Implementing Hospital Accreditation:
Individual Experiences of Process and Impacts

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Implementing Hospital Accreditation: Individual Experiences of Process and Impacts

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Declaration

The author hereby declares that, except where duly acknowledged, this thesis is entirely her own work.

Signed:______________________

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Dedication

For my parents

Abstract

Implementing Hospital Accreditation:
Individual Experiences of Process and Impacts

Brigid M. Milner

There is a global trend towards the pursuit of healthcare quality, driven forward as countries attempt to engage in the more effective management of resources and services, amidst concerns about increasing costs, competing priorities and patient safety. One approach to managing quality on an organisation-wide basis, and in a hospital context, is through the implementation of accreditation, which involves the assessment of work and organisational practices against predefined standards, conducted by multidisciplinary clinical and support services teams. The level of compliance against these standards is then evaluated by an external team of surveyors, on behalf of an independent body, and on the basis of this, an accreditation rating is arrived at for the organisation. Arising from this, the multidisciplinary teams move forward into the continuous improvement phase of the accreditation cycle, in order to action identified risks and opportunities for the development and enhancement of health services.

In terms of the implementation process and impacts associated with organisation-wide quality approaches such as accreditation, the literature highlights that these are not well understood, nor reported on in any depth, from the perspective of those actively involved with, and closest to them (Walshe et al. 2001;Ovretveit & Gustafson 2002;Grol, Baker, & Moss 2002;Ovretveit & Gustafson 2003). Furthermore, with reference to Ireland, accreditation has only relatively recently (2002) been adopted as the key vehicle for improving the quality of healthcare in publicly funded acute-care hospitals. As such, a paucity of literature exists within these particular areas. As a timely response to the recognised gaps in knowledge and understanding, and by positioning the study within the wider body of literature relating to organisational change and specifically, the Weisbord (1976a) change model, the research has posed the following research question:

What are the experiences of individual team members in terms of the accreditation implementation process and the individual and organisational impacts associated with this, in a large acute-care hospital context?

The research was approached from a philosophical position of anti-positivism and a methodologically pragmatic stance. A descriptive single case study research design was adopted in the context of a large acute-care hospital, where the units of analysis were the individual accreditation team members (population - two hundred and four) who were listed as being involved with the first phase of accreditation. The primary research was supported by the utilisation of non-participant observation, questionnaires and semi-structured interviews and centred on a number of themes integral to the implementation process (leadership; communication; involvement and participation; training; teams; reward) and impacts, in terms of those arising at the individual and organisational levels. Furthermore, the data collection facilitated the exploration of the extent of, and reasons for, differences in the experiences of both

the implementation process and impacts, between those in clinical work roles and accreditation teams and those in support services and more administratively orientated functions and teams.

The findings from this study indicate that despite the positive assessments of several aspects of the accreditation implementation process, there were also a number of shortcomings associated with this and in particular, respondents identified the areas of leadership, communication, involvement and participation and training as having been problematic. As such, the conclusion arrived at was one of ‘partial implementation’. Despite these issues and somewhat paradoxically, accreditation was identified as contributing to, and impacting positively on, individual learning and development; future career progression; organisational communication; multidisciplinary working; the development of standards; work relationships; morale; hospital reputation and the overall standard and delivery of care at the research site. However, this research also found that accreditation had contributed to individual role conflict and furthermore, was perceived to have potentially impacted on service provision itself. Finally, the majority of results from this study have also demonstrated that those in clinical services roles and accreditation teams were more negative in their assessments of their experiences of the accreditation implementation process and impacts, than their support services counterparts.

Importantly, this study has contributed to knowledge and understanding of the under-researched areas of the hospital accreditation implementation process and associated impacts, from the perspective of individual accreditation team members. Furthermore, this has been achieved within an Irish healthcare context. This research may provide a useful framework and additional avenues of enquiry to other researchers in the field and also inform the practice and policy associated with accreditation implementation. Finally, a number of limitations are inherent within the study and relate to generalisability, issues of validity and reliability within the research methods and the potential bias of the author themselves.

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List of Acronyms

CCHSA	Canadian Council for Health Services Accreditation
CQI	Continuous Quality Improvement
CSO	Central Statistics Office
DBG	Delivering Better Government
DBLG	Delivering Better Local Government
DOHC	Department of Health and Children
ESRI	Economic and Social Research Institute
EU	European Union
GDP	Gross Domestic Product
HIPE	Hospital In-patient Enquiry
HIQA	Health Information and Quality Authority
HSE	Health Services Executive
IHSAB	Irish Health Services Accreditation Board
ISQua	International Society for Quality in Healthcare Alpha Standards Assessment Programme
JCAHO	Joint Commission on the Accreditation of Healthcare Organisations
JCI	Joint Commission International
KFOA	Kings Fund Organisational Audit
NPM	New Public Management
OECD	Organisation for Economic Cooperation and Development
QCS	Quality Customer Service
SMI	Strategic Management Initiative
TQM	Total Quality Management
UK	United Kingdom
US	United States
WHO	World Health Organisation

Chapter 1: Introduction

1.0 Introduction

This chapter seeks to provide the rationale for conducting this doctoral thesis on acute-care hospital accreditation and in particular, the specific focus on the individual experiences of accreditation team members of the implementation process and the impacts that may arise at both the individual and organisational levels. In doing so, the chapter addresses the background to the study, its location within the literature and the framing of the research question and the associated research objectives. The existing studies in the area are reviewed and the gaps that have been identified within the literature are presented. In order to contextualise the research, a detailed description of the research site and the case study itself (the first phase of accreditation implementation) is also offered. Finally, the structure for the remainder of the thesis is outlined.

1.1 Background to the Research

There is a global trend towards the pursuit of healthcare quality, driven forward as countries attempt to engage in the more effective management of resources and services, amidst concerns about increasing costs, competing priorities and patient safety (Ferlie & Shortell 2001;World Health Organisation 2003;Sweeney 2004;Scrivens 2005;Dey, Hariharan, & Brookes 2006;Gowen III, McFadden, & Tallon 2006;Natarajan 2006;Lagrosen, Backstrom, & Lagrosen 2007). Moreover, the quest for quality has become the touchstone in debates about the organisation, financing and delivery of healthcare and as the OECD (2004b) note:

"Attention to the quality of care is a relatively new policy concern...nevertheless innovation in this area appears promising, and many changes, such as those designed to reduce medical injuries and decrease the provision of unnecessary care, stand to improve the cost-effectiveness of health-care delivery. Many countries have taken steps toward quality improvement, but more is needed in some countries" (p.37).

In relation to publicly provided health services, this drive for improved quality may also be viewed with reference to the wider public sector reform agenda, where some of the key tenets of the New Public Management (NPM) paradigm focus on the

proactive management and measurement of quality (Hood 1991;Osborne & Gaebler 1992;Dunleavy & Hood 1994;Pollitt 1995;Ferlie & Steane 2002;Hughes 2003). In relation to Ireland, the public sector reform agenda has been articulated through the publication of the Strategic Management Initiative (1994) and Delivering Better Government (1996) and represents Ireland's own approach to NPM and the modernisation agenda and, in turn, emphasises the heightened priority given to enhancing the quality of public services (Verheijen & Millar 1998;Roche 1998;Embleton 1999;Murray 2001;Buckley 2004;National Economic and Social Forum 2006).

As a subset of the wider public sector, the health service has also been subject to reform and successive reviews and strategy documents have served to recognise both the existing deficiencies (including concerns about quality) and the necessity for wide-scale change (Department of Health 1989;Department of Health 1994). The most recent - *Quality and Fairness* - (Department of Health and Children 2001) and the subsequent Health Service Reform Programme (Department of Health and Children 2003) provides the current framework for wide-scale change and reorganisation within the sector, central to which is the improvement of existing levels of service quality (Sweeney 2004).

At the same time, there is also extensive debate as to what constitutes quality in healthcare (Morgan & Potter 1995;Blumenthal 1996b;Zabada, Rivers, & Munchus 1998;Jackson 2001;Boaden 2006). This is evidenced by the plethora of definitions offered in the literature which include 'doing the right thing' to achieve the best possible clinical outcomes; patient safety; giving patients what they need as opposed to what they want; providing services at the lowest cost; retaining talented staff and satisfying policy makers and healthcare funders (Ovretveit 1992;Leahy 1998;Lerer 2000;Black & Gruen 2005). Integral to this, it is also widely accepted (Ellis & Whittington 1993;Close 1997;Eggli & Halfon 2003;Dey & Hariharan 2006) that quality in healthcare encompasses three separate but related facets - those of structure, process and outcome (Donabedian 1980;1982;1985;2005) which require an integrated and balanced approach to their management (Donabedian 1980;Kimberly & Minivielle 2000;IHSAB 2004).

Reflecting the fact that interest in quality has permeated the public sector and within this, the healthcare environment (Kirkpatrick & Martinez Lucio 1995b;Wisniewski & Donnelly 1996;Hazlett & Hill 2000;McAdam, Reid, & Saulters 2002;Ennis, Harrington, & Williams 2004), there are also a range of approaches that may be deployed in its management (Close 1997;Saturno 1999;Lerer 2000;Ovretveit & Gustafson 2003). With particular reference to health service settings, these may be categorised in terms of technical and process focused efforts (Kimberly & Minivielle 2000). Technical approaches encompass activities such as the development of clinical guidelines, outcomes studies, clinical audits and evidence-based medicine. Recognising the scientific and clinical focus, these types of approaches are outside the remit of this study. Process type efforts are broader in scope and address quality on an organisation-wide basis and are embodied in approaches such as benchmarking, Total Quality Management (TQM), Continuous Quality Improvement (CQI) and what is the particular focus of this study - accreditation (Kimberly & Minivielle 2000).

As an organisation-wide quality approach, accreditation has been variously defined and as Bruchacova (2001) notes *"There is a considerable difference in the perception of the role of accreditation. The interpretations vary from a badge of achievement to a management tool to create change"* (p.155). One of the more comprehensive definitions is offered by Scrivens (1995a) who views accreditation as *"... a process used for the assessment of the quality of organisational activity. It is based on a system of external peer review using standards...an assessment of compliance with standards is conducted by health service personnel, on behalf of an independent body. The outcome of the process is a grading or score awarded to a health service organisation which denotes the level of compliance with the standards...Accreditation systems encompass not only processes of monitoring. They are also vehicles for education and organisational development"* (Scrivens 1995a p.1). In short, accreditation aims to enhance the quality of healthcare services and through this achieve higher standards of safety for both patients and staff. Moreover, it seeks to contribute to improved organisational effectiveness through the systematic review of organisational practices against predefined standards and the actioning of opportunities for improvement (James & Hunt 1996;Shaw 2000;Sheaff 2002;World Health Organisation 2003;Pomey et al. 2004).

Accreditation has enjoyed wide-scale interest and increasingly, greater levels of adoption on a global basis (Scrivens 1997b;Schyve 1998;Nicholas 1999;Walshe et al. 2001;Shaw 2001;World Health Organisation 2003;Shaw 2004;Braithwaite et al. 2006), although as will be demonstrated at later stages of this chapter, there has been little empirical research in the area. Despite the fact that accreditation originated in the United States in the early 20th century (Ellis & Whittington 1993;Klazinga 2000;Braithwaite et al. 2006), in Ireland it was only with the formal establishment of the Irish Health Services Accreditation Board (IHSAB) in 2002 that the integration of acute-care accreditation into the wider public healthcare management field was achieved. Accreditation was, and continues to be, the primary vehicle for approaching the improvement of quality in a holistic vein within an acute-care hospital context (i.e. *"A hospital providing medical and surgical treatment of relatively short duration. All, except district hospitals, are consultant-staffed. District hospitals are classified as acute where the average length of stay is less than 30 days"* (Department of Health and Children 2001 p.201) (Accreditation Steering Group 1999a;Department of Health and Children 2002b;Sweeney 2004).

The accreditation process itself is based on a cycle of activities. In the first instance, it involves a self-assessment (the first phase of the accreditation), typically requiring twelve to eighteen months to complete. This is characterised by the formation of clinical and support services multi-disciplinary teams from amongst the employee body, who are charged with reviewing, evaluating and rating the current state of practice and service within the hospital against the predefined standards of IHSAB and the collection of work-based evidence to support this assessment (IHSAB 2004). At the end of the self-assessment phase, the completed standards and supporting documentation are evaluated by a visiting IHSAB peer review survey team who, in turn, arrive at an overall assessment and rating for the hospital. The focus of the second phase involves the multidisciplinary teams progressing the opportunities for improvement and associated plans that may have been identified and developed during the first phase, in a continuous improvement mode. An entire cycle is completed within approximately three years (IHSAB 2004), but it is the self-assessment stage (the first phase) of accreditation that forms the focus of this research.

1.2 Research Question and Research Objectives

Recognising that acute-care hospital accreditation is a relatively new phenomenon in Ireland, this study seeks to answer the following research question:

> *What are the experiences of individual team members in terms of the accreditation implementation process and the individual and organisational impacts associated with this, in a large acute-care hospital context?*

Arising from this, are a number of specific research objectives:

(i) To review and synthesise themes within the existing literature in the area of organisational change and quality implementation and impacts, with particular reference to quality in healthcare and hospital accreditation;

(ii) To explore the experiences[1] of individual team members with reference to the implementation process surrounding the first phase of accreditation;

(iii) To identify the experiences of individual team members in terms of impacts at both the individual and organisational levels arising from the first phase of accreditation;

(iv) To establish the extent of, and reasons for, any differences between individual team members, in terms of their experiences of the implementation process and individual and organisational impacts associated with the first phase of accreditation, based on team type and work role.

The following sections will aim to locate this study within the organisational change and quality implementation literatures. They will furthermore provide the rationale for why research in this area is both timely and appropriate in terms of responding to an under-researched area. Finally, it will also be demonstrated that both the

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[1] In the context of this study, experiences are defined as the totality of an individual's perceptions, thoughts, memories and encounters.

methodologies and targeted respondents within this study have been selected based upon a recognition that the existing body of literature has not addressed these sufficiently in the empirical research in the area.

1.3 Locating the Research

This study is positioned within the broad field of organisational change based on the recognition that the implementation of quality is likely to be inextricably linked to the process of effectively managing change (Thompson 1995;Henderson & McAdam 1998;Huq & Martin 2000;Boaden 2006;Rad 2006;Singh & Smith 2006). For Close (1997) *"Quality management is…dependent on managing the process of change"*(p.76), while Ovretveit (1999) further acknowledges that change and its management is *"…the weakest link in the healthcare quality improvement chain"* (p.242). At the same time, it has also been recognised that organisation-wide quality approaches are only as good as their implementation (Milakovich 1991). As such, organisational change provides an important theoretical lens through which to explore the quality and accreditation implementation process, where the implementation process implies the actions and activities associated with the commencement and continuance of an organisational change such as accreditation.

This research draws specifically on the planned organisational change literature based on the assessment that the implementation of accreditation in a publicly funded acute-care hospital context is representative of this type of change. In particular, content models of organisational change are addressed based on their ability to *"…define factors that comprise the targets of successful and unsuccessful change efforts"* (Armenakis & Bedian 1999 p.295) and also to approach the examination of change in a more diagnostic vein, as a basis for building an understanding of complex organisational problems and hence developing and guiding appropriate change strategies (Lok & Crawford 2000;Caluwe & Vermaak 2003;Harrison 2005;Rodsutti & Makayathorn 2005;Shacklady-Smith 2006). Models of this genre offer a platform for considering the elements or variables of the change process and their interrelationships therein, with an explicit acknowledgement of the environment (Armenakis & Bedian 1999;Di Pofi 2002;Harrison 2005).

Weisbord's (1976a) Six-Box Organisational Model is one such model and has been selected as the basis for the development of the conceptual framework for this study, in particular because, on interpretation, it bears a strong similarity to the 'soft' or 'people' facets of quality implementation. These represent the *"…human factor"* (Wilkinson 2004 p.1021) which is pivotal to the success of a quality approach (Schonberger 1994;Samson & Terziovski 1999;Ghobadian & Gallear 2001;Edwards & Sohal 2003;Wilkinson 2004;Rahman & Bullock 2005;Boon & Arumugam 2005;Vouzas & Psychogios 2007) and which emphasises the necessity for the effective management of, and provision for, the supporting structures for people within the implementation process. Wilkinson & Brown (2003) argue that these 'soft' aspects of quality are instrumental to, but are often given less attention in, the quality implementation process. Within the context of this study and its conceptual framework, these are seen to encompass leadership; communication; involvement and participation; training; teams and reward. Moreover, given that Ghobadian & Gallear (2001) also argue that the implementation process has the potential to influence the outcomes arising from a quality approach, the conceptual framework additionally incorporates both the individual and organisational impacts that may be associated with accreditation implementation.

1.4 Existing Research on Accreditation

Despite the longevity of accreditation as an approach for managing quality in a healthcare context, there has been an almost complete absence of empirical research that has examined organisation-wide accreditation implementation and/or the impacts arising from it. At the commencement of this study proper, the author had located a limited number of studies within the existing body of literature that had addressed these issues in a healthcare and, specifically, an acute-care hospital context. Duckett's (1983) study conducted with reference to the Australian accreditation scheme, examined accreditation implementation across twenty-three hospitals over a two year period. Based on semi-structured interviews with senior management respondents at each site, the study aimed to identify changes in the hospitals' functioning that had occurred over the period as a result of implementing accreditation (i.e. impacts). In particular, the study found that accreditation had improved organisational communication; contributed to the strengthening of working

relationships between departments and disciplines; had instigated regular meetings amongst medical staff; had initiated the updating of internal documentation and introduced processes relating to regular review of clinical practices, physical facilities and safety. However, the study also noted that medical staff had been both uncooperative and somewhat indifferent towards the process and that this had, in turn, hampered self-assessment preparations.

In a UK healthcare context, the studies conducted, and reported as part of a working paper series, by Redmayne et al. (1995) and Steiner, Scrivens, & Klein (1995) addressed the implementation process and benefits and impacts of accreditation. In exploring issues of implementation, Redmayne et al. (1995) examined two case organisations which were undergoing the implementation of the Kings Fund Organisational Audit (KFOA) accreditation scheme. Of note, the structure for implementation was based on high-level steering groups who, in turn, delegated work to other staff at the research sites. While the study utilised interviews, a post-accreditation survey questionnaire and limited observational methods, these were primarily targeted at members of these groups and to a lesser extent at those to whom work had been delegated and who were involved, albeit indirectly, with accreditation. Moreover, all respondents in the study were primarily in managerial roles. The research identified a number of difficulties associated with the implementation process, including issues in relation to communication; training; the lack of participation of doctors and the time required to complete the standards in advance of the external audit. Cynicism about accreditation was also noted amongst several respondents, but paradoxically, the findings recorded that post-survey, the majority view was that the accreditation process had been a worthwhile exercise.

The study conducted by Steiner, Scrivens, & Klein (1995) provided a view of accreditation and its impacts based on the perspectives of Chief Executives of National Health Service (NHS) Trusts, Directors of Quality and Managers of Community and Independent Hospitals. In particular, they found that accreditation had led to the development of improved internal documentation, had introduced a practice of internal audit and had enhanced both inter-departmental communication and staff morale. At the same time, respondents also noted that accreditation

implementation had increased their workloads and had meant that activities with a lesser priority had been displaced.

Finally, and more recently, Pomey et al. (2004) explored the implementation and impacts of the compulsory accreditation system in France, using a case study research design, based on a large teaching hospital. Using semi-structured interviews with those involved with the self-assessment process, and questionnaires aimed at the majority of the wider hospital workforce and supported by documentary analysis, the study found that those in administrative roles had formed a more positive view of both the accreditation implementation process and associated impacts than their clinically based colleagues. Furthermore, the research identified that doctors had been particularly resistant towards accreditation and that this was evidenced in a general lack of involvement. However, the process was also largely identified by respondents as having created irreversible change at the research site. This was seen to have manifested in terms of improved communications and working relationships; an acknowledgement of mutual interdependencies; the identification of indicators and positive developments in working practices

On reflection, the studies by Redmayne et al. (1995) and Pomey et al. (2004) bear the closest approximations to this research and are similar in some, but not all characteristics. As this study aims to address both the detailed implementation process and impacts in terms of those at the individual and organisational levels associated with accreditation, it extends beyond the aforementioned studies in terms of focus, methods and respondents. In doing so, it formally integrates the 'soft' elements of quality implementation within a conceptual framework, which has not been explicitly articulated in the current body of empirical work. Furthermore, it proposes to adopt a combination of research methods (observations, questionnaires and semi-structured interviews) to execute the study over the course of the first phase of accreditation (self-assessment) at the research site, which only Redmayne et al. (1995) have been shown to have previously deployed in this context. In addition, it seeks to elicit the responses of those individuals who are central to the process - the accreditation team members - which again, only Redmayne et al. (1995) and also Pomey et al. (2004) have targeted. Finally, this review also demonstrates that none of

existing accreditation implementation and impacts research has been conducted within an Irish context, which this study further seeks to address.

1.5 Gaps in the Literature and Contribution of the Research

While acknowledging the contributions from the aforementioned authors, what must be accepted is that there is an overall paucity of empirical studies and related literature in the area of healthcare and hospital accreditation. In particular, this is especially marked in relation to the implementation process and the impacts arising at individual and organisational levels. This research seeks to respond to this gap and make a contribution to knowledge and understanding of these issues, from the perspective of the experiences of the individual accreditation team member. Furthermore, Saturno (1999), while recognising the many models of quality management and improvement in existence, also argues that on close examination, they are, in fact, very similar, being founded on a planning, monitoring and improvement cycle. This has also been recognised by the World Health Organisation (2003) who note that an overall feature of most quality approaches in healthcare is likewise the notion of a cycle of activities, based on defining standards, measuring against them and subsequently implementing improvements and change, which clearly align with the IHSAB accreditation process outlined earlier. With this in mind, the author believes that this study may also be responding to, and hence contributing to, the existing empirical research relating to quality approaches, both in general and specifically in healthcare contexts, other than accreditation.

The following discussion aims to capture the calls for research in both quality and accreditation implementation and associated impacts that have been made within the literature. Moreover, it also seeks to acknowledge that the existing literature identifies the scope for further research that is descriptive in nature, incorporating tailored methodologies and focusing on respondents who are actively involved with implementing quality approaches. On the basis of this, the author will endeavour to identify the contribution that this study will make to knowledge and understanding of these issues.

The absence of research and subsequent understanding of the area of quality implementation and its supporting processes, has been noted by a number of commentators. For example, Counte & Meurer (2001) and Ovretveit & Gustafson (2002;2003) argue that in relation to quality improvement programmes (including accreditation) in healthcare, there is a lack of empirically-based research relating to the necessary conditions required for the achievement of maximum effectiveness and also how to implement them. This is despite the fact, as they also recognise, that the implementation and on-going maintenance of quality approaches in healthcare organisations necessitates more resources than any clinical treatment and creates demands on both individuals and organisations as a result of the implementation exercise (Ovretveit & Gustafson 2002;Ovretveit & Gustafson 2003;Weiner et al. 2006). Acknowledging this, the dilemma appears to remain as to *"…how to ensure they are well implemented"* (Ovretveit & Gustafson 2002 p.270).

The absence of both literature and understanding is also noted by Grol, Baker, & Moss (2002) who, in acknowledging the links between managing change and quality implementation, posit the view that more understanding and evidence is required of implementation issues in healthcare and that *"Studying the effects of specific strategies will provide some answers to some questions about effective change, but will address some of the basic questions about critical success factors in the change process."* (Grol, Baker, & Moss 2002 p.111). Similarly, Francois et al. (2003) concur with this position and identify that a major research imperative in the field of healthcare quality is in the area of implementation strategies and modalities, irrespective of the quality management model adopted.

Ovretveit & Gustafson (2002;2003) argue that studies in the quality implementation arena have the potential to provide decision-makers with guidance, grounded in robust research, on how best to implement quality improvement programmes and hence make a contribution to their effectiveness. They also note that most of the research studies on quality in healthcare that have focused on organisation-wide implementations, have studied approaches such as TQM or CQI and comment that *"Few other types of quality improvement programmes have been systematically studied or evaluated"* (Ovretveit & Gustafson 2003 p.759). Furthermore, Ovretveit

(2003b) observes that many of the research studies originating in the United States are conducted within a private hospital/healthcare context and, as such, cautions on the extent to which conclusions may be transferred to European and publicly funded health service organisations.

In the more general commentary on managing quality implementation, similar arguments have been made. For example, Ghobadian & Gallear (2001) note that knowledge about the quality implementation process is highly fragmented and that in the literature *"Findings and conclusions drawn from the 'full' process of implementation appear to be rarely presented"* (p.345) and, as such, call for *"…substantive research"* (p.345) to add to the existing body of knowledge. Edwards & Sohal (2003) have also recognised that relatively little research has addressed the implementation process associated with quality approaches, despite the fact that it is claimed to be the key for capitalising on the benefits of quality. Similarly, Rijinders & Boer (2004) argue that the problem with progressing quality improvement in an organisation lies with its implementation but note that the literature does not adequately address these issues in a meaningful way. Finally, Edwards & Sohal (2003) also suggest that the 'people' or 'human' side of quality implementation requires further exploration given that it has the potential to influence the overall success and organisational penetration of a quality approach.

In relation to this research, the author has been cognisant of these observations and is seeking to respond to these in this study by focusing on the *implementation process* associated with acute-care hospital accreditation and with particular reference to the 'people' or 'soft' side of quality.

With reference to the impacts from quality approaches, and specifically accreditation, there have likewise been calls for research to actively address these issues. Adinolfi (2003) has argued that much of the literature in the quality in healthcare field is prescriptive and simply reports on quality approaches with little consideration of the organisation-wide impacts. Similarly, Walshe et al. (2001), while acknowledging the fact that external review approaches such as accreditation are widely used, note the absence of research on their impact has meant that they are not well understood. As such, the author aims to respond to these calls by exploring

the individual and organisational impacts arising from the first phase of accreditation, as part of this study. As further evidence of the relevance of this aspect of the research, Braithwaite et al. (2006) have very recently noted that studies into the effectiveness of accreditation are still at an embryonic stage and in particular, that: *"After decades of accreditation development in health, and multi-million euro, dollar and pound investments, the extent to which accreditation processes and outcomes accurately reflect and motivate high quality clinical and organisational performance is poorly understood and under-investigated"* (Braithwaite et al. 2006 p.2). Moreover, they note the imperative and value of exploring this area: *"Researching the impact of accreditation on individual and organisational performance is an important undertaking"* (Braithwaite et al. 2006 p.8).

The existing literature has also recognised the scope for alternative methodologies to be adopted in studies on quality in healthcare. For example, Grol, Baker, & Moss (2002) suggest that future research in this area needs to utilise tailored research methodologies and propose observational studies of existing change processes and in-depth qualitative studies on critical success factors and barriers to change in quality improvement programmes, as possible approaches and avenues to explore. Likewise, Ovretveit & Gustafson (2002) identify that descriptive case design will have significant value in terms of contributing to an enhanced understanding of implementation issues and of particular relevance to this study, note that:

"This design simply aims to describe the programme as implemented. There is no attempt to gather data about outcomes, but knowledgeable stakeholders' expectations of outcome and perceptions of the strengths and weaknesses of the programme can be gathered. Why is this descriptive design sometimes useful? Some quality improvement programmes are prescribed and standardised - for example a quality accreditation or external review. In these cases a description of the intervention activities is available which others can use to understand what was done" (Ovretveit & Gustafson 2002 p.272).

Furthermore, they present an additional justification of this position in terms of its application, where they argue that a *"…realistic and useful research strategy is to describe the programmes and their context and discover factors that are critical for*

successful implementation as judged by different parties. In a relatively short time this will provide useful data for a more research informed management of these programmes" (Ovretveit & Gustafson 2003 p.761). With this in mind, the author is seeking to respond to these calls by a adopting *a research design based on a descriptive case study, which incorporates non-participant observation, questionnaires and semi-structured interviews.*

In terms of the targeted respondents within the existing body of research, Adinolfi (2003) notes that many of the empirical studies on quality in healthcare have utilised surveys which have been frequently directed at respondents in senior management roles. Adinolfi (2003) argues that this, in turn, has the potential to bias the results and as a result, the existing research may be limited in its scope to explore the context and views of the various stakeholders in the implementation process. In contrast, Grol, Baker, & Moss (2002) and Ovretveit & Gustafson (2002) also posit the view that many of the existing studies in quality in healthcare are focused at patient level, while quality approaches are focused on professionals, teams and whole organisations and as such, these represent under-researched individuals, groups and entities. Reflecting these positions, this study is designed to explore *the experiences individual accreditation team members* during the first phase of accreditation at the research site.

Finally, in terms of the contribution to practice and policy and, in particular, that in Ireland, accreditation, as previously acknowledged, is now the primary vehicle for improving healthcare quality in acute-care hospitals, which itself is a stated objective of the current health strategy, *Quality and Fairness* (Department of Health and Children 2001). This study aims contribute to a greater understanding of accreditation implementation issues and the associated individual and organisational impacts, for those working within the health services sector. Furthermore, it may be of particular interest to those charged with managing the accreditation process itself and also to policy-makers and funders of public health services, both in Ireland and elsewhere.

1.6 Research Site and Case Study Background

In providing the following background description, the aim is to develop an insight into the organisational environment in which the case study (the first phase of accreditation implementation) was located and hence illustrates the context in which the primary research was executed during this study. Moreover, it offers an appreciation of a number of specific activities relating to the accreditation exercise itself which took place at the research site, both leading up to and during the accreditation process. The description has been developed using data drawn from a number of published sources[2], interviews and documentary information provided by senior management at the research site and the Regional Quality and Accreditation Manager and finally, by the author's attendance at a number of accreditation communication and training sessions.

1.6.1 The Research Site: Organisational Profile

The research site is a large, acute-care hospital located within the Republic of Ireland. Built in the 1980s on the site of a former hospital, it is one of five acute-care hospitals within the geographic region. The organisation serves not only a local population but also acts the regional centre for range of specialisisms including orthopaedic trauma; nephrology; ophthalmology; haematology, oncology and palliative care; dermatology; endocrinology and diabetes; vascular surgery; paediatric and neo-natal services; sexual assault and pathology and laboratory services. Within this, it provides a number of specialist clinical and diagnostic services encompassing Accident and Emergency; specialist breast care surgery; medical and surgical day care; acute psychiatry; early pregnancy assessment; cardiac diagnostics and radiology including MRI, CT scanning and ultrasound. In addition, a number of therapeutic facilities are also available on-site including physiotherapy; speech, language and occupational therapies; occupational health; dietetics; cardiac rehabilitation and social work.

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[2] Published numerical data relating to both the research site and the accreditation implementation has been rounded or presented as percentages in order to preserve the anonymity of the research site.

The hospital has four hundred and seventy-four in-patient beds and seventy-one day beds. Funding for service provision at the research site has increased significantly in the last decade. Between 1997 and 2006 the annual operating budget grew by 183%. In 2006, approximately €110 million of this budget was allocated to pay and €48 million to non-pay expenditure. The hospital has some fifteen hundred employees, of which 68% are in the overall clinical services area and 32% are in support services. In relation to the latter, some 50% of support services staff work in management and administrative roles. In terms of the numbers of Hospital Consultants at the site, this increased by 54% between 1997 and 2003, reflecting growth in the provision of clinical specialisms.

The senior management team is comprised of the General and Deputy General Managers; the Director of Nursing; the HR Manager; the IT Manager; the Finance Manager; the Accreditation Manager; a management representative from the one of the Allied Health Professional groups and the Chairperson from the Medical Board (a Consultant). The research site is also affiliated to a Medical School within Ireland, as a teaching hospital, and is also part of the national medical rotation training scheme. It additionally facilitates pre-registration training to nursing students in partnership with a local third-level education provider and also to other groups, including Cardiac Technicians and Health Care Attendants.

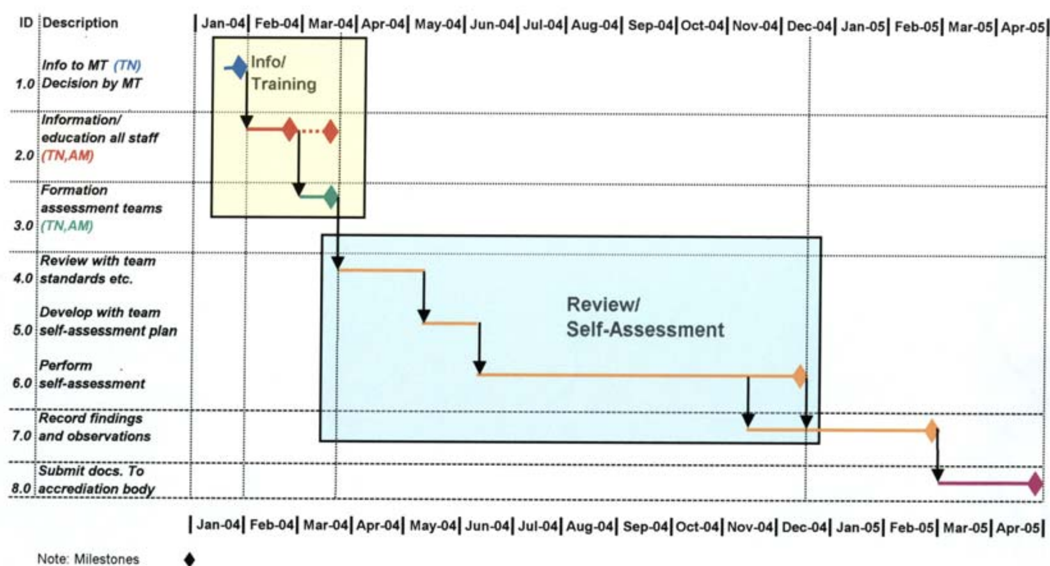
The population of the region, which the hospital serves, has undergone considerable growth in the last three decades. Between 1971 and 2002, the population grew by almost 29% and more specifically between 1996 and 2002, this growth was just over 8% (Department of Health and Children 2002a). The latest census data (2006), indicates that from 2002 to 2006, the population within the region increased by a further 8.7%. At the point at which accreditation commenced proper (2004), the regional population stood at approximately 500,000. Likewise, the intensity of demand for hospital services relative to per 1000 population within the region also increased in recent years. This is reflected in the HIPE (Hospital In-patient Enquiry) statistics (ESRI 2006), indicating that between 1992 and 2001, hospital discharges per 1000 population within the region grew by just over 80%. At the research site, activity has also intensified, with in-patient days used increasing by 6.2% between 2003 and 2006 and patient discharges also growing by 11% during the same period.

At the commencement of accreditation proper, the hospital was part of a wider regional health service structure, with a corporate executive responsible for overall governance of all acute, psychiatric and community care services and payments to primary care providers within the region. At the regional level, a range of corporate services were provided including HR, IT, finance, technical and management services and regional communications. On the 1st January 2005, the regional structure was dissolved as a legal entity and replaced by the new Health Services Executive. National boundaries were redrawn to create a number of larger geographic networks and the research site, as an acute-care hospital, assumed a new reporting relationship to the Network Manager and the newly established National Hospitals Office. The former regional office continues to provide some corporate services across the network.

1.6.2 Case Study Background: Implementing Accreditation

The senior management team at the research site made the formal and voluntary application to IHSAB in December 2003, with a view to the actual IHSAB survey visit taking place in June or July 2005. The timelines and deliverables for the implementation are presented in the project plan depicted in figure 1.1.

Figure 1.1 - Project Plan for First Phase of Accreditation



1.6.3 Initial Resources for Accreditation Implementation

Recognising the need for resources to be allocated to the process at the outset, the senior management team committed to providing both a dedicated meeting room and a full-time Accreditation Administrator who would be based there, which were in place by late January 2004. In relation to providing leadership, and the assignment of accompanying responsibility for the management of the process and the facilitation and on-going support to the accreditation teams, a decision was taken by both the General Manager and the Regional Quality and Accreditation Manager for the leadership role to be shared between the Deputy General Manager and the Deputy Director of Nursing who were both senior managers within the organisation. In terms of operational arrangements, both individuals moved to their accreditation roles as Accreditation Managers on a half-time basis, which, in turn, allowed them to each facilitate five of the ten accreditation teams, whilst also focusing on the overall project management and resourcing of the process.

1.6.4 Communications for Accreditation Implementation

Having put what were identified as the preliminary supporting resources in place, the initial communications exercise started across the hospital at the end of January 2004, with the objective of providing a basic understanding of the process and an awareness that it was about to commence, amongst staff at the research site. As a result of this, it was also hoped that volunteers would come forward to their line managers with a view to participating in an accreditation team. These sessions were led by individual Accreditation Managers and lasted approximately twenty minutes, with opportunities for questions at the end. The presentations covered multiple issues including reiterating the mission and corporate strategy of the hospital and how accreditation related to the health strategy *Quality and Fairness*. The rationale for the hospital voluntarily signing up to the IHSAB accreditation process was also addressed, in terms of aiming to shift from a departmental to service focus at the site; the potential to develop a quality improvement and a ‘no blame’ culture; the ability to enhance staff recruitment and research activity and overall, to provide evidence of ‘good’ services across the hospital. Other articulated benefits included improving accountability, focusing on users of the service and creating a safer working environment for both clinical and support services staff.

Several technical aspects of accreditation were also incorporated into the sessions, including an explanation of what accreditation was and how it operated. In terms of trying to simplify this, one of the Accreditation Managers described it as *"…checking everything from when the patient comes in until they leave and everything that goes with that"*. The content also included the 'plan, do, check, act' cycle of quality improvement; an overview of the grouping of the IHSAB accreditation standards and integral criteria; the self-assessment process and the rating scale used by IHSAB.

The longevity and on-going nature of the accreditation process and the associated development of a continuous improvement culture, was also underlined during the presentations. As one of the Accreditation Managers stated *"It will take years to make it happen"*. Other issues that were highlighted included that while the IHSAB scheme was currently voluntary, it may become mandatory in time; the fact that no hospital in the State had received full accreditation; that involvement in the process, at the individual level, was voluntary; that participation by individuals would mean extra work and that this and the team meetings that they would attend, would have to be completed during work time.

The sessions took place at different venues around the hospital. In a number of instances, employees were invited to sessions held in various meeting and training rooms, while in other cases, the Accreditation Managers visited specific work locations (e.g. a theatre) and gave a verbal presentation, without any supporting MS PowerPoint slides. In each presentation, staff were provided with a detailed handout summarising the key issues from the presentation. By the end of February 2004, some eight hundred of the hospitals total workforce had attended the initial communications sessions.

Other communications measures initiated over the course of the first phase of accreditation included the development of accreditation newsletters which were issued on a quarterly basis, commencing in September 2004. In attempting to reach all hospital staff, this was attached to the employee payslip. In addition, an accreditation sign was placed in the main foyer of the hospital and stands with

information on the accreditation process, were placed in Nurses and patient areas from the end of January 2005.

1.6.5 Accreditation Team Formation

Also by the end of February, a list for each of the ten accreditation teams, with a combined membership of two hundred and four members, had been confirmed by the Accreditation Managers. Senior line managers within each of the clinical and support services disciplines to which the IHSAB standards applied, sought volunteers and additionally approached specific individuals who they felt would be able to provide crucial input to the process. Furthermore, members of the regional health services structure whose contributions were also deemed vital, were contacted by the Regional Quality and Accreditation Manager and the two Accreditation Managers, and were asked to participate in the process.

1.6.6 Training for Accreditation Implementation

Having established the composition of the accreditation teams, a half-day training session for all team members was organised in early March and took place at a local hotel. The aim of the session was to provide more information about the rationale for the accreditation process at the research site and also further insights into the technical aspects of accreditation and the self-assessment process. The General Manager for the hospital gave a short address on the motivations and objectives for commencing accreditation. They highlighted what they believed to be the scope to create and strengthen linkages with external healthcare providers, the emphasis that accreditation placed on employee involvement and partnership and the potential to manage the hospital's culture through accreditation. On this issue, the General Manager noted that accreditation would be instrumental in *"…challenging culture…challenging the way we work"*. Furthermore, they underlined the forthcoming changes within the reporting structure for the hospital, moving away from the region and being replaced with a direct report to the National Hospitals Office. Accreditation, they suggested, might be a vehicle for anticipating and achieving the standards and practices that the Office might expect the research site to demonstrate in the future. The General Manager did acknowledge that it had been hard to engage with everyone in the hospital, despite the concerted efforts of the two Accreditation Managers and that some staff had still not heard about accreditation.

The detailed aspects of accreditation were then addressed within the presentation, by the Regional Quality and Accreditation Manager. They also articulated a number of the benefits of accreditation, describing it as *"…a wonderful process for an organisation…[it] shows up the good stuff and is supported by evidence"* and that it would create *"…accountability…everyone together is accountable"*. They also highlighted a number of other positive aspects of the process, reflected in the following comments:

"[Accreditation] helps ensure a safe and high quality service".

"[It] creates an opening and questioning culture".

"Health services are good at doing but not good at planning and evaluating. Accreditation focuses us to do this".

"Accreditation has secondary gains...people actually sitting around the table and discussing services".

The timelines for the self-assessment stage were also underlined and the Regional Quality and Accreditation Manager emphasised that *"…the clock is ticking"*. Moreover, they highlighted the requirement for submission of the completed standards to IHSAB six to eight weeks prior to the survey visit and also that all the supporting evidence would need to have been collated by this time, in order for individual files to be created and indexing to take place by the Accreditation Administrator. The composition of the IHSAB survey team was also explained, in that a typical team would usually be comprised of a number of senior clinical services and support services managers from other hospitals in the Republic and also a medical representative from another country (for example, from Canada or Australia). The surveyors would expect to meet each team for an interview to discuss their submitted standards and supporting evidence. The Regional Quality and Accreditation Manager emphasised the thoroughness and robustness of the process and the fact that it encompassed the activities of the entire organisation. They further explained that while the clinical standards were the same for the six teams, the evidence of compliance and practice would be different depending on the specialism.

In relation to the support services standards, they also underlined the fact that these also addressed risk, just as the clinical standards did, and that risks that were identified had the potential to impact on the whole organisation and, in turn, result in a lower accreditation rating for the hospital.

At this point, a number of comments were forthcoming from team members which focused only on the issue of time to complete the process. These included *"We are already short of time. I'm not sure how we are going to complete this"* and *"We are working and we don't have time for this"*. The Regional Quality and Accreditation Manager acknowledged these and reiterated the positive aspects of progressing with the process.

The detailed and technical aspects of the accreditation standards and the self-assessment process were then addressed, using a prepared IHSAB MS PowerPoint presentation, again by the Regional Quality and Accreditation Manager. This included exploring the terminology used in the standards and integral criteria, using examples of what this might translate into in practice, what a completed standard and supporting evidence list might look like and finally, a sample quality improvement plan. A number of queries were raised by team members that sought clarification on the process, standards and accreditation terminology.

The session drew to a close with each team being required to commit to a date for their first meeting between 22nd and 31st March. The purpose of this meeting would be to agree a schedule amongst the team for all subsequent meetings for the self-assessment phase of accreditation, up to the IHSAB survey visit. Based on this, the two Accreditation Managers would then allocate themselves between the ten teams as supporting facilitators, based on their individual availability. The presentation ended with an initial date being agreed for each team. Overall, the half-day session represented the only formal training that team members received prior to commencing the self-assessment stage proper in mid-April 2004.

Despite it being part of their articulated role, IHSAB were unable to provide any formal training to team members relating to accreditation prior to October 2004. The Accreditation Managers received on-going requests and queries from team members

about the possibility of further training but they were left to explain that while IHSAB should have provided the training to the teams at the beginning of the self-assessment process, they had been delayed due to scheduling and resourcing issues. When the training eventually was provided in October, the session served to address the standards in some detail and, in particular, the completion of the necessary documentation, the self-assessment rating process against the predefined criteria within the standards and the assessment of risk based on this. Guidance and examples were also provided on evidence of compliance and what might be considered as acceptable by the IHSAB surveyors.

As the self-assessment stage progressed, requests were also made by team members to meet with accreditation participants from other hospitals to discuss and gain an insight into their experiences of the process. Responding to this, the Accreditation Managers invited a clinical services team member from another hospital that had completed the self-assessment stage, to meet with some of the teams at the research site. This offered the opportunity for team members to hear at first hand how the process had progressed and, in particular, the format that the survey visit and the team interviews had taken and to ask questions on particular concerns that they might have.

A final formal training session was organised in May 2005 and offered all team members that attended, the opportunity to observe two mock IHSAB interviews. Held off-site at a local hotel, IHSAB provided a four-person panel of surveyors to conduct a typical survey interview with two of the teams from the research site - one clinical and one support services. Lasting a full morning, the session addressed the standards that had been submitted by the teams, a discussion of the evidence of compliance and the assessment of risks. In addition, for the clinical services team, the surveyors noted the absence of certain material from the standards relating to clinical practices and queried the participation of Hospital Consultants and their medical teams in the completion of the documentation.

1.6.7 The IHSAB Survey

The IHSAB survey visit took place over five days in mid-June 2005. The survey team comprised six members - two Directors of Nursing and a CEO and a Deputy CEO of large acute-care hospitals within the State, an Australian Hospital Consultant and a service user. Over the course of the survey visit, the team interviewed all ten accreditation teams; reviewed the evidence of compliance submitted by each team; took a number of tours of the facilities, wards and operating theatres and met with members of the senior management in the hospital. The report from the survey team was made to the research site in August 2005 and denied the hospital accreditation and rated it as *'Pre-Accreditation, Level 1'*. The second phase of accreditation - continuous improvement - commenced in January 2006.

1.7 Structure of the Thesis

As the penultimate section within this chapter, the structure of remainder of this thesis is outlined as follows:

Chapter 2 develops the context for this study, in terms of the public sector and healthcare reform agenda in Ireland, with specific reference to the NPM paradigm. In particular, it traces the emergence of quality as a central issue to the provision of public and health services in Ireland and explores the current drivers for the programme of healthcare reform. Furthermore, the limited evidence relating to the extent of quality approaches in hospitals in Ireland is examined, prior to addressing the establishment and purpose of IHSAB and in particular, the specifics of its acute-care accreditation scheme.

Chapter 3 examines the literature on quality and its management and further extends this to issues of service and public sector service quality, which have particular relevance to this research. The definitional debate associated with quality in healthcare is also addressed, prior to a detailed exploration of accreditation, including its origins and the arguments made both in favour and against its adoption as an approach to managing quality in healthcare.

Chapter 4 introduces the quality implementation process and impacts, with reference to the literature on managing organisational change and with an acknowledgement of the challenges that healthcare organisations, and specifically hospitals, may present to the implementation of change and quality approaches. In particular, the different types of change are explored which, in turn, locates the implementation of accreditation within the planned organisational change literature. A number of models are considered to underpin the development of the conceptual framework for this study and the justification for utilising the Weisbord (1976a) Six-Box Organisational Model is presented. Based on this, six identified themes within the implementation process and separately, impacts in terms of those at the individual and organisational levels, are addressed, with reference to the organisational change and quality implementation literatures. Finally, the chapter also examines the body of literature that suggests that individuals in clinical services roles or disciplines may view quality approaches less favourably than their colleagues in administrative and support functions.

Chapter 5 captures the philosophical and methodological foundations for this study. The research design is also outlined with reference to descriptive research and the single case study approach that has been adopted is justified. The research methods integral to this (non-participant observation, questionnaires and semi-structured interviews) are also addressed in terms of their design; data collection; validity; reliability; sampling and data analysis. Furthermore, the ethical issues associated with this research are considered.

Chapter 6 presents the findings from the three research methods utilised during this study, under the six themes relating to the implementation process, the individual and organisational impacts and finally, in terms of interviewee explanations for the differences in the results between clinical and support services respondents. The chapter also addresses issues of non-response bias within the findings and presents adjustments to the results, where appropriate, to account for this.

Chapter 7 provides the interpretation and discussion of the findings, with reference to the literature on organisational change and quality implementation in the area and also to the wider context of accreditation implementation, as depicted in Chapter 2.

Chapter 8 moves to present the conclusions that have been drawn from this research study on acute-care hospital accreditation. Arising from this, a number of recommendations are proposed, both for further research in the area and also for practice and policy. Finally, the limitations associated with this research are acknowledged.

1.8 Conclusion

This chapter has sought to present the rationale for undertaking this study as the basis for a doctoral thesis. In doing so, it has provided an overview of the focus of the study with reference to the relevant literature in the area. The gaps in the existing body of literature on quality and accreditation implementation and impacts have been identified and an account has been offered as to how this particular research aims to respond to these. Finally, a detailed description of the research site and the case study itself has also been presented in order to contextualise the research. Chapter 2 now turns to addressing the wider context of accreditation implementation.

Chapter 2: The Context for Accreditation Implementation

2.0 Introduction

The purpose of this chapter is to lay the foundations for the examination of quality in healthcare and, more specifically, the process of implementing accreditation and exploring its associated impacts, in a publicly-funded acute-care hospital environment. This assessment will be made through an exploration of the wider public sector and healthcare context in which accreditation implementation occurs. The discussion presents various frameworks for examining how public welfare services are provided and funded, which, in turn, gives rise to the opportunity to investigate Ireland's position within accepted boundaries. Furthermore, the economic and social gains arising public welfare provision are also highlighted. The chapter then progresses to exploring the wider process of change in the Irish public sector, with specific reference to the concept of NPM, which is extensively used by commentators to frame the examination of public service reform. In particular, the discussion of NPM seeks to focus on the central tenet of developing quality which has relevance to this study. An examination of the Irish health services, and specifically the acute-care sector, is presented through a discussion of the evolution of the current healthcare reform programme and the exploration of the perceived necessity to improve the quality of services. The final sections deal with the establishment of IHSAB, its accreditation scheme and where this fits within the wider context of reform and change in the Irish healthcare sector.

2.1 The Significance of Public Sector Services

Public services and within, this provision for public welfare, are an integral part of society, although their organisation and delivery will be country specific (Manning 2003;Johnson 2003). Smith (1991) commenting on the significance and benefits of the public sector advocates:

"... [that] it is my belief that the public sector serves, and unites, the community in which markets and enterprise flourish. Socially and economically, public services play a vital role with the modern mixed economy. Socially the public services enable fair provision of essential services for the whole community. And economically, they support our infrastructure, help overcome market failures and encourage efficiency and competition" (p.515).

This argument in favour of public service provision is also made by Ferlie et al. (1996), Donnelly (1999), White (2000), the National Economic and Social Forum (2006) and Flynn (2007), who similarly identify both the gains arising from the sector and the services provided within it. For them, the core services that are central to the functioning of society such as health, education, social security and criminal justice may be both financed and delivered by the public sector. They further argue that increased expenditure in health and education are indicators of a developed post-industrial economy and society, whilst a growth in spending in areas such as social security and criminal justice, are evidence of the problems associated with economic development. Looking further at the rationale for the provision of publicly provided services and specifically 'welfare' *(i.e. "public mechanisms of support (in cash, in kind, or through public services) against a catalogue of standard social risks: old age, death of a supporting spouse, invalidity, sickness, maternity, and unemployment"* (Kennelly & O'Shea 1998 p.195)), Smith (1991) and Manning (2003) argue that public welfare seeks to satisfy the needs of the majority of a population at different stages of their lives and in doing so, strengthens a nation, both socially and economically. Moreover, and with particular reference to publicly provided healthcare in Ireland, Dooney and O'Toole (1998) suggest that the rationale for provision is far more fundamental:

"…health is perceived in the modern state as a basic human right, the protection of which is accepted as a valid function of the State." (p.211).

Finally, Farrington-Douglas & Brooks (2007), with specific reference to public hospitals, acknowledge that such organisations support a number of functions in relation to overall public policy, including clinical (concentrating on specialist health needs); economic (providing local employment); social (providing accessible health and other social services) and cultural (symbolising a robust welfare state).

Given the potential for such significant economic and societal gains to be made through the existence of the public sector, and the provision of public services such as healthcare, then a commitment to the continuous review and improvement of the overall management and delivery of services, would appear to be both logical and

deemed to be an on-going priority for most governments. Discussion in subsequent sections will seek to address how these issues have emerged as key priorities across the Irish public sector.

2.2 Frameworks for Examining the Provision of Public Services and Welfare

Prior to progressing to a detailed examination of the change agenda within the public sector and specifically, health services within Ireland, it may be useful to ascertain both the basis for provision and funding of these, in order to further contextualise this research study on healthcare accreditation. In progressing this, a number of frameworks are available in the literature (Esping-Anderson 1990;Leibfried 1993;Ham 1997;Paton 2000) which demonstrate where, and how, public services, welfare and specifically healthcare, are positioned within a given political system (Titmus 1974;Judge 1998). In relation to exploring Ireland's public services, Kennelly & O'Shea (1998) suggest that*"…the most useful way of understanding the long-term background to the welfare state in Ireland is by reference to the well-established analysis of welfare state regimes"*(p.199), while a similar case is made in relation to the examination of health services by O'Sullivan & Butler (2002), who posit the view that frameworks enable the exploration of developments in the area. Overall, addressing these frameworks should enable some understanding of the debate as to where Ireland is positioned in terms of providing and funding its public health services.

An extensive literature exists which attempts to classify welfare frameworks and within this, healthcare, and here the work of Esping-Anderson (1990), Leibfried (1993), Ham (1997) and Paton (2000) are some of the most widely cited. However, O'Donnell (1999) observes that *"Ireland appears to be an incongruous, even irreconcilable case"*(p.85) and suggests that as a country it cuts across many of the popular frameworks of welfare that are outlined in table 2.1.

Table 2.1 - Frameworks of Public Services and Welfare

Esping-Andersen (1990) - Three Worlds of Welfare Capitalism	Leibfried (1993) - Four Worlds of Welfare Capitalism	Ham (1997) - Categorisation of Healthcare Systems	Paton (2000) Three Categories of Funding System
(i) Conservative-corporatist framework, which emphasises the preservation of status differentials. Strong influence from the Catholic church and structures embodying vocationalist welfare preferred over State provision. Thought to be typified by Italy, Austria, France and Germany; (ii) Socialist democratic framework promoting equality in welfare. Found in countries such as Denmark, Norway and Sweden and characterised by taxation and social insurance as the main sources of funding and with the State as the primary provider of inclusive welfare services; (iii)The liberal framework - one in which means-tested assistance or embraces modest social insurance plans Australia, the USA, Canada, Ireland and the UK are examples of where this type of system is thought to exist with discretionary interventions from the State.	(i) Scandinavian Welfare States similar to Esping-Andersen's socialist democratic category and considered to be the 'modern welfare state'; (ii) Bismarck countries with characteristics similar to the conservative-corporatist approach of Esping-Anderson and relating to countries such as Germany and Austria; (iii) Anglo-Saxon countries mirroring the liberal framework of Esping-Andersen and relating to English speaking countries such as the UK, Australia, New Zealand and the USA; (iv) Latin-rim countries. Portugal, Spain and Greece are cited as Latin-rim countries with a rudimentary welfare state and with a link between the Catholic Church and welfare.	Uses funding system as the basis for categorisation of health system and differentiates between those: (i) Financed through public taxation; (ii) Financed through compulsory social insurance; (iii) Financed through private health insurance.	Uses funding system as the basis for categorisation of health system and differentiates between: (i) The German/Belgium 'Bismarck" model of general public contribution to 'sickness funds'; (ii) The UK/Swedish 'Beverage' model which provides funding from both tax revenue and social insurance; (iii) The Ireland/France 'mixed ' model.

The frameworks put forward by Esping-Andersen (1990) and Leibfried (1993) represent categorisations founded on strong political leanings and the characteristics of the welfare approach and the role of the State therein. In relation to the Esping-Andersen framework, and based on a detailed review of the methodology adopted, O'Donnell (1999) argues that: *"Ireland does not appear to illustrate the conclusions of Esping-Andersen's typology, not obligingly clustering with other countries, nor finding a home easily"* (p.75). Leibfried (1993) does not include Ireland in his depiction of European welfare states, although Olsson Hort (1993) and O'Cinneide

(1993) both argue that Ireland has many of the characteristics of an Anglo-Saxon country including having well developed social services. For them, this is further evidenced in terms of the existence of means testing for certain welfare services such as social security, public housing and of specific interest to this study, healthcare, where through the medical card system, the costs of primary, acute and other related services are paid directly by the State for eligible citizens.

In contrast, Ham (1997) and Paton (2000) depict more practical approaches for examining welfare and specifically, health services, in their frameworks based on funding policy. While precise in their classifications, Ireland again is shown to present a problem in terms of fitting one explicit categorisation. In the Ham (1997) framework, which is based on a review of healthcare reform activity and funding structures in Germany, the UK, Sweden, the Netherlands, and the US, healthcare in Ireland straddles all three approaches by virtue of its combined funding system, financed by tax revenue, compulsory social insurance and private health insurance. O'Sullivan and Butler (2002) explain that Ireland might easily fall into the first classification due to the dependency on public funding for healthcare. They also recognise that the contribution of private health insurance, direct payment for services (e.g. General Practitioner (GP) visits) and the health levy through PRSI contributions, gives rise to a situation where the Irish health services satisfy all three categorisations to some extent. Finally, for Paton (2000), fitting neither the 'Bismark' nor the 'Beveridge' formulae but acknowledging that it has elements of both, Ireland is simply consigned to being 'mixed' in its funding methods and overall approach to the provision of health services. This position is further supported by Wiley (2005) who notes that:

"The Irish health system has historically been categorised among those countries supporting the Beveridge-type model of healthcare provision though, in reality, this system has tended to draw from a number of models to evolve into the current 'mixed' system of health service funding and provision" (p.169).

Summing up the Irish position in relation to healthcare provision and funding, O'Sullivan and Butler (2002) argue that these are essentially *"…largely public funded…which incorporates a significant public-private mix"*(p.3).

However, this arrangement is not without its critics. For Wren (2003), the current system of funding has resulted in *"...two-tier access and two-care"* (p.139). Put simply, this dual system arises where those with private health insurance (over 45% of the Irish population and includes those who already have public entitlements, (Wiley 2005)) may not only be treated quicker but may also enjoy better care, in terms of private accommodation in a public hospital and greater access to hospital consultants who are paid for their services by the medical insurer (Wren 2003;2004). In relation to access in particular, Wiley (2005), citing a survey reported on by the ESRI in 2001, points out that this is also the public's perception of the Irish healthcare system, whereby *"…nearly nine out of ten people believe that required hospital care would be obtained more quickly in the private health system than in the public system"* (p.179). Arising from this 'mixed' model has been the creation and maintenance of what is often viewed as a fundamentally inequitable healthcare system in Ireland (Wren 2003;Nolan & Nolan 2004;Wren 2004), this, despite significant growth in expenditure in the area in recent years, which is discussed in later sections.

2.3 Public Sector Distinctiveness

In terms of attempting to initiate change and specifically, improve quality in organisations operating within the public sector domain, cognisance must be taken of the fundamental differences between these types of organisations and those operating in the private sector (Ackroyd, Hughes, & Soothill 1989;Brown, Waterhouse, & Flynn 2003;Feldman 2005;Flynn 2007). Seminal work by Osborne & Gaebler (1992), which addresses the process of change in public sector organisations in the United States, suggests that government and the supporting public sector organisations within it, are so fundamentally different from businesses that they cannot be managed in the same way. This view has been reiterated more recently by the OECD (2004a), who further argue as to the distinctiveness of public sector organisations, in terms of underlying objectives and values:

"…if we look at the private sector for models in modernising public employment we must not forget that the fundamental purpose of the public service is government, not management. The means paying attention to fundamental values like fairness, equity, justice and social cohesion to maintain confidence with governmental and political systems as a whole. Managerial aspects, while important, must be considered secondary"(p.2).

Table 2.2 represents a summary of the distinctive features of public sector organisations, as identified by Boyne (2002) and Kelman (2005), which may set them apart from those in the private sector. Boyne (2002), in his synthesis of a variety of studies on the distinctiveness of public service organisations, identifies four types of 'publicness', while Kelman (2005) suggests that public sector institutions may be characterised by nine differences from those organisations operating on a commercial basis in the private sector. In relation to Ireland and its public sector, virtually all the features are present to a varying extent. Reform efforts (discussed later) have, and continue to, increase the use of practices such as contracting and also enhance employee performance through the introduction of best practice human resource (HR) policies and systems such as performance management and development systems (O'Riordan 2004).

Table 2.2 - Features of Public Sector Distinctiveness

Boyne (2002)	Kelman (2005)
(i)Publicness and the organisational environment, including complexity (a variety of stakeholders and constraints on managers); permeability (easily influenced by external events and needing to be responsive to public needs); instability (political constraints may generate frequent changes in policy and short planning horizons for public managers); an absence of competitive pressures; (ii) Publicness and organisational goals. The pursuit of a range of goals that may be distinctive (such as accountability and equity) which require certain types of values and management processes; multiple and often conflicting goals arising from the demands of various stakeholders; goals that are often vague and ambiguous arising from being imposed by the political process rather than developed by managers themselves; (iii) Publicness and organisational structure. Internally, public sector organisations are likely to be more bureaucratic; be characterised by "red tape" and with less managerial autonomy and freedom; (iv) Publicness and managerial values. This is captured by the term "public sector ethos" where those working within public sector organisations are deemed to operate with a distinctive set of values, central to which is a strong motivation to serve the public and promote public interests. At the same time, organisational commitment is thought to be lower arising primarily from the rigid and inflexible human resource processes and procedures, which do not support the development of a performance and reward culture.	(i) Organisations operate in a political environment; (ii) Performance is not measured based on the generation of profit; (iii) Inability to use financial incentives to manage and influence the behaviours of employees and managers; (iv) Stronger alignment of many employees and managers to the overall objectives and purpose of the organisation; (v) A greater need for the organisations to operate across a number of boundaries in the solving problems; (vi) A dual government role in terms of not only delivering services but also fundamental societal obligations; (vii) The frequent use of contracting with private organisations; (viii) Public visibility of the organisations internal activities; (ix) An increased sensitivity by those (in the political system) providing the resources to the avoidance of scandals as opposed to the achievement of results.

2.4 Public Sector Reform and New Public Management

In the last two decades, the focus of many developed countries (Ireland included) has, and continues to be, on public sector reform and change (Flynn & Strehl 1996;O'Dowd & Hastings 1998;O'Brien 2002;Ferlie, Hartley, & Martin 2003;O'Riordan 2004;Jacobsen 2005;Poole, Mansfield, & Gould-Williams 2006;Horton 2006;Soltani, Lai, & Mahmoudi 2007). A central element of this has been the pursuit of improved quality of public services (National Economic and Social Forum 2006;Soltani, Lai, & Mahmoudi 2007) which has relevance to this study on healthcare accreditation. Matheson (2002), with particular reference to reform in OECD countries, comments on the growth in this area: *"Ten years ago only a few countries were seriously involved in public sector reform; now the public sectors of all countries are having to be reconfigured. Public management is*

receiving an unprecedented level of attention, and these pressures for change will not ease off in the next ten years" (p.1). Despite this increased focus, creating change may prove challenging. As Matheson (2002) identifies in relation to achieving public sector modernisation:*"…there is a fundamental problem in public management of separating rhetoric from reality and hopes and aspirations from actual achievement"*(p.6).

The concept of reform embodies changes to both the structures and processes of organisations in the public sector, with the fundamental objective of attempting to ensure that they function more effectively (Seedhouse 1995;Pollitt & Bouckaert 2004). For Pollitt & Bouckaert (2004), structural change might be evidenced by the merging or splitting of public sector organisations and creating smaller/larger numbers of departments to improve coordination and promote specialisation. Process change is likely to involve the redesign of systems - for example, setting quality standards for healthcare, introducing new budgetary procedures and making changes to existing HR systems and practices affecting public servants themselves. In pursuing change in this vein, the underlying rationale has been to resolve what are believed to be the inadequacies of the traditional model of public administration, ultimately to improve the economy, efficiency, effectiveness and overall value-for-money from the sector and to respond to the plethora of external pressures in existence in the organisational environment (Flynn & Strehl 1996;Ferlie & Steane 2002;Denhardt & Denhardt 2003;Hughes 2003;Gosling 2004;Jacobsen 2005;Feldman 2005). Ferlie & Steane (2002) comment, in particular, on the impact of the international external environment in that:

"Global developments have meant that nations increasingly compete on a variety of levels. The basis for competition between nations is not only in terms of market share but also in the scale, shape and role of their public sectors and the regulatory regimes that are emerging within them"(p.1459).

The range of strategies and initiatives deployed to drive the reform process are frequently referred to by using the umbrella term 'new public management', which represents a different, more private sector orientated model of management for public sector organisations to adopt (Ferlie & Steane 2002;Jacobsen 2005;Poole,

Mansfield, & Gould-Williams 2006). Hood (1995) explains that *"The term NPM was coined because some generic label seemed to be needed for a general, though not universal, shift in public management styles"* (p.94).

A prevailing theme in the literature and commentary on NPM is that of the 'borrowing' of management concepts and practice from the private sector (Brown, Waterhouse, & Flynn 2003;Poole, Mansfield, & Gould-Williams 2006). For O'Riordan (2004), NPM *"...which emphasises the importance of efficiency, effectiveness and accountability, involves bringing private sector ideas of management in to the public sector arena"*(p.14), with a view to improving their performance and within this, the quality of the services that they provide. Likewise, Brown, Waterhouse, & Flynn (2003) and Skalen (2004) suggest that private sector management practices falling within the domain of NPM might include quality management; benchmarking; customer surveys; improved cost control and the introduction of quasi-market conditions.

Talbot (2001) notes that *"NPM has been variously defined"* (p.292) and while a number of authors have attempted to capture what they believe to be the key facets or elements of the NPM, it is evident that there is not one single manifestation within the literature, as demonstrated by the differing perspectives presented in table 2.3. Early work by Hood (1991) presents a synthesis of the key components of NPM and identifies *"…seven overlapping precepts"*(p.4) that are identifiable in the reform strategies adopted by many countries, including the UK, Australia and several OECD countries, although he does highlight that *"…not all of the seven elements were equally present in all cases"*(p.40). In the United States, Osborne & Gaebler (1992) put forward ten 'principles' through which 'government entrepreneurs' could instigate wide-scale reform. In a similar vein, Pollitt (1995) identifies a pattern of changes that are deemed to constitute a 'shopping basket' containing, in this instance, eight key elements of NPM, while Dunleavy & Hood (1994) describe the move to NPM from traditional public administration in terms of a number of transitions. Finally, Ferlie & Steane (2002) and Hughes (2003) also identify a range of changes in public sector organisations that suggest that NPM is in evidence. Several commonalities exist between the various perspectives on NPM and evident within these is the reoccurring and explicit theme of the increased emphasis on

service quality, its measurement and the creation of standards and performance indicators to support this.

Table 2.3 - Perspectives on New Public Management

	Characteristics of New Public Management
Hood (1991)	(i)"Hands on professional management" in the public sector; ***(ii)Explicit standards and measures of performance;*** (iii)Greater emphasis on output controls; (iv)Shift to disaggregation of units in the public sector; (v)Shift to greater competition in the public sector; (vi)Stress on private sector styles of management practice; (vii)Stress on greater discipline and parsimony in resource use.
Osborne & Gaebler(1992)	(i)Catalytic Government, "Steering rather than Rowing". A greater focus on "steering" as a means of defining future paths and balancing needs and resources; (ii)Community-Owned Government, "Empowering rather than Serving". Repositioning to empower citizens and communities to be the sources of their own solutions; (iii) Competitive Government, "Injecting Competition into Service Delivery" to create better responsiveness and efficiency; (iv)Mission-Driven Government, "Transforming Rule-Driven Organisations". Focus on overall mission and ensuring that systems and budgets reflect this; (v)Results-orientated, "Funding Outcomes". Results and accountability based on performance; ***(vi)Customer-Driven Government, "Meeting the Needs of the Customer, not the Bureaucracy". Reorientation towards serving the customer first;*** (vii)Enterprising Government, "Earning rather than Spending". Seeking innovative ways of doing more with less; (viii)Anticipatory Government, "Prevention rather than Cure". Refocusing activity on prevention of problems to ensure greater future; (ix)Decentralised Government, "From Hierarchy to Participation and Teamwork". A movement towards devolved decision-making; (x)Market-Orientated Government, "Leveraging Change Through the Market". Seeking to allow market forces to act.
Dunleavy & Hood (1994)	***(i) The "reworking" of budgets with the objective of creating accounting transparency, where costs are assigned to quantitative outputs as opposed to inputs, with explicit performance indicators;*** (ii) The creation of contracts with clear links between incentives and performance; (iii)The establishment of "quasi market" forms through "purchaser/ provider" distinctions; (iv) Developing competition for the provision of services; (v)Allowing users greater ability to move between providers by "deconcentrating" providers through the creation of minimum sized agencies.
Pollitt (1995)	(i)Greater transparency in allocating resources and cost cutting; (ii)Decentralisation of management authority; (iii)Separation of provision and purchasing of services; (iv)A movement away from national systems of pay determination to local determination; (v) The introduction of market and quasi-market mechanisms; (vi)The creation of separate agencies from the large bureaucracy; ***(vii)Increasing emphasis on service quality and customer awareness;*** (viii)Staff performance management.
Ferlie & Steane (2002)	(i)Contracting out where the government ensures that the service is delivered but is not responsible for actual provision; ***(ii)Enhanced concern for quality of service which is client-centred and the development of which is supported by the use of benchmarks and quality standards, arising from other governments or the private sector;*** (iii)Wide spread financial reforms which are explicitly performance orientated; (iv)Changes in inter-governmental coordination and increased focus on regulatory compliance for organisations that contract to government.
Hughes (2003)	***(i)A greater attention to the achievement of results;*** (ii)Creation of organisations and personnel employment terms and conditions with greater flexibility; ***(iii)Development and measurement through performance indicators of clear individual and organisational objectives;*** (iv)Senior public servants will possibly be less neutral and non-partisan and more committed to the government of the day; (v)Public functions are more likely to be subject to market tests, for example contracting out; (vi)A movement towards the privatisation of government functions, creating a reduction in overall numbers of public sector institutions.

