and efforts associated with it. To demonstrate the benefits of involvement in the CCHSA's accreditation process, particularly in areas relating to quality, change, and patient safety, is one of the main goals of this research project. Making the value of the process more evident can help health care executives to make their decision regarding participation in this process.

➤ THE ACCREDITATION PROCESS IN CANADA

The Canadian Council on Health Services Accreditation (CCHSA) is an independent, non-profit organization that has been offering a voluntary, national accreditation program for health services organizations in Canada since 1958 (CCHSA 2000), although its roots lie with the hospital standardization program of the American College of Surgeons. As of December 31, 2003, there were 876 accredited organizations in the process, or more than 3,500 sites, services, and programs (CCHSA 2004).

According to its information pamphlet "About CCHSA and its Accreditation Program," the goal of the accreditation process is to give a health care organization the opportunity to "accurately assess [its] level of performance against a national set of standards set by CCHSA in collaboration with the health care and service industry." The accreditation process consists of two main components: the self-assessment phase and the peer review.

During the self-assessment phase, health services organizations form self-assessment or accreditation teams revolving around groups of national standards outlined by the CCHSA. For example, one group of standards is the "Leadership and Partnerships" group of standards. The Leadership and Partnerships team is comprised of management staff, including senior executives and representation from the board of directors, as well as the community. The group evaluates its organization against standards revolving

around the leadership and partnerships theme and rates itself on a scale of one (“poor”) to seven (“excellent”), as well as reporting on its strengths and weaknesses in each area. An example of such a standard from the CCHSA is:

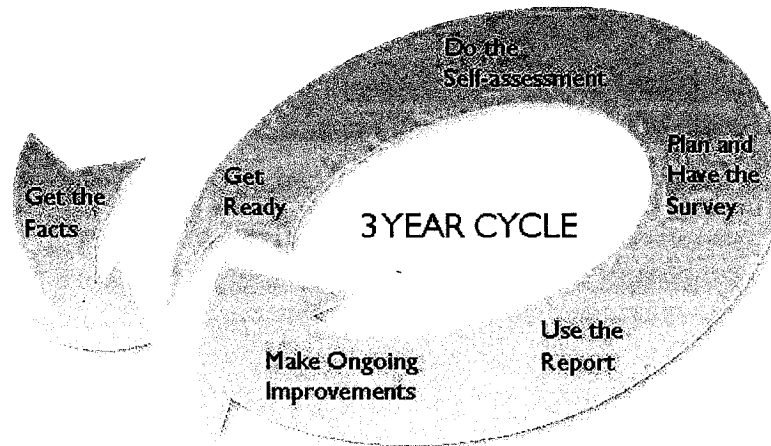
“5.2 The governing body operates according to the bylaws and corporate policies it sets.

- The governing body regularly reviews the bylaws and corporate policies to make sure they are current and applicable
- The governing body makes sure the organization complies with relevant laws and regulations
- The organization receives, reviews and acts on reports and legislative updates”

Other accreditation teams are formed around acute care standards, cancer care, mental health, critical care, ambulatory care, etc. The team design also aims to be as multi-disciplinary as possible, and in case of multiple sites within the organization, contain representation from all involved sites. Community representation is also a vital component of the teams.

During the peer review phase, CCHSA surveyors, who are executives from other health care organizations, come to the organization in order to give an outside evaluation of the health care organization. By reviewing the documents prepared by the teams and submitted to the CCHSA, in addition to conducting their own interviews and focus groups and visiting the organization, the surveyors rate the organization using the same standards and scale with which the organization rated itself. At the end of the visit, the surveyors hold a debriefing presentation giving preliminary results of the visit, before preparing a formal report in the weeks following the visit. This report lists the organization’s strengths, weaknesses, and the CCHSA’s recommendations for the organization. It is then up to the organization to use that report for quality improvement before they enter their next accreditation cycle.

Figure 1 - Three Year Accreditation Cycle (CCHSA 2002).



Currently, the CCHSA uses what it calls the AIM Standards, or Achieving Improved Measurement Standards. The AIM standards, which were introduced in 2000 and revised in 2002, group all standards into four quality dimensions (responsiveness, system competency, client/ community focus, and worklife) and twenty-two quality descriptors. Each standard is linked to one of these categories as an indicator. The focus of the AIM standards is on measurement of outcomes. The AIM standards also have a population health approach (CCHSA 2002).

➤ THE RESEARCH PROJECT

The goal of the research project is to evaluate the impact of the CCHSA accreditation process on organizational change dynamics, introduction of quality improvement, and patient safety.

The methodology used is a comparative multiple-case study of seven sites to determine whether there is a correlation between duration of involvement in the accreditation process and organization change, quality, and safety. The selected hospitals fall into the following categories:

- Recently accredited (one health care organization);
- Recently merged and accredited since the merger, along with a pre-merger history of accreditation (one health care organization);
- Regionalized and newly accredited, along with a pre-regionalization history of accreditation (two health care organizations);
- History of accreditation (two health care organizations); and
- Newly accredited (one health care organization).

This research project has been funded by the Canadian Institutes for Health Research (CIHR) with an associated budget of approximately \$160,000 over a three-year period beginning October 3, 2003 – the official launch date.

This thesis is a single-case study and analysis of one of the seven sites – the health care organization recently merged and accredited since the merger, with a pre-merger history of accreditation. In addition, it focuses on and tries to establish if the accreditation process can help the organization to be a “learning organisation.” This single-case study will then be used by the research team to complete the multiple-case study. For more information on the research design, please see Chapter 3 “Methodology.”

The chosen hospital, located in Ontario, will remain anonymous as part of our agreement with the hospital, and will from now on be referred to as “the Hospital.”

HYPOTHESES

1. PROJECT

The hypothesis of the research project is that “accreditation can be considered as an intervention in the Canadian healthcare system, and as such is likely to bring changes at the institutional level. The HCOs [health care organizations] accredited for more than ten years have learned to be more innovative in terms of organizational changes, and have implemented better quality and safety programs than those recently accredited because the process of accreditation promotes HCOs capacity-building” (Pomey 2003).

2. THESIS

The hypothesis of this thesis is that in addition to fostering organizational changes, quality improvement, and patient safety, the accreditation process fosters organizational learning in a health care organization by improving the conditions for organizational learning and encouraging a learning culture.

RESEARCH PROJECT TEAM

The research team consists of professors and students from the universities of Ottawa, Toronto, and Montreal. A member of the Canadian Council on Health Services Accreditation (CCHSA) is also involved.

1. PROFESSORS INVOLVED

Doug Angus, University of Ottawa

Marie-Pascale Pomey, University of Ottawa

Louise Lemieux-Charles, University of Toronto

André-Pierre Contandriopoulos, Université de Montréal

François Champagne, Université de Montréal

Jean-Louis Denis, Université de Montréal

2. CCHSA MEMBER

Gilles Lanteigne, Associate Executive Director

3. STUDENTS INVOLVED

Madeleine Drew, MHA Program, University of Ottawa

Amy Tosh, MHA Program, University of Ottawa

Sophia Weber, MHA Program, University of Ottawa

4. OTHER PARTICIPANT

Michèle Paré, Group of Research and Social Intervention, University of Montreal

2. ORGANIZATIONAL LEARNING LITERATURE REVIEW

➤ WHAT IS ORGANIZATIONAL LEARNING?

Organizational learning is “the process of improving action through knowledge and understanding” (Fiol & Lyles 803, Carroll & Edmondson 51). The learning process is a “cycle of action and reflection – that is, doing and thinking, performing and conversing” (Carroll & Edmondson 51). It is the “range of activities and processes by which the organization eventually reaches the ideal of a “Learning Organization.” Primarily, it is the transformational process to which the organizational stakeholders, individually and collectively, contribute their learning. It is an organizational change strategy” (deBurca 2000). A Learning Organization is an organization in which “learning has become integrated into the daily work practices of employees and as such offers a promising model for the functioning of healthcare organizations” (Mylopoulos).

Going a level deeper, learning itself is defined as “to become able to respond to a task-demand or an environmental pressure in a different way as a result of earlier response to the same task (practice) or as a result of other intervening relevant experience... The sign of learning is not a shift of response or performance as a consequence of change in stimulus-situation or in motivation, but rather a shift in performance when the stimulus-situation and motivation are essentially the same.” The defining property of learning, therefore, is “the combination of the same stimulus and different response” (Weick 164). In an organization, however, Weick argues that the stimulus situations rarely remain the same, which then implies that organizational learning is either an infrequent event, or a frequently occurring event but in a non-traditional form (163).

One reason why the factors for this traditional definition of learning do not frequently occur in hospitals, according to Weick, is that stimulus situations are in a state of flux, therefore constantly changing, yet responses are often the same due to established routines (165) upon which all behaviours in an organization are based (Levitt & March 517). In addition, Weick argues that when same stimuli do result in different responses,

it is not a result of learning, but rather of social situations, such as when people “forget how they responded to the same stimulus in the past, when they respond to the same stimulus differently in an attempt to relieve boredom or overload, when turnover is high, participation is fluid, socialization is informal, and mergers and acquisitions are common. In each of these cases, action is less history-dependent because there is less organizational history salient for each actor.” This basically implies that there is no evidence of learning, since other alternative explanations are excluded (Weick 167).

Going back to Karl Weick’s definition of learning, one can say that organizations, rather than being built to learn, are “patterns of means-ends relations deliberately designed to make the same routine response to different stimuli, a pattern that is antithetical to learning in the traditional sense” (Weick 168). Levitt and March, however, see routines themselves as evidence of organizational learning, since they are the capture of experiential lessons of history “in a way that makes the lessons, not the history, accessible to the organizations and organizational members who have not themselves experienced the history” (517). In additions, they do not view routines as being fixed, yet also constantly being transformed (520), which in turn could be considered the desired different response in Weick’s definition of learning.

There is also some disagreement on whether change can be seen as evidence of learning. Marlene Fiol and Marjorie Lyle believe that change is not evidence of organizational learning, whereas Nicolini and Meznar believe it is (727). Despite all of the disagreement on a definition and evidence of organizational learning, there appear to be three areas of consensus regarding the requirements of organizational learning (Fiol & Lyles 804, Nicolini & Meznar 728):

1. **Relevance of environmental alignment:** An organization must align itself with its environment to ensure survival, and organizations do this by learning, unlearning, and relearning based upon past behaviour. Change and learning are triggered by disequilibria in the environment (Nicolini & Meznar 729).

2. Distinction between individual and organizational learning: organizational learning is the result of individual learning (Nicolini & Mezner 729).
3. Presence of four contextual factors in the learning process: These factors, which create and reinforce learning and are created by learning, are organizational culture, strategy, structure, and environment (Fiol & Lyles 804).

Although there is disagreement on the definition of learning and the evidence of such, often arising from the different discipline backgrounds of researchers, Easterby-Smith et al. argue that this conceptual diversity is “likely to be helpful on the grounds that different disciplines have distinct ontologies [specifications of conceptualizations], which will not benefit from any forced attempts at integration, and that progress is more likely to be achieved if a degree of focus is maintained within each sub-area [of study]” (260).

➤ WHY FOSTER ORGANIZATIONAL LEARNING?

Organizational learning practices “can help to improve existing skills and knowledge and provide opportunities to discover better ways of working together” (Carroll & Edmondson 51). This is extremely important considering the current state of the health care system: high levels of preventable medical errors and unnecessary deaths resulting from latent failures, which are “hidden deficiencies, such as incorrect procedures, turf battles, overloaded employees, and non-functional back up systems that lie in wait for the right trigger.” Finding latent failures via near misses, audits, simulations, and also reducing the introduction of new latent failures, help to improve quality and safety (Carroll & Edmondson 52).

Another reason to foster organizational learning is the continuously evolving health care environment itself. Health care organizations must keep up to date with industry advances, especially when competing for funding. Hospitals therefore cannot rely on established practices, but must invent new processes and technologies – they need to learn new ways of doing things (Easterby-Smith et. al. 1998) - organizational learning efforts can buffer the hospital from the environmental chaos surrounding it (Edge & Laiken 97).

➤ DEVELOPMENT OF ORGANIZATIONAL LEARNING

A lot of organizational learning is the learning of “new routines for conducting work that accomplishes goals” such as improving quality of care. Routines in a health care organization, such as patient admissions, building maintenance, creation of a strategic plan, are constantly evolving with experience, technology, and the turnover of employees involved in the routine (Carroll & Edmondson 51). According to Levitt and March there are three phases for the development of routine-based organizational learning: 1) learning from direct experience, 2) interpretation of this experience, and 3) retaining the newly learned routine in organizational memory.

There are two methods by which organizations learn from direct experience: 1) trial-and-error experimentation, in which the use of a routine will increase with success and decrease with failure, and 2) organizational search, by which the organization draws from existing routines, possibly from other organizations, adopting any better ones found (Levitt & March 518). “[R]eflecting on ‘best practices’ often involves expeditions to other similar organizations to compare performance and experience” (Edge & Laiken 101). Learning from direct experience can also be considered “learning by doing.”

Once experiences have been interpreted and transformed into routines (Levitt & March 521), they are documented into the organization’s memory via manuals, procedures and practices, layout of equipment and facilities (Carroll & Edmondson 51).

The key to all learning is the flow of knowledge and information. Learning mechanisms, which are mechanisms of information and knowledge transfer that facilitate learning, include reviews, audits, problem investigations, performance appraisals, simulation and benchmarking (Carroll & Edmondson 52). Most of these learning mechanisms are local, among individuals or groups (Carroll & Edmondson 51), but the goal is to facilitate the spread of learning throughout the entire organization. This ability, and with it the nature of learning and its contribution to innovation and change, in turn “is influenced by the

organization's strategy, structure, communication practices and its social context" (deBurca 2000).

To implement organizational learning, "health care organizations must exploit technical skills, refining performance of repetitive tasks but, at the same time, they must explore potential opportunities, rethink assumptions underlying their practices, and seek significant innovations" (Carroll & Edmondson 53).

To summarize, the development of organizational learning is facilitated by (deBurca 2000):

- "Prior identification and recognition of capabilities and areas for improvement;
- A clear connection between the learning of tasks and its potential consequences;
- Opportunity to practice new skills and competencies;
- Performance feedback;
- A climate that encourages, facilitates, and rewards learning"

➤ BARRIERS TO ORGANIZATIONAL LEARNING

WHY BARRIERS EXIST

The nature of an organization is such that although its individual employees are naturally programmed to learn, the organization itself is not. A major inhibitor of organizational learning is traditions or superiors that resist change (Carroll & Edmondson 51). Another inhibitor is lack of teamwork, which is more apparent among physicians who “feel uncomfortable being part of the team as opposed to being the sole decision maker” (Carroll & Edmondson 54).

Errors can hinder the development of organizational learning both when interpreting and when documenting experiences into organizational memory. Examples of such errors are improperly recording experiences, overestimating probabilities, and overattributing events to actions.

Organizational learning can be stumped through what are known as “competency traps.” Competency traps arise from specialization of routines. As we know, many routines are the result of repetition, which is believed to increase expertise and/or competencies. Competencies are improved within frequently used procedures, in turn leading to an increase in the successful outcomes of the routine. A competency trap results when an organization favours the use of a routine with a high success rate, and specializes in it, then fails to gain experience in other superior routines that could have higher success rates associated with them (Levitt & March 520).

In addition to competency traps, “superstitious learning” is another error that can arise (Levitt & March 521, Carroll & Edmondson 51). Superstitious learning is when “people and organizations repeat behaviours that were associated with particularly positive results by chance but actually have no influence on outcomes. Doctors can get lots of experience doing the wrong thing, such as routinely performing tonsillectomies, a common practice in the past decades that is no longer considered beneficial” (Carroll & Edmondson 53). This brings us to rule-based and knowledge-based errors, errors that

involve applying the wrong solution, however skilfully, to the problem at hand, or lacking the appropriate knowledge. Rule-based and knowledge-errors can be a system problem, rather than a problem of individual competence (Carroll & Edmondson 53).

Another barrier is imposed by the highly complex and highly political environment in which a health care organization functions, causing it to be very bureaucratic and thereby slower to change (deBurca 2000). Capacity for change is key to learning, since organizational learning is in itself a change strategy – the point of learning is to make changes for the better, but this cannot work in the face of large resistance to any change, even if changes represent improvements in the way an organization operates!

OVERCOMING THE BARRIERS

In order to overcome barriers to organizational learning, the organization's leadership must be accommodating throughout all dimensions: executive, strategic, middle, line, and even from the individuals throughout the organization (Carroll & Edmondson 54). This often requires a shift in culture.

Although cultural change is most effective coming from the top down, “even CEOs cannot readily change a culture. Rather than opposing the culture, it is generally more effective to address acknowledged problems in new ways and to “tilt” the culture by reinterpreting new actions as consistent with existing cultural strengths. Instead of addressing culture or teamwork directly, executives could support new ways to improve surgical team performance, for example, and then portray teamwork as supporting culturally accepted goals and values of excellence, learning, and caring. Participants then experience for themselves how new ways of acting can meet shared goals, gradually shifting cultural beliefs, values, and assumptions” (Carroll & Edmondson 54).

To deal with physicians and their sense of independence and autonomy, one should not be telling them how to work, but rather develop “systems of communication and work

practices that ensure that patients get the right [treatment] at the right time, and that the right kinds of conversations are encouraged to support feedback and discovery” (Carroll & Edmondson 55).

Carroll and Edmondson state that “[a]ny experiment carries the risk of failure, but every failure is a learning opportunity, especially small failures” (54). Leaders should therefore “create the psychological safety for errors to be discussed, while also inspiring individuals and the organization to achieve a high standard of care. They must then persist as stakeholders discover that diverting resources to learning and process redesign will often mean that short term financial and production indicators look worse before they get better” (55).

Organizations can fall into the trap of believing that mandating the use of learning mechanisms can guarantee learning or change in work practices. According to Carroll and Edmondson “[w]hile controls are useful in addressing familiar and frequent problems, they may weaken the ability to address novel problems and see new opportunities” (52). Further, “[i]n order to stimulate innovation and change without creating resistance, informal leaders need sensitivity to the culture and politics of the organization. By building informal networks, creating communication structures to bridge boundaries, and finding ways to build coalitions within the existing power structure, they accelerate organizational learning” (54).

In conclusion, fostering an organizational learning culture requires a long-term focus on patient safety, quality, and organizational performance, as well as the organization’s stakeholders in order to recognize learning needs and to meet those needs (Carroll & Edmondson 52). A positive attitude towards learning and self-development must also be evident at all levels of management (deBurca 2000). One must, however, always keep in mind that the past is not a perfect predictor of the future (Levitt & March 531).

➤ ACCREDITATION AND ORGANIZATIONAL LEARNING

As previously mentioned, “organizational learning practices can help to improve existing skills and knowledge and provide opportunities to discover better ways of working together” (Carroll & Edmondson 51). This is a goal shared with the accreditation process as a whole, which recognizes the importance of organizational learning and has therefore also incorporated organizational learning into its accreditation standards, in particular its “Leadership and Partnerships” standards.

This thesis will show that accreditation also is a significant tool to help increase communication within the organization, which also leads to the transfer of knowledge and information (a learning mechanism), thereby fostering organizational learning. Furthermore, accreditation encourages the transfer of knowledge between organizations, for instance when a surveyor learns of a new routine or practice in the organization s/he is surveying, and then brings this newly learned routine or practice back to the organization s/he comes from (since accreditation surveys are all peer reviews). This is learning by organizational search, and is a common motivator for health care executives to become surveyors. Accreditation also is believed to help increase an organization’s capacity for change, which is another learning requirement.

If accreditation is a driver for change, and organizational learning is evidenced by change, then one can conclude that accreditation drives organizational learning. This is what this paper tries to demonstrate.

3. METHODOLOGY

➤ RESEARCH PROJECT DESIGN

The overall research project is designed as a comparative multiple-case study with three embedded units of analysis (institutional, operational & technique) (Pomey, 2003). The original intent was to select eight health care organizations to participate in the study: four that have been accredited for more than ten years and four that have been accredited only once. Each of these two types of organizations would have been coupled by matching their budgets, status' and geographic locations (urban/rural), as well as province (two from the western provinces, two from Ontario, two from Quebec and the two from the Maritimes). This design was later revised since during discussions among the researchers, they decided it would be more relevant to study organizations with different status' related to the accreditation process.

The chosen health care organizations were asked to select a representative that would coordinate interviews and focus groups in a two day period during which two researchers would visit. They were also being asked to assist with the distribution of two questionnaires. Despite having to modify the research design to now look at all possible scenarios instead of pairing the health care organizations, the researchers were able to obtain valuable insights that will be reported in the following sections of this thesis.

In summary, the data sources used in the research project include qualitative and quantitative data:

- Qualitative data:
 - Interviews with senior managers; and
 - Focus groups with employees who have been involved in the accreditation process.

- Quantitative data:
 - Organizational-wide questionnaires with selection of respondents:
 - Management Questionnaires; and
 - Culture Questionnaires.

- Documents and pamphlets provided by the organization for additional information; and

- Information about accreditation, organizational change, continuous quality improvement and safety programs.

Quantitative data was analyzed using SPSS and qualitative data using N-Vivo software.

STEPS AND TIMELINE

The following process was followed for the research, data collection, and analysis.

1. PRELIMINARY AND BACKGROUND WORK

Background research on the accreditation process and the research topic. This included:

- A tour of the CCHSA head office;
- Attendance of preliminary meeting with the research team (October 2, 2003) to develop tools and select the hospitals to be involved in the study; and
- Selection of a thesis and literature review topic.

➤ Timeframe: October 2003 - January 2004.

2. PILOT PROJECT AND ETHICS COMMITTEE SUBMISSION

A pilot project with two health care organizations in Quebec was conducted by Marie-Pascale Pomey to test the tools that were used in the research project. The purpose of the pilot was to ensure that the tools are easy to use and people friendly, yet comprehensive enough to get the feedback required for proper analysis.

The submission to the University of Ottawa Ethics Committee for final approval of the study design was prepared.

- Timeframe: End of January 2004 - February 2004.

3. PLANNING AND ORGANIZATION OF FIELD WORK

While waiting for approval by the University of Ottawa Ethics Committee, planning and organization of the field work / site visits commenced. Upon approval, a project meeting took place April 6, 2004 to discuss the results from the Ethics Committee and to also go over the results from the pilot project.

- Timeframe: March 2004 - May 2004.

4. SITE VISIT

The site visit to the selected anonymous Ontario Hospital that is the topic of this thesis took place June 16 and 17, 2004. Six interviews and two focus groups were conducted. In addition, during July and August 2004, Fifty-one management questionnaires and 169 culture questionnaires were collected.

- Timeframe: July 2004 – August 2004.

5. DATA REVIEW AND ENTRY

After all of the interviews and focus groups were completed, they were professionally transcribed and the transcriptions were then reviewed. The questionnaires were reviewed for completeness. The culture questionnaire data was then entered into SPSS. The literature review was completed before coding the focus groups and interviews into N-Vivo, as additional codes based on the literature review had to be developed. Preliminary results were discussed, questions asked and answered, and concerns were addressed at a project meeting on March 22, 2005.

- Timeframe: September 2004 – March 2005.

6. STATISTICAL ANALYSIS

Once all of the information was entered into the computer, a statistical analysis of the data was conducted following the set guidelines for the study.

- Timeframe: March 2005 – April 2005.

7. PREPARATION OF REPORT

After the analysis, the final step was finalizing the report in the form of this thesis paper.

- Timeframe: April 2005 – May 2005.

➤ THESIS RESEARCH DESIGN

The research design chosen is an embedded single-case study, which will then be part of a larger comparative embedded multiple-case study for the umbrella research project. A case study is deemed the appropriate research design in this scenario since “how” or “why” questions are being asked, we have little control over events, and the focus is on contemporary phenomena within some real-life context (Yin 1). A case study is used since we are trying to explain increased organizational learning, dynamics of change, quality and safety via accreditation. An embedded case study is one that has multiple units of analysis, which in this case are:

- Accreditation’s impact at the individual level;
- Accreditation’s impact at the group level;
- Accreditation’s impact at the organization-wide level; and
- Accreditation’s impact at the external partnerships level.

Although this single-case study can be regarded as a complete study on its own, it is part of a more important multi-case study made up of seven single-case studies.

CHOICE OF HOSPITAL

The hospital chosen for this study is, as it is known today, only seven years old. Prior to its merger, which was the result of the Health Services Restructuring Committee introduced by legislation in Ontario in 1996, the Hospital was three separate hospitals that had each already been in the accreditation process. The Hospital was therefore chosen as it has been in the accreditation process as a new entity for less than ten years and had just completed its second accreditation round since the merger. The hospitals that were merged together to form this entity had all been accredited before. In addition, not having any other ties to the organization meant that there was minimal risk of any conflicts of interest or biases arising.

The Hospital is an academic health sciences centre and currently has close to 1200 beds, a staff of over 10,600, and 1,125 physicians spread over three main sites and several other centres and satellites. There are approximately 177 managers and the bed distribution is approximately as follows: 414 Medicine, 281 Surgery, 56 Alternate Care, 81 OBS/GYN, 48 Critical Care, 138 Cardiac Care, 81 Mental Health, 72 Rehab, 28 Short term Rehab. Please note that the bed distribution is currently fluctuating and that the source of this information will not be referenced in order to maintain anonymity of the Hospital.

The Hospital had just finished completing its 2004 accreditation process before research team's site visit took place. Information was therefore being gathered on both the 2004 accreditation process as well as the 2000 process, the last process for which an accreditation report had been submitted at the time.

➤ “DIMENSIONS OF CHANGE” FRAMEWORK

The conceptual framework in used in this research project was developed by Marie-Pascale Pomey for use in a similar study conducted in France (2003). The framework is the result of a triangulation of various current change theories as well as a literature review of the implementation of quality initiatives in a health care setting (Pomey 2003).

The framework was designed to demonstrate the cyclical relationship between the conditions favouring change and the characteristics of change. The conditions favouring change have an impact on the characteristics of change, which in turn impact the conditions favouring further change.

The characteristics of change are (Pomey 2003):

- General Environment: The presence of external factors exerting pressure on the organization to encourage change.
- Basic conditions: The presence of autonomy and discretion with which individuals can operate and initiate new changes, in addition to a degree of dissatisfaction which creates a desire for change.
- Conception/Comprehension: Being able to understand changes and reflect upon them and the organization.
- Leadership and Competencies: The presence of leadership for quality improvement and change is essential, as well as competencies in these areas among management staff.
- Strategies: Change must be accompanied by training and communication strategies in order to generate professional buy-in.

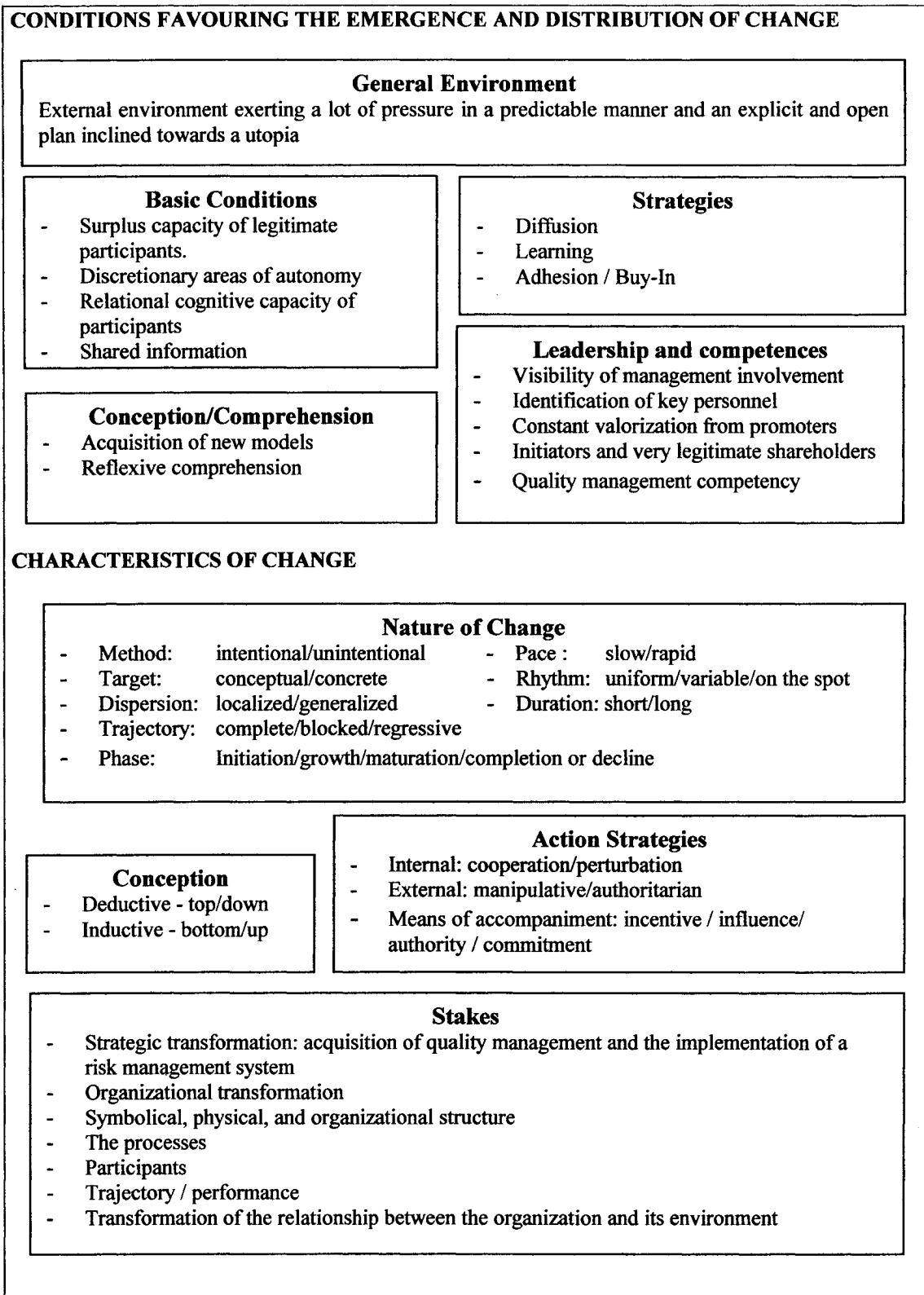
The conditions favouring change are (Pomey 2003):

- Nature of change: Determined by the methods (intentional/unintentional); the target (conceptual/ concrete); the extent (localized/ generalized); the pace (slow/ rapid); the rhythm (uniform/ variable/ on the spot); the duration (short/ long); the trajectory (complete/ blocked/ regressive) and finally the phase (Initiation/ growth/ maturation/ completion or decline).