The literature on NPM is largely characterised by the promotion of the superiority of private sector management approaches (Butler & Collins 2004;Poole, Mansfield, & Gould-Williams 2006) and that NPM is often endorsed, in many respects, as a solution to the ailments of the public sector. Dent, Chandler, & Barry (2004) identify that *"The appeal of NPM lies in the claim that it delivers improved public services and that it represents an empowerment of those it employs and those it seeks to serve"*(p.7), while Pollitt (1995) notes that in the many countries that have adopted the NPM paradigm, there is a belief *"...that NPM will yield greater economy, greater efficiency, rising standards of pubic service, keener 'ownership' and enhanced autonomy for service managers/providers and, last but not least, greater responsiveness by staff to the users of public services of all kinds"* (p.138). In fact, its popularity, as a term, and as a reflection of wide-scale reform efforts in a number of countries, has led a number of commentators to suggest that NPM has been subject to internationalisation or globalisation (Pollitt 1995;Common 1998;Pollitt 2001;Wise 2002;Pollitt & Bouckaert 2004;Pollitt 2005). However, Brown, Waterhouse, & Flynn (2003) caution that NPM practices implemented without sufficient consideration being given to the culture, politicisation and overall characteristics of organisations operating within the public sector, will be unlikely to fully achieve their objectives.

2.5 Reform and New Public Management in Ireland

Like other developed countries, the public sector in Ireland has been characterised by various measures aimed at reform, reorganisation and change (Murray 2001;McNamara et al. 2006;National Economic and Social Forum 2006). With particular reference to Ireland, the OECD Strategic Review and Reform document, *"Ireland - Modernising the Public Service"* (Embleton 1999) addresses the drivers and pressures for the reform of the Irish Public Service and within this, healthcare, and these mirror those found in other countries. Included in these are a range of external factors (escalating public service costs; rising public expectations; a need for greater cohesion between departments to improve service delivery and to facilitate cost-cutting and the acknowledgement of the importance of public sector to the national economy) and internal factors (a realisation by senior public servants of the need to change and the recognition that systems, working practices and technology

were outdated; an awareness of reform activities in other countries). Finally, from an international perspective, membership of the EU (National Economic and Social Forum 2006) and the active promotion of reform by organisations such as the OECD, have contributed to creating an agenda for change.

Adopting new approaches, such as NPM, to managing the public sector are frequently central to programmes of public sector reform. PA Consulting (2002) identify that:

"The emergence of the 'New Public Management' with its emphasis on managerialism and efficiency, influenced thinking considerably and through their contacts with OECD counterparts, senior Irish civil servants gained first hand insights to the progress of public management reform elsewhere…The realisation that alternative models of organisation and service delivery existed, further fuelled this interest in reform" (p.16).

The launch of the Strategic Management Initiative (SMI) (Department of the Taoiseach 1994) in 1994 heralded the beginning of plans for significant change and reform within the Irish Public Sector and was sold as a model that reflected international best practice (Roche 1998;Ennis, Harrington, & Williams 2004;National Economic and Social Forum 2006). McHugh & O'Brien (2000) identify the significance of the SMI in instigating change:

"Within the Republic of Ireland for example, public sector reform has been gathering momentum since the launch of the SMI…As part of this there were calls for quality service to the Government and the public; an open and flexible organisation; and a partnership between management and staff at all levels of the Civil Service" (p. 110).

The SMI focuses on three key areas: the contribution which public bodies can make to national development; the provision of excellent service to the public and finally, the effective use of resources (Embleton 1999;Boyle & Humphreys 2001). Of particular relevance to this study is the second theme - the provision of excellent service to the public, and for Roche (1998) and Embleton (1999), the SMI makes an

explicit commitment to developing more consumer or customer-orientated public services and to actively championing continuous quality improvement in the management of these. Furthermore, Verheijen & Millar (1998) and Buckley (2004) suggest that the SMI signalled the official embrace of NPM in Ireland. With it *"…came a new language of the public sector which brought concepts such as mission statements, strategic planning and crucially… the notion of public service users as customers"* (Buckley 2004 p.80).

Arising from the SMI, came both further initiatives and legislation affecting the way in which the public sector is operated and managed. For example, Better Local Government: A Programme for Change (1996) aimed to deliver change at a local government level, while from a legal perspective, statute such as the Pubic Service Management Act (1997) and the Freedom of Information Act (1997) serve to promote transparency and improved management within the sector (Boyle & Humphreys 2001;Adinolfi 2003;National Economic and Social Forum 2006). Delivering Better Government (DBG) (Department of the Taoiseach 1996) was aimed at reform in the Civil Service (and hence the Department of Health and Children) and is seen as the central policy document spearheading the programme of modernisation and change to the public sector and for furthering continuous improvements to services (Link 2002;National Economic and Social Forum 2006). Embleton (1999) notes that integral to DBG are a number of initiatives whose objectives are to deliver better government to consumers, through internal improvements and which, in turn, aim to manifest in quality services. O'Dowd & Hastings (1998) describe DBG *as "… a distinctively Irish variation of New Public Management"*(p.383) and highlight that, despite pressures that mirror those throughout the developed world on public sector spending, successive governments have rejected the *"…neo liberal"*(p.383) approach taken in other countries.

The DBG framework is identified by Murray (2001), who notes that it encompasses the aims of the delivery of quality services; a reduction in red tape arising from regulatory reform; addresses cross-departmental issues; seeks to provide service delivery that is both transparent and open and finally, quality service in relation to decision-making and policy advice. The importance and centrality of quality, in both

the SMI and DBG as vehicles for reform, is further reinforced by the then (and current) Taoiseach in his comments:

"…the interaction between the customer and the public service is at the heart of what we are about…it requires strong leadership, a change in organisational culture to put quality service to the customer first" (Ahern 1999 p.3).

In relation to attempting to improve quality across the service, a Quality Customer Service (QCS) Initiative was launched in 1997, on the back of the SMI and DBG (Humphreys, Butler, & O'Donnell 2001;Ennis, Harrington, & Williams 2004;National Economic and Social Forum 2006). A range of issues affecting the delivery of quality services were addressed including the development of quality service standards, improving timeliness and courtesy and the handling of complaints and appeals. Complementary to the development of the QCS initiative was the pursuance of external quality-related accreditation by a number (albeit small) of public sector organisations, as an indicator of a heightened commitment to quality. With reference to the Civil Service in particular, a review conducted on behalf of the Committee for Public Management Research entitled *A QCS Mark for the Irish Public Service* (Humphreys, Butler, & O'Donnell 2001) established that from a survey of twenty-eight Departments/Offices, a total of seven had received some form of quality-related accreditation or certification, either for the entire organisation or for a section(s), while one Department was progressing their application for the *Q*-Mark. A range of accreditation schemes were found to have been adopted across the Civil Service, including ISO, Excellence through People, CPD for Engineers awarded by the Institute of Engineers in Ireland, and the self-assessment tool - the Common Assessment Framework.

Murray (1999), commenting on the speed of change within the Irish public sector observes that: *"Over the past decade, our public service organisations have had to embrace change at an unprecedented pace and there is every sign that this rapid rate of change will continue"* (p.5). However, Boyle & Humphreys (2001) note a range of deficiencies in the Irish public sector system as evidence of slow movement towards reform and the overall improvement of service delivery. These include only the initial stages of developing engagement with the customer, for example, through

comment cards and satisfaction surveys; limited cross-and intra-organisational service delivery and, of particular significance to this study, low levels of explicit commitment by organisations to improving service standards. As further evidence of this, Boyle & Humphreys (2001) note very limited participation in accreditation and benchmarking of public services.

In relation to the QCS, Boyle and Humphreys (2001) acknowledge that *"There is little doubt that real progress has been made, both on the initiative of individual public bodies and following the launching of the QCS Initiative in 1997, with the quality of services delivered to the Irish Public"*(p. 56). However, they counter this with an overall assessment of the progress of the entire sector (including healthcare), towards the delivery of better quality services:

"…a genuine commitment to addressing the needs of the public remains relatively low in the pecking order of managerial priorities, compared for example, to meeting the internal political demands of the system. Rarely were customer service needs placed centre stage. Many public bodies lack that external or internal impetus to change and re-orient their business activities to become customer rather than process driven"(p.57).

In further support of this position, and with reference to the overall SMI and DBG, the PA Consulting (2002) evaluation of the progress of the initiatives aimed at creating reform, concluded that the Civil Service (of which the Department of Health and Children is a part) had become more effective in the previous ten years but that overall, the full implementation of modernisation was incomplete. In particular, it was noted that many Departments/Offices had made progress with reform but that most were still struggling with some barriers, most notably, those of a structural and cultural nature. The National Economic and Social Forum (2006) report *Improving the Quality of Public Services* concurs with this view, and similarly acknowledges that while there have been a number of positive developments in both the delivery and quality of public services in the last ten years arising from the reform agenda, there remains significant progress to be made. Of interest to this study on accreditation, they particularly identify the scope for the more extensive use of

standards to assess the quality of public services and suggest that this might be a central vehicle for improving the management of same.

McCarthy (2005) reinforces the view that some change has occurred in the public sector but also suggests that there is still significant progress to be made in a number of areas. This mirrors the observations of McNulty & Ferlie (2002) in their assessment of the varying level and pace of adoption of NPM, as a vehicle for change and reform (and within this, better quality service), across the UK public service, where they note that: *"Even within the public sector, different sub-sectors exhibit characteristic rates of movement towards NPM models"* (p. 47).

Finally, and as a further indication that public service reform and change remain firmly on the Government agenda, in early 2007 the Taoiseach, Bertie Ahern T.D. announced that he had requested the OECD to undertake a major review of public services in Ireland. In doing so, the OECD will benchmark services against those in other comparable countries and on the basis of this, make recommendations for the future direction of the reform programme (Department of the Taoiseach 2007). In commenting on the motivations for the review, he noted that:

"The Government is investing unprecedented levels of resources in public services. But problems remain - mainly with the delivery on the ground and maximising return on investment" (Department of the Taoiseach 2007).

2.6 Healthcare Reform in Ireland

Previous sections have highlighted the Irish model for the provision of public welfare and within this, publicly provided health services, which are an area of Government spending which impacts to some extent on almost all members of the population and, as such, is subject of on-going public attention, comment and frequently criticism (O'Keefe & O'Sullivan 1997;Quinn 2005;Walshe & Smith 2006). As is the case in many other countries (Walshe & Smith 2006), State involvement in healthcare services in Ireland has developed from its origins in the late eighteenth century, where the focus was primarily on the local delivery of basic services to the poor, to a country-wide system characterised by a multiplicity of services, providers and

technologies (Dooney & O'Toole 1998;Wren 2003;Quinn 2005). The obvious objective of providing health services to those who require them, has driven the development of the public healthcare system. Moreover, and in tandem with developments in the medical sciences and the foundation of the State in the early twentieth century, with an accompanying growth in democracy, it became widely accepted that the State had a fundamental obligation to the population to provide both medical and health services of a high standard (Department of Health 1989;Quinn 2005). Wren (2003) also highlights that there have been a multiplicity of additional factors at play in the historical development of the structure and delivery of Irish health services. In particular, she identifies the pervasive influence of the values of the Catholic Church and the medical profession's objective of preserving their private fee income.

As a subset of the wider public sector, the health service has been subject to some degree of change, under the broad umbrella of reform but with strategies and initiatives tailored and reflective of its broad remit and specific service requirements (O'Keefe & O'Sullivan 1997;Ennis & Harrington 1999b;Ennis, Harrington, & Williams 2004). Looking at the 1990s, interest in healthcare reform evolved in parallel with the wider public sector change agenda and, likewise, this is also reflected in global trends (World Health Organisation 2003;Blas 2004;Walshe & Smith 2006;Dixon 2006;Farrell, Henke, & Mango 2007). Ham (1997) observes that *"Healthcare reform is in fashion internationally. Under continuing pressure to contain costs, increase efficiency, and raise service standards, health policy makers have introduced a range of changes to healthcare in the quest for improved performance"*(p.1), while Klazinga (2000) argues that arising from a context of reform, there is scope for approaches such as accreditation, which foster greater levels of accountability. Paton (2000) and the National Economic and Social Forum (2006) also support Ham's (1997) view and posit that the globalisation of markets has affected national economies to the extent that they have sought to reform their public welfare and, in particular, healthcare provision, in order to improve their on-going competitiveness.

In relation to Ireland's experiences with healthcare reform, Wren (2003) argues that *"At key moments, Ireland has considered and walked away from fundamental*

reforms. When change has come, it has been incremental, driven by immediate political pressures rather than any grand reforming vision" (p.21). Between 1970 and 2001, two key review and strategy exercises had taken place in Ireland but without having significant impact on public health services themselves (Wren 2001;Wren 2003;Tussing & Wren 2006). The resulting reports acknowledged that the existing system was both inadequate, did not meet the needs of users or represent value-for-money to the taxpayer. The 1989 Report of the Commission on Health Spending (Department of Health 1989), which reported at a time of severe economic recession and resultant cuts in public expenditure and within this, health spending, noted that:

"The kernel of the Commission's conclusions is that the solution to the problems facing the Irish health services does not lie primarily in the system of health funding but rather in the way that services are planned, organised and delivered" (p.xi).

In the 1990's, the Department of Health set out its objectives for Irish healthcare through the publication of *Shaping a Healthier future: a Strategy for Effective Healthcare in the 1990s* (Department of Health 1994) and was an exercise that Wiley (2001a) identifies as being unique, novel and the first of its kind. Of particular note, is the weight given in the document to the need to deliver *"... the highest quality standards within the resources that are available"* (p.11). The strategy also explicitly targets the pursuance of two types of quality that the health service should seek to improve upon:

(i) The technical quality of the treatment or care: the strategy articulates that there must be the best possible outcome for the user in return for the resources committed to it. It also identifies that assessing volume of service would be an insufficient measure of effectiveness and instead, there is a need to evaluate outcomes through techniques such as clinical audit;

(ii) The consumer's perception of the quality of the service: the strategy acknowledges that these perceptions would be influenced by a range of factors including the efficiency of arrangements for treatments, courtesy of staff and the physical surroundings of where care is delivered. The

need to achieve and maintain quality standards across these areas is identified as crucial.

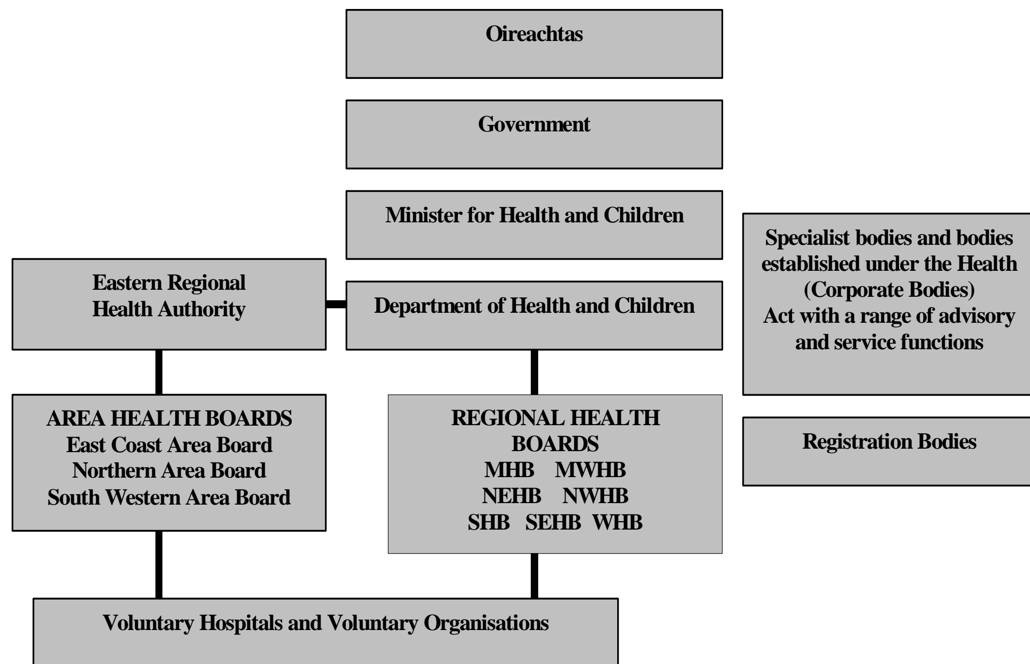
However, an ESRI critique of *Shaping a Healthier Future* by Wiley (2001a), identified a number of shortcomings with the strategy and its overall impact. Of relevance to the continued development of the quality agenda in healthcare, is the assessment that:

"Commentators were also generally of the view that far from considering the principles of equity, quality of care and accountability as having been accomplished since the publication… as much remains to be done towards their achievement, it would be expected that the principles would feature prominently in the 2001 strategy with greater emphasis on responsiveness, implementation, performance and delivery"(p.viii).

When in 2001 an ambitious and wide-ranging strategy for reform was proposed for the healthcare sector in *Quality and Fairness: a Health System for You* (Department of Health and Children 2001), the existing healthcare system had been in place for more than thirty years, without having undergone any significant change (Watson Wyatt-Prospectus 2003) and having been established primarily through the Health Act 1970 (Hensey 1988).

Figure 2.1 and table 2.4 provide both the outline of the structure and the incremental development of same, within the Irish healthcare system at the launch of *Quality and Fairness* in 2001. Significantly, the Health Service Reform Programme published by the Department of Health and Children (2003) notes the lack of strategic development of the system and recognises that the structure is highly fragmented (with over sixty bodies and agencies), overlapping and characterised by uncertainty around specific responsibilities for service delivery. This, in turn, made the service increasingly difficult to manage and hence deliver on its objectives (Watson Wyatt-Prospectus 2003;Joyce, Joyce, & Casey 2003;Department of Health and Children 2003).

Figure 2.1 - Structure of Health Service in Ireland at launch of Quality and Fairness (2001)



Source: Quality and Fairness: A Health System for You (Department of Health and Children, 2001, p. 42)

As depicted in figure 2.1, a fundamental element of the health service structure prior to *Quality and Fairness* and the subsequent Health Service Reform Programme, was the existence of the health boards with a direct reporting relationship to the Department of Health and Children (Quinn 2005). Based at a regional level, they were charged with the provision, funding and governance of healthcare services including those based at acute-hospital level, which is of specific relevance to this study. Additional public hospital services were provided and funded directly by the Department of Health and Children, through the voluntary/statute-based facilities, which were, and are, distinct from hospitals operating within the then health board structure. With their origins in the eighteenth century, and established by both lay people and religious orders, voluntary hospitals are operated and owned by boards of governors and religious orders and financed largely by the State (O'Hara 1998).

Table 2.4 - Incremental Development of Health Service Agencies

Pre - 1970	1971 - 1993	1994 - 2000	2001 - 2002
• Hospitals Trust Board (1936) • Pharmaceutical Society (1951) • Adoption Board (1952) • Poisons Council (1961) • Hospitals Bodies Administrative Bureau (1961- Establishment Order 1972) • Dublin Dental Hospital Board (1963) • Irish Blood Transfusion Service (1965)	• Regional Health Boards (1970) • St. James's Hospital Board (1971) • Comhairle na nOspidéal (1972) • Board for the Employment of the Blind (1972) • Beaumont Hospital Board (1972) • Medical Council (1978) • Post-graduate Medical and Dental Board (1978) • Leopardstown Park Hospital Board (1979) • An Board Altranais (1985) • Dental Council (1985) • Health Research Board (1986) • Drug Treatment Centre (1988) • St. Luke's and St. Anns's Hospital Board (1988) • National Cancer Registry Board (1991) • General Medical Services Payment Board (1972,1994	• Irish Medicines Board (1995) • Health Services Employers Agency (1996) • Board of the Adelaide, Meath Hospital(incorporati ng National Children's Hospital) (1996) • National Council on Aging and Older People (1997) • National Social Work Qualifications Board (1997) • Office for Health Management (1997) • Women's Health Council (1997) • National Breast Screening Board (1998) • Food Safety Authority of Ireland (1998) • Eastern Regional Health Authority (1999) • Area Health Boards (1999) • Food Safety Promotion Board (1999) • Institute of Public Health (1999) • National Council for the Professional Development of Nursery and Midwifery (1999) • National Disease Surveillance Centre (1999) • Social Services Inspectorate (2000) • Pre-hospital Emergency Care Council (2000)	• Crisis Pregnancy Agency (2001) • National children's Office (2001) • National Children's Advisory Council (2001) • Special Residential Services Board (2001) • **Irish Health Services Accreditation Board (2002)** • Office for Tobacco Control (2002) • Mental Health Commission (2002) • Health Board Executive (2002) • Health Information Quality Authority (planned) • National Hospitals Agency (planned)

Source: Audit of Structures and Functions in the Health System (Watson Wyatt -Prospectus, 2003, p. 259)

Table 2.4 highlights the proliferation of organisational entities within the Irish health service structure that have evolved over time. Of particular interest and relevance to this study, is the formal establishment in 2002 of the Irish Health Services

Accreditation Board as the body charged with introducing, in the first instance, the acute-care hospital accreditation scheme.

2.7 Current Reform Activity in Irish Healthcare

With the launch of *Quality and Fairness* in 2001, as a vision and strategy for the Health Service for the next decade, came the fundamental realisation of the need for reform and system-wide change across the publicly provided health services and this, in turn, reflected the reform agenda of the wider public service, articulated by the SMI (Quinn 2005). As McCarthy (2005) points out:

"In the health services, the requirements of more effective management, within the framework of the SMI goals, required radical restructuring of organisation and management accountability so as to better align structure and function in the management and delivery of a sophisticated and efficient health system" (p.4).

The pressures for change, and within this, improved levels of quality in the health sector and specifically acute-care services, in the main, mirror those driving the change agenda in the wider public sector (Ennis & Harrington 2002;Quinn 2005). Of particular significance are the issues of an inadequate structure; unparalleled growth in spending; demographic changes placing growing pressure on the service and greater expectations, coupled with greater dissatisfaction on the part of the consumer or service user. As Ennis, Harrington, & Williams (2004) observe:

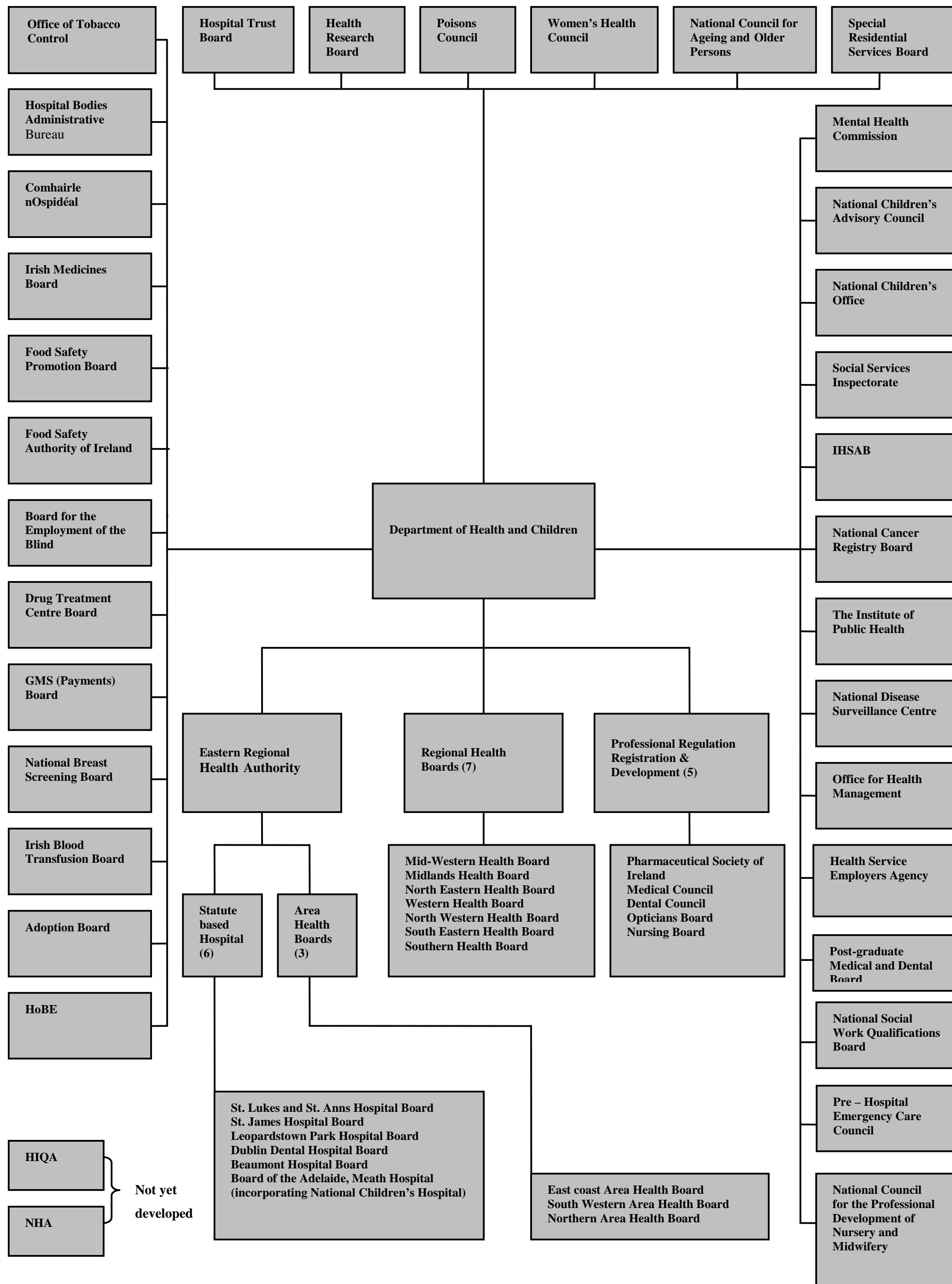
"…there is disquiet in the system: it costs too much, it excludes too many, it fails too often and it knows too little about its own effectiveness" (p.1145).

2.7.1 Inadequacies of the Existing Structure

As previously alluded to, up until the recent reform efforts, the existing healthcare system had been in place for over thirty years. Furthermore, the service was comprised of over sixty agencies and bodies, each charged with delivery of some facet of healthcare and has overall been acknowledged as being fragmented (Watson Wyatt-Prospectus 2003;Kinsella 2003;Quinn 2005). The Dialogue on Implementing Reform: Communication and Consultation Programme conducted on behalf of the

Office for Health Management (Joyce, Joyce, & Casey 2003) also highlights this fragmentation and identifies *"…overlap and uncertainty in terms of who was responsible for what"* (Joyce, Joyce, & Casey 2003 p.4). Figure 2.2 demonstrates the numerous and also autonomous bodies involved in the management, delivery and regulation of healthcare across the public sector, each of which, in turn, reported directly to the Department of Health and Children.

Figure 2.2 - Detailed Configuration of Agencies Pre-Health Service Reform Programme



Source: Audit of Structures and Functions in the Health System (Watson Wyatt-Prospectus, 2003, p. 20)

2.7.2 Growth in Healthcare Spending

Lynch (1998), Locock (2003) and Nolan (2005) highlight the steady growth in spending on healthcare as commonplace across affluent Western countries, irrespective of how the healthcare system is funded. Nolan & Nolan (2004) observe that *"... the most striking feature of Ireland's health spending is how rapidly it has been increasing in absolute terms in recent years…Even when adjusted for the increases in relevant prices, health spending has risen markedly in purchasing power terms"* (p.7). Wiley (2005) describes the review of health spending in Ireland since 1980 as *"...a story of two halves - retrenchment through the 1980s and expansion through the mid-to-late 1990s"* (p. 171-172). In an analysis of health spending, Wiley (2005) demonstrates how in constant terms (and at 1995 prices) non-capital health expenditure declined by 7% between 1980 and 1989. This compares with the more recent expansionist period of 1990 to 2000, where spending in constant terms grew by 78%. Furthermore, working in Euros, Wiley (2005) drawing on Department of Health and Children data, identifies how spending grew from €2.484 billion in 1992 to €8.167 billion in 2002.

More recently, the then and current Minister for Health and Children, Mary Harney T.D. has highlighted and reinforced her view of the Government's commitment to the current levels of overall health spending in Ireland and observed that *"€13 billion is State funded, representing about a quarter of public spending"*(Harney 2006a). One month later and responding to a motion of no confidence by the Irish Nurses Organisation, she further reiterated this by stating that *"The tax payers of this country are currently paying €13 billion towards health. That figure may well rise to €20 billion in six years time"* (Harney 2006b). Finally, in relation to spending in the current year (2007), Wall & Donnellan (2006) report on government estimates that expenditure is likely increase to approximately €14 billion.

However, despite the persuasiveness of the aforementioned statistics, the OECD's (2006) latest assessment of health spending across member countries presents a less optimistic view of Ireland's position. Based on 2004 data, Ireland's total health expenditure amounted to 7.1% of GDP, in comparison to the OECD average of 8.9%, with only Mexico, Poland, Korea and the Slovak Republic ranked below this. In terms of spending per capita on health, this was found to be slightly above the

OECD average, at $2596 but significantly lower than countries such as Germany, France, Norway and Canada, although Ireland is acknowledged to be one of the fastest growing of all OECD countries in terms of its healthcare expenditure. These figures have been further supported by the recent *Measuring Ireland's Progress* publication (Central Statistics Office 2007) which benchmarks Ireland unfavourably against the EU 25 average of 8.7% of GDP for health expenditure.

The OECD (2006) further explore how expenditure actually translates into resources for health services. For example, they identify that Irish healthcare has one of the lowest levels of physician density throughout the OECD, at 2.8 doctors per 1000 population, which compares unfavourably with the OECD average of 3.0. Conversely, with 15 nurses per 1000 population, Ireland is considered to have a high density of practicing nurses. Furthermore, the number of acute-care beds per 1000 population stands at only 2.9, again well below the OECD average which is 4.1.

Finally, and as previously mentioned, the conclusions arrived at by the Commission on Health Funding (Department of Health 1989) suggested that the problems and challenges facing the health services in Ireland were more to do with how services were planned and organised rather than the system of health funding (Quinn 2005). These observations are reflected in the Report of Independent Estimates Review Committee (Department of Finance 2002), whose role it is to review options for delivering on expenditure targets. The Committee specifically reviewed the position of the health service and commented that the growth in expenditure *"...simply cannot be sustained"* (Department of Finance 2002 p.16), and that *"…the first priority is to improve the delivery of existing services before new programmes/activities are started"*(Department of Finance 2002 p.18). Of particular note, is the Committee's observation that *"...there is a growing recognition that shortage of funding may no longer be the key issue in the health services. There is an insufficient relationship between increased funding and actual delivery of services"* (Department of Finance 2002 p.18).

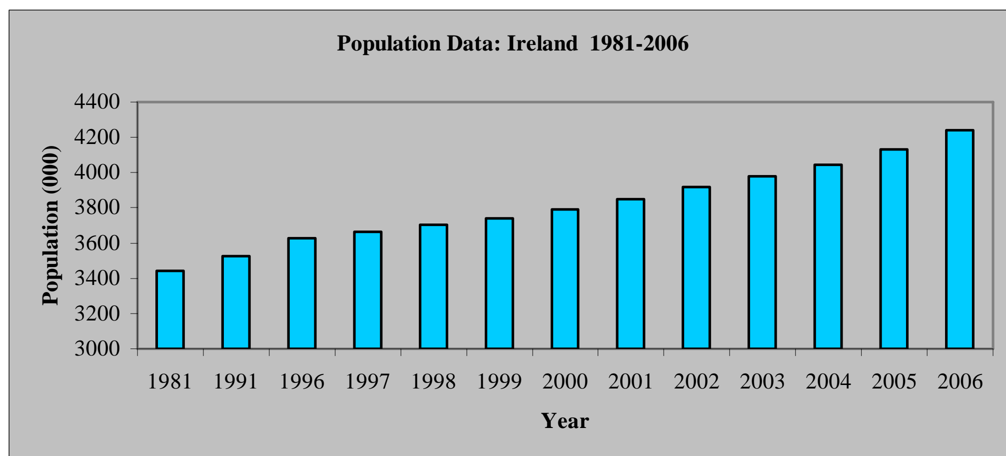
Similar sentiments are also expressed by Wiley (2001b), who queries the issue of spending relative to outputs from the service: *"The fact that health expenditure has been growing substantially in recent years is generally accepted…Given the very*

large commitments of exchequer resources to the health system, clarification of productivity and efficiency targets for the resources invested are essential if any advancement is to be made towards the achievement of the objective of securing 'value for money' within the public health sector" (p.68-69).

2.7.3 Demographic Change

The health strategy, *Quality and Fairness* (Department of Health and Children 2001) highlights that *"Population trends will have an important impact on the demands and pressures in the health system in the years to come"* (p. 54). Similarly, the report on the consultation process on *Quality and Fairness - Your Views about Health* (Colgan & Tubridy 2001) draws attention to the changing patterns of demography in Ireland, in particular, the increasing proportion of older people, refugees and asylum seekers all of whom have specific healthcare requirements and, as such, create demands on the service (Punch 2003;Quinn 2005). The Central Statistics Office data presented in figure 2.3 highlights the growth in population, with a 23.2% increase between 1981 and 2006 (from 3.44 million in 1981 to 4.24 million in 2006), which consequently has driven the demand for health services in Ireland.

Figure 2.3 - Population Growth in Ireland



Source: Central Statistics Office

2.7.4 Greater Expectations and Greater Dissatisfaction on the part of the Consumer/Service User

McCarthy (2005) identifies how the increasing expectations for the quality of services by those in Irish society are acting as a driver for change in the public sector: *"Citizens accustomed to a high level of responsiveness from the private sector, have experienced frustration and eventually a lack of confidence in the bureaucratic state"* (p.17). Greater expectations of service provision on the part of the 'consumer' or 'customer' are reflected in rising consumerism within Ireland (Humphreys & Worth-Butler 1999;Ennis, Harrington, & Williams 2004), while Buckley (2004) notes that it was only with the advent of the SMI, that the Irish public sector (and the health service) began to make increased references to the concepts of customers and customer care. These expectations have, in turn, been coupled with what Ennis, Harrington, & Williams (2004) identify as rising concerns amongst both patients and purchasers about the quality of services in Irish healthcare organisations.

The consultation process on *Quality and Fairness* (Colgan & Tubridy 2001) serves to provide an insight into the expectations for healthcare in Ireland and for the 2001 health strategy, from a variety of inputs, including public and health service organisations, personnel, patients and consumers of healthcare. Key issues explored within the consultation included both the quality and delivery of services; the existing organisation and infrastructure; health information systems and accountability and, in turn, generated a plethora of suggestions for change and improvement within the existing healthcare framework. Some of the most significant findings were around peoples' every-day experiences of the health service. Table 2.5 captures these evaluations and demonstrates a number of areas of dissatisfaction within the overall service delivery. Of specific interest to this study, is the discontentment with the acute-care sector, in terms of in-patient, outpatient, maternity and Accident and Emergency services.

Table 2.5 - Experiences of the Health Service

	Number of Mentions		
Aspect	**Positive**	**Negative**	**Total (N=300)**
Acute In - Patient	58 (45%)	70 (55%)	128 (100%)
A + E	9 (17%)	46 (83%)	55 (100%)
Community Care	22 (44%)	30 (56%)	52 (100%)
Out - patients Clinics	12 (25%)	37 (75%)	49 (100%)
Disability/ LTI	11 (33%)	23 (67%)	34 (100%)
GP Services	17 (57%)	13 (43%)	30 (100%)
Maternity Services	9 (39%)	14 (61%)	23 (100%)
Services or Older People	4 (24%)	13 (76%)	17 (100%)

Source: Your Views about Health. Report on the Consultation - Quality and Fairness (Colgan and Tubridy, 2001, p.40)

This discontent is also echoed through a number of other sources. For example, Wren (2003) quotes both an ESRI survey conducted in 2000 and published in 2001, that indicated that 95% of the population wanted more funding for the health service, in particular to reduce waiting lists, and an Irish Times opinion poll in May 2001, where 65% of voters saw the health service as being their key priority issue in influencing their vote. Wiley (2001b), also quoting the same ESRI survey and with specific reference to the quality of Irish health services, notes that *"The finding … that one respondent in four believed that the quality of care in the public health system was bad or very bad is a serious concern at any time but particularly in an environment where current health expenditure has more than doubled over a five year period"*(p.90). Finally, the *Audit of Structures and Functions in the Health System Report* (commonly known as the Prospectus Report) (Watson Wyatt-Prospectus 2003) commissioned on foot of *Quality and Fairness,* contributed further to the wave of criticism of the existing health system:

"Among patients, staff and the general public, there is a growing belief that there are more effective ways to organise our health service for the twenty first century" (p.9).

More recently, Donohoe (2006) reporting on the performance of the then and current Minister for Health, Mary Harney T.D., in transforming healthcare through the

Reform Programme, quoted an Irish Times/TNS MRBI opinion poll that indicated that 58% of individuals polled believed that there had been no improvement in the health service in the last two years and that the abolition of the health boards and the establishment of the Health Services Executive (HSE), had additionally yielded no identifiable benefits, despite the significant increases in expenditure, as outlined earlier.

2.8 Implementing Healthcare Reform

The current health strategy, *Quality and Fairness*, emphasises the need for quality to be at the heart of the service. Its content is explicit: *"A quality outlook must underpin the planning, management and delivery of services within the health system. Quality can then be measured in an objective way"* (Department of Health and Children 2001 p.86).

A range of recommendations for operationalising the strategy within the health service were subsequently developed through the commissioning and publication of three reports, namely the *Brennan Report* from the Commission on Financial Management and Control Systems in the Health Service (2003), the Watson Wyatt-*Prospectus Report* on the Audit of Structures and Functions in the Health System (2003) and the *Hanley Report* from the National Task Force on Medical Staffing (2003)(Kinsella 2003). Kinsella (2003), with particular reference to the acute-care sector, suggests that these reports *"…are indicative of a prospective paradigm shift in the structure, as well as the organisation and delivery, of acute-care"* (p.1).

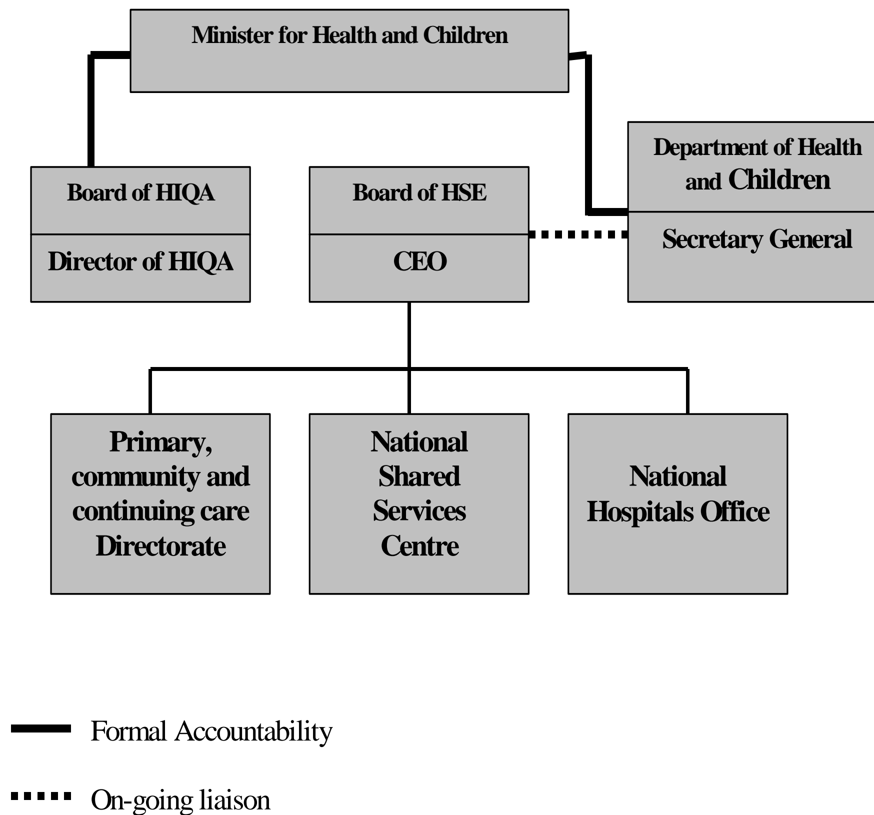
A number of issues are articulated in the Health Service Reform Programme (Department of Health and Children 2003), many of which are focused on the reform of the administrative structure underpinning the existing health system and the refocusing of the role of the Department of Health and Children on policy development. Key facets of the reforms are:

- *"Major rationalisation of health services agencies to reduce fragmentation. This includes the abolition of the health board/authority structures.*

- *Reorganisation of the Department of Health and Children, to ensure improved policy development and oversight.*
- *Establishment of the Health Services Executive (HSE), which will be the first, ever body charged with managing the health service as a single national entity.*
- *Establishment of three core areas within the HSE - a National Hospitals Office, a Primary, Community and Continuing Care Directorate and a National Shared Services Centre.*
- ***Establishment of a Health Information and Quality Authority to ensure that quality of care is promoted throughout the system.***
- *Complete modernisation of supporting processes (service planning; management reporting etc.) to improve planning and delivery of services, including maximising the impact of public funding."* (Department of Health and Children 2003 p.4).

Figure 2.4 outlines the new structure for the health services formalised by the Health Act 2004, as part of the programme of health services reform. On the 1st January 2005, the regional health boards were abolished and the HSE formally established (McNamara et al. 2006). Of interest to this study, is the role of the HSE as the single and over-arching management entity for the health services and the establishment of the National Hospitals Office, as the focal point for the management of the newly formed hospital networks throughout the State. Additionally, the development of the Health Information and Quality Authority (HIQA) is particularly significant to this research on healthcare accreditation, as it is charged, as part of its overall role, with *"…promoting and implementing quality assurance programmes nationally"* (Department of Health and Children 2003 p.8). Labanyi (2006) suggests that the Authority will be involved in the *"...forensic assessment of standards in the health services"*. The role of HIQA was formalised when it transitioned from an interim to a full statutory body in May 2007, under the Health Act 2007 (Department of Health and Children 2007).

Figure 2.4 - The Restructured Health Service



Source: The Health Service Reform Programme (Department of Health and Children, 2003, p.9)

Also in 2007, the previously autonomous IHSAB, whose role in introducing accreditation to the acute-care sector in Ireland will be examined in subsequent sections, was subsumed into the overall HIQA structure. The Department of Health and Children has overall responsibility for the funding of HIQA, and within this, its accreditation brief, while the corporate plan for the Authority is subject to approval by the Minister. Furthermore, in December 2006, a Patient Safety and Quality Unit was established within the Department to act as the primary policy link to HIQA on matters relating to quality and safety, patient advocacy and specifically, healthcare standards and accreditation (Milner 2007).

2.9 Quality and Accreditation in Irish Acute-Care Hospitals

Earlier sections have attempted to chart the development of the quality agenda within the wider Irish public service and also specifically identifying it as a heightened priority within healthcare. As the focus of this study is in the area of healthcare accreditation, as a means of improving overall quality and that the context for implementation is the acute-care hospital sector, it may be useful to provide some basic definitions and summary data in order to further contextualise the research, prior to any specific examination of issues pertaining to quality and accreditation both in this, and subsequent chapters.

2.9.1 Acute-Care Hospitals

Evans (2006) suggests that the term acute-care is normally associated with treatment for episodic or short-term illness, treatment for which, is usually received in hospital. This concurs with the definition provided within *Quality and Fairness* (Department of Health and Children 2001) which describes an acute-care hospital facility as:

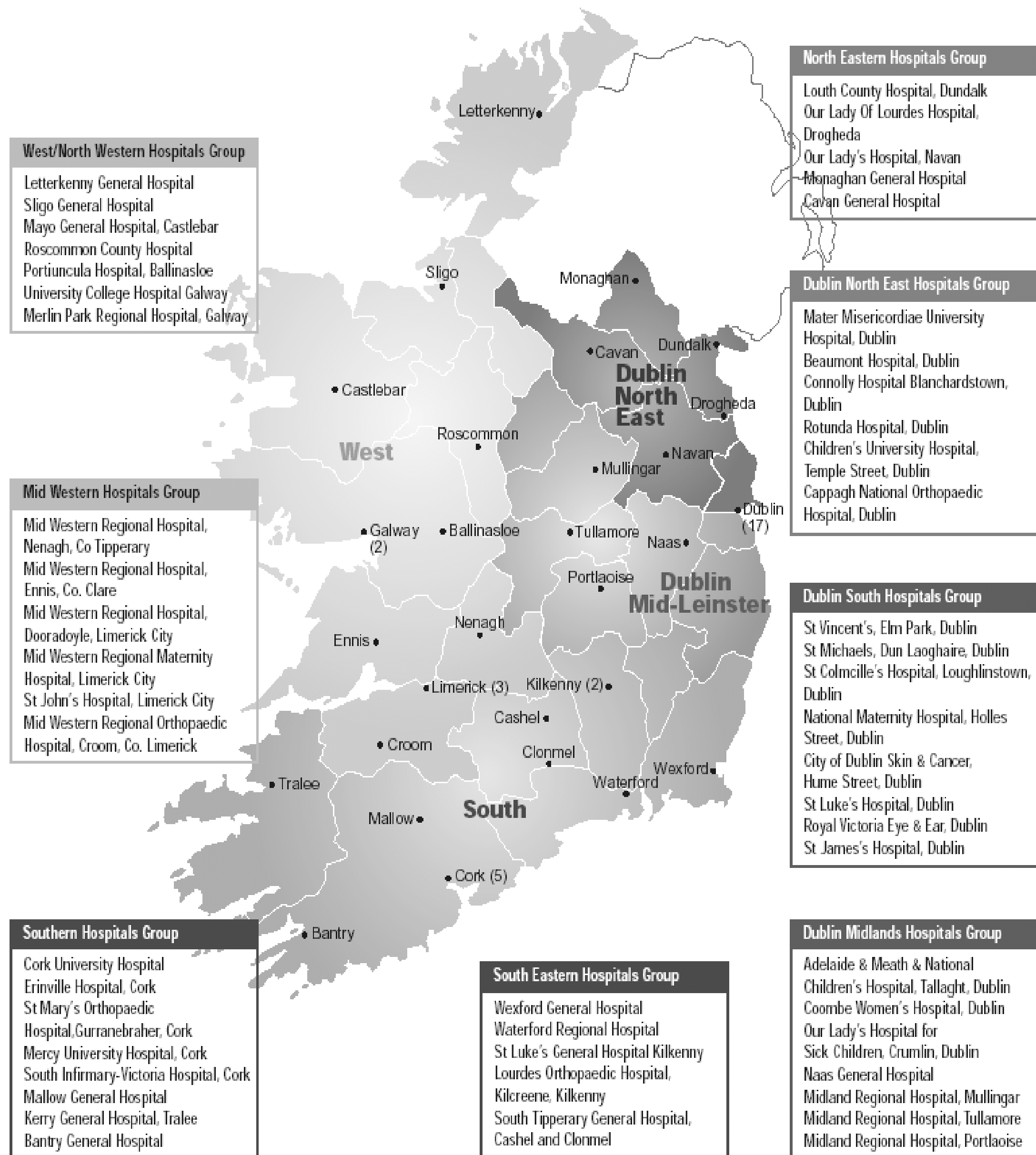
"A hospital providing medical and surgical treatment of relatively short duration. All, except district hospitals, are consultant-staffed. District hospitals are classified as acute where the average length of stay is less than 30 days" (p.201).

It is further noted by Evans (2006) that acute-care hospitals are characterised by the fact that they serve a geographic local population and that typically they will provide a range of specialisms including Accident and Emergency; general and specialist medicine and surgery; intensive care; trauma and orthopaedics and the wide spectrum of other clinical services required to support these.

Figure 2.5 illustrates the geographic dispersion of acute-care hospitals within the State, of which there are fifty-three. Previous sections have highlighted a growth in spending on public healthcare in Ireland, driven, in part, by increasing levels of activity. HIPE - the acute-care sector Hospital In-Patient Enquiry System is the principal source of national data for identifying changing levels of activity and hospital workload in Ireland, based on patient discharges. The most recent report to capture HIPE statistics by the ESRI (2006), covers the period 1992-2001 and shows a marked growth in activity within the acute-care sector. In relation to total

discharges (day patients and in-patients), activity increased by 119%, from 390,396 in 1992 to 856,261 in 2001 (ESRI, 2006). Not surprisingly this growth has created challenges for the existing system, in terms of health services delivery.

Figure 2.5 - Acute-care Hospitals in Ireland: 2005



Source: Annual Report and Financial Statements – HSE (2005 p.4).

2.9.2 Quality in Irish Healthcare

Prior to commencing further examination and discussion of the extent of quality management implementation in an Irish healthcare context, it may be useful to arrive at a standard term to capture the range of organisation-wide initiatives available for adoption. Subsequent chapters will seek to provide an appreciation of some of the quality approaches commonly adopted in organisations including those in healthcare, such as TQM and CQI. However, Saturno (1999) recognises the scope for confusion in the use of various terms within the quality and, specifically, the quality in healthcare field. Attempting to synthesise the plethora of terminology associated with quality initiatives in organisations, he defines a quality system, programme or plan as:

"…the structured set of resources and activities assembled with the explicit objective of maintaining and improving quality" (p.374).

While there is an obvious logic to this, and accepting that the terms 'system', 'programme' or 'plan' might be used interchangeably, the author instead advocates the adoption of a single, generic term 'quality approach' for the purposes of consistency throughout the remainder of this thesis, the exception being where specific literatures on healthcare accreditation are examined.

There is a notable paucity of literature dealing with the extent of implementation of organisation-wide quality approaches in healthcare in Ireland, despite the fact that as an area, it has received increased attention in recent years (Ennis & Harrington 2002;Ennis, Harrington, & Williams 2004). Only one study in the area was identified by the author, conducted by Ennis & Harrington (1999b) who surveyed both large and small hospitals (from more than fifteen hundred to less than one hundred beds), across the country in an attempt to gauge the scope of initiation of such approaches across the sector. The results indicated that only 25% of responding hospitals had developed any degree of involvement with quality approaches, with 13% responding that they had no plans to so in the future. Moreover, only 13% of quality approaches that had been implemented had been operational for more than twelve months. From this, Ennis & Harrington (1999b) concluded that the implementation of quality approaches across Irish hospitals was a relatively new phenomenon. However, the

results from the study did suggest a growing interest in the area of quality, as some 50% of responding hospitals indicated that they were intending to implement quality approaches in the near future (Ennis & Harrington 1999a;Ennis & Harrington 1999b).

2.10 The Development of Acute-Care Hospital Accreditation in Ireland

Accreditation within publicly funded hospitals in Ireland is a relatively new initiative (Sweeney 2004). The formal establishment of the Irish Health Services Accreditation Board (IHSAB) in 2002, via statutory instrument number 160 (Department of Health and Children 2002b) heralded the integration of hospital accreditation into the wider healthcare management field in Ireland (Sweeney 2004). The Board's purpose is articulated as being *"…to operate hospital accreditation programmes and to grant accreditation to hospitals meeting standards set or recognised by the Board"* (Department of Health and Children 2002b section 5 (1) a.).

The development of a formal accreditation scheme commenced in November 1998 as a result of a collaborative exercise between the Chief Executives of the Dublin Academic Teaching Hospitals and with the further support of the Department of Health and Children, who recognised the necessity and potential of accreditation within the acute-care sector (Sweeney 2004). Arising from an international review of accreditation practice, a tendering process was initiated to support the establishment of *"…an independent and internationally recognised Accreditation Scheme for the Irish health system"* (Accreditation Steering Group 1999b p.1) and the associated standards for the acute-care scheme. The contract was awarded to the Canadian Council for Health Services Accreditation (CCHSA) and the accreditation standards were completed in late 2000 and were further validated by the International Society for Quality in Healthcare Alpha Standards Assessment Programme (ISQua 2004;Sweeney 2004). The standards were subsequently reviewed and revised in 2004, with a reduction in individual criteria within each of the standards (www.ihsab.ie/scheme_review.htm).

The acute-care accreditation scheme was developed around an underpinning philosophy of being patient focused, the enhancement of the quality of service

delivery and being instrumental in promoting continuous quality improvement through regular evaluation (Accreditation Steering Group 1999a). Within this, the scheme aims to provide a safe environment for patients, staff and members of the public; place quality at the core of services and in doing so, develop a quality culture, and to promote the attainment of healthcare best practices (Accreditation Steering Group 1999a). As previously mentioned, in 2007 IHSAB was integrated into the HIQA structure on a statutory basis (Milner 2007, www.hiqa.ie).

The overall IHSAB brief was with the formulation, on-going review and day-to-day operation of accreditation via external assessment of quality in the healthcare services, with specific emphasis on acute-care hospitals (www.doh.ie/hinfo). The significance of accreditation is reinforced in the HSE Corporate Plan 2005-2008 (HSE 2004) who list as a high level action point: *"Improving the safety, effectiveness and quality of our services in collaboration with relevant external bodies (e.g. Irish Health Services Accreditation Board)"* and state that a key deliverable will be an *"Increased number of services participating in relevant programmes"* (p.26).

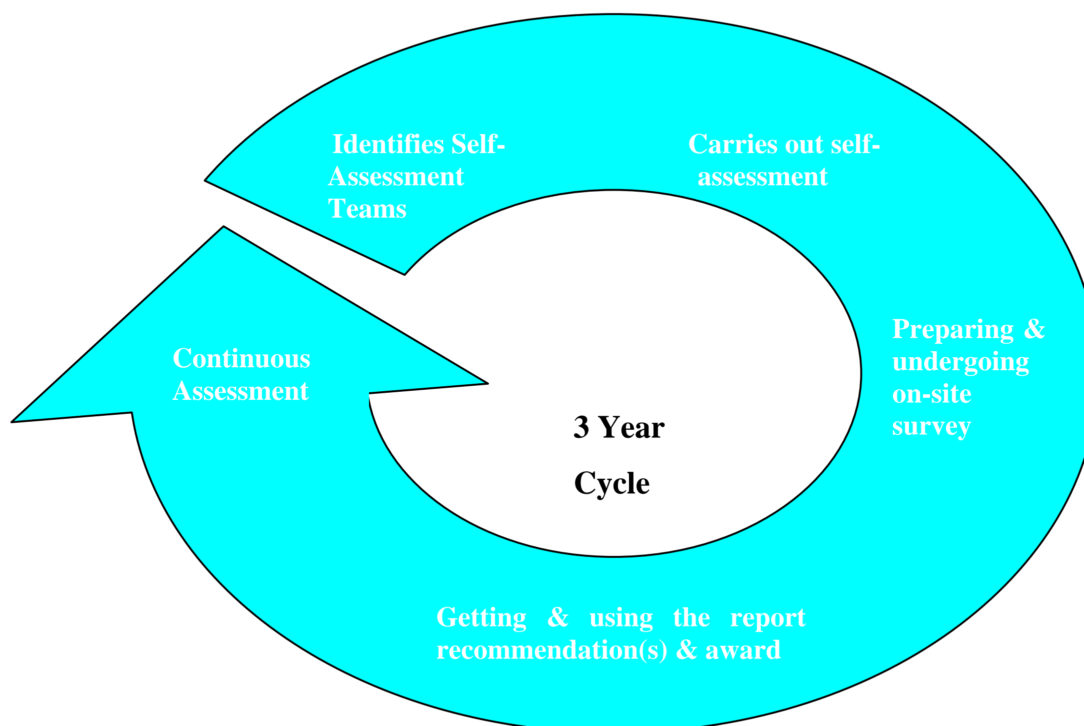
A key characteristic of the Irish approach to the accreditation process is that it is voluntary in nature, although the majority of the acute-care sector has now signed up to the scheme. The initial rollout commenced in 2002, with the major academic teaching hospitals, initially in Dublin and then across the country, and subsequently with all larger acute-care regional and general hospitals and other, smaller hospitals to which the standards are applicable (Sweeney 2004). In August 2006, IHSAB reported that *"Accreditation continues to grow in strength with participation now involving 90% of the acute hospitals"* (Boland 2006 p.2). However, whether accreditation is the most suitable approach for improving the quality of healthcare services at the organisation-wide level is a matter of some debate in the limited literature in the area and this is addressed in Chapter 3.

2.11 The IHSAB Accreditation Scheme

According to IHSAB *"The aim of the scheme is to provide for the objective and systematic evaluation of healthcare entities against a set of pre-defined quality standards. The accreditation process evaluates participating organisation's patient/client care, support services, leadership and partnerships initiatives against national standards that focus on processes and outcomes. The accreditation process gives health service organisations an effective way of assessing how they are performing"* (http://www.ihsab.ie/overview.html).

In relation to the accreditation cycle, figure 2.6 depicts the various phases involved with the process. Typically from the initiation of the hospital's application, to the first on-site survey, IHSAB estimate a twelve to eighteen month timeframe with a total three-year cycle (IHSAB 2004). Figure 2.6 also demonstrates the several distinct stages in the process and highlights what is the focus of this study - the self-assessment (first) phase - which *"…enables the organisation, and more specifically the self assessment teams, to identify what they are doing and how well they are doing it. This allows teams to consider where they have been, where they are now, and where they need to go"* (http://www.ihsab.ie/self_assessment).

Figure 2.6 - The Accreditation Cycle



Source: http://www.ihsab.ie/overview.html and *Acute Care Accreditation Scheme Standards and Guidelines: A Framework for the Continuous Improvement of the Quality and Safety of Patient/Client Centred Care*, 2nd edn, Irish Health Services Accreditation Board, p.48.

2.12 The ISHAB Acute-Care Accreditation Scheme (ACAS) Standards

The standards and individual criteria contained therein, are the foundations of the accreditation approach (Shaw 2000), including the scheme sponsored by IHSAB. For IHSAB *"The IHSAB Acute-Care Accreditation Standards form the cornerstone of the Acute-Care Accreditation Scheme and provide a framework within which identification and progression of quality and safety improvement initiatives can be effected in participating organisations"* (http://www.ihsab.ie/structure.html).

The ACAS standards are characterised by both breadth and depth and seek to capture both the level and type of activity, practice and standards across an entire hospital site, in both the clinical and support service domains (IHSAB 2004). The standards are grouped accordingly and embrace clinical care or service; human resource management; environment and facilities management; information management and

leadership and partnership and on the basis of these, self-assessment teams are formed, which are central to the accreditation process and hence this research. For IHSAB *"Inter-disciplinary self-assessment teams should include front line direct and indirect care/service providers and professionals, organisation leaders (management and/or governance), community partners, patients/clients, volunteers etc"* (IHSAB 2004 p.49).

Each individual set of standards relating to one of the above groups, embraces the 'plan-do-check-act' quality cycle and requires, in the first phase of accreditation, self-assessment teams to demonstrate in their practice (and supported by evidence of compliance), the extent to which this approach is utilised to plan, deliver and evaluate services within the hospital (IHSAB 2004). Actual practice is rated by the self-assessment teams and where this falls below a given level (rated as D or E as an indication of only minor compliance), a further assessment is required to identify risks to the patient/staff and/or the organisation (IHSAB 2004). This overall self-assessment process and the supporting evidence, is documented in a structured manner and is fundamental to supporting the team of IHSAB surveyors in arriving at an overall rating of the hospital during their visit to the site (see Appendix A for further detail on the accreditation standards and process).

2.13 Conclusion

This chapter has sought to provide the context for the implementation of acute-care hospital accreditation. Quality public services are accepted as being essential within a society and the reform programme, taking place in both the wider Irish public sector and specifically in healthcare, has endeavoured to focus greater attention and effort towards the improvement of these. In the acute-care sector, the key vehicle for this is the IHSAB accreditation process, which, in turn, is reliant on the contributions of individuals working together in multi-disciplinary teams, who are the particular focus of this study. Having addressed the aforementioned issues, Chapter 3 turns to exploring the literature specifically relating to quality, quality in healthcare and accreditation.

Chapter 3: Literature Review - Quality, Quality in Healthcare and Accreditation

3.0 Introduction

This chapter is intended to serve as the basis for the examination at a later stage, of the implementation process and associated impacts of hospital accreditation, which is an approach which seeks to improve the overall quality of healthcare services within an organisation. With this in mind, it is necessary to examine the concept of quality itself through exploring briefly, issues of definition, the fundamental concepts surrounding quality approaches and the ideas and views of some of the key contributors in the field. As healthcare is service-based, it is also pertinent to give some consideration to service quality, prior to a detailed discussion of healthcare quality and more specifically, accreditation.

3.1 Defining Quality

The field of quality and its management, is now considered to be a mature discipline (DeFeo & Janssen 2001;Sousa & Voss 2002;Lewis, Pun, & Lalla 2006;Lagrosen, Backstrom, & Lagrosen 2007). However, quality as a management term has posed several challenges in terms developing a precise definition. Garvin (1992) observes that *"Quality is an unusually slippery concept, easy to visualise and yet exasperatingly difficult to define. Conflicting definitions are common"* (p.126), a view also supported by Dean & Bowen (1994), Anand (1997), Wilkinson et al. (1998), Yong & Wilkinson (2002), Sousa & Voss (2002), Dale (2003c) and Goetsch & Davis (2003). Some of the implications arising from the definitional debate are also identified by Garvin (1984) who argues that *"Quality is a complex and multifaceted concept. It is also the source of great confusion: managers - particularly those in different functions - frequently fail to communicate precisely what they mean by the term. The result is often endless debate and the inability to show real progress on the quality front"* (p. 39).

In an analysis that is reflective of the earlier work of Garvin (1984), Yong & Wilkinson (2002) attempt to capture some of the more popular definitions of quality that form the basis for much of the discourse in the field and they purport that circumstances and context will determine the appropriateness of usage of a particular definition. For Yong & Wilkinson (2002):

(i) Quality is excellence, determined by the innate and superior attributes of a product or service;

(ii) Quality is value, being a function of both cost, price and relative to the performance of the product or service;

(iii) Quality is conformance to specification, being a function of adherence to tolerance limits and reliability of the product or service;

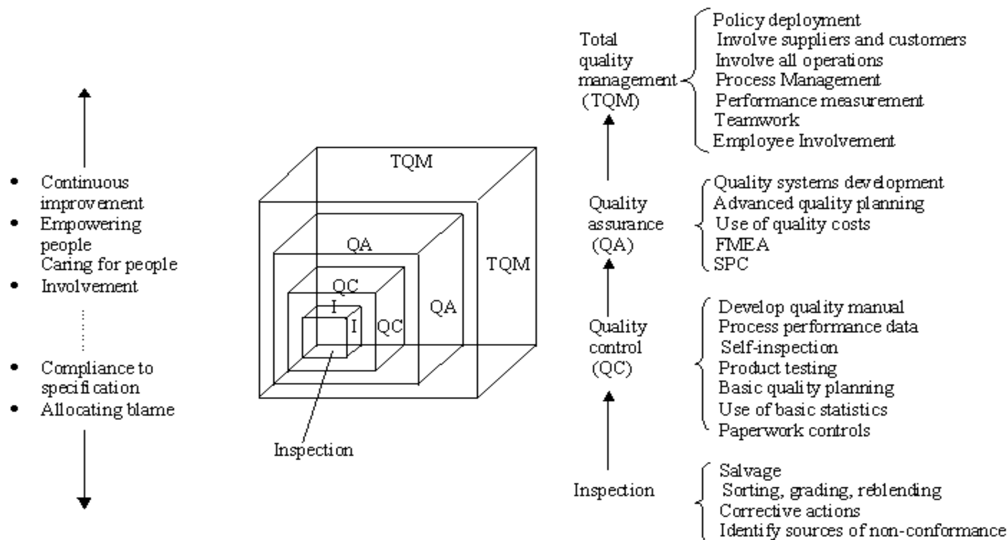
(iv) Quality is meeting and/or exceeding customers' expectations of the product or service.

3.2 Evolution of Quality Management as a Discipline

Quality management has been defined as *"…a philosophy or an approach to management that can be characterized by its principles, practices and techniques"* (Dean & Bowen 1994 p.394) and which represents the basis for continuous improvement within an organisation (Frangou 2002;Hazilah & Manaf 2005). As previously noted, it is considered to be a mature discipline, with the potential for application across a range of organisational types and sectors, including public healthcare organisations (Donnelly 1999;DeFeo & Janssen 2001;Sousa & Voss 2002;Frangou 2002). There are a number of underlying approaches to managing and improving quality that have developed at a rapid pace in recent years and, likewise, organisations have assimilated these in stages, with varying momentum, and contingent on their degree of strategy-quality integration (Belohlav 1993;Black & Porter 1995;Calingo 1996;Cameron & Barnett 2000;Kumar & Douglas 2002;Dale 2003c). As Belohlav (1993) notes *"Just as there are different levels of quality, there are also different levels of quality management. One can produce defect free products and services, but it is not the same as total quality management"* (p.66).

Dale (2003c) provides a useful depiction of the four distinct phases or levels in the evolution of quality management or what Leonard & McAdam (2004) term as 'eras'. Figure 3.1 captures the progression of the discipline from Inspection through to TQM (now frequently referred to as CQI (Boaden 2006)), encompassing the range and features of each approach and the shift in management philosophy and style to support the transition (Ghobadian & Gallear 2001;Kumar & Douglas 2002). Table 3.1 attempts to summarise the central tenets of each approach.

Figure 3.1 - Phases in the Evolution of Quality Management



Source: Dale, B. 2003c, "TQM: an overview," in *Managing Quality*, B. Dale, ed., Blackwell, p.21

Of particular significance to this study on acute-care hospital accreditation, is firstly the emergence of the discipline of quality assurance and within this, the development of quality systems which are comparable in terms of standard setting and third party audit and review, to the elements of accreditation (Morgan & Potter 1995), as outlined in Chapter 2. However, quality systems such as ISO 9000 have themselves been subject to criticisms which clearly resonate with a number of issues that will be raised later in this chapter and also in Chapter 4 with specific reference to implementing organisation-wide quality approaches in healthcare contexts. In particular, it has been suggested that ISO 9000 is bureaucratic; costly to implement; frequently struggles to gain employee commitment towards the approach; creates excessive workloads for those involved and furthermore, that the majority of the internal problems associated with its implementation relate to human resource issues (Motwani, Kumar & Cheng 1996;Abraham et al 2000;Gotzamani &Tsiotras 2002;Boiral & Roy 2007).

Finally, the progression towards TQM sees the emergence of involvement of all operations and the improved management of processes, which mirror the

organisationally holistic approach of accreditation, while the development of teamwork and the introduction of employee involvement are key vehicles for the implementation of the IHSAB model.

Table 3.1 - Key Elements of the Phases of Quality Management

Inspection	Dale (2003c) describes a simple inspection system as one where *"…one or more of the characteristics of the product, service or activity are examined, measured, tested, or assessed and compared with specified requirements to assess conformity with a specification or performance standard"* (p.22). Yong & Wilkinson (2002) and Dale (2003c) suggest that inspection occurs after-the-event and lacks a preventative focus other than identifying contributory factors such as employees, suppliers or operations. Additionally, the approach is locally/departmentally based and has an insufficient organisation-wide perspective.
Quality Control	The Quality Control concept aims to seek assurance that the final product meets predetermined specifications and acceptable tolerance limits and is characterised by the organisation working in *"…a detection-type mode"* (Dale 2003c p. 22). Central to the approach is the utilisation of statistical techniques, sampling methods and control charts.
Quality Assurance and Standards	Quality Assurance (QA) embodies an approach to examining the process itself ,with a view to improvement and preventing problems at source and introduces the plan, do, check, act (PDCA) cycle, focusing on continuous improvement (Burrill & Ledolter 1999;Dale 2003c). In partnership with quality assurance efforts are likely to come the development and implementation of formal quality systems (QMS) *("…the organisational structure, responsibilities, procedures, processes and resources for implementing quality management"* (Dale 1994b p.334)) and the conformance of these to externally recognised third party standards. Application for certification against these involves audit and the awarding of accreditation by an externally recognised body such as the International Organization for Standardisation (ISO)(Goetsch & Davis 2003). Beckford (1998) notes that a QMS *"…enables the organisation to demonstrate to itself, its customers, and importantly to an independent accreditation body, that it has established an effective system for managing the quality of its products and services"* (p. 237).
Total Quality Management	TQM involves deploying quality management tools, techniques and principles across the organisation, with employee participation and backwards and forwards in the value chain from suppliers to customers (Dean & Bowen 1994;Yong & Wilkinson 2002;McAdam & Henderson 2004). It can be characterised by a number of constitute elements such as the commitment and leadership of the CEO; planning and organising; use of tools and techniques of quality management; provision of education and training; employee involvement; teamwork; measurement and feedback and finally, culture change (Dale 2003b). He also notes that *"Individual systems, procedures and requirements may be no higher than for a quality assurance level of quality management, but they will pervade every person, activity and function of the organization"* (Dale 2003c p. 26).

Huggins (1998), suggests that the *"...credit for sounding the wakeup call"*(p.60) in the quality discipline can be attributed to a small number of key thinkers who are globally recognised as having driven both the theoretical and practical development of the various phases associated with the field of quality (Sahney & Warden 1991;Redman & Mathews 1998;Dale et al. 2001;Stewart 2003;Boon & Arumugam 2005;Boaden 2006;Vouzas & Psychogios 2007). The objective of this section is not

to present an exhaustive description or discussion of the quality philosophies or classical *"…schools"* (Kruger 2001 p.146). Instead, a brief portrayal of central ideas of a selection of the prominent and influential thinkers in the field, is presented in table 3.2, based on the position of Dale, Boaden & Lascelles (1994) who argue that *"In the West, the four best known are Crosby, Deming, Feigenbaum and Juran"* (p.3), who approach the management of quality from an organisation-wide perspective (Daily & Bishop 2003). This depiction also attempts to demonstrate the commonalities that exist between the approaches, in terms of the focus on the fundamental and interrelated requirements of the customer/user themselves; the objective of process improvement; better product (and service) quality and the scope for increased cost effectiveness, all of which have the potential to make a positive impact on competitiveness or, for those organisations operating in the public sector, improved value-for-money from budgetary spend (Black & Porter 1995;Feinberg 1998;Claver, Tari, & Molina 2003).

Of particular interest to this study is the emphasis, albeit in differing degrees (Dale 2003b), on the 'people' or 'soft' aspects of quality reflected within the various positions advocated by the 'gurus'. The role of leadership and within this, management commitment to the quality approach and its implementation, are explicitly highlighted by Deming and Crosby, while Dale (2003b) also notes that Feigenbaum emphasises this as being critical to successful implementation. Wilkinson & Brown (2003) in an assessment of the work of Crosby and Juran, note that the role and participation of employees in continuous improvement activities is minimal although this might be a source of debate with reference to Crosby's tenets, where the establishment of quality improvement teams is specifically highlighted and hence implies some degree of employee input. Feigenbaum particularly mentions the requirement for involvement and effort on an individual basis, while Deming, in his emphasis on the organisation-wide nature of quality efforts implies a role for employees.

The use of teams in quality implementation, as mentioned already, features in the ideas of Crosby, but also in those of Deming and Feigenbaum, where team contribution to quality approaches is acknowledged. The importance of training to support quality implementation is also evident amongst the principles espoused by

the “gurus”. Crosby advocates its provision (although for supervisors only) as do Deming and Juran, as being instrumental in developing the necessary competencies in the human resources within the organisation. The role of recognition is featured in the ideas posited by Crosby and Juran, as a means of motivating, acknowledging and reinforcing the contributions of those who participate in quality approaches. Finally, the requirement for communication throughout the organisation to build awareness and purpose towards the need to implement the quality approach and also on its subsequent progress and results, is explicitly stated in the work of Juran, Crosby and Deming (Dwyer 2002;Dale 2003b).

Table 3.2 - Quality 'Gurus': Key Principles for Managing Quality

Crosby (1984)	Deming (1982)	Feigenbaum (1991)	Juran (1992)
1. Management Commitment;	1. Create constancy of purpose for continual improvement;	1. Quality is a company wide process;	1. Build awareness of the need and opportunity for improvement;
2. Quality Improvement Teams;	2. Adopt the new philosophy;	2. Quality is what the customer says it is;	2. Set goals for improvement;
3. Quality Measurement;	3. Eliminate the need for mass inspection;	3. Quality and cost are a sum not a difference;	3. Organise to reach for goals;
4. Cost of Quality Evaluation;	4. End practice of lowest tender contracts;	4. Quality requires both individual and team zealotry;	4. Provide training;
5. Quality Awareness;	5. Work continuously for improvement in every process, using statistical methods;	5. Quality is a way of managing;	5. Carry out projects to solve problems;
6. Corrective Action;	6. Institute modern methods of training on the job for all staff;	6. Quality and innovation are mutually dependent;	6. Report progress;
7. Establish an ad hoc committee for the zero defects programme;	7. Institute modern methods of leadership based on quality not numbers;	7. Quality is an ethic;	7. Give recognition;
8. Supervisor Training;	8. Drive out fear by encouraging two-way communication;	8. Quality requires continuous improvement;	8. Communicate results;
9. Zero Defects Day;	9, Break down barriers between departments;	9. Quality is the most-cost effective, least capital intensive route to productivity;	9. Keep the score;
10. Goal Setting;	10. Eliminate exhortations made without providing methods and system to do so;	10. Quality is implemented with a total system connected with customers and suppliers.	10. Maintain momentum.
11. Error cause removal;	11. Eliminate arbitrary numerical targets;		
12. Recognition;	12. Foster pride in workmanship;		
13. Quality Councils;	13. Institute vigorous programmes of education and encourage self-development;		
14. Do it over again.	14. Create top management structure to push the above points every day.		

3.3 The Strategic Perspective on Quality

Just as the previous sections have sought to address the key issues relating to the evolution of the field of quality, so this discussion aims to further develop the strategic perspective on quality. It is not intended to provide an in-depth analysis of empirical research demonstrating the links between any particular quality approach and organisational performance, but rather, seeks to demonstrate that for most organisations, quality is likely to be implicit, if not explicit, within their strategic objectives.

Enshrined in the key ideas of Crosby, Deming, Feigenbaum and Juran that have been previously presented, is a strategic perspective that seeks to emphasise the profound impact that managing quality may make to organisational competitiveness (Hackman & Wageman 1995;Badri, Davis, & Davis 1995;Redman & Mathews 1998;Samson & Terziovski 1999;Ghobadian & Gallear 2001;Beer 2003;Taylor & Wright 2003;Chang 2005) and moreover to organisational survival (Kia Liang Tan 1997;Warwood & Roberts 2004;Rad 2006). As Parasuraman (1985) comments on quality itself *"…its importance is unequivocal"* (p.41). It is now widely accepted in the broader management and quality literature that the strategic and proactive pursuit of quality is an imperative for organisations who are seeking to achieve both improved performance and value-for-money (Berry, Parasuraman, & Zeithaml 1988;Garvin 1992;Belohlav 1993;Calingo 1996;Belohlav 1996;Wilcox et al. 1996;Zbaracki 1998;DeFeo & Janssen 2001;Sousa & Voss 2002;Dale 2003c;McAdam & Henderson 2004;Leonard & McAdam 2004;Sigala & Christou 2006). Furthermore, in relation to public sector organisations, the discussion of NPM and also the on-going reform of the Irish public sector (and within this, healthcare) in Chapter 2, highlighted the elevation of quality to a strategic position, where its pursuit is explicitly stated as a desirable organisational goal (Hood 1991;Osborne & Gaebler 1992;Dunleavy & Hood 1994;Pollitt 1995;Embleton 1999;Department of Health and Children 2001;Humphreys, Butler, & O'Donnell 2001;Ferlie & Steane 2002;Humphreys 2003;Hughes 2003;Department of Health and Children 2003).

Reinforcing the contention that quality has become a strategic issue, Belohlav (1993) observes that *"A common denominator in many of the discussions on competitiveness and strategy is the issue of quality"* (p.55) and so much so, that he argues that it

became the major competitive paradigm for the 1990s (Belohlav 1996). This is supported more recently by Frangou (2002), who posits the view that acceptance of the competitiveness argument has fuelled the interest in strategic quality. Moreover, for Galetto (1999) *"Quality has always been a competitive advantage…quality is a serious and difficult business; it has become an integral part of management"* (p.19). However, this view is countered by Dory and Schier (2002) and Singh & Smith (2006) who argue that quality is not a strategy in itself, but is instead part of a wider organisational strategy. Likewise, Srinidhi (1998) argues that the management of quality must not be practiced in isolation from other initiatives and from overall organisational strategy. In addition, he advocates that *"…quality concepts are integrated into the vision and goals of the firm, in the formulation of the policies and actions required for change management and in the deployment of the strategy"* (Srinidhi 1998 p.42). Viewing quality strategically has also led organisations to take a greater cognisance of their internal operations, in particular, focusing on issues and activities that contribute to or hinder strategic capability, while still remaining externally focused on both their competitive environment and markets, in the overall strategy development and implementation process (Belohlav 1993;1996;Claver, Tari, & Molina 2003).

One route to exploring how quality interfaces with strategy is through the approach popularised by Michael Porter in the area of generic strategies (Tari 2005). Porter's (1980) contention is that organisations will seek to compete on the basis of one of three, generic strategies. He categorises these as cost leadership, aimed at creating economies of scale, tight control over total costs and overheads and the avoidance of customers whose contribution is at the margin; differentiation, where the organisational focus is with the creation of products or services that are perceived to be unique by virtue of their innate features, design, brand image, customer service and other dimensions and finally, focus. Porter (1980) suggests that a focus strategy will see an organisation serving only part of the overall market, either through a cost leadership or differentiation approach. He also posits that it is unlikely that organisations will be able to pursue more than one strategy at a time arising from differing resource, structural and management style requirements and internal capacities.

In relation to where quality might feature in the Porter model, *"..the most visible link between quality and strategy"*(Belohlav 1993 p.59) lies with the differentiation and focus-differentiation approaches. Here the objective is to produce a product or service that provides the features that consumers or users consider to be important and unique, relative to other organisations in the market or some niche market and thus sits comfortably with much of the previous discussion around the definition of quality. However, Belohlav (1993;1996) also argues that central to the maxims of quality is a focus on the elimination of waste and non-value adding activities, process improvement and achieving overall gains in cost effectiveness, which he suggests are compatible with Porter's cost-leadership strategy and, in turn, can impact positively on competitive position. For Belohlav (1996):

"In terms of Porter's generic strategies, attaining high quality creates the capacity to pursue not only a differentiation strategy, but also a low-cost strategy. As a result, competitors may find that even rigorous adherence to a single generic strategy, as suggested by Porter, may not be enough to remain competitive with the quality company" (p.13).

In relation to the external organisational environment, the demands of consumers for improved quality products and services is ever increasing and hence makes it a strategic issue (Black & Porter 1995;Redman & Mathews 1998;DeFeo & Janssen 2001;Claver, Tari, & Molina 2003;Dale 2003c;Balbaster Benavent, Cruz Ros, & Moreno-Luzon 2005;Tari 2005). As DeFeo & Janssen (2001) note *"…customers have tasted quality and want more"* (p.93). As an example, Chapter 2 highlights how expectations about the quality of public services (including healthcare) in Ireland had risen dramatically in recent years and that these expectations are not always met (Embleton 1999;Humphreys & Worth-Butler 1999;McHugh & O'Brien 2000;Department of Health and Children 2001;Wren 2001;Boyle & Humphreys 2001;Wren 2003;Buckley 2004;McCarthy 2005). From a competitive perspective, the advent of globalisation and technology development allows products to be made, and services to be delivered, geographically distant from the point of consumption. As Goetsch & Davis (2003) surmise *"Companies that used to compete only on a local, regional and national level now find themselves competing against companies from throughout the world...Only those who are able to produce world-class quality*

can compete on this level" (p.42). These factors have ultimately created momentum for a more strategic orientation towards quality in most organisations (Calingo 1996;Kumar & Douglas 2002;Dale 2003c;Rad 2006).

However, despite the growth in both interest in, and implementation of, quality approaches at the strategic level, Zbaracki (1998), Ghobadian & Gallear (2001) and Sila & Ebrahimpour (2003) observe that some commentators see it simply as an organisational fad, full of rhetoric. In particular, the work of Hackman & Wageman (1995) challenges whether organisation-wide quality approaches will require such fundamental change that an organisation may not be able to accommodate them and moreover, that these changes *"…may be more window dressing than real"* (p.336). Finally, Frangou (2002) cites the failure level of organisations in terms of both implementation and resultant organisational performance as the basis for querying the value of quality approaches. However, despite this debate, the management of quality is now widely accepted as being a key requirement for all organisations.

3.4 Quality in Services and Public Services

As the healthcare sector is service-based, an examination of the core issues relating to services and the underlying management of their quality, is deemed appropriate. While Behara & Gunderson (2001) and Boaden (2006) note that the dominant focus of the key publications in the quality field have been on product quality and manufacturing contexts, the service quality literature is now both extensive and robust (Redman et al. 1995;Redman & Mathews 1998;Rowley 1998;Hing Yee Tsang & Antony 2001;Lagrosen & Lagrosen 2003;Kang 2006). The strategic relevance of service quality mirrors those arguments previously presented in the general area of quality and as Sigala & Christou (2006) comment, with reference to the global organisational context:

"Overall, within this turbulent economic environment, business competitiveness and performance is currently being related to issues such as service quality" (p.345).

Services have been variously defined. An early contributor to the study of the service sector and quality therein, Gronroos (1984), adopts a working definition as *"…the*

objects of transaction offered by firms and institutions that generally offer services or that consider themselves service organisations" (p.19). More recent offerings are from Palmer (2005) - *"The production of an essentially intangible benefit, either in its own right or as a significant element of a tangible product, which through some form of exchange, satisfies an identified need"* (p.3) and from Zeithaml, Bitner, & Gremler (2006), who view services simply as *"…deeds, processes and performances"* (p.4).

Services differ fundamentally from products (Parasuraman 1985;Berry, Parasuraman, & Zeithaml 1988;Desmet, Van Looy, & Dierdonck 1998;Zeithaml, Bitner, & Gremler 2006) and hence managing their quality presents a range of challenges, arising primarily from their innate characteristics (Walsh 1991;Redman & Mathews 1998;Rowley 1998). Table 3.3 summarises the seminal work by Parasuraman (1985) on services and service quality. It highlights what are widely accepted as the distinctive characteristics of services that set them apart from goods or products and the implications arising from these, in particular for the achievement of quality. As Parasuraman (1985) argues *"…three well documented characteristics of services - intangibility, heterogeneity and inseparability - must be acknowledged for a full understanding of service quality"* (p.42).

Table 3.3 - Differences between Goods and Services

Goods	Services	Resulting Implications
Tangible	Intangible	Services cannot inventoried; Services cannot be easily patented; Services cannot be readily displayed or communicated; Pricing is difficult.
Standardized	Heterogeneous	Service delivery and customer satisfaction depend on employee and customer actions; Service quality depends on many uncontrollable factors; There is no sure knowledge that the service delivered matches what was planned and promoted.
Production separate from consumption	Simultaneous production and consumption	Customers affect each other; Employees affect the service outcome; Decentralisation may be essential; Mass production is difficult.
Non-perishable	Perishable	It is difficult to synchronize supply and demand with services; Services cannot be returned or resold.

Source: Parasuraman, A. 1985, "A Conceptual Model of Service Quality and its Implications for Future Research", *Journal of Marketing*, vol. 49, no. Fall, p.41-50

Berry, Zeithaml, & Parasuraman (1985) identify the kernel of the divergence between products and services - that production and consumption are frequently inseperable. In terms of defining service quality, what is often seen as the product manufacturing approach ('conformance to specifications') has given way to a wider and more customer-orientated perspective, based on expectations and needs. Parasuraman (1985) suggests that service quality *"...is a measure of how well the service level delivered matches customer expectations. Delivering quality service means conforming to customers expectations on a consistent basis"* (p.42), while Palmer (2005) similarly posits the view that it is the customer who is best placed to define quality, based on the satisfaction of their particular needs.

Customer expectations are central to the management of service quality (Gronroos 1984;Parasuraman 1985;Berry, Parasuraman, & Zeithaml 1988;Rowley 1998;Kang 2006) and this fits with the 'Quality as meeting and/or exceeding customers' expectations' definition presented earlier. For Berry, Parasuraman, & Zeithaml (1988) *"...it is the customer's definition of quality, not management's that counts"*(p.35) and that arising from this *"Customers' expectations for a particular service shape their assessment of the quality of the service"* (p.37). Customers will arrive at an assessment of the quality of the service via a comparison of what they

actually want or expect versus what they actually get or perceive that they are getting (Gronroos 1984;Berry, Parasuraman, & Zeithaml 1988;Gronroos 2001;Lewis 2003).

Table 3.4 captures the research conducted by Berry, Zeithaml, & Parasuraman (1985) and Parasuraman (1985) where they identify what they believe to be the key determinants of service quality, although the emphasis and relative importance of each may differ between industries or sectors.

Table 3.4 - Determinants of Service Quality

Determinants of Service Quality
Reliability e.g. the ability to execute the service on an accurate, consistent and dependable basis;
Responsiveness e.g. the scope, commitment and readiness of employees to help customers and to provide a prompt and timely service;
Competence e.g. the requisite knowledge and skill of contact and support staff to provide the service and the organisational research capability;
Access e.g. ease of contact and overall approachability where operating hours are convenient, waiting times are not excessive and facilities are conveniently located;
Courtesy e.g. respect, politeness and consideration towards the customer by contact staff;
Communication e.g. informing customers using appropriate language and also listening to customers and their concerns;
Credibility e.g. honesty and trustworthiness where the customers interests are central in the organisation;
Security e.g. the absence of risk, danger and doubt and with appropriate standards of confidentiality;
Understanding the customer e.g. establishing, as precisely as possible, the customer's needs and where appropriate providing individualised attention;
Tangibles e.g. the facets of the service that have physical attributes including the physical environment for service delivery, the appearance of staff and the equipment and technology used in the delivery of the service.

Source: Adapted from Parasuraman, A. 1985, "A Conceptual Model of Service Quality and its Implications for Future Research", *Journal of Marketing*, vol. 49, no. Fall, pp. 41-51 and Berry, L., Zeithaml, V., & Parasuraman, A. 1985, "Quality Counts in Services, Too", *Business Horizons* no. May-June, pp. 44-52

Of equal significance in the exploration of quality in the domain of services, are the dimensions of service quality itself and the interrelationships therein. The Gronroos (1984) framework is cited extensively in the service quality literature and has clear applicability to healthcare scenarios. In summarising the central theme to the dimensions of service quality, Gronroos (1984) distinguishes between 'technical quality' - what is actually delivered (the output) and 'functional quality' - how it is delivered (the process), which Palmer (2005) further argues is frequently as important as the service outcomes, and replaces the traditional product features of a physical product (Gronroos 1984;Gronroos 2001). Parasuraman (2002) suggests that

what is actually produced *"…is a set of 'performances' that are typically produced and consumed simultaneously through one or more interactions between producers and customers"*(p.7). For Gronroos (1984):

"Because the service is produced in interaction with the consumer, this technical quality dimension will not account for total quality which consumers perceive they have received. They obviously will also be influenced by the way in which the technical quality is transferred to them" (p.39).

In an examination of the Gronroos (1984) thesis, Kang & James (2004) and Kang (2006) posit that for some services, the technical aspects of quality may be difficult to evaluate. Citing healthcare services specifically, they note that the technical abilities and competence of the provider and the immediate outcomes from treatment, may prove challenging for the patient (the customer) to judge. Hence, they (the patient), may transfer their focus to the process of service delivery and *"…rely on the attributes such as reliability and empathy to assess quality"* (Kang & James 2004 p.267).

Just as quality approaches have permeated service organisations in the private sector, Chapter 2 has highlighted that the quality of services has received increased attention in the public sector, frequently as a result of public service reform and the pursuit of the NPM paradigm (Kirkpatrick & Martinez Lucio 1995a;Rowley 1998;Schedler & Felix 2000;Flynn 2007). For Kirkpatrick & Martinez Lucio (1995a) and Erridge, Fee, & McIlroy (1998) with specific reference to the UK, this is held to be evidence of the move towards the commercialisation of services delivered in the public sector. This trend is also mirrored elsewhere in the literature on public sector quality, which underlines the increasing interest and implementation of quality approaches, in particular, because of the potential to facilitate organisational change, aimed at resolving the alleged inefficiencies and lack of customer focus and, in turn, to improve overall value for money from expenditure (Walsh 1991;Redman et al. 1995;Kirkpatrick & Martinez Lucio 1995a;Kirkpatrick & Martinez Lucio 1995b;Wisniewski & Donnelly 1996;Hazlett & Hill 2000;Yong & Wilkinson 2002;Doherty & Horne 2002;McAdam, Reid, & Saulters 2002;Ennis, Harrington, & Williams 2004).

Echoing the earlier discussion in Chapter 2, Dale (1994a), Kirkpatrick & Martinez Lucio (1995a), Redman et al. (1995), Donnelly (1999) and Gaster & Squires (2003b) note that the interest in quality in the public sector is around ensuring that public services are delivered as responsively, consistently and equitably as possible to those who need them, but acknowledge that the complexities of the services, the multiple stakeholders and environment that public sector organisations operate in, may present a challenge to quality implementation. This position is also supported by Erridge, Fee, & McIlroy (1998), Schedler & Felix (2000) and Flynn (2007) who argue that private sector quality practices cannot be directly transposed on to public sector organisations, due to their uniqueness which, in turn, is reflective of the argument presented in Chapter 2. In particular, they suggest that many of the quality approaches espoused in the quality literature are not explicitly applicable to organisations providing public services, where the strategic goals are not to extract profit or increase market share, a view also supported by Redman et al. (1995). For Flynn (2007) there is also a much more fundamental explanation for this - *"The underlying reason is that people who use public services are citizens as well as customers. Their access to services is frequently a right which derives from meeting eligibility criteria or simply being a citizen, rather than the ability to pay"* (p.164). By virtue of this, what are frequently overstretched and under-funded organisations may deliberately not want to present themselves as being too attractive, as this may, in turn, add to an existing demand that is already a challenge to meet (Flynn 2007). Moreover, the political dimension to public services may mean that decisions about what services to provide, by what means, and in what quantity, are often beyond the scope of healthcare managers' briefs (Walsh 1991;Flynn 2007). In summary, the direct transfer of quality approaches traditionally associated with adoption in the private sector is unlikely to be completely achievable given the distinctive characteristics of public sector organisations.

3.5 Quality in Healthcare

Previous sections have presented a portrayal of the key issues relating to the concept of quality. They have also sought to outline the fundamental differences that characterise services and highlight a number of challenges that are presented to the management of quality in services, and more specifically, public services. Having

addressed these, the overarching theme of this study - quality in healthcare - may now be explored and where relevant, links to the IHSAB accreditation model are signalled.

3.5.1 Defining Quality in Healthcare

Just as previous discussion has alluded to the debate on the general definition of quality, so too emerges a similar discourse on what constitutes quality in healthcare (Morgan & Potter 1995;Zabada, Rivers, & Munchus 1998;Jackson 2001;Squires 2003a;Boaden 2006). As Blumenthal (1996b) observes *"Experts have struggled for decades to formulate a concise, meaningful, and generally applicable definition of quality of healthcare"*(p.892), while Rowley (1998), Zabada, Rivers, & Munchus (1998), Jefferson (2002) and Squires (2003a;2003b) argue that the kernel of the issue is that quality means different things to different stakeholders and whether they are internal or external to the organisation. However, despite this challenge, Nevers (1993) suggests that there is a strong rationale for attempting to attain a degree of clarity on the issue as *"The old saying 'The first step to solving a problem is defining it' holds true for healthcare organizations committed to quality improvement programs. Healthcare organizations must first define quality if they hope to achieve real, lasting quality improvements"* (p.18).

The seminal work of one of the leading figures in both the theory and management of healthcare quality, Donabedian (1980), highlights that pinpointing a definition may pose a challenge - *"To assess the quality of medical care, one must first unravel a mystery: the meaning of quality itself. It remains to be seen whether this can be done by patiently teasing out its several strands or whether one must, in despair, use a sword to cut the Gordian knot"*(p.3). Twenty-five years later, it would appear that his position on what constitutes healthcare quality is still no clearer:

"The definition of quality may be almost anything anyone wishes it to be, although it is, ordinarily, a reflection of the values and goals current in the medical care system and in the larger society of which it is part" (Donabedian 2005 p.692).

Despite the challenges outlined, a range of contrasting definitions are presented in the literature and central to these is the fact that *"…quality in healthcare is firmly*

grounded in the ethical tenets of non-malfeasance and beneficences" (Lerer 2000 p.169). For example, Ovretveit (1992) referring to his own publication, states *"Quality in this book means something different. It means a service which gives people what they need, as well as what they want, and does so at the lowest cost"*(p.1) and is distinct from the usual notion of service quality (outlined previously), which is associated with *"…giving us what we want - that quality is customer satisfaction"* (Ovretveit 1992 p.1). The focus on 'need' is a particular feature of the debate on quality in the healthcare field, as patients/clients/users as 'consumers' are often limited in their ability to evaluate some of the more technical elements of the service provided (Ellis & Whittington 1993;Blumenthal 1996b;Zabada, Rivers, & Munchus 1998;Arce 1998;Nwabueze 2001;Boaden 2006). As Donabedian (1980) comments *"Clients generally only have a very incomplete understanding of the science and technology of care, so that their judgements concerning these aspects of care can be faulty"*(p.25).

Ovretveit (1992) also provides an extended definition of quality as it applies to healthcare, which takes cognisance of the influence of, and constraints imposed by, external stakeholders such as policy makers and funders (for example in Ireland, the Department of Finance, the Department of Health and Children and the HSE). He presents this as:

"Fully meeting the needs of those who need the service most, at the lowest cost to the organisation, within the limits and directives set by higher authorities and purchasers"(p.2).

An alternative perspective is offered by Leahy (1998) which represents a more holistic view of healthcare quality, acknowledging the range of stakeholders and multiple objectives:

"Within healthcare, quality has been defined as doing the right thing consistently to ensure the best possible clinical outcome for patients, satisfaction for all customers, retention of talented staff and a good financial performance" (p.106).

Finally, what must be the fundamental objective of quality in healthcare - patient/client safety - is addressed by Black & Gruen (2005) who posit the view that this, delivered in a timely and equitable manner, is evidence of good quality healthcare:

"A high quality health service would provide care that is effective (the benefits outweigh any possible danger or harm), provided in a humane way (that treats people with respect and is timely) and is equitable (is available to everyone in need regardless of their sex age, ethnicity etc). Note that this definition does not include any consideration of the other key attribute, cost or efficiency. The challenge for healthcare policy makers and mangers is to provide good quality care at a reasonable cost" (p.202).

Previous discussion of the literature on the nature of services has alluded to how the production and consumption of services are often inseparable (Parasuraman 1985;Berry, Parasuraman, & Zeithaml 1988) and this is supported by Sheaff (2002) who states that *"…healthcare consists of services, where production and consumption are the same process"*(p.172). This point is also illustrated by Donabedian (1980), where he notes that *"….judgements about quality are often made not about the medical care in itself, but indirectly about the persons who provide care, and about the settings or systems within which care is provided. As a result, the attributes of these persons and the settings and the attributes of the care itself are used, alternatively or simultaneously, both to define and to judge quality"* (p.3). This position is also supported by Kimberly & Minivielle (2000) and Dey & Hariharan (2006) who acknowledge the interrelationships of the various facets of quality in assessing, managing and enhancing it.

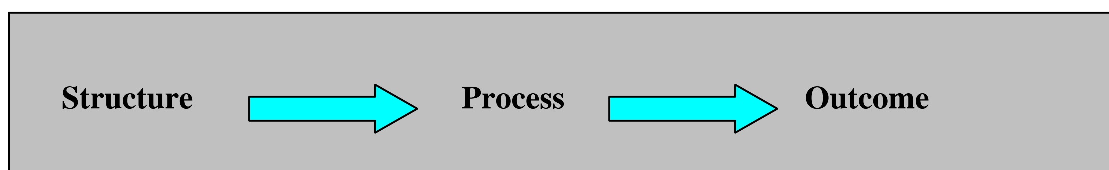
Donabedian (1980;1982;1985;2005) differentiates between the technical and interpersonal elements of healthcare quality, as dimensions of quality (Beerg, Schellekens, & Bergen 2005). Moreover, for Blumenthal (1996b), good technical quality consists of *"…doing the right thing right"* (p.892), while the quality of the interaction (between the care-giver (e.g. a Doctor) and a patient) is dependent on several elements in their relationship and these mirror the central ideas posited by

Gronroos (1984;2001), Parasuraman (2002) and Kang & James (2004) in the general area of technical and process service quality. For Donabedian (1982):

"The process of healthcare is, itself, divisible into two main components: technical care and the management of the interpersonal relationship between the practitioner and the client. The interpersonal process is the necessary vehicle for the application of technical care, but it is also important in its own right, since it may itself, be either therapeutic or hurtful, and because those who take part are expected to respect individual sensibilities...the amenities of care are also relevant to the assessment of quality, though one has the option of regarding them either as properties of the care itself, or of the circumstances under which the care is provided" (p.4).

Donabedian (1980;1982;1985;2005) attempts to resolve the difficulties of definition by deconstructing quality into separate but interrelated elements (Ellis & Whittington 1993). Through this exercise he distinguishes between the quality of 'structure', 'process' and 'outcome' and argues that there are technical and interpersonal features associated with each (Close 1997). The Donabedian approach has become the means by which healthcare managers and professionals conceptualise and assess the quality of care (Blumenthal 1996a;Close 1997;Parsley & Corrigan 1999;Eggli & Halfon 2003;Dey & Hariharan 2006). Moreover, it has particular relevance to the specifics of this study - hospital accreditation - as IHSAB (2004) make an explicit reference to it in explaining the underpinning quality improvement principles to the acute-care hospital accreditation scheme and further adopt it as a basis for categorising *"...evidence of compliance"*(p.45) within each of the individual criteria which make up the ACAS standards (see Appendix A). Figure 3.2 summarises the 'structure', 'process' and 'outcome' relationship.

Figure 3.2 - The Functional Relationship between Structure, Process and Outcome



Source: Donabedian, A. 1980, *Explorations in Quality Assessment and Monitoring* Health Administration Press, p. 83

The first strand of the Donabedian (1980) framework for quality in healthcare is that of structure. This element embodies the resources deployed in the provision of care and the organisational characteristics which determine how care is provided (Donabedian 1980;Ellis & Whittington 1993;Stamatis 1996;Blumenthal 1996a;Parsley & Corrigan 1999;IHSAB 2004;Black & Gruen 2005;Donabedian 2005). According to Donabedian (1980):

"The concept of structure includes the human, physical and financial resources that are needed to provide medical care. The term embraces the number, distribution and qualifications of professional personnel and so too, the number and size, equipment and geographic dispersion of hospitals and other facilities, But the concept goes beyond the factors of production to include the ways in which the financing and delivery of health services are organised, both formally and informally"(p.81).

The overall significance of structure lies with the fact that it is the means by which sufficient resources and organisational systems are provided and enabled and for Donabedian (1980), this represents the central means for the provision of quality in healthcare.

As the second strand of healthcare quality, Donabedian (1980) identifies process which he describes as *"... the set of activities that go on within and between practitioners and patients. This set of activities I have called the 'process of care'"*(p.79). He further deconstructs this to capture both what he regards as the technical management element (i.e. the science and technology underpinning what is normally accepted to be good technical care) and that of the interpersonal process. This latter process incorporates what are deemed to be sound ethical and behavioural values, which, in turn, *"...govern the relationships among people, in general, and between healthcare professionals and clients in particular"*(p.80). Berwick, Godfrey, & Roessner (1990), Ellis & Whittington (1993) and Scrivens (2005) also identify further dimensions of process as including a range of activities from access to care, diagnosis, the provision of treatment interventions, discharge and after-care supports, health promotion and the full spectrum of technical and administrative

pillars to enable the provision of healthcare. IHSAB (2004) supports this view and additionally emphasise the role of procedures to capture and guide processes.

The third and final element of the Donabedian approach, is outcome. This is *"... a change in a patients current and future health status that can be attributed to antecedent healthcare"* (Donabedian 1980 p.82-83). Included in outcomes are positive changes in physical, psychological and social well-being; length of stay; longevity and also improvements in knowledge and behaviours relating to health on the part of the patient (Donabedian 1980;Ellis & Whittington 1993;Stamatis 1996;Blumenthal 1996a;Parsley & Corrigan 1999;IHSAB 2004). However, the problems associated with the assessment of outcomes are addressed by Walsh (1991) who argues that *"…where the nature of the problem is constantly shifting and is difficult to define, it may be particularly hard to define the nature of the actual or intended outcome and therefore make any judgement about quality"* (p.512).

Donabedian (1980) sums up the functionality of the relationships between structure, process and outcome by observing that *"…structural characteristics of the settings in which care takes place have a propensity to influence the process of care so that its quality is diminished or enhanced. Similarly, changes in the process of care, including variations in its quality, will influence the effect of care on health status"*(p.84). Accepting the aforementioned interrelationships, IHSAB (2004) contend that where healthcare organisations are pursing programmes with the overall objective of improving quality, they need *"…to look at using a balance between structure, process and outcomes"* (p.13) and similarly, Kimberly & Minivielle (2000) posit that the challenge for management is *"... to recognize the many facets of quality [and] to recognize their interdependence and the fact that they should not be managed piecemeal, but in concert"* (p.7).

3.5.2 The Growth in Quality in Healthcare

Chapter 2 has addressed the international growth of NPM, integral to which is the pursuit of quality, an objective which has also permeated the healthcare field (Dawson & Dargie 2001;McNulty & Ferlie 2002;Ennis, Harrington, & Williams 2004;Hassan 2005;Gowen III, McFadden, & Tallon 2006;Dey & Hariharan 2006;Lagrosen, Backstrom, & Lagrosen 2007) to the extent that Naveh & Stern

(2005) claim that there appears to be a consensus that healthcare is in need of an on-going process of quality improvement. This development has been noted by the OECD (2004b) who also recognise the growing interest given to quality in the healthcare area:

"Attention to the quality of care is a relatively new policy concern….Nevertheless. innovation in this area appears promising, and many changes, such as those designed to reduce medical injuries and decrease the provision of unnecessary care, stand to improve the cost-effectiveness of health-care delivery. Many countries have taken steps toward quality improvement, but more is needed in some countries" (p.37).

Reflecting this, there appears to be a global trend towards the management of healthcare quality, driven forward as countries attempt to engage in the effective management of healthcare resources and services, in the context of concerns about increasing costs, competing priorities and patient safety (Blumenthal 1996c;Arce 1998;Irvine et al. 1999;Ferlie & Shortell 2001;World Health Organisation 2003;Yang 2003;Scrivens 2005;Gowen III, McFadden, & Tallon 2006;Miguel 2006), a trend which is also emerging in Ireland (Ennis & Harrington 1999a;Ennis & Harrington 1999b;Ennis & Harrington 2002;Ennis, Harrington, & Williams 2004). However, reflecting on what they judge to have been the lack of success with many previous quality efforts in healthcare organisations in the US, Berwick, James, & Coye (2003) argue that the problem lies with the fact that quality is not viewed strategically. As they note *"…healthcare organizations have not made quality improvement a central business strategy; in most places, quality improvement remains a secondary program that affects only a few core processes or diagnoses at a time. Among the many complex reasons for this lack of progress, two are critical: the failure to align incentives and achieve integration across care settings and the absence of a market imperative to improve quality - the lack of a 'business case' for quality"* (p.I35).

Hazilah & Manaf (2005) echo a number of the observations made in Chapter 2 and, in particular, note that the interest in healthcare quality has been, in part, driven by escalating costs for health services provision and that this has, in turn, led to many

commentators to query whether greater levels of spending inevitably lead to better quality care or whether this, in fact, can be achieved at a lower cost. Likewise, there is growing pressure being exerted by multiple stakeholders including governments, policy makers and funders on healthcare organisations to proactively deliver on higher quality care (Sewell 1997;Scrivens 1997a;Huq & Martin 2000;Shaw 2000;Bruchacova 2001;Ovretveit 2003b;Rad 2006;Farrington-Douglas & Brooks 2007) and this reflects the prevailing position in relation to publicly funded Irish health services outlined in Chapter 2. For Ovretveit (2003b) *"Healthcare organisations are increasingly expected by governments, funders and patients to introduce quality control systems and outcome improvement strategies. Many healthcare managers and practitioners also believe that action should be taken, but are unsure of how to proceed, especially within resource constraints"*(p.4). Moreover, and again reflecting similar issues alluded to in Chapter 2, patients and service users are increasingly coming to expect the same service standards that they receive in the private sector (Milakovich 1991;Thompson 1995;Stewart 2003;Squires 2003b;Rad 2006). Finally, and what must be considered as the overarching rationale for progressing the quality agenda, there is an increasing acknowledgement that patient safety is likely to be compromised without adequate attention to the overall constituents of the quality of care (McFadden, Stock, & Gowen III 2006;Gowen III, McFadden, & Tallon 2006;Miguel 2006;Natarajan 2006;Farrington-Douglas & Brooks 2007;Lagrosen, Backstrom, & Lagrosen 2007). In summary, it can be argued that, arising from multiple pressures, the pursuit of quality has become the touchstone in debates about the organisation, financing and delivery of healthcare services.

3.5.3 Approaches to Managing Quality in Healthcare

Quality in a healthcare context has traditionally been 'owned' by the medical profession, whose roles are often characterised by high levels of professional autonomy and who may, in turn, be unreceptive to change that may give managers greater control over patient care (Milakovich 1991;Wakefield & Wakefield 1993;Morgan & Potter 1995;O'Keefe & O'Sullivan 1997;Kennedy 1998;Adinolfi 2003;Degeling & Carr 2004;Boaden 2006). However, diffusion of organisation-wide quality approaches such as TQM and CQI has meant that quality has gradually spread into the domain of healthcare managers, who may view it as a strategic

objective for the organisation, the achievement of which is the responsibility of every employee (Milakovich 1991;Counte, Oleske, & Hill 1992;Degeling & Carr 2004;Boaden 2006). Previous discussion has addressed the problematic nature of defining healthcare quality but there would appear to be greater clarity surrounding the approaches to managing it. However, while Lerer (2000) observes that *"Although quality in healthcare may be difficult to define, the settings in which it is applied and many of the methods used, are easy to identify"* (p.171), Naveh & Stern (2005) note there is an absence of agreement as to which approach might usefully achieve enhanced quality.

The range of approaches deployed in the management of quality in healthcare settings at an organisational level, to a large extent mirror those with the potential to be applied in both the manufacturing and general services sector (Close 1997;Arce 1998;Saturno 1999;Lerer 2000;Huq & Martin 2000;Eggli & Halfon 2003;Dey & Hariharan 2006;Lagrosen, Backstrom, & Lagrosen 2007). As Lerer (2000) comments *"A terminological cornucopia with words and phrases... is a feature of quality in healthcare. These terms represent the methodology, tools or...techniques whereby quality is practiced in healthcare"*(p.170), while Ovretveit (2003b) notes that with particular reference to hospital organisations, the dilemma will be which approach will be most appropriate and moreover, which approach should governments promote? Kimberly & Minivielle (2000) draw on the previously discussed technical and process dimensions of healthcare quality as a basis for categorising approaches in the area. They suggest that technical approaches focus on the scientific and medical aspects of quality and incorporate exercises such as the development of clinical guidelines, outcomes studies, clinical audits and evidence-based medicine (Jefferson 2002).

The second category - that of process - comprises efforts focused on *"...improving the overall quality of the experience of giving and receiving care"* (p.7). Examples of initiatives include CQI, TQM, ISO, performance measurement, benchmarking and accreditation (Close 1997;Arce 1998;Huq & Martin 2000;Sweeney & Heaton 2000;Jefferson 2002). These efforts are identified by Kimberly & Minivielle (2000) as being *"…broader in scope than the purely technical dimensions and touch on the way in which services are organized and delivered"*(p.7). Moreover, and for

accreditation in particular, Ellis & Whittington (1993) recognise that the approach, incorporating a review of the entire healthcare organisation, goes beyond the often technical and professional domain of managing quality. For the purposes of the forthcoming discussion, the focus lies with the accreditation approach.

3.6 Healthcare Accreditation

Chapter 2 and Appendix A have provided an overview of the IHSAB acute-care hospital accreditation approach which has particular relevance to this study. What is now required is further exploration of the overall accreditation approach in terms of definition, its development and adoption across international healthcare systems and the benefits and criticisms that may be associated with its usage.

3.6.1 Defining Accreditation

As has been the case with defining quality and quality in healthcare, there exists a diverse range of definitions to describe the accreditation approach (Hurst 1997). In relation to this, Bruchacova (2001) notes that *"There is a considerable difference in the perception of the role of accreditation. The interpretations vary from a badge of achievement to a management tool to create change"* (p.155). Reflecting upon both the definitions presented in earlier chapters and the additional perspectives offered here, this becomes evident.

In the first instance, Scrivens (1995a) presents a comprehensive definition of healthcare accreditation, which has particular resonance for this study, given that Chapter 1 has already identified that the implementation of accreditation may be viewed in the context of planned organisational change (organisational development). For Scrivens (1995a), accreditation is *"... a process used for the assessment of the quality of organisational activity. It is based on a system of external peer review using standards…an assessment of compliance with standards is conducted by health service personnel, on behalf of an independent body. The outcome of the process is a grading or score awarded to a health service organisation which denotes the level of compliance with the standards…Accreditation systems encompass not only processes of monitoring. They*

are also vehicles for education and organisational development" (Scrivens 1995a p.1).

The organisation-wide nature of accreditation is underlined in the definitions offered by both James & Hunt (1996) and Pomey et al. (2004):

"[Accreditation is] an organisation-wide quality assessment tool and examines the function of the hospital as a whole rather than either an activity or outcomes of specific departments, clinical specialities or procedures, it is a framework of organisational standards which are concerned with the systems and process for the delivery of healthcare" (James & Hunt 1996 p.49).

And:

"The accreditation process, which comprises a self-assessment, a field visit and a report looks at the entire organization and thus serves to arrive at a global appreciation of the hospital" (Pomey et al. 2004 p.113).

The World Health Organisation (2003) also note the role of multi-disciplinary teams in their definition of healthcare accreditation:

"The term 'accreditation' (applied to organisations rather than specialty clinical training) reflects the origins of systematic assessment of hospitals against specific standards…accreditation is usually performed by a multidisciplinary team of health professionals and is assessed against published standards for the environment in which clinical care is delivered"(World Health Organisation 2003 p.58-59).

Moreover, accreditation represents what might be termed as an 'off-the-self' approach to managing quality in healthcare and is distinct from those organisation-wide quality approaches which have been formulated and developed within an organisation itself and which are organisation and context specific (Taylor 1995). As such, it represents an external mechanism, which Shaw (2000) defines as *"…a regional or (potentially) national process voluntarily entered by service provider organizations for the improvement of organization and delivery of health services*

assessed against explicit, published standards by peer group teams moderated by a non-partisan authority involving (but impartial to) users, providers, purchasers and government" (p.169). Furthermore, the strength of the accreditation approach is that it is specifically focused on the unique and detailed aspects of healthcare services (Klazinga 2000;Heaton 2000).

Central to accreditation and to this study in particular, is the process of self-assessment or self-evaluation (Close 1997;Shaw 2000;Bohigas & Heaton 2000). Self-assessment features extensively in the wider quality literature, in particular, in relation to the Balbridge, European Foundation for Quality Management (EFQM) and ISO frameworks and awards (Taylor 1995;van der Wiele et al. 1996;Frangou 2002;Kumar & Douglas 2002;Balbaster Benavent, Cruz Ros, & Moreno-Luzon 2005). Kumar & Douglas (2002) and Balbaster Benavent, Cruz Ros, & Moreno-Luzon (2005) identify that the general process of self-assessment is instrumental in yielding a number of benefits to organisations. Such benefits include identifying strengths and weaknesses in existing practices, process and structures; forming the basis from which improvements may be planned and actioned; encouraging the organisation to be more externally focused through comparison against external benchmarks of practice; facilitating the organisation-wide integration of quality practices and providing a structured approach for addressing quality improvement.

Bohigas & Heaton (2000) and Shaw (2000) note that in relation to accreditation, participating organisations normally undertake self-assessment by completing pre-defined questionnaires, often including comprehensive criteria against which to demonstrate compliance in terms of practices and procedures across the organisation (as is the case with the IHSAB approach) and these, in turn, are supported by organisational information which acts as evidence for this. For Shaw (2000), this normally represents the starting point for the external review survey exercise, undertaken by trained assessors or surveyors who are pivotal to the process (Pongpirul et al. 2006).

With clear application to the IHSAB accreditation approach outlined in Chapter 2, Balbaster Benavent, Cruz Ros, & Moreno-Luzon (2005) note that *"Self-assessment is not an isolated exercise. Self-assessment implies the performing of several*

activities in a defined time-sequence and constitutes a cyclical process. This characteristic allows firms to continuously improve their position with respect to the last self-assessment. Self-assessment is not limited only to comparing an organisation's management system and results with a reference model. It is a planned activity that requires both technical and human preparation and where commitment and involvement of the top management is vital" (p.434).

3.6.2 The Development of the Accreditation Approach

Healthcare accreditation, as an approach to managing quality, originated in the USA in the early 20th century (Ellis & Whittington 1993;Scrivens 1995c;Scrivens 1997b;Arce 1998;Roa & Rooney 1999;Heaton 2000;Nandraj et al. 2001;Rawlins 2001;Braithwaite et al. 2006). Ellis & Whittington (1993) and Shaw (2000) describe how in 1917, as a response to the shortcomings of hospital records systems, the American College of Surgeons developed the Hospitals Standardisation Programme which compelled those hospitals seeking accreditation as training hospitals, to submit their records systems for evaluation to them. The approach evolved and developed as a mechanism for medical professionals to improve the management and quality of clinical practice in order to increase professional standards and develop a safe environment for training and practice (Scrivens 1995c;Scrivens 1997b). Accreditation increased in popularity until the College of Surgeons joined with a number of other professional bodies to establish the Joint Commission on the Accreditation of Hospitals in 1952. This body evolved into the Joint Commission on the Accreditation of Healthcare Organisations (JCAHO) and is now the main accrediting organisation in the USA, where it operates a voluntary accreditation model. It also operates an international arm - the Joint Commission International (JCI) established in 1998, for accrediting individual healthcare organisations in other countries and a number of private hospitals in Ireland have allied themselves to this model.

Despite the fact that Natarajan (2006) argues that accreditation represents a traditional approach to managing quality in healthcare contexts, internationally there is a rapidly emerging interest in accreditation, for both hospitals and other healthcare organisations (Scrivens 1997b;Schyve 1998;Nicholas 1999;Huang et al. 2000;Walshe et al. 2001;Shaw 2001;Rawlins 2001;World Health Organisation

2003;Yang 2003;Shaw 2004;Braithwaite et al. 2006). Braithwaite et al. (2006) argue that in many countries, accreditation has been the foundation of strategies for managing quality in healthcare and moreover, interest in accreditation is also reflected in the evolving literature on its use (Walshe et al. 2001).

The World Health Organisation (2003) global review of quality and accreditation in health services supports the view that there has been a growth in the development of accreditation schemes. Recent examples (from 1995 onwards) of the establishment of national accreditation schemes include those in Argentina, China, Germany, the Netherlands, Thailand, Zambia, Lithuania and Ireland, such a geographic spread demonstrating that accreditation is deemed to be a quality approach with applicability in both economically and socially developed and developing countries. Scrivens (1995d) contends that the newer systems are founded on the experiences of the more mature models such as those of JCAHO, the Australian Council on Healthcare Standards and the Canadian Council for Health Services Accreditation. For Natarajan (2006) these types of organisations frequently form the foundation of a country's regulatory structure for healthcare.

3.6.3 Motivations for Implementing Accreditation

Schyve (1998), commenting in the global healthcare context, argues that the reasons for adoption of accreditation are varied:

" …the self motivated desire to improve among healthcare professionals worldwide; the desire to improve population health; the trend towards privatisation of health care in many countries; the concerns about the value received for healthcare expenditures in the light of growing costs of healthcare; the increasing availability of information on quality of care issues over the global Internet; and the interest of multinational companies in providing safe and effective healthcare for their employees who are located in many countries around the globe" (p.467).

While improving the overall quality of healthcare through the identification and implementation of better, safer and potentially more cost-effectiveness processes, must be the fundamental objective for implementing accreditation (Bair & Milner 1995;Schyve 2000;Collopy 2000;Sheaff 2002;Saufl 2003), a variety of other

motivations exist which, in turn, have contributed to the growth in its adoption as a means of addressing quality in healthcare. In the first instance, the central issue of patient safety is at the forefront of the motivations for implementing accreditation and the approach may offer the scope to identify and, therefore, reduce risks to the patient (O'Leary 2000;Schyve 2000). This is also acknowledged by Natarajan (2006) who similarly notes the overall positive aspects of accreditation, in that it aims to achieve safeguards for service-users in terms of the standards of healthcare that are delivered through at the very least, the engagement and involvement of healthcare professionals in the assessment and improvement of quality.

The potential for accreditation to improve accountability is mentioned widely in the available literature. Scrivens (1995c) identifies the accountability that may be leveraged from introducing national programmes of accreditation - *"Accreditation is being perceived as an appropriate vehicle for ensuring public accountability for delivering healthcare"* (p.180). This increased accountability may be aimed at the healthcare provider at the organisational level but this may, in turn, impact on the accountability of departments and individuals (Hurst 1997;Sewell 1997;Shaw 2000;Klazinga 2000;Heaton 2000). For Duckett (1983) and Heaton (2000), this improved accountability is achieved by introducing the comparability of standards that accreditation offers. Associated with this may be the emergence of using the self-assessment process and overall accreditation ratings as the basis for funding and budgetary decisions, both inside and external to the organisation, for example from government funders (Bohigas et al. 1996;Schyve 2000).

The scope for increasing the credibility of the healthcare provider/organisation and the accompanying improvement in the confidence of service-users, employees and funders in the quality of process, structures and outcomes, may also serve as a motivation for implementing accreditation (Steiner, Scrivens, & Klein 1995;James & Hunt 1996;Sewell 1997;Schyve 2000;Klazinga 2000;Saufl 2003;Gaster & Squires 2003a;Rad 2006). For example, Bohigas et al. (1996) suggest that accreditation may help to achieve professional standing in comparison to other hospitals. In a similar vein, Pomey et al. (2005) posit the view that *"Accreditation is a means of publicly recognizing that a healthcare organization meets predetermined national standards"* (p.51) and that additionally, accreditation carries a *"…brand image"* (p.52) to market

to healthcare authorities and other stakeholders about the quality of the healthcare services provided (James & Hunt 1996;Pomey et al. 2005).

Finally, accreditation may be implemented with the deliberate intention of using it as a vehicle for achieving organisational development and change within a healthcare environment (Steiner, Scrivens, & Klein 1995;James & Hunt 1996;Shaw 2003;Sweeney 2004;Pomey et al. 2005). James & Hunt (1996) suggest accreditation may be driven by a change agenda based on the potential to focus the organisation on continuous improvement. Likewise, Duckett (1983) argues that implementing accreditation may be instigated as a means of influencing and changing the behaviours of staff (most notably those in the medical sphere) within the organisation.

3.6.4 Criticisms of Accreditation

Just as the aforementioned section has sought to provide an insight into the motivations for implementing accreditation, this must, in turn, be balanced by the criticisms of it that also appear in the literature, as an organisation-wide quality approach. At the most basic level, Dey & Hariharan (2006), while acknowledging that accreditation provides a framework for the identification of issues, problems and risks, argue that it does not offer a framework of strategies for corrections and improvement and hence, as a process, its effectiveness is questionable.

Milakovich (1991) argues that the external regulation and review offered by accreditation may actually fail in its efforts to improve the quality of care. With specific reference to the Joint Commission approach in the US, he posits the view that accreditation represents an ineffectual model for improving quality across the organisation and serves to create passive resistance or overt opposition from hospital staff. This, he suggests, stems from the perceived view of accreditation as being to regulate the procedures within the organisation and to contain costs and, in doing so, reduce healthcare services. As an alternative, he suggests that healthcare professionals should voluntarily implement approaches such as TQM. This position is echoed in the observations made by Scrivens (1995b) during her reflections on the critics of accreditation who she acknowledges, likewise, view accreditation as being an approach that is initiated from outside as opposed to internal to the organisation.

Gaster & Squires (2003a) suggest that the external monitoring process on which accreditation is based *"…may be felt mainly as an irritant and a diversion from doing the 'real job'"* (p.87) in a healthcare organisation. They further purport that the process may be divisive as it may mean that the organisation is labelled a failure by virtue of its accreditation rating. This view is also held by Natarajan (2006) who observes that the accreditation approach may be interpreted as punishing organisations as a result of non-compliance. Moreover, Sewell (1997) observes that *"Accreditation is often viewed as a necessary evil"* (p.21) and that it has the potential to develop into *"…a paper-chase exercise"* (p.21), with no guarantee of improving quality and that it is built around rigid standards and integral criteria that fail to address the service outcomes of patients.

In a similarly questioning vein, Braithwaite et al. (2006) ask whether the accreditation approach is worthwhile and justified, given that research into its effectiveness (in terms of high quality clinical and organisational performance) is at an embryonic stage and, in particular, that the espoused benefits are underpinned by a very limited body of empirical evidence. Given that most healthcare organisations are subject to funding constraints, they suggest that the implementation costs of accreditation may be considerable and, as such, represent a drain on already scarce resources. Citing approximate costs, based on US data from 2003, they note that annual costs for a medium-sized organisation might run to $630,000 per annum, while first year costs, including the initial survey, would add an additional $370,000. The significant costs associated with the initial implementation of accreditation have also been previously recognised by Redmayne et al. (1995), Steiner, Scrivens, & Klein (1995) and Hurst (1997), although Hurst (1997) qualifies this by arguing that savings will be made in the long run if accreditation uncovers unsafe and inefficient practices. Finally, Pomey et al. (2005) observe that accreditation will fail in its ability to generate organisational change and quality improvement where its implementation is weak. Instead it has the potential to become *"…an essentially bureaucratic exercise that will not serve thoroughly to review organizational processes in order to improve structures and treatment modalities as a whole"* (p.52).

3.7 Conclusion

This chapter has sought to address the key issues relating to quality, quality in healthcare and accreditation, which, in turn, will serve as basis for examining the implementation process and individual and organisational impacts associated with the hospital accreditation approach. A range of definitions of quality and approaches to its management, have been presented and the strategic perspective on quality itself has been discussed. The facets of service and the elements of healthcare quality have been identified, with an acknowledgement of the complexities associated with these. Accreditation has been defined from a variety of viewpoints and finally, the motivations for, and criticisms of, the approach have been recognised. It is within this informed context that Chapter 4 now turns to the implementation process and impacts arising from accreditation itself.

Chapter 4: Literature Review - The Accreditation Implementation Process and Impacts

4.0 Introduction

This chapter provides an examination of the range of issues relating to the accreditation implementation process, the individual and organisational impacts that may arise from this, and acknowledges and discusses the possibility that individual experiences of these may differ based on work role or discipline within a healthcare context. Previously, Chapter 2 has served to demonstrate the urgency and hence motivations, that exist within the Irish healthcare system for wide-scale change in the management and provision of publicly provided health services and within this, the improvement in the quality of healthcare. This is now acknowledged as a strategic priority at government and HSE level, requiring change in the way that services are organised, managed and delivered and also in how the quality of these services is achieved. At the same time, recognition is given to the specific characteristics of the public sector, which may present a particular challenge to achieving change and quality implementation. As an underpinning to this, Chapter 3 has sought to develop an acceptance of quality as a strategic priority and, in particular, for those organisations charged with providing healthcare services.

Irrespective of sector, the implementation of quality approaches requires change in organisations. With specific reference to the definitions of accreditation offered in Chapter 3, the range of activities associated with its implementation, coupled with the potential for accreditation itself to be utilised as a management tool for creating change, implies that there is merit in exploring some of the central tenets surrounding organisational change and implementation, and within this, quality implementation. Consideration is given to the extent, type and models of change that may serve to both guide this research in terms of a theoretical framework and to underpin the development of a conceptual framework, with a particular emphasis on the degree to which these reflect the 'soft' or 'people' aspects of change and implementation. This is of particular significance given that this research, in the first instance, focuses on the series of connected actions and activities allied to the accreditation implementation process and furthermore, with a specific reference to those that interface directly with individual accreditation team members, whose experiences or *"…lived experiences"* (Buchanan 2003 p.664) are central to the study. On achieving this, the chapter then turns to identifying the impacts that may arise at an individual and organisational level from accreditation implementation. Finally, consideration is

given to the potential for experiences of both the implementation process and impacts to differ, based on individual work role or discipline within the healthcare organisation.

4.1 Accreditation Implementation and Impacts within a wider Literature

Chapter 1 identified that there exists a paucity of literature in the specific domain of acute-care accreditation, its implementation and impacts. Acceptance of this position necessitates the need to draw upon sources within the wider change management implementation, quality and healthcare quality implementation fields, in order to create the theoretical foundations for the execution of primary research.

A review of the literature is thus presented that draws on both direct (relating to healthcare organisations) and to a lesser extent, indirect evidence (non-healthcare organisations) (Ovretveit 2003a), being cognisant of the degree of specific relevance to accreditation and with an acknowledgement that the sources differ in both format and tone. Moreover, the implementation of quality approaches other than accreditation are examined, based on their ability to inform the research.

The decision to draw from a wider literature base is legitimised by a number of commentators. In relation to the field of change management, Pettigrew, Ferlie, & McKee (1992), Thomas (1996), Garside (1997), Davies (2001), Iles & Sutherland (2001) and Coghlan & McAuliffe (2003), while acknowledging the distinctiveness of the public sector and within this healthcare, recognise that consideration of approaches arising within other sectors, including the private sector, may prove fruitful. This view is also supported by Ferlie (1997) who additionally notes that healthcare organisations are increasingly adopting quality approaches and that the implementation of these can be usefully informed by the change management literature. Joss & Kogan (1995) and Saturno (1999) argue that while the healthcare context may be unique, the methods deployed in the implementation of quality are likely to be common across organisations, irrespective of their field or industry. Arising from their comparative study of commercial organisations with those in the NHS, Joss & Kogan (1995) posit that the implementation of quality approaches in the private sector may provide valuable lessons for publicly funded healthcare

organisations in terms of underlining the necessity to establish the organisational implementation requirements for the medium to long term; the visible demonstration of senior management leadership and commitment to implementation; creating an organisation-wide understanding of the quality approach being implemented and initiating a reflective and critical review process, a view also supported by Boaden (2006).

The fundamental similarities between various quality approaches may also serve to inform implementation and impact issues arising in the accreditation area where there is a more limited body of existing literature (Saturno 1999). For Saturno (1999) at a conceptual level, what is important is to understand what approaches do and not what they are called and to accept the benefits of the inclusiveness that arises from exploring a range of possible quality approaches. He observes that:

"There are many models for quality improvement...a closer, less superficial look at the different models reveals how similar they are, and how much they are influenced by terminology, 'dialects', cultures and commercial biases. Almost all these models can be recognized in the simple 'design (or planning)-monitoring-improvement' model" (Saturno 1999 p.373).

This position is also reinforced by the WHO (2003) who have further identified that there is no formal international classification of quality approaches with specific reference to healthcare. However, there is recognition that an overall feature of quality approaches is the notion of a cycle of activities, based on defining standards, measuring against them and implementing change and these clearly relate to the characteristics of accreditation as outlined in Chapters 2 and 3. Specifically, the WHO (2003) cite a number of commonalities such as:

(i) Most quality management concepts advocate the entire cycle and depict this as a continuous process;

(ii) The majority of practical tools utilised in the field of healthcare quality focus on standards or measurement;

(iii) Most approaches recognise that the failure to effectively manage change in behaviour of those working within healthcare organisations is the most frequent cause of ineffectual quality initiatives and that the solutions to this are similar between organisations.

As a further reflection of the argument for utilising a broad range of literature sources, and as a particularly relevant example, O'Leary (2000) highlights that accreditation as an approach for improving healthcare quality, is couched in the language of continuous quality improvement, where the focus is organisation-wide, contingent on employee participation and central to which is the on-going evaluation of current processes and practices, with a view to continuously enhancing them. Therefore, based on the similarity arguments posited by Saturno (1999), O'Leary (2000) and the World Health Organisation (2003), drawing on the additional implementation literatures pertaining to approaches such as TQM and CQI is deemed appropriate.

In summary then, a literature is presented derived from change management and the implementation of organisation-wide quality approaches. This particularly aims to give a specific emphasis to healthcare and accreditation where possible, which, in turn, provides an appreciation of the implementation process, individual and organisational impacts and any differences in terms of experiences of these, based on work role or discipline within the organisation.

4.2 Organisational Change and Quality Implementation

The objective of this section, in the first instance, is to demonstrate the link between organisational change to the more specific field of quality implementation, and by extension, accreditation. In exploring this link, an acknowledgement of the challenges to change and quality implementation that may arise from the specific organisational characteristics of healthcare and within this, hospital organisations, is made. As previously stated, the focus of this research is with the ‘soft’ or ‘people’ aspects of change and implementation and, as such, this also necessitates attention.

In reviewing the literature on organisational change, due consideration is given to identifying the extent of change that accreditation implementation in a publicly

funded hospital context may represent. On achieving this, it provides a logical link to ruminating on the type of change and concomitantly, the available models of change that may serve to represent the theoretical framework (i.e. the theory(s) or issues in which the research is embedded (Kumar 2005)) and also act as middle range theory for the research. These middle range theories are likely to address empirical enquiry and operate in a limited domain, and in doing so, overcome the criticism that has been levied at grand theories, in terms of their remoteness from organisations, change and social behaviour (Bryman 2004). The resultant theoretical framework will then underpin the development of a conceptual framework (i.e. the aspects and interpretation of the theoretical framework which become the basis for the inquiry (Kumar 2005)) for accreditation implementation. With this in mind, subsequent discussion additionally aims to provide 'signposts' and application to this research study on accreditation, where appropriate.

A range of definitions of change management are available in the literature which provide the critical link to organisational strategy, which gives direction to the change effort. For example, Todnem By (2005) proposes that change management is *"... the process of continually renewing an organization's direction, structure and capabilities to serve the ever-changing needs of external and internal customers"* (p.369), while Garside (1997) suggests that *"…change management [is] the link between the vision of the organisation and its workings - the process by which strategy is actually implemented, and by which changes are actually made to happen"* (p.S8).

This latter definition is particularly appealing in the context of this research, as it captures the scope of change and is thus instrumental in explicitly operationalising the actions and activities associated with implementation and by extension, the implementation process surrounding accreditation. In doing this, it also implies the strategic imperative of the change itself - improving the overall quality of care - which has been acknowledged in Chapter 2, as a priority for the management and delivery of health services in Ireland. This is supported in the observations of Woodman (1989) who posits that *"…at some level of abstraction"* (p.224) the goal of all change and its management, is organisational effectiveness and that research in

the area is frequently focused on illuminating and understanding supporting antecedents and processes.

Organisations, both in the private and public sector, are subject to a variety of changes throughout the course of their existence, triggered by a multitude of both internal and external factors or drivers (Burnes 2000;Rollinson & Broadfield 2002;Buchanan 2004;Leppitt 2006;Sminia & Van Nisterlrooij 2006;Rad 2006;Soltani, Lai, & Mahmoudi 2007) which, in turn, require management through the implementation process (Doyle, Claydon, & Buchanan 2000;Whelan-Barry, Gordon, & Hinings 2003;Bamford & Daniel 2005). For Van de Ven & Poole (1995) these represent *"…diverse units and actors"* (p.526) whose influence may extend across an organisational entity and, in turn, may work to sway the momentum of the change process. Chapter 2 has identified that a number of largely external environmental factors, primarily societal, economic and political, but also those internal to the sector itself, have created the impetus for change in the Irish health services. Moreover, these are also recognised as having led to the increased attention and associated activity given to improving the quality of care, and as a subset of this, the implementation of accreditation. However, public sector and specifically, healthcare organisations, may provide special challenges to the management of change and, as such, there is merit in exploring this issue further.

4.2.1 Changing Healthcare and Hospital Organisations

The characteristics of healthcare organisations, and in particular hospitals, constitute the internal context or *"…medium"* (Greenhalgh et al. 2005 p.134) through which the management of change flows and hence this requires specific exploration and recognition in undertaking this study on accreditation implementation. Addressing first the wider issues, Chapter 2 has highlighted some of the distinctive characteristics of public sector organisations. In relation to the creation of change, these features may be amplified. Sminia & Van Nisterlrooij (2006) argue that *"There are a number of profound differences between public sector organizations and private sector organizations when it comes to organizational change"* (p.100) and suggest that the presence of multiple decision-makers, a large and diverse body of stakeholders and a more bureaucratic design, create particular challenges to

implementation, an assessment also supported by Thomas (1996) and Cummings & Worley (2001).

In exploring the organisational characteristics that may have some bearing on this research, Mintzberg (1989) suggests that configuration may be a useful means of classification. For Mintzberg (1989), a configuration represents a system comprised of networks of interrelationships. Of relevance to healthcare organisations and specifically hospitals, is what Mintzberg (1989) describes as the *"…professional organization"* (p.175). In this type of organisational configuration, work is likely to be highly complex, specialised and undertaken and controlled by professionals who constitute the *"…operating core"* (Mintzberg 1989 p.99) which is the key element of the organisation (Mintzberg 1989;Surgeon 1990;Brock 2006).

The structure assumed is that of a *"…professional bureaucracy"* (Mintzberg 1989 p.174). Here organisational functioning is reliant on trained professionals who are likely to have significant levels of control over their work, remaining close to the clients that they serve, while remaining largely independent from their colleagues and with almost complete discretion in exercising judgement (Weisbord 1976b;Surgeon 1990;O'Keefe & O'Sullivan 1997;Mintzberg 1998;Wiener 2000;Ham, Kipping, & McLeod 2003;Tucker & Edmonson 2003;Degeling & Carr 2004;Lega & DePietro 2005;Brock 2006;Walshe & Smith 2006). Operating standards and procedures for professionals are set largely outside the organisation and are difficult to learn and acquire (Mintzberg 1989;Sutherland & Dawson 1998). Supporting the *"…operating core"* (Mintzberg 1989 p.99) is the administrative and management structure, or the *"…level headed engines"* (Sutherland & Dawson 1998 p.S16) who may not only lack the ability to exert direct power and influence over professionals due to the extent of their expertise and autonomy, but may also be subject to the collective control of professionals who seek to influence decisions such as promotions and resources that may affect them (Mintzberg 1989). For Mintzberg (1989) this *"…sharply circumscribe the capacity of central administrators to manage the professionals…through direct supervision and the designation of internal standards (rules, job descriptions, policies). Even the designation of standards of output or performance is discouraged by the intractable problem of operationalizing the goals of professional work"* (p.184).