- Conception and strategies: Source of change and strategies used to diffuse it. Change can be inductive or deductive.

- Stakes: Relate to strategic, organisational, and relational transformations. Strategic transformations pertain to conformity with the accreditation process and the adoption of quality management and patient safety practices.

Figure 2 - Dimensions of Change Framework



➤ DATA COLLECTION TOOLS

Three main data collection tools were used in this research: Interviews, Focus Groups, and Questionnaires. An additional tool is some documentation provided by the Hospital.

The quantitative data collection tools used were designed according to a conceptual framework for the dimensions of change and tested at two sites – one in English, one in French - as part of the study's pilot project.

INTERVIEWS

Structured interviews, which are interviews in which the respondents are asked the same questions in the same sequence (Schermerhorn et. al. 420), were used to gather information on some of the hospital's characteristics, factors of change, and the hospital's involvement in the accreditation process as well as resulting changes. Structured interviews were used to gather the same information from all respondents, so that their answers could be compared afterwards. This helps to increase construct validity of the study. Also, using a structured interview allowed the research team to send the questions to the participants in advance so that they could prepare their answers. Many of the questions asked the interviewees to remember what happened during the previous accreditation's self-assessment phase, which took place in 2000, and the team wanted to give them the time to reflect back those four years. In light of this long period of recall, the intent was not to gather specific details, but rather general impressions.

One unstructured telephone interview was also held with a director to gather information on organizational learning.

1. SELECTION OF PARTICIPANTS

The interview team consisted of the author (Sophia Weber) and the Principal Investigator. The interviewees were selected by the Quality Coordinator that was working with the research team to set up the two-day visit. All six interviewees were senior managers at the Hospital. Five were vice-presidents, one was a director. The reason senior managers were chosen was that they are enablers of the accreditation process and of any strategic and operational changes that would result from the accreditation process. They are also involved with the accreditation teams.

2. INTERVIEW PROCESS

Copies of the interview questions, project information, and consent forms were sent to the participants ahead of time, to give them a chance to prepare.

The actual interview took place over two days, with two interviews in the morning and one in the afternoon of the first day, and one in the morning and two in the afternoon of the second day. The interviews took place on site at the Hospital, either in the participants' offices, or another location of their choosing. They were 45 minutes to 90 minutes in duration, depending on how much time the interviewees had and how much time was needed to complete the interview. In addition to recording the interviews (which were later transcribed), notes were taken to ensure that the information was reliable.

3. INTERVIEW CONTENT

The questions are categorized following the "Dimensions of Change" conceptual framework around which the project is designed. The questions pertain to the

characteristics of the hospital that can influence factors of change, the accreditation process and any implemented changes related to the accreditation process.

The framework's first dimension, "Conditions Favoured by the Emergence and Distribution of Change," is explored in the interview's section on "Hospital Characteristics / Factors of Change." The framework's second dimension, "Characteristics of change" is explored in the interview's section "Accreditation and changes in line with the latest survey." The interview section entitled "Changes of the relationship between the Hospital and its network in connection with the accreditation" shows how the framework's second dimension links back into the first to complete the cycle.

1. *Introduction*: This section asks for information about the interviewee's background, current position, and career at the Hospital.
2. *Factors of Change / Hospital Characteristics*: This section requests information about certain conditions that favour the emergence and distribution of change, in line with the conceptual model. In particular, it addresses decision-making and leadership participation in changes. It also asks about leadership and management involvement in quality improvement.
3. *Accreditation*: This section addresses the hospital's accreditation, in particular resources dedicated to the process and reasons for entering the process. It also asks whether a financial estimate for the accreditation's total cost and a return on investment estimate exist.
4. *Accreditation and changes in line with the latest survey*: This section addresses changes that were implemented as a result of the self-assessment or as a result of the hospital's final report after its 2000 accreditation. It looks at the nature of the changes and the conditions under which they took place. It also asks about the self-assessment phase itself: how long it took and whether

it could be integrated with daily activities, who was involved in the changes (professionals, CEO, or groups independent of accreditation), and which external factors were responsible for changes over the past five years.

5. *Changes of the relationship between the Hospital and its network in connection with the accreditation:* This section looks at how the hospital's relationship with its environment has changed as a result of accreditation, whether the hospital became more responsive to its environment's needs. It also asks about the impact on its connection to its partners and administrative and financial structures.
6. *Conclusion:* This section wraps up the interview with questions concerning the interviewee's perception of the process as a whole, how it would characterize and assess the process, and whether it believes the hospital's participation in accreditation helps it to be more reactive to change.

Please see Appendix A for a copy of the interview questions (modified for hospital anonymity), developed by Marie-Pascale Pomey et.al (2004). The recommendations from the CCHSA's 2000 accreditation report were used to guide the discussion of examples during the interviews.

FOCUS GROUPS

Two focus groups were conducted at the Hospital. A focus group is a gathering of individuals in which discussion about certain topics and experiences is encouraged. Focus groups allow researchers to gather multiple perspectives on one topic, and when conflicting perspectives exist, they are discussed in the group. An important characteristic of focus groups is that the participants encourage and provoke information from one another, through discussion, that might otherwise not come out in a structured interview.

1. SELECTION OF PARTICIPANTS

Each focus group brought participants from a particular area together. In addition to the research team, the first focus group comprised participants from clinical services, while the second focus group comprised participants from support services. The common denominator was that all participants had been involved with a self-assessment team, either in 2000, 2004, or both. Some of the participants knew each other, others did not, which then also encouraged communication and exchange of new information between the participants.

2. FOCUS GROUP PROCESS

The focus groups were one hour each, and took place one per day during the two-day visit. They took place in boardrooms where all participants could sit around in a circle. The focus group questions were prepared in advance. Notes were taken, and the focus group discussions were recorded for transcription.

The first focus group had eight participants, one of which was originally scheduled to participate in the second focus group, and two regrets. The second focus group was unfortunately much smaller, with only two participants in addition to the research team due to one member switching to the first team, and four regrets. This did, however, allow us to go into more detail for some of the questions.

3. Focus Group Content

The first part of the focus group questions, developed by the project Principal Investigator relates to the 2004 self-assessment phase, and changes implemented and problems encountered during the self-assessment phase. The participants were asked how the self-assessment teams were formed; whether any problems were discovered

during the self-assessment and if these resulted in any changes; whether they used the report from the 2000 accreditation; and what they thought about the debriefing presentation held at the end of the 2004 accreditation team visit.

The second part of the focus group questions relates to the results of the 2000 accreditation process, and changes implemented afterwards. The participants were asked whether they received a copy of the 2000 report and what happened with it, and whether any changes that resulted from the report were tracked.

The focus group questions conclude with the participants' perceptions of the process and how it has benefited them, and what they think of the survey tools and standards used.

Please see Appendix B for a copy of the focus group questions (modified for hospital anonymity). The recommendations from the CCHSA's 2000 accreditation report were used to guide the discussion of examples during the focus groups.

QUESTIONNAIRES

Two questionnaires were used to study the quality improvement program and the culture of the Hospital. Both of these questionnaires were developed by Stephen Shortell for his "Quality Improvement Implementation Survey" (1992). They were together as components of one large questionnaire, however, for this project, the components were separated into the "management" and "culture" questionnaires and adapted for the project's needs. Adaptations included changes to the format, and the addition, change, and removal of questions.

The first questionnaire, the "Management Questionnaire," was sent to the Hospital's management staff. The second questionnaire, the "Culture Questionnaire," was directed at all staff, management, front line, and support, and was distributed in person during lunchtime on three days in August, in all three cafeterias of the Hospital.

1. MANAGEMENT QUESTIONNAIRE

The management questionnaire was used in order to gather information on the management of quality of care as well as professional involvement. The questionnaire contains four sections:

A. *Quality of Care*: This section gathers information on the hospital's involvement in Quality Improvement (QI) across seven areas:

i. *Leadership*: Examines senior leadership involvement in QI in eleven questions. Respondents are asked whether senior executives provide visible leadership in supporting quality improvement; allocate available resources; participate in QI activities; have articulated a clear vision for QI; have demonstrated an ability to manage change; act on QI suggestions; have a thorough understanding of how to implement QI; generate confidence in QI efforts; are personally involved in QI; and whether the CEO is the primary driving force behind QI. Evaluates 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 into the hospital's management system (including the extent to which the hospital addresses its public responsibilities and corporate leadership)" (Shortell 1992).

ii. *Information and Analysis*: Examines the collection and use of QI data in seven questions. Respondents are asked whether their team collects a wide range of QI data; uses a wide range of quality data to make improvements; continuously tries to improve how it uses quality data; tries to improve accuracy and relevancy of its quality data; tries to improve the timeliness of its quality data; is involved in determining what data to collect for QI; and compares its quality data to other

organizations. Evaluates the “extent to which the scope, management, and use of data and information maintain a customer focus, drive quality excellence, and improve operational and competitive performance” (Shortell 1992).

- iii. *Strategic Quality Planning*: Examines the setting of QI goals in seven questions. Respondents are asked whether employees are given adequate time to plan and test improvements; are involved in developing these plans; whether each department and group maintains specific QI goals; whether the organization’s QI goals are known throughout the organization; whether middle managers play a key role in setting QI priorities; whether external customers play a key role in setting QI priorities; and whether non-managerial employees also play a key role in setting QI priorities. Evaluates the “extent to which employee's are involved and empowered ... in the hospital's quality planning efforts.” (Shortell 1992).

- iv. *Human Resources Utilization*: Examines the investment in HR for QI initiatives in eight questions. Respondents are asked whether employees are given education and training in how to identify QI opportunities, statistical and other quantitative methods for QI, and improving job skills and performance; whether employees are rewarded and recognized for QI; have the authority to correct quality problems; are supported when they take risks for QI; whether inter-departmental cooperation for QI is supported and encouraged; and whether the organization has an effective system for employees to make QI suggestions. Evaluates the “extent to which hospital employees are provided adequate education and training for quality improvement efforts” (Shortell 1992).

- v. *Quality Management*: Examines QI implementation and management in nine questions. The respondents are asked whether the organization regularly checks equipment and supplies; has effective policies to support QI; works closely with suppliers for QI; tries to design quality into new services as they are being developed; views quality assurance as a continuing search for improvement; encourages employees to keep QI records; whether data from suppliers is used in the QI plan; and the services provided are thoroughly tested for quality. Evaluates “the extent to which all work units, including research and development units and suppliers, contribute to overall quality and operational performance requirements” and examines the “key elements of process management including design, management of day-to-day production and delivery, improvement of quality and operational performance, and quality assessment.” (Shortell 1992).
- vi. *Quality Results*: Examines the results from QI initiatives in five questions. The respondents are asked if over the past few years, the organization has shown steady, measurable improvements in the quality of customer satisfaction, services provided by administration, care provided to medical, surgical and obstetric patients, services provided by clinical support departments, and whether the organization has maintained a high quality despite budget constraints. Evaluates the extent to which the hospital has “shown measurable improvement in quality, hospital operational performance, and supplier quality” (Shortell 1992).
- vii. *Customer Satisfaction*: Examines the measurement of patient, doctor, and employee satisfaction in nine questions. Respondents are asked whether the organization does a good job of assessing patient needs and future patient needs; whether employees promptly resolve patient complaints, studies complaints to identify patterns, and uses data from

patients to improve services; whether patient satisfaction data is widely communicated; whether the organization does a good job assessing physician satisfaction and employees satisfaction; and uses satisfaction data when designing new services. Evaluates the extent to which the hospital “effectively assesses and meets customer (including patients, employees, physicians) requirements and expectations” (Shortell 1992).

B. Professional Participation to Organizational Management: This section measures respondents’ level of involvement in the organization’s management. Respondents are asked about their involvement in administrative decisions in the areas of budgets, human resources, professional practices, and the acquisition of new equipment and technologies. They are also asked if they are consulted in the decision-making process and if their opinion is taken into consideration. Lastly, they are asked how they would rate their and other professionals’ level of participation in the organization’s management.

C. Accreditation Impact: This section, developed for this study, examines the impact of the accreditation process on dynamics of change in fourteen questions. The respondents are asked whether important changes were implemented during self-assessment and whether they participated in the implementation of these changes; whether they were part of a self-assessment team; whether they learned of the recommendations made since the last survey; whether the recommendations were opportunity to implement changes and if they participated in these changes; whether accreditation enables the improvement of patient care, the development of shared values, better use of internal resources, better response to population needs, and better response to its partners; whether accreditation contributes to the development of collaboration with partners, is a tool to implement changes; and whether the

organization's participation in accreditation enables it to be more responsive when changes are implemented.

D. Information About Yourself: This last section, also developed for this study, asks for personal and professional information about the respondent. The respondents are asked to indicate gender, age range, working status, duration of employment at the organization, primary area with which they are associated, occupation, whether they are a member of an organization-wide quality assurance or quality improvement steering council, and whether they have been involved in the last accreditation process.

For the first and third sections (A and C), the respondents were asked to rate each question either "1 – Strongly disagree," "2 – Disagree," "3 – Neither disagree nor agree," "4 – Agree," "5 – Strongly agree," or "9 – Don't know." The second section (B) asked respondents to rate each question from "1 – Never" to "5 – Always." The fourth section (D) requires respondents to check the box that applies for each question.

Another, slightly different French version of the management questionnaire was accidentally sent out. It only had thirteen questions in Section C on Accreditation Impact (it was missing question C3 from the English version) and it had two different questions than the English version of the questionnaire in Section D, "Information About Yourself." From the English version, question 3 "What is your working status at this hospital?" and question 5 "Which of the following areas are you primarily associated with" were not in the French version. From the French version, question 4 "Do you have a clinical background?" (translated) and question 7 "How do you judge your involvement in the accreditation process on a scale from 1 to 10?" (translated) were not in the English version. Luckily, only one French questionnaire was returned, so when the data from the English and French questionnaires was compiled into SPSS, the effects of this oversight were minimal.

The complete English version of the management questionnaire can be found in Appendix C1. The French version of Section D of the management questionnaire can be found in Appendix C2.

Distribution of Questionnaires

The management questionnaires were distributed in both English and in French via email on June 3, 2004. They were sent to the Quality Coordinator working with us at the hospital, who then sent them to all of the hospital's 177 managers. The hospital's managers could then return them via email or print them out and anonymously return them to the Quality Coordinator via internal mail.

Response Rate

In total, fifty-one management questionnaires were returned to the Quality Coordinator, eight of them (seven English, one French) as a soft copy via email, the rest as a hard copy via internal mail. There are approximately 177 managers at the Hospital, giving us a response rate of 28.8 per cent.

2. CULTURE QUESTIONNAIRE

The culture questionnaire, adapted from Quinn, R.E., and J.R. Kimberly (1984) was used to gain insight into the hospital's organizational culture across four dimensions:

1. *The Organization's Character*: Is the organization more often like an extended family; dynamic and entrepreneurial; formal, structured, and bureaucratic; or very production oriented, where people are not personally involved?
2. *The Organization's Managers*: Are managers warm and caring, seeking to develop employees' potential; risk takers, encouraging employees to take risks;

rule-enforcers; or coordinators and coaches, helping employees to meet the organization's goal and objectives?

3. *The Organization's Cohesion*: Is the glue that holds the organization together loyalty and tradition, with high commitment; commitment to innovation and development; formal rules and policies, with maintaining a smooth operation being important; or emphasis on tasks and goal accomplishment, production orientated?
4. *The Organization's Emphasis*: Does the organization emphasize human resources; growth and acquisition of new resources; permanence and stability (efficient and smooth operations); or competitive actions and achievements?

The respondents weigh the four scenarios within each of the four dimensions by indicating which scenario applies which percentage of the time. The goal of rating these four dimensions is to determine what type culture applies to the Hospital. The four culture types, taken from R.E. Quinn and J.R. Kimberly (1984), are:

- *Group*: The extent to which the respondent perceives the culture to be based on norms and values associated with affiliation, teamwork, and participation.
- *Developmental*: The extent to which the respondent perceives the culture to be based on risk-taking, innovation, and change.
- *Hierarchical*: The extent to which the respondent perceives the culture to reflect the values and norms associated with bureaucracy.
- *Rational*: The extent to which the respondent perceives the culture to emphasize efficiency and achievement.

The complete culture questionnaire can be found in Appendix D.

Distribution of Questionnaires

The culture questionnaires were distributed in both English and in French (direct translation) to random employees of all levels and occupations in the cafeterias of the Hospital's three sites.

At the first site (August 10, 2004), the author was handing them out by herself trying to be in two places at the same time: 1) manning the table she had set up outside of the cafeteria's main entrance, where she also had a ballot box for those who completed the questionnaires to also fill out a ballot for a chance to win a \$20 gift certificate to Second Cup, and 2) inside the cafeteria, walking up to employees while they were eating at their tables, briefly explaining the research project and questionnaire to them, and encouraging them to complete one and return it to her at the table outside of the main entrance. Having one person try to distribute the questionnaires proved rather difficult, and the author was only able to collect thirty-one questionnaires on this first day.

At the second and third sites (August 11 and 12, 2004), the author had another member of the research team assist her by manning the table while she approached people inside the cafeteria. This made the process much easier, and they were able to collect one hundred questionnaires at this site. Due to the relatively small size of the third site, they were only able to collect another forty questionnaires there.

A draw for a \$20 gift certificate to Second Cup took place for all three sites, and the winners – one from each site - received their certificates via mail in September 2004.

Response Rate

The total number of culture questionnaires collected was 171, of which two were discarded due to incompleteness, leaving 169 to be used in the analysis. Since the questionnaire was not distributed to all employees at the hospital, a response rate cannot be calculated. There are approximately 11,825 staff and physicians at the hospital, so a

convenient sample of 1.6 percent of all staff and physicians was obtained. This is unfortunately very low. If the author were to take into consideration that many of the Hospital's employees are casual, part-time, so rarely at the Hospital, and calculate a response rate based the number of full-time equivalents (FTEs), she would get a more favourable sample rate (there are approximately 6,680 FTE, which do not include the hospital's 2530 casual bodies). The author unfortunately did not keep track of the number of questionnaires that were returned empty, since some respondents found them too difficult and/or time consuming to complete, and therefore refused to do so. It is estimated though that this number would be around twenty.

DOCUMENTATION

The Hospital provided the following documentation: Its 2000 and 2004 Accreditation Reports, and internal accreditation team reports from various self-assessment teams for the 2004 accreditation:

- Information Management;
- Leadership and Partnerships;
- Mental Health;
- Cardiac Surgery;
- Critical Care;
- Cardiac Rehabilitation;
- Cardiology;
- Eye Care;
- Maternal/Child;
- Rehabilitation Centre – Musculoskeletal;
- Environmental Management; and
- Geriatrics.

4. RESULTS

➤ RESPONDENT CHARACTERISTICS

In this section you will find the respondents' characteristics for the culture and management questionnaires. All of the SPSS output used for these sections can be found in Appendix E.

CULTURE QUESTIONNAIRE

Of the 169 questionnaires entered into SPSS, only 167 were eligible for analysis. Others were removed due to too many missing variables.

For the purpose of statistical analysis, groups of characteristics from Part B "General Information" with small representation were grouped into larger groups. For question B.2 "What is your age?" the answers for "Below 30 Years" and "Between 30 to 45 years" were grouped into one new category "Up to and including 45," and "Between 46 to 55 Years" and "Over 55 Years" were grouped together into another category, "Over 45." For question B.4 "How long have you worked for or been associated with this organization?" the months were converted back into years and grouped into "Less than 10 Years" and "10 or More Years." For question B.5 "What is your occupational category?" "Medical Doctors" (four in total) were grouped into "Administration." There were no "Volunteer" respondents.

For the characteristics, some additional variables were missing, making the responses out of 166 or 167. The respondents' characteristics are as follows:

- Of the 166 genders indicated, 130 were female (78.3%) and 36 were male (21.7%). As previously mentioned in Chapter 3 "Methodology," this interestingly enough coincides almost exactly with the distribution of male and female

employees throughout all of the Hospital's staff: 78.63% female and 21.37% male!

- Of the 167 ages identified, 103 (61.7%) were up to and including 45 years of age and 64 (38.3%) were over 45 years of age.
- Out of 166 respondents, 12 (7.2%) were in management positions and 154 (92.8%) were not.
- Out of 167 respondents, 90 (53.9%) were with the organization (including pre-merger sites) for less than ten years and 77 (46.1%) were with the organization for ten years or more.
- Out of 167 respondents, the breakdown by occupation type is as follows:
 - 48 (28.7%) were allied health professionals
 - 24 (14.4%) were in administration
 - 56 (32.9%) were nurses (who make up approximately 68% of all staff)
 - 23 (13.8%) were support staff (who make up approximately 11% of all staff)
 - 17 (10.2%) were "other" occupations

Table 1 – Culture Questionnaire Respondent Characteristics

Occupation Type	Gender		Age		Management		Years /w Hospital		Total
	Female	Male	<=45	>45	Yes	No	< 10	>= 10	
Allied Health	42	6	35	13	1	47	30	18	48
Administration	20	4	15	9	4	20	16	8	24
Nurses	47	8	32	23	5	50	21	34	55
Support Staff	8	15	11	12	1	21	11	12	23*
Other	13	3	10	7	1	16	12	5	17*
Total	130	36	103	64	12	154	90	77	167
	166		167		166		167		

* Occupation type was indicated, however, other characteristic was not, so value might only appear in totals.

MANAGEMENT QUESTIONNAIRE

Of the 51 questionnaires entered into SPSS, only 49 were eligible for analysis. Others were removed due to too many missing variables.

As with the culture questionnaires, for the purpose of statistical analysis, characteristics groups from Part D "Information About Yourself" with small representation were grouped into larger groups. For question D.2 "What is your age?" the answers for "Below 30 Years" and "30 to 45 Years" were grouped into one new category "Up to and Including 45 Years," and "46 to 55 Years" and "Over 55 Years" were grouped together into another category, "Over 45 Years." For question D.3 "How long have you worked for or been associated with this organization?" the months were converted back into years and grouped into "10 Years or Less" and "More than 10 Years." For question D.6 "What is your occupation?" the groups "Physician" and "Physiotherapist" were merged into the "Other" category.

For the characteristics, some variables were not entered, making the responses out of 46 to 49. The respondents' characteristics are as follows:

- Of the 49 genders identified, 41 (83.7%) were female and 8 (16.3%) were male.
- Of the 49 ages identified, 25 (51.0%) were up to and including 45 years of age and 24 (49.0%) were over 45 years of age.
- Of the 48 working status' identified, 47 (97.9%) were full-time and 1 (2.1%) was part-time.
- Out of 49 respondents, 23 (46.9%) were with the organization (including pre-merger sites) for ten years or less and 26 (53.1%) were with the organization for more than ten years.

- Out of 48 respondents that indicated the area that they work in, the breakdown is as follows:
 - 4 (8.3%) were in Medicine
 - 5 (10.4%) were in Surgery
 - 7 (14.6%) were in GYNOB
 - 5 (10.4%) were in Clinical Support
 - 27 (56.3%) were in other areas

- Out of 47 respondents that indicated an occupation, 19 (40.4%) were nurses and 28 (59.6%) were “other” occupations.

- Of the 47 respondents, 17 (36.2%) were member of a quality body and 30 (63.8%) were not.

- Out of 48 respondents, 35 (72.9%) were involved in the last accreditation process and 13 (27.1%) were not.

Table 2 - Management Questionnaire Respondent Characteristics 1

Area	Gender		Age		Status		Years /w Hospital		Total
	F	M	<=45	>45	F/T	P/T	=< 10	> 10	
Medicine	3	1	2	2	4	0	0	4	4
Surgery	5	0	2	3	5	0	1	4	5
GYNOB	6	1	4	2	7	0	3	4	7
Clinical	4	1	3	2	5	0	3	2	5
Other	22	5	13	14	26	1	16	10	27*
Total	41*	8	25*	24*	47	1	23	26*	48
	49		49		48		49		
Area	Nurse		Quality Body		Accreditation		Total		
	Yes	No	Yes	No	Yes	No			
Medicine	4	0	3	1	4	0	4		
Surgery	4	1	0	5	3	2	5		
GYNOB	6	1	2	4	6	0	7*		
Clinical	0	5	2	2	2	3	5		
Other	5	19	9	17	19	7	27*		
Total	19	28	17	30	35	13	48		
	47		47		48				

* Area was indicated, however, other characteristic was not, so value might only appear in totals.

INTERVIEWS

Five of the six interviewees were female, the other was male. All female interviewees had a background in Nursing, the male interviewee in Law. They all have a master's degree. They have been with the organization from five to twenty-seven years. At least two respondents are known to be surveyors for the CCHSA, and are also known to have the Certified Health Executive (CHE) designation.

FOCUS GROUPS

As mentioned in Chapter 3 "Methodology", the first focus group comprised participants from clinical services, while the second focus group comprised participants from support services, with the common denominator being that all participants had been involved with a self-assessment team, either in 2000, 2004, or both.

More specifically, the first focus group had representation from areas such as Geriatrics, Mental Health, Rehabilitation, and Eye Care. The second focus group had representation from Human Resources and Management.

➤ ORGANIZATIONAL CULTURE

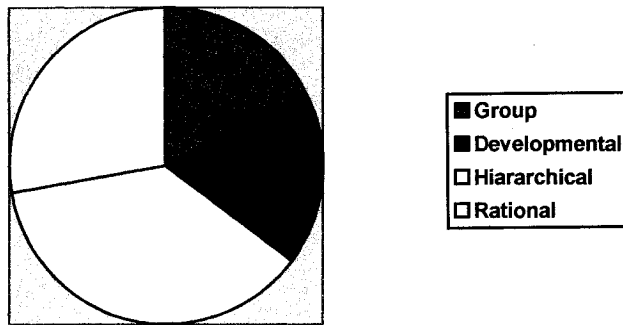
Based on the culture questionnaire results, the mean values for the culture types are as follows:

- Group Culture: 17.54
- Developmental Culture: 17.83
- **Hierarchical Culture: 36.92**
- Rational Culture: 27.71

Table 3 - Culture Scores

	Mean	Standard Deviation	Range
Group	17.54	11.998	0-51
Developmental	17.83	9.178	0-73
Hierarchical	36.92	14.847	9-85
Rational	27.71	10.545	0-58

Chart 1 - Culture Scores Pie Chart



This means that first and foremost, the Hospital is perceived to have a hierarchical culture 36.92 percent of the time, a rational culture 27.71 of the time, a developmental culture 17.83 percent of the time, and a group culture 17.54 percent of the time.

To find out whether significant differences in the responses exist based on individual respondents' characteristics, two sample t-tests and an ANOVA test were used to

compare the mean responses by each characteristic. No significant differences were found in mean culture values based on respondents' age, gender, time with the organization, or whether they were in a management position or not, based on two-sample t-tests with a 90% level of confidence. Significant differences in the responses were found, however, based on respondents' occupation when conducting an ANOVA test with a 95% level of confidence when it came to whether the Hospital has a rational culture or not.

Looking up the mean values, we find that "Allied Health" has a mean of 30.77, "Administration" has a mean of 27.12, "Nurse" has a mean of 26.45, "Support" staff a mean of 23.20, and "Other" occupation has a mean of 30.11. "Allied Health" and "Other," for example, therefore perceive the culture to be more rational than "Support" staff does.

Table 4 - Significant Differences in Culture Questionnaire Means

Culture	Allied	Administration	Nurse	Support	Other
Rational Culture	30.77	27.12	26.45	23.20	30.11

Although multiple testing was used, due to the exploratory nature of the analysis, no compensation (e.g. Bonferroni Correction) was applied.