In this type of organisation, there may be a noticeable absence of mechanisms to control the work of professionals, other than those exercised by themselves, and no immediate means to right the problems and deficiencies in the organisation that professionals may decide to ignore (Sutherland & Dawson 1998;Ennis & Harrington 1999b;Ennis, Harrington, & Williams 2004). Mintzberg (1989), however, does suggest that certain types of decisions, such as those of a financial nature that may be less directly related to the professional remit, come distinctly within, and hence are, the prerogative of the administrative domain. In relation to quality implementation, Surgeon (1990), Sutherland & Dawson (1998) and Davies, Nutley, & Mannion (2000) posit that the management of quality, while considered to traditionally be the responsibility of healthcare professionals, is increasingly falling within the scope of healthcare managers, who are charged with achieving value-for-money across all elements of the service and which necessitates the integrated efforts of professionals and non-clinical managers and staff. However, the practical achievement of this may prove challenging (Zabada, Rivers, & Munchus 1998;McHugh & Bennett 1999;Wiener 2000).

Bearing in mind that Mintzberg (1989) suggests that hospitals are representative examples of professional organisations, to what extent might these characteristics influence the organisational change and quality implementation process? Friedman & White (1999) suggest that, despite being *"…in dire need of intervention"* (p.41), healthcare organisations have traditionally *"…had a natural aversion"*(p.41) to pursuing change interventions and within this, organisational-wide quality approaches. The characteristics of healthcare organisations and specifically hospitals, may not be conducive to implementing organisational improvement activities as they differ fundamentally from manufacturing and most other service-type organisations (Shortell et al. 1995;Grol & Jones 2000;Nwabueze 2001;Lega & DePietro 2005;Walshe & Smith 2006;Farrington-Douglas & Brooks 2007). As Goldsmith (1989) notes *"…hospitals are vastly more complex than a typical business"*(p.105) and this may present the possibility that they may provide a less favourable terrain for change and quality implementation than their private sector, non-healthcare counterparts (Weisbord 1976b;Berwick, Godfrey, & Roessner 1990;Garvin 1990;Ennis & Harrington 1999a;Counte & Meurer 2001;Nwabueze 2001;Badrick &

Preston 2001;Yasin et al. 2002;Ham, Kipping, & McLeod 2003). However, this is somewhat countered by Pettigrew, Ferlie, & McKee (1992) who argue that organisational change rarely takes place in a completely receptive internal context.

Clearly reflecting the propositions of Mintzberg (1989), Friedman & White (1999) observe that providers of healthcare services *"...[are] socialised to be autonomous and to initiate professional judgment rather than to be team players"* (p.41) and undertake complex work for which they have high levels of qualifications, none of which may be conducive to supporting change and implementing quality (Weisbord 1976b;Morgan & Potter 1995;Zabada, Rivers, & Munchus 1998;Badrick & Preston 2001;Boaden 2006). Moreover, Surgeon (1990) and Caluwe & Vermaak (2003) suggest that professional organisations, such as hospitals, are characterised by tensions and proper account needs to be taken of this in terms of implementing change. These tensions are highlighted by Garvin (1990), Morgan & Potter (1995) and Brooks (2006) who identify that hospitals, in particular, tend to operate with dual and often conflicting lines of authority, comprising on the one-hand, medical staff and on the other, those in administrative and support roles, which, in turn, can create barriers to effective planning and the furtherance of the change and quality agendas. Duckett (1983) and Badrick & Preston (2001) argue that the situation may, in reality, be even more complex in that there are, in fact, three *"…separate limbs"* (Badrick & Preston 2001 p.168) of authority, namely medical, nursing and administration, which compete in the exercise of power and control. For Mintzberg (1997), Sutherland & Dawson (1998) and Coghlan & McAuliffe (2003) these 'limbs' may live in different and somewhat disconnected worlds. This view is reinforced by the findings from the comparative study by Ferlie & Shortell (2001) of the UK and United States (US) healthcare systems, where professional autonomy and clinical freedom were found to be the prevailing ideologies and placed doctors, in particular, in a strong position to resist initiatives and the introduction of organisational change, relating to systems designed to deliver improvements in quality.

Being cognisant of these issues in terms of managing the implementation of change, Hope Hailey & Balogun (2002) suggest that *"In public sector organisations, such as hospitals, where diverse and powerful stakeholders can hold differing agendas, understanding the position of different stakeholders, and the appropriate range of*

change styles to employ, can be particularly important" (p.159). This view is also supported by Ovretveit (1992) in relation to publicly provided health services, who argues that in introducing quality approaches, as an example of change, the values and professional backgrounds of staff need to recognised and that if quality approaches are imposed, the prevailing and often conflicted working relationships and accompanying attitudes, will be reinforced. For Ferlie & Shortell (2001) ultimately, change aimed at improving healthcare quality, may only be progressed and realised where the organisation is able to create a climate through its decision-making, operating and human resource systems and practices, where the core priorities are teamwork, learning and customer focus.

4.2.2 The Significance of Organisational Change to the Implementation of Quality

Chapter 3 has highlighted the growth in the implementation of quality approaches in organisations, including those in the healthcare field. For Burnes (2000), McAdam & Bannister (2001), Yeh (2003) and Soltani, Lai, & Mahmoudi (2007), the adoption of organisational quality approaches represents one of the most prevalent changes in organisations in recent years, while Duckett (1983), Steiner, Scrivens, & Klein (1995) and Pomey et al. (2004) established in their studies of accreditation, that the approach has the ability to stimulate and create change in hospital organisations. Huq & Martin (2000) identify that most programmes of change have a major social component by virtue of the involvement of people and, of significance for this research, where individual experiences of accreditation implementation are explored, Burnes (2000) observes that *"Undoubtedly the way in which such changes are managed, and the appropriateness of the approach adopted, have major implications for the way people experience change and their perceptions of the outcome"* (p.252).

The significance of change management to the implementation of quality approaches is captured by both Anjard (1995) who suggests that, by implementing quality *"…change within the organisation is inevitable…and change by definition, must be managed"* (p.14), and by Close (1997), who observes that *"Quality management is… dependent on managing the process of change"*(p.76). Moreover, for Ovretveit (1999) change, and its management, is *"…the weakest link in the healthcare quality improvement chain"* (p.242). Hence, managing change seems to be inextricably

linked to implementation (Thompson 1995;Henderson & McAdam 1998;Huq & Martin 2000;Boaden 2006;Rad 2006;Singh & Smith 2006) and, as such, provides an important theoretical lens through which to explore quality and accreditation implementation.

Commenting on the phrase 'change management' Clegg & Walsh (2004) note that *"It conjures up a focus on the implementation phase"* (p.232), while Balogun & Hope Hailey (1999) purport that *"Implementation is often conceived of in terms of the planning for change, with scant attention to managing the transition process itself. Specific attention is required to both the design and management of the transition state"* (p.15). Davies (2001), Iles & Sutherland (2001) and Coghlan & McAuliffe (2003) argue that well-supported implementation is critical to ensuring that the change is both effective and takes root, so that the organisation does not revert to functioning in its old ways. Change represents an organisational transition, enabling the embeddedness of quality practices and processes throughout the organisation, with a view to ultimately enhancing the quality of care. Successful implementation may therefore be critical to the effectiveness of quality approaches in organisations, including those in the healthcare sector (Reger et al. 1994;Blumenthal & Kilo 1998;Weiner et al. 2006;Alexander et al. 2006;McFadden, Stock, & Gowen III 2006) and this can be also viewed in terms of the instrumentality of the change process (Hackman & Wageman 1995;Joss & Kogan 1995;Hamzah & Zairi 1996b;Garside 1997;Francois et al. 2003;Huq 2005).

It may be pertinent to reflect on what might be meant by the terms 'implementation' and 'process', bearing in mind their centrality to this research. Approaching the elements separately, Klein & Sorra (1996), who include quality approaches as an example of an organisation-wide innovation and change, necessitating the coordinated use of multiple organisational members, present implementation as *"…the transition period during which targeted organisational members ideally become increasingly skilful, consistent and committed in their use of an innovation"* (p.1057).

In a similar vein, Weiner et al. (2006) also provide a useful definition, with particular reference healthcare contexts:

"By implementation, we refer to the transition period, following the decision to adopt a new idea or practice, when intended users put the new idea or practice in to use - for example where clinical and non-clinical staff begin applying QI principles and practices to improve clinical care processes" (p.308).

In terms of process, this can be viewed in broad terms as progression in the organisation over time (Van de Ven & Poole 1995). Pettigrew, Ferlie, & McKee (1992) offer a more specific perspective as *"…actions, reactions and interactions of the various interested parties as they negotiate around proposals for change"* (p.7), while Armenakis & Bedian (1999) also make the link to change in describing process as *"…actions undertaken during the enactment of an intended change"* (p.295). Therefore, the implementation process implies actions and activities associated with the commencement and continuance of an organisational change, such as accreditation. However, Hill & Wilkinson (1995), Yong & Wilkinson (1999) and Chang (2005) caution that organisation-wide quality approaches that are implemented in a fragmented, unsystematic and ill-thought-out manner, run the risk of only 'partial' implementation which may, in turn, mean that the quality approach is never fully developed within the organisation.

The significance of the implementation process is multifaceted. Hackman & Wageman (1995) note that quality implementation done well allows the organisation to *"…improve itself and in the process, better serve its community and its own members"* (p.339), which echo both the overall objectives of quality approaches and aspirations for improving quality in healthcare and introducing accreditation, as presented in Chapters 2 and 3. Gustafson, Demarie, & Mullane (1994), McAdam & Bannister (2001), Beer (2003), Hansson, Backlund, & Lycke (2003), Taylor & Wright (2003) and Bauer, Falshaw, & Oakland (2005) similarly argue that a properly implemented quality approach will contribute to organisational performance. This is further supported by Ghobadian & Gallear (2001) who suggest that implementation will influence both the impact and perceived worth of the quality approach, has the potential to influence employee values, attitudes and behaviour in a positive way and that acceptance or rejection of the approach will be determined by early experiences of it. Moreover, Alexander et al. (2006) in particular, suggest that the implementation

process plays a pivotal role in the long term success of a quality approach within an organisation. Addressing healthcare specifically, in their quantitative study of over eighteen hundred hospitals in the US, they established that the presence of supports, resources and infrastructure for implementation were significantly associated with the diffusion and embeddedness of a quality approach within a hospital organisation.

The role of implementation in relation to quality approaches (and specifically within a healthcare context) is summed up by Milakovich (1991) in his observations, where he argues that *"The best quality-improvement systems are only as good as their organisation-wide implementation"* (p.16), a view also supported by Reger et al. (1994), Shin, Kalinowski, & El-enein (1998), Jackson (2001) and Edwards & Sohal (2003). But it is Wilkinson & Brown (2003) who capture what is fundamentally at the centre of this research - that quality approaches (accreditation included) - as an example of organisational change, however promising, need to be implemented and that this is reliant on people. It is the people, human resources or as previously termed *"…targeted organisational members"* (Klein & Sorra 1996 p.1057) or *"…intended users"*(Weiner et al. 2006 p.308) within the organisation, who have the potential to make implementation happen and who are likely to require support, organisation, resources and recognition by virtue of their participation (Hill & Wilkinson 1995;Edwards & Sohal 2003;Tucker & Edmonson 2003;Berwick, James, & Coye 2003;Gowen III, McFadden, & Tallon 2006). This, in turn, represents the *"…soft"* (Wilkinson 1992 p.325) side of quality implementation and change (Wilkinson 1992;Paton & McCalman 2000) which has a *"…100 per cent people orientation"* (Paton & McCalman 2000 p.21).

The 'soft' side of quality places emphasis on the management of people within the quality implementation process and all activities aimed at supporting those involved with the achievement of quality (Wilkinson 1992;Snape et al. 1995;Redman & Mathews 1998;Fletcher 1999;Wilkinson & Brown 2003;Wilkinson 2004;Tari & Sabater 2006;Boaden 2006;Vouzas & Psychogios 2007). For Wilkinson (2004) this represents the *"…human factor"* (Wilkinson 2004 p.1021) which is pivotal to the success of quality implementation (Schonberger 1994;Samson & Terziovski 1999;Ghobadian & Gallear 2001;Edwards & Sohal 2003;Wilkinson 2004;Rahman & Bullock 2005;Boon & Arumugam 2005;Vouzas & Psychogios 2007). This view is

also supported by Fletcher (1999), Daily & Bishop (2003) and Lewis, Pun, & Lalla (2006) who argue that a significant portion of organisation-wide quality approaches focus on human resource related activities, and by Dwyer (2002) who reflects that, based on an examination of the views of a number of the quality 'gurus', *"…achieving quality is a people phenomenon"* (p.525). However, Singh & Smith (2006) acknowledge that the area is complex and, in reality, may be difficult to manage.

While there is some disagreement as to the absolute composition of the 'soft' side of quality implementation (Vouzas & Psychogios 2007) within the literature - prescriptive, theoretical and empirical - there are a number of reoccurring themes. These include the presence of effective leadership; team working; communication; continuous training; employee involvement and recognition, which Schonberger (1994) argues should be seen as being interconnected during the implementation of an organisation-wide quality approach. While the intention is not to progress discussion of any, or all, of these further at this stage, acknowledgement of the degree of relevance to this research may be appropriate. This resides primarily in the fact that a major focus of this study is concerned with the series of connected actions and activities, allied to the accreditation implementation process, and with specific reference those that interface directly with individual accreditation team members, whose experiences or *"…lived experiences"* (Buchanan 2003 p.664) are central to the study.

4.2.3 The Extent and Type of Change

The previous discussion has aimed to develop an appreciation of the link between organisational change and quality implementation, with a particular emphasis on the 'soft' or 'people' elements of this. Returning to the overall field of change, prior to moving to giving consideration to any particular change model, as the basis for the theoretical framework, it is useful to reflect on the characteristics of the actual change itself i.e. implementing acute-care accreditation and, in doing so, develop a basis for model selection which will, in turn, serve as a platform for the development of a conceptual framework for this research. On reviewing the literature that attempts to categorise the very nature of change, what becomes apparent is the extensive use

of differing and often confusing terminology (Garside 1997;Todnem By 2005;Hughes 2006) and the forthcoming discussion strives to be cognisant of this.

In the first instance, reflecting on whether change is discontinuous or continuous may be appropriate. The former is characterised by rapidly executed shifts and transformation in some, or all, of organisation's culture, structure and strategy brought about by considerable external force and/or fundamental internal problems and is likely to be one-off in nature (Van de Ven & Poole 1995;Ashburner, Ferlie, & Fitzgerald 1996;Iles & Sutherland 2001;Senior 2002;Hope Hailey & Balogun 2002;Jones 2004;McNulty & Ferlie 2004;Todnem By 2005). For Luecke (2003), discontinuous change represents *"…a single, abrupt shift from the past"*(p.102), generating challenges to existing activity, ways of thinking and behaving, which is then characterised by often long periods of consolidation (Hope Hailey & Balogun 2002). This is viewed by Van de Ven & Poole (1995) as change in the constructive mode, where the organisation, as an entity, may produce new routines that *"…may (or may not) create an original (re) formulation of the entity"* (p.522) and forms second order change, which embodies the surrender of past assumptions (Thomas 1996;Ashburner, Ferlie, & Fitzgerald 1996).

Conversely, continuous change aims to foster a scenario where both the organisation and those within it, monitor and respond appropriately, on an on-going basis, to signals from within, and external to, the organisation (Luecke 2003;Todnem By 2005) and is characteristic of organisation-wide quality approaches (Zorn, Page, & Cheney 2000;Jones 2004). Luecke (2003) argues that this type of change is made through a series of small or *"…incremental"* (Luecke 2003 p.103) steps, which represent *"…frequent improvements"* (Luecke 2003 p.103) in the change process. This might also realistically represent what Todnem By (2005) describes as *"…bumpy continuous change"* (p.373), where change is punctuated by increases in the pace of change (Buchanan & Fitzgerald 2007). Hope Hailey & Balogun (2002) usefully develop the concept of continuous, incremental change further, by distinguishing between the extent of change in terms of whether it is evolutionary or one of adaptation. They suggest that evolutionary change is likely to be transformational, implemented in stages, through inter-related initiatives on a gradual basis.

In contrast, adaptive change is viewed as less fundamental, although still implemented in a gradual and staged approach, and represents more of a realignment within the organisation (Hope Hailey & Balogun 2002) where the key values, beliefs and assumptions within the organisation remain unchanged (Goodstein & Burke 1997;Balogun & Hope Hailey 1999;Jones 2004;McNulty & Ferlie 2004). This view is also reinforced by examining the earlier theoretical work of Van de Ven & Poole (1995), who consider this as first order change, where smaller scale change occurs within the existing organisational framework, developing extensions to what already exists. In the longer term these *"…may culminate to produce a larger change in degree or quality of the entity"* (Van de Ven & Poole 1995 p.522).

How then does this view of the extent of change relate to implementing quality approaches and more specifically accreditation? A recent study by Johnson (2004) linking organisational change models to the implementation of quality standards (ISO 9000), posits that this type of change is primarily discontinuous in nature, where preparation for implementation and registration represents a *"…revolutionary"* (Johnson 2004 p.161) period after which the organisation returns to a steady state. Subsequent external quality audits are seen, in turn, to give rise to further periodic *"…revolutionary"* (Johnson 2004 p.161) phases. Johnson (2004) however, does acknowledge that continuous, incremental change will also be on-going in the organisation as, once implemented, constant improvements will need to be made to the organisational quality management system, to respond to changes in customer requirements and the competitive landscape.

In relation to the implementation of acute-care hospital accreditation, the author for this study argues in favour of a somewhat different position. Accreditation, as outlined in Chapters 2 and 3, might logically be deduced as having the characteristics of continuous, incremental change. The process is on-going and each phase might be interpreted in terms of the steps to which Luecke (2003) refers. While the final preparations for the IHSAB survey are likely to herald increased levels of activity from those directly involved and represent a 'bump' (Todnem By 2005) in managing the change, the accreditation process, both conceptually and, as depicted in previous chapters, does not cease post-visit. Instead, activity turns to the continuous improvement phase, where efforts are focused on translating into action, the

opportunities for improvement and the specific recommendations of the third-party survey.

The extent to which accreditation represents evolutionary or adaptive change is less obvious. Chapter 2 has served to demonstrate the range of factors acting as drivers for reform and change in the Irish Health Services, and within this, the impetus for improving upon existing levels of quality of care. With reference to the overall Health Service Reform Programme (Department of Health and Children 2003), this might easily be interpreted as being evolutionary and transformational in nature. However, while accreditation has provided the central vehicle for the internal review and external assessment of hospital practices with a view to improvement, it has done so within both the existing confines of the hospital organisation itself and the conditions under which individuals are employed. Weighing up these considerations, the author concludes that the extent of accreditation as a change, is likely to be more adaptive, generating an on-going realignment of practices across the organisation and as such, as an example of change, it is *"…nested"* (Van de Ven & Poole 1995 p.534) within the wider process of reform and change across the health services sector.

Secondly and relatedly, change needs to be considered in terms of whether it represents emergent or planned change. The literature on change commonly categorises models in terms of emergent or planned approaches and this, in turn, represents the basis for much of the discourse (Iles & Sutherland 2001;Rollinson & Broadfield 2002;Bamford & Forrester 2003;Burnes 2004a;Todnem By 2005;Hughes 2006). In the context of change, a model captures the set of beliefs and assumptions, which, in composite, represent reality and serve to guide action. For Tichy (1983) *"…models are at the heart of organisational change. They provide guidelines for selecting diagnostic information and for arranging information into meaningful patterns"* (p.39), a view also supported by Beer & Spector (1993). Burnes (2004a) however, sums up what is the crux of the issue - that is not in the adoption of any one stance either in favour of the emergent or planned approach, but rather *"…to choose the most appropriate approach for the type of change being undertaken and the circumstances in which it is being undertaken"* (p.886-887).

The emergent approach to change is seen to be a continuously developing and unfolding process, necessitating on-going responsiveness to unanticipated issues, as

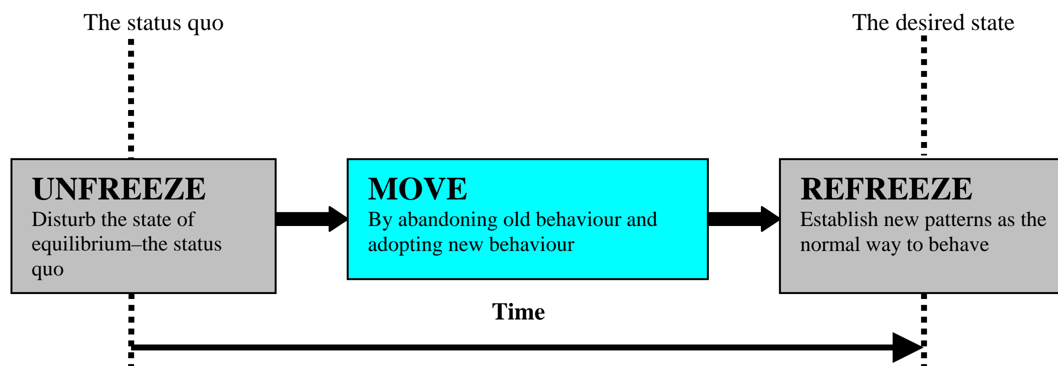
they arise both internal and external to the organisation and which may, as a result, require radical and transformational change (Burnes 1996;Todnem By 2005). The unpredictable nature of change is at the heart of the emergent approach and hence the process the change is characterised by complexity, where there may be greater weight given to assessing the extent of readiness of change (Van de Ven & Poole 1995;Bamford & Forrester 2003;Todnem By 2005). At the same time, the cultural, historical and political features of the organisation are also be given due consideration in change implementation (Pettigrew & Whipp 1991;Burnes 1996). The emergent models of Kanter (1992), Kotter (1995) and Luecke (2003) appear frequently in the literature and represent the change process as a series of phases or steps. For Coram & Burnes (2001), emergent change is *"... a continuous process of experiment and adaptation aimed at matching an organisation's capabilities to the needs and dictates of a dynamic and uncertain environment"* (p.97) and by definition, may lack applicability to organisations situated in largely stable environments, such as those in the public sector (Coram & Burnes 2001).

Looking at the field of planned change, at its most basic level, it implies considered, systematic and deliberate planning and subsequent implementation, to achieve specific outcomes, utilising a series of pre-determined steps or phases indicating which processes will create change (Senior 2002;Rollinson & Broadfield 2002;Bamford & Forrester 2003;Todnem By 2005;Hughes 2006). For Coram & Burnes (2001) such steps or phases are likely to include diagnosis, action and evaluation. Armenakis & Bedian (1999) suggest planned models bearing these characteristics represent process models, advancing a sequence of steps to follow in managing organisational change.

The seminal work of Kurt Lewin from the 1940s underpins the body of work associated with planned change or organisation development (OD), as it is often referred to (Burnes 2000;Cummings & Worley 2001;Coghlan & McAuliffe 2003;Burnes 2004b;Buchanan & Fitzgerald 2007;Soltani, Lai, & Mahmoudi 2007). Figure 4.1 illustrates Lewin's model and highlights the three key stages in organisational change - those of unfreezing, moving and refreezing, where old behaviours need to relinquished prior to new behaviours being able to surface and solidify. Lewin's model provides a general framework for viewing organisational

change as a series of stages or steps, although it is recognised that each step is broad and provides limited detail in itself (Burnes 1996;Appelbaum & Wohl 2000;Cummings & Worley 2001;Coghlan & McAuliffe 2003).

Figure 4.1 - Lewin's Three-Step Model of Change



Source: Rollinson, D. & Broadfield, A. 2002, *Organisational Behaviour and Analysis: An Integrated Approach*, 2nd edn, Prentice Hall, p.669

The planned approach to change, however, has meet with considerable criticism, not least because it seems to imply that change happens in a linear manner and in that it fails in its applicability to achieve transformational, radical and rapid change (Pettigrew & Whipp 1991;Kanter, Stein, & Jick 1992;Burnes 1996;Ferlie 1997;Senior 2002;Bamford & Forrester 2003;Todnem By 2005;Soltani, Lai, & Mahmoudi 2007). Coram & Burnes (2001), Senior (2002) and Burnes (2004b) observe that the planned approach assumes that the characteristics of the environment are mainly known, predictable and stable and, as such, can be factored into the change planning process. Moreover, it is also deemed to rely on a top-down approach (Burnes 2000;Senior 2002;Bamford & Forrester 2003), where senior management have sole responsibility for determining and implementing change. This latter point, Balogun & Hope Hailey (1999) suggest, is a frequent mistake in interpretation: *"…although top-down change is clearly driven by the top executives, this does not mean that a top-down change approach is never collaborative or participative"* (Balogun & Hope Hailey 1999 p.28). This is further supported by Burnes (2004b) who, on reviewing Lewin's work on planned change, argues that

Lewin fully acknowledged the necessity to harness the commitment and involvement from those involved in change across the organisation, as a contributor to change success.

Despite these purported shortcomings, the planned approach would appear to have particular relevance to change that is continuous and incremental in nature (Packard 1995;Todnem By 2005). Furthermore, this has particular significance for this research bearing in mind the previous consideration given to accreditation as an organisational change and, in particular, that it is characterised by a cycle and integral stages, whose achievement require planning and actioning in a systematic manner. Moreover, Chapter 2 and earlier discussion in this chapter, has attempted to present the characteristics of the public sector and, within this, publicly funded health service organisations which, despite being subject to a variety of influences, operate in a largely stable and known environment, shielded from the turbulent and competitive contexts in which most private sector organisations operate. With this in mind, it is possible to arrive at an acceptance that the implementation of acute-care accreditation is generally characteristic of the planned approach to change and hence there is merit in exploring models in this domain as a means of developing the theoretical and conceptual basis for this research.

4.2.4 Change Model Selection and Conceptual Framework

A plethora of rich and diverse planned change models exist in the literature as a basis for conceptualising and managing organisational change and these, in turn, differ in format (Woodman 1989;Shacklady-Smith 2006). Close (1997) and Ford & Evans (2001) suggest that using models gives direction to the determination of what is assessed or examined and that the availability of a model provides both structure and coordination to the range of actions and activities being investigated. Moreover, Garside (1997) argues that by reflecting on the theory implied within a model and the logic and common sense that often lies behind it, may be useful in terms of understanding and steering a pathway towards the successful management of change and quality implementation in healthcare contexts. Having given due consideration to the foregoing, the aim is to arrive at the selection of a change model to serve as the theoretical framework for this research. In doing so, this should contribute to the development of a conceptual framework, reflecting a comprehensive view of reality

for this research, an approach favoured by Johnson (2004), who posits that change models may support the generation of conceptual frameworks to underpin empirical research in the quality implementation field.

The central tenets of Lewin's thesis provide the basis for more recent approaches to planned change and, as previously alluded to, the step or phase features are a key characteristics of many of the models, which Bullock & Batten (1985) describe as a *"…organizational states"*(p.401), each with associated actions and activities or *"…change processes"* (p.401) (the mechanisms used for the organisation to move from one state to another) (Hamlin, Keep, & Ash 2001;Bamford & Forrester 2003;Gustafson et al. 2003;Hughes 2006). Hamlin, Keep, & Ash (2001) suggests that while there are subtle differences between the process or phased-type models, the similarities are evident.

The prevalence in the literature of the model of Bullock & Batten (1985) is noted by Bamford & Forrester (2003), particularly as this represents a synthesis of over thirty of the pre-existing planned change models. Here, planned change is distilled into four separate phases - those of exploration; planning; action and integration (Bullock & Batten 1985). Similarly, Hamlin, Keep, & Ash (2001) give specific recognition to the model of change developed by W. Warner Burke and his colleagues (Burke et al. 1991), where change is again conceptualised in terms of four stages - this time as the planning of change; managing the people side of change; managing the organisational side of change and the evaluation of the change effort. Overall, the underlying similarities between numerous approaches to planned change, leads Hamlin, Keep, & Ash (2001) to propose a generic model based on the distillation of a number of these. They suggest that successful change can be achieved through diagnosis; the creation of strategic vision; planning the change strategy; securing ownership, commitment and involvement; project management of the implementation and the stabilisation, integration and consolidation of change to ensure perpetuation.

While these models and their integral phases address, either explicitly or implicitly, many of the elements that are central to this research and that be will used to support subsequent discussion, they fail to capture the totality of issues that are relevant to the 'soft' side of quality implementation. An alternative grouping of planned change

models is grounded in the concepts of open systems theory (Katz & Kahn 1978), where the organisation is viewed as a set on interrelated subsystems, interacting with each other to transform inputs into outputs, while simultaneously being influenced by and influencing the environment in which it operates (Burke & Litwin 1992;Beer & Spector 1993;Lok & Crawford 2000;Iles & Sutherland 2001;Senior 2002;Rollinson & Broadfield 2002;Harrison 2005). Organisational effectiveness is influenced not by any singular and independent element or component of the organisation but instead by the interface between multiple factors (Beer & Spector 1993;Iles & Sutherland 2001;Rollinson & Broadfield 2002;Daily & Bishop 2003).

Katz & Kahn (1978) argue that:

"Social organizations as contrived systems are sets of such patterned behavioral events…In the most generic sense the structure of a social organization is contained in its various functions. In small subsystems the functions may be directly observable in the human activities involved; in larger sectors of organizational activity the overall patterns and functions are also inferred from observable events, but less directly" (p.754).

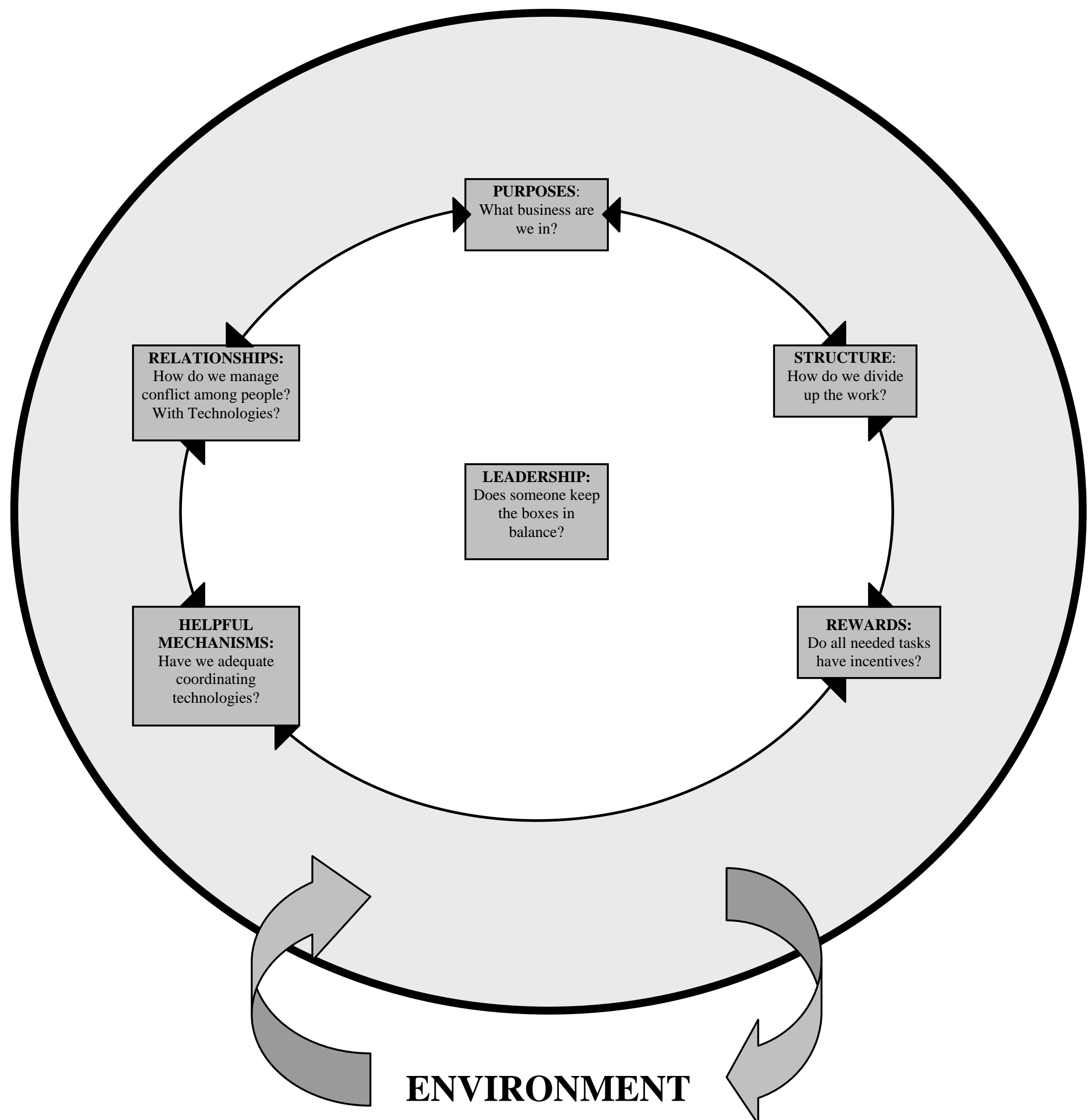
They further qualify the emphasis that is placed on the degree of openness to the environment by positing that organisations, as systems, have boundaries behind which exist system properties, behaviours and relationships. Without boundaries the organisation ceases to exist as a separate system (Katz & Kahn 1978).

For Armenakis & Bedian (1999) this grouping represent content models which, at a deeper level, attempt to *"…define factors that comprise the targets of successful and unsuccessful change efforts"* (p.295). Models of this type approach the examination of change in a more diagnostic vein, as a basis for building an understanding of complex organisational problems and hence developing and guiding appropriate change strategies (Lok & Crawford 2000;Caluwe & Vermaak 2003;Harrison 2005;Rodsutti & Makayathorn 2005;Shacklady-Smith 2006). Models of this genre offer a platform for considering the elements or variables and their interrelationships within the change process, with an explicit acknowledgement of the environment (Armenakis & Bedian 1999;Di Pofi 2002;Harrison 2005).

Caluwe & Vermaak (2003) argue that the choice of model is equally as deliberate as the change process itself. In terms of identifying an appropriate model in which to situate this research in the broader field of organisational change and also to serve in developing an overarching conceptual framework, two fundamental conditions have influenced the selection. In the first instance, as the research focuses on the 'soft' or 'people' related aspects of quality and accreditation implementation, an appropriate model would serve to reflect these key dimensions, elements or themes and, in doing so, be closely allied to, and reflective of, organisation-wide quality approaches. Secondly, in seeking to achieve this, considering and hence demonstrating the robustness of the model is an imperative.

Again, there are a range of models that conceptualise this approach and fall within the content category (for example, Nadler & Tushman (1980), Tichy (1983), Burke & Litwin (1992)), but the objective is not to provide an in-depth and detailed review of these, with a view to rejection. Instead, the intention is to present the rationale for the use of the model proposed by Weisbord (1976a) as the basis for both the theoretical and the conceptual framework for this research on the implementation of acute-care hospital accreditation and the impacts that may arise from this at the individual and organisational levels. Weisbord's (1976a) Six-Box Organisational Model focuses on organisational processes or *"…activity"* (Weisbord 1976a p.431) integral to organisations and which are fundamental to the process of change (Kanter, Stein, & Jick 1992;Iles & Sutherland 2001) and is depicted in Figure 4.2.

Figure 4.2 - Weisbord's (1976a) Six-Box Organisational Model



Source: Weisbord, M. 1976a, "Organizational Diagnosis: Six Places to Look for Trouble with or without a Theory", *Group & Organization Studies*, vol. 1, no. 4, p.432

Weisbord (1976a;1987), and latterly Lok & Crawford (2000) and Iles & Sutherland (2001), suggest that the general rationale for use of the model may be twofold: (i) to identify the strengths and weaknesses within the organisation in terms of its internal processes relating to a particular issue and (ii) to identify reasons why either producers or consumers of a particular output are dissatisfied, which may serve to guide, manage and re-orientate organisational change. With reference to this research, this would appear to be particularly relevant. In the first instance, the research may uncover strengths or weaknesses or the presence of enablers or

inhibitors to the accreditation implementation process, based on the themes within the model. Secondly and relatedly, individual participants within the accreditation process are, in effect, the producers of the self-assessment stage of the approach. Through the exploration of individual experiences, the research may reveal areas of satisfaction and dissatisfaction with the process. Weisbord (1976a) suggests that through this assessment, an understanding may be gained of *"... the gaps in the organization between 'what is' and 'what ought to be'"* (p.435), with reference to the internal activities or process represented in the model.

The Weisbord (1976a) model is both important and useful on a number of other fronts. It serves to integrate a number of the strengths of the theoretical and empirical underpinnings of the wider change management and quality implementation literatures and also that which emanates from the more normative, yet widely cited literatures in the area. Intuitively the model is uncomplicated but comprehensive to the extent that it is reflective of the key variables, activities or organisational infrastructure and their interrelationships and interdependencies, that may relate to the change process (Shaw 1997;Lok & Crawford 2000). This feature is particularly beneficial, according to Caluwe & Vermaak (2003), who argue that for a model to be manageable, there is likely to be some level of abstraction.

The provenance and robustness of the model appears to be highly credible, set in a longitudinal context. Lok & Crawford (2000) acknowledge that the model has recognition, acceptance and longevity and has served as the basis for the development of the change models of Nadler & Tushman (1980), Tichy (1983) and Burke & Litwin (1992). Woodman (1989) also argues that Weisbord's (1976a) model has a robust foundation, underpinned by the theories and practices of Kurt Lewin, Eric Trist and Douglas McGregor. Ford & Evans (2001) posit that it represents a prominent model of the organisational change process which is also supported by Beer & Spector (1993), while Johnson (2004) describes it as one of the many *"...well-defined and applied organizational change models in existence"* (p.154). Moreover, it meets the three criteria offered by Levinson (1972) on which to judge a diagnostic model for organisational change in that it is comprehensive, encompassing key organisational functions, whilst also acknowledging the external environment; in achieving the former, it provides direction for the collection of data

on which to base the diagnosis and finally, provides a starting point from which researchers can develop an understanding of the change process.

Exploring the model in more depth, its applicability as a theoretical framework for this research begins to surface. Looking at figure 4.2, in the first instance the environment is acknowledged. Weisbord (1976a) describes the environment with reference to open systems theory in terms *"...forces difficult to control from inside that demand a response"* (p.433), such as customers and governments and here there is a clear resonance to this study, where Chapter 2 has sought to provide the context for accreditation implementation. For Armenakis & Bedian (1999), the environment provides the enabling or constraining context in which change takes place, while Balogun & Hope Hailey (1999) argue that this represents the *"...why"* (p.3) of change.

Moving then to the specifics of the 'boxes', six key elements are presented which, on interpretation, bear a strong similarity to the 'soft' facets of an organisation-wide quality approach such as accreditation, which is the focus of this research. This interpretation is supported by Johnson (2004), who argues that the Weisbord (1976a) model bears a close resemblance to, and is hence compatible with, wider quality management systems. Subsequent discussion aims to commence the development and demonstration of this link to accreditation implementation under the dimensions of communication; teams; involvement and participation; reward; training and leadership, which appear extensively in both the change management and quality implementation literatures. The Weisbord (1976a) Six-Box Organisational Model therefore comprises:

(i) Purposes. For Weisbord (1976a), purposes represent a tension between what the organisation is compelled to do in order to survive and move forward and what it would like to do, in an idealistic sense, culminating in the development of organisational priorities which, in turn, manifest in projects or programmes. Purposes need to be considered in terms of goal clarity and Weisbord (1976a) posits that this is determined by *"How well articulated are these goals in the formal system?"* (p.436). In terms of operationalising change, this

reflects the extent to which clarity exists for organisational members as to the mission and purpose of change (Lok & Crawford 2000) and for accreditation implementation, this could logically extend to the *communication* that disseminates this;

(ii) Structure. Here the requirement for a fit between the goal or output and the structure generating it, reflecting how tasks are divided, is achieved (Weisbord 1976a) and, in turn, whether the structure *"…serves that purpose"* (Lok & Crawford 2000 p.110). Looking at accreditation as an example of organisational change, the supporting structures for implementation are the accreditation *teams*;

(iii) Relationships. The nature of relationships between individuals and individuals and their work roles, may affect the change process (Lok & Crawford 2000). Weisbord (1976a) argues that dysfunctional interdependences occur where *"People work together and do not do it well"* (p.439) and that built-in conflict exists not only between individuals, but also between individuals and the nature and requirements of their work roles. In order for quality and accreditation implementation to progress, the *involvement and participation* of individuals is required and their ability to deliver on accreditation objectives and tasks, may be underpinned by the quality and sufficiency of the aforementioned relationships;

(iv) Rewards. This dimension of the model captures the requirement to integrate *reward* into the process of managing change (Lok & Crawford 2000). Weisbord (1976a) notes that reward and by extension, recognition, are *"…symbols of worthy work that is needed and valued by the organization"* (p.440) and in an accreditation context, may be instrumental in reinforcing individual contribution and on-going commitment to the process;

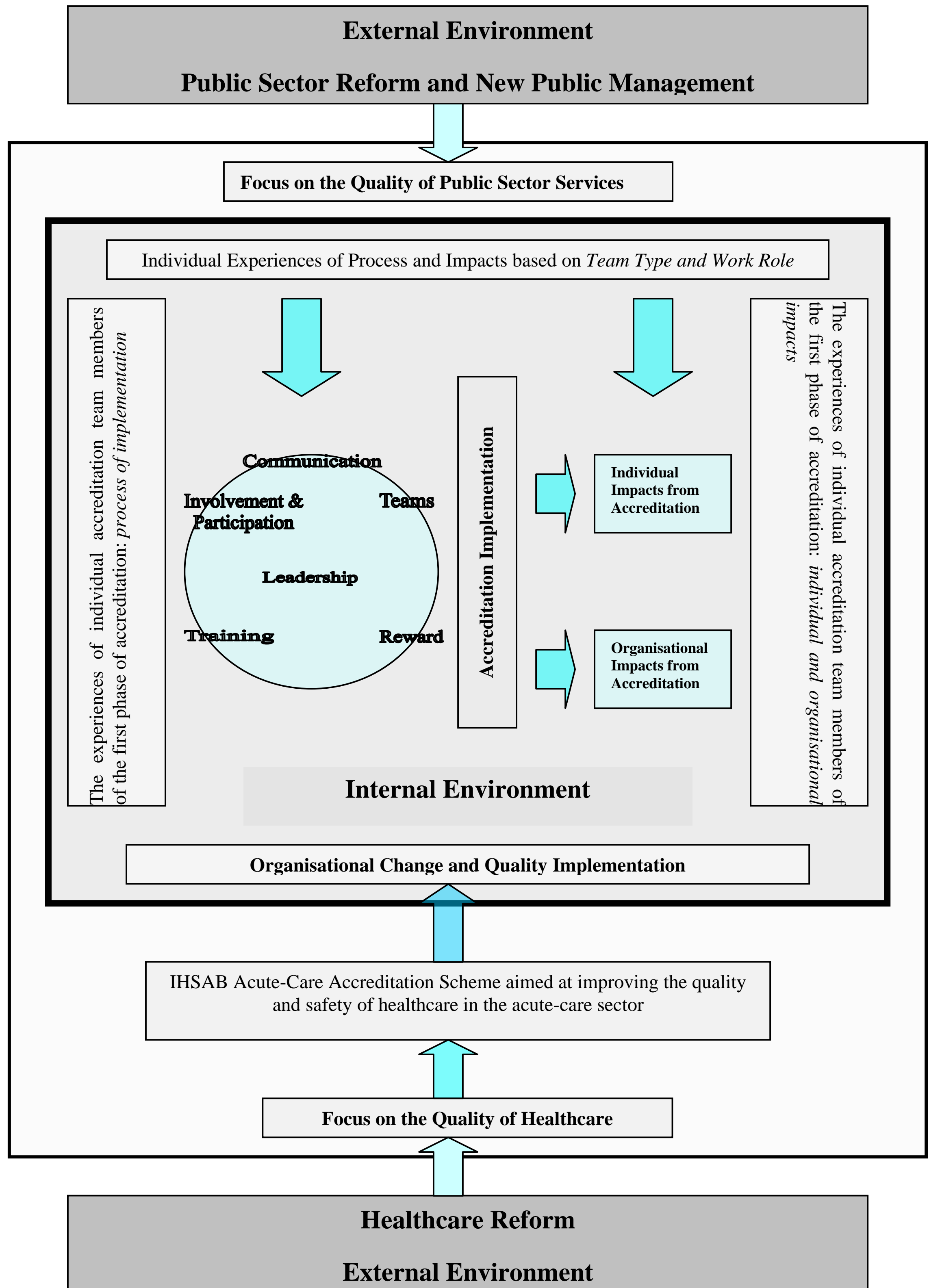
(v) Helpful Mechanisms. Weisbord (1976a) suggests that these may take a number of different forms such as procedures, policies, systems and other activities that support and facilitate concentrated efforts in the

domain of creating change. In the context of quality and accreditation implementation, an example of one of these mechanisms might be the provision of the necessary *training* to develop both the requisite knowledge relating to the accreditation process and the supporting skills to enable individuals to function in a team environment;

(vi) Leadership. The function of leadership is seen to *"…define, embody, and defend purposes and to manage internal conflict"* (Weisbord 1976a p.442) and sits at the core of the model ensuring the support and maintenance of the other elements (Lok & Crawford 2000). Within accreditation, *leadership* is likely to be instrumental to implementation and may need to be evidenced not only through senior management but also through those charged with directly leading and managing the process.

Having attempted to demonstrate the links between Weisbord (1976a) model of change and the 'soft' or 'people' elements of quality and accreditation implementation, the next step is to extend this to the development of a conceptual framework to underpin the empirical component of this study. Figure 4.3 aims to depict this framework which will, in turn, bound the remainder of the literature review and also serve to support the organisation and presentation of primary research data. In adapting the model to a conceptual framework, steps have been taken to reflect the scope and approach taken in this research.

Figure 4.3 - A Conceptual Framework for Examining the Acute-Care Accreditation Implementation Process and Impacts



The conceptual framework in the first instance, explicitly extends the environment to encapsulate both the internal and external context, a revision also supported by Lok & Crawford (2000). This move formally recognises both the interaction between the internal and external environments and the influence of the internal organisational environment that may be brought to bear on any or all of the six elements of the implementation process and the two other elements that relate to associated impacts within the framework. Secondly, the framework removes the causality from the implementation process that is implied in the original model and, instead, depicts links between the elements, indicating relationships but without causality, which is reflective of the objectives and approach taken in the primary research stage of this study. Finally, the framework extends the original model to recognise the impacts that may arise at both an individual and organisational levels, in this instance from the overall accreditation implementation process and from the six elements within this, and moreover, the scope for differing experiences of these based on work role and also team type, which are reflected in the IHSAB accreditation approach.

4.3 The Accreditation Implementation Process

This section attempts to draw on the change management and quality implementation process literature and specifically that from within the healthcare context, to identify a number of elements of relevance to this study and hence to develop an appreciation of the issues that are explored at the primary research stage.

The initial discussion seeks to address a number of themes around the 'people' dimensions of the quality implementation process, with particular reference to healthcare organisations and within the boundaries of the conceptual framework. Within each of these themes are specific actions and activities and Ghobadian & Gallear (2001) suggest that each has a *"...focus"* (p.347) that directly integrates and contributes to the implementation process. In terms of developing a discussion of these, Claver, Tari, & Molina (2003) identify that most studies on organisation-wide quality approaches and their implementation, draw on three separate strands of literature which, in turn, reflect the development of the field (Tari 2005;Tari & Sabater 2006). In the first instance, the contributions of the quality leaders or 'gurus' are considered, although these are often viewed as being overly prescriptive (Hill &

Wilkinson 1995;McAdam & Bannister 2001;Taylor & Wright 2003;Sila & Ebrahimpour 2003;Singh & Smith 2006). Secondly, the formal evaluation models such as the Malcolm Balbridge National Quality Award and the EFQM Award are also acknowledged. Finally, the body of theoretical, conceptual and empirical work relating to quality implementation naturally features extensively. Accepting that these, coupled with sources from the organisational change field, are reflective of the overall body of literature in relation to quality implementation, the following discussion is built around these perspectives but with an acknowledgement that in conducting a doctoral study, the requisite emphasis lies in developing a sound theoretical and empirical basis as the platform for primary research.

4.3.1 Leadership

The exercise of effective leadership by management is central to the change process (Weisbord 1976a;Tichy 1983;Woodman 1989;Pettigrew, Ferlie, & McKee 1992;Jennings, Miller, & Materna 1997;Gustafson et al. 2003;Higgs & Rowland 2005;Oakland & Tanner 2007). While Greenberg & Baron (1993) present leadership as *"…the process whereby one individual influences other group members towards the attainment or defined group or organizational goals"* (p.444), this fails to capture the complete instrumentality of leadership across the organisation during change. Instead, Cummings & Worley (2001) present a more comprehensive appreciation of the role of leadership by management, expressing this in terms of five major activities. In the first instance, they suggest that motivating and creating readiness and acceptance of the need for change amongst employees, is key leadership task for management. Secondly, they argue that the creation of a vision for change, encompassing the purpose and overall rationale, is also evidence of leadership. Thirdly, in recognition that organisations are often comprised of powerful individuals and groups, whose cooperation may be crucial to the effective implementation of change, the development of political support is also deemed to be a fundamental leadership activity. The fourth activity lies in the management of the transition involving the development of a plan representing change actions and a requisite transitional structure. Finally, Cummings & Worley (2001) posit that leadership is responsible for sustaining the momentum for change efforts through competency and skill development; the provision of resources; reinforcing new behaviours and developing a support system within which change agents can operate.

Summing up the imperative for leadership, Johnson & Johnson (1997) comment *"Change requires leadership, a prime mover to push for implementation"* (p.208).

These activities clearly resonate in the literatures on both organisational change and quality implementation and as Hamzah & Zairi (1996b), Kia Liang Tan (1997) and Lakshman (2006) argue, the exercise of leadership over these activities is not exclusively in the domain of senior management but instead, needs to be in evidence at all levels in the organisation and sees management move from a controlling to supporting role (Zabada, Rivers, & Munchus 1998;Kammerlind, Dahlgaard, & Rutberg 2004;Degeling & Carr 2004;Peck 2006;Buchanan & Fitzgerald 2007;Lagrosen, Backstrom, & Lagrosen 2007). Despite being located within the emergent change literature, both Kanter, Stein, & Jick (1992) and Kotter (1995) support this view, while Burke & Litwin (1992) suggest that the function of leadership concerns supplying direction to implementation, while also serving as a role model for organisational members. Pascale, Millemann, & Gioja (1997), Fernandez & Rainey (2006) and Sminia & Van Nisterlrooij (2006) suggest that leadership provides both the focus and supporting maintenance to employee involvement and, is additionally charged, with resolving complex and often interwoven problems in the change process (Pettigrew, Ferlie, & McKee 1992;Tierney 1999;Degeling & Carr 2004). For Woodward & Hendry (2004) *"…managerial leadership"* (p.157) should be in evidence during implementation as employees will constantly make judgements on how effectively the change is being led and managed (Burke & Litwin 1992;Tierney 1999). However, in the public sector (Thomas 1996) and professional organisations such as hospitals, exerting effective leadership may prove particularly challenging as many employees are *"…ostensible equals"* (Mintzberg 1998 p.144), who may not be receptive to more traditional modes of direction from management (Mintzberg 1997).

The initial and on-going leadership by management to a quality approach is considered to be imperative (Boaden & Dale 1993;Anjard 1995;Brashier et al. 1996;Zabada, Rivers, & Munchus 1998;Dayton 2001;Beer 2003;Hansson, Backlund, & Lycke 2003;Harrington & Williams 2004) and lack of progress in this direction is stressed as a contributory factor in the failure of quality approaches in organisations (Leatherman & Sutherland 2003;Warwood & Roberts 2004;Lakshman 2006).

Shortell, Bennett, & Byck (1998) in using a gardening analogy, liken leadership to constant attention, allowing quality to flourish, while empirical evidence of this is provided by Samson & Terziovski (1999) who demonstrated in their study of quality practices and operational performance, that these were positively related to the existence of effective leadership in the organisation. Advocacy of leadership is also in evidence in many of the central teachings of the quality 'gurus' (for example, Deming, Crosby, Juran and Feigenbaum) (Dale 2003b). For Daily & Bishop (2003) the exercise of leadership by management may lead to *"…increased organizational commitment by employees which, in turn, may lead to a cultural shift favouring involvement and quality improvement"* (p.399) through actively promoting, supporting and directing quality values and the systems underpinning the quality approach (Reeves & Bednar 1993;Samson & Terziovski 1999;Fletcher 1999;Harrington & Williams 2004;Huq 2005;Lakshman 2006). Similarly, Penland (1997) and Alexander et al. (2006) suggest that in a healthcare context, leadership may serve to influence staff and, in particular, doctor participation to quality teams. Leadership by management may need to be demonstrated in a concrete and visible way and at the senior management level, leadership acts as an important driver for quality approaches through the articulation of priorities and also in the sanctioning of resources to support implementation (Ovretveit 1992;Anjard 1995;Ahire, Golhar, & Waller 1996;Hamzah & Zairi 1996b;Hearnshaw et al. 1998;Daily & Bishop 2003;Rad 2006).

Effective leadership is likely to be required of those directly responsible for managing the quality approach, for whom successfully actioning the five leadership activities is particularly important (Berwick, Godfrey, & Roessner 1990;Pettigrew, Ferlie, & McKee 1992;Brashier et al. 1996;Lammers et al. 1996;Siegal et al. 1996;Ahire, Golhar, & Waller 1996;Wagar & Rondeau 1998;Ovretveit 1999;Gandhi et al. 2000;Ryan 2004;Pomey et al. 2005). As the initial stages of quality implementation may be very task orientated, quality managers are likely to be concerned with ensuring that the implementation is effectively facilitated and project managed, supporting individuals within teams and ensuring that the quality approach meets its project plan and deliverables (Perry 1995;Proehl 1997;Nwabueze 2001;Badrick & Preston 2001;Pomey et al. 2004;Gollop et al. 2004). This issue is particularly highlighted in the study of organisations within eight regional health

authorities conducted by Joss & Kogan (1995), where they found that shortcomings in the competencies of quality programme managers contributed to the quality approach failing to be fully implemented in the organisation.

4.3.2 Communication

Without communication, change runs the risk of not being enacted and, moreover, it is the mechanism by which individuals create the reality in which they exist during the change process (Thomas 1996;Dutton et al. 2001;Caluwe & Vermaak 2003;Buchanan & Fitzgerald 2007;Oakland & Tanner 2007). It is also the means by which a knowledge and understanding of the change itself and resulting consequences is constructed (Ford & Ford 1995;Lewis 1999;Bordia et al. 2004;Soltani, Lai, & Mahmoudi 2007), based on information disseminated about the change process itself (Lewis et al. 2006). Furthermore, employees may perceive change related communication differently from those in managerial roles charged with implementing change, by virtue of their distance in the hierarchy from the key decision-makers in the change process and may, as a result, rely on peers, supervisors and line managers for information (Lewis 2006). For Kitchen & Daly (2002) *"Communication is a key issue in the successful implementation of change programmes because it is used as a tool for announcing, explaining or preparing people for change and preparing them for the positive and negative effects of impending change"* (p.50).

The importance of communication is widely highlighted in the organisational change literature and, likewise, is believed to be central to the process of implementation (Ford & Ford 1995;Lewis 1999;Elving 2005;Lewis 2006), not least because it may serve to reduce the amount of cynicism associated with the change amongst employees (Reichers, Wanous, & Austin 1997). For example, within the four-phase model advocated by Bullock & Batten (1985), the 'action phase', incorporating the implementation process, advocates that communication is a key activity, while similarly this is reinforced by Burke et al. (1991), who at the 'planning change' and 'managing the people side of change' stages of their model, articulate the role and significance of communication in initiating and continuing the change process.

Similarly, the contributions of Kanter (1992), Kotter (1995) and Luecke (2003) also acknowledge the instrumentality of communication, not least because it enables the creation of the vision of change (Lewis 1999;Lewis et al. 2006;Lewis 2006). Kanter (1992), Luecke (2003) and Lewis (2006) importantly recognise that communication in the context of managing change, should not be unilateral and rather facilitate open dialogue covering progress, channelling feedback, concerns and resistance and may be viewed as *"…a dialogic process wherein various stakeholders engage one another in clarification, negotiation of meaning, and perspective taking"*(Lewis 2006 p.40). This, in turn, may give employees a sense of control over change implementation (Ford & Ford 1995;Reichers, Wanous, & Austin 1997;Bordia et al. 2004;Lewis et al. 2006). However, this position is somewhat countered by Lewis (1999) who, while acknowledging the benefits of two-way communication to the change process, suggests that a degree of balance in terms of deploying the direction and focus of communication efforts may need to be achieved.

Luecke (2003) extends his consideration of communicating for change to incorporate the issues that might be included. He suggests that the nature, scope and timelines for change should be explicit, adopting a diverse range of communication styles and methods targeted at the appropriate audience or stakeholders (Lewis 1999;Barrett 2002;Lewis et al. 2006). In turn, this may be viewed as an organisational campaign to spread and sell the content of change, to achieve buy-in from employees and moreover, to reduce resistance (Ford & Ford 1995;Redman & Mathews 1998;Lewis 1999;Zorn, Page, & Cheney 2000;Kitchen & Daly 2002;Elving 2005), although as Zorn, Page, & Cheney (2000) note, this might be looked upon as a 'seduction' strategy and attempting to achieve control over employees.

Alexander (1997) and Sirkin, Keenan, & Jackson (2005) situate communication at the heart of organisational change and argue that this must, in turn, be delivered in a timely, accurate, appropriate and consistent manner or risk the alienation of those closest to the change and reduce the prospect of participation (Lewis 1999). For Balogun & Hope Hailey (1999), the issue of timing is crucial as *"…the later the communication, the less time and opportunity for employees to absorb, understand and adjust to what they are being told"* (p.176) and should be evident at every stage of the change process and contain messages not only about the change and but also

about the change process itself (Boyle & Humphreys 2001;Caluwe & Vermaak 2003;Fernandez & Rainey 2006). This, in turn, is likely to contribute to the extent of readiness for change across the organisation (Elving 2005).

Effective and on-going organisation-wide communication is likewise a requirement for quality implementation, without which the process may be hindered and fail to achieve the necessary embeddedness (Black & Porter 1995;Hamzah & Zairi 1996a;Thiagarajan & Zairi 1997;Lewis 2000;Nwabueze 2001;Hing Yee Tsang & Antony 2001;Huq 2005;Lagrosen, Backstrom, & Lagrosen 2007). Moreover, feedback to those involved with the process may also be essential to ensure that there is an appreciation of progress to date with change and quality related activities and that the next steps in the overall process are relayed (Kia Liang Tan 1997;Alexander 1997;Balogun & Hope Hailey 1999;Lewis 2000;Gollop et al. 2004).

This necessity for communication throughout the organisation is explicitly stated in the work of the quality 'gurus' Crosby (1984), Deming (1986) and Juran (1992) and also appears in the wider quality management literature. For example, Baidoun (2003) emphasises the need for every facet of the quality approach to be presented and discussed throughout all levels in the organisation, while the holistic nature of many quality approaches such as accreditation, in that it applies to every part of the hospital entity, requires an awareness and understanding of purpose, necessity, process and implications on the part every employee who is, in turn, responsible for and affected by it (Milakovich 1991;Alexander 1997;Fletcher 1999;Ennis & Harrington 1999a;Jackson 2001;Caluwe & Vermaak 2003;Squires 2003). Likewise, Stamatis (1996) argues that communication at both the organisation and team level enables information to be disseminated about the process and progress around this.

For Ovretveit (1992), communication in a healthcare context is an implementation prerequisite, enabling employees to become clear about their responsibilities and develop ownership of the quality approach. Communication may also contribute to promoting the benefits of implementation and, as a result, influence participation, which furthermore, is achieved by sending the message that there is "*...something tangible in it for staff and managers*" (Ovretveit, 1992, p.138). Finally, creating an acceptance that the quality approach is not a one-off exercise but a continuous, on-

going activity in the organisation is a likely goal of communication and hence done effectively, may serve to reduce resistance in implementation (Reeves & Bednar 1993;Leahy 1998;Zabada, Rivers, & Munchus 1998;Lewis 2000;Jackson 2001).

To achieve this, Close (1997) argues that those leading the approach need to *"…communicate like you have never communicated before"* (p.103), but being mindful that too much information may serve to hinder the implementation of a quality approach by overloading or 'swamping' employees (Hamzah & Zairi 1996a). This is particularly crucial given that those who are not team members are likely to be called upon to support and assist their colleagues who are playing more central roles within the process and therefore need to understand the quality approach, their own role within it and how, in turn, they contribute to the process of implementation (Brown 1994;Redmayne et al. 1995;Close 1997;Higgins & Routhieaux 1999;Gollop et al. 2004;Ryan 2004;Mills & Weeks 2004;Huq 2005). In terms of implementing quality approaches, communication must work well up, down and across the organisation (Hillman 1991;Lewis 2006), utilising a diverse range of media channels (briefing sessions, special events, notice boards) including verbal and written (paper and electronic) communications, being mindful of the use and relevance of both language and the message itself (Hillman 1991;Hamzah & Zairi 1996a;Balogun & Hope Hailey 1999;Jackson 2001;Kitchen & Daly 2002;Lewis et al. 2006;Lewis 2006). However, Hillman (1991) notes that some organisational members may be unreceptive to the content of quality-related communication or alternatively not remember what information they have received.

The necessity for organisation-wide publicity to support implementation is further reinforced by James & Hunt (1996) who address this as a specific requirement before embarking on hospital accreditation and also throughout the course of the process, so as to maximise participation by employees. Moreover, Thiagarajan & Zairi (1997) argue that the impact of inconsistent and unclear communication may be that those involved in quality activities end up focusing on the wrong priorities which, in turn, may contribute to disillusionment and loss of momentum with the approach. This may manifest in the context of the teams themselves, where clear communication is required to focus on objectives and timing and hence capitalise on employee participation (Cole, Bacdayan, & White 1993;James & Hunt 1996;Hearnshaw et al.

1998). Finally, the research by Gollop et al. (2004) serves to capture what may be some of the key risks arising from poor communication in quality implementation within a healthcare context. Based on interviews with both clinical and non-clinical respondents in senior management positions in the NHS, they established a lack of clarity and understanding about the process arising from the early promotion, communication and first exposure to the language and methodology of the quality approach. In particular respondents *"…encountered considerable misunderstanding about aims, methods, and benefits"* (Gollop et al. 2004 p.111), which they suggested originated from the style, content and perceived lack of applicable examples of the initial presentations. In turn, this was deemed to have contributed to scepticism and resistance, manifesting in a lack of participation with the approach.

4.3.3 Involvement and Participation

There appears to be a considerable degree of consensus in the literature on the significance of involvement and participation of employees in change management and quality implementation. Involvement and participation *"…means simply engaging jointly with others in some set of activities"* (Katz & Kahn 1978 p.766). Pascale, Millemann, & Gioja (1997) argue that organisational change may only be successfully achieved where employees are fully incorporated as *"…meaningful contributors"* (p.131) into the change process itself. Participation and involvement represent the 'bottom up' element that may contribute to successful change implementation (Boyle & Humphreys 2001;Sminia & Van Nisterlrooij 2006;Fernandez & Rainey 2006;Oakland & Tanner 2007). Alexander (1997), Gustafson et al. (2003) and Waldersee & Griffiths (2004) also support this view and argue that participation is a means of securing support for change from amongst the workforce and that in a public sector change context, these represent a key and powerful stakeholder group (Fernandez & Rainey 2006;National Economic and Social Forum 2006;Soltani, Lai, & Mahmoudi 2007).

Where quality approaches are focused at organisation-level interventions, securing the multi-level involvement and participation of key contributors is imperative (Wakefield & Wakefield 1993;Black & Porter 1995;Hamzah & Zairi 1996b;Close 1997;Wilkinson, Godfrey, & Marchington 1997;Tari & Sabater 2006) and with cognisance of the necessity to deploy human resources in the most effective and

efficient way (Kennedy 1998;Redman & Mathews 1998;Rhinehart 2000;Stewart 2003). Getting the right people involved is likely to be crucial and furthermore, the power of quality approaches will be dissipated if employees do not participate enthusiastically (Ovretveit 1992;Ennis & Harrington 1999b;Lagrosen, Backstrom, & Lagrosen 2007). Taylor & Wright (2003) identified in their study that where organisations had failed to motivate their employees to participate in a quality approach, the approach itself was less likely to be perceived as being successful. Similarly, a recent study by Pongpirul et al. (2006) on the implementation of accreditation in Thailand, indicated that 93% of healthcare professional respondents saw lack of staff participation as a problem, while 24% of these saw it as a major obstacle to hospital accreditation implementation. Overall, involvement and participation aims is to ensure that both the review of existing practice and proposals for change and improvement are considered in a representative context and based on the adage that those who perform the work are generally best placed to have a greater understanding of the issues, problems and possible solutions to these (Berwick, Godfrey, & Roessner 1990;Beer, Eisenstat, & Spector 1990;Badri, Davis, & Davis 1995;Brashier et al. 1996;Kivimaki et al. 1997;Shin, Kalinowski, & El-enein 1998;Jackson 2001;Nwabueze 2001).

Without participation, implementing quality approaches such as accreditation, involving external assessment, may represent a waste of resources, which have associated costs as the hospital is unable to fully and accurately document its real situation (Eggli & Halfon 2003). For O'Leary (2000) the issue is straightforward: *"…if we truly expect to improve the safety of patient care, those who directly provide the care must engage in the improvement process"* (p.728) and moreover, also accept that as constituents of the approach, that implementation is their responsibility (Anjard 1995;Zabada, Rivers, & Munchus 1998;Shin, Kalinowski, & El-enein 1998;Pomey et al. 2005).

Participation within change and furthermore, within quality implementation, is likely to be reliant on drawing from all disciplines, functions and levels within the organisation (Ovretveit 1992;Lammers et al. 1996;Nwabueze 2001;Ham, Kipping, & McLeod 2003;Leatherman & Sutherland 2003;Scrivens 2005;Alexander et al. 2006). Pascale, Millemann, & Gioja (1997) observe that the problem with change

implementation is that the numbers of committed individuals involved across the organisation *"…is simply too small"* (p.127) and that more employees need to take active roles. In a hospital this could include *"…everyone from the senior executive to the nurse at the bedside, the unit clerk and the housekeeper"* (Wakefield & Wakefield 1993 p.84) and securing this involvement should be done as early as possible in the programme (Close 1997). Jackson (2001) underlines that it is the responsibility of both line managers and programme managers for the quality approach to harness this contribution, while Alexander et al. (2006) suggest that participation may be a function of leadership. Furthermore, consideration should be given to whether participation is either voluntary or mandatory (Boaden & Dale 1993;Dale 2003a), although Dale (2003a) argues that team members should be willing participants rather than their involvement being the product of coercion. Once this is secured, team members should attend all quality-related meetings as required, other than in exceptional circumstances (Dale 2003a).

For Wilkinson & Brown (2003), advocates of quality approaches have understated the challenges associated with ensuring that employees throughout the organisation participate and 'buy-in' to the approach. Failure to achieve this has the potential to undermine quality approaches such as accreditation (Redmayne et al. 1995;Brashier et al. 1996;Close 1997;Gandhi et al. 2000;Gillies et al. 2000;Rad 2006). In securing involvement, there is an accompanying need to harness personal responsibility and accountability on the part of the individual participant, as a contributor to the quality team functioning (Huq & Martin 2000). Additionally, there is a further necessity to recognise the high degree of task interdependence, evidenced by the tasks being defined collectively and where the associated work is distributed, requiring all team members to contribute (Stamatis 1996;Colquitt 2004). For Cacioppe (1999) *"…this involves completing one's share of the work and facilitating the work of other group members"* (p.324). Where this is compromised, violation of equity and fairness within the team may occur which may, in turn, result in decreased motivation and discontentment with both the team and quality process. Weller Jr (1995) argues that *"When employees perceive or experience unfair or unjust treatment, their motivation to perform at their best suffers. In some cases, acts of inequity detract from performance outcomes and quality is sacrificed"* (p.46).

The links between equity or inequity and motivation is captured in the seminal work of J. Stacy Adams (Rollinson & Broadfield 2002;Gordon 2002;Buchanan 2004) who suggests that individuals evaluate their inputs (e.g. effort, experience, attitude), relative to their outcomes (e.g. reward, recognition, responsibility, promotion) and then compare this ratio to a 'comparison other', triggering a perceptual judgement about equitable treatment. Colquitt (2004) suggests this is more likely to occur in scenarios of high task dependency and that the 'comparison other' is usually in close proximity to the individual, doing similar or identical work or tasks (Rollinson & Broadfield 2002). Where perceived unfavourable inequity arises, this may quickly give rise to resentment and, in turn, to individuals experiencing dissatisfaction, tensions within the work setting, sub-standard performance, cutting back on inputs and ultimately, removing themselves from the particular work setting or the organisation itself (Weller Jr 1995;Stamatis 1996;Johnson & Johnson 1997;Gordon 2002;Woodward & Hendry 2004;Buchanan 2004). As evidence of this, the research on quality teams in a healthcare context conducted by Higgins & Routhieaux (1999) demonstrated that a failure to delegate tasks *"…evenly"* (p.9) and equitably, resulted in the declining participation of team members, with just a few individuals being left to complete the majority of the work.

The absence of doctor/physician involvement and participation in quality approaches is a reoccurring theme in the literature (Ovretveit 1996;Ovretveit 1999;Ovretveit 2005) and for Shortell, Bennett, & Byck (1998) an examination of their role merits particular attention. For embeddedness to take place, doctors in particular need to play a central role, reflecting their clinical expertise (Duckett 1983;Berwick, Godfrey, & Roessner 1990;Redmayne et al. 1995;Joss & Kogan 1995;Gandhi et al. 2000;Huq & Martin 2000;Counte & Meurer 2001;James 2002;Ham, Kipping, & McLeod 2003;Pomey et al. 2005). However, as previously discussed in both Chapter 3 and in earlier sections of this chapter, organisation-wide quality approaches may be interpreted as a means of attempting to exert greater control and challenging the autonomy of the medical profession. James & Hunt (1996) in their observations of the Kings Fund accreditation process in the UK, singled out medical staff as the most challenging group to motivate to participate, as they perceived the exercise as generating minimal benefits at the clinical level. As a consequence, these factors may affect their participation. This somewhat pessimistic picture of physician

involvement is somewhat countered by Ovretveit (1996) who argues that it is incorrect to assume that doctors are not interested in, or involved in, quality approaches, as they are likely to be engaged with activities around improving medical quality.

The problems associated with low or non-participation of doctors in quality approaches has been highlighted in a number of healthcare studies. For example, Higgins & Routhieaux (1999) established that quality improvement teams were more likely to be effective where doctors actively participated in meetings and related quality activities, while Hearnshaw et al. (1998) described the sporadic attendance of doctors at team meetings as a major obstacle to progressing a quality approach and had the subsequent effect of negatively influencing the commitment of other team members. Similarly, in the research conducted by Gollop et al. (2004) addressing quality implementation in the UK, doctors were identified as the lynchpin of the change process and that their lack of participation had the potential to seriously hinder successful implementation. In the studies relating specifically to accreditation by Duckett (1983), Redmayne et al. (1995) and Pomey et al. (2004), difficulties arose with the process due to an absence of both interest from, and participation of, key contributors such as doctors, who were particularly singled out as having low levels of involvement. Duckett (1983) found that many of the medical staff within the hospitals participating in the study were indifferent to accreditation and that this had implications of the preparations (the self-assessment phase) associated with the survey.

A factor that has the potential to influence involvement and participation of all employees, is the availability of time (Alexander 1997;Eggli & Halfon 2003). Implementing change and within this, quality approaches, is likely to necessitate drawing on the time of employees at all levels within the organisation. Woodward & Hendry (2004) suggest that implementation becomes problematic where the requirements needed to support change, such as participants time, are misinterpreted or underestimated. For Morris, Haigh, & Kanji (1994), individual quality team members may have differing views on the amount of time and effort they are willing to invest in contributing to the team objectives and moreover, there may be no explicit understanding across the organisation of both the time requirements and

constraints under which teams are working. Shortell, Bennett, & Byck (1998) observe that involvement in quality approaches is *"…very demanding of individuals and organisations: cognitively, emotionally, physically and some might say spiritually"* (p.605), while Sirkin, Keenan, & Jackson (2005) capture this in terms of *"…effort"* (p.113) in their framework of factors influencing the outcome of change and acknowledge that those involved with change management are already subject to the daily demands of their work roles. Contributing to teams charged with implementing change may be *"…additive"* (VanRooyen et al. 1999 p.815), placing extra responsibility on to employees and thus creating the potential to overstretch the existing internal resources within the organisation (Lam 1995;Steensma & Tetteroo 2000;Berwick, James, & Coye 2003;Weiner et al. 2006). Participation may also generate role conflicts for those involved (Caluwe & Vermaak 2003) and may create a challenge to the objectives of their line managers (Boaden & Dale 1993;Joss & Kogan 1995;Steensma & Tetteroo 2000), who are tasked with ensuring the delivery of acceptable levels of service.

The role and significance of middle managers, who may also function as the line managers of accreditation participants, is highlighted by Greig (1993), Boaden & Dale (1993) and Harrington & Williams (2004). For Wooldridge & Floyd (1990) middle managers are crucial to *"…supporting initiatives from operating levels"* (p.231). Nwabueze (2001) tempers the emphasis on the significance of senior management in the literature by arguing that middle managers, as critical champions of the quality approach, have a greater influence on implementation and hence success. Middle managers are likely to act as facilitators to quality implementation which, in turn, may affect the extent to which those involved in quality teams are actively supported in these roles (Feinberg 1996;1998;Harrington & Williams 2004). As Lakshman (2006) reflects: *"Participation of managers and employees at all levels can be enhanced when leaders at each level institutionalise a culture that facilitates such participation"* (p.50). Feinberg (1996) suggests that a manifestation of a lack of support from line managers for involvement and participation by employees, may be demonstrated in terms of not actively accommodating individuals to attend team meetings, extracting those that do attend, from these forums and not providing time for associated quality tasks outside meetings. For Feinberg (1998) *"All employees can contribute to improvement. It follows from this that managers*

have both an economic imperative and even a moral imperative to provide all employees with the opportunity to contribute. This requires the provision of time, training, access to information, and (most important) the possibility of implementation" (p.16).

As a key vehicle for implementing quality approaches, teams represent a *"…parallel learning structure"* (Krishnan et al. 1993 p.12) within the formal organisation (Field & Sinha 2000). These parallel structures allow individuals time for reflection, enquiry and the initiation of changes, conducted away from the normal working environment (Iles & Sutherland 2001). This absence from the care setting is, Ovretveit (1999) notes, a frequent criticism amongst a number of commentators on the cost-effectiveness of quality improvement teams. This is also reflected in the wider observations made by Hope Hailey & Balogun (2002), who note that more participative change approaches require more time, and hence funds, and also by Todnem By (2005), who gives recognition to the costs associated with on-going and continuous change processes in organisations.

While recognised for their potential effectiveness in terms of harnessing and capitalising on the enthusiasm, knowledge and skills of participants, these parallel structures may give rise to problems and dilemmas for those involved (Krishnan et al. 1993;Book, Hellstrom, & Olsson 2003;Tucker & Edmonson 2003). The availability of, and prioritisation of, time to attend team meetings and complete quality and accreditation tasks outside of these meetings, is a key resource to support participation and involvement within the implementation process, the absence of which is likely to frustrate an organisation-wide quality programme (Reeves & Bednar 1993;Redmayne et al. 1995;Steiner, Scrivens, & Klein 1995;James & Hunt 1996;Yong & Wilkinson 1999;Gandhi et al. 2000;Francois et al. 2003;Book, Hellstrom, & Olsson 2003;Eggli & Halfon 2003;Daily & Bishop 2003;Gollop et al. 2004). In the wider context of implementing change, this represents what Pettigrew, Ferlie, & McKee (1992) describe as the *"…duality of simultaneously managing continuity and change…holding together an organization while simultaneously reshaping it"* (p.299), where explicit tensions may exist between progressing the process of change and maintaining the day-to-day provision of services.

This availability may be a function of the initial and on-going support of colleagues and line managers, who provide cover for those charged with direct involvement (Yang 2003) and also the extent to which there is either an organisational or specific work area policy on the provision of *"...protected time"* (Shaw 2004 p.10) or *"…release time"* (Higgins & Routhieaux 1999 p.8). Providing individual team members with time to attend both team meetings and to complete associated quality tasks during normal working hours, features as a recommendation for both the planning and implementation of quality approaches (Hearnshaw et al. 1998;Higgins & Routhieaux 1999). For those working in a clinical care context, this may be a particularly important support, where there is an obvious tension between providing care services and team participation. Moreover, the significance of the provision of protected time is underlined by the World Health Organisation in their guidelines for resources to support the implementation of national programmes for hospital accreditation in a European context (Shaw 2004).

Close (1997) articulates the aspiration that *"Quality is not a technique or task to do in addition to everything else. Instead it is a philosophy or way of doing something which is embodied into every aspect of the organisation's working life. If this is not the case then quality will be quickly seen as a fad, flavour of the month or just another bandwagon"* (p.90). However, the reality for implementation may be different. Greig's (1993) study of quality teams in the NHS cited lack of time to meet as a major reason for team failure. Similarly, Boaden & Dale (1993) found in their research on quality improvement teams that finding time to meet as a team was problematic and additionally, that meetings themselves had an adverse knock-on effect on service provision, due to the absence of staff, problems that are mirrored in the study by Higgins & Routhieaux (1999) in a healthcare context. The Hearnshaw et al. (1998) research on healthcare quality teams found that team members were both sceptical and anxious in relation to the time commitment associated with participation in team meetings and in completing follow-up tasks, and also noted that frequently team members arrived late to meetings which, in turn, delayed commencement and shortened meeting time.

Likewise, the study by Gandhi et al. (2000) noted that a shortage of time created obstacles to quality approaches. In their research, they observed that *"…the critical*

factor seemed to be that quality improvement was viewed as something that required extra effort and time, and the current work life simply did not allow this" (p.121). Finally, the study by Book, Hellstrom, & Olsson (2003) conducted across Swedish healthcare organisations serves to add further weight to this issue, having established that some 50% of respondents (healthcare managers) to their survey identified quality-related activities to be in conflict with their normal work.

With specific reference to accreditation, the James & Hunt (1996) research examined the Kings Fund Organisational Audit (KFOA) accreditation approach in the UK and the implications for people participating in accreditation. The study focused on the time commitment required for accreditation tasks and highlighted that these may not be prioritised by those involved, as few organisations made allowances or set aside time for accreditation activities. They found in practice that at the initial stages of accreditation, employees while attending weekly meetings in work time, frequently completed accreditation activities and tasks in their personal time so as not to compromise the care of the patient. They noted, however, from observations of other organisations that had gone through the KFOA accreditation exercise that this practice frequently did not continue and *"…that employees seem less likely to carry out their accreditation tasks within their leisure time and substitute or delay other current activities. More importantly, individuals, most notably those performing a clinical role, ignore their accreditation role and either do nothing with the accreditation exercise or leave their activities to the last minute and fail to do justice to their accreditation role, both of which could be responsible for the high number of organisations failing to meet the KFOA standards"* (James & Hunt 1996 p.52).

This would seem to concur with Ovretveit's (1997) argument that the lack of time for such activities is, in fact, symptomatic of the fact that participants in quality approaches (such as accreditation) do not view it as integral to their daily work and thus as separate, and even secondary, to their normal work role which, in turn, affects their involvement and participation. However, the overall commentary that reflects the problematic nature of the time required for employee participation in accreditation, is countered by Rawlins (2001) who comments *"It is true that these staff may be away from other duties for a time, but the alternative is to allow*

healthcare institutions to continue to struggle without the benefit of modern methods of quality improvement" (p.674).

4.3.4 Training

For the change process to be fully realised, the development of new analytical and interpersonal competencies and supporting knowledge need to be developed, if individuals are expected to work effectively in a team environment and to both identify and solve problems (Balogun & Hope Hailey 1999;Buchanan & Fitzgerald 2007;Soltani, Lai, & Mahmoudi 2007). In the absence of any of these elements, the effectiveness of the change process is likely to be threatened (Beer, Eisenstat, & Spector 1990;Kassicieh & Yourstone 1998;Fernandez & Rainey 2006). Instrumental to this is the provision of training (Gustafson et al. 2003;Soltani, Lai, & Mahmoudi 2007). This view is supported by Sirkin, Keenan, & Jackson (2005) who similarly identify, as part of their four-fold factors affecting the outcome of any change initiative, the issue of the *"…performance integrity"* (p.111) of teams. Within this, they specifically highlight the dependency on members' skills and competencies as being central to successfully implementing change programmes and these may, in turn, be leveraged by training.

Training is explicitly mentioned as a requisite for implementing and managing quality by a number of the 'gurus', most notably Crosby (1984), Deming (1986) and Juran (1992). With specific reference to quality in the Irish public sector, the National Economic and Social Forum (2006) observe that *"…training and development is…a necessary ingredient in efforts to improve the quality and responsiveness of public services"* (p.99). Moreover, training that is provided in an effective and timely manner is central to the implementation of quality approaches in healthcare and within this, hospital accreditation, and requires an initial and on-going investment to be made (Berwick, Godfrey, & Roessner 1990;Motwani, Frahm, & Kathawala 1994;Brown 1994;Palmer & Wilson 1995;Nwabueze & Kanji 1997;Nwabueze 2001;Mathews et al. 2001;McFadden, Stock, & Gowen III 2006). Within this, it is a primary means for supporting and fully enabling involvement and participation activities (Kanter 1983;Dale 2003a;Smith et al. 2004;British Columbia Medical Association 2005;Balbaster Benavent, Cruz Ros, & Moreno-Luzon 2005). The quantitative study by Black & Porter (1995) supports this position by

establishing training, as part of the overall approach to people management in an organisation, as a critical factor in quality implementation, which is also reinforced by the findings of Shortell et al. (1995), who in a study of sixty-one hospitals in the US found that organisations that emphasised quality-related training were more likely to be successful in their implementation.

For Ahire, Golhar, & Waller (1996), Huq & Martin (2000), Mathews et al. (2001) and Daily & Bishop (2003), employee participation will be rendered ineffective in the absence of systematic quality-related training. This must be planned and orientated to ensure that it is delivered prior to the full roll-out of the quality approach and then, on an on-going basis (Motwani, Frahm, & Kathawala 1994;Kennedy 1998;Kassicieh & Yourstone 1998;Redman & Mathews 1998;Vermeulen & Crous 2000) and *"…just-in-time"* (Brown 1994 p.8) so that the knowledge and skills developed may be utilised immediately (Mosel & Shamp 1993;Kassicieh & Yourstone 1998;Higgins & Routhieaux 1999). Motwani, Frahm, & Kathawala (1994) further suggest that quality-related training may lack credibility with employees if management within the organisation fail to utilise the new competencies developed through participation in training programmes.

A consistently delivered focus on both providing an understanding of the quality approach itself, coupled with the tools and techniques that are required by participants within the process to complete the requisite tasks, and to work effectively as a team, are crucial before any progress can be made with implementation (Ovretveit 1992;Redmayne et al. 1995;Brashier et al. 1996;Close 1997;Ovretveit 1999;Gandhi et al. 2000;Ferlie & Shortell 2001;Book, Hellstrom, & Olsson 2003;Huq 2005). For Daily & Bishop (2003):

"…a well-designed training program can prepare individuals to work effectively in a team environment, efficiently employ team productivity techniques such as team goal-setting and team problem-solving, and develop interpersonal skills and conflict management techniques necessary for teams to function well" (p.398).

This is also reinforced by Snape et al. (1995) and Smith et al. (2004) who similarly argue that central to the successful implementation of a quality approach is the

development of behavioural and non-technical skills to support teamworking. Moreover, providing effective training may reduce resistance to the implementation of the quality approach itself, by creating awareness of the relevance of the quality approach and having provided individuals with enhanced skills (Daily & Bishop 2003).

The importance of developing both knowledge and skills in the training process is reinforced by Wright (1997), Shortell, Bennett, & Byck (1998), Jackson (2001) and Mathews et al. (2001) and this becomes even more crucial given that Scrivens (1995b) notes that the language of accreditation is *"…complicated"* (p.11). Joss & Kogan (1995) confirmed in their study of quality implementation in the NHS, that, not surprisingly, understanding of the quality approach was correlated with the extent of training provision and that the emphasis of training tended to be focused on understanding, at the expense of some of the tools and techniques for the approach itself. Wright (1997) also addressing training for quality in the NHS, established that a lack of full appreciation of the basic quality concepts amongst some healthcare employees meant that they were utilising tools and approaches without actually understanding the fundamental objective of doing so. In a similar vein, Hearnshaw et al. (1998) also note from their study of quality implementation in a health service context, that lack of specific quality training left team members feeling out of their depth with the approach. Finally, and more recently, the hospital-based research by Rad (2006) found that the absence of sufficient and effective quality-related training and education had posed a major barrier to the successful implementation of an organisation-wide quality approach.

If training is poor in terms of definition, delivery, timing and length this may affect the subsequent participation of employee groups, such as doctors, in organisation-wide quality approaches (Ovretveit 1996). As an option, Berwick, Godfrey, & Roessner (1990) suggest that the team meeting may be a good arena in which to deliver training but being mindful that it should also demonstrate to those involved, the relevance and fit with day-to-day activities (Brashier et al. 1996). By participating in training as a team, the informal structure and hierarchies of the organisation may also be broken down and serve to remove *"…barriers between the ranks"* (Ahire, Golhar, & Waller 1996 p.26).

The literature also highlights the scope for the development of the skills and competencies of team leaders, who play a pivotal role in establishing and maintaining the efficacy of the team process and, particularly, the forums in which the teams meet (Stamatis 1996). According to Hamzah & Zairi (1996a) *"The team leader is responsible for inculcating the team culture"* (p.24), while Stamatis (1996) and Dale (2003a) suggest that the remit of the team leader includes confirming that team members are aware of the meeting protocol; commencing meetings on time and ensuring that they run to schedule; clarifying with team members what is expected on them; encouraging participation both to, and at, meetings; taking responsibility for the progress and direction of the team and providing regular reports and feedback on this to the team itself. Hence team leader effectiveness is pivotal to the quality team process and, therefore, providing targeted training that augments the existing competencies of those assuming these roles, might be looked upon as a key priority (Milakovich 1991;Boaden & Dale 1993;Mosel & Shamp 1993;Brown 1994;Borrelli, Cable, & Higgs 1995;Proehl 1997;Dale 2003a). Berwick, Godfrey, & Roessner (1990) argue that training programmes for quality must include team leadership skills and suggest that these might include brain storming, conflict resolution and meeting planning and management and that these will support team leaders in fulfilling their roles (Sanchez et al. 2006). Failure to action this is demonstrated in the study of quality teams in the NHS by Grieg (1993), who discovered that lack of training for quality team leaders was seen as contributing to the failure of the team itself.

4.3.5 Teams

Prior to entering into an examination of the pertinent issues around teams within the quality implementation process, it may be useful to provide clarification of the term 'team' as a basis for moving forward. The definition provided by Cohen & Bailey (1997), arrived at after an extensive review of the literature around teams, would appear to fit within the parameters of this study, where self-assessment accreditation teams (as outlined in Chapter 2) are central to the quality approach. For Cohen & Bailey (1997):

"A team is a collection of individuals who are interdependent in their tasks, who share the responsibility for outcomes, who see themselves and who are seen by

others as an intact social entity embedded in one or more larger social systems and who manage relationships across organizational boundaries" (p.241).

In particular, quality teams (including those formed for accreditation purposes) are representative of parallel teams, which draw on individuals from different roles, disciplines and work units (multidisciplinary, inter and intra-departmental) and represent a separate parallel but complementary structure, to the existing organisation (Cohen & Bailey 1997;Higgins & Routhieaux 1999;Dale 2003a;Parker 2006). Stamatis (1996) also notes that these teams may elicit participation on a part-time or full-time basis. In the part-time mode, individuals contribute but still remain largely in their normal work roles, removing themselves to attend meetings and to complete related tasks where necessary, and this clearly reflects the model operated during the accreditation process.

As West et al. (2004) observe *"Teamworking offers a powerful strategy for managing change"*(p.270) and is frequently the key vehicle utilised for implementation, facilitating new perspectives and personal initiative, coupled with a degree of mutual commitment (Weisbord 1987;Caluwe & Vermaak 2003). Likewise, teams feature heavily as a pillar in quality implementation and within this, accreditation, requiring support from a platform of training and management (Schonberger 1994;Steensma & Tetteroo 2000;Daily & Bishop 2003;Dale 2003a;Gowen III, McFadden, & Tallon 2006). They provide the participative framework for improvement activities through the recognition that collaborative working may be the most effective means of improving the quality of services, including those provided by healthcare organisations (Kia Liang Tan 1997;Hearnshaw et al. 1998;Daily & Bishop 2003;Cooney & Sohal 2004;Harrington & Williams 2004;Alexander et al. 2005). This position is captured by Morris, Haigh, & Kanji (1994) who argue that *"…teams are not instituted merely to facilitate the manufacturing or service delivery processes, but are created as vehicles through which problems of poor quality are detected, prevented and solved, thus permitting the never-ending spiral of continuous quality improvement to be successfully commenced"* (p.162). Similarly, Dale (2003a) signals that teams bring several benefits to organisations pursuing quality approaches including providing a means by which management and employees develop an enhanced commitment to quality

principles; serving as an additional means of communication between management, employees and across functions; supporting the development of individual and collective responsibility and accountability for quality and facilitating behaviour and attitude change.

Multidisciplinary, inter and intra-departmental teams in a healthcare environment have the potential to play a central and very visible role in healthcare organisations (Ovretveit 1999;Alexander et al. 2005;British Columbia Medical Association 2005;Parker 2006) and have the capacity to *"…systematically examine the processes under their control and identify areas for improvement"* (Joss & Kogan 1995 p.18) by harnessing the contributions of clinical professionals and non-clinical employees (Weiner et al. 2006). Beer, Eisenstat, & Spector (1990) emphasise in their discussion of the change process, the importance of teamwork and within this, coordination and, in particular, note its relevance to capitalising on identifying and acting on opportunities for improving quality. Black & Porter (1995) and Warwood & Roberts (2004) also identify teamwork structures as a critical factor in a quality approach. However, while Ferlie & Shortell (2001) recognise that healthcare organisations need to develop the core priority of teamwork in the pursuit of quality, this may prove challenging bearing in mind the levels of professional autonomy that are frequently exercised (Mosel & Shamp 1993;McHugh & Bennett 1999;Yang 2003).

Accepting the criticality of teams then (Berwick, Godfrey, & Roessner 1990;Beer, Eisenstat, & Spector 1990;Wilkinson 1992;Lammers et al. 1996;Cooney & Sohal 2004;Scrivens 2005;Alexander et al. 2006), the efficacy of the forums within which they meet, are an important element of the change and quality implementation process (Weisbord 1987;Stamatis 1996;Higgins & Routhieaux 1999;Mills & Weeks 2004). The outcomes from team efforts are likely to be more successful where teams operate on the interdependent *"…norms"* (Mosel & Shamp 1993 p.54) of mutual accountability, openness and respect, ensuring on-going participation and follow-through on the part of team members (Weisbord 1987;Katzenbach & Smith 1993;Borrelli, Cable, & Higgs 1995;Hamzah & Zairi 1996b;Higgins & Routhieaux 1999;Hing Yee Tsang & Antony 2001). These, in turn, are reflective of both the team functioning i.e. *"...how well team members work together in discharging the team's responsibilities"* (Alexander et al p.1138-1339) and evidence of *"….healthy internal*

processes" (Cohen & Bailey 1997 p.281). Dale (2003a) suggests that some of the observable characteristics of team effectiveness include open dialogue and participation across the entire team; members listen and acknowledge the views of others with a positive attitude; the operating procedures of the team are respected and there is clarity in terms of both the overall objectives of the team process and the allied individual team members responsibilities. Likewise, the absence of any of these may render the team ineffective (Kanter 1983;Tierney 1999;Dale 2003a)

Regular team meetings and their effective management, facilitate the exchange of ideas that are held to be fundamental to overall goal achievement for the team (Reeves & Bednar 1993;Tausch & Harter 2001;Caluwe & Vermaak 2003;Dale 2003a) and hence there is an imperative to pay particular attention to the dynamics and quality of team meetings (Mosel & Shamp 1993;Higgins & Routhieaux 1999;Sirkin, Keenan, & Jackson 2005). For Kanter (1983) scepticism about participatory vehicles, such as teams, may creep in where there is *"Too much talk, too little action"* (p.254). Berwick, Godfrey, & Roessner (1990) capture the significance of meetings in their observations in relation to quality teams in healthcare contexts: *"…teams and well-run team meetings can help keep projects on schedule and moving along. The team can create deadlines, set agendas, and help its members feel both shared enthusiasm and mutual obligations"* (p.68). However, Wiener (2000) observes that quality team meetings may often be adversarial due to the potentially controversial and challenging nature of the issues under discussion.

Mosel & Shamp (1993) similarly observe that team management will significantly impact on the effectiveness of quality teams. They suggest that team *"…roadmaps"* (p.51) need to be in evidence, marking and communicating the progress with the quality approach and associated timelines and also that a common meeting structure, using agendas and assigning roles and responsibilities, needs to be adopted as standard practice. The Reeves & Bednar (1993) US-based study of the implementation of an organisation-wide quality approach identified from responding middle and top managers, their perceptions of possible hindrances to implementation in their organisation, which included what they described as faulty group processes, relating to the way in which quality teams operated and how their meetings were managed. Similarly, the study of healthcare quality teams by Higgins & Routhieaux

(1999) cited both the inefficient and ineffective use of team meetings as a barrier to the successful use of teams. Examples of poor practice included meetings exceeding their allotted time due to unresolved conflicts, lack of direction and specific goals; an absence of an agenda or meetings not adhering to the agreed agenda. Moreover, proper note must also be taken of the costs, particularly those of an indirect nature, associated with team participation in quality approaches such as accreditation. Involvement requires participants' time, which is a resource, and there are opportunity costs associated with this which may be substantial (Steiner, Scrivens, & Klein 1995;Pomey et al. 2004). Where that time is being spent in an unproductive team environment, there are unlikely to be significant benefits arising from the allocation of that resource.

Weisbord (1987) and Lawford (2003) posit that the synergistic benefits of teamwork can only be derived where all team members have equal value and influence in the context in which they operate and are supported by a culture of open dialogue (Johnson & Johnson 1997;Huq & Martin 2000;Sheard & Kakabadse 2002;Caluwe & Vermaak 2003). Posing a threat to this, however, is the extent to which work hierarchies may transfer to the team environment and influence the balance of power, participation and acceptance of contributions made within these forums (Morris, Haigh, & Kanji 1994;Hamzah & Zairi 1996b;Johnson & Johnson 1997;Hearnshaw et al. 1998;Daily & Bishop 2003;Parker 2006). This is what Kanter (1983) describes as the *"…seductiveness of the hierarchy*" (p.256) and observes that:

"Teams that are pulled together from different external statuses, with the awareness that they will be returning to them, may slip into deference patterns which give those with higher status more air time, give their opinions more weight, and generally provide them with a privileged position within the group" (p.256).

This is particularly highlighted by Hearnshaw et al. (1998) in their study of implementing a quality approach in a healthcare context. They established that in some teams, the ideas of individuals lower down the work hierarchy were ignored in the group decision-making process, despite the fact that they had could have offered both valid and correct solutions to the problem under discussion. Moreover, and as a reflection of this, in some instances the team approach was seen as challenging the

natural hierarchy within the organisation (Anjard 1995;Hearnshaw et al. 1998). Relatedly, the extent to which team members actively participate within the team-meeting environment may also support or hinder the overall effectiveness of the team approach. Factors such as the team politics; the extent to which team members have the necessary skills and knowledge to contribute to team discussions; regular meeting attendance; individual characteristics and team leader ability to elicit balanced individual participation across the team, may influence the efficacy of the process (Kanter 1983;Johnson & Johnson 1997).

4.3.6 Reward

The availability of reward to motivate and recognise current and on-going individual contribution may represent an important lever for supporting the organisation through the change process, serving to reinforce newly formed practices and behaviours over time (McHugh & Bennett 1999;Beer & Nohria 2000;Allen & Kilmann 2001). However, some consideration should be given to the term 'reward' itself, as it may be interpreted as being broad in scope and, as such, may take many forms, both financial and non-financial (Weisbord 1976a;Weisbord 1987;Pettigrew, Ferlie, & McKee 1992;Burke & Litwin 1992;Balogun & Hope Hailey 1999;Gustafson et al. 2003). As Armstrong (2007) comments, reward *"…deals with the strategies, policies and processes required to ensure that the contribution of people to the organisation is recognised by both financial and non-financial means"* (p.3) and includes pay, employee benefits and non-financial rewards, such as learning and development opportunities and employee recognition (Armstrong 2007).

Boaden & Dale (1993), Hackman & Wageman (1995), Redman & Mathews (1998) and Tari & Sabater (2006) all suggest that there is no agreement in the literature as to whether participants in quality approaches should be rewarded. The availability of reward may serve to determine support, reinforce and incentivise the involvement and participation of those actively engaged with quality approaches and, in turn, may also signal recognition for individual contribution (Borrelli, Cable, & Higgs 1995;Lammers et al. 1996;Ahire, Golhar, & Waller 1996;Hearnshaw et al. 1998;Kassicieh & Yourstone 1998;Nwabueze 2001). Allen & Kilmann (2001) further argue that the reward system should be aligned to the quality approach and

that this may signify a departure from existing practice, based on relative position within the hierarchy of the organisation. In their quantitative study conducted in the US, they established that the use of reward practices such as profit-sharing, gain-sharing and compensatory time exhibited a significant and positive effect on the relationship between an organisation-wide quality approach and perceived firm performance. However, the study of quality teams conducted by Boaden & Dale (1993) established that, while in practice some team members had been paid overtime for attending quality related meetings out of normal working hours, as an organisational policy, it was officially discouraged.

Conversely, the absence of rewards, including those that are non-financial as is frequently the case in the public sector, may mean that individuals withhold their commitment to a quality approach and refrain from participation (Cole, Bacdayan, & White 1993;Weiner et al. 2006). Cacioppe (1999) argues that *"…rewards are one of the loudest and clearest ways leaders of an organisation can send a message about what they consider important"* (p.322) and that where organisations require people to work in teams, reward and recognition must underpin the teamwork approach (Ovretveit 1992;Reeves & Bednar 1993;Kia Liang Tan 1997;Higgins & Routhieaux 1999;Huq & Martin 2000). As Ovretveit (1992) notes, *"All too often staff spend time improving the service and their effort or the results are not recognised, or their conscientiousness is exploited...Colleagues' and managers' recognition and valuation of a person's achievements are too rare in health services"* (p.139). He suggests that both informal and formal recognition and reward need to be the cornerstones of a quality approach. As evidence of this, Reeves & Bednar (1993) found in their study of quality implementation in a hospital context that insufficient rewards had served as a barrier to full adoption of the quality approach.

Recognition, as an example of non-financial reward, is a central feature of the ideas espoused by Crosby (1984) and Juran (1992), who view it as both a motivational tool and a means of acknowledging and reinforcing participatory behaviours in quality approaches to ensure that they continue on an on-going basis (Reeves & Bednar 1993;Schonberger 1994;Hill & Wilkinson 1995;Redman & Mathews 1998;Higgins & Routhieaux 1999). This is supported by Koch & Sabugeiro (1992) who observe that *"…it is important that the personal commitment of quality improvement team*

members is addressed and discussed…the team members' commitment needs to be sustained and reinforced, and recognised"(p.281). This is also borne out by Hamzah & Zairi (1996a) who cite recognition as an example of best practice in their study of 'people' related practices in quality implementation, although acknowledge that the recognition process needs to be managed fairly i.e. with equal treatment for equal accomplishment (Hamzah & Zairi 1996b). Likewise, Baidoun (2003) describes recognition as a *"…basic"* (p.157) for increasing the involvement of all employees in a quality approach, which supports the Black & Porter (1995) findings that employee recognition, as an element of people management practice, represents a critical success factor in the implementation of an organisation-wide quality approach.

The ability to offer reward that has a financial dimension to it, however, is limited within most public sector organisations. The discussion presented in Chapter 2 captured the key characteristics of public sector type organisations and within this, identified the constraints within which they operate, including the frequent inability to exercise discretion in relation to reward. Balogun & Hope Hailey (1999) reinforce this position with reference to employee involvement with change management activities and note that pure financial rewards are likely to be off-limits for most public sector employees. Instead, they suggest that utilising other rewards such as profiling staff as exemplar contributors to the change process or public recognition events may be instrumental in motivating participants and securing their continued contribution. However, Gaster & Squires (2003a) argue, with particular reference to employee involvement in external assessment in healthcare, that it is often assumed that reward is unnecessary and that increased job satisfaction and better results will be the main incentives for participation. Countering this is the position adopted by Cacioppe (1999), who suggests recognition is still a requirement and that a range of recognition approaches and awards may be utilised in these types of organisations including praise, feedback, written and public recognition and non-cash awards, while Kia Liang Tan (1997) reinforces the view that rewards do not have to be monetary in nature and that *"Compliments and managers' recognition also often motivate employees self-esteem"* (p.157).

4.4 Accreditation Impacts

Having given consideration to a number of themes relating to the accreditation implementation process, the focus turns to two of the remaining elements of the conceptual framework which seek to explore the impacts that may arise at both the individual and organisational levels, from implementing organisation-wide quality approaches and specifically, healthcare accreditation.

4.4.1 Individual Impacts

A range of impacts are identified as having the potential to arise at an individual employee level, from being associated with quality approaches and specifically, those related to accreditation, within the existing literature,. In the first instance, a reoccurring issue is the scope for enhanced learning and development arising from participation in, and contribution to, quality approaches (Cole, Bacdayan, & White 1993;Hackman & Wageman 1995;Hurst 1997;Rawlins 2001;Dale 2003a). Iles & Sutherland (2001) and Alexander et al. (2005) highlight that parallel structures, such as quality teams, are a key vehicle for individual learning and professional growth and hence those involved may accrue these as a benefit from participation, a view also supported by Kia Liang Tan (1997) who argues that *"Teams offer people more room for growth and change than traditional structures"* (p.156).

Specifically teams potentially offer opportunities for critical reflection; the exchange of ideas with colleagues; stimulation from debate; the enhancement of work-specific and organisational knowledge and the improvement in individual work practices arising from this (Berwick, Godfrey, & Roessner 1990;Morris, Haigh, & Kanji 1994;Redmayne et al. 1995;Gandhi et al. 2000;Francois et al. 2003;Pomey et al. 2004;Pomey et al. 2005). In short, participation may encourage employees to think differently about the nature and impact of their jobs and, in turn, some element of behavioural change may occur (Hill 1997).

Daily & Bishop (2003) note that *"…working in teams can be instrumental in employees developing comprehensive and in-depth views of organizational issues and institutions through the pooling of knowledge"* (p.398), while Cooney & Sohal

(2004) argue that involvement in quality teams gives rise to work role expansion and increased functional flexibility, which are, in themselves, developmental. Focusing specifically on the healthcare context, Joss & Kogan (1995) reported from their study of NHS organisations that continued individual involvement in a quality approach contributed to greater understanding of quality, organisational issues and strategy. In a similar vein, the Grieg (1993) study on quality teams in the NHS, established that participants believed that involvement had been developmental. Finally, respondents in the study by Pomey et al. (2004), addressing the implementation of accreditation in a large French teaching hospital, identified individual learning, in particular, as a significant benefit emerging from participation in the approach.

Furthermore, and as a result of team participation and subsequent individual development, Ahire, Golhar, & Waller (1996) and Cacioppe (1999) also argue that career advancement and promotion may arise, although Lam's (1995) findings would appear to temper this to some extent. Examining perceived changes arising from participation in a quality approach, only 18% of respondents indicated that involvement had increased opportunities for advancement (Lam 1995).

While the aforementioned benefits have significance, Yeh (2003) posits that successful implementation of a quality approach *"…requires employees' engagement in extra-role behaviours"* (p.257) which may, in turn, give rise to tensions in the work context (Steensma & Tetteroo 2000), an increased workload (Lam 1995;Lagrosen, Backstrom, & Lagrosen 2007) and role conflict (*"…the simultaneous occurrence of two or more role expectations such that compliance with one would make compliance with the other more difficult"* (Katz & Kahn 1978 p.204)). The dual requirements to fulfil both daily work activities and to make an active contribution to quality approaches such as accreditation, may result in fundamental conflicts and dilemmas for individuals, and particularly for those working in clinical environments, where removing themselves from the normal work setting to either attend training, team meetings or work on quality-related tasks may have implications for care provision (Redmayne et al. 1995;James & Hunt 1996;Gandhi et al. 2000;Francois et al. 2003;Book, Hellstrom, & Olsson 2003).

4.4.2 Organisational Impacts

A number of impacts may accrue at the organisational level from the implementation of quality approaches. What may also be of relevance is the suggestion made in the studies conducted in healthcare contexts by Greig (1993), Redmayne et al. (1995) and Ennis & Harrington (1999a) that despite difficulties with the quality implementation process, positive organisational impacts may still arise. Whether organisation-wide quality approaches actually impact on, and enhance quality, and specifically the quality of healthcare, is debated in the literature and Naveh & Stern (2005) note that many of the improvements take place at the departmental and procedure level. Hackman & Wageman (1995), Taylor & Wright (2003) and Hassan (2005) also recognise the challenges posed to measurement and attribution, in identifying the impacts arising from the implementation of an organisation-wide quality approach and particularly those related to non-financial performance.

Weiner et al. (2006) commenting on the existing studies in the area note that *"…most have used perceptual measures of impact or self-reported estimates of cost or clinical impact rather than objectively derived measures of clinical quality"* (p.311), an approach which is reflected in the studies by Lammers et al. (1996) and more recently by Rad (2006), where perceived improvement is used as proxy for actual improvement in a healthcare organisation. Moreover, as a further example, the study by Shortell et al. (1995) identified that perceptions of quality implementation related to clinical efficiency and that the perceived existence of barriers to quality implementation led to poorer outcomes in terms of this. However, Taylor & Wright (2003) note that by adopting this approach, there is a risk of self-reporting bias, although they do also acknowledge that perceptual assessments may actually be closer to the reality of the situation than those arrived at by often incomplete objective data (Taylor & Wright 2003).

There are also a number of other impacts that may emerge at the organisational level. For example, there is scope for an organisation-wide quality approach to further embed the concepts of quality, standards, evaluation and review against these standards, within the organisational culture (Rawlins 2001;Lagrosen, Backstrom, & Lagrosen 2007). In their study on healthcare organisations in the NHS, Joss & Kogan (1995) established that resulting from the successful implementation of a quality

approach, was the on-going and systematic monitoring and review of clinical activities. This is mirrored in the findings of the Hearnshaw et al. (1998) study, where the implementation of the quality approach had given rise to the development and use of written standards and protocols. More recently, Lagrosen, Backstrom, & Lagrosen (2007) have found that by implementing a quality approach in a hospital setting, there had been an increased use of evaluations and greater progress towards actioning improvements.

In relation to accreditation in particular, the study by Steiner, Scrivens, & Klein (1995) highlighted from a Chief Executive and Director of Quality perspective, that the implementation of the process had actively facilitated and supported this transition to a standards-based culture. This also concurs the earlier work of Duckett (1983) who found that for the hospitals involved with the study, accreditation had been pivotal in heightening the levels of audit and review within the organisation. Duckett (1983) also established that at a management and administration level, the preparations for the accreditation survey were instrumental in formalising up-to-date organisational charts, job descriptions and procedures manuals. Furthermore, in the clinical arena, accreditation initiated measures to be taken to ensure, for example, that medical records and discharge summaries were completed correctly, that nursing and overall care philosophies were reflected upon and revised and that procedures manuals were updated to reflect current clinical practice. Finally, Duckett (1983) also noted that physical facilities and safety procedures also underwent review and subsequent change, by virtue of the accreditation approach.

Also arising from the implementation of quality approaches may come enhanced levels of communication within the organisation, between employees and management and between employees across the organisation (Berwick, Godfrey, & Roessner 1990;Brown 1994;Hill 1997;Steensma & Tetteroo 2000;Nwabueze 2001;Cooney & Sohal 2004) or at least an acknowledgement that communications need to be addressed (Hearnshaw et al. 1998). A number of studies have highlighted how as a result of individuals working together on quality related tasks, communication may improve within and across departmental and organisational levels, while the initial and on-going organisational communication exercise relating to the process, may serve to create a greater degree of awareness of the key strategic

priorities (Duckett 1983;Berwick, Godfrey, & Roessner 1990;Boaden & Dale 1993;Redmayne et al. 1995;Steiner, Scrivens, & Klein 1995;Francois et al. 2003;Pomey et al. 2004;Huq 2005). Hammersley & Pinnington (1999) suggest that quality efforts on the part of individuals within one team may necessitate communication with other employees in different parts of the organisation, who may be tasked with addressing similar issues and problems. This may create improved communication but also the *"…migrating of quality solutions"* (Hammersley & Pinnington 1999 p.31) by virtue of this.

The study by Duckett (1983) also established that implementing accreditation had specifically re-ignited the meetings of medical staff and had thus facilitated improved communication between the medical staff and the hospital, while Joss & Kogan (1995) found that by implementing an organisational-wide quality approach, communication between functions and disciplines improved. This is also supported by Pomey et al. (2005) who comment that *"…the major contribution of accreditation preparations has not been the improvement in practices - which is the primary objective of this process - but rather the creation of a forum to discuss the values, knowledge and cultural heritage shared by professionals in the organization"* (p.53).

As most quality approaches, including accreditation, adopt a multidisciplinary team model as the primary instrument of improvement activities, then arising from this may be an increased level of multidisciplinary working within the organisation (Counte, Oleske, & Hill 1992;Redmayne et al. 1995;Joss & Kogan 1995). Of particular interest, Pomey et al. (2005) observe that accreditation *"…provides an excellent opportunity to form multi-professional and multidisciplinary working groups"* (p.52). Berwick, Godfrey, & Roessner (1990) note that these teams facilitate the development of understanding, dialogue and knowledge of organisational processes for those participating in them. Without participation, individuals might never meet each other. Gandhi et al. (2000) also support this view and suggest that by establishing teams and encouraging multidisciplinary working, this created "…. *time to think, compare, share ideas, firm up plans for change, and use each other as a sounding board, on the specific topics at hand -[it] was a unique opportunity given the system and organisational stress these managers and physicians operate under daily"* (p.122).

Relatedly, Nwabueze (2001) suggests that implementing a quality approach may mean the development of a *"...new set of interrelationships"* (p.663). Arising from the individual opportunities to exchange ideas with colleagues and to work in a multidisciplinary team environment, may come improved quality in the relationships between employees and groups in the organisation (Berwick, Godfrey, & Roessner 1990;Morris, Haigh, & Kanji 1994;Harrington & Williams 2004;Pomey et al. 2005). In Lam's (1995) research on perceived changes arising from involvement with a quality approach, improved relationships with fellow workers received the second highest rating from respondents. Moreover, in relation to accreditation, the early study by Duckett (1983) demonstrated that even after accreditation had been awarded, key staff within the hospital organisations met on a more frequent basis and hence strengthened existing relationships, multidisciplinary working and organisational functioning. The findings of Steiner, Scrivens, & Klein (1995) also reinforce this view and highlighted improved multidisciplinary working and organisational relationships as benefits accruing from accreditation implementation. Finally, the research by Pomey et al. (2004) identified how accreditation had been perceived as serving to create social capital across the acute-care hospital research site, through the establishment and enhancement of relationships and heightening the awareness of the interdependencies within and between departments, disciplines and professionals.

4.5 Experiences of Quality Implementation Based on Work Role or Discipline in the Organisation

The final issue to be reflected on from the perspective of the conceptual framework is whether the individual participants experiences of a quality approach, in terms of the implementation process and the associated impacts, may differ as a result of their work role (or discipline) within a healthcare context and, moreover, if this is in the clinical or administrative area. While previous discussion has alluded to the challenges associated with attempting to engage doctors in organisation-wide quality approaches, a number of empirical studies serve to provide a deeper insight into the issue (Gollop & Ketley 2007). The research undertaken by Gollop et al. (2004) sought to identify factors that supported or hindered the spread and sustainability of new practices such as quality approaches within the NHS and, in particular, why

individuals might be sceptical or resistant towards these. Based on responses from both managers and clinicians, the study found that scepticism from medical staff was more likely to be prevalent than from administrative staff. This finding is, likewise, reinforced by Hazilah & Manaf (2005) in their study of the implementation of an organisation-wide quality approach in publicly provided healthcare organisations in Malaysia. Here they established differences between the perceptions of physician and non-physician respondents about the quality approach, with physicians rating the approach significantly less favourably than their non-physician colleagues. Finally and in a similar vein, the Pomey et al. (2004) investigation of the accreditation system in France identified differences in perceptions of the accreditation process based on occupation, where those in administrative positions had more positive attitudes towards the process and were less critical of the accreditation approach, than their colleagues in clinically based roles.

4.6 Conclusion

This chapter has aimed to develop the theoretical basis for this study on hospital accreditation through the examination of the management of change literature. By virtue of this, a conceptual framework for the research has been arrived at, upon which the exploration of the key issues for the accreditation implementation process and individual and organisational impacts has been founded. A review of the literature has been presented with reference to this and based on an acknowledgment that there exists a paucity of literature relating specifically to healthcare and hospital accreditation. Finally, recognition has been given to the potential for differing experiences of the implementation process and associated impacts, based on individual work role or discipline within the healthcare organisation. On the basis of this, Chapter 5 progresses to considering the operationalisation of the study through the research methodology.

Chapter 5: Research Methodology

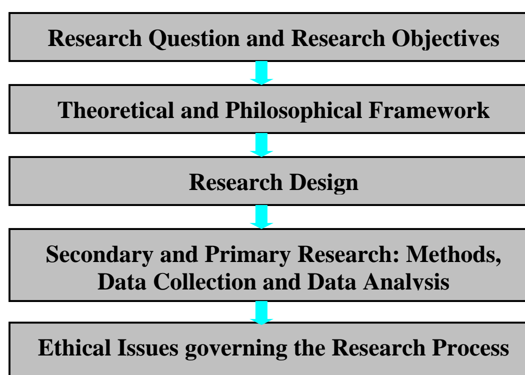
5.0 Introduction

The purpose of this chapter is to develop both the theoretical and philosophical positions and illustrate the methodological pathway associated with this research exercise. The study is located within the broad field of social science research which, fundamentally, is characterised by data collection, using a range of methods, targeted at people in their social contexts (Somekh et al. 2005) and, as such, due consideration is given to the philosophical foundations of this type of research. The emergence of an appropriate research design arising from this examination also is explored, with particular reference to the case study approach and its operationalisation. This is then addressed in terms of the research methods deployed, the rigour associated with these and subsequent data analysis. Finally, cognisance is taken of the ethical issues that may arise over the course of the research process.

5.1 The Research Process - An Overview

The research exercise may be viewed as a process and this additionally suggests a plan of activity. While authors such as Brannick (1997), Kumar (2005) and Walliman (2005) present comprehensive approaches to reflect this, the author has chosen to distil these views and this is presented in figure 5.1, as a framework that not only captures the key phases within the research process but which will also serve as a basis for structuring subsequent theoretical and methodological discussion.

Figure 5.1 - Elements of the Research Process



5.2 Research Question and Research Objectives

The formulation of an overarching research question contributes to clarity in the statement of the overall research issue and reflects the researcher's identification of the need for a specific course of inquiry (Strauss & Corbin 1998;Sim & Wright 2000). For Bryman (2004), *"Research questions are crucial"* (p.31) in that they serve to guide the entire research exercise, from literature searching and the design of primary research, through to data analysis and synthesis. Arising from the research question, the research objectives define the research in measurable terms and create boundaries and scope to the study, in order to ensure that the research is both manageable and achievable in terms of size (Strauss & Corbin 1998;Zikmund 2000;Domegan & Fleming 2003;Kumar 2005). The following research question and associated objectives attempt to reflect this instrumentality, in terms of the focus and scope of the research, and also aims to emphasise the descriptive nature of the research (discussed later), which seeks to arrive at answers to questions of who, when, where, how and 'what' (Zikmund 2000).

Research Question:

What are the experiences of individual team members in terms of the accreditation implementation process and the individual and organisational impacts associated with this, in a large acute-care hospital context?

Research Objectives:

(i) To review and synthesise themes within the existing literature in the area of organisational change and quality implementation and impacts, with particular reference to quality in healthcare and hospital accreditation;

(ii) To explore the experiences of individual team members with reference to the implementation process surrounding the first phase of accreditation;

(iii) To identify the experiences of individual team members in terms of impacts at both the individual and organisational levels arising from the first phase of accreditation;

(iv) To establish the extent of, and reasons for, any differences between individual team members, in terms of their experiences of the implementation process and individual and organisational impacts associated with the first phase of accreditation, based on team type and work role.

5.3 Theoretical and Philosophical Framework

The theoretical and philosophical position that informs the research process may be characterised by various facets (Burrell & Morgan 1979;Easterby-Smith, Thorpe, & Lowe 2002;Lindlof & Taylor 2002;Bryman 2004). This research, addressing individual experiences of the accreditation process and impacts, is located within the social sciences and reflecting this, Burrell & Morgan (1979) have developed a framework which encompasses a range of assumptions, reflected on dimensions, which determine the nature and scope of the research. These are outlined in table 5.1 and are adopted as a useful means of structuring the examination of the key issues in forthcoming sections, which will, in turn, serve as an opportunity to address the theoretical and philosophical stance taken in this study.

Table 5.1 - A Framework for Analysing Research Assumptions

Objectivist Approach		Subjective-Objective Dimension		Subjectivist Approach
Realism	←	Ontology	→	Nominalism
Positivism	←	Epistemology	→	Anti-positivist
Determinism	←	Human Nature	→	Voluntarism
Nomothetic	←	Methodology	→	Ideographic

Source: Burrell, G. & Morgan, G. 1979, *Sociological Paradigms and Organisational Analysis* Heinemann, p.3

For Holden & Lynch (2004), there are significant interrelationships between these four dimensions:

"The researcher will find that these assumptions are consequential to each other, that is, their view of ontology effects their epistemological persuasion which in turn, affects their view of human nature, consequently, choice of methodology logically follows the assumptions the researcher has already made" (p.398).

This view is also supported by Morgan & Smircich (1980) and Easterby-Smith, Thorpe, & Lowe (2002) who acknowledge the importance of the theoretical underpinnings to subsequent research design and methodology. For Morgan & Smircich (1980) *"… the case for any research method, whether qualitative or quantitative…cannot be considered or presented in the abstract, because the choice and adequacy of a method embodies a variety of assumptions about the nature of knowledge and the methods through which that knowledge can be obtained, as well as a set of assumptions about the nature of the phenomena to be investigated"* (p.491).

These positions have had a fundamental bearing on the overall research design, selection of data collection methods and subsequent data analysis, undertaken in this study. The nature of the research itself, as reflected in the research question and specific research objectives, have provided the reference point from which the author has considered the ontological, epistemological, human nature and methodological foundations for the research and subsequent sections serve to provide a detailed treatment of these.

Whilst the theoretical and philosophical dimensions are depicted as polar opposites in table 5.1, Burrell & Morgan (1979) also accept that intermediate positions have emerged and that these have, in turn, propagated different ideas and approaches to research. Similarly, this view is also supported by Yates (2004), who highlights some of the seminal ideas of the eighteenth century philosopher, Immanuael Kant, who suggests that a compromise might be reached between *"…ideas and thoughts that lead us to truth"* (p.135) and *"…observed empirical facts [that] guide us to the truth"* (p.135). Morgan & Smircich (1980) make an attempt to summarise these alternatives and these are presented in table 5.2, which, in turn, will have some relevance in later discussions.

Table 5.2 - Continuum of Basic Assumptions on the Objective-Subjective Debate

Objectivist ◄				►	**Subjectivist**
Core Ontological Assumptions	Reality as a concrete structure	Reality as a concrete process	Reality as a contextual field of information	Reality as a realm of symbolic discourse	Reality as social construction	Reality is a projection of human imagination
Basic Epistemological Stance	To construct a positivist science	To study systems, process, change	To map contexts	To understand patterns of symbolic discourse	To understand how social reality is created	To obtain phenomenological insight
Assumptions About Human Nature	Man as a responder	Man as an adaptor	Man as an information processor	Man as an actor	Man as a social constructor	Man as pure spirit, consciousness being
Research Methods	Laboratory experiments and surveys	Historical analysis	Contextual analysis	Symbolic analysis	Hermeneutics	Exploration of pure subjectivity

Source: Adapted from Morgan, G. & Smircich, L. 1980, "The Case for Qualitative Research", *Academy of Management Review*, vol. 5, no. 4, p.492

Each of the theoretical dimensions outlined by Burrell & Morgan (1979), is grounded within the overarching objectivist and subjectivist perspective. For the objectivist, the world is seen in terms of *"…hard, external, objective reality"*(Burrell & Morgan 1979 p.3) which, in turn, is likely to be reflected in research activity that focuses on the analysis on relationships between various factors. The subjectivist emphasises the relevance of the *"…subjective experience of individuals in the creation of the social world*" (Burrell & Morgan 1979 p.3) and the pursuit of understanding and interpretation of that world through different research modes, which is of particular relevance to this research, given that it seeks to explore individual experiences of acute-care hospital accreditation. In reviewing the literature in the area, what becomes apparent is that there are a plethora of terms, frequently used interchangeably, in relation to objectivism and subjectivism and the related paradigms. Prior to progressing the discussion further, it is useful to categorise some of the more common terms to avoid confusion in later sections and these are presented in table 5.3.

Table 5.3 - Common Terms in Research Theory

Objectivist	Subjectivist
Quantitative	Qualitative
Positivist	Anti-positivist
Scientific	Phenomenological
Experimentalist	Humanist
Traditionalist	Interpretivist
Functionalist	Social Constructionist

Source: Adapted from Holden, M. & Lynch, P. 2004, "Choosing the Appropriate Methodology: Understanding Research Philosophy", *The Marketing Review*, vol. 4, p.399

5.3.1 Ontological Position

Ontology embraces the basic nature of social entities and reality and whether these are dependent or independent of individual consciousness (Easterby-Smith, Thorpe, & Lowe 2002;Saunders, Lewis, & Thornhill 2003;Bryman 2004;Jankowicz 2005). For Bryman (2004), issues of social ontology must not be separated from the conduct of research, as assumptions and commitments of an ontological nature will influence the research questions and objectives that are formulated and the actual research carried out, as has been the case in this study.

Burrell & Morgan (1979) and Saunders, Lewis, & Thornhill (2003) suggest that ontology may be depicted in the continuum of realism and nominalism, where realism is founded on the assumption that social entities and reality are independent of human beliefs and thoughts. Based on this, facts are viewed as concrete (Easterby-Smith, Thorpe, & Lowe 2002). Nominalism takes the opposite view, in that social entities and reality are, in fact, a projection of the human imagination and a product of individual consciousness (Morgan & Smircich 1980) and arising from this, facts are human creations (Easterby-Smith, Thorpe, & Lowe 2002). As a consequence, Bryman (2004) argues that the ontological position will be reflected in the overarching research question and, in turn, will influence the design of the research and data collection. Based on this, the research under discussion would appear to sit within an ontology of nominalism, as the focus of the research is in the exploration of team members' individual interpretations of their reality within the accreditation process and how they experience the exercise to impact on themselves and the organisation.

5.3.2 Epistemological Position

Epistemology involves the study of the scope, nature and utility of knowledge. Fundamental to this is the essence of knowledge - what it is and what is considered to be acceptable as knowledge within a particular discipline and the philosophical position taken in relation to this (Habermas 1968;Burrell & Morgan 1979;Elgin 1998;Gill & Johnson 2002;Easterby-Smith, Thorpe, & Lowe 2002;Saunders, Lewis, & Thornhill 2003;Bryman 2004;Jankowicz 2005). The significance of this is articulated by both Brannick (1997) who notes that *"What academic/postgraduate researchers will accept as scientific knowledge tends to depend on their philosophy of knowledge - their chosen epistemology"* (p.6), and Balnaves & Caputi (2001) who argue that *"It is the philosophical and theoretical underpinning of research that affects what a researcher counts as evidence"* (p.52). As such, this has been a fundamental consideration for the author in both designing and conducting this study.

The two main paradigms are the positivist and anti-positivist approaches and what separates them is the debate as to whether the methodology, and supporting approaches of the physical and natural sciences, can be applied and deployed to the study of social phenomena (Burrell & Morgan 1979;Bryman 2004;Kumar 2005). As Morgan & Smircich (1980) observe:

"The grounds for knowledge in each of these perspectives are different because the fundamental conceptions of social reality to which the proponents of each position subscribe, are poles apart"(p.493).

The positivist perspective is used to *"…characterise epistemologies which seek to explain and predict what happens in the social world by searching for regularities and causal relationships between its constituent elements"* (Burrell & Morgan 1979 p.5). Positivism is founded on the premise that the development of research and knowledge arising from this, is both systematic and empirical and that most types of other activity is metaphysical. It denies the importance of human subjectivity (Johnson & Duberly 2000;Gill & Johnson 2002), an issue which is central to this study, which focuses on the experiences of individuals. Positivism also assumes that the context for research is a closed system, where no external factors are able to

influence the way in which the system functions (Yates 2004). For Burrell & Morgan (1979) positivism *"…seeks to explain and predict what happens in the social world by searching for irregularities and causal relationships between its constituent elements"* (p.5). Central to this are a number of characteristics (Lee 1991;Black 1999;Yates 2004) including:

(i) Naturalism - assuming that all phenomena can studied and explained in the same way through the adoption of scientific methods;

(ii) Phenomenalism - based on the assumption that only knowledge based experiences that are observed are robust and that the real world can be measured directly;

(iii) Nominalism - words are only as reflections of things and only those ideas or concepts directly experienced by the senses are meaningful;

(iv) Atomism - the objects of a study are in their smallest units and focus on individuals and individual units;

(v) Scientific laws - seeking to locate empirical regularities through observations and from this, develop laws and general statements which hold across a variety of contexts;

(vi) Facts/values - facts enable empirical verification through observation and measurement and hence may be regarded as scientific and additionally, limit and isolate the value system of the researcher.

The converse of this, and at the other end of the epistemological continuum, is the anti-positivist/interpretivist (Burrell & Morgan 1979;Lee 1991;Jankowicz 2005) or social constructionist (Easterby-Smith, Thorpe, & Lowe 2002) perspective. According to Burrell & Morgan (1979) *"For the anti-positivist , the social world is essentially relativistic and can only be understood from the point of view of the individuals who are directly involved in the activities which are to be studied"* (p.5). This takes the position that focuses on the ways in which ideas are developed and used and in the context of open systems, where there is an acceptance of the external factors that influence social life and hence the research process (Yates 2004). The general anti-positivist view is founded on the belief that the focus of the social sciences i.e. individuals and their organisations, is fundamentally different from the natural sciences and requires the researcher to attempt to interpret the meaning

within social interactions, processes and experiences (Easterby-Smith, Thorpe, & Lowe 2002). As Bryman (2004) notes *"The study of the social world therefore requires a different logic of research procedure, one that reflects the distinctiveness of humans as against the natural order"*(p.13). For supporters of this approach, a positivist and scientific prospective sacrifices the rich data and understanding that may be derived from accepting this stance (Morgan & Smircich 1980;Saunders, Lewis, & Thornhill 2003).

At the anti-positivist extreme, a number of characteristics are also deemed to exist. Jankowicz (2005) suggests that these include:

(i) Individual phenomena may be examined and analysed in terms of issues;

(ii) Data may be collected by both participants and observers and with varying levels of involvement and detachment on their part;

(iii) It is difficult to determine the truth in an absolute sense. Consensus may be achieved, although sometimes differences may also need to be accepted;

(iv) The objective of research and enquiry is to achieve understanding, with a view to predicting future outcomes.

While depicted as opposites of the same continuum, the two positions can be reconciled to varying degrees, where mapping contexts and understanding the creation of social reality, adopt intermediary positions (Morgan & Smircich 1980) and this has been previously been outlined in table 5.2.

In relation to this study and its epistemological position, the research is positioned within the general anti-positivist doctrine and fits with many of the characteristics outlined by Jankowicz (2005). The research question and objective focus on the experiences of team members within the accreditation exercise, in terms of process and individual and organisational impacts, and aims to extract both a depth and richness to understanding the complexities of the interactions between individuals, the accreditation process and also within the context of the research site. The research is conducted in an open system context, where the external influences on

participants are recognised within the accreditation process and where the researcher is unable to completely detach themselves from the social interactions and phenomena within the study. As such, the research does not lend itself to supporting the positivist paradigm.

5.3.3 Human Nature Position

Morgan & Smircich (1980) identify that the prevailing assumptions made about human nature also inform the philosophical underpinnings of the research process and this has informed the design of this study on accreditation team member experiences. Accepting the objectivist approach to research, individuals are seen to be reduced to a status of being excited by, and responding to, external stimuli within the social environment (determinism)(Gill & Johnson 2002). Morgan & Smircich (1980) term this as *"…man as a responder"* (p.492) and describe how these stimuli condition them (individuals) to behave and respond in ways that are both predictable and to some extent, "*…lawful*" (p.495). Conversely, and from a subjectivist viewpoint, voluntarism assumes that individuals shape their world and exercise free will and are not subject to the influences arising from external stimuli (Morgan & Smircich 1980). As an intermediate position, Burrell & Morgan (1979) contend that elements of both positions may be adopted and this is particularly relevant to this study, whereby participants in accreditation may be governed by, and react to, the forces within the organisation, but may also have individual autonomy and exercise free will which, in turn, will impact on their behaviour. Thus, the research is likely to occupy an intermediary position on the human nature continuum as outlined in table 5.2.

5.3.4 Methodological Position

The epistemological, ontological and human nature stance taken during the research exercise will, in turn, influence the methodological position and the overall research strategy adopted (Burrell & Morgan 1979;Morgan & Smircich 1980;Bryman 2004), which has been a key consideration for the author during this research exercise. The methodology is essentially, as Balnaves & Caputi (2001) describe it *"…the science of finding out"*(p.52), while Bryman (2004) posits that the research strategy is *"...a general orientation to the conduct of social research"* (p.19).

While clear distinctions may be made at the philosophical level, this may not be as obvious in methodological terms (Burrell & Morgan 1979;Lee 1991;Easterby-Smith, Thorpe, & Lowe 2002). Revisiting the objectivist-subjectivist continuum in table 5.1, methodology within this framework may be categorised as being either nomothetic or ideographic, where nomothetic methodologies have as their goal *"…constructing generalised laws"* (Yates 2004 p.135), while ideographic methodologies aim to create *"…detailed descriptions of particular circumstances"*(Yates 2004 p.135). For Balnaves & Caputi (2001) these simply reflect different styles of inquiry. Gill & Johnson (2002) provide a useful summary of the competing perspectives and possible methodologies that may be employed and these are outlined in table 5.4.

Table 5.4 - A Comparison of Nomothetic and Ideographic Methods

Nomothetic methods emphasise	Ideographic methods emphasise
1. Deduction	1. Induction
2. Explanation via analysis of causal relationships and explanation by covering laws (etic)	2. Explanations of subjective meaning systems and explanation by understanding (emic)
3. Generation and use of quantitative data	3. Generation and use of qualitative data
4. Use of various controls, physical or statistical, so as to allow the testing of hypotheses	4. Commitment to researching everyday settings, to allow access to, and minimise reactivity among the subjects of the research
5. Highly structured research methodology to ensure replicability of 1,2,3, and 4	5. Minimum structure to ensure 2, 3 and 4 (and as a result of 1)

Source: Adapted from Gill, J. & Johnson, P. 2002, *Research Methods for Managers*, 3rd edn, Sage, p.44

The nomothetic approach parallels the positivist perspective outlined earlier and reflects the scientific and systematic philosophy for conducting research. Gill & & Johnson (2002) suggest that the approach is highly deductive (where theoretical and conceptual hypotheses are established and then tested and subjected to empirical scrutiny (Gummesson 1991;Lee 1991;Gill & Johnson 2002;Easterby-Smith, Thorpe, & Lowe 2002;Bryman 2004)) and relies on the 'etic' - an analytical approach, where explanations of the behaviour of the actors within the research process, are derived from the imposition of an external frame of reference or logic (Cresswell 1998;Gill & Johnson 2002). The approach is likely to both utilise and generate quantitative data within a highly structured research methodology and may lend itself to research

designs such as experimentation, quasi-experimentation and surveys (Gill & Johnson 2002).

The ideographic position adopts a more inductive approach (where observations contribute to the development of theory about and accounts and explanations of what has been observed (Lee 1991;Gill & Johnson 2002;Easterby-Smith, Thorpe, & Lowe 2002;Bryman 2004)). Central to this is the notion of the 'emic' - an explanation of events or a given situation which draws on the subjectivity and internal logics of those actors within the research process (Cresswell 1998;Gill & Johnson 2002). This, in turn, reflects a more anti-positivist/interpretivist prospective. An ideographic methodology is more likely to draw on and generate qualitative data from research conducted in everyday, naturalistic settings, with the objective of gaining an insight into situations and with a sensitivity to the potential for reactivity (the impact of the researcher on both the study site and on those individuals who are the focus of the study (Cresswell 1998;Gill & Johnson 2002;Robson 2002;Bryman 2004)). Fundamentally, ideographic approaches *"…assume that each culture is unique and no one law or classification can govern them all"* (Balnaves & Caputi 2001 p.52). Gill & Johnson (2002) suggest that research designs such as action research, surveys and ethnography may reflect an ideographic position.

What becomes clear in methodological and research strategy terms, is that research is often not conducted solely from a purely nomothetic or ideographic perspective and that this, in turn, is reflected in both table 5.2 and also the wider debate on qualitative and quantitative research (Lee 1991;Barbour 1999;Onwuegbuzie & Leech 2005). In simple terms, qualitative research would suggest that the data generated within a study would not lend itself to measurement, would be usually characterised by an emphasis on words and would have an epistemology of anti-positivism and an ontology of nominalism. Likewise for quantitative research, the assumption is that the quantification and measurement of data is possible and this would suggest a positivist and realism stance. However, Lee (1991), Barbour (1999), Bryman (2004) and David & Sutton (2004) argue that this view of methodological and research strategy issues is overly simplistic and that the traditional deductive (testing theory) - inductive (generating theory) divide and the accompanying assumptions, as

presented in table 5.4, may not hold in the execution of research activity. For Bryman (2004):

"…quantitative and qualitative research represents different research strategies and that each carries with it striking differences in terms of the role of theory, epistemological issues, and ontological concerns. However, the distinction is not a hard-and-fast one: studies that have the broad characteristics of one research strategy may have a characteristic of the other" (p.21).

David & Sutton (2004) also support this view in relation to qualitative and quantitative research and argue that there are a number of *"…blurred distinctions, none of which are absolute"* (p.42). Bryman (2004) further underpins this position and takes the *"…technical"* (p. 454) version of the quantitative and qualitative research debate, where both strategies are seen as compatible and where there is an acceptance of the philosophical assumptions on which each is based, but with an acknowledgement that research methods are *"…autonomous"* (p.454). For Gill & Johnson (2002) this may result in methodological pluralism and *"…implies the possibility of rapprochement between ideographic and nomothetic methodologies"* (p.169), while Onwuegbuzie & Leech (2005) advocate that this represents taking the *"…pragmatist"* (p. 377) position. For Ritchie (2003), this becomes evident in practice, where studies that have a degree of qualitative orientation may still be informed by existing knowledge, theory and the development of a conceptual framework, which has been the case with this research, where there is evidence of elements of both induction and deduction.

In summarising the theoretical and philosophical position for this study, which focuses on individual experiences of the accreditation implementation process and impacts, the research can be said to be underpinned by an anti-positivistic/interpretative epistemology, which accepts the interpretation of the meaning within social interactions, processes and experiences as a basis for knowledge creation. Furthermore, an ontology of nominalism is assumed, that acknowledges that reality is a projection of the human imagination and a product of individual consciousness; a view of human nature that encompasses both elements of determinism and voluntarism and a methodology that acknowledges and reconciles

both the nomothetic and ideographic positions and adopts both a qualitative and quantitative (pragmatic) approach to research. This methodological pragmatism is reflected in the fact that a conceptual framework to represent this study has already been developed (and depicted in Chapter 4), implying that a degree of prior knowledge has been brought to the primary research exercise.

5.4 Research Design

Having developed the ontological, epistemological, human nature and methodological stance for this study, the author then progressed to reflecting on the most appropriate research design, which might serve to answer the overarching research question and assist in the achievement of the research objectives. The significance of the research design is highlighted by Easterby-Smith, Thorpe, & Lowe (2002) who purport that *"…research designs are about organizing research activity, including the collection of data, in ways that are most likely to achieve the research aims"* (p.43), while Yin (2003b) argues that *"…a research design is the logic that links the data collected (and the conclusions to be drawn) to the initial questions of the study"* (p.19).