Looking at the Spearman's correlation coefficient to determine the correlation, we see that there is significant correlation at the 0.01 level of significance for the responses pertaining to group culture. For some of the responses pertaining to developmental, hierarchical, and rational cultures, the correlations are weak. This means that there is a weaker link between the answers for those cultures – they do not move in the same direction, i.e. for one category, the answer would indicate a more developmental culture, whereas in another category, the answer would indicate a less developmental culture.

All of the SPSS output used for this section can be found in Appendix E.

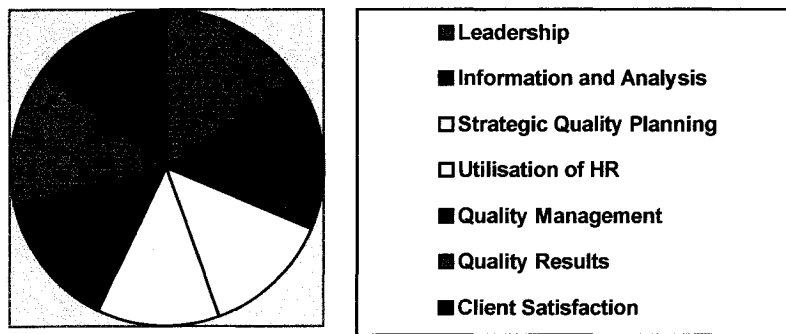
➤ **MANAGEMENT PERCEPTION OF QUALITY IMPROVEMENT**

The way the scale for this questionnaire is designed, a “1” would indicate a lack of a trait, and a “5” the presence of a trait. The average values for the Hospital’s commitment to particular areas, based on section A of the Management Questionnaire, are as follows.

Table 5 - Quality Improvement Scores

	Mean	Standard Deviation	Range	Cronbach’s Alpha
Leadership	3.95	0.55	2.20-5.00	0.868
Information and Analysis	4.03	0.70	1.00-5.00	0.936
Strategic Quality Planning	3.36	0.56	1.80-4.86	0.686
Utilisation of Human Resources	3.16	0.66	1.50-4.63	0.833
Quality Management	3.62	0.51	2.17-5.00	0.831
Quality Results	3.65	0.61	2.33-4.80	0.806
Client Satisfaction	3.74	0.47	2.67-5.00	0.852

Chart 2 – Quality Improvement Scores Pie Chart



We see that “Information and Analysis” ranks highest, which means that “scope, management, and use of data and information maintain a customer focus, drive quality excellence, and improve operational and competitive performance.” There also is clear and visible leadership from senior management as well as clear values which are integrated into the management system. However, the lower quality results and quality

management scores do not reflect this since according to management, there have not necessarily been measurable improvements and all work units do not necessarily contribute to overall quality and operational performance requirements. Utilization of Human Resources ranks lowest, indicating that employees do not necessarily perceive themselves as receiving adequate education and training for quality improvement efforts (Shortell 1992).

The result of the Management Questionnaire’s section B “Professional Participation” is as follows:

Table 6 - Professional Participation

	Mean	Standard Deviation	Range	Cronbach’s Alpha
Professional Participation	3.79	0.68	1.75-5.00	0.839

This would indicate that respondents do participate in the organization’s management in terms of administrative decisions such as budget, equipment, and human resources, and that they are also consulted in the decision-making process and their opinions are valued, however, the fact that the respondents do not on average fully agree with this (“fully agree” would be a score of 4 or more), is more indication of an hierarchical culture as was already determined by the culture questionnaire.

Cronbach’s alpha is used to determine reliability of the responses, to measure “construct”, or in other words to measure whether the questionnaire used elicits consistent and reliable responses (Reynaldo and Santos 1999). An alpha greater than 0.70 is considered favourable and an alpha less than 0.70 is considered unfavourable. Reliability issues were found for the Strategic Quality Planning statistic with $\alpha = 0.686$. Information and Analysis is the only item with an alpha greater than 0.9 ($\alpha = 0.936$), which could indicate redundancies in the scale used, since the more items you have, the higher the alpha gets. There could be too many questions in the questionnaire covering the same thing. Looking at the questions, one could, for example, combine questions 12

and 13 into one new question: “The hospital collects and uses a wide range of data and information about the quality of care and services to make improvements.” Questions 15 and 16 could also be merged into one question “The hospital continuously tries to improve the accuracy, relevance, and timeliness of its data on the quality of care and services provided.” This could then increase the reliability of the Information and Analysis score.

To find out whether significant differences in the responses exist based on individual respondents’ characteristics, two sample t-tests with a 90% level of significance were used to compare the mean responses by each characteristic. No significant differences were found in mean values based on respondents’ age and gender and dependent upon whether the respondent was a member of a quality body. Although multiple testing was used, due to the exploratory nature of the analysis, no compensation (e.g. Bonferroni Correction) was applied.

Significant differences were however found in the following responses:

- The utilization of human resources based on respondents’ number of years with the organization, occupation, and whether the respondent was involved with the last accreditation - nurses perceive themselves as having been better prepared for QI efforts, as do employees that have been with the hospital for longer than ten years, and those that were involved in the last accreditation;
- Strategic quality planning and occupation - nurses perceive themselves as being more empowered in QI efforts than do other occupational groups;
- Information and analysis and whether the respondent was involved with the last accreditation – those involved perceive information management to be more customer and quality focused than those not involved; and

- Professional participation and whether the respondent was involved with the last accreditation – those involved perceive themselves to be more involved and empowered in decision-making.

Table 7 - Significant Differences in Management Questionnaire Means

Factor	Years with Hospital		Occupation		Involved in Last Accreditation	
	<= 10	> 10	Nurse	Other	Yes	No
Utilization of Human Resources	2.90	3.33	3.41	2.96	3.24	2.83
Strategic Planning of Quality			3.51	3.23		
Information and Analysis					4.16	3.71
Professional Participation					3.88	3.46

All of the SPSS output used for this section can be found in Appendix E.

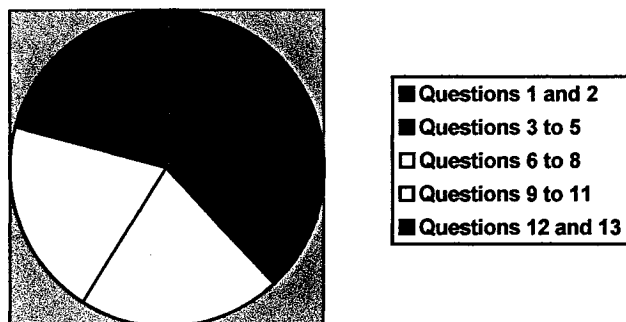
➤ ACCREDITATION IMPACT

The results of section C of the Management Questionnaire, “Accreditation Impact,” after question 3 from the English version of the questionnaire has been removed for consistency with the French version of the questionnaire, are as follows:

Table 8 - Accreditation Impact

	Mean	Standard Deviation	Range	Cronbach’s Alpha
Overall Impact	3.74	0.79	1.92-5.00	0.950
Questions 1 and 2	3.23	1.13	1.00-5.00	0.771
Questions 3 to 5	3.77	0.89	1.00-5.00	0.783
Questions 6 to 8	3.86	0.96	1.67-5.00	0.913
Questions 9 to 11	3.74	0.94	1.67-5.00	0.925
Questions 12 and 13	3.83	0.97	1.50-5.00	0.865

Chart 3 – Accreditation Impact Scores Pie Chart



All of these values indicate that the respondents somewhat, but not fully, agree with the following (ranked lowest to highest):

- During the last self-assessment phase, important changes were implemented in which the respondents were involved (Q1 & Q2). This aspect is ranked lowest, most participants neither agree nor disagree on average;

- Accreditation helps the Hospital to better respond to the needs of its population and partners, and contributes to the development of collaboration with these partners (Q9 - Q11);
- The respondents learned of the recommendations, and they were an opportunity to implement changes in which they participated (Q3 - Q5);
- Accreditation is a valuable tool to implement changes, and enables the Hospital to be more responsive when these changes are implemented (Q12 & Q13); and
- Accreditation enables the improvement of patient care, development of shared values, and the better use of internal resources (Q6 - Q8). This aspect is ranked highest, meaning that respondents lean towards agreeing with it on average.

Significant differences in the responses were found depending on occupation, age, and involvement in last accreditation based on a two-sample t-test with a 95% level of confidence.

Table 9 - Significant Difference in Mean Accreditation Impact

Factor	Age		Occupation		Involved in Last Accreditation	
	<= 45	> 45	Nurse	Other	Yes	No
Overall Impact			4.04	3.51		
Questions 1 and 2					3.52	2.63
Questions 3 to 5			4.03	3.56		
Questions 6 to 8	3.60	4.10	4.23	3.56		
Questions 9 to 11			4.11	3.50		
Questions 12 and 13	3.58	4.04	4.13	3.57		

The most significant difference is with nurses, who rate the impact of accreditation higher than other professionals. The older employees also tend to rank some aspects of accreditation higher than younger employees. This could possibly be since they have been working in the field longer and therefore are more aware of the impact of

accreditation. Interesting to note is how those not involved in the last accreditation rate the level of changes implemented during the self-assessment lower than those involved with the accreditation. This could be since those not involved are not as aware of what is implemented during and/or due to the self-assessment phase.

All of the SPSS output used for this section can be found in Appendix F.

➤ RESULTS FROM INTERVIEWS AND FOCUS GROUPS

The interviews and focus groups were coded using N-Vivo and following the coding scheme developed by the research team that can be found in Appendix F. This section discusses the results based on the Dimensions of Change framework that this project is built around. In the following chapter, “Discussion and Analysis,” results will be discussed in the context of accreditation and specific research questions that this thesis seeks to answer.

Sections of the interviews will be quoted, however, the sources will not be properly referenced for anonymity reasons. It will be revealed if the source is an interview, focus group, or document, and if it is an interview, the level of the interviewee will be given.

CONDITIONS FAVOURING CHANGE

1. GENERAL ENVIRONMENT

General Environment

External environment exerting a lot of pressure in a predictable manner and an explicit and open plan inclined towards a utopia

The greatest external pressure exerted on the Hospital was a result of the Ontario Health Services Restructuring Commission which forced the merger that created the Hospital in 1998. Since then, other organizations have also merged into the Hospital, forcing it to encounter numerous issues related to the merging of programs, departments, and positions while facing the pressure to increase efficiency (the goal of the Commission).

“Then once you do that [the merger], you have the issue of consolidating programs, so that you know you’re going to consolidate the joints surgery on one campus, the thoracics on one campus, or cancer services, inpatient cancer on one campus, trauma on another campus” (VP Interview).

Provincial legislation with its accountability agreement is also adding increased financial pressure to the hospital, which has already been under an eight year fiscal “siege” as one interviewee described it. This means that issues get prioritized if they relate to programs, patient education, and patient safety, while others can be tabled for six, seven, or eight years without any change. There also is a “national trend towards integration and population health,” which is now embedded in the accreditation standards. Legislations relating to patient safety, occupational health and safety, and infection control are also exerting pressure, and thereby forcing change upon the Hospital.

“Yeah, well definitely there was merger, and definitely we had an operational review. Definitely we went through two different boards, and two different CEO’s, and org[anizational] structures, and definitely we had budget problems, where we had to make adjustments. These things are significant drivers of change, external drivers of change. You know technology and opportunity drives changes to the patient populations we serve, and certainly there’s this idea of patient rights, and patient choice. We talk about infection control and safety, these things are everywhere. So you know ... it’s just staying up with opportunity” (VP Interview).

Unfortunately, due to the enormous pressures and changes that have occurred at the hospital, a feeling of fatigue could emerge and affect change. As they were told by the CCHSA surveyors, the Hospital has to stop and take a breath since people have been working so hard since the merger, that if they don’t slow down, they might be forced to.

2. BASIC CONDITIONS

Although the surveyors recommend that the Hospital slow down, the Hospital does not seem to be on that path. As one interviewee stated:

Basic Conditions

- Surplus capacity of legitimate participants.
- Discretionary areas of autonomy
- Relational cognitive capacity of participants
- Shared information

“I’ve been here for twenty-one years, and I’ve never worked so hard in my life, I must say, but I’ve never had a day where I did not want to come into work. I enjoy my job. I think most people in the organization do, because they see that we’re making improvements in care, improvements in patients and staff” (VP Interview).

Another interviewee also stated that the expectations of new people coming into positions are increasing, just being master’s prepared is no longer enough. This could indicate that the Hospital is trying to increase the cognitive capacities of its actors.

There is a high degree of autonomy encouraged at the Hospital, which facilitates the implementation of changes. The doctors have autonomy and clinical teams have the autonomy to make decisions affecting their areas. Nurses and allied health professionals also have autonomy and are encouraged to work within their full scope of practice:

“[W]e have a new model of care that’s been rolled out in the organization corporately, plus to all of our satellites. We have satellite dialysis programs ... and our model of nursing care is going to roll out there as well, where it talks about the nurse[s] being fully autonomous, and practicing at their full scope of practice. So I think from a nursing perspective, we’ve never been better. I think when you look at a number of the allied health professionals, we are expecting them to function at their full scope of practice. I’ve looked at the RPN [registered practical nurse] role, there were registered practical nurses working here, and they’re a regulated body, but they used to just, you know, do tasks that an unregulated health care worker could have done, but we made the commitment that we would ensure that an RPN can give medications. We’ve paid for

them to get the course, the medication course, so that they're now doing that. So that if we do have an RPN, [s/he is] functioning at full scope of practice" (VP Interview).

People generally have the opportunity to make their own decisions within their portfolios and move on them if they do not cost the organization, and when they do, they can get the funds to support them (VP Interview). The Board of Directors meetings are also open to all staff, and they can come and participate in decisions being made there:

"I think that it's a very flexible organization that allows autonomy where it's need[ed], and the decisions to be made at the right level" (VP Interview).

3. STRATEGIES

The Hospital employs several strategies to encourage and foster change. For example, encouraging the open flow of information throughout the Hospital. The CEO holds

regular open forums where employees have the opportunity to learn what decisions are being made and to bring forward their concerns. Surveys are also regularly distributed and Vice-presidents regularly visit their departments to communicate with their staff. Professional practice and development are also encouraged via professional teams that meet regularly and are responsible for maintaining "professional integrity, and professional practice, and best standards for all the things that they do, and then build those back into the clinical teams that they work with so not just isolate them" (VP Interview).

Strategies
- Diffusion
- Learning
- Adhesion / Buy-In

Participation of all stakeholders is encouraged by the Hospital: "I think if we push the decision making down to the lowest level possible, and so ... staff, manager, directors have opportunity to participate in the decision" (VP Interview). At the Vice-President level, there is a stakeholder list to ensure that the input of all stakeholders is sought out and integrated into the decisions made, often via formal and informal forums and

stakeholder consultations. Consumers are also included via consumer advisory groups and other forums, where they sit around the table, help recommend change and then participate in that change (VP Interview).

Every decision taken to the Board of Directors has to be accompanied by a communication plan for the hospital (VP Interview). One of the purposes of this communication plan is to overcome resistance to change. The Hospital is not quite there yet though, since “communication is [still] one of [its] biggest challenges” (VP Interview).

4. LEADERSHIP AND COMPETENCIES

The Hospital has a high level of leadership diffusion, meaning that all levels are involved with and responsible for the creation of quality initiatives, from nurses up to senior management. As was also seen through the Management Questionnaire, where “Leadership” had a mean of 3.95 ($\alpha = 0.868$), there is a high degree of leadership from the CEO and the Board of Directors, and this leadership is visible throughout the entire organization, especially since it is a participatory form of leadership, with the CEO trying to get all levels involved in initiatives relating to quality and even budget:

Leadership and competences

- Visibility of management involvement
- Identification of key personnel
- Constant valorization from promoters
- Initiators and very legitimate shareholders
- Quality management competency

“Another initiative that [the CEO] did a number of years ago was, we were in a severe budget crunch, and he went to the staff and asked us, the front line staff, for ideas in terms of budget initiatives and ... our initiatives came forward, they were prioritised and many of them were actually ... implemented as a follow-up to that service” (Director Interview).

The values of the Hospital are also being pushed throughout the organization, with the CEO bringing them directly to the front line in addition to getting buy-in from the physicians:

“[The CEO] has only been in his position for just over two years, but he has developed a very strong vision for the organization. I think that everybody knows what his vision is. I think the physicians know his vision now more than they ever have known a vision. They are all behind it, because they realize we have to be an academic health sciences centre” (VP Interview).

“He [the CEO] went to the entire organization and asked the organization what should be our corporate values and those have been established, so, you know, working together, respect, compassion, those were established based on the feedback from the entire organization” (Director Interview).

This results in a high commitment to the Hospital’s values:

“I think everybody knows the vision statement. I can rhyme that off in my sleep for God’s sake, and I think people are aware of the core values, and if you look at our performance appraisal tool that we have, the core values are right there, which you know is respect, quality, commitment, and teamwork. They are the four core values for the organization. We expect our employees to be measured against them. I think the fact that their performance will be based on those core values is very important. It shows that we are committed to those core values, and that we do value them” (VP Interview).

The Hospital tries to hire physicians that already have leadership and administration skills (VP Interview), and this leadership, along with the leadership of key senior managers, is helping the Hospital to become recognized as a leader in some areas, especially quality and patient safety, both within the community and nationally.

“[T]here is certainly a push from our senior management team to look outwards. And I mean, I think quite honestly, that can only happen after things internally are set. Four years ago, we could not have done this because there was too much internally to look

after. But now [the CEO] and the Board, definitely they are positioning the Hospital to be a leader in the community. We have created a roll called Vice-President of Networks that takes a lead in communicating with our community partners. [The CEO] has initiated a number of regional initiatives so there is planning going on for a regional lab system” (Director Interview).

The Hospital also has representation on both the National Quality Council and the National Patient Safety Council (VP Interview.)

5. CONCEPTION AND COMPREHENSION

The organization has the ability to critique and assess itself, which is important in the organizational change process, as identifying

<p>Conception/Comprehension</p> <ul style="list-style-type: none">- Acquisition of new models- Reflexive comprehension
--

issues is the first step to implementing change. For example, the organization is aware of the major gap that exists between the frontline staff delivering care, and the management and support staff, and is working to rectify the situation.

There could, however, be a problem of management not understanding quality improvement and its tools:

“I don’t think the organization or management have a good understanding overall of basic quality improvement tools ... If there are specific measurable targets for quality of care, they are not well communicated. I don’t know what they are beyond the vague definition of quality” (Management Questionnaire Respondent).

The hospital is also aware of its limits when contemplating change, and tries to maintain a degree of realism:

“I told my teams, don’t put anything down for areas of improvement if you don’t think that a) you can do it, or b) it’s going to be of value. I just don’t want a big long list of

wishes. If you don't have a plan to improve it, or you don't think you can improve it, then take it out. Because there's nothing worse than saying, 'I do this, but I want to do this.' Okay, well then what are your plans to get there even if it's a 10 year plan? So that's the difference ... It shouldn't just be a list of, like if you're going to reflect on yourself, right? If I have to say, 'Okay what are my plans for my own professional improvement' or whatever. I can't write down, 'I'm going to learn Japanese,' because there's no way I'm ever going to learn Japanese, or take the time to do it" (VP Interview).

"It's much easier sometimes to make ... change[s] in a small organization, than a large place like this ... just because of the size of the place ... [Y]ou look at the complexity of the organization, sometimes you may not be able to make the changes as quickly as you want to ... just because of the complexity, whereas in the smaller place, they can, and ... you know it might be a heck of a lot easier for them to get a better [accreditation] rating than for us, because it's a very small organization, with a very predictable type of patient population, that they're serving, right?" (VP Interview)

An interesting, but not surprising phenomenon is that the front line staff is much more willing to critique the organization than senior management is. There was much more open criticism of the organization in the focus groups than in the senior management interviews.

Despite its limitations, the organization is committed to facilitating change. It has recently created a very new position and hired a "Core Process Transformation Coordinator" that will identify key areas in the organization, and start looking at the processes in place to make sure they are as efficient as possible (VP Interview).

Overall, there is a high commitment to change. The Hospital looks for issues to work on, instead of just waiting until they become a necessity:

"Clinical practice is a good one. Each year the nurses pick out five or six things they want to work on. The chiefs all have medical staff meetings where they talk about a variety of things and then we have cross-functional teams ... Those teams are where a lot of things happen. I have an administrative team where a lot of different ideas and things

will come up. We also do probably, about twice a year, planning days where I bring all of my administrative staff and they basically manage most of the staff, with the exception of physicians, and then we decide what the priorities are going to be and new things that might be out there that we need to take a look at and stuff” (VP Interviews).

CHARACTERISTICS OF CHANGE

1. NATURE OF CHANGE

Nature of Change			
- Method:	intentional/unintentional	- Pace :	slow/rapid
- Target:	conceptual/concrete	- Rhythm:	uniform/variable/on the spot
- Dispersion:	localized/generalized	- Duration:	short/long
- Trajectory:	complete/blocked/regressive		
- Phase:	Initiation/growth/maturation/completion or decline		

Most of the changes are intentional and relate to quality:

“I can’t really count it, but I would expect at least 85%-95% of our strategic and operational initiatives are based on quality improvement projects of one kind or another, including access, sustainability, looking at admission functions, and it’s all based on this you know ‘see, do, think, act’ [cycle], you know what I mean, this whole thing, and pushing the agenda for improvement” (VP Interview).

Other changes are also initiated with the intent to find efficiencies, which can in turn be reinvested into the Hospital:

“To improve the care, to be more efficient, and also if we find savings that we will reinvest those in patient care - I think that that is the true value in the organization. I can give you another example, where we worked with the orthopaedic surgeons, where they used to use all these different devices for hips and knees, right? We worked with the physicians, and they’re a tough group. They are a very tough group, orthopaedic surgeons. We worked with them to go to one vender for hip, and one vender for your

knee instrument. We've saved \$832,000 by doing it. We reinvested that to do more procedures to shorten the waiting list in the community" (VP Interview).

The organization tries to make its decision-making process as swift as possible, to foster more rapid implementation of changes.

"But there is informal stuff if someone has an issue or a problem that gets raised in passing at an open forum or something, it will make its way rather quickly up to the Executive Committee and then they will either put a working group to it or just make a decision. We have a very short decision time frame here because at our Executive Committee, all the chiefs, all the VPs - everybody is sitting in the room so you can decide today what you are going to do tomorrow" (VP Interview).

Regarding the rhythm of change, it has been one of uninterrupted constant flux:

"Well you probably already heard that there has been a merger, and there were two sets of reorganizations; one in April 1998, when [the former CEO] came, and then one in October of whatever 2001 or 2000 when [the former CEO] left. And I would say that although there has been a lot of stability ... there has been some shuffling, and certainly some people left, and in between, there was a budget downsizing, so I would say there has been a constant flux" (VP Interview).

The dispersion of change at the Hospital is one of a decentralized nature, where changes are often confined to their respective departments. There is, however, a trend towards more centralization since increasing emphasis is being placed on a multi-disciplinary approach:

"I think pretty much every clinical team in my portfolio has a multidisciplinary structure in place. That brings up ideas around best practices" (Director Interview).

2. CONCEPTION

As was previously alluded to, there is a trend towards inductive, or bottom-up, decision making at the Hospital, although some decisions by nature come from the top. This was made evident over and over again during the interviews with various senior managers:

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|---|
| <p style="text-align: center;">Conception</p> <ul style="list-style-type: none">- Deductive - top/down- Inductive - bottom/up |
|---|

“[A]nything that is a new program or a new way for caring for patients always happens by the clinical teams. It comes from a grass roots sort of piece. The administrative changes come from the Executive Committee. Things like capital planning, changes to the website, those kind of things, they come from the Executive Committee. Budgeting is an interesting piece we have targets that are set by the Ministry [of Health and Long-Term Care] so a bit of our budget is driven by the volumes they tell us we have to do. The clinical teams will take a look at what the targets are and they will see if the targets match or don’t match, and they will make recommendations around volumes and what they think they need to serve the patients. The managers do the actual budget so they say ‘if you want to do 5000 of these cases, this is how much it is going to cost.’ And the Executive Committee will put the revenue piece on it and say ‘well we are just short \$2 million here’ and we go back and forth a bit, and then the board does the final approval. Those kinds of deficit discussions go up and down the line” (VP Interview).

“The changes happen all over the place. The clinical ones are almost always at the level of the team. It would be very unusual for the Executive Committee to step in and tell people how to care for the patients” (VP Interview).

3. ACTION STRATEGIES

There is a high commitment towards cooperation within the hospital - teamwork is not only strongly encouraged,

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| <p style="text-align: center;">Action Strategies</p> <ul style="list-style-type: none">- Internal: cooperation/perturbation- External: manipulative/authoritarian- Means of accompaniment: incentive / influence/ authority / commitment |
|---|

but also a requirement within the organization, especially within management and the clinical teams.

The main incentives accompanying change are the drive towards higher levels of efficiency, which can be seen by the high score attributed to a rational culture based on the culture questionnaire ($\bar{x} = 27.71$), and the Hospital's commitment to quality:

“Right now, the initiative for this year is the Emergency Department. We know the patient flow in the Emergency Department is terrible. Patients can wait 13 hours or 33 hours some days to get to a bed. So we want to look at the process from before the patient comes in to when they hit the Emergency Department until they're admitted to the bed, because we really think that there are opportunities to find and create efficiencies. So we're going to hire somebody, who is going to work with teams, and they're going to work with the Emergency Department” (VP Interview).

Based on the results of the culture questionnaire, however, the Hospital is mainly perceived as being authoritarian, rather than a group culture, which is in line with the previous description of the gap between management and front-line staff. An element of patronization was also found during the interview with this quote: “You know [the frontline staff] have union issues. It's an opportunity to sound off to the CEO about how hard done by they are” (VP Interview). There is therefore obviously more work to be done in this area.

4. STAKES

Stakes
- Strategic transformation: acquisition of quality management and the implementation of a risk management system
- Organizational transformation
- Symbolical, physical, and organizational structure
- The processes
- Participants
- Trajectory / performance
- Transformation of the relationship between the organization and its environment

There has been a transformation of the relationship between the organization and its environment. The Hospital tries to be more responsive to its environment's needs.

“You know I think this year, with the new standards, and a focus on population health, I think that it's driven the organization to start to think differently about how we provide care, and start to look at trends more so than we have in the past. I think we're also looking outside the walls more than what we have. I can take an outpatient population of diabetics or asthma patients that we see. I think it's giving us more of a focus to start looking at our community partners, and how can we work with physicians in the community, agencies in the community for patients to manage their care better. So that they don't have to come into the hospital for their care. So I think that it's given us some direction on forming more partnerships, and working with the community to improve the care of our population in the area from my perspective” (VP Interview).

The Hospital also tries to increase participation in changes, for example via its Physician and Employee Satisfaction Survey that seeks feedback to which the Hospital responds with an action plan framework. Community Physicians are also consulted:

“Once a year we take the cardiologists in the city and internal medicine physicians who are interested in cardiology and [we] take them on an off site retreat and they talk about best practice and they do sort of educate and those kinds of things. We have a telehealth set-up that we use quite a bit ... to provide cardiac education to other centres. So, a number of us are in close contacts with those hospitals regularly so we have already some processes in place. We do send them a regional update, kind of like a newsletter, once a month. It tells them by hospital, specifically by physician, who is on the waiting list, how long they have waited, what the results were like, how fast they got in. It talks about any new programs that are coming. So it's a newsletter that goes to all of the CEO's, all of the referring physicians, and all of the department heads of the referral hospitals” (VP Interview).

That the hospital attempts to be more responsive to its environment's needs is shown in the results of questions Q9 to Q11 of the “Impact of Accreditation” section of the Management Questionnaire. These questions received a score of $\bar{x} = 3.74$ ($\alpha = 0.925$),

which shows that respondents tend to agree that accreditation helps the Hospital to better respond to the needs of its population and partners, and contributes to the development of collaboration with these partners.

ORGANIZATIONAL LEARNING

As was discussed in Chapter 2 “Organizational Learning Literature Review,” the three areas of consensus regarding organizational learning which are also necessities of its evolution are:

1. Relevance of environmental alignment;
2. Distinction between individual and organizational learning; and
3. Presence of four contextual factors in the learning process (organizational culture, strategy, structure, and environment).

1. ENVIRONMENTAL ALIGNMENT

The Hospital realizes the relevance of environmental alignment. This can be seen in its attempts to become more responsive to its environment’s needs, such as increasing the community’s involvement in its decision-making and changes (Q9 to Q11 “Impact of Accreditation” $\bar{x} = 3.74, \alpha = 0.925$).

The 2004 Accreditation Report’s detailed Community Partners Focus Group feedback report praises the Hospital’s openness towards collaboration with its community partners. According to the CCHSA, the Hospital is a leader in the development and implementation of many regional projects, such as a regional electronic medical record system and a regional laboratory system. These collaborations provide ample opportunity for the sharing of knowledge among community partners.

2. INDIVIDUAL VERSUS ORGANIZATIONAL LEARNING

The Hospital seems to make the distinction between individual and organizational learning and tries to foster both with its Organizational Learning and Development Department, which offers training and education to individual staff for individual learning, recognizing that individual learning is the basic building block of organizational learning. Learning is, however, still somewhat decentralized since Human Resources also offers training, in addition to the Nursing Professional Practice Department. One identified weakness was the absence of a centralized information system that shows all of the training the employees have received throughout the different departments (VP Interview).