Prior to adopting any one research design, consideration must be given to the nature of the actual research itself (reflected in the research question and objectives) and the extent to which this encompasses an exploratory, descriptive or causal design (Domegan & Fleming 2003). Table 5.5 outlines the principle features of each approach.

Table 5.5 - Considerations in Choosing a Research Design

	Exploratory Research	Descriptive Research	Causal Research
Data Type	Qualitative	Qualitative or Quantitative	Quantitative
Aims	To explore, chart, identify	To describe, quantify	To establish cause and effect
Nature of Variables	Unknown, undocumented	Known associations and documented	Known exactly, clearly supported
Degree of Formality	Relatively little	Some to extensive	High mathematical content
Data	Literature review Expert surveys Focus groups In-depth interviews Projective techniques	Literature Review Surveys Observation Panels	Literature Review Expert survey Experiments Surveys Observations
Sample Size	Small	Small or large	Large
Question Types	Probing Response driven	Some probing Interviewer driven	No probing
Hypothesis	Generates, Develops	Tests and/or Generates, Develops	Tests

Source: Domegan, C. & Fleming, D. 2003, *Marketing Research in Ireland: Theory and Practice*, 2nd edn, Gill & Macmillan, p.66

The categorisations presented by Domegan & Fleming (2003) and depicted in table 5.5, serve to highlight some of the key features of the different research approaches. Where the research is considered to be of an exploratory nature, it is accepted that little is known about the central issues and that the research will to some extent uncover and reveal patterns, trends, attitudes and behaviours that were previously unknown and lacked understanding and that may, in turn, lead to more extensive research (Zikmund 2000;Kumar 2005). As outlined in table 5.5, the studies of this nature are likely to rely on qualitative data generated from small samples, with a reliance on in-depth interviews as a means of exploring key issues.

Causal research (Zikmund 2000;Domegan & Fleming 2003), or what Kumar (2005) describes as both correlational and explanatory, seeks to identify 'cause and effect' associations, interdependencies and relationships between two or more variables (Domegan & Fleming 2003). With this type of approach, it is typical to arrive at an explanation of the relationship (Zikmund 2000). Causal research is characterised by the generation of quantitative data, derived from large samples, but without the probing techniques utilised in other approaches.

The final approach - descriptive research - is of particular relevance to this study. As already mentioned, Zikmund (2000) and additionally, Sim & Wright (2000), argue that this type of research is particularly relevant for addressing issues of who, how, when, where and 'what' and within this, may contribute to determining experiences, attitudes and needs of individuals and groups. For Zikmund (2000), there is particular value in descriptive studies: *"It is clear that a mere description may provide important information and that in many situations descriptive information is all that is needed to solve business problems"* (p.50). Based on this, the study falls within the domain of descriptive research as it seeks to focus on individual accreditation team members experiences of the accreditation process and impacts.

Accepting the significance of the research design, as outlined, a number of options are available to the researcher. What becomes necessary is to both select and justify a particular design, based on both the nature of the research issue and question, the philosophical underpinnings to this and also develop an acceptance that no single design is inferior or superior to another. For Hakim (2000) :

"No single type of study is inherently inferior or superior to others. Each does a particular job and should be selected according to the nature of the issues or questions to be addressed" (p.11-12).

Bryman (2004) underlines the functionality of research design in that it *"... provides a framework for the collection and analysis of data"*(p.27). He suggests that inherent within this, is a reflection of the weight and significance given to various dimensions of the research process, including the degree of appreciation and acceptance of social phenomena and their interconnections, and the extent to which causal relationships between variables may be expressed. Moreover, it also encompasses the meaning and understanding of behaviour in its social context and the extent of generalisations to larger groups, as opposed to those who form part of the study, and hence underpins the philosophical and theoretical basis on which the research is conducted. This position is also supported by Easterby-Smith, Thorpe, & Lowe (2002) who posit the view that there are a number of key choices to be made in research design and that these, in turn, are closely allied to the basic epistemological dichotomy outlined earlier. Table 5.6 summarises these and in relation to this research, focusing on the

experiences of accreditation team members, the study would appear to lend itself to an alignment whereby the researcher requires some degree of involvement, in order to identify both the facets of the implementation process and the experiences of team members to same, and any impacts arising; where relatively small numbers are the targets for the research; where some attempt at theory generation might be made; where methods that bear similarities to fieldwork are appropriate and where there is some consideration of context in the formulation of theory and its resultant applicability outside of this.

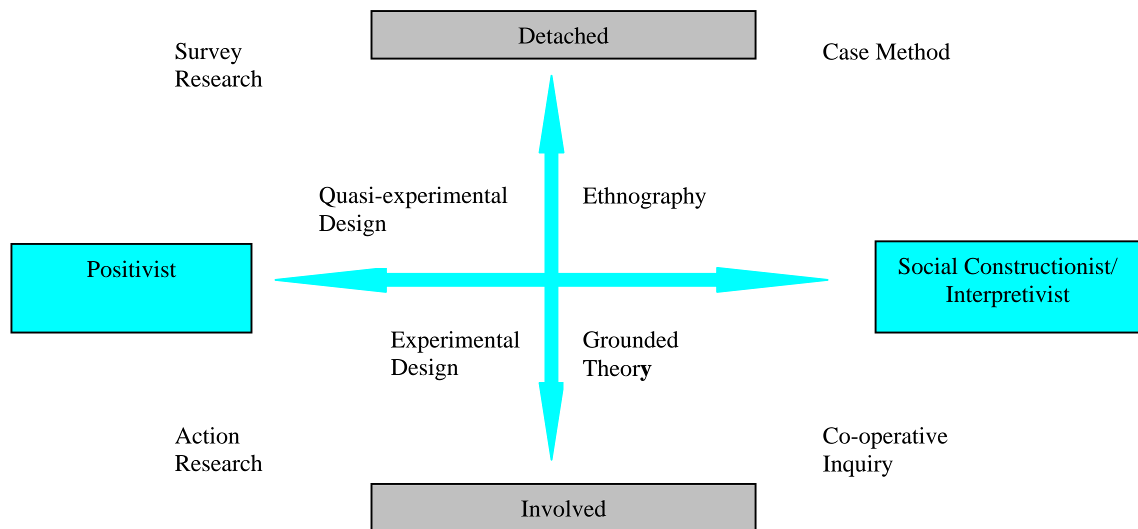
Table 5.6 - Key Choices of Research Design

Researcher is independent	vs.	Researcher is involved
Large samples	vs.	Small numbers
Testing theories	vs.	Generating theories
Experimental design	vs.	Fieldwork methods
Universal theory	vs.	Local Knowledge

Source: Adapted from Easterby-Smith, M., Thorpe, R., & Lowe, A. 2002, *Management Research*, 2nd edn, Sage, p.43

Figure 5.2 outlines a number of research designs that may be employed and it is not the intention of this discussion to provide a detailed description of each. Instead, the basis for adopting the case study research design (explored in detail at later stages) is presented. The Easterby-Smith, Thorpe, & Lowe (2002) depiction of the dual axis of positivism vs. social constructionist/interpretivist (anti-positivist) epistemology and involved vs. detached research roles, provides a useful basis for exploring the options available for the research design of this study. Previous sections have served to locate the research within the general anti-positivist/social constructionist epistemology. At the same time, proper account must be taken of the role of the researcher in relation to the organisation where the implementation of accreditation takes place. In this instance, the author is external to the organisation, not being employed at the research site or within the larger regional health service structure, and thus is not a participant (team member) in the accreditation exercise. As such, they may be viewed as being more detached from the research process within the Easterby-Smith, Thorpe, & Lowe (2002) framework and from this, the adoption of the case study, as a research design, is concluded to be appropriate.

Figure 5.2 - Matrix of Research Designs



Source: Adapted from Easterby-Smith, M., Thorpe, R., & Lowe, A. 2002, *Management Research*, 2nd edn, Sage, p.57

5.4.1 The Case Study Research Design

The case study, as a research design, has been variously defined. For example, Hamel, Dufor, & Fortin (1993) suggest that *"… a case study is an in-depth study of the cases under consideration, and this depth has become another feature of the case study approach"* (p.1).

An alternative definition is presented by Hakim (2000), who argues that case studies, at their most basic, provide accounts of a descriptive nature of one or more cases - *"Case studies take as their subject one or more selected examples of a social entity- such as communities, social groups, organisations, events, life histories, families, work teams, roles or relationships - which are studied using a variety of techniques"* (p.59).

Finally, Stark & Torrance (2005) see the case study as seeking to *"…engage with a report of the complexity of social activity in order to represent the meanings that individual social actors bring to those settings and manufacture in them. Case study assumes that 'social reality' is created through social interaction, albeit in particular contexts and histories, and seeks to identify and describe before trying to theorize"* (p.33).

Case studies, as a key pillar of research design, offer a number of benefits, which have relevance to this study. Firstly, they have the potential to allow for intensive research, which may achieve depth, and in doing so, enable the development of a rich description of events to illuminate understanding (Eisenhardt 1989;Sandelowski 1996;Robson 2002;Yin 2003a;Stark & Torrance 2005). Secondly, they acknowledge context, complexity and ambiguity (Gummesson 2007). Thirdly, Pettigrew (1990) and Bryman (2004) suggest that they offer the opportunity to study phenomena in a longitudinal manner and to capture any changes or developments that may arise in their natural surroundings. Fourthly, case studies have the potential to provide further refinement and additional insight to existing studies, which Bauer, Falshaw, & Oakland (2005) suggests has particular relevance for undertaking research in the quality implementation field. Finally, Yin (2003b) argues that case studies offer the opportunity to answer research questions which address 'what', that they require no control over behavioural actions and have the scope to focus on contemporary events.

Of specific relevance to this study enacted in a healthcare context, is the argument presented by Keen (2006), who posits that case studies, as a research design, *"…are most valuable when planned change is occurring in a messy real world setting"* (p.113), as they may provide valuable insights into why implementation proves challenging. This mirrors the view of Ovretveit & Gustafson (2002), who identify that case study research, in a descriptive vein, will have significant value in terms of contributing to an enhanced understanding of implementation issues:

"This design simply aims to describe the programme as implemented. There is no attempt to gather data about outcomes, but knowledgeable stakeholders' expectations of outcome and perceptions of the strengths and weaknesses of the programme can be gathered. Why is this descriptive design sometimes useful? Some quality improvement programmes are prescribed and standardised - for example a quality accreditation or external review. In these cases a description of the intervention activities is available which others can use to understand what was done" (Ovretveit & Gustafson 2002 p.272).

Furthermore, Ovretveit & Gustafson (2002) posit the view that describing and contextualising an organisation-wide quality approach, through case study research in a healthcare environment, may enable the discovery of factors that are critical to successful implementation. Likewise, potential deficiencies within the implementation process, as viewed by different organisational groups, may also be identified and that these, in turn, have the potential to provide useful insights, informed by research, into the management of implementation (Ovretveit & Gustafson 2002). Moreover, the relevance of case based research to investigating potential quality implementation impacts is also highlighted by Samson & Terziovski (1999) who suggest that pursuing research in this vein may also serve to offer valuable insights from different parties. Overall, the aforementioned benefits and relevance of case study research serve to support the decision to adopt this as the research design within this study.

The fundamental issue in terms of case study design is whether to adopt a single or multiple case approach and this is primarily determined by either's ability to answer the research question (Hamel, Dufor, & Fortin 1993;Yin 2003b;George & Bennett 2004;Keen 2006) and also represents a trade-off between coverage and depth (Dyer & Wilkins 1991;Stark & Torrance 2005). Eisenhardt (1989) is a strong advocate of multiple case studies and argues that with fewer than four cases, both the theory arising and its empirical grounding, may be *"…unconvincing"* (p.545). Dyer & Wilkins (1991) counter this in their view that *"…[it is] the careful study of a single case that leads researchers to see new theoretical relationships and question old ones"* (p.614), while for Stake (1994;1995), the kernel of the issue is epistemological in that centres on what can actually be learned from the single case.

Possibly a more balanced view of the rationale for adopting a single case approach is presented by Yin (2003b). He suggests a number of circumstances under which it possible to consider the adoption of a single case study as a robust research design:

(i) Where the single case represents a critical case within which to test a well-formulated theory and to confirm that this theory is either correct or can be the subject of alternative explanations;

(ii) Where the single case is either a unique or extreme case and hence no patterns are able to be established;

(iii) Where the case is a representative or typical case and where the aim is to capture the conditions of a situation and hence to be informed about the experiences of the average organisation or individual within it;

(iv) Where the case is a revelatory case in that the phenomenon has been previously inaccessible to study;

(v) Where the case is worthy of longitudinal study through examination at two or more different stages/points in time.

In relation to this research study, the grounds for the adoption of a single case research design are that the case (the implementation of accreditation exercise) is both representative and typical of other implementations using the IHSAB acute-care accreditation model within Ireland, and that the context is also typical - i.e. a publicly funded acute-care hospital.

While accepting that the single case may be an appropriate research design, Yin (2003b;2004) cautions on the risks that may also be associated with the approach. In the first instance, there is a need to endeavour to ensure that the case is actually the case it is thought to be and that it is representative, in terms of the 'typical case' scenario, of the phenomena to be studied (Stake 1994;Yin 2003b;Gerring 2007). This is similar to Bryman's (2004) categorisation of *"…exemplifying case"* (p.51), where the selection of a case is based on its ability to provide a suitable context in which to answer a research question, for example, because the organisation is known to have implemented a particular initiative, which happens to be the focus of the research study.

Secondly and of equal significance, is the issue of access. Yin (2003b) and Mulhall (2003) emphasise that where a commitment is made to a single case design, that high levels of access will be needed to facilitate the collection of data. Access is also alluded to by Stake (1994), who suggests that levels of access should be discussed and agreements adhered to by the researcher. Mulhall (2003) provides deeper insights into gaining access and argues that it *"…involves a subtle but rarely acknowledged process of presenting oneself in the 'correct' way. Entrance may be*

denied if consciously or unconsciously the researcher does not meet the cultural expectations of gatekeepers" (p. 310). Here the 'gatekeepers' are those individuals who control and have power to grant access within the research context (Foster 1996;Yates 2004;Pope & Mays 2006).

In terms of this research, at the outset of the research exercise efforts were made to ensure that the case was in fact, representative of other similar or 'average' cases. A number of initial meetings with the Regional Quality and Accreditation Manager, two members of the senior management team at the research site (one of whom was charged with 'leading off' on the accreditation exercise and having joint responsibility managing the process and facilitating five of the ten accreditation teams); a review of the IHSAB website (www.ihsab.ie) and the IHSAB acute-care accreditation standards (IHSAB 2004), served to confirm this. The research site, as a context for the research, is a publicly funded, large acute-care hospital (within the definitions of an acute-care hospital presented in Chapter 2) and serves as a regional centre for a diverse range of clinical services. In terms of the implementation of accreditation exercise - the case - it is representative of other cases that have adopted the IHSAB accreditation model and to which the standards apply. Moreover, the assurances provided by both the Regional Quality and Accreditation Manager and the two senior managers at the research site, confirmed that the accreditation exercise would actually be implemented within the timeframe for the research study. This was additionally reinforced by a number of other factors, including that the entire senior management team had committed to the accreditation exercise and in relation to this, had applied to IHSAB to commence the process; that there was a project plan, with definite timelines and deliverables in place and finally, that there had been a commitment to deploying an administrative resource to support the overall implementation. On the basis of this, the researcher was able to derive a degree of confidence in their determination that the case was typical of the case that it was judged to be in the first instance (an implementation of accreditation exercise).

As previously alluded to, the issue of access is pivotal to the conduct of research and where a single case design is adopted, the impact of problems with access to the research site, to the case itself and the respondents within it, carries considerable risk. In relation to this research, a number of features existed and measures were taken to

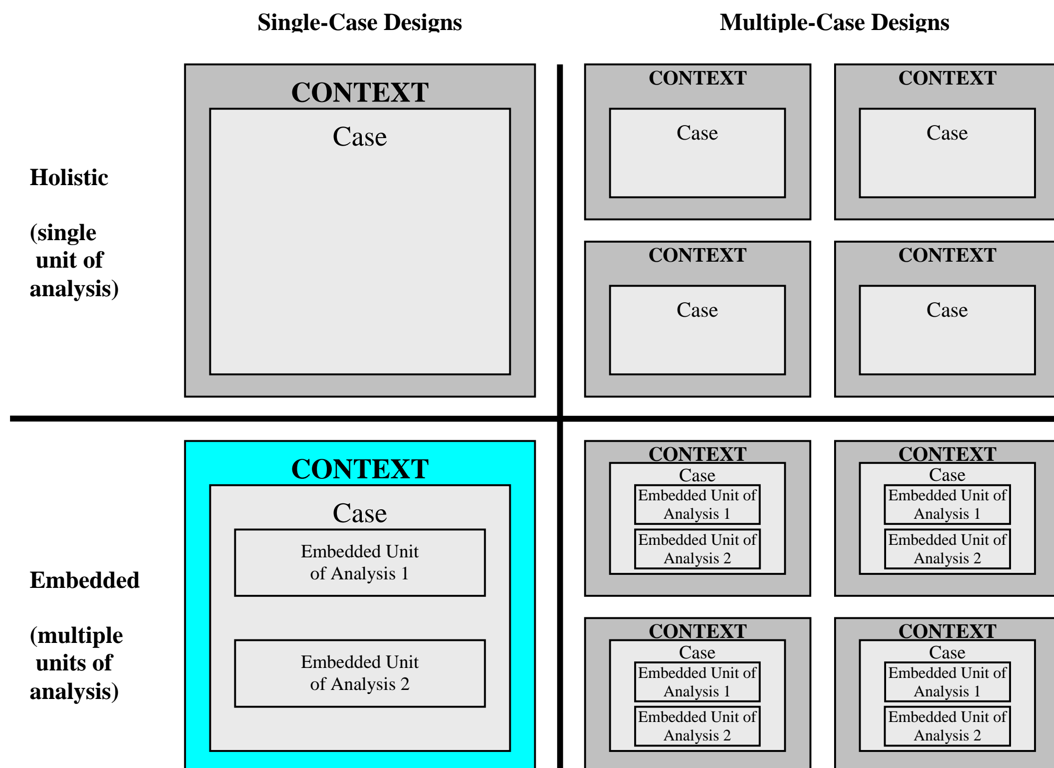
ensure on-going access and hence facilitated the data collection element of the research process itself. Firstly, the author is positioned within the Centre for Management Research in Healthcare and Healthcare Economics, Waterford Institute of Technology (WIT). The Centre was established with the explicit support of a regional health structure, of which the research site and within this, the case, is part. A number of research projects run within the Centre, each with a specific link to individual senior managers within the regional health structure, who act as 'gatekeepers' and partners to the individual studies. Within this, they actively champion and facilitate access to research sites, where appropriate. As the 'gatekeeper' for the study, the Regional Quality and Accreditation Manager endeavoured to facilitate access and ensure on-going commitment to the exercise via a number of measures. At the initial stages, they gained a commitment from the senior management team at the research site to both allow the research to proceed and to facilitate the types of data collection required by the author (as an observer at team meetings, the administration of questionnaires to team members and also conducting interviews with them). Secondly, the 'gatekeeper' ensured that the two Accreditation Managers, who were responsible for leading and managing the process and facilitating the teams at the research site, were aware of the author's role and objectives and their intention to be present on-site over the course of the self-assessment process and beyond this, at the interviewing stage.

The 'gatekeeper' also sought to confirm that the two Accreditation Managers at the research site would communicate the role of the author to team members, within the context of the team meetings and the purpose of the data collection exercises. Specifically, in relation to the administration of the two questionnaires (discussed in a later section), the on-going legitimacy of the research was also reinforced via supporting covering letters from the 'gatekeeper' to accompany the questionnaires, which aimed to underline the importance and value of the research.

While the single case study may be accepted as an appropriate and justified approach to this research and where the risks have been both considered and anticipated, there are deeper issues within the case itself and the phenomena under review, that need to be examined. For Eisenhardt (1989) and Yin (2003b), these are essentially questions of whether the case approach adopted is either holistic or embedded - i.e. is the case

investigated only from a global or holistic perspective or have more than one unit of analysis or multiple subunits been examined? These issues are fundamental to the conduct of case-based research. Figure 5.3 illustrates the single-multiple, embedded-holistic combinations, where the lower left quadrant represents the design principles adopted in this research.

Figure 5.3 - Basic Types of Designs for Case Studies

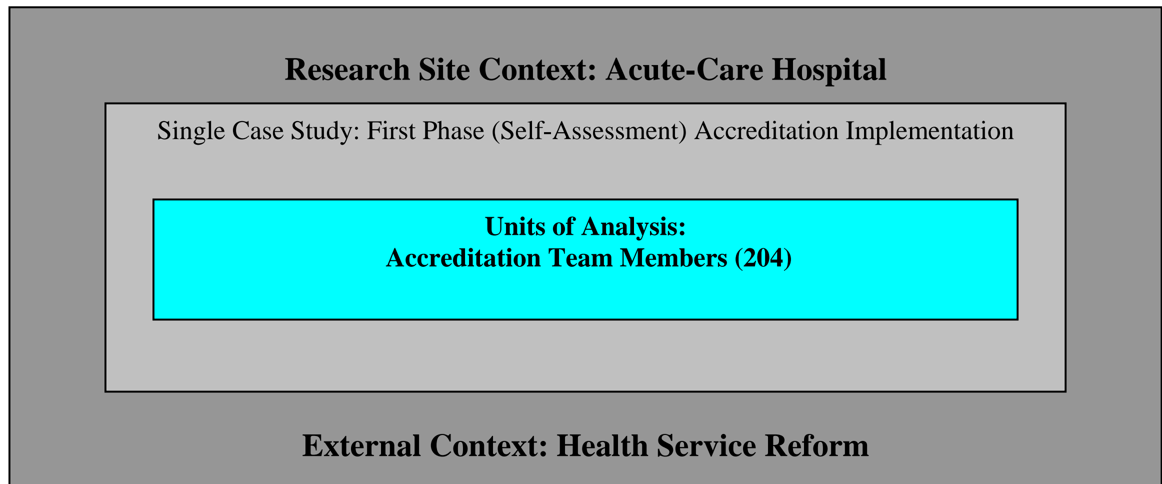


Source: Yin, R. 2003, *Case Study Research: Design and Methods* Sage, p. 40

For this research, the case is actually the first-phase of accreditation implementation exercise and not the organisation (the acute-care hospital) itself. Instead the organisation provides the context in which the accreditation exercise takes place and likewise, the health service reform programme and accompanying drivers, provide an additional backdrop in which to appreciate the influences within the external organisational environment. The units of analysis or subunits are the individual accreditation team members (two hundred and four in total) whose experiences of the implementation process and the individual and organisational impacts of

accreditation are the central focus for the study. These overall interrelationships are captured in figure 5.4. Therefore, it may be accepted that the case is of an embedded nature and for Yin (2003b), by taking this approach *"The subunits can often add significant opportunities for extensive analysis, enhancing the insights into the single case"* (p.46).

Figure 5.4 - Single Case Study Context and Units of Analysis



5.4.2 Validity and Reliability

Yin (2003b) argues that for case studies to stand up to examination in terms of rigour, they must be subject to the assessment of both validity and reliability. While the author accepts the weight must be given to these, in both the design of the case study and specific research methods employed therein (discussed later), they also are cognisant of the views of Daft (1983) who advocates for *"…common sense"* (p.543) in the conduct of research. As he observes:

"Objective proof seldom will exist somewhere outside one's self that will demonstrate correctiveness or validity. No statistical test will do this for us; no amount of replication will make acceptable an idea that does not square with experience"(Daft 1983 p.543).

With this in mind, the author sought to reconcile both positions in accounting for validity and reliability in both the research design (the case study) and the methods deployed.

Three approaches to assessing validity for case studies are suggested by Yin (2003b). Firstly, *"...construct validity"* (p.34) - ensuring that the right measures for the concepts being researched are being examined - requires consideration. Yin (2003b) suggests that this may be particularly challenging in case study research, where a researcher may use subjective judgements in data collection and thus fails in the obligation to generate sufficient measures. Validity, however, may be improved by drawing from multiple sources of data, allowing for the development of converging lines of inquiry (Keen 2006). This approach was adopted in this study by deploying non-participant observation, questionnaires and semi-structured interviews, built around both the conceptual framework outlined in Chapter 4, and based on the underpinning literature. Secondly, Yin (2003b) argues in favour of addressing *"...internal validity"* (p.34) - the exploration and establishment of causal relationships. Of particular relevance to this research is that Yin (2003b), qualifies the relevance of internal validity and posits that it lacks relevance to descriptive research, such as that undertaken in this study.

The final test of validity for case studies put forward by Yin (2003b) is that of *"...external validity"* (p.34), which determines the domain to which the findings from the study may be generalised - i.e. can they be generalised outside of the case study itself? For Sandelowski (1996), Gomm, Hammersley, & Foster (2000), Patton & Appelbaum (2003) and Yin (2003b) doubts about this issue represent a criticism that is frequently levied at case study research, although as Kennedy (1979) notes: *"Data might offer confirming or disconfirming evidence, but never conclusive evidence. Not even in grouped studies can the evaluator generate conclusive evidence of generalizability"* (p.664). Yin's (2003b) position, however, attempts to counter the dissent by arguing that generalisations might be made from research results to theory.

Attempts to create reliability also contribute to the rigour of the case study research design. Reliability seeks to establish that the activities and operations of the research exercise could be replicated and yield the same results from the same case study. Yin (2003b) suggests that this can be achieved by deploying a case study protocol, containing the operational steps of the study, which another researcher could easily

follow should they wish to repeat the research. For Yin (2003b) *"... the protocol contains the instrument as well as the procedures and general rules to be followed in using the protocol"* (p.67) and should include an overview of the case study research; the basis for case selection and the methods to be used for working in the actual research environment. Table 5.7 outlines the case study protocol used for this research and summarises a number of issues that have already been addressed and also others that will be examined in forthcoming sections.

Table 5.7 - The Case Study Protocol

	Description	Date
Protocol Purpose	This protocol endeavours to guide the single case study research undertaken by the author relating to the IHSAB accreditation process. Principally, this research aims to address the following research question and research objectives: ***What are the experiences of individual team members in terms of the accreditation implementation process and the individual and organisational impacts associated with this, in a large acute-care hospital context?*** (i) To review and synthesise themes within the existing literature in the area of organisational change and quality implementation and impacts, with particular reference to quality in healthcare and hospital accreditation; (ii) To explore the experiences of individual team members with reference to the implementation process surrounding the first phase of accreditation; (iii) To identify the experiences of individual team members in terms of impacts at both the individual and organisational levels arising from the first phase of accreditation; (iv) To establish the extent of, and reasons for, any differences between individual team members, in terms of their experiences of the implementation process and individual and organisational impacts associated with the first phase of accreditation, based on team type and work role.	
Case Selection	**Research Site/Organisational Context:** An acute-care hospital *("A hospital providing medical and surgical treatment of relatively short duration. All, except district hospitals, are consultant-staffed. District hospitals are classified as acute where the average length of stay is less than 30 days")* that is planning to commence the first phase (self-assessment stage) of the IHSAB accreditation process for the first time. **The Case:** The accreditation implementation process exercise comprising all individual team members who represent the units of analysis. The author identified one case meeting these criteria where access could be gained.	
Case Duration	The duration of the self-assessment stage (estimated 15-18 months) plus an additional 6 months to incorporate semi-structured interviews (maximum 24 months).	January 2004-December 2005
Case Access	Access negotiated to the research site and to the case itself via the 'gatekeeper' to the study and senior management at the research site.	November 2003 to January 2004
Data Collection Methods	The following data collection methods and supporting procedures seek to satisfy both the overall research question and research objectives: Access to 5 of the 10 accreditation teams via non-participant observations of bi-weekly team meetings over the duration of the self-assessment process. Use of observation schedule incorporating structure and allowing for flexibility, with objective to attend a minimum a 80% of meetings. Interim (5-8 months) and immediate post-IHSAB survey questionnaires to all members of all teams. Some common items between questionnaires but otherwise independent. Aim to achieve maximum response rates using covering letter from 'gatekeeper' and follow-up letters. Semi-structured interviews with cooperating accreditation team members' post-IHSAB survey. Interview guide incorporating questions under general themes with scope for flexibility and exploration. Interviews conducted within boundaries outlined in interview protocol and to be recorded, where possible. Objective to achieve maximum number of interview volunteers through questionnaire 2 and with representation from clinical services and support services teams. (Supporting equipment and resources for use at the research site: stationery; pens; tape recorders x 2; supply of tapes and batteries; mobile phone and interview room).	 April 2004-May 2005 9th -20th August 2004 and 17th June 2005 September – December 2005
Case Study Report	Formal verbal presentation to 'gatekeeper' and senior management team at research site. Written, largely chronologically structured report. This should be presented under the themes from the conceptual framework incorporating the results based on the sequence of research methods deployed over the course of first phase of self-assessment process.	30th January 2006 June 2007

Adapted from Remenyni et al. (1998), Yin (2003b) and Kelliher (2006)

5.5 Secondary and Primary Research: Methods, Data Collection and Data Analysis

The following sections address the specifics of the secondary and primary data collection. In relation to the latter, particular attention is given to primary research method design and development; administration; validity and reliability and subsequent data analysis. These are, in turn, framed with reference to the theoretical and philosophical underpinnings for this study, which have previously been alluded to.

5.5.1 Secondary Research and Data Collection

Multiple sources of secondary research (i.e. that which has already been published (Cooper & Schindler 1998;Remenyni et al. 1998) were used in conducting this study. Relevant literature and reports were obtained through the library holdings, inter-library loans facility and on-line databases (Emerald, Business Source Premier and Proquest) of Waterford Institute of Technology. The additional library resources of the Institute of Public Administration and the on-line databases of the Chartered Institute of Personnel and Development were also utilised.

Numerous websites were also accessed including those of the HSE; Department of Health and Children; IHSAB and the OECD. In addition, a Freedom of Information request was made to IHSAB and provided background information on the establishment and operation of the acute-care accreditation scheme, while the research site also supplied organisational data that facilitated the writing of the background and context to the case study itself as detailed in Chapter 1.

5.5.2 Primary Research and Data Collection

Eisenhardt (1989) argues that case studies, as a research design, are likely to embody a number of data collection methods which may be qualitative, quantitative or both and highlights that *"…the combination of data types can be highly synergistic"* (p. 538), adding greater flexibility to investigative techniques, which may ultimately expand the scope of a study (Sandelowski 2000;Onwuegbuzie & Leech 2005;Moffatt et al. 2006;Keen 2006). This view is also taken by Stake (1994), Yin (2003b;2004) and Gerring (2007) who argue that the adoption of the case study, as a design, should not be limited to any one type of data and that multiple data collection methods and data types, strengthens the overall case design itself. Cresswell & Plano Clark (2007) posit the view that this mixed approach, incorporating quantitative and qualitative

data collection *"…provides a better understanding of research problems than either approach alone"* (p.5), a position also taken by Zikmund (2000) and O'Cathain & Thomas (2006). Moreover, Sim & Wright (2000) suggest that embracing a variety of research methods is typical of case study research designs that are descriptive in nature and that they enable the production of a fuller account of the phenomena which are the objects of study.

In terms of the qualitative data that may arise, this has the potential to provide detailed and in-depth descriptions of interactions and situations, which are embedded in context and allow for the development of *"…thick description"* (Gilmore & Carson 1996 p.22) and explanation of phenomena (Geertz 1973;Miles 1979;Gilmore & Carson 1996). Furthermore, Sandelowski (2001) and Pope, Ziebland, & Mays (2006) argue that much of this qualitative data may lend itself to quantification which, in turn, adds to meaning and creates a stronger appreciation of the complexity of qualitative data. Likewise, data that has strong quantitative dimensions to it, brings structure and facilitates measurement. By adopting a combined approach to utilising various methods and collecting different types of data, this puts the researcher in *"…a better position to use qualitative research to inform the quantitative portion of research studies, and vice versa"* (Onwuegbuzie & Leech 2005 p.383).

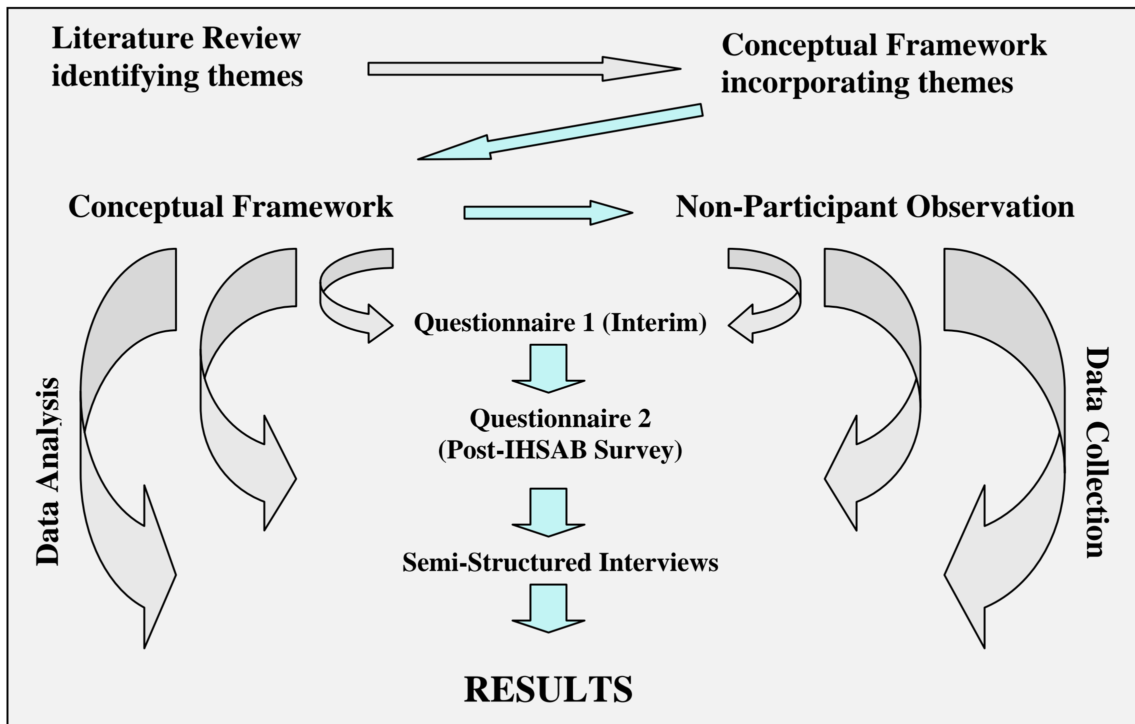
Looking specifically at the scope for combined methods to explore issues relating to quality implementation in a healthcare context, Grol, Baker, & Moss (2002) identify the potential for research studies in the area to adopt tailored research approaches, using combined methods, and propose examples such as observational studies of existing change processes and in-depth studies, incorporating a qualitative element, on critical success factors and barriers to change in quality improvement programmes, as possible avenues to explore. Moreover, Keen (2006) captures the strength of mixed methods in his observations on implementation issues in a healthcare context:

“Asking participants about their experiences, and observing them in meetings and other work settings, can provide rich data for descriptive and explanatory accounts of the ways in which policies and more specific interventions work and their subsequent impacts” (p.113).

Consideration also needs to be given to the sequencing of methods and how and when integration will occur, as this affects the research design (O'Cathain & Thomas 2006). In relation to this study, three principal methods were deployed - non-participant observations, questionnaires and semi-structured interviews. These methods were utilised in a concurrent, and a phased approach, each serving to generate data in its own right and also providing the basis for exploring issues in greater depth in subsequent stages. For example, the observational data was instrumental in informing both the questionnaire content and also the development of the interview guide. Likewise, the analysis of the questionnaire data also provided a focus for the identification of a number of the questions posed at the interview stage. This overall approach is supported by the recent observations of Pope, Ziebland, & Mays (2006) who in focusing on the analysis of data, argue that this (the analysis) begins during data collection and serves to influence and shape further data collection. In turn, this interim or sequential analysis is of further benefit in that it allows the researcher to explore emerging issues in greater depth (Gilmore & Carson 1996;Pope, Ziebland, & Mays 2006).

Figure 5.5 seeks to illustrate the overall relationship between the literature review, the conceptual framework, the integration and sequencing of research methods and analysis deployed during this study. Here the literature provided *a priori* themes, which were incorporated into an overall conceptual framework for the study. This, in turn, served to give direction to the observational phase of the research exercise. Both the conceptual framework and the data from the observations, subsequently informed the development of both questionnaires, while questionnaire 1 additionally provided further focus for the design and content of the second, post-IHSAB survey questionnaire. Finally, the interview guide for the semi-structured interviews was derived from both the conceptual framework and the results from the preceding research methods.

Figure 5.5 - Overview of the linkages between the Literature Review, Conceptual Framework, Research Methods and Data Analysis



Finally, adopting a combined methods approach also facilitates triangulation (Jick 1979;Stake 1994;Adler & Adler 1994;Yin 2003b;Cresswell & Plano Clark 2007), which Stake (1994) defines as *"... a process of using multiple perceptions to clarify meaning, verifying the repeatability of an observation or interpretation. But, acknowledging that no observations or interpretations are perfectly repeatable, triangulation serves also to clarify meaning by identifying different ways the phenomena is being seen"* (p.241). Jick (1979), Barbour (1999) and Onwuegbuzie & Leech (2005) suggest that triangulation emphasises the complimentary, rather than the competing, nature of quantitative and qualitative methodologies, is instrumental in cancelling out the relative strengths and weaknesses of various methods and finally, contributes to greater reliability and validity in the methodological approach.

The following sections aim to provide a detailed treatment of the primary research methods employed during this study. Issues addressed include method design; data management (i.e. *"…the coherent process of data collection; storage and retrieval"* (Huberman & Miles 1994 p.428)); validity; reliability; sampling and data analysis.

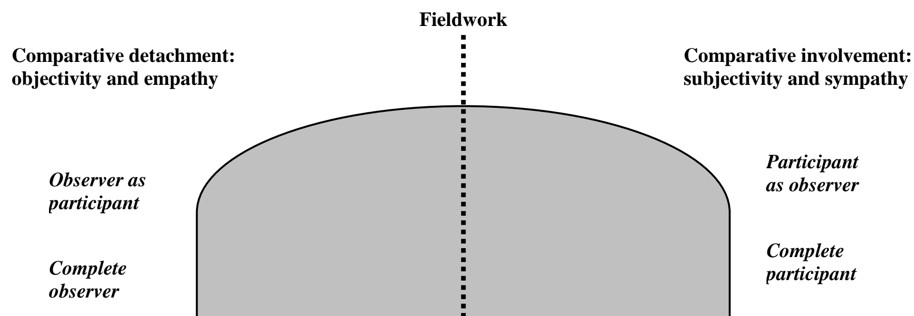
5.5.3 Non-Participant Observation

Observational methods are founded on the detailed observation of talk and behaviour and rely on watching and the subsequent recording of this (Mays & Pope 1995;Mason 1996;Silverman 2001;Easterby-Smith, Thorpe, & Lowe 2002). Adler & Adler (1994) and Gummesson (2007) note, that as a method, it is under-utilised in the management field and hence the scope to directly explore personal experiences are sacrificed and also the opportunity to overcome any differences between what research respondents say and what they actually do (Zikmund 2000;Bryman 2004). For Mays & Pope (1995) this is particularly useful as observation may serve to *"…circumvent the biases inherent in the accounts people give of their actions caused by factors such as the wish to present themselves in a good light, differences in recall, selectivity, and the influence of the roles they occupy"* (p.183). Moreover, Pope & Mays (2006) argue that observation represents a useful research method for the everyday study of professionals in a healthcare context, while Pope, van Royen, & Baker (2002) note that it is also particularly appropriate for examining quality issues in healthcare, as it allows researchers to uncover actual behaviour. Furthermore, the earlier insights offered by Grol & Jones (2000), who in recognising the relevance of managing change to the implementation process in a healthcare context, note that *"… observational studies are often valuable in identifying problems in creating change"* (p.32).

In relation to case study research, Yin (2003b) notes *"By making a field visit to the case study 'site' you are creating the opportunity for direct observations…some relevant behaviours or environmental conditions will be available for observation"* (p.92). This view concurs with that of Adler & Adler (1994), Mason (1996) and Silverman (2001) who acknowledge the potential of observational methods to extract data about social processes in a *"…naturally occurring context"* (Silverman 2001 p.14).

In conducting studies that have an observational element to them, the researcher may have a variety of avenues open to them in terms of their role. Figure 5.6 depicts a range of possibilities and the final selection is determined by a number of factors, including the nature and purpose of the research itself; the research setting; access and any existing relationship and role that the researcher may already have at the research site (for example, if they are already an employee) (Foster 1996).

Figure 5.6 - Researcher Roles in Observational Research



Source: Foster, P. 1996, "Observational Research," in *Data Collection and Analysis*, R. Sapsford & V. Jupp, eds., Open University Press, p.73

In this research, as the author was not employed at the research site nor within the wider health services structure, the role assumed was one of observer, with no level of participation in the actual accreditation process or the supporting team meetings. In this respect, the objective of the author, as a non-participant, was to be what Robson (2002) describes as a *"…pure observer, seeking to be an unnoticed part of the wallpaper"* (p.313) who *"...watches and listens to (a) what others do, (b) what they say, and (c) the circumstances in which these actions and comments occur"* (Lee 1999 p.99). This encapsulates one of the key features of many observations - that of non-interventionalism, where the researcher seeks neither to stimulate or manipulate subjects or respondents (Adler & Adler 1994).

Central to conducting observational research are the issues of *"…informed consent"* (Mulhall 2003 p.309) from subjects and ethical behaviour, on the part of the researcher (Adler & Adler 1994;Yates 2004;Jones & Somekh 2005;Goodwin 2006)

and over the course of the study, a key priority for the author was to ensure, on an on-going basis, that their role was not misrepresented. As previously outlined, both the 'gatekeeper' and the two Accreditation Managers were instrumental in communicating the role and function of the author, as an observer, to team members over the course of the first phase of the accreditation process and, in turn, provided the opportunity for individual team members to furnish any objections to the exercise.

Observational methods may vary in terms of the level of structure applied (Dey 1993;Robson 2002;Pope & Mays 2006). Unstructured and informal observations provide the observer with freedom to decide what information is gathered and also as to how this should be recorded (Foster 1996;Jones & Somekh 2005). Conversely, structured or systematic observation (Robson 2002;Bryman 2004;Jones & Somekh 2005) approaches data collection with a set of explicitly developed rules for conducting the process, supported by the utilisation of an observation schedule which is the research instrument (Saunders, Lewis, & Thornhill 2003). However, Foster (1996) and Punch (1998) note that the distinction between the use of unstructured observation and structured observation may be somewhat artificial when it comes to practice. They suggest that in the very early stages of many studies, observations may have less structure and this may serve to develop more precision around the themes and sub-categories of subsequent observations.

In relation to this research, and as a reflection of the pragmatic methodological position outlined earlier, a combination of the two approaches was adopted where the observation schedule (Appendix B) exhibits a degree of structure but also incorporates flexibility in the data recording process and attempts to support the pursuit of the overall research question and objectives themselves (Robson 2002;Bryman 2004). The construction of an observation schedule around *"…theoretically saturated"* (Silverman 2006 p.92) themes supports the process of capturing incidents or events and attempts to ensure consistency, while facilitating subsequent analysis (Adler & Adler 1994;Mason 1996;Silverman 2006). The author also embraced the advice of Foster (1996) and Punch (1998), so that in the first two meetings for each team observed, a less structured approach was adopted and recorded data only under the general headings outlined in the conceptual framework.

As a result of this, a more detailed schedule was developed and utilised in subsequent meeting observations.

In developing a supporting coding system within the observation schedule to record and hence reflect themes and sub-themes as they occurred, Robson (2002) suggests that this should be mutually exclusive, with single categories for each incident coded, where possible, and that the system itself should be easy to use. In terms of the unit to be coded, this will be determined by time or an event (Foster 1996;Robson 2002). In the former case, an interval of time is coded, and records what is happening at that time, while in the latter, observers record an event only when it occurs. With event coding, not only the event but also the frequency of the event may be noted (Foster 1996). This, in turn, may allow for the aggregation of that data with reference to each type of behaviour or incident that was originally recorded (Bryman 2004) and in aggregating data, there is scope for quantification, which Sandelowski (2001) argues is integral to research which has a qualitative orientation.

The more quantitatively orientated observational data may also be accompanied by field notes (detailed descriptions of what has been observed (Marshall 1999)), which was the approach taken in this study. Mason (1996) and Pope & Mays (2006) posit that this descriptive data may encompass both descriptions (the physical environment, people and actions) and the dialogue of what was said and, in turn, provide complementary and enriched research data (Sandelowski 2001;Mulhall 2003). As Sandelowski (2001) comments *"The meaning qualitative researchers seek depends, in part, on number, just as number depends on meaning"* (p.231) and is also particularly suitable to mixed method studies, such as this one.

Appendix B contains the event driven observation schedule and integrated coding system. This reflects the themes and sub-themes of what was observed during this research, and is based on the conceptual framework for the study, as outlined in Chapter 4. Using the schedule, the author waited for an event to occur and coded the type of event based on the themes laid out within the schedule. This additionally facilitated capturing the frequency of the event within the accreditation team meeting. The schedule also facilitated the noting of descriptive material and incorporated a final generic section to cover other comments on the observation of

the team meeting. Each event was coded as either an occurrence of the incidence of an event in a positive sense (for example, evidence of one of the two Accreditation Managers motivating the team or committing to resolve resource issues in relation to the accreditation processes) by using the "+" notation or by using "-" for when the event was negative - e.g. where individual team members attended meetings without having completed accreditation tasks. In relation to the subcategories covering levels of attendance, the cancellation of meetings and meetings starting more than ten minutes late, the "+" notation was used to indicate that this had occurred. Finally, frequencies of incidents greater than 1, were expressed in brackets alongside the "+" and "-" notations.

5.5.3.1 Validity and Reliability

Gummesson (2007) acknowledges that there are a number of variants to validity but also argues that the central issue is *"... does the research properly capture the critical aspects of the phenomenon we want to understand?"* (p.132). While accepting this argument, where observation that has some degree of structure is deployed, Bryman (2004) suggests that two strands to validity should be satisfied. In the first instance, issues of validity are concerned with as to whether *"…the measure reflects the concept is has been designed to measure"* (Bryman 2004 p.174). Here two facets of validity may have relevance for observational research. Face validity - if the measure reflects in terms of content, the concept under review, which may be established by those with familiarly and expertise in the area, reviewing the instrument (Foster 1996;Bryman 2004;Marks 2004). In this research exercise, the observation schedule, as the research instrument, was examined by another researcher in the area of quality management, who was familiar with observational techniques. They confirmed that the instrument had face validity. Moreover, convergent validity may be established by utilising different methods to compare the same concept (Foster 1996;Zikmund 2000;Robson 2002). In this research, the use of questionnaires and semi-structured interviews, in addition to observational data, serves to achieve this.

Secondly, the extent to which error may have occurred in the use of the observational schedule may also pose a threat to validity - is it being used as it was intended? Bryman (2004) suggests that this can be a particular problem where multiple

observers are used and where they may lack a complete understanding of the instrument and its use. In this study, as the author had both developed and also became the sole user of the observation schedule, this threat was negated. Moreover, the possibility that subjects may change their behaviour by virtue of the fact that they are being observed, may also pose a risk to validity (Foster 1996;Bryman 2004). Despite non-participant observation seeking to achieve a neutral researcher position or as Robson (2002) describes it *"…habituation"* (p.328), King (2004) and Jones & Somekh (2005) argue that this may be difficult to achieve as subjects may interpret and respond to the researcher in some way. Adler & Adler (1994) describe this as *"…observer effects"* (p.382), while Bryman (2004) suggests that this is *"…the reactive effect"* (p.174) and argues that instead of typical data being collected, what arises may, in fact, be atypical (Bryman 2004). In order to minimise the reactivity of subjects (individual team members) to the observation process in this study, the author took a number of measures including consistently arriving at the meeting room before the team themselves; sitting in the same seat, positioned in a corner, with minimal bodily movements; avoiding eye contact; discrete note taking; not engaging in, or contributing to, any discussions during the course of the meeting and only leaving the room after every member of the team had departed.

Adler & Adler (1994) and Saunders, Lewis, & Thornhill (2003) note that there are other challenges to the validity of observational research. As the method relies on the perceptions of the observer themselves, the data generated reflects a subjective interpretation of the situation. As Foster (1996) comments *"…observations are inevitably filtered though the interpretive lens of the observer"* (p.59). However, Adler & Adler (1994) do suggest that quotes from subjects may serve to both confirm and enrich observational data and this research has incorporated this approach. Zikmund (2000) also highlights the risk posed by observer bias to the observation process, resulting from distorted measurement based on the cognitive behaviour or actions of the observer. The quality of observation may be influenced by the observer's memory; the speed of their note taking; the pace of the event that is being observed and environmental factors that may influence how much detail is actually recorded. Additionally, there are likely to be numerous interpretations of non-verbal behaviour. In relation to this research, the author was cognisant of these

risks and attempted to both alert and responsive to the content and characteristics of the observational environment.

Bryman (2004) addresses two issues relating to reliability in conducting observational research. In the first instance, he tackles the issue of consistency or lack thereof, between different observers that may threaten the rigour of a research exercise. In this study, this problem did not emerge as the author represented the sole observer of accreditation team meetings. Secondly, and of relevance to this study, Bryman (2004) deals with *"…intra-observer consistency"* (p.173) - i.e. the consistent application of the observation schedule for the duration of the research exercise (in this instance, fourteen months), which he, and Foster (1996), note may be difficult to achieve given the ability of people, including researchers, to behave differently over time. This view is also supported by Robson (2002) who describes this as *"…observer drift"* (p.343) and suggests that this may be overcome by the observer periodically returning to the original guidelines for using the instrument. Being mindful of this, the author sought to remain vigilant in attempting to exercise the uniform use of the observation schedule and was mindful that problems such as fatigue and lapses of attention (Foster 1996), might compromise reliability.

5.5.3.2 Sampling

Central to both the conduct of the observational element of this study and also to the other research methods deployed, are the notions of the target population, the sampling frame and sampling within this (Robson 2002). For Bryman (2004), the population is simply *"The universe of units from which the sample is to be selected"* (p.87), while the sampling frame is the list of all units within the population from which the sample is drawn (Zikmund 2000;Bryman 2004). Finally, the sample itself is the section of the population which will be subject to investigation during the research (Zikmund 2000;Bryman 2004). Addressing the first two issues in relation to this research, the population for the observational research was made up of the two hundred and four individual team members, organised into ten accreditation teams, while the sampling frame is represented in the list of team members, their associated team and their schedule of team meetings, during which the observations took place.

Foster (1996) notes that is difficult for the researcher to observe every subject and event and with this in mind, advocates that a sample should be selected on which to base both analysis and conclusions. The strategy adopted in this research is one of a non-probability convenience sample. In terms of non-probability, this approach lacks the grounding in the canons of probability sampling, where each unit in the population has an equal change of being selected. Instead the researcher (taking a convenience approach), samples on the basis of what is accessible to them, which Robson (2002) observes is a common approach in studies taking place in organisations. The convenience element for this research lies in the availability, and hence accessibility, of the author to conduct observations on Monday and Tuesday afternoons. While adopting this approach, efforts were also made to ensure that the sample was representative of the population itself (Mays & Pope 1995;Robson 2002;Bryman 2004). The author sought to observe individual team members, as they convened in their team meetings, on these days and this amounted to being present at the bi-weekly meetings of three clinical services teams and two support services teams, representing 50% of each categorisation. This further translated into potentially having the opportunity to observe 47.7% of clinical services and 47.3% of support services team members (see table 5.8).

As previously alluded to, the observational data collected arose from attendance at team meetings over the course of a fourteen-month period (April 2004-May 2005), which represented the team meeting element of the first phase of the accreditation process. These meetings were held, and hence observed, in a dedicated accreditation meeting room at the research site. The exception to this was one meeting of a clinical services team that took place in a ward meeting room, in an attempt to increase the level of attendance at the meeting. Each meeting was timetabled to last for one hour thirty minutes, although some of the meetings started late and finished early. In addition, for one (Team 7), arising from meetings missed due to Bank Holidays, some meetings were scheduled for three hours. All planned meetings that the author was made aware of were attended, with the exception of those between the 28th June 2004 and 9th July 2004 and 20th September 2004 to 27th September 2004. The team demographics and total number of observations conducted, is represented in table 5.8.

Table 5.8 - Summary of Team Demographics and Team Observations

Team Number	Team Type	Number of Members	Total Number of Members	Number of Team Meetings Observed	Total Number of Meetings Observed
Team 1	**Clinical**	**21**		18	
Team 2	**Clinical**	**19**		17	
Team 3	**Clinical**	**22**		21	56
Team 4	Clinical	24			
Team 5	Clinical	20			
Team 6	Clinical	24	130		
Team 7	**Support**	**21**		15	
Team 8	**Support**	**14**		18	33
Team 9	Support	20			
Team 10	Support	19	74		
Total			204		89

5.5.3.3 Data Analysis

Kelley et al (2003) argue that the function of analysis is to *"…summarize data so it is easily understood and provides the answers to our original questions"* (p.265), through the process of careful examination. Much of the data from the observational research in this study lent itself to quantification, which is an exercise according to Barbour (1999) and Sandelowski (2001) that has merit and has been previously been recognised. Central to this is the scope for patterns to surface through*"…quantitative translation"* (Sandelowski 2001 p.231) and this may enable the creation of descriptive quantitative data. Analysing and then displaying data numerically, may facilitate issues to *"…emerge with greater clarity"* (Dey 1993 p.198) and may generate an increased focus on a key finding.

The quantification of observational data also contributes to ensuring that the researcher does not over-represent or under-represent data in their accounts or, in turn, smooth or average this out, with the result of *"…cleaning up the contradictions and messiness of human accounts and lives"* (Sandelowski 2001 p.234). Based on both the overall themes outlined within the conceptual framework and the structure of the observational schedule, the data was analysed using Microsoft Excel by means of the template, as outlined in Appendix B. Data based on percentages and frequencies were generated and reflect the recommendations of Sandelowski (2001), and are confirmed in the practices evidenced in the recent observational studies of Lierbach (2005) and Parkes & Thomas (2007). Adopting the guidance offered by Dey (1993) and Sandelowski (2001), the author attempted not to *"…overload"* (Dey 1993 p.198) through the analysis process, the subsequent presentation of data. With

this mind, much of the data was tabulated based on the themes and sub-themes that exhibited high levels of incidence over the observational period, while those that displayed lower frequencies are examined in the main body of text.

The qualitative data arising from the observations took the form of field notes (*"…detailed, highly descriptive accounts of what was observed, a chronology of events, and a description of the people involved, and their talk and behaviour"* (Pope & Mays 2006 p.37)), which also incorporated direct quotes from subjects. The use of quotes in the analysis and reporting of results from any research method (including observational research) is advocated by Sandelowski (1994b) as being instrumental in adding to *"…both the documentary and aesthetic value of a research report and, thereby, draw[ing] more attention to the voices of people who might otherwise have remained unheard"* (p.480). Moreover, quotes from respondents may serve to provide evidence of a specific issue and a concrete illustration of feelings, experiences and thoughts (Sandelowski 1994b). Recognising the value of this, the author has sought to preserve and subsequently present direct quotations from both the observational element and other methods deployed within this study.

Strauss & Corbin (1998) stress that the purpose of qualitative analysis is to examine not only the actual events and accounts of respondents or those generated through observations but also the interpretations of those events, on the part of the researcher. The pragmatic methodological position taken in this study also extends to the analysis of qualitative data. At either end of the methodological continuum, the themes, sub-themes and resulting categories and codes, which ultimately provide the structure to the analysis, are either identified at the commencement (*a priori*), taking a deductive approach or gradually, in an inductive vein, based on the researcher's interpretative and intuitive abilities. Marshall (1999) offers a useful illustration of this continuum, as depicted in figure 5.7, which also suggests that a combined qualitative analytical strategy may be deployed, based on predetermined themes and categories, but also accepting that these may be subject to revision as the analytical process progresses (Marshall 1999). This position is also reinforced by Pope, Ziebland, & Mays (2006) who note that *"In practice, many researchers find that they move between induction and deduction in the same analysis"* (p.67) and by Dey (1993) who argues that:

"…in social research, the dividing line between formulating and testing theories is barely discernable…It is difficult to separate the process of discovering theory from the process of evaluating it. Much of the task of qualitative analysis is not just to develop conceptualizations but to examine their adequacy in the light of the data" (p.52).

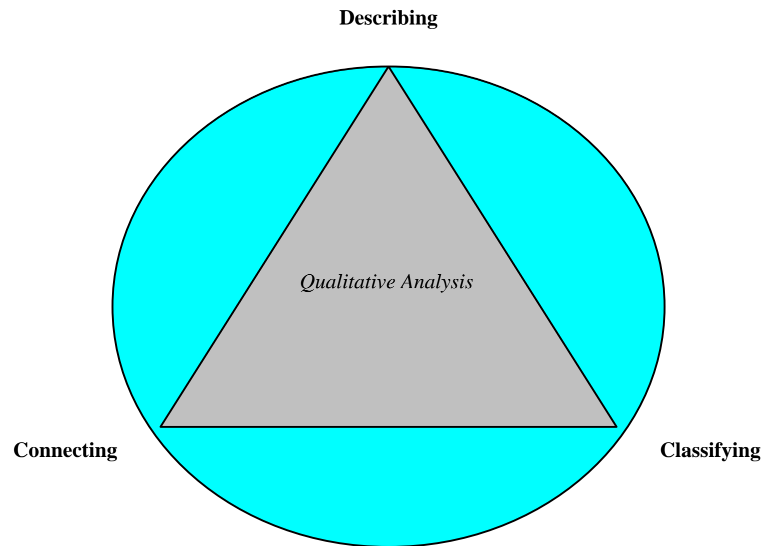
Figure 5.7 - A Continuum of Analysis Strategies

Source: Adapted from Marshall, C. 1999, *Designing Qualitative Research*, 3rd edn, Sage, p.151

In relation to this research, elements of both a deductive and inductive approach are in evidence and reflect the combined analytical style advocated by Marshall (1999). The conceptual framework derived from the literature review provided the initial set of overarching themes on which to develop categories, while the on-going analysis provides the flexibility for additional themes and sub-themes to emerge.

Miles (1994) and Marshall (1999) note that a range of analytic strategies are available to the researcher and in terms of progressing this research, the author adopted Dey's (1993) suggestion of viewing qualitative data analysis as a circular process. For Dey (1993) *"The core of qualitative analysis lies in the related processes of describing phenomena, classifying it, and seeing how our concepts interconnect"* (p.30) and this process is outlined in figure 5.8, where the on-going and iterative nature of analysis is depicted.

Figure 5.8 - The Circular Process of Qualitative Data Analysis



Source: Dey, I. 1993, *Qualitative Data Analysis* Routledge, p.31

The starting point for qualitative data analysis is the generation of comprehensive and in-depth descriptions of the phenomena which are the focus of the research (Dey 1993) and, in turn, manifest in *"…thick description"* (Geertz 1973 p.6) or *"…thorough descriptions"* (Dey 1993 p.31). Description at this level may embody context, the intentions of those who may be the focus of the research and the process in which their actions may be embedded, and thus serves as a foundation for interpreting and any subsequent explanation of social actions (Dey 1993). As such, these may be worthy of closer examination:

(i) Context. Dey (1993) advocates that description should incorporate context as it is instrumental in situating the actions of those who may be the subjects of the research exercise in a wider social and organisational domain;

(ii) Intentions. For Dey (1993), this relates to how the subjects of a study *"…perceive and define situations, including their own intentions, according to their own understanding of their motivations, and of the contexts in which they act"* (p.36) and how these, in turn, may be

confirmed or contradicted by the researcher's own interpretation and other data sources. As such, these should be reflected in description;

(iii) Process. Dey (1993) suggests that process is *"…bound up with the idea of change, and the circumstances, conditions, actions and mechanisms through which change comes about"* (p.38). Hence description should include any changes and developments in the events, which may be central to a study.

In relation to this study, the author has sought to incorporate the foregoing into the development of the 'thick' description of the qualitative data arising from not only the observational research, but also the other methods adopted in the course of this research.

Classification represents the second stage of the analysis of qualitative data, based on the approach advocated by Dey (1993), and involves the assessment of data and the subsequent assignment of this to a theme or category, in a process that Dey (1993) describes as *"…funnelling"* (p.42). Here data reduction takes place, which involves the condensing or shortening of text, which allows for progression to data aggregation, where *"…higher order headings"* (Graneheim & Lundman 2004 p.106) are arrived at, represented in categories and themes, with accompanying codes, which relate to and describe an aspect of an experience (Dey 1993;Miles & Huberman 1994;Onwuegbuzie & Leech 2005;Pope, Ziebland, & Mays 2006). This reflects a thematic analytical approach (Joffe & Yardley 2004), where a theme may relate to the manifest content of the data i.e. something that is directly mentioned or observable, or to content at the latent level, where something is implied. Thematic analysis is also particularly useful as it has the potential to embrace a pragmatic methodological approach and a combined analytical style, in that it allows for issues that are anticipated (for example, issues arising in the literature that are subsequently explored through primary research) and also those that emerge through the process of analysis (Pope, Ziebland, & Mays 2006;Grbich 2007). This has been the approach utilised during this study, where the relevant literature, the subsequent conceptual framework and the patterns within data itself, have provided the basis from which themes within the qualitative findings have surfaced.

Finally, the process of qualitative data analysis involves attempting to substantively connect the data based on its classifications and within this, to identify patterns, which may also lend themselves to some degree of quantification (Dey 1993;Pope, Ziebland, & Mays 2006;Silverman 2006;Grbich 2007). Here the overall objective is to arrive at an *"…account"* (Dey 1993 p.237), which integrates the relationships and concepts arising from the analytical exercise into a *"…coherent whole"* (Dey 1993 p.237) using text, tabulations and diagrams as appropriate. Overall, the process of qualitative data analysis was supported by the use of QSR NVivo, Version 7 software during this research and the author's reflections on this are contained in Appendix C.

5.5.4 Questionnaires

The second methodological pillar of the case study was the design and subsequent administration of two separate questionnaires, to each of the two hundred and four team members who, as already outlined, represent the units of analysis for this study. The intention here was to identify team members' experiences of accreditation at an interim point in the process itself and them immediately after the IHSAB survey, when the self-assessment stage had been completed and to explore the extent to which any developments had occurred. As with the observations, the author sought to reaffirm the informed consent for the questionnaires with both the 'gatekeeper' and the two Accreditation Managers, while team members were free to voice any concerns to either the author or those involved with managing the process.

Utilising questionnaires offered the potential opportunity to elicit the views of all members of all ten teams on their experiences of the accreditation process and impacts, as reflected in the research question and research objectives. Reflecting the pragmatic methodological position adopted in this research, the questionnaire method in this instance primarily provided the opportunity to collect and analyse data on the experiences of team members in an overall structured manner, based on both the themes depicted in the conceptual framework and supported by the underpinning literature and the data arising from the observational research.

The type of questionnaires employed in this research were self-completion or self-administered, as they are also known, which are characterised by the respondents

completing the questionnaire themselves (Zikmund 2000;McColl et al. 2001;Saunders, Lewis, & Thornhill 2003;Bryman 2004). This type of questionnaire offers a number of distinct advantages, in terms of being quick to administer, while still achieving coverage of the population; convenient for respondents who can complete the questionnaire at their leisure and the absence of problems such as interviewer or observer effects, which are associated with other research methods (Zikmund 2000;Robson 2002). However, these advantages are offset by problems around lack of opportunity to probe and prompt and also in relation to response rates (Punch 1998;Bryman 2004).

5.5.4.1 Questionnaire Design

The design of the questionnaire is fundamental to eliciting the required data from respondents, influencing the response rate and subsequently facilitating the analysis of data to provide good quality research results (Kelley et al. 2003;Bryman 2004). For Zikmund (2000) *"Relevance and accuracy are the two basic criteria to be met if the questionnaire is to achieve the researcher's purposes"* (p.309). In terms of this research, relevancy has been addressed (as already mentioned) through both the issues arising from the literature in the area, which underpins the conceptual framework and the results obtained from the observational research. These, in turn, served to inform the content of the questionnaires. Accuracy is achieved through the consideration of both validity and reliability and these are discussed in a later section.

In considering the facets of design, the initial cover to the questionnaire, outlining the purpose and instructions for completion, has the potential to influence the initial impression of the questionnaire and hence impact on the response rate (Oppenheim 1992;McColl et al. 2001;Saunders, Lewis, & Thornhill 2003). In relation to this study, both questionnaires (see Appendix D) included the logos for Waterford Institute of Technology and the health board (questionnaire 1), and the HSE (questionnaire 2), in order to reinforce the legitimacy of the research. The cover page also included the hospital name, the title of the process (IHSAB implementation) and whether the questionnaire related to the interim or phase 1 completion assessment of the accreditation process. The instructions for completion included the reiteration of the purpose and boundaries of the questionnaire and the confidentiality of responses

from the covering letter (discussed later), how to indicate a response to a particular question and finally, guidelines for return.

The main body of the questionnaires was built around a number of different question types and also based on a number of sections, which reflected basic respondent information, followed by questions framed based on the timelines and aspects of the accreditation process. This reflects the *"…funnel technique"* (Zikmund 2000 p.323), where the questionnaire captures the respondent's frame of reference prior to asking more focused questions about the key research issues. For example, in questionnaire 2, this was evidenced in the sequencing of the sections around 'you and your accreditation team'; 'looking back on the accreditation process'; 'awareness of the accreditation process' and 'looking ahead to phase 2 of the accreditation process'. In addition, each section included a brief description of the boundaries for the questions.

The initial section of each questionnaire included a number of nominal scales in a closed dichotomous and determinant choice question format, developed to collect personal factual data about respondents (Zikmund 2000;Bryman 2004). The final question was open-ended, which Robson (2002) suggests has merit in that it allows respondents to provide responses on issues that have not previously been addressed, the elaboration on previous issues contained in the questionnaire and a potential source of rich qualitative data. In this study, the final question sought to provide respondents with the opportunity to furnish additional comments on the accreditation process.

The remainder of the questionnaires were populated by closed, ordinal scale Likert items, which serve as a useful means of identifying respondents' feelings, opinions, views and beliefs on a range of issues (Oppenheim 1992;David & Sutton 2004). In this research, items were developed to reflect multiple facets of each theme, as depicted in the conceptual framework, but without the explicit intention of creating specific consistency between each. Each item took the form of a statement accompanied by a non-forced choice (Zikmund 2000;De Vaus 2002), five-point scale, which Robson (2002) and Bryman (2004) observe is a frequently used design format, incorporating strongly agree (1); agree (2); uncertain (3); disagree (4) and

strongly disagree (5). Using Likert items is particularly beneficial in that it allows the questionnaire to address multiple issues, while potentially reducing the time taken by the respondent to provide their views on these. Moreover, each statement may provide the respondent with clarity in relation to the question (Bryman 2004). All questions within the questionnaire were accompanied by a numerical code to facilitate subsequent data analysis (Oppenheim 1992;Saunders, Lewis, & Thornhill 2003), with the exception of the final open-ended question, which as Swift (1996) notes, requires structuring and coding at some subsequent point. Finally, the second questionnaire also included a request to the respondent to participate in a confidential interview to discuss their insights into the accreditation process. A section was provided for the individual to include their name and a contact phone number.

An additional feature of questionnaire design relates to the overall layout and physical appearance of the instrument itself. Zikmund (2000) and Bryman (2004) suggest that a cramped presentation has the potential reduce the response rate but also acknowledge that a more ‘bulky’ questionnaire may have the same effect. They suggest that efforts should be made to make the questionnaire appear attractive but also as short as possible, by reducing the margins and space between questions (but not so much that there is a risk of questions being omitted) and printing the questionnaire in a booklet format and incorporating questions on both sides of the page. In relation to this research, the author has sought to adhere to this advice. In particular, consideration was given to the most effective means of presenting the Likert items (thirty-five in questionnaire 1 and fifty in questionnaire 2) and, as such, a decision was taken to display these horizontally, in a table format, keeping questions and answers together, based on the advice of Bryman (2004), who observes that vertical presentation may take up too much space on a questionnaire.