3. CONTEXTUAL FACTORS

Regarding the contextual factors required by organizational learning, they all seem to be present at the Hospital.

Culture

Important cultural elements for organization learning are the presence of teamwork, the encouragement of risk taking, as well as an open culture where issues can be discussed without fear of repercussion.

Teamwork is a requirement in management. Although the hospital is encouraging the formation of multi-disciplinary teams, and teamwork is an important value for the organization, it is still a problem on the front-line according to one manager, where there is a tendency to work in silos. The culture questionnaire's results do also not show a predominant team culture ($\bar{x} = 17.54$). Unfortunately, some manager seems to be unaware of this problem, since they perceive a team culture to be thoroughly integrated into the organization:

“I think the people see themselves as a team; there really isn’t much of a pecking order. You can talk to pretty well everyone; we are very much a flat organization. There is only one level between a staff nurse and a VP and the physicians are brought into a lot of the committees so they feel, they are not always happy with the decisions sometimes, but they have lots of opportunities to talk” (VP Interview).

In terms of patients, management of course does not encourage any risk taking, however, in terms of process improvement tools and techniques, it is encouraged for the purpose of learning (Director Interview). The hospital is also currently going through a leadership competency exercise, one of the competencies identified for the leadership role being around the area of risk taking. The development of this competency framework is seen as a tangible demonstration that the hospital’s culture supports organizational learning by a Director (Interview). In summary, risk taking may not be embedded across the organization, but it is encouraged in a lot of areas.

The Hospital also has an open culture:

“Hospitals in general, particularly academic hospitals, are places where there’s lots of innovative health care professionals, and people who work in hospitals have mixed allegiances; so they have an allegiance to their profession, which sometimes can be as strong as the allegiance to the organization. So they’re not all embarrassed about making issues with the CEO or whatever” (VP Interview).

One of the identified cultural barriers to organizational learning is adherence to traditions and superiors that resist change. Change is the norm at the hospital, which also recognizes that resisting change is a part of being human (Director Interview).

Strategy

The Hospital is nationally recognized as an academic health sciences centre of choice, with a commitment to continuous improvement and learning. The Hospital has its

Department of Organizational Learning and Development and various strategies in place for continuing education, in particular skills training and research.

The Hospital also participates in a number of external benchmarking exercises, such as the provincial Hospital Report, and Haye Group benchmarking. When developing new protocols, the hospital's employees always go back to literature and check who is setting the benchmarks, confer with colleagues in other institutions, and even conduct site visits (Director Interview). They also participate in external workshops and conferences:

“We've certainly looked not only at things we do within our own four walls, but a lot to do with integrating, or looking at continuity of care with our partners. It's been a big change, big change, because before that lots of people worked, just to take care of themselves, and now we look at it from the patient's point of view, going through all these different systems” (VP Interview).

The Hospital is working on improving the communication between departments and the transfer of knowledge between departments (a learning mechanism). This helps to share what each department is working on, and avoids a duplication of efforts.

“It is not so much knowing the people, but knowing what the people are doing and what are the different projects people are working on, and how do we then build on the communication piece around that so that there's not two departments working on the same issue” (Focus Group Participants).

The merger also helped the different sites to learn from other sites, increasing the Hospital's overall knowledge capital.

“I think at the [first] campus, we have a role that was called “Patient Care Assistant” that the [second] campus didn't have, nor did the [third] campus. Now that we have corporate positions, and managers at the [second] campus saw that position over here, which is an unregulated health care worker, saw the benefits of those types of positions, they would say, “Oh I would like to get a PCA. How do I get a PCA to help out on the

floor?” So I think there’s been some consolidating of positions that has occurred since the merger” (VP Interview).

Another strategy is to improve communication with the hospital’s stakeholders and environment, as these can also all learn from one another:

“[w]e try to make sure that there’s regular forums or retreats ... when a significant change has to be made, to have presentations, and bring people up to date on, and get input and feedback, because sometimes we think something is a good idea. It has implications. I think that there’s a good track record of trying to get feedback. Here and at the Hospital, only a little bit differently, we do have consumer advisory groups, and as you can see ... consumer participation is one of our values. So we make no decisions clinically or administratively without asking our advisory committee for advice. Now, we might not take their advice” (VP Interview).

Structure

There is a learning structure in place, as is seen in its learning oriented departments, along with a structure to commit what was learned to organizational memory.

The Hospital has an intranet where it stores corporate policies and procedures relating to fire, disaster, infection control, and human resource policies. There also is a plan in place to improve access to computers for front-line staff. Email is commonly used for communication (Director Interview).

Environment

The Hospital is not only building partnerships with its external community, but it is also comparing itself to the external community with its benchmarking practices.

“The Ontario Report comes out quarterly. So we participate in that and we get those reports quarterly. When we get the reports, we sit down with the team and say okay, what’s improved, what still needs improvement. Based on general themes, we decided on two or three areas that we are going to target” (Director Interview).

“So in all of the teams I have participated in, we ask the questions ‘from your perspective, can you give us some suggestions from other sites you’ve visited?’” (Director Interview).

5. ANALYSIS AND DISCUSSION

This chapter discusses the conditions favouring change as determined via select organizational characteristics, the changes that can be attributed to and occur in line with accreditation, the accreditation process overall, and the impact of accreditation on organizational learning. As was the case in Chapter 4 “Results,” quotes from the interviews and focus groups are used, yet not properly referenced for anonymity reasons. It is only indicated whether the quote comes from a document, a focus group or an interview, in which case the level of the interviewee is revealed.

This discussion will also try to answer specific research questions related to the accreditation process and its impact on the hospital, which can be found in the following table:

Table 11 - Research Questions

<p>Conditions Favouring Change</p>	<p>What are the organizational characteristics of the hospital?</p> <ul style="list-style-type: none"> - Organizational stability - Organizational culture - Decision-making - Leadership
<p>Changes in line with Accreditation</p>	<p>What changes were implemented during the self-assessment phase?</p> <ul style="list-style-type: none"> - At the individual practices level - At the group practices level - At the organizational level - At the external partnerships level <p>What changes were implemented during the accreditation survey?</p> <ul style="list-style-type: none"> - At the individual practices level - At the group practices level - At the organizational level - At the external partnerships level <p>What changes were implemented as a result of the accreditation report, and in particular as a result of its recommendations?</p> <ul style="list-style-type: none"> - At the individual practices level - At the group practices level - At the organizational level - At the external partnerships level
<p>Other Changes</p>	<p>What other changes were implemented at the hospital?</p> <ul style="list-style-type: none"> - At the individual practices level - At the group practices level - At the organizational level - At the external partnerships level
<p>The Accreditation Process</p>	<p>What are the organization's expectations of the accreditation process?</p> <p>What is the organization's opinion of the accreditation process?</p> <p>Did accreditation help the organization to be more reactive to change?</p>

➤ CONDITIONS FAVOURING CHANGE

ORGANIZATIONAL CHARACTERISTICS: ORGANIZATIONAL STABILITY

There have been many shifts in the Hospital's structure due to its merger and subsequent reorganization by the Ministry of Health and Long Term Care. Positions and programs have been created, consolidated, moved and eliminated and the organization was flattened.

“[T]hey were giving out pink slips, basically our jobs as we knew them were gone, so we could re-apply for whatever position we wanted to. So I went through that myself, pretty well the majority of the workforce [did]” (VP Interview).

In terms of human resources, the management level was most affected by this change, with frontline staff least affected.

“I would say, as you move down in the organization, there was less turmoil in terms of turnover, but particularly at the Director and Senior Management, Board and CEO levels, there [were] tremendous transitions” (Director Interview).

“[T]he nurses stayed where they were. You know they weren't really affected by the merger. I would say that the people who were affected by the merger the most are the director level and up, because directors have been asked now to take on a corporate responsibility, wear a corporate hat, and be responsible for programs corporately” (VP Interview).

More recently, the Hospital has been hiring again, resulting in a shift in its population and demographics towards a younger workforce. The Hospital also currently enjoys one of the lowest nursing vacancy rates in the country, around 2%, with a turnover rate of 9, which is much lower than the 20 it used to be.

ORGANIZATIONAL CHARACTERISTICS: ORGANIZATIONAL CULTURE

According to Shortell's Quality Improvement Implementation Survey, "[a]t the hospital level, no hospital is likely to be totally characterized as only one of the culture types ... although at the individual level some respondents may characterize the hospitals as all one type. Hospitals are likely to be a combination of the culture types. In fact, this may be a necessity since hospitals, as do most other organizations, need to have at least some aspects of hierarchical (e.g., rules, stability), rational (e.g., planning, efficiency), developmental (e.g., growth), and group (e.g., participation) cultures. The crucial factor for QI implementation is the distribution of the importance of each of these types, that is, which one(s) are predominant. Common belief is that a significant commitment to a culture emphasizing empowerment, autonomy, and risk-taking is necessary for the successful implementation of CQI/TQM. Thus, hospital cultures that emphasize group and developmental components (at least a combined score of 50) should help promote QI implementation efforts." Unfortunately, the Hospital's combined score is only 35.37, which means that some work is still necessary to change the organization's culture. From Carroll & Edmondson (54) we know that such a change in culture is most effective when it comes from top leadership.

Shortell recommends the following strategies to help shift the organization to a group culture:

- Development of multi-disciplinary teams;
- Increasing multi-skilled training and thus creating a more flexible work force;
- Aligning incentives, rewards, performance appraisal and financial control systems with the new culture;
- Keeping the values in front of people on a daily basis; and
- Providing needed support.

The Hospital encourages a multidisciplinary approach and keeps its values, which are integrated into performance appraisal, at the forefront.

“I think pretty much every clinical team in my portfolio has a multidisciplinary structure in place. That brings up ideas around best practices” (Director Interview).

“All our clinical planning was done in teams, so for program consolidations, for making recommendations about what programs should be at what site, all of that planning was done with multidisciplinary clinical planning, led usually by a nurse and a physician or a clinical director and a physician, but around the table is a wide variety of stakeholders” (Director Interview).

“I know if I’ve got a very strong team that [has] the same values of the organization that we all agree on, then my job is much easier, and I know that they’re going to support their managers. And if the managers are strong, they’re going to have high expectations of the staff, and the patients should get better care. So it’s a very ripple effect” (VP Interview).

Regarding multi-skilled training and the creation of a more flexible work force, the hospital encourages its staff to be more flexible in how it approaches its work:

“They know that we’ve got the tripartite mission in clinical, academics and research, and I think that’s something that people really, they just thought we just provide clinical care, but we have a mandate of providing strong educational programs, physicians, nurses, allied health, techs, but we have a strong research mandate as well, and I think that people now have that peaked cap on. You know you just change your peak, whichever one you wear today. Is this my research peak or is it my clinical peak? And I think people truly are thinking about the three areas of focus now more than ever” (VP Interview).

According to all interviewees, the Hospital can be considered dynamic and enterprising - dynamic in the sense that it continuously seems to change and improve itself, never remaining stagnant, and enterprising in the sense that it is much more business focused and oriented towards efficiencies of scale and scope.

“You know any time that you look at a new board, new manager, change of structure and process, and an obligation to be accountable and to measure efficiencies, it sort of drives you to, and from my perspective, to continuous quality improvement. I mean okay now you’ve hit this plateau, well what’s the next plateau, right? And so certainly that’s my own thoughts in the things that I do and the things that affect the organization. So, just that in itself I think drives us” (VP Interview).

“And when you talk about are we enterprising, it’s very interesting. I chaired a meeting last night, where one of the physicians said afterwards, he said, ‘You know, I don’t want to say that we’ve become more business focused, but’ he said, ‘the discussions we’re having now are very different.’ He said, ‘A year ago, or two years ago, we wouldn’t have had these discussions on how we can bring in money so that we can open up another O.R., how we could generate funds to improve patient care.’ He said, ‘You know we wouldn’t even have thought of things like this, or had these discussions.’ He said, ‘It’s very interesting now that it’s very, no it kind of is much more business oriented than it has ever been, but we’re having those discussions because we see the benefits of raising funds, and putting [them] towards improved patient care” (VP Interview).

ORGANIZATIONAL CHARACTERISTICS: DECISION-MAKING

There are numerous structures in place for decision-making. These include multi-disciplinary committees, and committees that encourage membership from all levels of the organization. These committees then have a high degree of autonomy and decision-making authority:

"Our Executive Committee is quit unusual: it is probably 2/3 physicians and 1/3 administration ... our executive decision making body is primarily clinicians as opposed to administration, so the medical staff and the staff that work here have a lot of say because all [of] the chiefs are on the committee” (VP Interview).

“We have Professional Advisory Council meetings, where all of [the] disciplines are represented for them to bring their issues forward. We have a corporate Nursing Clinical

Practice Committee, where there is one nurse from every unit that sits on that committee"... "and all of the issues related to the clinical practices of nurses, not necessarily administration, but their clinical practice [are brought to this committee] ... [T]hey review things, they make those recommendations, and so long as they are within the scope of nursing those recommendations are instituted from that level, [and] that committee doesn't have to go up [to a higher level]" (VP Interview).

A similar study conducted in Australia, which has a similar voluntary accreditation process, found accreditation to have an impact on decision-making by encouraging the formation of such decision-making structures and committees (Duckett 1577).

Other important committees include the Professional Advisory Committee, the Medical Advisory Committee, and the Corporate Operations Committee:

"If it's an issue that's going to affect all three campuses corporately, I might bring it forward to our Corporate Operations Committee that's chaired by our Chief Operating Officer. If he feels it needs to go up to the senior management level, then it will be brought forward for discussion and approval. So I think there's certainly a decision making structure within the organization that, I think, individuals respect, and they bring forward" (VP Interview).

With autonomy and decision-making comes responsibility, which is also diffused throughout all levels of the organization:

"[W]e have a unit-based focus so we have expectations of the level of the unit. The nurses are involved directly in creating some of the quality initiatives. The managers do point prevalent studies; so for pain and falls and for skin, so they are responsible for the corporate ones. I do overall direction things, so I might, with our quality person I am spearheading a whole new piece on safety. So each level of the organization has some degree of responsibility. I would say the managers carry the bulk of it because they make sure the unit based stuff gets done; they organize it and make sure people get off and they hold responsibility for the corporate ones as well. The point-prevalent studies

are big and we repeat them every year to get a big pool of data to show what is happening” (VP Interview).

ORGANIZATIONAL CHARACTERISTICS: LEADERSHIP

The Hospital’s leadership is recognized and well respected throughout the organization:

“Certainly there’s strong leadership from the Board, there’s strong leadership from the CEO and there is strong leadership from the senior management team” (Director Interview).

“I just passed a physician here not so long ago, this afternoon, and he said, ‘The senior team and the whole management structure that we have right now with the people in those positions,’ he said, ‘it’s never been better.’ And here’s a physician that’s been in the hospital for quite some time. He said, ‘the group is very collaborative. They are very focused on the vision. They are very goal driven, and they want to achieve results.’ He said, ‘I’ve never been in an environment that’s been as exciting to be in,’ and I agree completely” (VP Interview).

Leadership also ranks highly in the management questionnaire results. Leadership received the second highest value, 3.95, which means that many respondents believe that senior executives' personal leadership and involvement creates and sustains a clear customer focus and visible quality values.

➤ CHANGES IN LINE WITH ACCREDITATION

The most favourable phase of the accreditation process in which to implement changes according to the majority of the interviewees is the self-assessment phase. The Australian study on accreditation also found that hospitals perceived the “preparatory phase” as the most effective to implement change (Duckett 1574). This does, however, contradict findings by the CCHSA, which also conducted a study on the impact of accreditation (2003):

“Organizations rated the self-assessment component as the least effective aspect of the accreditation program at 80 per cent, while the peer review component was rated the most effective aspect at 93 per cent.”

The results of this study might not see the self-assessment as the most effective part of accreditation, however, it still recognizes that “many opportunities for improvement are identified by the organization ... during the self-assessment process” (CCHSA 2003).

With many of the changes, it is difficult for the Hospital to pinpoint the source of change – whether it was a direct result of the accreditation process, or other factors.

“Those [changes] would have happened anyway as part of our own strategic planning but accreditation really allowed hands to share the burden, you know between sort of the front line” (Focus Group Participant).

“I have to say that for us, too, it was true that what was done would have been done anyways. Everything was either identified or planned, and it was a matter of being able to move them through” (Focus Group Participant).

As one Vice-President interviewed said, it is a bit of a “chicken or the egg” situation – which came first? Did the accreditation process influence the change, or did the change influence the accreditation process?

CHANGES IMPLEMENTED DURING THE SELF-ASSESSMENT PHASE

One interviewed Vice-President expressed the opinion that many possibilities for change discovered during the self-assessment were not implemented since the accreditation team members were probably not sure whether they were able to implement the change:

“You know why, because the people around the table weren’t necessarily, or probably didn’t think that they were in a position to implement a change.”

A comment written on the back of one of the management questionnaires confirms this:

“Re: quality assurance, have the authority to suggest changes ... but do not always have the ability to make repairs.”

This could explain why the degree to which important changes were implemented during self-assessment phase (Questions 1 and 2 of section C “Accreditation Impact” in the Management Questionnaire) only received a score of $\bar{x} = 3.23$ ($\alpha = 0.771$). Communication of what the accreditation team members can and cannot do, what their levels of authority are, could help to improve this.

It is also difficult to attribute changes to the self-assessment phase. It is likely that the teams would not have written about obvious changes while preparing the accreditation team documents:

“[H]ow do I know that? Like if the team is meeting, and they say, ‘okay here’s where I think we can improve,’ and they say, ‘Oh that’s not hard to do, let’s just do that,’ then it wouldn’t have got into the documentation, and nobody would have seen it.” (VP Interview).

1. AT THE INDIVIDUAL PRACTICES LEVEL

Working together in the accreditation teams helped people across the sites learn about practices occurring at other sites, and transfer ideas and processes throughout the organization:

“[A]lthough we had an IT team for the 2000 survey, it was predominantly the people who were working at [first campus]. With this survey, there was more participation from the [second campus]... so it really brought them together as a team, which they really hadn’t been as much. And what it did lead to was a real close look at what each of them were doing, and how they could create, and share and standardize some of their processes. So they want to continue doing that, because they really enjoyed that opportunity ... So they really developed some synergy working together” (Focus Group Participant).

It also helped individual members from the different sites overcome their differences and see themselves as one organization after the merger:

“I actually remember doing the orientation for, I did them all in 2000, and there were some teams that I walked into the room, and you could just feel the tension. Like they were there, they didn’t want to be there, and they didn’t have the time, and they had groups from one campus on one side of the table, and groups from the other, and from the third campus, and there would be a few at the back, and it was just awful. And they were all sitting there like this, and they weren’t going to talk to each other. And it was amazing, by the end of the process, everybody was sitting with everybody else, and this time around ... [n]obody talked about campuses, it was all, you know, [the “Hospital”]. So it was quite dramatic ... I told some of them, I said, “You know when I compare my orientation meeting with you this time compared to last time, it’s just phenomenal. It’s just phenomenal” (Focus Group Participant).

2. AT THE GROUP PRACTICES LEVEL

Accreditation is helping to shift the organization's culture towards a group culture, with many accreditation teams choosing to stay together and continue meeting regularly after accreditation, since they see the benefits of working together:

“I think one of the most important changes is that the group stayed together. And I think that was because of the accreditation ... so that was really key” (Focus Group Participant).

“Surgery never really had program management meetings, which they now got formalized as a result of accreditation” (VP Interview).

Some of these groups even stay together as a new structure, taking on new functions and initiatives, which is in effect a change in a management practice. An example is the HR strategic plan. An accreditation team, with stakeholders from throughout the organization, became the steering committee that would oversee the implementation of the HR strategic plan, since the plan “affects all departments, so it is really those stakeholders that need to be around the table to monitor the implementation and evaluate the strategic plan if it rolls out” (Director Interview).

A similar phenomenon was observed in the Australian study:

“In a number of hospitals there was a flow-on from accreditation meetings in that the key personnel met more frequently even after accreditation had been awarded. Not unexpectedly there were reports of subsequent strengthening of the links between the members of the senior executive” (Duckett 1575).

A recommendation that arose out of the 2000 Accreditation Report was the integration and standardization of clinical practices among the three sites, which was a major undertaking between the 2000 and 2004 accreditation processes. During the latest self-

assessment, the clinical teams had the opportunity to improve and further develop their practices:

“I think in my clinical teams, and in internal medicine, because we have researchers in patient safety, we’ve decided to focus on the outcomes [of one of the researcher’s] last studies, and that was that patients discharged from Internal Medicine, particular groups of patients, are at high risk for developing discharge complications within the first few days. So what we have decided is that we are going to set up an urgent clinic where the same team that looked after the patient on the unit, can see the patient a few days later on the ward, same pair of eyes and can assess the patient for potential complications. So we made the decision after talking about it through the self-assessment and now we are in the process of implementing the clinic. So that’s an example of a clinical change” (Director Interview).

3. AT THE ORGANIZATIONAL LEVEL

Accreditation is perceived to have had major organizational impacts on the Hospital right after its merger, when the organization was still struggling to merge its structures:

“I would say after the last run there [were] more organizational changes just because we were newly merged and we did not have a lot of those structures in place. So, the accreditation process really drove the need to form these corporate teams. So for example, Internal Medicine had a multidisciplinary team at the [first campus] and the [second campus] had one, the Emergency Department had one so those teams then became corporate. I think a lot of it is organization teams were formed back then. Whereas probably through this process we are more fine tuning” (Director Interview).

It was, however, an opportunity to resolve organizational issues:

“[A]n example: the IT Program had a number of issues identified, and then they kept track of them, and as they worked through them ... probably about over 50% of the IT had already [been] done by the time of the survey” (Focus Group Participant).

The use of indicators is a challenge in the health care environment, since it is difficult to develop standardized indicators that can be used for benchmarking between organizations and that are then also easily measurable by staff:

“I think probably the main [change] in my teams was the need to focus on creating particular indicators to monitor. We also decided it is very difficult when it comes to things such as patient safety and patient satisfaction, you could be measuring a thousand things, but what are the three or four most important things that we are going to focus on for the next year. That sort of came out of the accreditation process and the self-assessment.” (Director Interview).

This change was based upon a recommendation in the 2000 Accreditation Report, which stated that the Hospital needs to supplement its corporate indicators with team-specific ones in order to effectively measure the results of its quality improvement activities.

4. AT THE EXTERNAL PARTNERSHIPS LEVEL

The biggest change that resulted from the self-assessment process and the Hospital’s relationship with its external environment was that the Hospital learned the value of patient and community involvement in its teams and decisions, since the process required the placement of patient and community representatives on the accreditation teams.

“[O]ne of the recommendations that we had had during the [leaderships and partnerships] discussion was that some of our partners that are in the community should sit on a regular committee, and meet with us more regularly so we could have some of these open dialogues” (VP Interview).

The Australian study did not find accreditation to improve the hospitals’ role in their respective community (Duckett 1578). However, the study did not mention whether there was community involvement in the preparation phase in Australia.

There is much mention throughout the interviews of the continued use of focus groups for information after the self-assessment:

“The one change that I can talk about is the focus groups. We thought they were valuable” (VP Interview).

“There were some clinical things that were found; we’ve made decisions out of this last round, we’ve decided that we would do the focus groups more regularly because it gave us good information. It is always an opportunity to share among the teams because you can get off on different directions around that, so there are some changes. Because they are already part of the teams, there were a number of clinical changes that happened but I wouldn’t say it was driven by the accreditation, it was just part of the process” (VP Interview).

CHANGES IMPLEMENTED DURING THE SITE VISIT

No changes were identified to have occurred during the CCHSA surveyor’s site visit. It is not necessarily a phase seen as an opportunity to implement major changes:

“If you would have asked me 15 years ago, people would use the visit as an opportunity to lobby for things but that has been gone for about ten years or so ... I think the self-assessment would drive; we wouldn’t wait for a report to tell us what to do. I think in the self-assessment if we found something that was wrong we would fix it right away. The visit is so short that it is just a nice visit, it is a chat really. It’s very nice, it’s not as rigid as it used to be so it has a different flavour to it” (VP Interview).

Although the site visit might not be the best time to implement changes, it can still have a significant impact:

“You know what, I think the time [that] has the biggest impact is the visit ... I see the value in all phases, but I think when the staff have somebody external come in, ask them questions, talk to them about their program, they have the opportunity to, you know, pat

themselves on the back that they're doing a great job in some areas, but also the accreditors give them the feedback on how they could make improvements. That's the team that's been working very well together. I think they take those recommendations very seriously, and I think the fact that it's coming from somebody externally has a significant impact on how they hear that information, and what they're going to do with it" (VP Interview).

CHANGES IMPLEMENTED AS A RESULT OF THE ACCREDITATION REPORT, AND IN PARTICULAR ITS RECOMMENDATIONS

The degree to which recommendations were an opportunity to implement changes (Questions 3 to 5 of Section C the "Accreditation Impact" of the Management Questionnaire) received a score of $\bar{x} = 3.77$ ($\alpha = 0.783$).

1. AT THE INDIVIDUAL PRACTICES LEVEL

The Hospital's 2000 Accreditation Report recommended the development of an ethics committee, which the Hospital established. The 2004 Accreditation Report then recommended the addition of a full-time ethicist:

"The only thing related to this most recent survey is, I think they did say we should have a clinical ethicist, and we just talked yesterday about whether or not we were going to hire one. I think that was a recommendation that did come from the accreditation survey, this past one, and so it will mean probably a new position being developed in the organization. So that will change our structure to some respect. Other than that, I can't think of anything else, to be honest with you" (VP Interview).

2. AT THE GROUP PRACTICES LEVEL

The 2000 Accreditation Report recommended improving the processes related to maintaining the patients' health records, including the progress notes:

“They piloted putting the notes at the patient’s bedside, and so they put some of the, you know the vital signs record, the integrated progress notes right at the patient’s bedside so that people would document as soon as they provided the care. So it was always up to date. So that was something that was recommended and piloted” (VP Interview).

3. AT THE ORGANIZATIONAL LEVEL

The 2000 Accreditation Report recommended the Hospital implement a co-ordinated corporate quality improvement structure to ensure that continuous quality improvement is integrated throughout the entire organization.

Since then, the Hospital has begun to implement a new Quality Improvement framework in 2003 in order to introduce a standardized approach to quality improvement to the Hospital. The goal of this framework is to “ensure that all priorities for QI are well communicated and monitored with relevant indicators of performance” (Leadership and Partnerships Accreditation Team Document). A Quality Council was formed in December 2003 and has since developed a Quality Improvement Plan for 2004/05 (Information Technology Accreditation Team Document).

The Hospital sees the value of the CCHSA accreditation standards and their contribution to quality, and is therefore encouraging all teams, even those not being surveyed in accreditation, to evaluate themselves against the standards:

“For some of the teams, where they weren’t being surveyed, we had them set up some self accreditation. There was a self-assessment tool that we asked them to pull a multidisciplinary team together [for]. Not always did the docs participate, but we picked

out, I think it was about seven key areas, I think, that were AIM standards that we asked them to do a self assessment [with], which they did” (VP Interview).

4. AT THE EXTERNAL PARTNERSHIPS LEVEL

Since no recommendations were made in the 2000 Accreditation Report regarding the Hospital and its external partnerships, other than that the Board should consider the Hospital’s impact on its partners, it is difficult to pinpoint changes at the external partnerships level related to the submission of the 2000 report. It can be said though, that since the Hospital recognized the benefits of having community members present in the decision-making process, and decided to continue to seek community input, the community now influences the Hospital’s changes, thanks to accreditation.

➤ OTHER CHANGES

The most significant major changes that have taken place, which were not a result of accreditation, were the result of the Hospital's merger.

“[T]he merger had to happen first. It was the catalyst. Subsequent to the merger, there were other, later aspects of the merger, the [censored] Hospital, then the rehabilitation centre, and then most recently the cancer centre” (VP Interview).

1. AT THE INDIVIDUAL PRACTICES LEVEL

A positive change from the merger on an individual level is how it affected management's cohesion:

“I think, there is one thing about having your Board and senior management team sort of taken apart by the Ministry. You know, the Ministry steps in to run your show. You sort of band together and I think that has had some positive spin off” (Director Interview).

2. AT THE GROUP PRACTICES LEVEL

The merger helped to create and diffuse one new culture and foster teamwork:

“[E]ach of the predecessor organizations [had] different cultural characteristics, different models of care, how they provide service to their patients and when you move them all together, we had to develop some standards for proceeding. So, I guess the health care professionals at all levels were impacted by those changes” (VP Interview).

Other changes are also taking place at the clinical practices level:

“And the other thing is that the best practices guidelines will be very interesting. We will phone every patient who has acute coronary syndrome and we will ask them whether or not they are on the guidelines. 15% of them shouldn’t be on the guidelines because of contraindications, but if you are not on the guidelines, then it will drop into the system and we will call and say ‘we notice that you are not on Aspirin, is there some reason that you are not on it?’ If they say ‘no’ then we will get them on it. If they say ‘yes’ then it will go into the database that that patient should never be on Aspirin. At the end it will give the ability to make a scorecard that says “of the 4000 patients admitted, 85% are on Aspirin, 25% are on this...” So it’s a nice scorecard. We have to design the questions for that, we haven’t done that yet. That is our next step, our next project” (VP Interview).

3. AT THE ORGANIZATIONAL LEVEL

At an organizational level, there was a lot of integration and consolidation that took place as a result of the merger (and which was facilitated by the accreditation).

“Well I think it’s huge changes resulting from the merger. So including multiple program consolidations, integration of the cancer centre ... Integrating a wide variety of union contracts. Integrating major information systems to support integration. Bed closures, other financial initiatives to balance the budget, and over the last two years or so a new Board and senior management teams setting a new direction” (Director Interview).

These efforts have tied up many resources, making it more difficult to dedicate them to quality improvement:

“The biggest barrier to quality improvement [is] the budget restrictions. Not clear if the funds are being distributed equitably based on needs and mission of each program” (Management Questionnaire Respondent).

4. AT THE EXTERNAL PARTNERSHIPS LEVEL

At the external level, there is the involvement of patient's and families in quality assurance:

“We have the comment card program, so not only do we participate in the Ontario Hospital Satisfaction survey, we have a comment card program so that patients and families can give regular feedback, and we have a patient visit program. So the Vice-Presidents and some of the Directors go on a regular basis and go to wards, we visit with patients and families, we ask them specific questions about their care, what works well” (Director Interview).

There is also the emergency department initiative, which was mentioned in Chapter 4 “Results” and which has as a goal to improve patient flow since patients are now waiting sometimes 13, at times even 33 hours for a bed.

➤ THE ACCREDITATION PROCESS

THE ORGANIZATION'S EXPECTATIONS AND OPINIONS

One of the organization's main motivations for participating in the accreditation process was its usefulness as a merger tool:

"We went through the survey within the first two years of merging and we could have put it off three years, but we ended up using it as a merger tool" (VP Interview).

"Four years ago we were a newly merged organization and you have to realize that the [first campus] and the [second campus] never spoke to each other. So these teams were brought together that were archenemies and arch rivals and expect[ed] to work together, you know, through the accreditation process. However, having said that and having experienced how difficult that was, I think the timing was perfect, that it drove teamwork that may not have happened naturally, and the teams that were in place four years ago, I would think for the most part are still together now" (Director Interview).

When asked whether other forms of evaluation could have had the same effect as the CCHSA's accreditation, one focus group participant responded:

"I don't think so because I mean as I look at [it], there's dozens of different types of certification, accreditation, inspections and stuff like that, but they tend to be very focused on a particular department, or particular service or program. The advantage with the CCHSA is that [it] is across the organization, so you've got to look outside your own department, your own program, and to work across" (Focus Group Participant).

According to an interviewed Vice-President, accreditation also is an opportunity to validate what they are doing, get advice on areas to improve, and to receive an external review. Also, "the process of doing a self assessment ... allows us to compile probably some different perspectives than we normally would have."

“I think that the accreditation standards are set up to identify, rather than to be a problem finder, identify opportunities for improvement” (Focus Group Participant).

“But [the teams] see the advantages of doing it, because from our perspective, it pulls the program teams together. It almost forces them to get together, and review their standards, review their care, review themselves based on those AIM standards, and I think it’s a real good thing for them to do, because they get to see what they’re doing well, and where they need to make some changes, and some opportunities for improvement. Plus they get to hear from the surveyors if there are other ideas and things that are going on, they get that feedback. Right? And they really know for the next couple of years, based on the recommendations that come back, where they should be putting their energy, and working on particular initiatives for [those] next few years.” (VP Interview).

The Hospital also sees the ties between the accreditation process and continuous quality improvement:

“[Accreditation] actually helps people put their head in a different space, even to react to the change of, ‘Okay we identified that we’d rather do this, so what are we doing to do about it? You identified it, team. So now what are we going to do about it?’ So I think it provokes CQI definitely” (VP Interview).

The CCHSA’s study on the impact of accreditation and the power of recommendations also recognizes that accreditation helps the evolution of quality improvement with time. Over a ten-year period, the percentage of organizations in the accreditation process that had adopted a quality improvement approach increased from 49 per cent to 87 per cent (34).

Despite realizing the benefits of participating in the accreditation process, there is still a feeling that it is not truly a voluntary experience, but compulsory:

“I think we’re obligated to enter the accreditation process. It’s not really an option” (VP Interview).

“In a teaching facility, if you are not accredited it threatens your teaching program. So it is not really a choice that you get” (VP Interview).

One of the main complaints about the accreditation process is its tediousness and repetitiveness:

“We start well in advance getting ready for these things. I can tell you that. Oh my God! Everyone sees it as ‘Oh gees, not accreditation again!’ Honestly, that is probably the feeling that everybody gets like ‘Here we go again...’” (VP Interview).

“It is very time consuming, it is labour intensive, so the teams meet and it’s time above and beyond the regular day to day activities” (Director Interview).

“Again it’s a lot of work, you know and having spent hours reading the standards, they seemed to ask the same question[s] [in] different ways” (VP Interview).

Accreditation teams seem to react to repetitiveness by taking shortcuts:

“As a surveyor, I see it, and then you see the same answer, cut and paste here, where it’s somewhere else. Well what’s the point? Let’s ask it once and answer it once, and if it applies to another standard, fine don’t ask it again, but just leave it alone. It’s been done. You know, simplify” (VP Interview).

It would be in the CCHSA’s best interest to try and simplify the process as much as possible:

“[M]y cautions are that you know from a hospital perspective, there’s lots of other places that we have obligations to comply to standards and this is another one. This is voluntary. I ask myself, what if nobody did it? What if all of a sudden one hospital or ten hospitals say ‘You know what, we’re not going to do this any more?’ You know what would happen, a lot would follow ... you know you say ‘Okay I’m paying you money to take something that is voluntary that I’m already doing another way ... but my funder doesn’t necessarily use [accreditation] to give me my money, and my patients

don't necessarily look at [accreditation] to see if they should come here to do their surgery.'" (VP Interview).

Developing the standards so that they are easier to integrate with existing initiatives would also benefit those involved:

"In the longer term it would be great in a way to find how to streamline the tool and integrate it into existing tools we already use, we got the accountability framework, the strategic plan" (Focus Group Participant).

One interviewed Vice-President wouldn't mind seeing the Ministry use accreditation as a part of its current accountability initiatives:

"[Y]ou know I would hope that the results of the accreditation ... I wouldn't mind if it had an impact on how you were funded to be honest with you, because it would show that, it doesn't show our efficiencies per se, but it shows how much we've done, and I think the benefits of going through that and getting an excellent rating. It should have an impact on your finances."

Regarding the actual survey in 2004, one focus group participant felt that the CCHSA surveyors' interviews were like defending a thesis. As for the debriefing at the end of the survey, many focus group participants were wary of it:

"I would actually, I had a funny reaction to that. For one hour ... I thought the debriefing was so ridiculously positive that it made me feel the whole thing was a bit of a...I am just anxious to see what the final recommendations are. I think that we do a good job and I think that we are good at what we do, but there is a million things that we could do better, and I just found that whole one-hour thing was just too much 'you guys are so great blah, blah' I found it meaningless, to be honest" (Focus Group Participants).

"The debriefing was a show..." (Focus Group Participant).

“We are all smart enough to know that we are not that perfect, we have lots of things to do otherwise we wouldn’t be doing the work that we are” (Focus Group Participants).

Although an extremely positive debriefing would seem desirable, the Hospital hopes that it “didn’t spend hours and hours and days and days for [the surveyor] to just say, “Man, you guys are great” (Focus Group Participant).

“Like let’s say you got an accreditation. It’s a four star, it’s perfect. There is no recommendation, a lot of affirmations, maybe a suggestion here or there, because everyone likes to give you at least something to suggest, tweaking here and there. Okay then you’re validating your activities, but you haven’t changed anything. You’re probably not going to change anything, and you’ve invested an awful lot of time to validate, I would think is that value? Especially if that time took you away from maybe some other thing that you could have been doing about something else?” (VP Interview).

There seems to be an incongruence with how respondents value the accreditation process as per interviews and focus groups, and based on the results of the management questionnaire. All of the qualitative data is very positive, the respondents highly value the process. The quantitative data, however, is not as positive. None of the responses to the “Accreditation Impact” section of the Management Questionnaire were overwhelmingly positive. The section measured the value of accreditation from different angles, with all of the values being between 3.23 and 3.86, so on average respondents somewhat, but not fully, agreeing with the aspects measured. Looking at the ranges of the responses, there were those who did not see any value in accreditation. A possible explanation for the extremely positive response in the interviews could be a form of bias, since the interviewees are programmed to promote accreditation to those around them, since they are demanding a lot of time and effort for it. Leadership must believe in the value of accreditation, otherwise it will be unable to motivate the accreditation teams.

Overall, one would hope that accreditation in Canada has the impact on morale as accreditation has been shown to have in Australia (Duckett 1577).

WHETHER ACCREDITATION HELPED THE ORGANIZATION TO BE MORE REACTIVE TO CHANGE

Everyone interviewed believed that accreditation helped the organization to be more reactive to change. One respondent believes that the fostering of teamwork is what makes the Hospital reactive to change:

“I think in order to be reactive to change, you got to be functioning as a team ... teams react to change and [for] individual[s] it is difficult to react to change ... [B]ecause the process supports and promotes teamwork, this also contributes to being able to react to change” (Director Interview).

“Well because it’s an opportunity for teams, for staff, to sit together with, you know, clients, or physicians, or whatever, and ask them questions. So yes, it’s usually more inclined to be receptive to change if you have those people together, and you know certain constituencies are saying there’s issues with this, or issues with that. You’re being responsible.” (VP Interview).

Another respondent believes the aspect that brings about the capacity to react to change is how accreditation forces the organization to reflect upon itself:

“I think that certainly in teaching hospitals, they have so much change going on, that accreditation is no longer a stick to make them change. It is an opportunity for them to sit back and say, ‘what have we done?’ and get organized and make a list of accomplishments and things that they want to do, and that’s probably a valuable process. That is probably the most valuable thing now about the accreditation; sitting down and looking at what you have done and being very clear on what you are going to do in the future, and where the gaps are. And take the time to do it. And it forces you to do it right” (VP Interview).

“I think overall accreditation is a valuable process because it can drive change and it can make an organization look at things that it might not have otherwise” (Director Interview).

Nevertheless, there are still those that resist, and not even accreditation can change that.

“[I]n a teaching hospital there is just so much change that goes on that I think people are change weary, but they don’t resist change for the sake of change. There is that small group of people that, no matter what, accreditation doesn’t make a difference one way or the other. The real resisters, they resist” (VP Interview).

➤ ACCREDITATION AND ORGANIZATIONAL LEARNING

According to the CCHSA's study on the impact of accreditation, organizations view accreditation as being "responsible for facilitating their ability to become learning organizations over time" (2003).

In the literature review, it was theorized that if accreditation is a driver for change, and organizational learning is evidenced by change, then one could conclude that accreditation drives organizational learning.

Accreditation has been shown to have increased the Hospital's capacity for change, then driven change, along with the merger, which was aided by accreditation. Accreditation has also improved communication and collaboration.

"In oncology one of the biggest things, and it wasn't so much that we identified a problem, but it was looking at how... looking at the communication piece and looking at oncology as a whole within the organization so huge, we knew that we didn't know about everything that was happening in oncology, and I think the accreditation helped us to identify what resources were available, or what different areas are doing, and so hopefully that will help to bring people together and improve the collaboration and the working together ... Through the accreditation we found out that surgery wasn't part of the team that did the accreditation, however, a proportion of the patients on which they performed surgery had cancer. So in fact if you really look at cancer, it would be a huge portion of what the hospital does. So how do you define that and how do you improve the communication and the collaboration ... perhaps in the future we will bring in the surgery oncology piece into the rest of the oncology piece" (Focus Group Participants).

Regarding the stimulus-response definition of learning, as Weick argued, the Hospital's merger could be reason for new responses, or routines, since these all had to be recreated. One could, however, disagree and say that it was in fact a form of learning, as the Hospital's teams were discussing existing routines from the different sites and taking the best practices to establish the new routines for the merged Hospital, which is a form of

learning by organizational search. Transformed routines are also seen as evidence of learning by Levitt and March. Accreditation was a major driver in this learning:

“[T]hough there was a lot of chaos in the merger, so support services were difficult and so [were] some of the services that we were used to getting, they stumbled a bit until the merger got going. And there was lots of change, the policy change. When they merged, every time there were two policies on the same thing they were different. So what inevitably happened was you get a third policy which doesn’t match either of them. So for us every time they change a corporate policy, is a change for us, so we were the beneficiary [of] lots of change on the policy side” (VP Interview).

While accreditation might not always initiate change, it can yield the opportunity to pull together aspects of current initiatives already underway, and evaluate those and learn what one is truly doing and what still needs to be done to continue to improve:

“We have two regional evidence-based projects on the go. They wouldn’t get prompted by accreditation. I think what accreditation does, is that it makes you pull all of the evidence-based stuff you’re doing together and make a long list of what it is, and gives you a really good view of how much you are really doing. Because all of us think we’re doing lots of it, but when you get through the guidelines, you got the big laundry list of what you are really doing, so it’s quite illuminating I think” (VP Interview).

DeBurca (2000) stated that a positive attitude towards learning must also be present at the management level. The organization is commitment towards education and training, and has formalized this commitment in its departments, such as the Organizational Learning and Development department. This commitment is also seen in examples such as the one given where managers send their RPNs on a medication course so that they can give medications and thereby function within their full scope of practice. Nevertheless, based on the results of the management questionnaire, this area could be improved upon.

Accreditation is also a means to benchmark oneself, as one is being compared to ones’ peers, since the self-assessment is done against national standards.

Organizations can learn from the surveyors, interviews, debriefing, and the final report. According to one Director, accreditation is a learning experience in terms of standards, and the surveyors also get the opportunity to look for good practices and bring them back to their home organizations (organizational search), or gain contacts to share with their colleagues, which are the main motivators for becoming a CCHSA surveyor.

Overall, we can see that most key values and initiatives are in place for the Hospital to be a Learning Organization. One of the areas still lacking, however, is the organization's culture. Management's perception of the culture and overall staff perception of the culture are not in sync. Staff does not perceive the culture to be of a developmental nature, encouraging risk-taking and innovation, which is vital for the hospital to be a true Learning Organization. This has, however, been improving.

6. DATA QUALITY

The factors determining the quality of our data are validity (construct, internal, and external) and reliability. The psychometric properties of the research design and tools used have already been established in a study conducted by the principal investigator in France (Pomey 2003), upon which this research project is based.

The French translations of Shortell's tools were most recently tested by Andre Paccioni in a research project currently underway at the University of Montreal (2005). The interview and focus group questions were initially written in French by Pomey (2004), then translated by the author of this thesis, a member of the research team that fully understands the questions objectives, and then checked for accuracy by another member of the research team. The fact that the original author of the questions was the one asking them at the Hospital also ensures accuracy of the translations.

One important aspect of a logical nature had to be kept in mind during this case study: Due to the nature of the design, and how this single case study was using tools so that it could be combined with other single case studies to form a multiple-case study, the author risked the research flaw of gathering evidence that does not address the research question of the smaller single-case study. The author is studying a single organization, yet some of the research questions pertain to the Hospital's relationship to other organizations (its external partners). According to Yin (21), research questions that ask about an organization's relationship with another organization, but do not ask the other organization about this relationship, constitute a "logical problem" in the research design. Ideally, to be valid, the author could therefore only answer such questions by also asking the Hospital's external partners about their perception on the change in relationship. In this thesis, however, the author is not researching the relationship itself, but how the Hospital perceives its relationship with external partners and how this perception has changed through accreditation. This "logical problem" that Yin warns us could arise is therefore not an issue in this case study.

➤ VALIDITY OF THE STUDY

Construct validity refers to whether the correct operational measures have been identified for the concepts being studied (Yin 34). Fortunately, construct validity has already for the most part been established since this research design has already been used in a study conducted in France (Pomey 2003). The French study researched the same variables and came to the same results. The tools themselves have also been used in previous studies. The culture questionnaire developed by Quinn was used in the *Western Network Quality Improvement Study*, the *National Study for the Assessment of Implementation and Impact of Clinical Quality Improvement Efforts*, and the *Health Systems Integration Study*. Shortell developed the management questionnaire for use in the *Western Network Quality Improvement Study*, the results of which were later validated in an independent survey - *National Survey of Hospital Quality Improvement* (Shortell 2004), establishing construct validity, since the tools measuring the same variables in different studies, resulted in the same findings.

The use of multiple, structured sources of evidence also increases construct validity. These multiple sources used are interviews, focus groups, questionnaires, and some documentation. The use of multiple sources of evidence to address construct validity is referred to as *data triangulation*. The multiple sources increase validity as they provide multiple measures of the same phenomenon (Yin 99). *Investigator triangulation* is also used, since two investigators visited the Hospital to conduct the interviews and focus groups.

Internal validity refers to the establishment of a “causal relationship, whereby certain conditions are shown to lead to other conditions” (Yin34) and whether the research design has taken into account all factors that cause the hypothesized effects of accreditation, or whether other factors have been overlooked (Yin 36). Internal validity is important, since inferences are being made about the impact of accreditation based on the data collected. This is a challenge with this research project as for some of the

changes indicated, it is unclear whether they are a result of accreditation or of another factor. This will be discussed in Chapter 5 “Analysis and Discussion.”

External validity refers to whether the results of this study can be generalized to other sites that are in the same situation (Yin 34). External validity is being tested by applying the same research design and methodology to the other sites of the overarching research project with an accreditation history to produce the same results and support the project’s hypothesis. The fact that this study is coming to the same conclusions as the previous study conducted in France with many of the same tools, is another indication of external validity.

As a final step to ensure validity of the study, this report will be sent back to the Hospital where it can be ascertained that this report does indeed reflect the Hospital’s perception.

➤ RELIABILITY OF THE STUDY

Reliability refers to whether the results of the study can be repeated with the same research design (Yin 34).

The response rate of questionnaires as well as the number of interviews conducted influence the study's reliability. The response rate for the management questionnaire is adequate. The low response rate of the culture questionnaire leaves room for unrepresentative sampling, also given the fact that more than half of the questionnaires collected (100), were from one of the three sites, and each site still has certain reminiscent cultural elements from before the merger. We do know though that the sample was representative when gender was concerned, since 78.3 per cent of respondents were female 21.7 per cent were male, which coincides with the gender representation of employees throughout all of the Hospital's employees: 78.63 per cent female and 21.37 per cent male. Another measure to ensure reliability is the use of multiple data collection tools to measure the same things, such as leadership visibility, which is measured through the management questionnaires, as well as through the interview grid.

Some of the documentation used, such as the accreditation team documentation provided by the hospital, brings with it a risk of biases, which also affect reliability. The accreditation reports, however, coming from an independent external source (the CCHSA) have a higher degree of reliability.

The fact that the research project's design has already been used in France, could make this research project a test for the design's reliability, as the research team is replicating the study to try and achieve the same results that were achieved in France. Having a second person independently code a few questionnaires into N-Vivo to check whether comparable results were obtained also increases reliability. The fact that other investigators will be reviewing the evidence directly for the multiple case study, without being limited to this written report, will also dramatically increase reliability (Yin 102).

Some final statistical tools used to test the reliability of the quantitative data are Spearman's correlation coefficient and Cronbach's alpha. Their use will be discussed in Chapter 4 "Results."

➤ OBJECTIVITY

The fact that the researchers are in no means attached to the hospital studied helps to reduce researcher bias and ensure a certain degree of objectivity, since the outcomes of the study in no means have any bearing on the researcher.

➤ LIMITATIONS OF THE STUDY AND LESSONS LEARNED

There are several limitations that influence the reliability and validity of our data, and also certain lessons that have been learned for future studies of this design.

BIASES

The main quality issue for the qualitative data is the presence of biases, be it researcher or respondent biases. Although the use of structural interviews and the promise to maintain the interviewees anonymous try to help reduce respondent bias, it is not enough.

The main respondent bias stems from the position of the interviewees. Being senior executives, who are responsible for representing the hospital in the best possible light, they are more likely to try and bring out the positive and minimize the negative when it comes to revealing information. This is “programmed” into their nature, and affects internal validity. The presence of respondent biases was evident when comparing the results from the focus groups to the results of the interviews. The focus group participants were more willing to criticize the organisation than the interview participants from the senior management team were. More bias can arise from the fact that the Quality Coordinator was responsible for selecting the interviewees to participate in the study. The researchers are unaware of the criteria used in selecting these interviewees.

Researcher bias could possibly arise during interpretation of the umbrella research project, since a member of the research team is the CCHSA’s Associate Executive Director, for whom it would be advantageous and important to have results favouring the CCHSA’s accreditation process. The presence of the principal investigators and other researchers that have no ties to the CCHSA helps to minimize this.

LESSONS LEARNED

There are several things that could be done differently if this study were to be repeated to increase quality of the data and results.

The culture questionnaire could be included with the management questionnaire when it is sent out to all managers of the hospital. It would be interesting to see how management perceives the organization's culture. It was seen that there is disjoint in management's perception of the culture and other staff's perception, since interviewee respondents seem to perceive the culture as being one of a strong group nature, although the culture questionnaire shows the opposite, with "group" ranking lowest of all culture types with a mean of 17.54.

Sampling from the cafeteria for the culture questionnaire is not random, and probably not representative (depending on the sample size obtained), since all staff does not go to the cafeteria, or not on the day and time that the questionnaires were distributed. Based on percentages of respondents in occupational areas and percentages of staff in these occupational areas, for example with nursing staff making up 68% of staff, but only 33% of culture questionnaire respondents, we can see that the sample is not fully representative.

There was a mistake made in the distribution of the English and French management questionnaires, where changes were made to one version, yet not to the other, resulting in different versions of the same questionnaire being sent out. Such mistakes can be avoided with more attention to detail in the future.

It would have been of interest to see how many questionnaires were returned empty. It is not a simple matter of saying "This is how many questionnaires we started with, this is how many have been completed" since once questionnaires were returned empty, they were added back into the pile of questionnaires to be distributed again to employees. A questionnaire could have been returned and given to someone else several times, making

it impossible to deduct a number of empty questionnaires based on the total amount and number completed.

There is an assumption missing on three of the “Impact of Accreditation” questions in Part C of the management questionnaires, questions 3 to 5 that deal with changes resulting from the CCHSA’s recommendations. The researcher’s goal was to ascertain whether the self-assessment phase (explored in questions 1 and 2) made more of an impact than the time period following the report, and preceding the next accreditation round’s self-assessment phase. Unfortunately, this was not specified in the questions themselves, they just mentioned the recommendations without specifying which part of the cycle was being explored. For all the respondents knew, the questions were exploring changes made following recommendations possibly right up to the next accreditation survey, so including the following self-assessment phase. Normally, two sample t-tests could have been conducted to confirm that there is a significant difference in management’s perception of the impact of the two phases, however, it cannot be assumed that the respondents understood these questions as they were intended. Conducting such a t-test with the goal of increasing reliability of the responses would in this case actually decrease reliability.

7. CONCLUSION

This case study has been a long and enriching endeavour, with a wealth of information gathered. The study looked at organizational change, its characteristics, and conditions favouring this change, and then it looked at the impact of accreditation on change, quality and safety. It also looked at whether accreditation improved conditions for organizational learning and whether it encouraged a learning culture. Overall, the results are very positive - the CCHSA accreditation process has been found to stimulate change.

The most important driver of change is an organization's culture. One could say it is the foundation on which all change and quality measures are built. The hospital's culture is of a hierarchical nature ($\bar{x} = 36.92$), but with the help of organizational initiatives, strong leadership, and accreditation, it is evolving towards a group culture. The hospital has a high commitment towards information and analysis ($\bar{x} = 4.03$, $\alpha = 0.936$), however, employees do not always perceive themselves as being provided adequate education and training for quality improvement efforts ($\bar{x} = 3.12$, $\alpha = 0.833$). They do perceive themselves as having a say in the organization's management in terms of administrative decisions such as budget, equipment, and human resources, and they are also consulted in the decision-making process ($\bar{x} = 3.79$, $\alpha = 0.839$) and have a degree of autonomy with which to act.

The Hospital is operating in a high-pressure environment, in which everyone has to work hard. Although there is a level of bureaucracy, employees are granted autonomy to work within their scopes of practice. The hospital does have a high commitment to open communication and empowerment. Its senior executives seek participation and involvement from all levels of the organization, holding open forums, open board meetings, and visiting the departments to speak with front-line staff. The hospital is trying to push decision-making to lower levels. Clinical changes originate at the front line, often in clinical teams. The hospital has committed itself to taking a multidisciplinary approach towards patient care. In addition, through accreditation, the hospital has seen the benefits of patient and community involvement in its decision-

making process. The hospital is aware of its strengths and weaknesses and instead of trying to hide these, brings them out into the open to be worked on. It is committed to facilitating changes towards continuous quality improvements. This commitment to quality is now stronger with the newly established Quality Council and its new Quality Improvement Plan for 2004/05. Most of the changes that take place are intentional and relate to the hospital's quality improvement initiatives. There is also a high commitment to changes pertaining to improving efficiency, the main goal of the merger that created the hospital.

The merger, along with subsequent merging and integration of a few more organizations, was the biggest source of change at the hospital, which brought with it a phase of high instability and turmoil. Accreditation has helped the hospital to stabilize, and has helped to pull the organization together and overcome the cultural differences reminiscent of the separate rival organizations that were merged. It now enjoys low vacancy and turnover rates.

The fact that the accreditation process could help the hospital stabilize after its merger was a major benefit that management was able to foresee, which is why it decided to use accreditation as a merger tool, rather than postponing it until it was in a more stable condition. Accreditation has helped bring about change at all levels of the organization, across four dimensions: individual, group, organizational, and external. Individually, accreditation influenced functions and practices, as well as individuals' perception of the organization. At a group level, accreditation brought groups together, which then often stayed in place after accreditation to continue their quality improvement work. At an organization-wide level, accreditation helped to foster a common culture, and influenced the development of standardized policies, procedures, and practices, in addition to pushing the development of a more formal quality framework. At an external level, accreditation positively influenced the hospital's relationship with its environment, in particular the way in which the hospital involves its external partners and community in its decisions. The most favourable phase in which these changes have occurred was the

hospital's self-assessment phase. More changes have probably occurred than the hospital is aware of, since many do not make their way into the accreditation team documents.

There is a high commitment towards organizational learning at the Hospital, despite the lower perception of this reflected in the management questionnaire. Most key values and initiatives are in place for the Hospital to be considered a Learning Organization. These include a capacity for change, the sharing of information and transfer of knowledge within the organization via multidisciplinary teams, and between organizations via the participation in benchmarking exercises, and by means of the accreditation process. The hospital is also trying to create an open culture in which mistakes can be discussed and learned from, and is encouraging risk-taking at the management level. For the Hospital to be a true Learning Organization, however, its culture must shift towards a mix of a group and developmental nature, under the guidance of the CEO and senior management. A stronger commitment towards quality improvement education and training are also still necessary.

8. APPENDICES

➤ APPENDIX A: INTERVIEW QUESTIONS

Interview Questionnaire

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 at the hospital and in this position?

2. Factors of Change / Hospital Characteristics

- 2.1 Did the professionals working at the hospital change much over the past five years? At the management level, clinical services level, support level and others?
- 2.2 Could the hospital 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 hospital'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 health care 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 at the hospital?
- 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 at the hospital who are recognized for their competencies in the area of quality improvement and safety?

3. Accreditation

- 3.1 Why did this hospital enter the accreditation process? What are the hospital's goals?
- 3.2 Did you hesitate before entering the last 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 hospital's accreditation? And the return on investment?
- 3.5 Over the course of the accreditation cycles in which the hospital 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 2004 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 in 2000 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 relate to the organization's practices? If so, please give examples relating to health care services, management, or in other sectors at the hospital.
- Did new functions or jobs appear?
 - Can you give me examples of innovative modes of strategic directions or special changes that were implemented at the hospital? 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 hospital'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 hospital, 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 hospital 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 Were you or the hospital's CEO 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 hospital over the past five years? If yes, which and could you give us some examples?
- 4.18 Where did the most important changes at the hospital 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 hospital and its network in connection with the accreditation

- 5.1 In which manner did the accreditation help the hospital 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 hospital 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 hospital 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 standards? When are you expecting the final report?
- 6.2 How do you characterize the accreditation experience for the hospital? (Advantages / disadvantages)
- 6.3 Do you believe that your hospital'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 B: FOCUS GROUP QUESTIONS

Focus group - Self-Assessment Teams

The questions we ask will refer to your latest accreditation survey of May 2004 and to that of early 2000.

For your 2004 accreditation:

1. Could you tell us how the self-assessment teams were formed? Were they a continuation of the teams from the 2000 accreditation? Are they new teams? Did they originate from quality improvement teams?
2. When you carried out the self-assessment at the hospital, did you discover any problems in the organization?
 - A. If so, which ones?
 - B. Did you take any measures to correct them before the survey?
 - i. If so, please give examples.
 - ii. If not, why not?
3. How would you characterize the changes implemented during the self assessment?
4. How did you use the self-assessment and the recommendations of the 2000 accreditation report to carry out your self-assessment for 2004?
5. When the CCHSA surveyors held their debriefing at the end of their visit, what did they conclude?
 - a. Did you agree with their results?
 - i. If so, why? Give examples
 - ii. If not, why? Give examples
 - b. What kind of award, do you think, will the hospital receive?