Each questionnaire underwent testing in order to ensure that the instruments and the individual questions contained therein operated well (Robson 2002;Kelley et al. 2003). Taking a convenience approach (Zikmund 2000) and based on the resources and opportunities available to the author (Robson 2002), a total of six team members from across the five teams that were part of the observational research, were asked to review the initial questionnaire in terms of its ease of use; clarity of instructions; understanding of individual questions and overall appearance and to provide verbal

feedback to the author. This exercise was, in turn, repeated for the second questionnaire. Moreover, both questionnaires were evaluated by the 'gatekeeper' to the study, who also reviewed the accompanying covering letters from the author. Finally, the author themselves completed ten questionnaires with 'dummy' data, which was then analysed using the Statistical Package for Social Sciences (SPSS) Version 12 to ensure that the questionnaires lent themselves to meaningful analysis. Based on the aforementioned measures, minor adjustments were made to the questionnaires prior to administration. Appendix D contains the final versions of both questionnaires.

5.5.4.2 Validity and Reliability

The dual issues of validity and reliability have been previously addressed in relation to the study design and observational research. Likewise, they are central concerns in the utilisation of questionnaires. Recapping, validity focuses on whether a measure actually measures what is supposed to measure (Punch 1998;Zikmund 2000). Face validity was established by a review of the research instruments conducted by both another researcher in the field of quality management and by the Regional Quality and Accreditation Manager who acted as the 'gatekeeper' to the study. Moreover, convergent validity as alluded to earlier, may be established by utilising different methods to compare the same concept, such the use of non-participant observations and semi-structured interviews, as was the case in this study.

The ability of the questionnaire instruments to yield consistent results over time is manifested in their reliability and demonstrating this proved to be somewhat problematic in this research. As previously mentioned, the Likert items were not developed with the intention of establishing relationships between them in order to arrive at some overall measure or measures. However, the author did approach reliability in terms of the extent of internal consistency between the items (Saunders, Lewis, & Thornhill 2003;Bryman 2004;Clark-Carter & Marks 2004) which, in turn, served as a basis for providing direction to the grouping of items within the findings under specific themes and as reflected in the calculation of Cronbach's alpha (Saunders, Lewis, & Thornhill 2003). It should be noted however, that specific items fell naturally into groups. Appendix E contains the question groupings and accompanying Cronbach's alpha values, where appropriate. Reliability is generally

accepted to be achieved based on values of .7 or more (Black 1999;De Vaus 2002). For questionnaire 1, this was realised in three of the five groups on which the calculation was performed. In relation to the second and final questionnaire, reliability was achieved for six out of the eight question groups.

The extent to which the questionnaires might yield repeatable results to serve as an indication of reliability (Punch 1998;Clark-Carter & Marks 2004), was also considered by the author. Here the test-retest method involves administering the questionnaires on two separate occasions to the same respondents, in order to establish if the results are stable over time. Attempting to achieve this, proved challenging for the author. As previously outlined, the testing process was facilitated by a number of team members who provided valuable feedback on the questionnaires in terms of their appearance and the wording and clarity of the questions. When the author broached the possibility of the team members actually completing the questionnaires and then revisiting these two weeks later in a repeat exercise, an explicit lack of cooperation was voiced. Reasons included that the author would know who the respondents were and hence their answers, and also that they (the team members) could not guarantee that they would be at the next meeting and thus be able to complete the questionnaire again. With is in mind, and reflecting on the fact that in conducting the study, the author was effectively a 'guest' in the organisation, they reached an overall decision not to progress with any further attempts to satisfy the test-retest objective, being mindful that they risked being perceived as placing an unnecessary drain on the time of accreditation team members.

While acknowledging the limitations arising from the inability to confirm that stability of the questionnaires, some reassurance may be taken from the criticisms of the test-retest approach to establishing reliability. These include the suggestion that the initial measure may alert and sensitise respondents to their involvement within the research study, which, in turn, may affect the results derived from the second measure. Moreover, if the elapsed time between the two measures is long, there is some potential for responses to change, based on factors affecting the respondents themselves (Yates 2004;Bryman 2004;Marks 2004). Finally, a pragmatic Zikmund (2000) observes that *"…reliability is a necessary for validity, but a reliable*

instrument may not be valid….A reliable but invalid instrument will yield consistently inaccurate results" (p.281).

5.5.4.3 Sampling

Central to the use of the questionnaire method are the notions of the target population, the sampling frame and sampling within this, which have been addressed in a previous section. For both questionnaires, the target population was the body of team members (two hundred and four), as previously outlined in table 5.8, who made up the accreditation teams, while the sampling frame for this was the list of accreditation team members. In relation to sampling, as the entire population was surveyed using the questionnaire instruments, through a census approach (*"…the complete enumeration of all members of the population"* (Bryman 2004 p.87)), this issue did not arise.

5.5.4.4 Response Rates

Questionnaires such as those deployed in this research, which were largely administered through the internal mail system at the research site, run the risk of low response rates (Punch 1998;Zikmund 2000;Marks 2004). This is of significance as there may be an element of non-response bias arising from the possibility that those who do respond are different than those who do not, thus affecting the findings (Bryman 2004). In relation to this research, the issue of non-response bias is addressed in Chapter 6.

In seeking to maximise the potential response rate from both questionnaires used in this research, several measures where taken in terms of the design of the questionnaire itself and the supporting documentation and reflect the advice offered by Cooper & Schindler (1998), De Vaus (2002), Saunders, Lewis, & Thornhill (2003), Bryman (2004) and Puffer et al. (2004).

As previously discussed, the author attempted to incorporate the principles of good design into the actual questionnaires themselves in order to influence amongst other things, the overall response rate that might be achieved. In relation to the supporting documentation, the covering letter for each questionnaire aimed to communicate the nature of the research and its sponsorship by the research site and the wider health

service structure, the purpose of the questionnaire and the confidentiality attached to the replies. Additional information included an estimate of how long the instrument would take to complete; instructions and date for return and finally, an acknowledgment of appreciation for participation (see Appendix D). In order to further add to the legitimacy of the research, a copy of a covering letter from the Regional Quality and Accreditation Manager (the 'gatekeeper') was also attached on top of the author's covering letter and the questionnaire itself. This letter called on team members to participate in the research and emphasised the benefits of the findings to the overall accreditation process (Appendix D). The final enclosure to the documentation was the inclusion of a stamped addressed envelope for return of the completed questionnaire.

The first questionnaire was distributed to individual team members at each of the ten meetings that took place over the period 9th August to 20th August 2004. The identification of team members who had not been present, was facilitated by the Accreditation Administrator and the remaining questionnaires were sent in the internal mail at the research site, with a further covering letter explaining that the questionnaire had been circulated at the earlier team meeting (see Appendix D). The second questionnaire was sent to members in the internal mail on the day of the completion of the IHSAB survey visit (17th June 2005). Reminder letters were sent immediately after the passing of the return dates for each questionnaire and acknowledged, with appreciation, those respondents who had already returned the questionnaire and called on those who had not, to consider completing it within the following ten days (see Appendix D).

In terms of the adequacy of response rates, Bryman (2004) cites the following classification in terms of the acceptability of response rates, although acknowledges that in practice, many studies rarely achieve acceptable levels:

- Over 85%: excellent
- 70-85%: very good
- 60-70%: acceptable
- 50-60%: barely acceptable
- Below 50%: not acceptable.

In relation to this research, questionnaire 1, administered five months into the self-assessment process attained a response rate of 62.2%. The second questionnaire was deployed immediately post-IHSAB survey visit to the research site, and a response rate of 52.4% was achieved. A more detailed breakdown of these rates is presented in Chapter 6. Using the aforementioned ratings, the questionnaires achieved a response rate that was acceptable (questionnaire 1) and barely acceptable (questionnaire 2).

5.5.4.5 Data Analysis

With the exception of the comments contained in the open-ended questions, data from both questionnaires was entered into the statistical software package SPSS, based on the assigned codes. Where item non-response occurs, Zikmund (2000) advocates using a *"…plug value"* (p.419) to record missing values, an approach also endorsed by Swift (1996) and David & Sutton (2004). In this research, the author chose to record missing values using the numerical score '9'. The exception to this was the question relating to the percentage of team meetings attended, where missing data was coded as '11'. In addition, all returned questionnaires were deemed usable for analysis.

Basic descriptive statistics were generated from the initial questions on each questionnaire, transforming raw data into a format of frequencies and percentages, aiming to facilitate easy interpretation (Zikmund 2000). Some of this data further lent itself to the application of cross-tabulations (contingency tables), which are advocated by Conover (1980), Punch (1998) and Kumar (2005) as a useful mechanism for generating descriptive statistics, with more depth, and facilitates the detailed exploration of responses by different groups (Domegan & Fleming 2003;David & Sutton 2004).

In relation to analysing the Likert items, Zikmund (2000) observes that one possible analytical avenue might be to develop an index comprised of several items to form an overall scale, reflecting a common theme. In relation to this research, this has not been the objective and in particular, because it has the potential to conceal different and finer patterns of responses to specific items (Zikmund 2000). Instead, individual items were analysed using the comparison of means approach, which facilitates not only the calculation of the overall mean score for each item but also the mean scores

for predetermined groupings for each item (Remenyni et al. 1998;De Vaus 2002), in this case, based on team type and work role.

Non-parametric tests were adopted based on their underlying assumption that the data from the research is not drawn from a population with a normal distribution and hence tests of this kind are distribution free (Conover 1980;Hines & Montgomery 1990;Black 1999;Balnaves & Caputi 2001;David & Sutton 2004). Moreover, and of particular relevance to the types of scales utilised in the questionnaires deployed in this study, Zikmund (2000) argues that *"…the meaning of the phrase non-parametric test has been extended to include any test that uses nominal-scaled or ordinal-scaled data"* (p. 499). In relation to the cross-tabulations, the chi-square test was deployed to identify if differences between the variables were statistically significant, based on a probability of less than 5% (P-value < .005) (Conover 1980;Black 1999;Balnaves & Caputi 2001;De Vaus 2002). For the Likert items, two principle tests were employed. The Mann-Whitney test was utilised to compare the means of two groups (team type) and to establish if any statistically significant differences existed between these (Conover 1980;Hines & Montgomery 1990). Furthermore, the pursuance of the analysis of work role called for the use of the Kruskal-Wallis test, which allows for the comparison of three or more groups to ascertain if any statistically significant differences existed between these (Conover 1980;Hines & Montgomery 1990).

Finally, in relation to both the chi-square and Mann-Whitney tests relating to the analysis of the data based on team type, one-tailed tests were applied, which impose a specific direction to the alternative (research) hypothesis (Conover 1980;Bland & Altman 1994;Domegan & Fleming 2003;Clark-Carter & Marks 2004). David & Sutton (2004) advocate that for one-tailed tests to be used *"The researcher must have good evidence or theory to be confident of the direction that the test should be applied"* (p.315). In relation to this research, Chapter 4 has served to highlight that previous studies have indicated that those individuals working in clinical areas may be harder to convince of the merits of organisation-wide quality approaches, such as accreditation, than their support and administrative colleagues and that this may, in turn, influence both their involvement and personal evaluations of such activities. Moreover, much of the observational data that was collected in this study also supported this position (see Chapter 6). Based on this, and using team type as a proxy

for those in clinical versus support and administrative roles, the author decided to apply one-tailed tests to ascertain if statistically significant differences existed between the two groups, based on the alternative (research) hypothesis that clinical services team respondents were more negative in their views of the IHSAB accreditation process than their support services counterparts. The standard two-sided test was applied to the analysis based on work role, as this was represented by more than two groups (Bland & Altman 1994).

The responses to the open-ended question contained in both questionnaires, which asked respondents to comment on issues that they felt were working well within the accreditation process or to identify any changes they would like to see made, represented unstructured, qualitative data. Here data has not already been subject to categorisation and coding based on the researcher's analytical themes. (Boulton & Hammersley 1996). The data was prepared using verbatim transcription to provide a record of what was written and further supplemented with the necessary identifying headings required for analysis using NVivo software. As with the qualitative data from the observational research, and reflecting the pragmatic methodological position taken within this study, a degree of assignment was made as a basis for bringing structure to the data, grounded in the general themes outlined in the conceptual framework, while at the same time incorporating flexibility so as to allow for other themes and sub-themes to emerge during the analytical process.

5.5.5 Semi-Structured Interviews

The final phase of the primary research exercise incorporated the use of semi-structured interviews which have the potential to uncover and generate a detailed understanding of respondents' experiences relating to a particular research issue (Rubin & Rubin 1995;Dingwall 1997;Rapley 2004;Wilkinson, Joffe, & Yardley 2004). For Rapley (2004), semi-structured interviews provide the opportunity for *"…social encounters where speakers collaborate in producing retrospective (and prospective) accounts or versions of their past (or future) actions, experiences, feelings and thoughts"* (p.16). This is particularly relevant to this study and the interviewing phase within it, which was conducted post-completion of the self-assessment stage, where the aim was to capture the experiences of team members of accreditation in a retrospective mode. Moreover, interviews specifically offer the

prospect of exploring further, issues raised via other sources and, in turn, to verify and validate these (Lindlof & Taylor 2002;Denscombe 2003).

Like observational research, interviews differ in relation to the level of structure that may be applied (Fontana & Frey 1994;Punch 1998;Britten 2006). Structured interviews operate from a series of pre-defined questions posed to the respondent, combined with a set of pre-set response categories and are highly standardised and offer little or no room for variation (Fontana & Frey 1994;Kumar 2005). Unstructured interviews lie at the opposite end of the interview spectrum, where little or no *a priori* structure or question categorisation are formulated as this may constrain the scope of inquiry (Fontana & Frey 1994;Britten 2006). The intermediate position is occupied by interviews that are semi-structured in nature, which Pope, van Royen, & Baker (2002) describe as *"…typically based on a flexible topic guide that provides a loose structure of open-ended questions to explore experiences and attitudes"* (p.148).

Adopting a semi-structured approach with respondents provides some degree of flexibility in the interviewing process (Punch 1998;Zikmund 2000;Bryman 2004;Kumar 2005) as it allows for the researcher to explore issues that arise during the course of the interview, while still using the interview guide to both structure and drive the dialogue (Denscombe 2003;Silverman 2006). Moreover, Wilkinson, Joffe, & Yardley (2004) argue that as the approach utilises open-ended questions, this generates responses that reflect individual reaction to the research issues, as opposed to those arising from forced choices, in highly structured and predefined instruments. For Wilkinson, Joffe, & Yardley (2004), semi-structured interviews *"…have the ability to follow emotional rather than rational pathways of thought"* (p.42) with respondents, which may, in turn, add to the richness of the resulting data.

Being cognisant of these issues, the author chose to adopt the one-to-one semi-structured interview format, face-to face with respondents, based on the format's ability to reconcile both structure and flexibility, which further reflects the pragmatic methodological position discussed in earlier sections.

The interview guide (Lindlof & Taylor 2002;Rapley 2004;King 2004) containing groupings of questions based on themes, was informed by both the conceptual framework and the observational and questionnaire data (see figure 5.5) and offered the opportunity to explore specific issues relating to experiences of accreditation in more depth (Appendix F). Kumar (2005) advises that the interview questions themselves have the potential to operate well with respondents where they are open-ended, non-leading, sensitive, avoid unnecessary jargon and have clarity. They also suggest that in terms of sequence, the interview guide should commence with background, general and easy to answer questions, prior to moving on to more sensitive and challenging issues, an overall approach adopted by the author.

In terms of the practicalities of arranging, managing and conducting the interview process itself, the author followed the guidance offered by McCraken (1988), Fontana & Frey (1994), Easterby-Smith, Thorpe, & Lowe (2002), Denscombe (2003) and Rapley (2004) which, in turn, reflect the more recent suggestions of Britten (2006).

Twenty-eight accreditation team members (fourteen clinical services and fourteen support services) indicated in their completed post-IHSAB survey questionnaires that they were willing to discuss their experiences of the accreditation process and thus were deemed to represent knowledgeable informants (Rapley 2004). Based on the details provided, the author contacted each of them by phone in September and October 2005 to reconfirm their willingness to be interviewed and to arrange a time, date and location to meet between then and December 2005. These were, in turn, reiterated in a written confirmation to the interviewee, which also sought to reassure them of the confidential nature of the discussion and the maximum expected length of the interview. Sample correspondence is contained in Appendix F. All interviews took place either at the research site, interviewees' places of work or at WIT, to facilitate respondents.

In terms of preparing for the interview itself, the author arrived at least fifteen minutes before each interview in order to arrange the seating; to ensure that the necessary documents were laid out; the tape recorders tested and also to post a 'do not disturb' sign on the meeting room door. On arrival, the interviewee was

welcomed and thanked for facilitating the author, which, in turn, served to establish an initial rapport. The author recapped on the purpose of the interview and then proceeded to outline the function of the interview protocol, which McCraken (1988) advocates as a useful tool for explaining the rationale for an interview and also as a means of gaining informed consent (Fontana & Frey 1994). The protocol (Appendix F) covered a range of issues including reassuring the interviewee that their participation was voluntary and that they could withdraw from the process at any time. It also facilitated the author seeking permission for the interview to be recorded, to which all twenty-eight respondents consented. The entire protocol was read to the interviewee by the author and then each respondent was asked to sign this. In addition, every interviewee was given a copy to retain.

Adopting a semi-structured approach, the interview commenced with the author seeking to build further rapport with the interviewee, in order to both develop trust and ensure the credibility of both the interviewer and the research itself. The author sought to actively listen and pay attention for the duration of the interview which, in turn, facilitated the identification of opportunities for further probing of issues where appropriate, as offered by the semi-structured interview format. Moreover, they (the author) aimed to build an empathetic, non-judgemental interview atmosphere, which would allow the interviewee's feelings to come to the fore. In aiming to deliver on these objectives, the author drew upon her own personal competencies as an experienced selection interviewer in the Human Resource Management field.

In conducting the interview, the author was mindful of the respondent's time. While the confirmatory letter had indicated the interview would last a maximum of one hour, thirty minutes, the author sought to ensure the full accommodation of the interview questions within the guide and also incorporate scope for further probing, as appropriate. As such, interviews lasted from forty-five minutes to one hour, fifty minutes. At the end of each interview, the respondents were again thanked for their participation and time. A further follow-up letter reiterated this and also the confidential nature of their responses (Appendix F).

5.5.5.1 Validity and Reliability

While representing a somewhat less structured research method aimed at generating qualitative data, some consideration was given to issues of validity and reliability for the semi-structured interviews conducted during this research. In relation to the face validity of the interview guide, which reflected the general, but not exhaustive line, of questioning and discussion for the interview (Bryman 2004;Gillham 2005), this was reviewed by both the 'gatekeeper' and another academic with expertise in the field of quality management, who suggested minor changes, primarily based on wording and sequencing of questions. More specifically, Saunders, Lewis, & Thornhill (2003) also suggest that validity for the semi-structured interview - *"…the extent to which the researcher gains access to their participants' knowledge and experience, and is able to infer a meaning that the participant intended from the language that used by this person"* (p.253) - has the potential to be high where the interview itself is carefully conducted, which was the aim of the author at all times.

As standardisation is inherently lacking in semi-structured interviews, there is scope for concerns to arise in relation satisfying reliability in terms of achieving similar results via another researcher, and also in relation to the bias that may be brought to the process by the interviewer or the interviewee themselves (Saunders, Lewis, & Thornhill 2003;Gillham 2005;Sarantakos 2005). In relation to the former, Saunders, Lewis, & Thornhill (2003) suggest that results arising from the use of a non-standardised instrument are not necessarily intended to be repeatable, as they reflect the dynamic and complex reality of the situation at the point at which the interview was conducted. As such, establishing reliability of this type is not feasible, although they do favour that a full documentary trail be kept that might be referred to by other researchers who may seek to use a similar approach (Saunders, Lewis, & Thornhill 2003;Sarantakos 2005), as was adopted in this study.

The extent to which bias is introduced into the interview process may also present a threat to the reliability of the semi-structured interview (Saunders, Lewis, & Thornhill 2003;Sarantakos 2005). In relation to any bias arising from the behaviour and conduct of the interviewer (the author) which, in turn, might influence the interviewee and their responses, resulting in potential interviewee (response) bias, the careful preparation for, and management of, the interview itself as discussed

previously, in addition to the author seeking to present themselves in a professional and credible manner, sought to negate this risk.

5.5.5.2 Sampling

O'Cathain & Thomas (2006) identify one of the benefits of using a mixed research design is that links between methods may be built into the research design. As they comment *"A survey may identify a sample for in-depth interview. Here the link is that the analysis of one method produces a sampling frame for the other method that would otherwise be unavailable or difficult to obtain."* (p.107). This recent observation confirms the practice adopted in this research, as questionnaire 2 requested respondents to participate in a confidential interview on the accreditation process. Only those who responded to the questionnaire were eligible to share their experiences in an interview with the author, thus constituting the population. From this, the sample of twenty-eight interviewees was created, based on the self-selection of respondents which, in turn, represented a convenience sample for the author (Bryman 2004;Kumar 2005).

5.5.5.3 Data Analysis

Verbatim transcription of the audio tapes followed the advice of Sandelowski (1994a), Pope, Ziebland, & Mays (2006) and Silverman (2006) incorporating any 'ums' and 'ers' that occurred in the responses to preserve the full content of what was said. The transcripts, in turn, became the raw data of the author (Henn, Weinstein, & Foard 2006). Being mindful of the sensitivity and confidentiality of the content of the interviews, the transcription itself was undertaken by another member of the Centre for Management Research in Healthcare and Health Economics, under the guidance of the author, thus ensuring that the recordings did not venture outside to a more public domain. Subsequent proofing of the transcripts against the original recording, is also advocated by Sandelowski (1994a) and Bryman (2004) and this approach was adopted by the author. The analysis of this qualitative data then proceeded using the previously described process advocated by Dey (1993), and supported by the use of NVivo software.

5.6 Ethical Issues governing the Research Process

Maintaining the highest ethical standards should be central to conducting research (Saunders, Lewis, & Thornhill 2003;Goodwin 2006). As Stake (1994) notes *"The value of the best research is not likely to outweigh injury to a person exposed... researchers are guests in the private spaces of the world. Their manners should be good and their code of ethics strict"* (p.244). At the same time, there is a need to be sensitive to the fact that case based research is likely to involve the exploration of respondents personal assessments and views of the phenomena within the study, which without the appropriate levels of both confidentiality and anonymity, present the risk of embarrassment, conflict and loss of standing (Stake 1994;De Vaus 2002;Bryman 2004). Based on this guidance, all documentation received by team members in advance of responding to either the questionnaires or acting as an interviewee, sought to emphasise both the anonymity and confidentiality of their participation.

Throughout the course of this study the author sought to conduct herself both ethically and professionally, being mindful that she would be party to sensitive information, particularly by virtue of attendance at accreditation team meetings. Finally, as a Chartered Fellow of the Chartered Institute of Personnel and Development, the author is bound by a professional code of conduct, central to which are the requirements to respect and uphold confidentially and to act in an ethical manner.

5.7 Conclusion

This chapter has sought to develop an appreciation of the theoretical and philosophical underpinnings associated with this research, which are anti-positivistic, nominalistic and are characterised by both determinism and voluntarism. The descriptive single case study research design has been rationalised in terms of its potential and relevance for undertaking research on quality implementation in a healthcare context. Issues such as the representativeness of the case, access to both the research site and the case itself and the individual team members who, as the units of analysis, are the focus of this study, have also been considered. The relative strength of the combined research methods approach and the individual methods,

which are the pillars of the research design, have also been addressed. Moreover, the methodological pluralism, which exists within the study, has been explored in relation to the extent that it may influence the process of data collection and analysis. Finally, the ethical issues relating to undertaking the study at the research site have been reflected upon. Having addressed the fundamental theoretical, philosophical and methodological considerations for this study, Chapter 6 progresses to presenting the findings arising from the primary research process itself.

Chapter 6: Findings

6.0 Introduction

In this chapter, the findings that have been arrived at from the three research methods deployed during the execution of this study on hospital accreditation - non-participant observations, questionnaires and semi-structured interviews - are presented. Reflecting the guidance offered by Sandelowski (2003) and Yin (2003b) on the reporting of descriptive case events over time, which is particularly relevant to this research, the findings are largely structured around the themes, as depicted in the conceptual framework and also address the results based on the sequence of research methods utilised over the course of the first phase of the accreditation process. Furthermore, in order to preserve the anonymity of both the research site and individual respondents, all identifying information has been removed.

6.1 Summary of Non-Participant Observation Activity, Questionnaire Response Rates and Interview Demographics

This section provides a summary of the activity and demographics relating to the non-participant observations, the response rates derived from the administration of the interim and post-IHSAB survey questionnaires and finally, the semi-structured interviews conducted during the course of this research. As a starting point, table 6.1 outlines the demographics of the accreditation teams at the research site, which comprised ten teams (six clinical services and four support services), with a total membership of two hundred and four.

Table 6.1 - Team Demographics

Team Number	Team Type	Number of Members	Total
Team 1	**Clinical**	**21**	
Team 2	**Clinical**	**19**	
Team 3	**Clinical**	**22**	
Team 4	Clinical	24	
Team 5	Clinical	20	
Team 6	Clinical	24	130
Team 7	**Support**	**21**	
Team 8	**Support**	**14**	
Team 9	Support	20	
Team 10	Support	19	74
Total			204

6.1.1 Non-Participant Observations

The total number of accreditation team meetings observed is summarised in table 6.2 and indicates that eighty-nine separate observations where conducted over the course of the self-assessment process (April 2004 to May 2005), with five of the ten teams. The number of meetings observed for Team 7 was the lowest. This was due mainly to meetings being scheduled on Mondays with the resulting impact that a number were missed, due to Bank Holidays. In order to progress the work of the team, several meetings were extended to three-hour sessions.

Table 6.2 - Summary of Number of Observations of Individual Teams

Team Number	Team Type	Number of Team Members	Number of Team Meetings Observed
Team 1	**Clinical**	21	18
Team 2	**Clinical**	19	17
Team 3	**Clinical**	22	21
Team 7	**Support**	21	15
Team 8	**Support**	14	18
Total		97	89

6.1.2 Questionnaires

The interim questionnaire, administered in August 2004 elicited an overall response rate of 62.2 %, while the second questionnaire achieved a somewhat lower response of 52.4%. Whilst Chapter 5 has sought to suggest that the response rates achieved were acceptable (questionnaire 1) and barely acceptable (questionnaire 2) (Bryman 2004), the level of response to the instruments declined by almost 10% from questionnaire 1 to questionnaire 2. There are a number of possible explanations for this. In relation to questionnaire 1, the author personally distributed the questionnaires to the team members at their meetings and, in doing, so was able to provide a brief explanation of the purpose of the exercise, in addition to that already contained in the covering letters. In 'personalising' the distribution, this may have impacted positively on the willingness to complete the questionnaire, as the respondents were able to identify the author individually.

The fall-off in the response rate to questionnaire 2 might be explained by the fact that the IHSAB survey had just been completed and that team members were, in turn, fatigued as a result of their efforts in preparing for the site visit and the accreditation

team interview. This might, therefore, have made them less inclined to take the time to complete and return the questionnaire. Team members may also have taken holidays immediately after the survey, as they had been requested not to do so in the lead up to the IHSAB visit. As a result, they may have missed both the initial return date and the extended return date, as outlined in the reminder letter. A further possible explanation for the decline in the response rate may be that it was completely administered via the internal mail system at the research site, without any personal contact from the author, which had been the case with the initial questionnaire. Finally, the post-IHSAB questionnaire represented the second such request for accreditation team members' views on the accreditation process and, as such, may have influenced their willingness to respond. The detailed response rates for questionnaires 1 and 2 are presented in tables 6.3, 6.4 and 6.5.

Table 6.3 - Team Role Response Rates: Questionnaires 1 & 2
(TM - Team Member, TL - Team Leader)

Questionnaire 1		Total Population (Combined Teams) Size	Number of Respondents	%	% Response Rate
Valid	TM	194	116	91.3	59.7
	TL	10	9	7.1	90.0
	Total	204	125	98.4	
Missing			2	1.6	
Total		204	127	100.0	62.2
Questionnaire 2		**Total Population (Combined Teams) Size**	**Number of Respondents**	**%**	**% Response Rate**
Valid	TM	194	98	91.6	50.5
	TL	10	9	8.4	90.0
Total		204	107	100.0	52.4

Table 6.4 summarises the response data based on team type for both questionnaires. In both instances, the response rate for the combined support services teams was higher than that achieved from those in the clinical services area.

Table 6.4 - Team Type Response Rates: Questionnaires 1 & 2
(CS - Clinical Services, SS - Support Services)

Questionnaire 1		**Total Population (Combined Teams) Size**	**Number of Respondents**	**%**	**% Response Rate**
Valid	CS	130	66	52.0	50.7
	SS	74	61	48.0	82.4
	Total				
Total		204	127	100.0	62.2
Questionnaire 2		**Total Population (Combined Teams) Size**	**Number of Respondents**	**%**	**% Response Rate**
Valid	CS	130	59	55.1	45.3
	SS	74	47	43.9	63.5
	Total	204	106	99.1	
Missing			1	.9	
Total			107	100.0	52.4

The summary response data for work roles is presented in table 6.5. Despite referring to the original team list, which provided some degree of detail as to the work role composition of the total team population, it was not possible to arrive at an accurate overall picture as to the absolute numbers in each work role. As such, this data is not presented. It is, however, worthwhile noting that some respondents, while identifying themselves as having a work role with a clinical orientation, were members of support services teams. This is reflected in the summary data from tables 6.4 and 6.5, where there were sixty-six and fifty-nine clinical services team respondents respectively to questionnaires 1 and 2, while the numbers who identified themselves as having clinical work roles was eighty-three for questionnaire 1 and sixty-eight for questionnaire 2. There was some limited evidence to be gained of the detail behind this data from examining the team list and what became apparent was that some managers from the clinical areas were members of support services teams. These included the Director of Nursing; Chief Pharmacist; Physiotherapy Manager; Director of Nurse Practice Development; Director of Public Health; Occupational Health Manager and the Radiology Manager.

Roles covered by the category ‘Other’ in both questionnaires were in the support services area, ranging from senior management through to those in the technical area. These included the General Manager; Deputy General Manager; Patient Services

Officer; Partnership Coordinator; Catering Officer; Management Accountant; Hospital Chaplin; Fire Officer; Librarian; Medical Physicist; Bed Manager; Medical Records Coordinator; Cleaning and Waste Manager and those who simply described themselves as being in clerical and administration roles.

Table 6.5 - Work Role Response Rates: Questionnaires 1 & 2
(AHP - Allied Health Professional, Con - Consultant, NCHD -Non Consultant Hospital Doctor)

Questionnaire 1		Number of Respondents	%	% Response Rate
Valid	Nurse	53	41.7	
	AHP	25	19.7	
	Con	4	3.1	
	NCHD	1	.8	
	Other	43	33.9	
	Total	126	99.2	
Missing		1	.8	
Total		127	100.0	62.2
Questionnaire 2		**Number of Respondents**	**%**	**% Response Rate**
Valid	Nurse	45	42.1	
	AHP	19	17.8	
	Con	3	2.8	
	NCHD	1	.9	
	Other	39	36.4	
Total		107	100.0	52.4

The response rates to the final open-ended question in each questionnaire are contained in table 6.6, which was consistently high over both questionnaires for those who responded.

Table 6.6 - Team Type Response Rates to Open-Ended Question: Questionnaires 1 & 2

Questionnaire 1		Total Population (Combined Teams) Size	Number of Respondents	Number of Respondents completing open-ended question	%
Valid	CS	130	66	58	87.9
	SS	74	61	46	75.4
Total		204	127	104	81.9
Questionnaire 2		**Total Population (Combined Teams) Size**	**Number of Respondents**	**Number of Respondents completing open-ended question**	**%**
Valid	CS	130	59	45	76.3
	SS	74	47	36	76.6
	Total	204	106		
Missing			1		
Total			107	81	75.7

As demonstrated in table 6.7, the majority of respondents were based at the research site. Reflecting the health board structure and its supporting regional role, eight respondents to the first questionnaire indicated that this was their work location. As the HSE had been established and the health board structure legally dissolved at the time questionnaire 2 was administered, three respondents specified that they were based at the HSE Regional Office, although it should be noted that this was still the same geographic location as the health board.

Table 6.7 - Work Location Response Rates: Questionnaires 1 & 2

Questionnaire 1		Number of Respondents	%	% Response Rate
Valid	XXXH	111	87.4	
	Health Board HQ	8	6.3	
	Other	7	5.5	
	Total	126	99.2	
Missing		1	.8	
Total		127	100.0	62.2
Questionnaire 2		**Number of Respondents**	**%**	**% Response Rate**
Valid	XXXH	95	88.8	
	HSE Regional Office	3	2.8	
	Other	7	6.5	
	Total	105	98.1	
		2	1.9	
Total		107	100.0	52.4

In relation to the quantitative questionnaire data, the results are primarily summarised based on team type and work role. This, in turn, will serve to identify any differences that may exist within these groups using the comparison of means approach, as outlined in Chapter 5 and as a vehicle for furthering a key research objective. Looking specifically at the results analysed based on work role, two of the five groups (Consultants and NCHDs) have very small frequencies and, as such, statistical significance will be mostly influenced by the other three dominant groups. As an example, the data demonstrate numerous instances where the responding Consultant group were clearly more negative in their assessment of the individual Likert items, but as this group was so small, in most of these cases statistical significance is not achieved.

A number of questions and resulting data from questionnaire 1 lent themselves to analysis using cross-tabulations (contingency tables), which was also addressed in Chapter 5. Some cells within these tables were characterised by very few entries. Conditions for the use of the Pearson Chi-Square test are not strictly met in these circumstances (the usual requirement for this being that each expected cell frequency should be five or more (Zikmund 2000;David & Sutton 2004)). With this in mind, the P-values may therefore not be accurate. Moreover, and as with the comparison of means, it is possible in such sparse tables to have clear differences apparent among different groups, yet not have a statistically significant result (Zikmund 2000).

Consideration is also given to the extent to which statistical differences may exist between those who did respond to the questionnaires and those who did not i.e. the potential for non-response error (Elliot 1991;Zikmund 2000). This may be explored by a comparison of the demographics of the target population with that of the respondents, although, as previously highlighted, this is only achievable in terms of team type. In relation to this research, for questionnaire 1, 82.4% of support services team members returned questionnaires in comparison to only 50.7% of members from clinical services teams. This difference was found to be statistically significant ($\chi^2 = 20.12$, df = 1, $p<.001$) and this implies that there is therefore a real possibility of non-response bias in the overall mean scores arising from the questionnaire. In most cases, and as reflected in the results, clinical respondents were more negative in

their views towards the questions and Likert items. Hence the overall mean scores may underestimate the actual mean score in the population i.e. the mean scores would actually be higher (exhibiting greater levels of disagreement). This pattern is also exhibited in questionnaire 2, where 63.5% of support services and 45.3% of clinical services team members responded, again with statistically significant differences arising (χ^2 = 6.21, df = 1, p =.013). In attempting to account for this, the overall mean scores for the Likert items on each questionnaire have been weighted to reflect this, as advised by Elliot (1991), and these are reflected in the tables displaying results based on team type.

6.1.3 Interviews

Table 6.8 provides a breakdown of the interview respondents based on team type. As outlined in Chapter 5, questionnaire 2 offered respondents the opportunity to participate in a confidential interview to explore their experiences of the accreditation process in more depth and, as such, the interviewees were drawn from those who actually returned the second questionnaire. Of these, fourteen clinical respondents and fourteen support services respondents indicated that they were willing to be interviewed and no statistically significant differences arose (χ^2=.231, df=1, p=.63) in terms of the response rate. An additional consideration is whether any response bias (Zikmund 2000) exists with those who indicated that they were willing to be interviewed i.e. that they were more positive or negative in their views than those that did not, in their responses to questionnaire 2. A non-parametric test (Mann-Whitney) confirmed that that no statistically significant differences existed between the two groups in relation to their responses to the items in questionnaire 2 and this is reflected in the P-values outlined in Appendix G.

Table 6.8 - Summary of Interview Respondents based on Team Type

Team Type	Number of Questionnaire 2 Respondents	Number of Interviewees and % of Questionnaire 2 Respondents
Clinical Services	59	14 (23.7)
Support Services	47	14 (28.8)
Total	106	
Missing	1	
Total	107	28

This section has aimed to present an analysis the level of activity surrounding the collection of the observational data, the detailed response rates for questionnaires 1 and 2 and a summary of interviewees based on team type, with due consideration being given to possible limitations within the data.

The following sections progress on to the examination the findings. As a reflection of both the conceptual framework for the study and the specific research objectives themselves, these are sequenced as follows:

- Background - Previous Involvement in Quality and Accreditation;
- Accreditation Implementation Process (leadership; communications; involvement and participation; training; teams; reward);
- Accreditation Impacts (individual and organisational);
- Respondent Explanations of Differences between Clinical Services and Support Services Findings

6.2 Background

Two questions were posed to team members through questionnaire 1, with the intention of eliciting background data for the research relating to the extent of respondents previous involvement with both quality initiatives in healthcare and more specifically, accreditation. This, in turn, may serve to provide an indication of the experience base from which team members were commencing the process. The summary results for this are outlined in table 6.9 and indicate that only 37% of respondents had had any prior involvement with quality initiatives, while this was substantially lower, at 18.1%, for healthcare accreditation.

Table 6.9 - Previous Involvement in Quality Initiatives and Accreditation in Healthcare: Questionnaire 1

Questionnaire 1 Item Have you had any previous involvement with quality initiatives in either XXXH or any other healthcare setting?		Number of Respondents	%
Valid	Yes	47	37.0
	No	80	63.0
Total		127	100.0
Questionnaire 1 Item Have you had any previous involvement with a healthcare accreditation process?		Number of Respondents	%
Valid	Yes	23	18.1
	No	103	81.1
	Total	126	99.2
Missing		1	.8
Total		127	100.0

Of those who indicated that they had some prior involvement with quality initiatives, these primarily related to their particular work area. Specific examples included reviewing the standards for diabetes care; implementing ISO 9000 in elderly care and also in a medical laboratory; applying to become a WHO baby friendly hospital; implementing HACCP for food handling; information leaflets audit; review and audit of cardiac rehabilitation services and setting up a quality steering group in a hospital. Those indicating previous involvement with healthcare accreditation outlined that this had been acquired in Ireland (in another hospital within the region; within the Dublin teaching hospitals and also in a private hospital context) and abroad - in the UK, Canada and Australia. Several respondents also specified that they had been involved with accreditation schemes such as ISO 9000 implementation in a medical laboratory and the WHO baby friendly hospital award.

A deeper examination of this involvement is presented in tables 6.10 and 6.11. Using a cross-tabulation based on team type, the results outlined in table 6.10 indicate that almost 43% of support services respondents had previous involvement with quality initiatives in a healthcare setting, as compared to only 31.8% of those responding from the clinical services teams, although this pattern was reversed for involvement with healthcare accreditation. Here, 19.7% of clinical services respondents answered ‘Yes’ to previous involvement, while only 16.7% responded in this vein from the support services group.

Table 6.10 - Cross-tabulation of Previous Involvement in Quality Initiatives and Accreditation in Healthcare based on Team Type: Questionnaire 1

Questionnaire 1 Item Have you had any previous involvement with quality initiatives in either XXXH or any other healthcare setting?	Team Type	Number of Respondents and % Yes	Number of Respondents and % No	Total Number of Respondents and %	P -Value
Valid	CS	21 (31.8)	45 (68.2)	66 (51.9)	.104
	SS	26 (42.6)	35 (57.4)	61 (48.1)	
		47 (37.0)	80 (63.0)	127 (100.0)	
Questionnaire 1 Item Have you had any previous involvement with a healthcare accreditation process?	Team Type	Number of Respondents and % Yes	Number of Respondents and % No	Total Number of Respondents and %	P-Value
Valid	CS	13 (19.7)	53 (80.3)	66 (52.4)	.330
	SS	10 (16.7)	50 (83.3)	60 (47.6)	
		23 (18.3)	103 (81.7)	126 (100.0)	

*Indicates statistical significance (1 tailed) at 5% level

In exploring the data in terms of work role and those groups that had previous experience of quality initiatives, AHPs and Nurses returned the lowest percentages across the five groups (28% and 37.7% respectively). However, in relation to confirming prior involvement with accreditation, the lowest percentages where achieved by the ‘Other’ group, with 16.7% and the Nurse group, with only 13.2%. For both questions, 50% of the responding Consultants indicated previous involvement.

Table 6.11 - Cross-tabulation of Previous Involvement in Quality Initiatives and Accreditation in Healthcare based on Work Role: Questionnaire 1

Questionnaire 1 Item Have you had any previous involvement with quality initiatives in either XXXH or any other healthcare setting?	Work Role	Number of Respondents and % Yes	Number of Respondents and % No	Total Number of Respondents and %	P -Value
Valid	Nurse	20 (37.7)	33 (62.3)	53 (42.1)	.702
	AHP	7 (28.0)	18 (72.0)	25 (19.8)	
	Con	2 (50.0)	2 (50.0)	4 (3.2)	
	NCHD	0	1 (100.0)	1 (.8)	
	Other	18 (41.9)	25 (58.1)	43 (34.1)	
		47 (37.3)	79 (62.7)	126 (100.0)	
Questionnaire 1 Item Have you had any previous involvement with a healthcare accreditation process?	Work Role	Number of Respondents and % Yes	Number of Respondents and % No	Total Number of Respondents and %	P-Value
Valid	Nurse	7 (13.2)	46 (86.8)	53 (42.4)	.244
	AHP	7 (28.0)	18 (72.0)	25 (20.0)	
	Con	2 (50.0)	2 (50.0)	4 (3.2)	
	NCHD	0	1 (100.0)	1 (.8)	
	Other	7 (16.7)	35 (83.3)	42 (33.6)	
		23 (18.4)	102 (81.6)	125 (100.0)	

†Indicates statistical significance (2 tailed) at 5% level

6.3 Accreditation Implementation Process

The following sections present the key findings under the six themes, as outlined in the conceptual framework, that relate to team members experiences of the accreditation implementation process.

6.3.1 Leadership

As a feature of the conceptual framework for this research, the area of leadership was addressed during the observations of the team meetings and also through the other research methods deployed. Over the course of the first phase of accreditation, there appeared to be positive evidence of this. In focusing on the observational data, the primary source for leadership for the process was with the two Accreditation Managers who each worked with five of the individual teams, providing leadership, support and facilitation to the meeting process and the overall project management of the first phase of accreditation. The observational data provided clear verification of this over the course of the fourteen months of the self-assessment stage. This was primarily centred on giving direction to the team on how to progress, motivating the

team and focusing on the plan and timelines for the implementation. These behaviours were often observed more than once in any given individual meeting. Table 6.12 summarises the data relating to this.

Table 6.12 - Summary of Key Leadership Observations

Team Number	Team Type	Number of Team Meetings Observed	Giving Direction (Frequency)	Motivating the Team (Frequency)	Focus on Plan and Timelines (Frequency)
Team 1	**Clinical**	18	21	12	15
Team 2	**Clinical**	17	19	10	20
Team 3	**Clinical**	21	17	8	23
Team 7	**Support**	15	8	7	17
Team 8	**Support**	18	16	8	16

Providing direction to the process featured heavily in terms of the leadership roles of the individual Accreditation Managers. This included clarifying how the accreditation process worked; the meaning of individual IHSAB standards and criteria; providing examples and guidance on evidence of compliance to support the standards and also on how to draft quality improvement plans. Likewise, there was evidence of both Accreditation Managers offering encouragement and seeking to motivate the teams and the individuals in them. This was apparent over the period of the observations and became particularly prevalent as the teams started to struggle, not only with completing the standards themselves, but also with the impact of low attendance rates at meetings (discussed later). On one occasion, this encouragement was encapsulated in the comment:

"Don't get blocked with the statistics and ratings. You are doing fine"(July 2004).

The Accreditation Managers also focused on the project plan for the self-assessment stage and frequently reminded the team of their progress against the timelines for the first phase of accreditation. Examples of this included prompting members to edit standards and also to collect evidence by certain dates, so that these could be collated and an overall indexing system developed, in advance of the IHSAB survey visit. Reflecting the difficulty all the teams experienced in completing the standards, this comprised both positive and negative assessment in terms of a team being on target

in progressing the process or, being behind target and having outstanding standards and related items still to complete.

To a lesser extent there was evidence of those leading accreditation, promoting the benefits of process and committing to resolve resource issues. In relation to the latter, this arose in terms of attempting to organise Internet access for some staff (primarily clinical), who had expressed a need for it in order to complete their IHSAB standards. This also took the form towards the end of the self-assessment stage of being asked by team members to contact regular non-attendees to ensure their participation at the IHSAB survey team interview.

This positive assessment of the leadership for the self-assessment stage of the accreditation process was also noted by a minority (three) of respondents to the open-ended question in questionnaire 1 and these acknowledged both the support from, and management of, the process by the Accreditation Managers:

"I feel the support from the facilitators is good and aims at moving forward" (CS).

"The management of the accreditation process seems to be working very well. XXX and YYY are very approachable and accessible" (SS).

Despite this, and arising from the same qualitative data, was also the suggestion that accreditation might require a dedicated and full-time role or roles to lead and manage the process going forward:

"I feel there should be a specific Accreditation Facilitator attached to the Hospital" (CS).

"I feel posts fully dedicated to managing accreditation should have been created by the health board" (CS).

"This is an important process with potential for major improvements in services, it deserves a dedicated team to provide the leadership and manage the day-to day operations of this huge exercise" (SS).

The results outlined in tables 6.13 and 6.14 arising from questionnaire 2, clearly support the data collected during the team meeting observations. The mean scores based on team type, indicate agreement with both statements relating to the sufficiency of leadership and the assessment of the management of the overall process, although the support services respondents were more positive in their views than their clinical services counterparts and these differences are statistically significant. This is also mirrored in the data based on work role, although the sole Consultant responding to the leadership item indicated that they were uncertain as to whether there had been sufficient leadership for the process. Again, statistically significant differences are achieved here.

Table 6.13 - Comparison of Means for Leadership based on Team Type: Questionnaire 2

Questionnaire 2 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score, Standard Deviation and Weighted Mean	Team Type	N	Mean Score and Standard Deviation	P-Value
There was sufficient leadership for the process	2.25 (1.109) 2.33	CS	57	2.67 (1.107)	.000*
		SS	46	1.74 (.880)	
The overall accreditation process was well managed	2.30 (.938) 2.36	CS	60	2.68 (.930)	.000*
		SS	46	1.80 (.687)	

*Indicates statistical significance (1 tailed) at 5% level

Table 6.14 - Comparison of Means for Leadership based on Work Role: Questionnaire 2

Questionnaire 2 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score and Standard Deviation	Work Role	N	Mean Score and Standard Deviation	P-Value
There was sufficient leadership for the process	2.25 (1.109)	Nurse	43	2.49 (1.077)	.001†
		AHP	19	2.63 (1.065)	
		Con	1	3.00	
		NCHD	1	2.00	
		Other	39	1.79 (1.056)	
The overall accreditation process was well managed	2.30 (.938)	Nurse	45	2.62 (.936)	.001†
		AHP	19	2.42 (.769)	
		Con	2	2.50 (.707)	
		NCHD	1	2.00	
		Other	39	1.87 (.894)	

†Indicates statistical significance (2 tailed) at 5% level

The comments included in the open-ended responses in questionnaire 2 gave further weight to the positive assessments made against the Likert items relating to team members experiences of the leadership and management of the accreditation process. While only five respondents (four from support services teams and one from a clinical services team) highlighted these issues in their remarks, there was a definite strength to some of the evaluations:

"The encouragement given by XXX and YYY was exceptional. Their leadership was without fault" (SS).

"I felt that XXX and YYY were great, very enthusiastic supportive and hardworking" (CS).

"I think the leadership for accreditation at XXX Hospital was excellent and I hope that phase 2 will be as positive" (SS).

"I feel that the work which XXX, as Accreditation Manager, put into the process provided good leadership and direction for the teams. The contributions XXX made

in the process and to our team made our roles clearer and allowed us to approach the Accreditation process with confidence" (SS).

At the same time, a less optimistic view of the leadership surrounding accreditation was also presented in the qualitative data from the second questionnaire, although again by only a few (three) respondents, and with a similar strength in their assessments:

"Need more education, guidance and leadership" (CS).

"Obvious need for dedicated overall leader and team to take charge of the process. Co-ordinate efforts of each team to ensure appropriate supports are available" (SS).

"I feel the accreditation process was not implemented well - the process is worthwhile but was lacking in leadership" (CS).

This mixed pattern of views on the leadership associated with the implementation of self-assessment was also borne out in the opinions expressed during the semi-structured interviews. Reflecting back on the self-assessment stage, on one hand respondents acknowledged the effort and commitment of the two Accreditation Managers who had both worked in the roles on a part-time basis, while still retaining many of the responsibilities of their senior management positions. On the other, there was recognition that there was scope for even greater leadership to be brought to the process. As one interviewee commented:

"I think a coordinator to actually take over the whole accreditation process was one area [absent] you know, I mean there should have been somebody just for accreditation and not just two people who also had their own jobs to do" (CS).

The scope for a dedicated management role(s) for the accreditation process to be created also emerged again in the qualitative questionnaire data, arising once the self-assessment stage had been completed. Five respondents identified that they felt this was a particular resourcing requirement that would bring further leadership to

accreditation at the research site and a cross-section of comments illustrate the forcefulness of their views:

"We need a full-time person dedicated to accreditation employed here" (CS).

"Obvious need for dedicated overall leader and team to take charge of the process. Co-ordinate efforts of each team to ensure appropriate supports are available" (SS).

"Management of the Accreditation administrative process in-house needs to be properly resourced. Otherwise both the accreditation process and the day to day management of the hospital will under achieve" (SS).

This issue was subsequently explored with interviewees in more depth and all twenty-eight respondents agreed that the establishment of a full-time and dedicated Quality and Accreditation Manager role at the research site, would be a positive development in terms of the on-going leadership of the process. Some of the benefits are encapsulated in the following comments:

"Personally I think that would be a good idea, I think if you have a central leadership, if they could give the overall picture, if you have somebody up there that has a clear picture of what's happening and can run it and is committed to it, yes, it would help" (SS).

"Yes I think it's essential I think there has to be somebody at the helm, because when you have that many people in a team sitting around a table the approach is going to take that many different opinions and there has to be one lead person and everybody has to be approaching it in the same format or it is pointless... I think it is essential"(CS).

Moreover, respondents identified other positive outcomes from the appointment of a dedicated leader for accreditation, including being able to identify and engage with key contributors throughout the hospital and at the regional level; being a single point of reference for team members; bringing focus, structure and coordination to

the process; following up required actions and finally, encouraging those participating in the process.

6.3.2 Communication

The role of communication within the accreditation implementation process was explored by all three research methods deployed in this study. Table 6.15 summarises the key findings on communication extracted from the observations of the team meetings. Exploring the extent of understanding within the team, created by the communications process, principally emerged as an issue in relation to difficulties experienced with grasping and comprehending the overall accreditation process, the IHSAB standards themselves and struggling with the language contained within them. This was particularly noticeable in the early meetings of the teams but was also prevalent over the course of the fourteen-month observational period. A number of remarks recorded during meetings reflect these difficulties:

"Some of the stuff [in the standards] is nebulous" (May 2004)

"I get the impression that this accreditation model is definitely a Beaumont Hospital type of thing. I can't see how it applies to us" (May 2004).

"People don't know what material is available" (April 2005).

"We're not sure what should be in a quality improvement plan and not sure what we have to do" (April 2005).

Table 6.15 - Summary of Key Communication Observations

Team Number	Team Type	Number of Team Meetings Observed	Understanding and Awareness of the Accreditation Process within the Team (Frequency)	Understanding and Awareness of the Accreditation Process across the Hospital (Frequency)	Feedback to Team on Progress with the Accreditation Process (Frequency)	Communication Methods and Media to Support the Accreditation Process (Frequency)
Team 1	**Clinical**	18	5	3	15	2
Team 2	**Clinical**	17	8	0	20	1
Team 3	**Clinical**	21	6	1	23	1
Team 7	**Support**	15	1	0	17	0
Team 8	**Support**	18	8	2	16	1

In relation to Team 7, the issue of understanding of the accreditation process within the team arose only once. This may be explained by the fact that the team was largely populated by a number of senior managers from both the hospital itself and also within the wider regional health service structure, and who might legitimately be expected to have had a deeper level of understanding of accreditation by virtue of this.

In terms of the views on the understanding and awareness of accreditation across the hospital, while the issue was broached on only a few occasions in the meetings, the sentiments of the discussions amongst members progressed in a particular vein i.e. that staff across the hospital were not aware of what was going on with the accreditation process. This was encapsulated in the following comments:

"Does everyone in the hospital know about accreditation? I'm not sure they do"(July 2004).

"I'm not convinced that people know what's going on and that there's an award involved" (November 2004).

"A lot of staff don't know what we're doing" (May 2005).

Feedback to the team and the individual members within it, on progress with the process was a frequent feature of meetings and was provided primarily by the two Accreditation Managers, each working with five of the teams. The content of this feedback mirrors that already presented in examination of leadership and focused on the project plan and timelines for the process. Feedback invariably took the form of summing up where the team was in relation to what was outstanding and how this compared to other teams. An example of this is reflected in the comment:

"There are still four standards left to complete. You're making good progress but there is still quite a lot left to do. Some of the other teams have completed their standards and are working on their quality improvement plans" (March 2005).

The communication methods and media used to support the accreditation process generated some discussion amongst team members during meetings, although primarily in the form of problems or deficiencies. For example, in Team 1 and Team 2, a number of members complained that on two occasions they had not received documentation to review in the internal mail prior to a scheduled meeting and that this had impeded the efficacy of the subsequent discussion. Likewise, the absence of certain communications media also surfaced at a meeting of Team 3:

"There should be a newsletter" (July 2004).

On a more positive note, at one meeting, one of the Accreditation Managers raised the fact that a new sign on the accreditation process was going up in the hospital foyer and that stands with information on accreditation would be placed in nurses and patient areas. However, this information was imparted in January 2005, some eleven months after the accreditation process had commenced at the research site.

The findings from questionnaires 1 and 2 and also from the semi-structured interviews largely reflect those arising from the observational research and, furthermore, present an extended examination of issues relating to communication within the context of the implementation of accreditation. In achieving this, the findings are presented under the three sub-themes of general understanding, awareness of the accreditation process outside of the teams and communications between team members and work colleagues, in relation to accreditation.

6.3.2.1 Communication: General Understanding

The first two items from questionnaire 1 in table 6.16, presents an analysis of the data based on team type and focuses on both the level of individual understanding of the process and the expectations associated with being a team member, prior to joining the team. The mean scores for both statements register disagreement i.e. that both clinical services and support services respondents a lacked sufficient understanding, while the level of disagreement is stronger for the clinical services group. In addition for the second item, the differences between the two groups are statistically significant. The extent to which the communications sessions that had

taken place across the hospital, prior to the commencement of the self-assessment phase, had provided clarity about the process to team members was then explored. The support services respondents registered a degree of agreement with this statement, with a mean score of 2.91, in contrast to the clinical services respondents whose views were more negative (3.34). In addition, statistically significant differences arise between the two groups. The fourth item, relating to understanding how accreditation could improve the standard and delivery of healthcare in the hospital, elicited agreement from both groups, while the final item on awareness of the time commitment associated with accreditation, registered a degree of agreement from the support services group and uncertainty from clinical services respondents.

Table 6.16 - Comparison of Means for Communication based on Team Type: Questionnaire 1

Questionnaire 1 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score, Standard Deviation and Weighted Mean	Team Type	N	Mean Score and Standard Deviation	P-Value
Prior to joining the team, I had a sufficient understanding of the accreditation process	3.37 (1.151) 3.39	CS	66	3.45 (1.243)	.144
		SS	60	3.28 (1.043)	
Prior to joining the team, I had a sufficient understanding of what would be expected of me as a team member	3.40 (1.082) 3.47	CS	66	3.67 (1.057)	.001*
		SS	60	3.12 (1.043)	
The communication sessions on the accreditation process gave me a clear understanding of what was involved	3.13 (1.031) 3.18	CS	58	3.34 (.943)	.020*
		SS	55	2.91 (1.041)	
At the start of the accreditation process I clearly understood how accreditation could improve the standard and delivery of healthcare in the hospital	2.41 (.999) 2.42	CS	64	2.45 (1.038)	.348
		SS	59	2.36 (.961)	
When I started the accreditation process I was aware of the time commitment associated with being a team member	2.88 (1.189) 2.91	CS	65	3.00 (1.225)	.161
		SS	60	2.75 (1.144)	

*Indicates statistical significance (1 tailed) at 5% level

Table 6.17 addresses the same items on communication from questionnaire 1, but analyses the data based on work role. Nurses and the ‘Other’ group register the lowest levels of understanding about the accreditation process, while the Nurse and AHP groups provide the most negative responses in relation to understanding the expectations associated with being a team member, prior to commencing accreditation, with mean scores of greater than 3.00. Likewise, a similar pattern of

disagreement is offered in the results for the next item relating to the efficacy of the initial communications sessions in providing respondents with a clear understanding of what was involved with the accreditation process, with Nurses and AHPs scoring the highest means and levels of disagreement - 3.29 and 3.22 respectively. The extent to which respondents understood how accreditation could improve both standards and delivery of healthcare yielded more positive responses, with all five, work role groups expressing agreement with the statement. However, the item relating to awareness of time commitment associated with accreditation generated mixed responses, with Nurses, presenting with a mean score of 3.21, indicating a level of disagreement with the statement. While the four responding Consultants, as a group, indicated that they were uncertain in their views towards this item, the remaining three groups all indicated some level of agreement revealing a level of appreciation of the time commitment associated with involvement at the commencement of the accreditation process.

Table 6.17 - Comparison of Means for Communication based on Work Role: Questionnaire 1

Questionnaire 1 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score and Standard Deviation	Work Role	N	Mean Score and Standard Deviation	P-Value
Prior to joining the team, I had a sufficient understanding of the accreditation process	3.37 (1.151)	Nurse	53	3.57 (1.152)	.371
		AHP	25	3.24 (1.165)	
		Con	4	2.75 (1.500)	
		NCHD	1	2.00	
		Other	42	3.29 (1.111)	
Prior to joining the team, I had a sufficient understanding of what would be expected of me as a team member	3.40 (1.082)	Nurse	53	3.68 (1.052)	.156
		AHP	25	3.36 (1.036)	
		Con	4	3.00 (1.414)	
		NCHD	1	3.00	
		Other	42	3.12 (1.087)	
The communication sessions on the accreditation process gave me a clear understanding of what was involved	3.13 (1.031)	Nurse	48	3.29 (1.071)	.556
		AHP	23	3.22 (.850)	
		Con	2	3.00 (1.414)	
		NCHD	1	3.00	
		Other	38	2.92 (1.075)	
At the start of the accreditation process I clearly understood how accreditation could improve the standard and delivery of healthcare in the hospital	2.41 (.999)	Nurse	53	2.49 (1.120)	.880
		AHP	24	2.21 (.884)	
		Con	3	2.67 (1.528)	
		NCHD	1	2.00	
		Other	41	2.39 (.891)	
When I started the accreditation process I was aware of the time commitment associated with being a team member	2.88 (1.189)	Nurse	52	3.21 (1.258)	.128
		AHP	25	2.72 (.980)	
		Con	4	3.00 (1.414)	
		NCHD	1	2.00	
		Other	42	2.60 (1.149)	

†Indicates statistical significance (2 tailed) at 5% level

Issues relating to individual understanding of accreditation and the extent to which the initial communications sessions had provided a degree of clarity about the process, were also borne out in the comments inputted to the open-ended question included in the interim questionnaire. While one clinical services team member acknowledged that the Accreditation Manager facilitating their team had provided very useful information, the remaining forty comments related to a general lack of understanding about the process, despite it being some five months into the first phase. Problems encountered included the interpretation of the IHSAB standards and criteria; what the required format for presentation of the standards would be; what was acceptable evidence of compliance and when any recommended changes were to be made. Some of these difficulties are expressed in the following comments:

"I just felt that some of the accreditation tasks are difficult to understand/confusing at times. It is hard to know exactly what is being asked and overlap between and within tasks I feel is often evident" (CS).

"I sometimes feel that the group struggles (as I do) to clarify what the evidence of compliance is or should be" (CS).

"I was given a standard without any explanation on how to fulfil same" (CS).

"I feel the questions for accreditation are very vague and information could be more clearly defined" (SS).

"There doesn't seem to be a complete understanding, I don't know whether it is detailed enough and whether we are capturing everything we should be capturing" (SS).

Questionnaire 2, administered immediately post-IHSAB survey, also included a number of items, many of which are reflective of those contained within the initial questionnaire. As with questionnaire 1, these items were intended to address individual team members' experiences and opinions of issues relating to communication, but in this instance, over the course of the first phase of accreditation, which had just been completed. Table 6.18 summarises the results for two of these items based on team type. Both the clinical services and support services respondents agreed that they had achieved a good understanding of the accreditation process by the end of the self-assessment (phase 1) process, with mean scores of 2.15 and 1.78 respectively, while the differences between the two groups are also statistically significant. The second item explored the level of understanding respondents had of next stage of accreditation - continuous improvement (phase 2). The results also demonstrate that both the clinical services and support services groups agreed that they have some understanding of phase 2, although this appears to be stronger with support services respondents (mean score 2.90 and 2.60).

Table 6.18 - Comparison of Means for Communication based on Team Type: Questionnaire 2

Questionnaire 2 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score, Standard Deviation and Weighted Mean	Team Type	N	Mean Score and Standard Deviation	P-Value
By the end of Phase 1, I had a good understanding of the accreditation process	1.99 (.872) 2.02	CS	60	2.15 (.899)	.008*
		SS	45	1.78 (.795)	
I have a clear understanding of what is involved in the next stage (Phase 2) of the accreditation process	2.76 (1.065) 2.79	CS	59	2.90 (1.078)	.117
		SS	47	2.60 (1.035)	

*Indicates statistical significance (1 tailed) at 5% level

Providing an alternative view of the questionnaire 2 communication related data, table 6.19 captures the results for the same two items based on work role. Four of the groups were in agreement that at the end of the self-assessment (phase 1) stage, they had a good understanding of accreditation, the exception being the responding Consultant group who indicated uncertainty (mean score 3.00). For the remaining item looking at understanding of phase 2, four of the five responding groups agreed to some extent, that they have a clear understanding of the next stage of accreditation, while the sole NCHD respondent specified that they were uncertain (mean score 3.00).

Table 6.19 - Comparison of Means for Communication based on Work Role: Questionnaire 2

Questionnaire 2 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score and Standard Deviation	Work Role	N	Mean Score and Standard Deviation	P-Value
By the end of Phase 1, I had a good understanding of the accreditation process	1.99 (.872)	Nurse	45	2.09 (.949)	.497
		AHP	19	1.89 (.737)	
		Con	2	3.00 (1.414)	
		NCHD	1	2.00	
		Other	38	1.87 (.811)	
I have a clear understanding of what is involved in the next stage (Phase 2) of the accreditation process	2.76 (1.065)	Nurse	44	2.64 (1.143)	.765
		AHP	19	2.95 (1.026)	
		Con	3	2.67 (1.528)	
		NCHD	1	3.00	
		Other	39	2.82 (.997)	

†Indicates statistical significance (2 tailed) at 5% level

While the quantitative results indicate that understanding of the accreditation process had developed and solidified by the end of the self-assessment process, the data arising from the open-ended question in the post-IHSAB survey questionnaire would suggest this had taken time to achieve. Furthermore, and in support of the questionnaire 1 findings, there were instances during the process where team members may have lacked a complete understanding of the process and perceived themselves to be hindered by, what they felt might be, a lack of effective communication. Some of the challenges experienced by individuals are reflected in the following comments:

"A greater understanding of the process developed as we progressed. A lot of time wasted initially trying to get to that level" (CS).

"I felt I didn't understand what Accreditation was all about until the end when the surveyors were scheduled. I had great difficulty understanding the process. Perhaps it was the way it was communicated it seemed to me that the management had a greater understanding of the process and I attended several meetings and as I walked out the door I wondered what it was all about so I felt communication was very poor, when you cannot grasp what its all about then your motivation is very low" (CS).

"I felt that the initial education session in the XXX hotel was not beneficial. At that stage, the Accreditation process was 'double dutch'. I felt that the information provided at the session did not give a clear explanation of what was ahead. It takes several months to actually get a grasp of what the process is about. More focused sessions for the individual teams would, I believe, have been more useful" (SS).

The interview findings provide further evidence of issues in relation to the communication process and the lack of understanding that had arisen in relation to various facets of accreditation. As one clinical services respondent observed:

"I just felt it, it just might have been a bit better communicated prior to your nomination, so you knew what the whole process was going to be about, what was going to be involved, I mean it was an invitation so it was very voluntary take-up, but

I just felt that it could have been just a little bit clearer as to what was involved in the process… people were doing the work and nobody really knew why… I spent a lot of the time wondering 'what am I supposed to be doing here?'"(CS).

This, in turn, serves to illustrate some of the consequences of the efficacy of the communication process had on accreditation. In the view of one interviewee, the absence of understanding had a fundamental effect on the accreditation process:

"Well I think that people will never fully row in behind accreditation on the clinical setting and even on our own setting, without understanding why they are doing this" (SS).

For another respondent, the consequences were identified at a much more individual level:

"I would feel that maybe a lot of people didn't really understand what was going on so that's the overall memory that is stays with me, I just felt that a lot of people didn't fully comprehend what was going on and to have spent eighteen months in that limbo situation I would feel was difficult"(SS).

It also became apparent from the responses of the interviewees that there was a strong perception that the volume of work and the extent of the time required in order to participate, had not been communicated to them:

"As the process evolved I think I became clearer, I think I was a bit muddy in the beginning I have to say, I wasn't quite sure what was expected, I know I went on the training, when they were came here to do the training with us, that certainly added more, but I hadn't really fully recognised the concept of the amount of standards that were there and the evidence of compliance that was required" (SS).

"I think people were really, including myself, really did not have a true understanding of what was expected"(SS).

Only four out of the total of twenty-eight interviewees indicated that they did not understand what was involved in phase 2 of accreditation. The remaining respondents were all able to identify, to a varying extent, that accreditation would move into the continuous improvement stage, where they would attempt to action the continuous improvement plans (and in doing so, reduce or eliminate identified risks) that had been developed during the self-assessment process.

6.3.2.2 Communication: Awareness of the Accreditation Process Outside the Teams

The results summarised in table 6.20 address the level of awareness of the accreditation process at the research site amongst staff, patients and associated healthcare organisations in the region i.e. those outside the teams, as viewed by team members. While both groups (clinical services and support services) agreed that there was awareness amongst staff that accreditation was taking place, this was not the case in relation to the awareness of the progress that had been made with the process (i.e. at five months into the process). Here, both groups recorded mean scores of greater than 3.00 and additionally, these differences are statistically significant. Moreover, assessments of the awareness of the actual aims and objectives amongst staff followed a similar pattern for clinical services respondents (mean score 3.34), while the support services responding group yielded a mean score of 3.00. Again, statistically significant differences arose between the two groups. Overall, this suggests that respondents believed that while staff at the research site knew that accreditation was taking place, there was an overall lack of understanding of the aims and objectives of, and progress with, the process.

Both clinical services and support services team respondents disagreed with the notion that patients were aware that accreditation was underway, with mean scores of 4.15 and 3.39 respectively and the differences between the two groups are also statistically significant. In relation to the extent to which other associated healthcare organisations were aware that the accreditation process was underway at the research site, support services respondents registered some level of agreement with this item (2.82), while the clinical services group indicated that they were largely uncertain in their views (mean score 3.03).