We are now going back to the accreditation in 2000:

6. When the final report was sent to the hospital in 2000, did each member of the self-assessment teams receive a copy?
 - a. If so, did management ask you/the self-assessment teams to review the results or to act on them?
 - b. If not, how did you/the self-assessment teams find out about the report?
7. After receiving the report, what did you/the self-assessment teams decide to do? How did you tackle the work on the recommendations or the weaknesses? Please, give us examples of actions.
8. How do you characterize the changes implemented after the release of the report?
 - a. In line with the weaknesses
 - b. In line with the recommendations
9. How do you keep track of the changes?
10. I wish to conclude with a few questions about 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. How did you get to know your organization better?
 - c. How were you able to feel more integrated in to 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.)?
11. What do you think of the survey tools and process used in 2004?

A. QUALITY OF CARE

In this section, you will evaluate your hospital's involvement in the improvement of customers' quality of care. Read the following sentences and circle the appropriate answer (1= strongly disagree, 5= strongly agree). When you answer these questions you must think of your hospital 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. The CEO is a primary driving force behind quality improvement efforts.	1	2	3	4	5	9
3. The senior executives allocate adequate organizational 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 executives 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. Senior executives seek 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	Disagree	Neither disagree nor agree	Agree	Strongly agree	Don't know
12. The hospital collects a wide range of data and information about the quality of care and services.	1	2	3	4	5	9
13. The hospital 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. The hospital continuously tries to improve how it uses data and information on the quality of care and services.	1	2	3	4	5	9
15. The hospital 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. The hospital continuously tries to improve the timeliness of its data on the quality of care and services provided.	1	2	3	4	5	9
17. Hospital employees are 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. The hospital compares its data to data on the quality of care and services at other hospitals.	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. Hospital 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 hospital maintains specific goals to improve quality.	1	2	3	4	5	9
21. The hospital's quality improvement goals are known throughout the organization.	1	2	3	4	5	9
22. Hospital 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. Hospital employees are given education and training in how to identify and act on quality improvement opportunities.	1	2	3	4	5	9
27. Hospital employees are given education and training in statistical and other quantitative methods that support quality improvement.	1	2	3	4	5	9
28. Hospital employees are given the needed education and training to improve job skills and performance.	1	2	3	4	5	9
29. Hospital 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. Hospital employees have the authority to correct problems in their area when quality standards are not being met.	1	2	3	4	5	9
32. Hospital employees are supported when they take necessary risks to improve quality.	1	2	3	4	5	9
33. The hospital 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 hospital 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 hospital provides.	1	2	3	4	5	9
36. Data from suppliers are used when developing the hospital's plan to improve quality.	1	2	3	4	5	9
37. The hospital has effective policies to support improving the quality of care and services.	1	2	3	4	5	9
38. The hospital works closely with suppliers to improve the quality of their products and services.	1	2	3	4	5	9
39. The hospital tries to design quality into new services as they are being developed.	1	2	3	4	5	9
40. The services that the hospital provides are thoroughly tested for quality before they are implemented.	1	2	3	4	5	9
41. The hospital views quality assurance as a continuing search for ways to improve.	1	2	3	4	5	9
42. The hospital 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 hospital has shown steady, measurable improvements in the quality of customer satisfaction	1	2	3	4	5	9
44. Over the past few years, the hospital 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 hospital 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 hospital 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 hospital 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 hospital does a good job of assessing current patient needs and expectations.	1	2	3	4	5	9
49. The hospital does a good job of assessing future patient needs and expectations.	1	2	3	4	5	9
50. Hospital 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 hospital uses data from patients to improve services.	1	2	3	4	5	9
53. Data on patient satisfaction are widely communicated to hospital staff.	1	2	3	4	5	9
54. The hospital does a good job of assessing physician satisfaction with hospital services.	1	2	3	4	5	9
55. The hospital uses data on customer expectations and/or satisfaction when designing new services.	1	2	3	4	5	9
56. The hospital 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 HOSPITAL MANAGEMENT

The goal of this section is to examine the degree of participation of the hospital'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 hospital's management?	1	2	3	4	5
	None				Very high
4. How would you rate the level of participation of professionals in the hospital'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 change dynamics at your hospital. 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 hospital.	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 your hospital 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 at the hospital.	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 at the hospital.	1	2	3	4	5	9
8. Accreditation enables the hospital to better use its internal resources.	1	2	3	4	5	9
9. Accreditation enables the hospital to better respond to the populations needs.	1	2	3	4	5	9
10. Accreditation enables the hospital to better respond to its partners (other hospitals, diverse organizations, private clinics, etc.)	1	2	3	4	5	9
11. Accreditation contributes to the development collaboration with partners in the health care system (other hospitals diverse organizations, etc.)	1	2	3	4	5	9
12. Accreditation is a valuable tool for the hospital to implement changes.	1	2	3	4	5	9
13. The hospital'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. What is your working status at this hospital?

Full time Occasional part time

Regular part time

4. How long have you worked for or been associated with this hospital?

/ ____ / years / ____ / months

5. Which of the following areas are you primarily associated with?

Medicine Surgery

Gynaecology Obstetric Clinical support departement
(laboratory, pharmacy, radiology, ...)

Other: Specify

6. What is your occupation?

Physician / ___ / Nurse / ___ /

Physiotherapist / ___ /

Other: / ___ / Specify:

7. Are you a member of the hospital-wide quality assurance or quality improvement steering council (or equivalent body)?

Yes No

8. Have you been involved in the last accreditation process?

Yes No

Thank you for your collaboration

Feel free to write comments on the back of this sheet

D. RENSEIGNEMENTS GÉNÉRAUX

1. Quel est votre sexe ?

Féminin

Masculin

2. Dans quelle catégorie d'âge vous situez-vous ?

Moins de 30 ans

/__/_/

Entre 30 et 45 ans

/__/_/

Entre 46 et 55 ans

/__/_/

Plus de 55 ans

/__/_/

3. Depuis combien de temps travaillez-vous au sein de l'organisation ?

/__/_/ années /__/_/ mois

5. Avez-vous une formation clinique?

Oui /__/_/

Non /__/_/

6. Quelle est votre occupation ?

Médecin

/__/_/

Infirmière/Infirmier /__/_/

Autres professionnels de santé

/__/_/

Spécifiez :

7. Vous avez été membre d'une équipe d'autoévaluation qui a participé au remplissage du manuel d'agrément.

Oui /__/_/

Non /__/_/

Êtes-vous membre d'une commission ayant un mandat dans le domaine de la qualité pour l'établissement (ou d'une commission équivalente)?

Oui /__/_/

Non /__/_/

8. Quel est votre niveau d'implication dans la procédure d'agrément sur une échelle de 1 à 10?

10



Merci de votre collaboration !

Si vous souhaitez faire des commentaires,
utilisez l'endos de ce questionnaire.

A. HOSPITAL CULTURE (Please distribute 100 points)	B. GENERAL INFORMATION
<p>a. This Hospital is a very personal place. It is a lot like an extended family. People seem to share a lot of themselves. Points for A</p> <p>b. This Hospital is a very dynamic and entrepreneurial place. People are willing to stick their necks out and take risks. Points for B</p> <p>c. It is a very formalized and structured place. Bureaucratic procedures generally govern what people do. Points for C</p> <p>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</p>	<p>1. What is your gender? Female <input type="checkbox"/> Male <input type="checkbox"/></p> <p>2. What is your age? Below 30 years <input type="checkbox"/> Between 30 to 45 years <input type="checkbox"/> Between 46 to 55 years <input type="checkbox"/> Over 55 years <input type="checkbox"/></p> <p>3. Are you in a management position? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>4. How long have you worked for or been associated with this hospital? ____ / year(s) / ____ / month(s)</p>
<p>(Please distribute 100 points)</p> <p>a. The glue that holds the Hospital together is loyalty and tradition. Commitment to this hospital runs high. Points for A</p> <p>b. The glue that holds the Hospital together is commitment to innovation and development. There is an emphasis on being first. Points for B</p> <p>c. The glue that holds the Hospital together is formal rules and policies. Maintaining a smooth running operation is important here. Points for C</p> <p>d. The glue that holds the Hospital together is the emphasis on tasks and goal accomplishment. A production orientation is commonly shared. Points for D</p>	<p>5. Which of the following areas are you primarily associated with? Medical Doctor <input type="checkbox"/> Nurse <input type="checkbox"/> Allied Health Professional <input type="checkbox"/> Support <input type="checkbox"/> Administration <input type="checkbox"/> Volunteers <input type="checkbox"/> Other (please specify): <input type="checkbox"/></p>
<p>(Please distribute 100 points)</p> <p>a. Managers are warm and caring. They seek to develop employees' full potential and act as their mentors or guides. Points for A</p> <p>b. Managers are risk-takers. They encourage employees to take risks and be innovative. Points for B</p> <p>c. Managers are rule-enforcers. They expect employees to follow established rules, policies, and procedures. Points for C</p> <p>d. Managers are coordinators and coaches. They help employees meet the hospital's goals and objectives. Points for D</p>	<p>Thank you for your collaboration!</p>

➤ APPENDIX E: SPSS OUTPUT

Management Questionnaire

Summary Statistics

		lead Leadership	info Information and Analysis	planning Strategic Planning of Quality	util Utilisation of Human Resources	qualmgmt Quality Managem ent	results Quality Results	satis Client Satisfactio n	particip Professionn al participatio n	impact Accreditati on impact (c3 out)
N	Valid	49	50	49	51	47	49	49	51	49
	Missing	2	1	2	0	4	2	2	0	2
Mean		3,9501	4,0286	3,3554	3,1562	3,6212	3,6520	3,7391	3,7864	3,7409
Std. Error of Mean		,07917	,09948	,08051	,09224	,07466	,08682	,06687	,09531	,11316
Median		3,9091	4,0000	3,4286	3,2500	3,6667	3,8000	3,7778	3,7500	3,7500
Mode		3,91(a)	4,00	3,43	3,00(a)	3,78	4,00	4,00	3,75(a)	3,58
Std. Deviation		,55418	,70342	,56360	,65871	,51184	,60776	,46812	,68066	,79210
Variance		,307	,495	,318	,434	,262	,369	,219	,463	,627
Skewness		-,569	-1,655	-,547	-,426	-,174	-,480	-,098	-,384	-,236
Std. Error of Skewness		,340	,337	,340	,333	,347	,340	,340	,333	,340
Kurtosis		1,257	5,944	1,720	,285	1,462	-,238	,368	,267	-,721
Std. Error of Kurtosis		,668	,662	,668	,656	,681	,668	,668	,656	,668
Range		2,80	4,00	3,06	3,13	2,83	2,47	2,33	3,25	3,08
Minimum		2,20	1,00	1,80	1,50	2,17	2,33	2,67	1,75	1,92
Maximum		5,00	5,00	4,86	4,63	5,00	4,80	5,00	5,00	5,00
Sum		193,56	201,43	164,41	160,97	170,20	178,95	183,21	193,10	183,30

a Multiple modes exist. The smallest value is shown

Means

		lead Leadership	info Information and Analysis	planning Strategic Planning of Quality	util Utilisation of Human Resources	qualmgmt Quality Managem ent	results Quality Results	satis Client Satisfactio n	particip Professionn al participatio n	impact Accreditatio n impact (c3 out)
1 <= 45 years	Mean	3,9480	4,0971	3,3202	3,0746	3,5459	3,6787	3,7636	3,7542	3,5545
	Minimum	2,82	2,71	1,86	1,50	2,17	2,33	2,67	2,67	2,33
	Maximum	5,00	5,00	4,29	4,13	4,14	4,40	4,56	5,00	5,00
	Std. Deviation	,46440	,59436	,59124	,58615	,49208	,55568	,44663	,60989	,77960
2 > 45 years	Mean	3,8860	3,9130	3,3795	3,2177	3,6806	3,5629	3,6944	3,8411	3,9062
	Minimum	2,20	1,00	1,80	1,80	2,56	2,33	2,78	1,75	1,92
	Maximum	4,91	5,00	4,86	4,63	5,00	4,80	5,00	5,00	5,00
	Std. Deviation	,62872	,80897	,56531	,74164	,55079	,65852	,50829	,75113	,77737
Total	Mean	3,9190	4,0089	3,3492	3,1447	3,6118	3,6245	3,7312	3,7968	3,7230
	Minimum	2,20	1,00	1,80	1,50	2,17	2,33	2,67	1,75	1,92
	Maximum	5,00	5,00	4,86	4,63	5,00	4,80	5,00	5,00	5,00
	Std. Deviation	,54218	,70382	,57316	,86375	,52009	,60207	,47248	,67694	,79041
	N	47	48	47	49	45	47	47	49	48

d4monthr Years with Organizati on		lead Leadersh ip	info Informat ion and Analysis	plannin g Strateg ic Plannin g of Quality	util Utilisati on of Human Resourc es	qualmgm t Quality Managem ent	qresult s Qualit y Results	satis Client Satisfacti on	particip Professio nmal participat ion	impact Accredita tion impact (c3 out)
1 <= 10 years	Mean	3,8021	3,9255	3,2123	2,8971	3,4392	3,5379	3,5999	3,6920	3,5841
	Minimum	2,20	2,71	1,86	1,50	2,17	2,33	2,67	2,67	1,92
	Maximum	4,55	5,00	4,14	3,75	4,14	4,40	4,38	5,00	5,00
	Std. Deviation N	,56915 22	,53430 23	,52335 22	,55567 23	,52213 21	,62524 22	,44409 23	,60106 23	,82099 23
2 > 10 years	Mean	4,0400	4,1257	3,4640	3,3349	3,7627	3,7247	3,8553	3,8293	3,8515
	Minimum	3,18	1,00	1,80	1,60	3,00	2,33	2,88	1,75	2,58
	Maximum	5,00	5,00	4,86	4,63	5,00	4,80	5,00	5,00	5,00
	Std. Deviation N	,53018 25	,85348 25	,59916 25	,68288 26	,47899 24	,60757 25	,47417 24	,75902 26	,75574 25
Total	Mean	3,9286	4,0298	3,3462	3,1294	3,6118	3,6372	3,7303	3,7649	3,7234
	Minimum	2,20	1,00	1,80	1,50	2,17	2,33	2,67	1,75	1,92
	Maximum	5,00	5,00	4,86	4,63	5,00	4,80	5,00	5,00	5,00
	Std. Deviation N	,55582 47	,71820 48	,57311 47	,65813 49	,52009 45	,61639 47	,47265 47	,68588 49	,79080 48

d6occupy r Occupati on		lead Leader ship	info Informat ion and Analysis	plannin g Strateg ic Plannin g of Qualit y	util Utilisati on of Human Resourc es	qualmgm t Quality Managem ent	qresu lts Qualit y Resu lts	satis Client Satisfac tion	particip Profess ionnal particip ation	impact Accredita tion impact (c3 out)
2 Nurse	Mean	4,0756	4,1579	3,5113	3,4079	3,6398	3,7018	3,6944	3,8684	4,0383
	Minimum	3,00	3,00	3,14	2,50	3,00	2,33	2,88	2,81	2,75
	Maximum	5,00	5,00	4,29	4,00	4,14	4,60	4,56	4,75	5,00
	Std. Deviation N	,56093 19	,62795 19	,32056 19	,41842 19	,39957 19	,60221 19	,42462 19	,60341 19	,63879 19
4 Other	Mean	3,8091	3,9365	3,2275	2,9631	3,5873	3,5784	3,7486	3,7202	3,5078
	Minimum	2,20	1,00	1,80	1,50	2,17	2,33	2,67	1,75	1,92
	Maximum	4,91	5,00	4,86	4,63	5,00	4,80	5,00	5,00	5,00
	Std. Deviation N	,53931 27	,79868 27	,70171 26	,74832 28	,62409 24	,63988 27	,52615 26	,74050 28	,85233 27
Total	Mean	3,9192	4,0280	3,3473	3,1429	3,6105	3,6293	3,7258	3,7801	3,7269
	Minimum	2,20	1,00	1,80	1,50	2,17	2,33	2,67	1,75	1,92
	Maximum	5,00	5,00	4,86	4,63	5,00	4,80	5,00	5,00	5,00
	Std. Deviation N	,55813 46	,73378 46	,58473 45	,66774 47	,53143 43	,62080 46	,48144 45	,68537 47	,80790 46

Area in Organization		Lead Leadership	Information and Analysis	Planning Strategic Planning of Quality	Utilization of Human Resources	Management Quality Management	Quality Results	Client Satisfaction	Professional Participation	Accreditation Impact (c3 out)
1 Medicine	Mean	3,9318	4,0000	3,6429	3,1563	3,5417	3,3833	3,6042	3,6406	3,9527
	Minimum	3,55	3,00	3,29	2,75	3,22	2,33	2,88	3,06	3,00
	Maximum	4,55	4,86	4,29	3,50	3,83	4,20	4,22	4,44	4,83
	Std. Deviation	,42882	,81650	,47380	,34422	,25000	,87496	,58096	,58935	,77939
2 Surgery	N	4	4	4	4	4	4	4	4	4
	Mean	4,0545	3,8286	3,3143	3,5500	3,7222	3,8000	3,8444	3,8750	3,6406
	Minimum	3,91	3,00	2,43	3,25	3,17	3,40	3,11	3,06	2,67
	Maximum	4,36	4,14	3,86	4,00	4,00	4,00	4,22	4,44	4,73
3 GYNOB	Std. Deviation	,17721	,46730	,56605	,28777	,34247	,28284	,42745	,54665	,84840
	N	5	5	5	5	5	5	5	5	5
	Mean	4,1455	4,3265	3,4490	3,3571	3,5258	3,8857	3,6409	3,6786	3,7262
	Minimum	2,20	3,57	3,14	1,88	2,56	2,40	2,78	2,81	1,92
4 Clinical Support	Maximum	5,00	5,00	4,14	4,00	4,13	4,60	4,56	4,50	5,00
	Std. Deviation	,96860	,65317	,33430	,74452	,62979	,74706	,59891	,73901	1,08776
	N	7	7	7	7	7	7	7	7	7
	Mean	3,9818	3,7714	3,6476	3,2250	3,8356	3,8167	3,9556	3,8000	3,7667
5 Other	Minimum	3,73	3,14	3,29	2,38	3,40	3,00	3,33	2,88	2,67
	Maximum	4,27	4,00	4,14	4,13	4,78	4,75	4,44	5,00	5,00
	Std. Deviation	,19709	,37253	,37131	,73633	,54492	,69262	,39752	,78237	,88074
	N	5	5	5	5	5	5	5	5	5
Total	Mean	3,8413	4,0212	3,1991	2,9293	3,5764	3,5359	3,6915	3,7932	3,6867
	Minimum	2,82	1,00	1,80	1,50	2,17	2,33	2,67	1,75	2,33
	Maximum	4,91	5,00	4,86	4,63	5,00	4,80	5,00	5,00	5,00
	Std. Deviation	,53916	,80394	,63445	,65249	,57717	,57123	,45298	,74372	,72604
Total	N	26	27	26	27	23	26	26	27	27
	Mean	3,9319	4,0179	3,3340	3,1061	3,6112	3,6330	3,7209	3,7730	3,7182
	Minimum	2,20	1,00	1,80	1,50	2,17	2,33	2,67	1,75	1,92
	Maximum	5,00	5,00	4,86	4,63	5,00	4,80	5,00	5,00	5,00
Total	Std. Deviation	,55852	,71375	,56494	,64581	,52749	,61311	,46930	,69256	,78413
	N	47	48	47	48	44	47	47	48	48

d7member Member of Quality Body		lead Leaders hip	info Informat ion and Analysis	plannin g Strateg ic Plannin g of Quality	util Utilisatio n of Human Resource s	qualmgn t Quality Manage ment	qresult s Qualit y Result s	satis Client Satisfact ion	particip Professi onal participat ion	impact Accredita tion impact (c3 out)
1 Yes	Mean	3,9205	4,1161	3,4792	3,1618	3,7247	3,6927	3,8585	3,8235	3,8843
	Minimum	2,82	2,71	1,86	1,88	2,78	2,33	2,88	2,81	2,33
	Maximum	5,00	5,00	4,86	4,63	5,00	4,80	5,00	5,00	5,00
	Std. Deviation N	,62446 16	,68852 16	,66268 16	,69424 17	,59162 16	,73346 16	,54443 16	,69113 17	,77608 16
2 No	Mean	3,9397	4,0000	3,2401	3,0947	3,5840	3,6022	3,6640	3,7326	3,6596
	Minimum	2,20	1,00	1,80	1,50	2,17	2,33	2,67	1,75	1,92
	Maximum	4,91	5,00	4,00	4,13	4,14	4,60	4,38	4,75	5,00
	Std. Deviation N	,54344 30	,76057 30	,50899 29	,65975 30	,49267 27	,56126 30	,41252 29	,72005 30	,83895 30
Total	Mean	3,9330	4,0404	3,3251	3,1189	3,6363	3,6337	3,7332	3,7655	3,7378
	Minimum	2,20	1,00	1,80	1,50	2,17	2,33	2,67	1,75	1,92
	Maximum	5,00	5,00	4,86	4,63	5,00	4,80	5,00	5,00	5,00
	Std. Deviation N	,56603 46	,73071 46	,57268 45	,66567 47	,52915 43	,61986 46	,46712 45	,70353 47	,81612 46

d8Involved Involved in last Accreditati on		lead Leader ship	info Informat ion and Analysi s	plannin g Strateg ic Plannin g of Qualit y	util Utilisatio n of Human Resource es	qualmgn t Quality Manage ment	qresult s Qualit y Result s	satis Client Satisfact ion	particip Professi onal participa tion	impact Accredit ation impact (c3 out)
1 Yes	Mean	3,9883	4,1639	3,3974	3,2426	3,6593	3,6740	3,7992	3,8804	3,8514
	Minimum	2,20	2,71	1,86	1,88	2,17	2,33	2,78	2,81	1,92
	Maximum	5,00	5,00	4,86	4,63	5,00	4,80	5,00	5,00	5,00
	Std. Deviation N	,59256 34	,55844 34	,54377 33	,60930 35	,56594 32	,63489 34	,44118 34	,65469 35	,77632 34
2 No	Mean	3,7937	3,7143	3,2044	2,8346	3,5684	3,5718	3,5683	3,4551	3,4672
	Minimum	2,82	1,00	1,80	1,50	2,89	2,33	2,67	1,75	2,33
	Maximum	4,36	5,00	4,14	4,13	4,14	4,20	4,38	4,50	4,83
	Std. Deviation N	,45449 13	,99317 13	,66305 13	,74011 13	,40060 12	,59190 13	,50222 12	,73489 13	,85700 13
Total	Mean	3,9345	4,0395	3,3429	3,1321	3,6345	3,6457	3,7390	3,7652	3,7451
	Minimum	2,20	1,00	1,80	1,50	2,17	2,33	2,67	1,75	1,92
	Maximum	5,00	5,00	4,86	4,63	5,00	4,80	5,00	5,00	5,00
	Std. Deviation N	,55993 47	,72275 47	,57898 46	,66482 48	,52310 44	,61863 47	,46358 46	,69601 48	,80877 47

d1gender Gender		impac1_2 Accreditation impact (Quest 1 et 2)	impac3a5 Accreditation impact (Quest 3 à 5)	impac6a8 Accreditation impact (Quest 6 à 8)	impac9a11 Accreditation impact (Quest 9 à 11)	impac12_13 Accreditation impact (Quest 12 et 13)
1 Female	Mean	3,2083	3,8208	3,8792	3,7949	3,9125
	Minimum	1,00	1,00	1,67	2,33	2,00
	Maximum	5,00	5,00	5,00	5,00	5,00
	Std. Deviation	1,16113	,87656	,92603	,83286	,83118
	N	36	40	40	39	40
2 Male	Mean	3,1250	3,4583	3,6250	3,2917	3,2500
	Minimum	2,50	2,00	2,00	1,67	1,50
	Maximum	5,00	5,00	5,00	5,00	5,00
	Std. Deviation	,91613	,95846	1,13302	1,29023	1,41421
	N	8	8	8	8	8
Total	Mean	3,1932	3,7604	3,8368	3,7092	3,8021
	Minimum	1,00	1,00	1,67	1,67	1,50
	Maximum	5,00	5,00	5,00	5,00	5,00
	Std. Deviation	1,11134	,89052	,95495	,92892	,96613
	N	44	48	48	47	48

d2ager Âge		impac1_2 Accreditation impact (Quest 1 et 2)	impac3a5 Accreditation impact (Quest 3 à 5)	impac6a8 Accreditation impact (Quest 6 à 8)	impac9a11 Accreditation impact (Quest 9 à 11)	impac12_13 Accreditation impact (Quest 12 et 13)
1 <= 45 years	Mean	3,1458	3,6800	3,5933	3,5733	3,5800
	Minimum	1,00	2,33	1,67	2,00	2,00
	Maximum	5,00	5,00	5,00	5,00	5,00
	Std. Deviation	1,08827	,74833	1,04757	,90533	1,03763
	N	24	25	25	25	25
2 > 45 years	Mean	3,3333	3,8768	4,1014	3,8636	4,0435
	Minimum	1,00	1,00	2,00	1,67	1,50
	Maximum	5,00	5,00	5,00	5,00	5,00
	Std. Deviation	1,19722	1,03745	,78131	,95207	,83819
	N	21	23	23	22	23
Total	Mean	3,2333	3,7743	3,8368	3,7092	3,8021
	Minimum	1,00	1,00	1,67	1,67	1,50
	Maximum	5,00	5,00	5,00	5,00	5,00
	Std. Deviation	1,13117	,89422	,95495	,92892	,96613
	N	45	48	48	47	48

d4monthr Years with Organization		impac1_2 Accreditation impact (Quest 1 et 2)	impac3a5 Accreditation impact (Quest 3 à 5)	impac6a8 Accreditation impact (Quest 6 à 8)	impac9a11 Accreditation impact (Quest 9 à 11)	impac12_13 Accreditation impact (Quest 12 et 13)
1 <= 10 years	Mean	3,0217	3,7319	3,7029	3,5362	3,6739
	Minimum	1,00	2,00	2,00	1,67	1,50
	Maximum	5,00	5,00	5,00	5,00	5,00
	Std. Deviation	1,22917	,84498	,94275	,90865	,99554
	N	23	23	23	23	23
2 > 10 years	Mean	3,4286	3,8000	3,9600	3,8750	3,9200
	Minimum	1,00	1,00	1,67	2,33	2,00
	Maximum	5,00	5,00	5,00	5,00	5,00
	Std. Deviation	1,01594	,95258	,96858	,93670	,94296
	N	21	25	25	24	25
Total	Mean	3,2159	3,7674	3,8368	3,7092	3,8021
	Minimum	1,00	1,00	1,67	1,67	1,50
	Maximum	5,00	5,00	5,00	5,00	5,00
	Std. Deviation	1,13812	,89373	,95495	,92892	,96613
	N	44	48	48	47	48

d6occupyr Occupation		impac1_2 Accreditation impact (Quest 1 et 2)	impac3a5 Accreditation impact (Quest 3 à 5)	impac6a8 Accreditation impact (Quest 6 à 8)	impac9a11 Accreditation impact (Quest 9 à 11)	impac12_13 Accreditation impact (Quest 12 et 13)
2 Nurse	Mean	3,3667	4,0263	4,2281	4,0175	4,1316
	Minimum	2,00	2,00	2,00	2,33	2,00
	Maximum	5,00	5,00	5,00	5,00	5,00
	Std. Deviation	,85496	,74590	,81689	,93936	,79656
	N	15	19	19	19	19
4 Other	Mean	3,2222	3,5556	3,5617	3,5000	3,5741
	Minimum	1,00	1,00	1,67	1,67	1,50
	Maximum	5,00	5,00	5,00	5,00	5,00
	Std. Deviation	1,24293	,97402	,99695	,90062	1,05342
	N	27	27	27	26	27
Total	Mean	3,2738	3,7500	3,8370	3,7185	3,8043
	Minimum	1,00	1,00	1,67	1,67	1,50
	Maximum	5,00	5,00	5,00	5,00	5,00
	Std. Deviation	1,11093	,90863	,97531	,94269	,98589
	N	42	46	46	45	46

d5area Area in Organization		impac1_2 Accreditatio n impact (Quest 1 et 2)	impac3a5 Accreditatio n impact (Quest 3 à 5)	impac6a8 Accreditatio n impact (Quest 6 à 8)	impac9a11 Accreditatio n impact (Quest 9 à 11)	impac12_13 Accreditatio n impact (Quest 12 et 13)
1 Medicine	Mean	3,0000	4,0833	4,0833	4,0833	4,0000
	Minimum	2,00	3,33	3,33	2,33	3,00
	Maximum	4,00	5,00	5,00	5,00	5,00
	Std. Deviation	,91287	,68718	,73912	1,25831	,81650
	N	4	4	4	4	4
2 Surgery	Mean	3,3750	3,5667	3,8000	3,6667	3,6000
	Minimum	3,00	2,00	2,00	2,67	2,00
	Maximum	4,00	4,50	5,00	5,00	5,00
	Std. Deviation	,47871	,96896	1,12052	1,00000	1,08397
	N	4	5	5	5	5
3 GYNOB	Mean	3,6000	3,6667	3,7619	3,6667	3,7143
	Minimum	2,50	2,00	2,00	1,67	1,50
	Maximum	5,00	5,00	5,00	5,00	5,00
	Std. Deviation	,96177	,94281	1,35693	1,38778	1,46791
	N	5	7	7	7	7
4 Clinical Support	Mean	3,6000	3,8667	3,9333	3,6000	3,8000
	Minimum	2,50	3,33	2,67	2,00	2,00
	Maximum	5,00	5,00	5,00	5,00	5,00
	Std. Deviation	1,08397	,69121	,86281	1,14018	1,09545
	N	5	5	5	5	5
5 Other	Mean	3,0385	3,7531	3,8086	3,6923	3,8333
	Minimum	1,00	1,00	1,67	2,33	2,00
	Maximum	5,00	5,00	5,00	5,00	5,00
	Std. Deviation	1,24838	,96340	,91603	,73589	,85485
	N	26	27	27	26	27
Total	Mean	3,1932	3,7604	3,8368	3,7092	3,8021
	Minimum	1,00	1,00	1,67	1,67	1,50
	Maximum	5,00	5,00	5,00	5,00	5,00
	Std. Deviation	1,11134	,89052	,95495	,92892	,96613
	N	44	48	48	47	48

d7member Member of Quality Body		impac1_2 Accreditatio n impact (Quest 1 et 2)	impac3a5 Accreditatio n impact (Quest 3 à 5)	impac6a8 Accreditatio n impact (Quest 6 à 8)	impac9a11 Accreditatio n impact (Quest 9 à 11)	impac12_13 Accreditatio n impact (Quest 12 et 13)
1 Yes	Mean	3,2000	3,8542	4,0625	3,8750	4,0313
	Minimum	1,50	1,00	2,00	2,00	2,00
	Maximum	5,00	5,00	5,00	5,00	5,00
	Std. Deviation	1,17716	1,08845	,87955	,96513	,84595
	N	15	16	16	16	16
2 No	Mean	3,2778	3,7056	3,7500	3,6667	3,7167
	Minimum	1,00	2,00	1,67	1,67	1,50
	Maximum	5,00	5,00	5,00	5,00	5,00
	Std. Deviation	1,08604	,81847	1,03460	,96773	1,07225
	N	27	30	30	29	30
Total	Mean	3,2500	3,7572	3,8587	3,7407	3,8261
	Minimum	1,00	1,00	1,67	1,67	1,50
	Maximum	5,00	5,00	5,00	5,00	5,00
	Std. Deviation	1,10569	,91200	,98505	,96108	1,00121
	N	42	46	46	45	46

d8involved Involved in last Accreditation		impac1_2 Accreditatio n impact (Quest 1 et 2)	impac3a5 Accreditatio n impact (Quest 3 à 5)	impac6a8 Accreditatio n impact (Quest 6 à 8)	impac9a11 Accreditatio n impact (Quest 9 à 11)	impac12_13 Accreditatio n impact (Quest 12 et 13)
1 Yes	Mean	3,5161	3,8922	3,9118	3,7843	3,8824
	Minimum	1,00	1,00	1,67	1,67	1,50
	Maximum	5,00	5,00	5,00	5,00	5,00
	Std. Deviation	,97881	,89789	,97203	,94951	1,00799
	N	31	34	34	34	34
2 No	Mean	2,6250	3,4231	3,7564	3,6389	3,6923
	Minimum	1,00	2,00	2,00	2,00	2,00
	Maximum	5,00	4,67	5,00	5,00	5,00
	Std. Deviation	1,17018	,85693	1,01975	,98942	,96907
	N	12	13	13	12	13
Total	Mean	3,2674	3,7624	3,8688	3,7464	3,8298
	Minimum	1,00	1,00	1,67	1,67	1,50
	Maximum	5,00	5,00	5,00	5,00	5,00
	Std. Deviation	1,09842	,90272	,97674	,95111	,99059
	N	43	47	47	46	47

T-Test by Gender

Group Statistics

	d1gender Gender	N	Mean	Std. Deviation	Std. Error Mean
lead Leadership	1 Female	39	3,9270	,49224	,07882
	2 Male	8	3,9558	,85660	,30285
info Information and Analysis	1 Female	40	4,0071	,74474	,11775
	2 Male	8	4,0714	,57143	,20203
planning Strategic Planning of Quality	1 Female	39	3,2968	,54080	,08660
	2 Male	8	3,5155	,68140	,24091
util Utilisation of Human Resources	1 Female	41	3,1130	,61581	,09617
	2 Male	8	3,1667	,84457	,29860
qualmgmt Quality Management	1 Female	37	3,6408	,41600	,06839
	2 Male	8	3,5054	,90024	,31828
qresults Quality Results	1 Female	39	3,6885	,55600	,08903
	2 Male	8	3,3625	,83141	,29395
satis Client Satisfaction	1 Female	39	3,7485	,40231	,06442
	2 Male	8	3,5861	,73731	,26068
particip Professionnal participation	1 Female	41	3,7485	,66710	,10418
	2 Male	8	3,8568	,82582	,29197
impact Accreditation impact (c3 out)	1 Female	40	3,7805	,72329	,11436
	2 Male	8	3,4063	1,03934	,36746

	d1gender Gender	N	Mean	Std. Deviation	Std. Error Mean
impac1_2 Accreditation impact (Quest 1 et 2)	1 Female	36	3,2083	1,16113	,19352
	2 Male	8	3,1250	,91613	,32390
impac3a5 Accreditation impact (Quest 3 à 5)	1 Female	40	3,8208	,87656	,13860
	2 Male	8	3,4583	,95846	,33887
impac6a8 Accreditation impact (Quest 6 à 8)	1 Female	40	3,8792	,92603	,14642
	2 Male	8	3,6250	1,13302	,40058
impac9a11 Accreditation impact (Quest 9 à 11)	1 Female	39	3,7949	,83286	,13336
	2 Male	8	3,2917	1,29023	,45616
impac12_13 Accreditation impact (Quest 12 et 13)	1 Female	40	3,9125	,83118	,13142
	2 Male	8	3,2500	1,41421	,50000

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	90% Confidence Interval of the Difference	
									Lower	Upper
lead Leadership	Equal variances assumed	2,399	,128	-,131	45	,896	-,02877	,21913	-,39678	,33924
	Equal variances not assumed			-,092	7,974	,929	-,02877	,31294	-,61095	,55341
info Information and Analysis	Equal variances assumed	,025	,876	-,230	46	,819	-,06429	,27926	-,53307	,40450
	Equal variances not assumed			-,275	12,309	,788	-,06429	,23384	-,48019	,35162
planning Strategic Planning of Quality	Equal variances assumed	,218	,642	-,997	45	,324	-,21865	,21928	-,58692	,14962
	Equal variances not assumed			-,854	8,898	,415	-,21865	,25600	-,68854	,25124
util Utilisation of Human Resources	Equal variances assumed	1,325	,256	-,212	47	,833	-,05369	,25315	-,47846	,37108
	Equal variances not assumed			-,171	8,512	,868	-,05369	,31371	-,63252	,52515
qualmgmt Quality Management	Equal variances assumed	7,614	,008	,660	43	,513	,13541	,20514	-,20945	,48027
	Equal variances not assumed			,416	7,658	,689	,13541	,32555	-,47349	,74430
qresults Quality Results	Equal variances assumed	3,154	,082	1,383	45	,173	,32596	,23563	-,06977	,72169
	Equal variances not assumed			1,061	8,330	,318	,32596	,30714	-,24225	,89417
satis Client Satisfaction	Equal variances assumed	3,596	,064	,890	45	,378	,16241	,18256	-,14418	,46901
	Equal variances not assumed			,605	7,876	,562	,16241	,26852	-,33794	,66276
particip Professional participation	Equal variances assumed	,821	,370	-,404	47	,688	-,10830	,26787	-,55776	,34117
	Equal variances not assumed			-,349	8,871	,735	-,10830	,31000	-,67751	,46092
impact Accreditation impact (c3 out)	Equal variances assumed	2,915	,094	1,239	46	,221	,37428	,30197	-,13263	,88119
	Equal variances not assumed			,973	8,408	,358	,37428	,38485	-,33689	1,0854

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	90% Confidence Interval of the Difference	
									Lower	Upper
impac1_2 Accreditation impact (Quest 1 et 2)	Equal variances assumed	1,243	,271	,190	42	,850	,08333	,43934	-,6556	,82228
	Equal variances not assumed			,221	12,569	,829	,08333	,37731	-,5866	,75328
impac3a5 Accreditation impact (Quest 3 à 5)	Equal variances assumed	,054	,817	1,052	46	,298	,36250	,34451	-,2158	,94081
	Equal variances not assumed			,990	9,490	,347	,36250	,36612	-,3047	1,0297
impac6a8 Accreditation impact (Quest 6 à 8)	Equal variances assumed	1,098	,300	,683	46	,498	,25417	,37197	-,3702	,87857
	Equal variances not assumed			,596	8,967	,566	,25417	,42650	-,5279	1,0363
impac9a11 Accreditation impact (Quest 9 à 11)	Equal variances assumed	3,452	,070	1,411	45	,165	,50321	,35672	-,0958	1,1022
	Equal variances not assumed			1,059	8,237	,320	,50321	,47526	-,3772	1,3836
impac12_13 Accreditation impact (Quest 12 et 13)	Equal variances assumed	6,993	,011	1,813	46	,076	,66250	,36539	,0491	1,2758
	Equal variances not assumed			1,281	7,994	,236	,66250	,51698	-,2989	1,6239

T-Test by Age

Group Statistics

	d2ager Âge	N	Mean	Std. Deviation	Std. Error Mean
lead Leadership	1 <= 45 years	25	3,9480	,46440	,09288
	2 > 45 years	22	3,8860	,62872	,13404
info Information and Analysis	1 <= 45 years	25	4,0971	,59436	,11887
	2 > 45 years	23	3,9130	,80897	,16868
planning Strategic Planning of Quality	1 <= 45 years	24	3,3202	,59124	,12069
	2 > 45 years	23	3,3795	,56531	,11787
util Utilisation of Human Resources	1 <= 45 years	25	3,0746	,58615	,11723
	2 > 45 years	24	3,2177	,74164	,15139
qualmgmt Quality Management	1 <= 45 years	23	3,5459	,49208	,10261
	2 > 45 years	22	3,6806	,55079	,11743
qresults Quality Results	1 <= 45 years	25	3,6787	,55568	,11114
	2 > 45 years	22	3,5629	,65852	,14040
satis Client Satisfaction	1 <= 45 years	25	3,7636	,44663	,08933
	2 > 45 years	22	3,6944	,50829	,10837
particip Professionnal participation	1 <= 45 years	25	3,7542	,60989	,12198
	2 > 45 years	24	3,8411	,75113	,15332
impact Accreditation impact (c3 out)	1 <= 45 years	25	3,5545	,77960	,15592
	2 > 45 years	23	3,9062	,77737	,16209

	d2ager Âge	N	Mean	Std. Deviation	Std. Error Mean
impac1_2 Accreditation impact (Quest 1 et 2)	1 <= 45 years	24	3,1458	1,08827	,22214
	2 > 45 years	21	3,3333	1,19722	,26125
impac3a5 Accreditation impact (Quest 3 à 5)	1 <= 45 years	25	3,6800	,74833	,14967
	2 > 45 years	23	3,8768	1,03745	,21632
impac6a8 Accreditation impact (Quest 6 à 8)	1 <= 45 years	25	3,5933	1,04757	,20951
	2 > 45 years	23	4,1014	,78131	,16292
impac9a11 Accreditation impact (Quest 9 à 11)	1 <= 45 years	25	3,5733	,90533	,18107
	2 > 45 years	22	3,8636	,95207	,20298
impac12_13 Accreditation impact (Quest 12 et 13)	1 <= 45 years	25	3,5800	1,03763	,20753
	2 > 45 years	23	4,0435	,83819	,17478

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	90% Confidence Interval of the Difference	
									Lower	Upper
lead Leadership	Equal variances assumed	2,897	,096	,388	45	,700	,06209	,15998	-,2066	,33076
	Equal variances not assumed			,381	38,284	,706	,06209	,16308	-,2128	,33698
info Information and Analysis	Equal variances assumed	,082	,777	,904	46	,371	,18410	,20375	-,1579	,52613
	Equal variances not assumed			,892	40,191	,378	,18410	,20636	-,1633	,53154
planning Strategic Planning of Quality	Equal variances assumed	,367	,548	-,351	45	,727	-,05927	,16886	-,3429	,22433
	Equal variances not assumed			-,351	45,000	,727	-,05927	,16870	-,3426	,22405
util Utilisation of Human Resources	Equal variances assumed	,814	,372	-,751	47	,456	-,14309	,19055	-,4628	,17664
	Equal variances not assumed			-,747	43,771	,459	-,14309	,19147	-,4648	,17866
qualmgmt Quality Management	Equal variances assumed	,085	,772	-,865	43	,392	-,13461	,15554	-,3961	,12687
	Equal variances not assumed			-,863	41,960	,393	-,13461	,15594	-,3969	,12768
qresults Quality Results	Equal variances assumed	,607	,440	,654	45	,517	,11579	,17711	-,1817	,41322
	Equal variances not assumed			,647	41,355	,521	,11579	,17906	-,1855	,41707
satis Client Satisfaction	Equal variances assumed	,020	,889	,496	45	,622	,06914	,13926	-,1647	,30303
	Equal variances not assumed			,492	42,189	,625	,06914	,14044	-,1670	,30533
particip Professional participation	Equal variances assumed	,609	,439	-,446	47	,658	-,08698	,19509	-,4143	,24036
	Equal variances not assumed			-,444	44,315	,659	-,08698	,19592	-,4161	,24217
impact Accreditation impact (c3 out)	Equal variances assumed	,105	,748	-1,564	46	,125	-,35171	,22494	-,7293	,02589
	Equal variances not assumed			-1,564	45,690	,125	-,35171	,22491	-,7293	,02589

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	90% Confidence Interval of the Difference	
									Lower	Upper
impac1_2 Accreditation impact (Quest 1 et 2)	Equal variances assumed	,315	,577	-,550	43	,585	-,1875	,34071	-,76026	,38526
	Equal variances not assumed			-,547	40,820	,588	-,1875	,34293	-,76467	,38967
impac3a5 Accreditation impact (Quest 3 à 5)	Equal variances assumed	,463	,499	-,758	46	,452	-,1968	,25954	-,63249	,23887
	Equal variances not assumed			-,748	39,753	,459	-,1968	,26305	-,63982	,24619
impac6a8 Accreditation impact (Quest 6 à 8)	Equal variances assumed	3,708	,060	-1,891	46	,065	-,5081	,26864	-,95907	-,05716
	Equal variances not assumed			-1,915	44,178	,062	-,5081	,26540	-,95401	-,06222
impac9a11 Accreditation impact (Quest 9 à 11)	Equal variances assumed	,000	,991	-1,071	45	,290	-,2903	,27111	-,74562	,16501
	Equal variances not assumed			-1,067	43,575	,292	-,2903	,27201	-,74743	,16683
impac12_13 Accreditation impact (Quest 12 et 13)	Equal variances assumed	2,291	,137	-1,693	46	,097	-,4635	,27376	-,92302	-,00393
	Equal variances not assumed			-1,708	45,273	,094	-,4635	,27132	-,91908	-,00788

T-Test by Years with Organization

Group Statistics

	d4monthr Years with Organization	N	Mean	Std. Deviation	Std. Error Mean
lead Leadership	1 <= 10 years	22	3,8021	,56915	,12134
	2 > 10 years	25	4,0400	,53018	,10604
info Information and Analysis	1 <= 10 years	23	3,9255	,53430	,11141
	2 > 10 years	25	4,1257	,85348	,17070
planning Strategic Planning of Quality	1 <= 10 years	22	3,2123	,52335	,11158
	2 > 10 years	25	3,4640	,59916	,11983
util Utilisation of Human Resources	1 <= 10 years	23	2,8971	,55567	,11587
	2 > 10 years	26	3,3349	,68288	,13392
qualimgmt Quality Management	1 <= 10 years	21	3,4392	,52213	,11394
	2 > 10 years	24	3,7627	,47899	,09777
qresults Quality Results	1 <= 10 years	22	3,5379	,62524	,13330
	2 > 10 years	25	3,7247	,60757	,12151
satis Client Satisfaction	1 <= 10 years	23	3,5999	,44409	,09260
	2 > 10 years	24	3,8553	,47417	,09679
particip Professionnal participation	1 <= 10 years	23	3,6920	,60106	,12533
	2 > 10 years	26	3,8293	,75902	,14886
impact Accreditation impact (c3 out)	1 <= 10 years	23	3,5841	,82099	,17119
	2 > 10 years	25	3,8515	,75574	,15115

	d4monthr Years with Organization	N	Mean	Std. Deviation	Std. Error Mean
impac1_2 Accreditation impact (Quest 1 et 2)	1 <= 10 years	23	3,0217	1,22917	,25630
	2 > 10 years	21	3,4286	1,01594	,22170
impac3a5 Accreditation impact (Quest 3 à 5)	1 <= 10 years	23	3,7319	,84498	,17619
	2 > 10 years	25	3,8000	,95258	,19052
impac6a8 Accreditation impact (Quest 6 à 8)	1 <= 10 years	23	3,7029	,94275	,19658
	2 > 10 years	25	3,9600	,96858	,19372
impac9a11 Accreditation impact (Quest 9 à 11)	1 <= 10 years	23	3,5362	,90865	,18947
	2 > 10 years	24	3,8750	,93670	,19120
impac12_13 Accreditation impact (Quest 12 et 13)	1 <= 10 years	23	3,6739	,99554	,20759
	2 > 10 years	25	3,9200	,94296	,18859

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	90% Confidence Interval of the Difference	
									Lower	Upper
lead Leadership	Equal variances assumed	,036	,850	-1,483	45	,145	-,23789	,16040	-,50727	,03150
	Equal variances not assumed			-1,476	43,250	,147	-,23789	,16115	-,50875	,03298
info Information and Analysis	Equal variances assumed	1,075	,305	-,964	46	,340	-,20025	,20766	-,54884	,14835
	Equal variances not assumed			-,982	40,738	,332	-,20025	,20384	-,54333	,14283
planning Strategic Planning of Quality	Equal variances assumed	,094	,761	-1,524	45	,135	-,25166	,16518	-,52907	,02575
	Equal variances not assumed			-1,537	44,999	,131	-,25166	,16374	-,52665	,02332
util Utilisation of Human Resources	Equal variances assumed	,884	,352	-2,441	47	,018	-,43779	,17935	-,73873	-,13685
	Equal variances not assumed			-2,472	46,700	,017	-,43779	,17709	-,73497	-,14061
qualmgmt Quality Management	Equal variances assumed	,384	,539	-2,168	43	,036	-,32352	,14926	-,57444	-,07261
	Equal variances not assumed			-2,155	40,978	,037	-,32352	,15014	-,57619	-,07085
qresults Quality Results	Equal variances assumed	,206	,652	-1,037	45	,305	-,18679	,18004	-,48915	,11557
	Equal variances not assumed			-1,036	43,886	,306	-,18679	,18038	-,48988	,11630
satis Client Satisfaction	Equal variances assumed	,076	,785	-1,904	45	,063	-,25541	,13414	-,48069	-,03013
	Equal variances not assumed			-1,907	44,978	,063	-,25541	,13395	-,48037	-,03045
particip Professional participation	Equal variances assumed	1,897	,175	-,696	47	,490	-,13730	,19740	-,46852	,19392
	Equal variances not assumed			-,706	46,470	,484	-,13730	,19459	-,46388	,18929
impact Accreditation impact (c3 out)	Equal variances assumed	,032	,858	-1,175	46	,246	-,26733	,22756	-,64933	,11467
	Equal variances not assumed			-1,171	44,745	,248	-,26733	,22837	-,65090	,11624

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	90% Confidence Interval of the Difference	
									Lower	Upper
impac1_2 Accreditation impact (Quest 1 et 2)	Equal variances assumed	1,567	,218	-1,190	42	,241	-,40683	,34186	-,98183	,16816
	Equal variances not assumed			-1,201	41,612	,237	-,40683	,33888	-,97693	,16327
impac3a5 Accreditation impact (Quest 3 à 5)	Equal variances assumed	,018	,894	-,261	46	,795	-,06812	,26082	-,50594	,36971
	Equal variances not assumed			-,262	45,945	,794	-,06812	,25950	-,50374	,36750
impac6a8 Accreditation impact (Quest 6 à 8)	Equal variances assumed	,202	,655	-,931	46	,357	-,25710	,27630	-,72092	,20672
	Equal variances not assumed			-,932	45,845	,356	-,25710	,27599	-,72042	,20622
impac9a11 Accreditation impact (Quest 9 à 11)	Equal variances assumed	,012	,913	-1,258	45	,215	-,33877	,26936	-,79113	,11360
	Equal variances not assumed			-1,259	44,992	,215	-,33877	,26918	-,79083	,11330
impac12_13 Accreditation impact (Quest 12 et 13)	Equal variances assumed	,136	,714	-,879	46	,384	-,24609	,27981	-,71580	,22363
	Equal variances not assumed			-,877	45,125	,385	-,24609	,28046	-,71707	,22490

T-Test by Occupation

Group Statistics

	d6occupyr Occupation	N	Mean	Std. Deviation	Std. Error Mean
lead Leadership	2 Nurse	19	4,0756	,56093	,12869
	4 Other	27	3,8091	,53931	,10379
info Information and Analysis	2 Nurse	19	4,1579	,62795	,14406
	4 Other	27	3,9365	,79868	,15371
planning Strategic Planning of Quality	2 Nurse	19	3,5113	,32056	,07354
	4 Other	26	3,2275	,70171	,13762
util Utilisation of Human Resources	2 Nurse	19	3,4079	,41842	,09599
	4 Other	28	2,9631	,74832	,14142
qualmgmt Quality Management	2 Nurse	19	3,6398	,39957	,09167
	4 Other	24	3,5873	,62409	,12739
qresults Quality Results	2 Nurse	19	3,7018	,60221	,13816
	4 Other	27	3,5784	,63988	,12314
satis Client Satisfaction	2 Nurse	19	3,6944	,42462	,09741
	4 Other	26	3,7486	,52615	,10319
particip Professional participation	2 Nurse	19	3,8684	,60341	,13843
	4 Other	28	3,7202	,74050	,13994
impact Accreditation impact (c3 out)	2 Nurse	19	4,0383	,63879	,14655
	4 Other	27	3,5078	,85233	,16403

	d6occupyr Occupation	N	Mean	Std. Deviation	Std. Error Mean
impac1_2 Accreditation impact (Quest 1 et 2)	2 Nurse	15	3,3667	,85496	,22075
	4 Other	27	3,2222	1,24293	,23920
impac3a5 Accreditation impact (Quest 3 à 5)	2 Nurse	19	4,0263	,74590	,17112
	4 Other	27	3,5556	,97402	,18745
impac6a8 Accreditation impact (Quest 6 à 8)	2 Nurse	19	4,2281	,81689	,18741
	4 Other	27	3,5617	,99695	,19186
impac9a11 Accreditation impact (Quest 9 à 11)	2 Nurse	19	4,0175	,93936	,21550
	4 Other	26	3,5000	,90062	,17663
impac12_13 Accreditation impact (Quest 12 et 13)	2 Nurse	19	4,1316	,79656	,18274
	4 Other	27	3,5741	1,05342	,20273

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	90% Confidence Interval of the Difference	
									Lower	Upper
lead Leadership	Equal variances assumed	,260	,613	1,623	44	,112	,26647	,16418	-,00938	,54232
	Equal variances not assumed			1,612	37,925	,115	,26647	,16533	-,01228	,54522
info Information and Analysis	Equal variances assumed	,036	,850	1,008	44	,319	,22139	,21969	-,14774	,59052
	Equal variances not assumed			1,051	43,385	,299	,22139	,21066	-,13268	,57546
planning Strategic Planning of Quality	Equal variances assumed	6,663	,013	1,639	43	,109	,28381	,17320	-,00735	,57496
	Equal variances not assumed			1,819	37,114	,077	,28381	,15603	,02058	,54703
util Utilisation of Human Resources	Equal variances assumed	3,464	,069	2,349	45	,023	,44484	,18939	,12677	,76291
	Equal variances not assumed			2,603	43,697	,013	,44484	,17092	,15762	,73207
qualmgmt Quality Management	Equal variances assumed	,923	,342	,319	41	,752	,05256	,16496	-,22505	,33018
	Equal variances not assumed			,335	39,465	,739	,05256	,15694	-,21180	,31692
qresults Quality Results	Equal variances assumed	,029	,865	,659	44	,513	,12336	,18708	-,19097	,43769
	Equal variances not assumed			,667	40,337	,509	,12336	,18507	-,18821	,43493
satis Client Satisfaction	Equal variances assumed	,866	,357	-,369	43	,714	-,05420	,14675	-,30090	,19250
	Equal variances not assumed			-,382	42,516	,704	-,05420	,14190	-,29281	,18441
particip Professional participation	Equal variances assumed	,047	,830	,724	45	,473	,14818	,20477	-,19572	,49209
	Equal variances not assumed			,753	43,383	,456	,14818	,19684	-,18266	,47902
impact Accreditation impact (c3 out)	Equal variances assumed	2,062	,158	2,294	44	,027	,53048	,23122	,14198	,91897
	Equal variances not assumed			2,412	43,781	,020	,53048	,21996	,16085	,90010

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	90% Confidence Interval of the Difference	
									Lower	Upper
impac1_2 Accreditation impact (Quest 1 et 2)	Equal variances assumed	4,385	,043	,400	40	,692	,14444	,36148	-,46423	,75312
	Equal variances not assumed			,444	37,982	,660	,14444	,32550	-,40433	,69322
impac3a5 Accreditation impact (Quest 3 à 5)	Equal variances assumed	2,361	,132	1,771	44	,084	,47076	,26585	,02407	,91745
	Equal variances not assumed			1,855	43,627	,070	,47076	,25381	,04422	,89730
impac6a8 Accreditation impact (Quest 6 à 8)	Equal variances assumed	1,794	,187	2,399	44	,021	,66634	,27774	,19967	1,1330
	Equal variances not assumed			2,484	42,888	,017	,66634	,26820	,21545	1,1172
impac9a11 Accreditation impact (Quest 9 à 11)	Equal variances assumed	,001	,971	1,870	43	,068	,51754	,27678	,05226	,98282
	Equal variances not assumed			1,857	37,969	,071	,51754	,27864	,04777	,98732
impac12_13 Accreditation impact (Quest 12 et 13)	Equal variances assumed	2,556	,117	1,946	44	,058	,55750	,28648	,07615	1,0389
	Equal variances not assumed			2,043	43,722	,047	,55750	,27294	,09885	1,0162

T-Test by Member of Quality Body

Group Statistics

	d7member Member of Quality Body	N	Mean	Std. Deviation	Std. Error Mean
lead Leadership	1 Yes	16	3,9205	,62446	,15611
	2 No	30	3,9397	,54344	,09922
info Information and Analysis	1 Yes	16	4,1161	,68852	,17213
	2 No	30	4,0000	,76057	,13886
planning Strategic Planning of Quality	1 Yes	16	3,4792	,66268	,16567
	2 No	29	3,2401	,50899	,09452
util Utilisation of Human Resources	1 Yes	17	3,1618	,69424	,16838
	2 No	30	3,0947	,65975	,12045
qualmgmt Quality Management	1 Yes	16	3,7247	,59162	,14791
	2 No	27	3,5840	,49267	,09482
qresults Quality Results	1 Yes	16	3,6927	,73346	,18336
	2 No	30	3,6022	,56126	,10247
satis Client Satisfaction	1 Yes	16	3,8585	,54443	,13611
	2 No	29	3,6640	,41252	,07660
particip Professionnal participation	1 Yes	17	3,8235	,69113	,16762
	2 No	30	3,7326	,72005	,13146
impact Accreditation impact (c3 out)	1 Yes	16	3,8843	,77608	,19402
	2 No	30	3,6596	,83895	,15317

	d7member Member of Quality Body	N	Mean	Std. Deviation	Std. Error Mean
impac1_2 Accreditation impact (Quest 1 et 2)	1 Yes	15	3,2000	1,17716	,30394
	2 No	27	3,2778	1,08604	,20901
impac3a5 Accreditation impact (Quest 3 à 5)	1 Yes	16	3,8542	1,08845	,27211
	2 No	30	3,7056	,81847	,14943
impac6a8 Accreditation impact (Quest 6 à 8)	1 Yes	16	4,0625	,87955	,21989
	2 No	30	3,7500	1,03460	,18889
impac9a11 Accreditation impact (Quest 9 à 11)	1 Yes	16	3,8750	,96513	,24128
	2 No	29	3,6667	,96773	,17970
impac12_13 Accreditation impact (Quest 12 et 13)	1 Yes	16	4,0313	,84595	,21149
	2 No	30	3,7167	1,07225	,19576

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	90% Confidence Interval of the Difference	
									Lower	Upper
lead Leadership	Equal variances assumed	,640	,428	-,109	44	,914	-,01928	,17718	-,31698	,27843
	Equal variances not assumed			-,104	27,264	,918	-,01928	,18498	-,33423	,29568
info Information and Analysis	Equal variances assumed	,157	,694	,509	44	,613	,11607	,22809	-,26717	,49932
	Equal variances not assumed			,525	33,531	,603	,11607	,22116	-,25804	,49018
planning Strategic Planning of Quality	Equal variances assumed	,472	,496	1,353	43	,183	,23910	,17668	-,05792	,53612
	Equal variances not assumed			1,254	24,938	,222	,23910	,19074	-,08673	,56493
util Utilisation of Human Resources	Equal variances assumed	,141	,709	,329	45	,744	,06708	,20407	-,27563	,40980
	Equal variances not assumed			,324	31,950	,748	,06708	,20703	-,28361	,41778
qualmgmt Quality Management	Equal variances assumed	,193	,663	,840	41	,406	,14066	,16753	-,14128	,42260
	Equal variances not assumed			,801	27,211	,430	,14066	,17569	-,15851	,43982
qresults Quality Results	Equal variances assumed	3,223	,079	,467	44	,642	,09049	,19358	-,23477	,41574
	Equal variances not assumed			,431	24,592	,670	,09049	,21005	-,26855	,44952
satis Client Satisfaction	Equal variances assumed	1,204	,279	1,349	43	,184	,19449	,14413	-,04780	,43679
	Equal variances not assumed			1,245	24,681	,225	,19449	,15618	-,07242	,46141
particip Professional participation	Equal variances assumed	,254	,617	,422	45	,675	,09089	,21551	-,27104	,45282
	Equal variances not assumed			,427	34,529	,672	,09089	,21303	-,26916	,45095
impact Accreditation impact (c3 out)	Equal variances assumed	,402	,529	,887	44	,380	,22463	,25325	-,20088	,65015
	Equal variances not assumed			,909	32,911	,370	,22463	,24719	-,19374	,64301

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	90% Confidence Interval of the Difference	
									Lower	Upper
impac1_2 Accreditation impact (Quest 1 et 2)	Equal variances assumed	,222	,640	-,216	40	,830	-,07778	,36028	-,68444	,52888
	Equal variances not assumed			-,211	27,107	,835	-,07778	,36887	-,70598	,55043
impac3a5 Accreditation impact (Quest 3 à 5)	Equal variances assumed	,550	,462	,522	44	,604	,14861	,28464	-,32964	,62687
	Equal variances not assumed			,479	24,270	,636	,14861	,31044	-,38228	,67951
impac6a8 Accreditation impact (Quest 6 à 8)	Equal variances assumed	,988	,326	1,025	44	,311	,31250	,30477	-,19958	,82458
	Equal variances not assumed			1,078	35,350	,288	,31250	,28988	-,17714	,80214
impac9a11 Accreditation impact (Quest 9 à 11)	Equal variances assumed	,056	,814	,692	43	,493	,20833	,30109	-,29782	,71449
	Equal variances not assumed			,692	31,126	,494	,20833	,30085	-,30170	,71837
impac12_13 Accreditation impact (Quest 12 et 13)	Equal variances assumed	1,882	,177	1,015	44	,316	,31458	,30984	-,20601	,83518
	Equal variances not assumed			1,092	37,484	,282	,31458	,28818	-,17145	,80062

T-Test by Involvement in Accreditation

Group Statistics

	d8involved Involved in last Accreditation	N	Mean	Std. Deviation	Std. Error Mean
lead Leadership	1 Yes	34	3,9883	,59256	,10162
	2 No	13	3,7937	,45449	,12605
info Information and Analysis	1 Yes	34	4,1639	,55844	,09577
	2 No	13	3,7143	,99317	,27546
planning Strategic Planning of Quality	1 Yes	33	3,3974	,54377	,09466
	2 No	13	3,2044	,66305	,18390
util Utilisation of Human Resources	1 Yes	35	3,2426	,60930	,10299
	2 No	13	2,8346	,74011	,20527
qualmgmt Quality Management	1 Yes	32	3,6593	,56594	,10004
	2 No	12	3,5684	,40060	,11564
qresults Quality Results	1 Yes	34	3,6740	,63489	,10888
	2 No	13	3,5718	,59190	,16416
satis Client Satisfaction	1 Yes	34	3,7992	,44118	,07566
	2 No	12	3,5683	,50222	,14498
particip Professionnal participation	1 Yes	35	3,8804	,65469	,11066
	2 No	13	3,4551	,73489	,20382
impact Accreditation impact (c3 out)	1 Yes	34	3,8514	,77632	,13314
	2 No	13	3,4672	,85700	,23769

	d8involved Involved in last Accreditation	N	Mean	Std. Deviation	Std. Error Mean
impac1_2 Accreditation impact (Quest 1 et 2)	1 Yes	31	3,5161	,97881	,17580
	2 No	12	2,6250	1,17018	,33780
impac3a5 Accreditation impact (Quest 3 à 5)	1 Yes	34	3,8922	,89789	,15399
	2 No	13	3,4231	,85693	,23767
impac6a8 Accreditation impact (Quest 6 à 8)	1 Yes	34	3,9118	,97203	,16670
	2 No	13	3,7564	1,01975	,28283
impac9a11 Accreditation impact (Quest 9 à 11)	1 Yes	34	3,7843	,94951	,16284
	2 No	12	3,6389	,98942	,28562
impac12_13 Accreditation impact (Quest 12 et 13)	1 Yes	34	3,8824	1,00799	,17287
	2 No	13	3,6923	,96907	,26877

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	90% Confidence Interval of the Difference	
									Lower	Upper
lead Leadership	Equal variances assumed	,694	,409	1,067	45	,292	,19456	,18231	-,11162	,50074
	Equal variances not assumed			1,202	28,318	,239	,19456	,16192	-,08078	,46989
info Information and Analysis	Equal variances assumed	2,412	,127	1,966	45	,055	,44958	,22867	,06555	,83361
	Equal variances not assumed			1,542	14,997	,144	,44958	,29163	-,06167	,96083
planning Strategic Planning of Quality	Equal variances assumed	,736	,396	1,018	44	,314	,19301	,18951	-,12541	,51143
	Equal variances not assumed			,933	18,709	,363	,19301	,20683	-,16491	,55093
util Utilisation of Human Resources	Equal variances assumed	,113	,738	1,944	46	,058	,40797	,20981	,05576	,76018
	Equal variances not assumed			1,776	18,391	,092	,40797	,22966	,01019	,80575
qualmgmt Quality Management	Equal variances assumed	,384	,539	,509	42	,613	,09090	,17862	-,20952	,39133
	Equal variances not assumed			,594	28,051	,557	,09090	,15291	-,16921	,35101
qresults Quality Results	Equal variances assumed	,040	,843	,503	45	,618	,10222	,20339	-,23935	,44380
	Equal variances not assumed			,519	23,244	,609	,10222	,19699	-,23524	,43969
satis Client Satisfaction	Equal variances assumed	1,253	,269	1,504	44	,140	,23092	,15352	-,02703	,48887
	Equal variances not assumed			1,412	17,378	,176	,23092	,16353	-,05321	,51505
particip Professional participation	Equal variances assumed	,006	,939	1,935	46	,059	,42523	,21974	,05637	,79409
	Equal variances not assumed			1,833	19,519	,082	,42523	,23193	,02474	,82572
impact Accreditation impact (c3 out)	Equal variances assumed	,980	,327	1,475	45	,147	,38413	,26043	-,05323	,82150
	Equal variances not assumed			1,410	19,995	,174	,38413	,27244	-,08575	,85401

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	90% Confidence Interval of the Difference	
									Lower	Upper
impac1_2 Accreditation impact (Quest 1 et 2)	Equal variances assumed	,387	,537	2,536	41	,015	,89113	,35142	,29973	1,48253
	Equal variances not assumed			2,340	17,300					
impac3a5 Accreditation impact (Quest 3 à 5)	Equal variances assumed	,069	,795	1,621	45	,112	,46908	,28929	-,01676	,95492
	Equal variances not assumed			1,656	22,732					
impac6a8 Accreditation impact (Quest 6 à 8)	Equal variances assumed	,353	,556	,484	45	,631	,15535	,32119	-,38406	,69477
	Equal variances not assumed			,473	20,870					
impac9a11 Accreditation impact (Quest 9 à 11)	Equal variances assumed	,038	,846	,451	44	,654	,14542	,32222	-,39599	,68684
	Equal variances not assumed			,442	18,656					
impac12_13 Accreditation impact (Quest 12 et 13)	Equal variances assumed	,002	,965	,584	45	,562	,19005	,32536	-,35637	,73646
	Equal variances not assumed			,595	22,577					

Reliability - Leadership

Case Processing Summary

		N	%
Cases	Valid	41	80,4
	Excluded(a)	10	19,6
	Total	51	100,0

a Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
,868	,868	11

Reliability - Information and Analysis

Case Processing Summary

		N	%
Cases	Valid	50	98,0
	Excluded(a)	1	2,0
	Total	51	100,0

a Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
,936	,937	7

Reliability - Strategic Quality Planning

Case Processing Summary

		N	%
Cases	Valid	43	84,3
	Excluded(a)	8	15,7
	Total	51	100,0

a Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
,686	,691	7

Reliability - Human Resources Utilization

Case Processing Summary

		N	%
Cases	Valid	46	90,2
	Excluded(a)	5	9,8
	Total	51	100,0

a Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
,833	,833	8

Reliability - Quality Management

a34-a42

Case Processing Summary

		N	%
Cases	Valid	35	68,6
	Excluded(a)	16	31,4
	Total	51	100,0

a Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
,831	,844	9

a43-47

Case Processing Summary

		N	%
Cases	Valid	35	68,6
	Excluded(a)	16	31,4
	Total	51	100,0

a Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
,806	,805	5

a43-a44

Case Processing Summary

		N	%
Cases	Valid	42	82,4
	Excluded(a)	9	17,6
	Total	51	100,0

a Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
,700	,704	2

a45-a47

Case Processing Summary

		N	%
Cases	Valid	36	70,6
	Excluded(a)	15	29,4
	Total	51	100,0

a Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
,709	,705	3

Reliability - Customer Satisfaction

Case Processing Summary

		N	%
Cases	Valid	31	60,8
	Excluded(a)	20	39,2
	Total	51	100,0

a Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
,852	,855	9

Reliability - Professional Participation Question 1

Case Processing Summary

		N	%
Cases	Valid	51	100,0
	Excluded(a)	0	,0
	Total	51	100,0

a Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
,839	,842	4

Reliability - Professional Participation

Questions 1 to 4

Case Processing Summary

		N	%
Cases	Valid	48	94,1
	Excluded(a)	3	5,9
	Total	51	100,0

a Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
,753	,755	4

Reliability - Accreditation Impact (C3 Removed)

Case Processing Summary

		N	%
Cases	Valid	34	66,7
	Excluded(a)	17	33,3
	Total	51	100,0

a Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
,950	,950	12

Reliability - Accreditation Impact --> Questions 1 and 2

Case Processing Summary

		N	%
Cases	Valid	38	74,5
	Excluded(a)	13	25,5
	Total	51	100,0

a Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
,771	,776	2

Reliability - Accreditation Impact --> Questions 3 to 5

Case Processing Summary

		N	%
Cases	Valid	45	88,2
	Excluded(a)	6	11,8
	Total	51	100,0

a Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
,783	,809	3

Reliability - Accreditation Impact --> Questions 6 to 8

Case Processing Summary

		N	%
Cases	Valid	47	92,2
	Excluded(a)	4	7,8
	Total	51	100,0

a Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
,913	,914	3

Reliability - Accreditation Impact --> Questions 9 to 11

Case Processing Summary

		N	%
Cases	Valid	46	90,2
	Excluded(a)	5	9,8
	Total	51	100,0

a Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
,925	,925	3

Reliability - Accreditation Impact --> Questions 12 and 13

Case Processing Summary

		N	%
Cases	Valid	45	88,2
	Excluded(a)	6	11,8
	Total	51	100,0

a Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
,865	,865	2

Culture Questionnaire

Nonparametric Correlations – Group

Correlations

			a1ar Org Character (% out of 100)	a2ar Org Managers (% out of 100)	a3ar Org Cohesion (% out of 100)	a4ar Org Emphasis (% out of 100)
Spearman's rho	a1ar Org Character (% out of 100)	Correlation Coefficient	1,000	,398(**)	,455(**)	,449(**)
		Sig. (2-tailed)	.	,000	,000	,000
		N	167	166	165	164
	a2ar Org Managers (% out of 100)	Correlation Coefficient	,398(**)	1,000	,465(**)	,453(**)
		Sig. (2-tailed)	,000	.	,000	,000
		N	166	168	164	163
	a3ar Org Cohesion (% out of 100)	Correlation Coefficient	,455(**)	,465(**)	1,000	,527(**)
		Sig. (2-tailed)	,000	,000	.	,000
		N	165	164	165	164
	a4ar Org Emphasis (% out of 100)	Correlation Coefficient	,449(**)	,453(**)	,527(**)	1,000
		Sig. (2-tailed)	,000	,000	,000	.
		N	164	163	164	164

** Correlation is significant at the 0.01 level (2-tailed).

Nonparametric Correlations - Developmental

Correlations

			a1br Org Character (% out of 100)	a2br Org Managers (% out of 100)	a3br Org Cohesion (% out of 100)	a4br Org Emphasis (% out of 100)
Spearman's rho	a1br Org Character (% out of 100)	Correlation Coefficient	1,000	,390(**)	,472(**)	,047
		Sig. (2-tailed)	.	,000	,000	,549
		N	167	166	165	164
	a2br Org Managers (% out of 100)	Correlation Coefficient	,390(**)	1,000	,478(**)	-,096
		Sig. (2-tailed)	,000	.	,000	,222
		N	166	168	164	163
	a3br Org Cohesion (% out of 100)	Correlation Coefficient	,472(**)	,478(**)	1,000	-,118
		Sig. (2-tailed)	,000	,000	.	,133
		N	165	164	165	164
	a4br Org Emphasis (% out of 100)	Correlation Coefficient	,047	-,096	-,118	1,000
		Sig. (2-tailed)	,549	,222	,133	.
		N	164	163	164	164

** Correlation is significant at the 0.01 level (2-tailed).

Nonparametric Correlations - Hierarchical

Correlations

			a1cr Org Character (% out of 100)	a2cr Org Managers (% out of 100)	a3cr Org Cohesion (% out of 100)	a4cr Org Emphasis (% out of 100)
Spearman's rho	a1cr Org Character (% out of 100)	Correlation	1,000	,267(**)	,346(**)	,081
		Coefficient	.	,000	,000	,304
		Sig. (2-tailed)	167	166	165	164
	a2cr Org Managers (% out of 100)	Correlation	,267(**)	1,000	,432(**)	,151
		Coefficient	,000	.	,000	,055
		Sig. (2-tailed)	166	168	164	163
	a3cr Org Cohesion (% out of 100)	Correlation	,346(**)	,432(**)	1,000	,252(**)
		Coefficient	,000	,000	.	,001
		Sig. (2-tailed)	165	164	165	164
	a4cr Org Emphasis (% out of 100)	Correlation	,081	,151	,252(**)	1,000
		Coefficient	,304	,055	,001	.
		Sig. (2-tailed)	164	163	164	164

** Correlation is significant at the 0.01 level (2-tailed).

Nonparametric Correlations - Rational

Correlations

			a1dr Org Character (% out of 100)	a2dr Org Managers (% out of 100)	a3dr Org Cohesion (% out of 100)	a4dr Org Emphasis (% out of 100)
Spearman's rho	a1dr Org Character (% out of 100)	Correlation	1,000	,161(*)	,194(*)	,103
		Coefficient	.	,038	,013	,190
		Sig. (2-tailed)	167	166	165	164
	a2dr Org Managers (% out of 100)	Correlation	,161(*)	1,000	,027	,067
		Coefficient	,038	.	,732	,399
		Sig. (2-tailed)	166	168	164	163
	a3dr Org Cohesion (% out of 100)	Correlation	,194(*)	,027	1,000	,070
		Coefficient	,013	,732	.	,375
		Sig. (2-tailed)	165	164	165	164
	a4dr Org Emphasis (% out of 100)	Correlation	,103	,067	,070	1,000
		Coefficient	,190	,399	,375	.
		Sig. (2-tailed)	164	163	164	164

* Correlation is significant at the 0.05 level (2-tailed).

Culture Questionnaire Score Distribution

Means

b1gender Gender		moy_a Group Culture	moy_b Developme ntal Culture	moy_c Hierarchical Culture	moy_d Rational Culture
1 Female	Mean	17,61	17,74	35,97	28,68
	Minimum	0	0	9	0
	Maximum	51	73	83	58
	Std. Deviation	12,591	9,478	14,557	11,118
	N	130	130	130	130
2 Male	Mean	17,78	18,31	39,45	24,46
	Minimum	0	0	19	6
	Maximum	42	36	85	41
	Std. Deviation	9,465	8,202	15,020	7,425
	N	36	36	36	36
Total	Mean	17,64	17,87	36,73	27,77
	Minimum	0	0	9	0
	Maximum	51	73	85	58
	Std. Deviation	11,956	9,196	14,683	10,554
	N	166	166	166	166

b2ager Âge		moy_a Group Culture	moy_b Developme ntal Culture	moy_c Hierarchical Culture	moy_d Rational Culture
1 <= 45 years	Mean	17,55	18,59	35,85	28,00
	Minimum	0	0	9	0
	Maximum	45	73	85	58
	Std. Deviation	11,311	9,667	14,091	11,060
	N	103	103	103	103
2 > 45 years	Mean	17,51	16,61	38,64	27,24
	Minimum	0	0	14	10
	Maximum	51	36	75	56
	Std. Deviation	13,122	8,258	15,954	9,725
	N	64	64	64	64
Total	Mean	17,54	17,83	36,92	27,71
	Minimum	0	0	9	0
	Maximum	51	73	85	58
	Std. Deviation	11,998	9,178	14,847	10,545
	N	167	167	167	167

b3manager Manager		moy_a Group Culture	moy_b Developme ntal Culture	moy_c Hierarchical Culture	moy_d Rational Culture
1 Yes	Mean	21,94	19,54	30,05	28,47
	Minimum	0	0	14	15
	Maximum	51	28	75	44
	Std. Deviation	13,493	7,931	16,328	8,174
	N	12	12	12	12
2 No	Mean	17,24	17,71	37,30	27,74
	Minimum	0	0	9	0
	Maximum	45	73	85	58
	Std. Deviation	11,879	9,305	14,578	10,701
	N	154	154	154	154
Total	Mean	17,58	17,85	36,77	27,80
	Minimum	0	0	9	0
	Maximum	51	73	85	58
	Std. Deviation	12,020	9,204	14,778	10,520
	N	166	166	166	166

b4monthr Years with Organization		moy_a Group Culture	moy_b Developme ntal Culture	moy_c Hierarchical Culture	moy_d Rational Culture
1 < 10 years	Mean	18,68	17,84	36,59	26,90
	Minimum	0	0	9	5
	Maximum	45	35	85	58
	Std. Deviation	11,286	8,164	15,663	10,018
	N	90	90	90	90
2 >= 10 years	Mean	16,21	17,83	37,30	28,66
	Minimum	0	0	14	0
	Maximum	51	73	70	58
	Std. Deviation	12,726	10,292	13,926	11,119
	N	77	77	77	77
Total	Mean	17,54	17,83	36,92	27,71
	Minimum	0	0	9	0
	Maximum	51	73	85	58
	Std. Deviation	11,998	9,178	14,847	10,545
	N	167	167	167	167

b5occupr Occupation		moy_a Group Culture	moy_b Developme ntal Culture	moy_c Hierarchical Culture	moy_d Rational Culture
2 Allied Health Professional	Mean	15,07	17,38	36,78	30,77
	Minimum	0	0	9	5
	Maximum	38	35	83	58
	Std. Deviation	11,195	8,742	14,689	11,848
	N	48	48	48	48
3 Administration	Mean	21,46	19,23	32,20	27,12
	Minimum	7	9	14	13
	Maximum	45	35	60	43
	Std. Deviation	8,492	6,392	13,321	7,858
	N	24	24	24	24
4 Nurse	Mean	19,71	17,09	36,76	26,45
	Minimum	0	0	10	6
	Maximum	51	35	75	56
	Std. Deviation	13,680	8,695	13,991	10,278
	N	55	55	55	55
5 Support	Mean	16,92	22,00	37,88	23,20
	Minimum	0	0	23	0
	Maximum	38	73	85	35
	Std. Deviation	9,401	13,630	16,924	8,605
	N	23	23	23	23
7 Other	Mean	12,79	13,93	43,17	30,11
	Minimum	0	5	17	19
	Maximum	38	27	75	58
	Std. Deviation	13,657	5,780	16,348	11,168
	N	17	17	17	17
Total	Mean	17,54	17,83	36,92	27,71
	Minimum	0	0	9	0
	Maximum	51	73	85	58
	Std. Deviation	11,998	9,178	14,847	10,545
	N	167	167	167	167

T-Test by Gender

Group Statistics

	b1gender Gender	N	Mean	Std. Deviation	Std. Error Mean
moy_a Group Culture	1 Female	130	17,61	12,591	1,104
	2 Male	36	17,78	9,465	1,577
moy_b Developmental Culture	1 Female	130	17,74	9,478	,831
	2 Male	36	18,31	8,202	1,367
moy_c Hierarchical Culture	1 Female	130	35,97	14,557	1,277
	2 Male	36	39,45	15,020	2,503
moy_d Rational Culture	1 Female	130	28,68	11,118	,975
	2 Male	36	24,46	7,425	1,237

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2- tailed)	Mean Differ- ence	Std. Error Differ- ence	90% Confidence Interval of the Difference	
									Lower	Upper
moy_a Group Culture	Equal variances assumed	5,724	,018	-,078	164	,938	-,176	2,259	-3,912	3,560
	Equal variances not assumed			-,091	72,960	,927	-,176	1,926	-3,384	3,032
moy_b Developmental Culture	Equal variances assumed	,216	,642	-,328	164	,743	-,570	1,737	-3,442	2,303
	Equal variances not assumed			-,356	63,323	,723	-,570	1,600	-3,240	2,101
moy_c Hierarchical Culture	Equal variances assumed	,036	,850	-1,261	164	,209	-3,480	2,760	-8,046	1,087
	Equal variances not assumed			-1,238	54,576	,221	-3,480	2,810	-8,182	1,222
moy_d Rational Culture	Equal variances assumed	5,515	,020	2,149	164	,033	4,225	1,966	,973	7,478
	Equal variances not assumed			2,682	83,251	,009	4,225	1,575	1,605	6,846

T-Test by Age

Group Statistics

	b2ager Âge	N	Mean	Std. Deviation	Std. Error Mean
moy_a Group Culture	1 <= 45 years	103	17,55	11,311	1,114
	2 > 45 years	64	17,51	13,122	1,640
moy_b Developmental Culture	1 <= 45 years	103	18,59	9,667	,952
	2 > 45 years	64	16,61	8,258	1,032
moy_c Hierarchical Culture	1 <= 45 years	103	35,85	14,091	1,388
	2 > 45 years	64	38,64	15,954	1,994
moy_d Rational Culture	1 <= 45 years	103	28,00	11,060	1,090
	2 > 45 years	64	27,24	9,725	1,216

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	90% Confidence Interval of the Difference	
									Lower	Upper
moy_a Group Culture	Equal variances assumed	2,576	,110	,023	165	,982	,044	1,915	-3,125	3,212
	Equal variances not assumed			,022	118,942	,982	,044	1,983	-3,244	3,331
moy_b Developmental Culture	Equal variances assumed	,093	,761	1,358	165	,176	1,979	1,457	-,431	4,390
	Equal variances not assumed			1,409	149,163	,161	1,979	1,405	-,345	4,304
moy_c Hierarchical Culture	Equal variances assumed	3,897	,050	-1,181	165	,239	-2,787	2,360	-6,691	1,118
	Equal variances not assumed			-1,147	121,277	,254	-2,787	2,430	-6,814	1,241
moy_d Rational Culture	Equal variances assumed	,488	,486	,454	165	,651	,764	1,682	-2,019	3,546
	Equal variances not assumed			,468	146,500	,641	,764	1,633	-1,939	3,466

T-Test by Years with Organization

Group Statistics

	b4monthr Years with Organization	N	Mean	Std. Deviation	Std. Error Mean
moy_a Group Culture	1 < 10 years	90	18,68	11,286	1,190
	2 >= 10 years	77	16,21	12,726	1,450
moy_b Developmental Culture	1 < 10 years	90	17,84	8,164	,861
	2 >= 10 years	77	17,83	10,292	1,173
moy_c Hierarchical Culture	1 < 10 years	90	36,59	15,663	1,651
	2 >= 10 years	77	37,30	13,926	1,587
moy_d Rational Culture	1 < 10 years	90	26,90	10,018	1,056
	2 >= 10 years	77	28,66	11,119	1,267

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	90% Confidence Interval of the Difference	
									Lower	Upper
moy_a Group Culture	Equal variances assumed	2,920	,089	1,329	165	,186	2,470	1,858	-604	5,544
	Equal variances not assumed			1,317	153,383	,190	2,470	1,876	-634	5,574
moy_b Developmental Culture	Equal variances assumed	,521	,472	,009	165	,993	,013	1,429	-2,351	2,377
	Equal variances not assumed			,009	144,172	,993	,013	1,455	-2,395	2,421
moy_c Hierarchical Culture	Equal variances assumed	,008	,931	-,311	165	,756	-,719	2,311	-4,542	3,104
	Equal variances not assumed			-,314	164,744	,754	-,719	2,290	-4,507	3,069
moy_d Rational Culture	Equal variances assumed	,928	,337	-1,078	165	,282	-1,764	1,636	-4,471	,942
	Equal variances not assumed			-1,070	154,558	,286	-1,764	1,649	-4,494	,965

Oneway ANOVA by Area

Descriptives

		N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
						Lower Bound	Upper Bound		
moy_a Group Culture	2 Allied Health Professional	48	15,07	11,195	1,616	11,82	18,32	0	38
	3 Administration	24	21,46	8,492	1,733	17,87	25,05	7	45
	4 Nurse	55	19,71	13,680	1,845	16,01	23,41	0	51
	5 Support	23	16,92	9,401	1,960	12,86	20,99	0	38
	7 Other	17	12,79	13,657	3,312	5,76	19,81	0	38
	Total	167	17,54	11,998	,928	15,70	19,37	0	51
moy_b Developmental Culture	2 Allied Health Professional	48	17,38	8,742	1,262	14,84	19,92	0	35
	3 Administration	24	19,23	6,392	1,305	16,53	21,93	9	35
	4 Nurse	55	17,09	8,695	1,172	14,74	19,44	0	35
	5 Support	23	22,00	13,630	2,842	16,11	27,89	0	73
	7 Other	17	13,93	5,780	1,402	10,96	16,90	5	27
	Total	167	17,83	9,178	,710	16,43	19,24	0	73
moy_c Hierarchical Culture	2 Allied Health Professional	48	36,78	14,689	2,120	32,52	41,05	9	83
	3 Administration	24	32,20	13,321	2,719	26,57	37,82	14	60
	4 Nurse	55	36,76	13,991	1,887	32,97	40,54	10	75
	5 Support	23	37,88	16,924	3,529	30,56	45,20	23	85
	7 Other	17	43,17	16,348	3,965	34,77	51,58	17	75
	Total	167	36,92	14,847	1,149	34,65	39,19	9	85
moy_d Rational Culture	2 Allied Health Professional	48	30,77	11,848	1,710	27,33	34,21	5	58
	3 Administration	24	27,12	7,858	1,604	23,80	30,44	13	43
	4 Nurse	55	26,45	10,278	1,386	23,67	29,23	6	56
	5 Support	23	23,20	8,605	1,794	19,48	26,92	0	35
	7 Other	17	30,11	11,168	2,709	24,37	35,85	19	58
	Total	167	27,71	10,545	,816	26,10	29,32	0	58

ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
moy_a Group Culture	Between Groups	1313,529	4	328,382	2,356	,056
	Within Groups	22583,160	162	139,402		
	Total	23896,689	166			
moy_b Developmental Culture	Between Groups	745,389	4	186,347	2,281	,063
	Within Groups	13236,356	162	81,706		
	Total	13981,745	166			
moy_c Hierarchical Culture	Between Groups	1223,983	4	305,996	1,402	,236
	Within Groups	35369,585	162	218,331		
	Total	36593,568	166			
moy_d Rational Culture	Between Groups	1111,482	4	277,870	2,595	,038
	Within Groups	17346,430	162	107,077		
	Total	18457,912	166			

➤ APPENDIX F – N VIVO CODES

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 eg: fora, 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 of 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	Eg. 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, eg 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 team work

IV. Quality programs and interventions

Quality programs	QP	structure	Organizational structure of a quality program eg: 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.
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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

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