Table 6.20 - Comparison of Means for Communication based on Team Type: Questionnaire 1

Questionnaire 1 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score, Standard Deviation and Weighted Mean	Team Type	N	Mean Score and Standard Deviation	P-Value
Staff in the hospital are aware that the accreditation process is taking place	2.45 (.856) 2.46	CS	64	2.50 (.891)	.338
		SS	57	2.40 (.821)	
Staff in the hospital are aware of the progress made to date by the accreditation teams	3.57 (.746) 3.60	CS	64	3.70 (.749)	.023*
		SS	58	3.43 (.728)	
Staff in the hospital are aware of the aims and objectives of the accreditation process	3.18 (.833) 3.22	CS	64	3.34 (.912)	.015*
		SS	58	3.00 (.701)	
Patients are aware that the accreditation process is underway	3.79 (.895) 3.87	CS	62	4.15 (.865)	.000*
		SS	56	3.39 (.755)	
Other associated healthcare organisations in the region are aware that the accreditation process in the hospital is underway	2.93 (.898) 2.95	CS	63	3.03 (.915)	.204
		SS	60	2.82 (.873)	

*Indicates statistical significance (1 tailed) at 5% level

The work role results, as summarised in table 6.21 for the items concentrating on awareness of the accreditation process amongst staff, patient and other associated healthcare organisations from questionnaire 1, offer a detailed picture of the views across the five groups. As with the results based in team type, there is a strong level of agreement that staff were aware that the accreditation process was taking place, with the exception of the Consultant group, who recorded a mean score of 3.00 (uncertain). However, this does not follow for the results for awareness of progress made by the accreditation teams. Here, levels of disagreement with the statement are indicated in four of the five work role groups, with the one NCHD respondent recording that they were uncertain (mean score 3.00) in their views and moreover, the differences between the five groups are statistically significant. On a related issue, a mixed set of opinions is found in the results on staff awareness of the aims and objectives of accreditation. While the nursing, AHP and Consultant groups all register varying levels of disagreement towards the item, the remaining two groups indicate agreement, suggesting the counter position and that there was some level of awareness amongst staff of the objectives of accreditation.

Patient and other associated healthcare organisation awareness are dealt with in two separate items in table 6.21. In relation to the former, all five, work role groups registered some level of disagreement in relation to patients being aware that the accreditation process was underway at the research site, with the Consultant group indicating the highest level of disagreement, reflected in a mean score of 4.33. In addition, statistically significant differences between the groups are identified. In focusing on the latter item - awareness among other health organisations in the region - another varied picture emerges. While medical staff (Consultants and NCHDs) indicated disagreement and uncertainly respectively as to awareness, reflected in the mean scores of 3.67 and 3.00, this was not the case for the remaining three groups, where varying levels of agreement with the statement were registered.

Table 6.21 - Comparison of Means for Communication based on Work Role: Questionnaire 1

Questionnaire 1 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score and Standard Deviation	Work Role	N	Mean Score and Standard Deviation	P-Value
Staff in the hospital are aware that the accreditation process is taking place	2.45 (.856)	Nurse	51	2.45 (.879)	.617
		AHP	24	2.33 (.702)	
		Con	4	3.00 (.816)	
		NCHD	1	2.00	
		Other	40	2.50 (.934)	
Staff in the hospital are aware of the progress made to date by the accreditation teams	3.57 (.746)	Nurse	52	3.79 (.800)	.026†
		AHP	24	3.54 (.654)	
		Con	4	3.75 (.957)	
		NCHD	1	3.00	
		Other	40	3.30 (.648)	
Staff in the hospital are aware of the aims and objectives of the accreditation process	3.18 (.833)	Nurse	52	3.35 (.883)	.057
		AHP	24	3.13 (.797)	
		Con	4	4.00 (1.155)	
		NCHD	1	2.00	
		Other	40	2.95 (.677)	
Patients are aware that the accreditation process is underway	3.79 (.895)	Nurse	49	4.10 (.872)	.006†
		AHP	24	3.63 (.875)	
		Con	3	4.33 (1.155)	
		NCHD	1	4.00	
		Other	40	3.43 (.781)	
Other associated healthcare organisations in the region are aware that the accreditation process in the hospital is underway	2.93 (.898)	Nurse	52	2.90 (.913)	.759
		AHP	24	2.83 (.702)	
		Con	3	3.67 (1.155)	
		NCHD	1	3.00	
		Other	42	2.90 (.932)	

†Indicates statistical significance (2 tailed) at 5% level

While the quantitative data from questionnaire 1 indicates that responding team members believed that staff across the research site were aware that the accreditation process was taking place, data from the open-ended question would suggest that in the views of some respondents, and further supporting the quantitative results, there was little understanding as to what was actually involved amongst the wider employee group. A total of ten individual comments were made and included:

"Other staff need more information about Accreditation process and how it will affect them" (CS).

"I have some reservations even though there were plenty of opportunities for staff members to attend information sessions on the accreditation process and failed to do so, and I feel because of this they are at a loss as to how the whole process works" (CS).

"Like to see more information distributed to employees on where we are at"(SS).

"More communication with staff not directly involved in process" (SS).

The items relating to staff, patient and associated health organisation awareness were included in questionnaire 2 and the results for these are presented in table 6.22. While both groups (clinical and support services team respondents) agreed that staff were aware that the process was underway, some disagreement surfaced again in relation to specific awareness around the aims and objectives of accreditation. This divergence of views is demonstrated in the mean score for the support services group of 2.81, while for clinical services this is 3.15 and additionally, statistically significant differences are recorded between these. Similarly, the results reflect disagreement on patient awareness (mean score of 3.34 for clinical services and 2.96 for support services), again with statistically significant differences. In contrast, both groups indicated that other associated healthcare organisations were aware that accreditation was underway at the research site and these results also demonstrate statistical significance.

Table 6.22 - Comparison of Means for Communication based on Team Type: Questionnaire 2

Questionnaire 2 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score, Standard Deviation and Weighted Mean	Team Type	N	Mean Score and Standard Deviation	P-Value
Staff in the hospital are aware that the accreditation process is taking place	2.23 (.695) 2.24	CS	60	2.27 (.710)	.355
		SS	47	2.19 (.680)	
Staff in the hospital are aware of the aims and objectives of the accreditation process	3.00 (.813) 3.03	CS	60	3.15 (.799)	.016*
		SS	47	2.81 (.798)	
Patients are aware that the accreditation process is underway	3.17 (.845) 3.20	CS	59	3.34 (.902)	.013*
		SS	47	2.96 (.721)	
Other associated healthcare organisations in the region are aware that the accreditation process in the hospital is underway	2.65 (.744) 2.69	CS	59	2.85 (.761)	.001*
		SS	47	2.40 (.648)	

*Indicates statistical significance (1 tailed) at 5% level

Looking at awareness across a number of items, the results in table 6.23 indicate agreement across all work role groups in relation to staff at the research site being aware that accreditation was taking place. In contrast, only the 'Other' group responded that they believed that staff were aware of the aims and objectives of process. The NCHD respondent indicated uncertainty in relation to the item, while the remaining three groups - Nurses, AHPs and Consultants all identified some level of disagreement with the content of the statement. Patient awareness was also addressed and four of the five groups indicated disagreement with the statement i.e. that patients were not aware that the process was underway. Finally, the results for awareness amongst other associated healthcare organisations demonstrate that all five responding groups agreed to varying extents, that there was awareness in these quarters and furthermore, these results are statistically significant.

Table 6.23 - Comparison of Means for Communication based on Work Role: Questionnaire 2

Questionnaire 2 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score and Standard Deviation	Work Role	N	Mean Score and Standard Deviation	P-Value
Staff in the hospital are aware that the accreditation process is taking place	2.23 (.695)	Nurse	45	2.31 (.733)	.356
		AHP	19	2.26 (.733)	
		Con	3	2.33 (.577)	
		NCHD	1	1.00	
		Other	39	2.15 (.630)	
Staff in the hospital are aware of the aims and objectives of the accreditation process	3.00 (.813)	Nurse	45	3.18 (.777)	.117
		AHP	19	3.05 (.780)	
		Con	3	3.33 (.577)	
		NCHD	1	3.00	
		Other	39	2.74 (.850)	
Patients are aware that the accreditation process is underway	3.17 (.845)	Nurse	45	3.20 (.919)	.125
		AHP	19	3.42 (.902)	
		Con	3	3.67 (.577)	
		NCHD	1	2.00	
		Other	38	3.00 (.697)	
Other associated healthcare organisations in the region are aware that the accreditation process in the hospital is underway	2.65 (.744)	Nurse	45	2.84 (.852)	.036†
		AHP	19	2.74 (.452)	
		Con	3	2.67 (1.155)	
		NCHD	1	2.00	
		Other	38	2.39 (.638)	

†Indicates statistical significance (2 tailed) at 5% level

The qualitative data from the second questionnaire continued in a similar vein to that extracted five months into the accreditation process. Again, what was viewed as a lack of understanding amongst the main body of employees in the hospital, was highlighted in a minority of responses (seven in total), despite the fact that the IHSAB survey had taken place (June 2005) and that accreditation proper had been underway at the research site since April 2004. These sentiments are reflected in the following views:

"A higher level of awareness for all staff on the positive effects of Accreditation for the Hospital - this would be a huge motivator for all staff"(CS).

"There was a large number of staff who do not understand what the process is about" (SS).

"While accreditation should be everyone's responsibility I feel that a lot of information and education and encouragement of all staff will be required" (SS).

The semi-structured interview responses were instrumental in reinforcing this position. Respondents, in the main, acknowledged that by the end of the self-assessment process there had been extensive communications activity across the hospital and, in particular, noted the use of specific media such as the newsletters and signage. However, as one clinical services interviewee commented in relation to the accreditation newsletter that was attached to employee payslips *"I think the people who read that were the people involved in accreditation, you know, and a lot of people would have, sort of, pulled them off and said 'well that has nothing to do with me' and put it in the bin" (CS).* Moreover, the efficacy and impact of both the communication efforts and the media, in terms of creating awareness and understanding of the accreditation process, was questioned by respondents, although there was some recognition that the building of awareness had been hindered, in part, by a potentially unreceptive audience. The following views seek to illustrate this:

"I suppose there was a sense that those people didn't know what this process was about at ground level...I don't know, like you would get the sense that people…whether they wanted to know or whether they knew about it and they didn't want to know, because I would have to say really that I think it was really well-publicised, perhaps not at the start but as the process went on and particularly near the end, the process was well advertised, it was well postered" (SS).

"There was certainly information sent out but I think a lot of people wouldn't be up to speed as much as people would like to think they are... also... Some people weren't interested but you need to constantly communicate"(SS).

"I think it took probably about six to eight months before they realised that accreditation was a word that was here to stay and I think only then that they... I wouldn't even know at this stage if they would really understand what the accreditation process is about, no I don't think, I definitely don't think they realised, definitely on the ground, you know, people didn't realise that accreditation was actually up and going in the hospital and even I think the week that we had the peer group here for the review…. so I think there probably could be an awful lot better communication and I think it needs to start from the top down and be filtered the whole way through...I think some people are just not willing to actually hear that

there is something else going on, because it is something extra. It needs to be incorporated because it is here to stay, but I think people just don't understand the actual process of accreditation, they don't realise what benefit can be got from it to actually improve things within their own area" (CS).

6.3.2.3 Communication: Between Team Members and Work Colleagues

Moving then to exploring the final sub-theme of communications - those between team members and their work colleagues - items relating to questionnaire 1 are presented in table 6.24. These enquire into the extent to which individual team members actively updated their colleagues about progress with the accreditation process and conversely, the level of interest expressed by those in the immediate work area of team members, in the progress of accreditation itself. The results for the first item indicate that both clinical services and support services respondents were active in informing colleagues about progress, although the support services responding group were more in agreement with this statement. However, in relation to the extent to which interest was expressed by those in the immediate work area, the results are markedly different, with mean scores for both groups of greater than 3.00, signifying disagreement with the statement and an overall lack of expression of interest from close work colleagues.

Table 6.24 - Comparison of Means for Communication based on Team Type: Questionnaire 1

Questionnaire 1 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score, Standard Deviation and Weighted Mean	Team Type	N	Mean Score and Standard Deviation	P-Value
I actively update my colleagues in my immediate work area on my team's progress with the accreditation process	2.83 (1.042) 2.87	CS	61	2.97 (1.016)	.070
		SS	54	2.69 (1.061)	
Those in my immediate work area express interest in my team's progress with accreditation	3.43 (1.093) 3.44	CS	62	3.47 (1.141)	.264
		SS	55	3.38 (1.045)	

*Indicates statistical significance (1 tailed) at 5% level

An analysis of the same two items based on work role indicates that in relation to the first item, the responding Consultant group indicated by their disagreement, that they had not updated their immediate colleagues on their team's progress, while the AHP

and NCHD groups responded that they were uncertain towards the statement. The remaining two groups both indicated that they had been active in updating colleagues on their team's progress with accreditation. Finally, expressions of interest in progress with accreditation from colleagues did not appear to be forthcoming and is reflected in the results for the last item on table 6.25. Four of the five responding work role groups confirmed this in their responses, with mean scores of greater than 3.00, with the sole NCHD respondent indicating uncertainty towards the statement.

Table 6.25 - Comparison of Means for Communication based on Work Role: Questionnaire 1

Questionnaire 1 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score and Standard Deviation	Work Role	N	Mean Score and Standard Deviation	P-Value
I actively update my colleagues in my immediate work area on my team's progress with the accreditation process	2.83 (1.042)	Nurse	50	2.76 (1.021)	.144
		AHP	23	3.00 (1.128)	
		Con	3	4.33 (.577)	
		NCHD	1	3.00	
		Other	37	2.70 (.996)	
Those in my immediate work area express interest in my team's progress with accreditation	3.43 (1.093)	Nurse	50	3.32 (1.236)	.133
		AHP	24	3.17 (1.049)	
		Con	3	4.67 (.577)	
		NCHD	1	3.00	
		Other	38	3.63 (.883)	

†Indicates statistical significance (2 tailed) at 5% level

Evidence of interest from work colleagues arose only once in the data from responses to the open-ended question contained in questionnaire 1, where a clinical services team member noted that in their experience, this had been the case:

"Some staff on the ward are interested but overall, a lot of staff don't know what 'Accreditation' is about" (CS).

Table 6.26 captures the items relating to updating colleagues and colleagues expressing interest in progress with accreditation, contained in questionnaire 2. Both items registered agreement with both clinical services and support services groups, although only marginally so for the second item, as reflected in the mean scores. Overall this implies some level of two-way communication about the process in the wider context of the research site.

Table 6.26 - Comparison of Means for Communication based on Team Type: Questionnaire 2

Questionnaire 2 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score, Standard Deviation and Weighted Mean	Team Type	N	Mean Score and Standard Deviation	P-Value
I actively updated my colleagues in my immediate work area on my team's progress with the accreditation process	2.38 (1.032) 2.36	CS	59	2.24 (.878)	.107
		SS	46	2.57 (1.186)	
Those in my immediate work area expressed interest in my team's progress with accreditation	2.96 (1.100) 2.96	CS	59	2.98 (1.137)	.445
		SS	46	2.93 (1.063)	

*Indicates statistical significance (1 tailed) at 5% level

Examining the results based on work role, as presented in table 6.27, provides an indication of a variety of positions. The Consultant work role group disagreed (mean score 4.00) that immediate work colleagues had expressed interest and there is also marginal disagreement with the statement amongst responding AHP and 'Other' groups (mean scores 3.11 and 3.05 respectively). The responding NCHD adopted a neutral and uncertain position, while Nurses were the only group to return a positive response (mean score 2.80) for the item.

Table 6.27 - Comparison of Means for Communication based on Work Role: Questionnaire 2

Questionnaire 2 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score and Standard Deviation	Work Role	N	Mean Score and Standard Deviation	P-Value
I actively updated my colleagues in my immediate work area on my team's progress with the accreditation process	2.38 (1.032)	Nurse	45	2.13 (.842)	.086
		AHP	19	2.26 (.806)	
		Con	2	1.50 (.707)	
		NCHD	1	2.00	
		Other	38	2.79 (1.234)	
Those in my immediate work area expressed interest in my team's progress with accreditation	2.96 (1.100)	Nurse	45	2.80 (1.160)	.642
		AHP	19	3.11 (1.100)	
		Con	1	4.00	
		NCHD	1	3.00	
		Other	39	3.05 (1.050)	

†Indicates statistical significance (2 tailed) at 5% level

Interviewees also provided further insight into their efforts to communicate their team's progress with the accreditation process to their immediate work colleagues, although this appeared to not always be met with any real degree of interest and

seemed to be particularly pronounced for those clinical services team respondents. As one respondent noted of their colleagues:

"No, accreditation is something that is going on outside their work remit and they don't know about it at all. The majority of staff don't know what you're doing and even if you explain it to them they'll say 'oh well, that doesn't affect me at all'"(CS).

Similar sentiments were also expressed by other respondents who had been equally challenged in their own personal communication efforts, as illustrated by the following comments:

"I would tell people but because they weren't part of the process and they weren't emotionally involved they didn't go deep into it" (SS).

"I talked to staff nurses and they didn't know what accreditation was, people did not know what you were doing" (CS).

"I would say that everybody was a little bit fed up of listening to people talk about accreditation and not really knowing what is going on, although you can understand the definition of it…Yes, absolutely. But then they wouldn't have the interest, you know, if you're not involved" (CS).

"I mean you bring it back to ward level but some of the staff up there still don't realise what accreditation is about, you know. They realise that we have gone through a process… I wouldn't think if you even went out and asked them you know what level we got or what grade we got in the accreditation, they wouldn't be able to answer you" (CS).

6.3.3 Involvement and Participation

As represented in the conceptual framework for this study, involvement and participation may play a key role in the implementation of accreditation. As the primary research has explored several facets of this, the findings are presented under a number of sub-themes in the following sections.

6.3.3.1 Involvement and Participation: How and Why?

As a starting point, table 6.28 summarises the results on how respondents became involved with the accreditation process as derived from questionnaire 1.

Table 6.28 - How Team Members Became Involved with the Accreditation Process: Questionnaire 1

Questionnaire 1 Item How you became involved with the accreditation process		Number of Respondents	%
Valid	Volunteered	18	14.2
	Were Asked	101	79.5
	Other	7	5.5
	Total	126	99.2
Missing		1	.8
Total		127	100.0

The data indicates that almost 80% of respondents were asked to participate in an accreditation team, while only 14.2% volunteered for the process. Some 5.5% indicated that they had become involved by some alternative means other than volunteering and being asked. These respondents elaborated on this with the following comments:

"I was told I was on a team" (CS).

"Volunteered by my Manager" (CS).

"Summoned to meeting explaining that we had all been nominated in teams" (SS).

"Received letter in ward post, without prior knowledge or approach from management" (CS).

"I was ordered to join" (SS).

"I was informed that I was appointed to a team"(SS).

The final respondent in this category indicated that they were a member of the hospital management team and became involved by virtue of this.

Looking at these results from the perspectives of team type and work role, table 6.29 indicates only marginal differences between the clinical services group and the support services group in relation to the percentages volunteering to take part in the accreditation process (15.4% vs. 13.1% respectively). The Nurse group returned the highest percentage of volunteers (19.2%) for the results based on work role, while both of the responding medical groups (Consultants and NCHDs) indicated that they had been asked to participate (100.0% and 100.0 respectively).

Table 6.29 - Cross-tabulation of How Team Member Became Involved with the Accreditation Process: Questionnaire 1 based on Team Type

Questionnaire 1 Item How you became involved with the accreditation process	Team Type	Number of Respondents and % Volunteered	Number of Respondents and % Were Asked	Number of Respondents and % Other	Total Number of Respondents and %	P -Value
Valid	CS	10 (15.4)	52 (80.0)	3 (4.6)	65 (51.6)	.425
	SS	8 (13.1)	49 (80.3)	4 (6.6)	61 (48.4)	
		18 (14.3)	101 (80.2)	7 (5.5)	126 (100.0)	
Questionnaire 1 Item How you became involved with the accreditation process	**Work Role**	**Number of Respondents and % Volunteered**	**Number of Respondents and % Were Asked**	**Number of Respondents and % Other**	**Total Number of Respondents and %**	**P-Value**
Valid	Nurse	10 (19.2)	37 (71.2)	5 (9.6)	52 (41.6)	.621
	AHP	4 (16.0)	20 (80.0)	1 (4.0)	25 (20.0)	
	Con	0	4 (100.0)	0	4 (3.2)	
	NCHD	0	1 (100.0)	0	1 (.8)	
	Other	4 (9.3)	38 (8.8)	1 (2.3)	43 (34.4)	
		18 (14.4)	100 (80.0)	7 (5.6)	125 (100.0)	

*Indicates statistical significance (1 tailed) at 5% level
†Indicates statistical significance (2 tailed) at 5% level

The semi-structured interviews offered a further opportunity to explore this issue in greater depth. Respondents were asked if they felt it was legitimate for line managers to ask their staff to participate in accreditation or if instead, the process should be populated by volunteers. The findings portrayed a mixed range of views. One set of opinions clearly demonstrated that respondents felt that it was reasonable for line managers to ask individuals to get involved in an accreditation team, although in

some cases with contingencies. Of interest, respondents particularly used the terms 'invite' and 'encourage' to describe the actions of line managers in approaching their staff:

"I think that definitely it is legitimate for a line manage to ask. If you were leaving it down to people volunteering, you would actually have nobody turning up like"(SS).

"I know we did identify and invite key people that we wanted involved, but like that you know you always have key people in organisations…the key people are the people who have the knowledge and while they are very critical, certainly you ask them, if they don't want to participate sure there's not a lot you can do…no one should have been nominated, it should have been a case of people are asked" (SS).

"No I think it's naive to think that you could only have volunteers. I think people need to, you need to recruit people, your core people, very well, you need doers to be involved in the process, to drive it, so you would definitely…I think you would definitely approach people, but you would approach people that you would feel would have something to offer the process, but their participation has to be completely voluntary" (CS).

With the opposing view, one interviewee was adamant that it was not acceptable for line managers to 'nominate' their staff for participation - *"No I think it's illegitimate for line managers to nominate" (CS).* Finally, what might be interpreted as an interim position was also articulated i.e. that line managers should both seek volunteers and also ask staff to participate:

"I think they could do a bit of both, I mean you have to look at, you know, certainly you put it out there initially if you get, you know, if you got enough volunteers and maybe there were people who really want to be involved and people who really don't want to be involved, I think if you push people who really, really don't want to be involved then they're just going to drag their heels throughout the whole thing" (CS).

Progressing the issue of involvement and participation further, table 6.30 summarises the results relating to why respondents became involved with the accreditation process and demonstrates that only 53.5% saw involvement as part of their overall work role. Some 23.6% of respondents indicated that they had felt pressurised to become involved with the accreditation process, while a further 8.7% of respondents specified that they have become involved for other reasons. These encompassed a range of motives including:

"Reflect work practices into Accreditation process" (CS).

"Key organisational goal - Executive Management Team" (SS).

"To strengthen partnership between Hospital and XXX YYY" (SS).

"To learn and educate myself re: operational procedures related to my department" (CS).

"I felt involvement would contribute to my professional development and the development of my department" (SS).

"I felt completely pressurised and with little help, time or knowledge given" (CS).

Table 6.30 - Reasons for Becoming Involved with the Accreditation Process: Questionnaire 1

I saw it as part of my overall work role		Number of Respondents	%
Valid	Yes	68	53.5
	No	59	46.5
Total		127	100.0
I felt pressurised to get involved		Number of Respondents	%
Valid	Yes	30	23.6
	No	97	76.4
Total		127	100.0
Other		Number of Respondents	%
Valid	Yes	11	8.7
	No	116	91.3
Total		127	100.0

The cross-tabulation presented in table 6.31, based on team type, indicates statistically significant differences between the clinical services and support services groups in terms of their views on involvement as part of their overall work role. This is reflected in that only 43.9% of clinical services respondents answered 'Yes' to this item, as compared with 63.9% of the support services group. In relation to the second item - feeling pressurised to get involved - there is a similarity in the percentages affirming the statement for both the clinical services and support services groups (24.2% and 23.0% respectively). Finally, the percentages for the remaining item - other reasons for involvement - are low for both groups, with only 7.5% of clinical services and 9.8% of the support services respondents citing this as a reason for involvement.

Table 6.31 - Cross-tabulation of Responses to Reasons for Becoming Involved with Accreditation Process based on Team Type: Questionnaire 1

Questionnaire 1 Item I saw it as part of my overall work role	Team Type	Number of Respondents and % Yes	Number of Respondents and % No	Total Number of Respondents and %	P-Value
Valid	CS	29 (43.9)	37 (56.1)	66 (52.0)	.012*
	SS	39 (63.9)	22 (36.1)	61 (48.0)	
		68 (53.5)	59 (46.5)	127 (100.0)	
Questionnaire 1 Item I felt pressurised to get involved	**Team Type**	**Number of Respondents and % Yes**	**Number of Respondents and % No**	**Total Number of Respondents and %**	**P-Value**
Valid	CS	16 (24.2)	50 (75.8)	66 (52.0)	.422
	SS	14 (23.0)	47 (77.0)	61 (48.0)	
		30 (23.6)	97 (76.4)	127 (100.0)	
Questionnaire 1 Item Other	**Team Type**	**Number of Respondents and % Yes**	**Number of Respondents and % No**	**Total Number of Respondents and %**	**P-Value**
Valid	CS	5 (7.5)	61 (92.5)	66 (52.0)	.326
	SS	6 (9.8)	55 (90.2)	61 (48.0)	
		11 (8.7)	116 (91.3)	127 (100.0)	

*Indicates statistical significance (1 tailed) at 5% level

Addressing the results based on work role, as outlined in table 6.32, a varied pattern of responses emerges in relation to the reason for involvement as being part of the overall work role, with only 43.4 % of responding Nurses and 25% of responding Consultants returning 'Yes' as their answer. Those experiencing the most pressure to get involved with the accreditation process were the Nurse and AHP groups (26.4%

and 32% of respondents respectively), while none of the Consultant or NCHD respondents indicated that they had other reasons for involvement.

Table 6.32 - Cross-tabulation of Responses to Reasons for Becoming Involved with Accreditation Process based on Team Type: Questionnaire 1

Questionnaire 1 Item I saw it as part of my overall work role	Work Role	Number of Respondents and % Yes	Number of Respondents and % No	Total Number of Respondents and %	P-Value
Valid	Nurse	23 (43.4)	30 (56.6)	53 (42.1)	.139
	AHP	16 (64.0)	9 (36.0)	25 (19.8)	
	Con	1 (25.0)	3 (75.0)	4 (3.2)	
	NCHD	1 (100.0)	0	1 (.8)	
	Other	27 (62.8)	16 (37.2)	43 (34.1)	
		68 (54.0)	58 (46.0)	126 (100.0)	
Questionnaire 1 Item I felt pressurised to get involved	Work Role	Number of Respondents and % Yes	Number of Respondents and % No	Total Number of Respondents and %	P-Value
Valid	Nurse	14 (26.4)	39 (73.6)	53 (42.1)	.595
	AHP	8 (32.0)	17 (68.0)	25 (19.8)	
	Con	1 (25.0)	3 (75.0)	4 (3.2)	
	NCHD	0	1 (100.0)	1 (.8)	
	Other	7 (16.3)	36 (83.7)	43 (34.1)	
		30 (23.8)	96 (76.2)	126 (100.0)	
Questionnaire 1 Item Other	Work Role	Number of Respondents and % Yes	Number of Respondents and % No	Total Number of Respondents and %	P-Value
Valid	Nurse	3 (5.7)	50 (94.3)	53 (42.1)	.775
	AHP	3 (12.0)	22 (88.0)	25 (19.8)	
	Con	0	4 (100.0)	4 (3.2)	
	NCHD	0	1 (100.0)	1 (.8)	
	Other	5 (11.6)	38 (22.4)	43 (34.1)	
		11 (8.7)	115 (91.3)	126 (100.0)	

†Indicates statistical significance (2 tailed) at 5% level

6.3.3.2 Involvement and Participation: Attendance

Based on observational data, the results for the level of attendance at team meetings is summarised in table 6.33. Only one team (Team 8) achieved a full attendance and for one meeting only (the first). For each of the five teams, at least 60% of their meetings were attended by less than half their members, based on a comparison with the overall team member list. Team 1 also experienced some 28% of its meeting being cancelled due to poor attendance, although for both support services teams, no meetings were cancelled as a result of lack of attendance.

Table 6.33 - Team Meeting Attendance Based on Individual Teams: Observations

Team Number	Team Type	Number of Team Members	Number of Team Meetings Observed	% of Meetings with Attendance less than 80%	% of Meetings with Attendance less than 50%	% of Meetings cancelled due to poor Attendance	Total
Team 1	**Clinical**	21	18	11	61	28	100
Team 2	**Clinical**	19	17	12	82	6	100
Team 3	**Clinical**	22	21	24	71	5	100
Team 7	**Support**	21	15	27	73	0	100
Team 8	**Support**	14	18	33	61	0	94*

* One meeting achieved full attendance.

The issue of attendance and apparent lack thereof, as an element of involvement and participation, became a feature of the discussions of many of the meetings across all five teams. Several of the meetings, particularly but not exclusively, for the clinical services groups, took place with five or less members in attendance. The absence of individuals from the process, who were working in key areas that were central to the completion of the standards, in turn, appeared to affect other members of the team. In Team 7, the continued absence of a representative from a crucial area to which an entire IHSAB standard applied, frustrated the team, both in sentiments and in progress with the self-assessment process. As one team member summed up:

"We need XXX YYY here now" (November 2004).

In another team, the extent of anger concerning poor attendance and participation was manifest in the remark of one team member:

"It sickens me. It's not fair on everyone else" (March 2005).

For the clinical teams, the lack of attendance of Consultants was particularly marked, and the results from the observations conducted over the fourteen-month period indicated that, in the clinical teams observed, only Team 3 benefited from the regular attendance and participation of a Consultant. In relation to Team 2, one Consultant attended a meeting in May 2004, at the beginning of the self-assessment process. There was palpable frustration within Teams 1 and 2 arising from the explicit lack of

involvement and participation of Consultant team members. This was evidenced in a number of comments:

"Dr XXX is the only one who has expressed any interest" (April 2004).

"The Consultant XXXs [clinical specialism] should be here" (May 2004).

"The team will fall down because the Consultants are not involved" (May 2005).

Moreover, in one meeting, a member felt so strongly about the lack of attendance and participation of Consultants within their team, that they asked this to be formerly added to the minutes of the meeting.

The low level of Consultant participation within the clinical services teams, in turn, was seen to be impacting on the teams ability to progress the self-assessment process and risked the standards being completed very much from a nursing and allied health professional perspective, with little or no medical input. Early on in the process (June 2004), team 1 were already beginning to struggle with trying to complete standards and collect evidence of compliance to support this, due to the lack of full multidisciplinary representation in their area. As one team member remarked:

"It feels like we are lacking".

There were also clearly concerns within the teams around whether those who had not attended team meetings either regularly or at all, would turn up for the team's IHSAB survey interview. Here the teams would be questioned by the IHSAB surveyors on the content and ratings of their self-assessment against the standards, the evidence of compliance to support this and the continuous improvement plans that had also been submitted. Worries were expressed in terms of members either not participating at all or else participating, but without a full appreciation of what had been submitted by the team to IHSAB. In Team 3, the Accreditation Manager asked the team leader if they were confident that the entire team would turn up for the survey interview. This was met with the response of:

"No, I'm not confident. But they'll have to be there" (May 2005).

In Team 8, an anxious team member asked:

"What happens if someone who hasn't attended drops the team in it?" (March 2005).

The issue of attendance was also addressed in the self-reports from team members contained in the two questionnaires and serve to confirm the findings from the observational exercise. The approximate percentage of team meeting attended by respondents is displayed in table 6.34 for both questionnaires and indicates a spread from complete non-attendance through to 100% attendance. The overall mean score for meetings attended derived from questionnaire 1 was 6.98 (69.8%), while this was 6.78 (67.8%) for questionnaire 2. Table 6.35 presents a more detailed breakdown of the mean scores based on various data categories across both questionnaires. Team leaders consistently reported higher attendance, as indicated in the mean scores, than team members. This difference was also found to be statistically significant in questionnaire 2. The mean scores for support services respondents also demonstrate a greater level of attendance at team meetings over their clinical services counterparts. Based on work roles, the scores show a range of means, with Consultants reporting a particularly low percentage attendance in both questionnaires. Statistically significant differences are reported between the mean scores for the work role groups in questionnaire 2.

Table 6.34 - Approximate Percentage of Formal Team Meetings Attended: Questionnaires 1 & 2

	% Attendance at Team Meetings	Questionnaire 1		Questionnaire 2	
		Number of Respondents	%	Number of Respondents	%
Valid	None	3	2.4	2	1.9
	10%	2	1.6	2	1.9
	20%	3	2.4	0	0
	30%	7	5.5	8	7.5
	40%	6	4.7	7	6.5
	50%	11	8.7	9	8.4
	60%	8	6.3	10	9.3
	70%	15	11.8	15	14.0
	80%	25	19.7	20	18.7
	90%	33	26.0	29	27.1
	100%	10	7.9	2	1.9
	Total	123	96.9	104	97.2
Missing		4	3.1	3	2.8
Total		127	100.0	107	100.0

Table 6.35 - Comparison of Means and Approximate Percentage of Formal Team Meetings Attended based on Team Role, Team Type and Work Role: Questionnaires 1 & 2

	Data Category	Questionnaire 1				Questionnaire 2			
		N	Mean Score and Standard Deviation (SD)	%	P-Value	N	Mean Score and Standard Deviation (SD)	%	P-Value
Team Role	TL	9	7.67 (2.179)	76.7	.372	9	8.67 (.707)	86.7	.003†
	TM	112	6.91 (2.538)	69.1		95	6.60 (2.345)	66.0	
Team Type	CS	63	6.83 (2.600)	68.3	.596	57	6.68 (2.197)	66.8	.430
	SS	60	7.13 (2.390)	71.3		46	6.85 (2.494)	68.5	
Work Role	Nurse	51	6.80 (2.514)	68.0	.290	44	6.91 (1.951)	69.1	.024†
	AHP	24	7.33 (1.903)	73.3		19	7.21 (1.813)	72.1	
	Con	4	3.00 (4.243)	30.0		3	1.00 (1.732)	10.0	
	NCHD	1	8.00	80.0		1	3.00	30.0	
	Other	42	7.31 (2.374)	73.1		37	6.97 (2.398)	69.7	

*Indicates statistical significance (1 tailed) at 5% level
†Indicates statistical significance (2 tailed) at 5% level

The lack of attendance at team meetings also emerged as an issue that respondents felt the need to comment on in their responses to the open-ended question in both questionnaires. Some twenty-one separate remarks were offered in questionnaire 1, which served to highlight the extent of dissatisfaction amongst members of clinical services and support services teams about the level of attendance, and hence participation in, team meetings and the overall accreditation process. These included:

"Team meetings working well for those who attend, however generally poor turnout"(CS).

"I feel there is general dissatisfaction among team members about the team 'members' who do not attend any meetings or do not seem to be contributing in any way" (CS).

"Resentment towards those who haven't attended regularly" (CS).

"I feel upset and annoyed in terms of the level of attendance and tones by other team members" (SS).

Moreover, the absence of Hospital Consultants and their medical teams from the meeting process was singled out for particular criticism by fifteen respondents (thirteen clinical and two support services):

"Accreditation process is underway within the hospital but without the support or input of a major group - the Medical/Clinicians. The gap left by this group is significant" (CS).

"Need commitment from Doctors - none are attending or contributing to the process from our team (nor planning to). Need Hospital Management to get commitment from doctors to contribute and work on accreditation process" (CS).

"We appear to be guessing what the medics input would be as none have been present at any meetings to date on our team" (CS).

"The non-involvement of medical practitioners in this process makes the process somewhat farcical; after all they possess most of the 'clout' in the organisation" (SS).

These views were echoed in the comments volunteered to the post-IHSAB survey questionnaire, where twenty-nine respondents had included observations on poor attendance in their remarks. In particular, one team member identified that this would need to be resolved going forward if accreditation was to have any real impact at the research site:

"The issues of poor or non-attendance by some team members needs addressing if we are to enable genuine and sustainable improvement" (SS).

Similarly, the lack of attendance and participation in accreditation activities by doctors continued to be voiced in responses to questionnaire 2. Thirteen respondents (twelve clinical and one support services) included comments in their open-ended responses, which underlined the evident frustration and anger felt in relation to this group:

"It was unfair that Consultants were listed as part of our team but had no input or contribution until group interview with examiners last week" (CS).

"On a final note, I think it is disgraceful the lack of Consultant input, especially XXX and YYY" (CS).

"Lack of Consultant/Medical team participation was a huge loss, it inhibited the process, the findings and in part the overall aim of Accreditation" (CS).

These overall concerns about attendance were also echoed in the interview findings. All twenty-eight respondents specifically stated that attendance had been a problem in their individual team. As one support services interviewee noted on the issue *"I know definitely we started out with more [people] than we finished with" (SS)*, while for a clinical services respondent, the memory was more vivid *"Ah yes it was an*

issue, you know, there were meetings where there could have been only four people, you know"(CS). Moreover, the specific absence of doctors from the process was also highlighted during the interviews and views were presented in what was largely a critical vein, and this was particularly apparent from the clinical services respondents who had been most affected:

"They don't ever participate, do they? You know, they think that they are above us really, they don't ever really participate"(SS).

"Well I think they don't get involved in anything other than to do with hospital consultants and they don't really answer to hospital management, they go directly to XXXXX, to the higher-level"(SS).

"They're not the slightest bit interested I think in what's going on in the hospital, well a lot of them I should say, they have their own agenda and they look after their own patch and they don't really, they leave it to everybody else to do"(CS).

"In my experience with other sort of practice initiatives, you know, their participation is the biggest hurdle"(CS).

Only the observations of one respondent (clinical services) attempted to allay the majority view as to the level of doctor participation in accreditation:

"I would recognise that it is much more difficult for the medics to attend and maybe we have to respect the fact that they are a group who can multitask. It's very, very difficult for doctors, and amongst all the clinical groups, it's very, very difficult for doctors to step away for a time, more so than most of the other professions. Most of the other professions have a team behind them, and the Consultants, they might have a team behind them, but they are still the head, and they are responsible so it's very difficult for them as a group. I've got some sympathy for them"(CS).

The impact of general non-attendance and specifically those from the medical group, also surfaced during the interviews. In particular, this was seen to manifest and contribute to a lack of motivation of other team members; an absence of continuity in

the team meetings; the frustration of both team members and the process itself and the inability to fully complete the standards and source adequate evidence of compliance. Moreover, the consequences of attendance problems going forward were also recognised by all interviewees. These include the inability to progress in a concrete manner with the continuous improvement plans, in a multidisciplinary, 'joined up' way, that would be actually meet the requirements of the hospital and furthermore, the possibility that the sustainability of accreditation itself would be threatened. This is reflected in the following observations:

"All the groups interlink and crossover, you know, the hospital cannot run without any one group, therefore the accreditation can't" (CS).

"I think if you have other groups not participating I don't think you can go forward really at all to be honest, you know, I think you are really at nothing"(CS).

6.3.3.3 Involvement and Participation: Equity and Fairness

A further issue arising from non-attendance at accreditation team meetings related to the number of IHSAB standards and related activities which those that that did attend were left to complete. In the clinical area, there were seventeen standards, each containing several individual criteria to review, support with evidence and also, where appropriate, develop quality improvement plans for. This was also the case for the support services teams, although they benefited to some extent, in having less standards to complete (Leadership and Partnership - thirteen; Human Resource Management - nine; Information Management - seven and Environment and Facilities Management - seven). In the absence of full attendance from all team members, participating individuals were often left to complete two and sometimes three standards on their own. One member of Team 7 vocalised the problems they experienced with this, having worked primarily single-handedly, with the occasional input from another team member, on reviewing a standard:

"I need someone to bounce it [the standard] off. Identifying all the issues and catching all the issues is difficult with just two people" (May 2004).

This overall issue suggesting perceptions of inequity, as reflected in discussions amongst team members, was noted in meetings by the author, with the following frequency: Team 1 (three); Team 2 (four); Team 3 (three); Team 7 (one); Team 8 (two) and suggests that this was particularly vocalised in the clinical services teams. As previously presented in relation to non-attendance, this inequity is encapsulated in the comment:

"It sickens me. It's not fair on everyone else" (March 2005).

An absence of support to team members from colleagues outside the groups also emerged as a problem. In both support services teams, it was noted during the meeting observations, that a number of members who were experiencing a lack of cooperation from some staff inside and outside the hospital (in the wider health service structure) in sourcing documentation to serve as evidence of compliance against the standards. In one of the clinical services teams, the difficulty also arose specifically in relation to the perceived lack of support given by the Consultant group to team members outside of the meetings. In one meeting of a clinical services team, the group were addressing a facet of the IHSAB standards covering the area of research. One team member suggested contacting the Consultants to clarify the position, to which another team member responded:

"There is no point. They wouldn't tell you" (April 2004).

The questionnaire findings largely reinforce those obtained during the fourteen months of observations. Table 6.36 summarises the views based on the experiences of individuals within the clinical services and support services teams. The fair and equitable distribution of tasks between those who attended the meetings and those who were listed as team members (including those who did not attend), is addressed in the first two items. While the results indicate that equity in task allocation had not been a problem between those who attended the meetings, as reflected in the mean scores, this was not the case with reference to those who were listed as being team members. While the support services group responded that there was equity, the results for the clinical services group registered disagreement, with a mean of 3.27. In addition, the differences between the two groups are statistically significant.

The extent to team members were supported by work colleagues, in completing accreditation tasks, is posed by the final item in table 6.36. Here, both groups registered some disagreement with the statement, although only marginally so for the support services group (mean score 3.09), suggesting that assistance might not always have been forthcoming.

Table 6.36 - Comparison of Means for Involvement and Participation based on Team Type: Questionnaire 1

Questionnaire 1 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score, Standard Deviation and Weighted Mean	Team Type	N	Mean Score and Standard Deviation	P-Value
Tasks are shared fairly and equitably between team members who attend the formal meetings	2.42 (.834) 2.45	CS	63	2.54 (.981)	.179
		SS	58	2.29 (.622)	
Tasks are shared fairly and equitably between all team members who are listed as being part of the team	3.05 (1.171) 3.10	CS	62	3.27 (1.244)	.023*
		SS	57	2.81 (1.043)	
My work colleagues, who are not team members, assist and support me in completing my accreditation tasks	3.16 (1.169) 3.17	CS	61	3.21 (1.280)	.272
		SS	55	3.09 (1.041)	

*Indicates statistical significance (1 tailed) at 5% level

Table 6.37 addresses the three items again, but this time from a work role perspective. While the first item registered agreement across all five groups, this is not the case for the second item relating to equity amongst those listed as being team members. Two of the five groups (Nurses, and AHPs) disagreed that there was equity, while the two responding medical groups (Consultants and NCHDs) both indicated that they were uncertain in relation to this issue. Only the ‘Other’ responding group were in agreement with the statement (mean score 2.79). For the item - assistance and support from work colleagues - the AHPs and NCHD groups both indicated that this had been their experience. However, the Nurse, ‘Other’ and Consultant groups all registered disagreement with this item, with the Consultant group registering the greatest level, with a mean score of 4.67. Additionally, statistically significant differences occur between the groups.

Table 6.37 - Comparison of Means for Involvement and Participation based on Work Role: Questionnaire 1

Questionnaire 1 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score and Standard Deviation	Work Role	N	Mean Score and Standard Deviation	P-Value
Tasks are shared fairly and equitably between team members who attend the formal meetings	2.42 (.834)	Nurse	53	2.53 (1.049)	.584
		AHP	24	2.25 (.676)	
		Con	2	2.00 (.000)	
		NCHD	1	2.00	
		Other	40	2.42 (.594)	
Tasks are shared fairly and equitably between all team members who are listed as being part of the team	3.05 (1.171)	Nurse	52	3.19 (1.284)	.707
		AHP	24	3.21 (1.318)	
		Con	2	3.00 (1.414)	
		NCHD	1	3.00	
		Other	39	2.79 (.894)	
My work colleagues, who are not team members, assist and support me in completing my accreditation tasks	3.16 (1.169)	Nurse	50	3.34 (1.239)	.001†
		AHP	23	2.35 (.775)	
		Con	3	4.67 (.577)	
		NCHD	1	2.00	
		Other	38	3.34 (1.047)	

†Indicates statistical significance (2 tailed) at 5% level

Concerns around equity and fairness were also expressed by a minority (four), of the respondents who elected to complete the open-ended question. Five months into the process, dissatisfaction was already beginning to surface in relation to the completion of accreditation tasks, as evidenced in the following comments:

"Work is being left to same people" (CS).

"My fear would be that the rest of us will have to take on the work of others" (CS).

"It is unfair to put this process on a few members" (SS).

Equity in the team context was also addressed in questionnaire 2, administered when the self-assessment stage had just been completed. The first three items in table 6.38 explore this issue and for the two items repeated from the initial questionnaire, the results represent a deterioration in views, based on the overall mean scores. The extent of equity in task allocation between those who attended team meetings registered agreement with both groups, although only marginally so for the clinical services team (mean score 2.97). For all three of the items relating to equity, the

clinical services group indicated higher levels of disagreement than their support services counterparts and statistically significant differences arise for items one and three. The fourth item on table 6.38 also continued with the theme of assistance and support to team members from work colleagues. In this instance, the position improved from that recorded at the five-month stage of the self-assessment process, as reflected in an overall mean score of 2.90. Despite this, the clinical services group still responded with marginal disagreement (3.05), while the support services group indicated agreement (2.72). The final item served to introduce the extent to which team members also experienced assistance and support from their line manager and the results indicate varying levels of agreement with this statement from both groups.

Table 6.38 - Comparison of Means for Involvement and Participation based on Team Type: Questionnaire 2

Questionnaire 2 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score, Standard Deviation and Weighted Mean	Team Type	N	Mean Score and Standard Deviation	P-Value
Everyone who was listed as a team member made a contribution to the accreditation process	3.52 (1.210) 3.58	CS	59	3.83 (1.053)	.002*
		SS	46	3.13 (1.293)	
Tasks were shared fairly and equitably between team members who attend the formal meetings	2.82 (1.099) 2.85	CS	59	2.97 (1.114)	.066
		SS	46	2.63 (1.062)	
Tasks were shared fairly and equitably between all team members who are listed as being part of the team	3.59 (1.171) 3.64	CS	59	3.90 (1.012)	.002*
		SS	45	3.18 (1.248)	
My work colleagues, who were not team members, assisted and supported me in completing my accreditation tasks	2.90 (1.148) 2.93	CS	58	3.05 (1.234)	.085
		SS	47	2.72 (1.015)	
My line manager assisted and supported me in completing my accreditation tasks	2.66 (1.247) 2.68	CS	57	2.82 (1.269)	.058
		SS	42	2.43 (1.192)	

*Indicates statistical significance (1 tailed) at 5% level

Finally, equity in the team and support from colleagues in completing accreditation tasks, is analysed based on work role and this is summarised in table 6.39. The greatest level of disagreement with the item relating to everyone listed as a team member making a contribution, arises with the nursing, AHP and Consultant groups. The responding medical groups (Consultants and NCHDs), registered uncertainty as to whether tasks were shared equitably between team members who attended the meetings, perhaps not surprisingly given the earlier results, highlighting their low levels of attendance. The third item addressing equity amongst those listed as team

members indicates that four of the five groups believed this had not been the case, with only the single NCHD respondent revealing that they were uncertain in their views. The fourth issue, on support from work colleagues, met with a somewhat varied response. The AHP, NCHD and 'Other' groups all indicated that they had received support, as reflected in their mean scores, while the responding Consultant group registered uncertainty and the Nurse respondents indicating, although only marginally, that this had not been their experience (mean score 3.05). Furthermore, only the single responding Consultant indicated that they had not received assistance and support from their line manager, which might be explained by the fact they there was no direct reporting relationship to the hospital manager and that having achieved a senior clinical position in the organisation, that they did not perceive themselves as having a line manager.

Table 6.39 - Comparison of Means for Involvement and Participation based on Work Role: Questionnaire 2

Questionnaire 2 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score and Standard Deviation	Work Role	N	Mean Score and Standard Deviation	P-Value
Everyone who was listed as a team member made a contribution to the accreditation process	3.52 (1.210)	Nurse	45	3.69 (1.125)	.102
		AHP	19	3.84 (1.167)	
		Con	1	4.00	
		NCHD	1	1.00	
		Other	39	3.23 (1.245)	
Tasks were shared fairly and equitably between team members who attend the formal meetings	2.82 (1.099)	Nurse	45	3.04 (1.127)	.450
		AHP	19	2.68 (.885)	
		Con	1	3.00	
		NCHD	1	3.00	
		Other	39	2.62 (1.161)	
Tasks were shared fairly and equitably between all team members who are listed as being part of the team	3.59 (1.171)	Nurse	44	3.80 (.978)	.369
		AHP	19	3.74 (1.327)	
		Con	1	4.00	
		NCHD	1	3.00	
		Other	39	3.28 (1.276)	
My work colleagues, who were not team members, assisted and supported me in completing my accreditation tasks	2.90 (1.148)	Nurse	44	3.05 (1.160)	.464
		AHP	19	2.53 (1.219)	
		Con	2	3.00 (2.828)	
		NCHD	1	2.00	
		Other	39	2.95 (1.025)	
My line manager assisted and supported me in completing my accreditation tasks	2.66 (1.247)	Nurse	43	2.65 (1.251)	.416
		AHP	17	2.41 (1.372)	
		Con	1	5.00	
		NCHD	1	3.00	
		Other	37	2.70 (1.175)	

†Indicates statistical significance (2 tailed) at 5% level

This dissatisfaction relating to the issue of the equity and fairness surrounding participation in the process, was also reiterated in ten separate comments from team members to the open-ended question in the questionnaire, who were vehement in their views:

"A lot of team members did not participate or did not complete tasks given to them. Nobody appeared to challenge these issues. The remaining members were expected to take up the slack" (CS).

"It was unfair that Consultants were listed as part of our team but had no input or contribution until group interview with examiners last week" (CS).

"Not all team members appeared to participate equally" (SS).

"Unfair distribution of workload among team members should be addressed - if people are not willing to attend meetings, they should be replaced on the team, so that the same willing few are not unfairly tasked with workload" (SS).

Moreover, for one team member, this inequity further extended to the lack of assistance and support given by colleagues in their immediate work area in relation to completing the IHSAB standards and sourcing appropriate evidence of compliance:

"I felt that as the only member of my department who was on a clinical service team, the rest of the department did not contribute to the accreditation process. I very much felt that all the work in representing my department fell to me. This is something that we need to look at within our department for Phase 2"(CS).

Findings from the semi-structured interviews only serve to further reinforce the aforementioned views. All respondents agreed that the findings from the questionnaire data accurately reflected what had been the actual position - that inequity had existed in terms of task allocation based on those listed as being members of the team, as reflected in the following observations:

"Only 40% were really doing it all"(SS).

"People who came to the meetings more often got more work, generally"(CS).

"I mean you had the doers and the not doers and the doers did everything and the other people did very little really, you know, and even their attendance wouldn't have been as good. So that tasks weren't shared fairly… I would agree with that, definitely I would, absolutely"(CS).

In relation to support from colleagues and line managers, the interviews presented a relatively positive assessment of this, which further support the overall findings from the questionnaires. The measured response of one clinical services interviewee serves to illustrate this:

"People did when they could, but it's just you know sometimes it's just not possible for them to take over or for them to handle your stuff because they are swamped"(CS).

For another respondent, support was given but only when it was asked for:

"In the sense that certainly it would be up to me to highlight any difficulties, which I would have done, and maybe to say there was an issue about it and it was acknowledged that it was, and there would have been times where it was time-consuming and there were times where you didn't quite get everything done, but again I think it's something that line managers need to be reminded of, you know, in the nicest way possible, in the sense that they can delegate a lot of work and every now and again you have to remind them that there's ten other things that you have to do as well, so I think it's a feature of management, that you just have to go to them and highlight it or flag it"(CS).

6.3.3.4 Involvement and Participation: Time

A further strand that runs through the overarching theme of involvement and participation relates to the issue of time constraints, as experienced by individual team members. Within the context of the observational data collection, this emerged in respect to the difficulties individual team members experienced in making time for accreditation, to both attend meetings and to complete associated tasks, and was vocalised with the following frequencies at meetings: Team 1 (seven); Team 2 (five); Team 3 (five); Team 7 (three) and Team 8 (three). These challenges took different forms. For members of the clinical services team, leaving the ward seemed to be a specific problem, in particular, if an emergency had occurred or a patient was being admitted. This was evidenced in team members frequently arriving late to meetings and offering their apologies based on this. Likewise, the lack of space within the busy working day to complete standards and collect evidence also exacerbated the accreditation process. As one clinical services member offered as an explanation for not having completed a standard:

"I'm sorry. I simply don't have time at work. I'm going to have to do it at home" (June 2004).

The shift and holiday patterns worked by many clinical team members and by those work colleagues whose input they might require, also created problems for some team members. Scheduling meetings to address these issues became problematic, although one team member in Team 2 highlighted that they had attempted to accomplish as much as possible over the phone. In one clinical services team, a meeting accomplished little as a number of team members had gone on holiday without submitting standards.

These issues were mirrored to a large extent in the discussions of those in the support services teams. While members were not leaving wards with patients, they were removing themselves from their normal work environment to attend meetings and this, in itself, was problematic. As one support services member remarked:

"Sorry I'm so late. I got a call from a TD's office as I was leaving"(November 2004).

The questionnaire results echo those derived from the observational research. Table 6.40 outlines three items relating to the overall issue of time from questionnaire 1. The issue of appropriate timing of meetings is met with agreement by both clinical services and support services respondents, although more so by the latter group and with statistically significant differences between these. However, evident problems are reflected in the mean scores for both groups for the remaining two items. Both leaving the work environment, and having sufficient time to meet with other members to complete accreditation tasks, were challenges for both groups, as demonstrated in their disagreement with both statements, but even more so for the clinical services group.

These issues are developed further in table 6.41, where the results are presented based on work role. While four of the five groups agreed that the meetings were scheduled at appropriate times (the remaining NCHD group respondent being uncertain), only the NCHD respondent registered any agreement towards the

remaining items. The other four groups all registered varying levels of disagreement and this was strongest in the Consultant group.

Table 6.40 - Comparison of Means for Involvement and Participation based on Team Type: Questionnaire 1

Questionnaire 1 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score, Standard Deviation and Weighted Mean	Team Type	N	Mean Score and Standard Deviation	P-Value
Formal team meetings are scheduled at appropriate times	2.39 (.794) 2.43	CS	62	2.63 (1.149)	.002*
		SS	58	2.09 (.801)	
I have no difficulty leaving my immediate work environment in order to attend a formal team meeting	3.64 (1.245) 3.66	CS	62	3.74 (1.173)	.215
		SS	59	3.53 (1.318)	
I get sufficient time to meet with other team members to complete the agreed tasks	3.38 (1.049) 3.41	CS	61	3.48 (1.089)	.140
		SS	56	3.29 (1.004)	

*Indicates statistical significance (1 tailed) at 5% level

Table 6.41 - Comparison of Means for Involvement and Participation based on Work Role: Questionnaire 1

Questionnaire 1 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score and Standard Deviation	Work Role	N	Mean Score and Standard Deviation	P-Value
Formal team meetings are scheduled at appropriate times	2.39 (.794)	Nurse	52	2.60 (1.241)	.204
		AHP	24	2.33 (.868)	
		Con	2	3.00 (1.414)	
		NCHD	1	2.00	
		Other	40	2.03 (.660)	
I have no difficulty leaving my immediate work environment in order to attend a formal team meeting	3.64 (1.245)	Nurse	53	3.83 (1.221)	.158
		AHP	24	3.63 (1.245)	
		Con	2	4.50 (.707)	
		NCHD	1	2.00	
		Other	40	3.35 (1.252)	
I get sufficient time to meet with other team members to complete the agreed tasks	3.38 (1.049)	Nurse	50	3.54 (1.110)	.310
		AHP	24	3.33 (.963)	
		Con	2	4.00 (1.414)	
		NCHD	1	2.00	
		Other	39	3.21 (1.005)	

†Indicates statistical significance (2 tailed) at 5% level

The specific difficulties being experienced by team members in relation to allocating time for involvement with accreditation, were expanded upon in the responses

volunteered to the open-ended question and at only five months into the process, a total of forty team members felt the need to mention this issue in their remarks. The comments provided reflected the challenges individuals were experiencing in terms of attempting to make time for accreditation, issues around the absence of protected time for involvement and the impact that this, in turn, had on existing workload. These issues are echoed in the following comments:

"Difficult to prioritise accreditation on top of all our workload issues" (CS).

"More time should be allocated - hard to do during working day" (CS).

"It is very difficult for me to participate due to massive clinical and administrative roles" (CS).

"I don't have the time to commit" (SS).

"Would like to see some specifically allocated time for accreditation 'legwork' and a reduced expectation that everything else can still be done" (SS).

The three items relating to time constraints also appear in questionnaire 2 and the results reflect, in the main, those returned in the initial questionnaire and are outlined in table 6.42. Both groups again responded that the meetings had been scheduled at appropriate times, although statistically significant differences arise between the clinical services and support services respondents. Conversely, there was disagreement from both groups in relation to having no difficulty leaving the work environment. The results for the final item relating to having time to meet other team members to complete accreditation tasks showed an improvement from those presented for questionnaire 1 for the support services group, reflected in the mean score increasing from 3.29 to 2.72. However, the clinical services group continued to register a level of disagreement with this statement and statistically significant differences are recorded between the two groups.

Table 6.42 - Comparison of Means for Involvement and Participation based on Team Type: Questionnaire 2

Questionnaire 2 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score, Standard Deviation and Weighted Mean	Team Type	N	Mean Score and Standard Deviation	P-Value
Formal team meetings were scheduled at appropriate times	2.30 (1.046) 2.36	CS	59	2.69 (1.071)	.000*
		SS	46	1.78 (.758)	
I had no difficulty leaving my immediate work environment in order to attend a formal team meeting	3.66 (1.292) 3.68	CS	59	3.80 (1.310)	.075
		SS	46	3.48 (1.260)	
I got sufficient time to meet with other team members to complete the agreed tasks	3.05 (1.155) 3.10	CS	59	3.31 (1.163)	.005*
		SS	46	2.72 (1.068)	

*Indicates statistical significance (1 tailed) at 5% level

The results presented in table 6.43 also address the issues around time constraints, but analysed on the basis of work role. Only the Consultant respondents indicated that they were uncertain about the appropriate timing of meetings (possibly as a reflection of their lack of general attendance), while the other four groups were in agreement with this and recorded statistically significant differences. Leaving the work environment to attend meetings appeared to have been most difficult for the AHPs, Consultants and NCHD respondents, who achieved the highest mean scores across the five groups. Similarly, the medical respondents (one Consultant and one NCHD) indicated that they had not gotten sufficient time to meet with other team members to complete tasks and this was reflected in mean scores of 4.00 and 4.00 respectively.

Table 6.43 - Comparison of Means for Involvement and Participation based on Work Role: Questionnaire 2

Questionnaire 2 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score and Standard Deviation	Work Role	N	Mean Score and Standard Deviation	P-Value
Formal team meetings were scheduled at appropriate times	2.30 (1.046)	Nurse	45	2.78 (1.126)	.001†
		AHP	19	1.95 (.780)	
		Con	1	3.00	
		NCHD	1	2.00	
		Other	39	1.90 (.852)	
I had no difficulty leaving my immediate work environment in order to attend a formal team meeting	3.66 (1.292)	Nurse	45	3.73 (1.355)	.092
		AHP	19	4.05 (1.026)	
		Con	2	5.00 (.000)	
		NCHD	1	4.00	
		Other	38	3.29 (1.293)	
I got sufficient time to meet with other team members to complete the agreed tasks	3.05 (1.155)	Nurse	45	3.29 (1.254)	.165
		AHP	19	2.89 (1.049)	
		Con	1	4.00	
		NCHD	1	4.00	
		Other	39	2.79 (1.056)	

†Indicates statistical significance (2 tailed) at 5% level

The issue of the time associated with participation in accreditation was reiterated in the qualitative data arising from the open-ended responses in questionnaire 2. A total of thirty-two team members offered comments, which continued in a similar vein to those volunteered in the initial questionnaire.

"More time should be given for staff to take part" (CS).

"Time is a serious limiting factor. It is difficult to slot an extra ½ day per fortnight into an already stretched clinical workload, not to mention the extra paperwork, research etc. Allowances must be made for the extra workload. Managers within departments need to be more supportive of staff who are team members and departments need to give a coordinated effort" (CS).

"Building time into the day/week rota to release people to the meetings would help greatly. It would relieve the pressure felt by those going to the meeting at leaving busy clinical areas behind, and also the pressure felt by those staff left behind"(CS).

"Huge time demands which left a lot of other necessary work undone" (SS).

"Protected time is required for this and this should be addressed" (SS).

The timing of the meetings surfaced as an issue with interviewees, who acknowledged that no meeting schedule could ever satisfy the availability of all team members. However, what did emerge was dissatisfaction with the fact that a number of meetings had taken place during lunch breaks, which effectively represented personal time and had additionally created further conflicts for those in clinical services roles, who themselves were required to provide cover for colleagues over the lunch period:

"You know coming on your lunch break is very informal all in all, if you've got something on, or you've got to go someplace, or if you've got to do a message or something, you know, it is your time off, it is your time off, you know, you're not paid for it, it's a rest time. I don't know if it is legal really to expect people to do that, so I think that needs to be acknowledged, people need to be given that sense of value that, you know, this is an important enough process for you to take an hour out of your working week to attend the meetings, I don't think that's a big ask, I think that needs to be done"(CS).

"I think they were trying to hold the meetings at lunchtime. Lunchtime is always a very bad time for the clinical area because of dinner breaks and stuff like that and cover and all of that, that was difficult so we looked at maybe the afternoon and that worked out a little bit better for everybody"(CS).

"Lunchtime was mostly used for our group meetings, but I found that at lot of them ran over and staff were under pressure and clinics started, so that wasn't ideal"(CS).

The lack of availability of time for accreditation also featured heavily in the responses from interviewees. It became apparent that for a minority (two) of respondents, where they had greater discretion in relation to how their work schedule was planned, problems were experienced to a lesser extent in terms of making time

to attend meetings and, in turn, completing accreditation tasks, although not without consequences:

"It was very easy for me given my role, you know. I mean, I don't have a chain of command to follow, I report to the hospital manager, so for me it was my time to manage, you know what I mean. It posed difficulties for other areas, certainly, in that I had some projects that slipped, you know, it was harder to manage my end of the business as such"(SS).

"At a personal level for me that wasn't too difficult as I didn't have a lot of clinical demands on me at the time, but with respect to people who had the clinical demands, which obviously will take the priority, will take the need and it's very, very difficult"(CS).

However, this was not the majority position and the vociferousness expressed as to the problematic nature of finding time for accreditation in the other data sources, was clearly evident in the views provided by the remaining interviewees, who further noted that 'protected time' needed to be created in order to facilitate their participation:

"It was a significant contribution in terms of time and a burden on everyone in addition to what they were doing, without any, how should we say, consideration to what they were doing in their alternative work and I think that was particularly significant"(CS).

"It was a lot of work and nobody was really allocated time to do the work, so it was really tight enough on the time schedule because of that" (CS).

"I think you need protected time, now I'm not sure of the cost associated with that"(CS).

Moreover, for some interviewees, the distinct lack of time during their normal working day, meant that accreditation-related tasks had been left to be completed during their personal time:

"Well the most difficult thing was it was quite time-consuming and very hard to fit it in with your work schedule. I did my own accreditation work outside of work"(SS).

"I suppose the clinical work had to come first really, you know, so that meant doing the accreditation work at home" (CS).

"I would have came early in the morning or stayed late in the evening, that was really just because I haven't got children, you know, and I'd much rather get my day's work done and then I can sit down and do something" (CS).

6.3.3.5 Involvement and Participation: Commitment to Involvement and Participation

The final strand to involvement and participation was addressed in the observational research, within questionnaire 2 and also in the semi-structured interviews and focused on the broad issue of commitment to involvement in the process. Previous discussion in relation to attendance at meetings may provide some general indication of overall commitment to accreditation. On one hand, the on-going participation of some team members, in often difficult circumstances, may demonstrate the existence of positive commitment, while the absence of others could be interpreted as a proxy for lack thereof. Within the context of the meetings, there is additional evidence of the latter and is again related to non-participation. Comments from two support services respondents serve to illustrate this:

"I spoke to XXX and YYY and they want to opt out" (June 2004).

"People are tired of it. They want out" (November 2004).

Within a clinical services context, a remark from a team member also resonates what might be interpreted as disaffection with the process:

"It's like a paper exercise to me. I can't see anything coming of this" (January 2005).

Table 6.44 summarises the results from a number of items from questionnaire 2, relating to commitment to being involved and participating in accreditation and paints an overall optimistic picture. Both the clinical services and support services respondent groups views of their commitment to both accreditation and their team met with positive assessments, as did seeing on-going involvement as part of their work role. Respondents also agreed that they would be happy to be involved in phase 2 of accreditation and would both support, and actively encourage, colleagues to become involved with the process. The final item, posing the issue that contributing to accreditation was everyone's responsibility, met with solid agreement from both groups, although the differences between these were statistically significant. Finally, and of note, the mean scores for every item in table 6.44 were lower for the support services respondents and hence indicate greater levels of agreement than their clinical services colleagues.

Table 6.44 - Comparison of Means for Involvement and Participation based on Team Type: Questionnaire 2

Questionnaire 2 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score, Standard Deviation and Weighted Mean	Team Type	N	Mean Score and Standard Deviation	P-Value
I was fully committed to accreditation at all stages of Phase 1 of the process	2.00 (.961) 2.01	CS	59	2.08 (.934)	.105
		SS	46	1.89 (.994)	
I was fully committed to my team at all stages of Phase 1 of the accreditation process	1.91 (.915) 1.93	CS	58	2.02 (.927)	.072
		SS	46	1.78 (.892)	
I see on-going involvement in the accreditation process as part of my work role	2.07 (.749) 2.09	CS	60	2.20 (.684)	.016*
		SS	47	1.91 (.803)	
I am happy to be involved as a team member in the next stage (Phase 2) of the accreditation process	2.07 (.839) 2.08	CS	60	2.18 (.854)	.515
		SS	47	1.91 (.803)	
I would willingly support colleagues who are involved in the next stage (Phase 2) of the accreditation process	1.73 (.542) 1.75	CS	59	1.80 (.518)	.079
		SS	46	1.65 (.566)	
I would actively encourage colleagues to get involved with the next stage (Phase 2) of the accreditation process	1.96 (.820) 1.97	CS	60	2.03 (.823)	.158
		SS	45	1.87 (.815)	
Contributing to accreditation is everyone's responsibility	1.53 (.636) 1.55	CS	59	1.63 (.641)	.027*
		SS	46	1.41 (.617)	

*Indicates statistical significance (1 tailed) at 5% level

The results for these items are also considered in terms of work roles in table 6.45. Only the single responding Consultant indicated that they had not been fully

committed to accreditation, although this improves (mean score 2.50) for the group when the item addresses commitment to the team. The remaining items reflect agreement across the majority of the groups, with some uncertainty being expressed by the medical respondents (Consultants and NCHD) in their assessments.

Table 6.45 - Comparison of Means for Involvement and Participation based on Work Role: Questionnaire 2

Questionnaire 2 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score and Standard Deviation	Work Role	N	Mean Score and Standard Deviation	P-Value
I was fully committed to accreditation at all stages of Phase 1 of the process	2.0 (.961)	Nurse	45	1.91 (.925)	.337
		AHP	19	2.11 (.875)	
		Con	1	5.00	
		NCHD	1	3.00	
		Other	39	1.95 (.944)	
I was fully committed to my team at all stages of Phase 1 of the accreditation process	1.91 (.915)	Nurse	44	1.84 (.745)	.491
		AHP	19	2.11 (1.100)	
		Con	2	2.50 (2.121)	
		NCHD	1	4.00	
		Other	38	1.82 (.896)	
I see on-going involvement in the accreditation process as part of my work role	2.07 (.749)	Nurse	45	2.07 (.688)	.656
		AHP	19	2.11 (.567)	
		Con	3	2.33 (1.528)	
		NCHD	1	3.00	
		Other	39	2.03 (.843)	
I am happy to be involved as a team member in the next stage (Phase 2) of the accreditation process	2.07 (.839)	Nurse	45	2.04 (.824)	.386
		AHP	19	2.16 (.765)	
		Con	3	3.00 (1.732)	
		NCHD	1	1.00	
		Other	39	1.95 (.793)	
I would willingly support colleagues who are involved in the next stage (Phase 2) of the accreditation process	1.73 (.542)	Nurse	44	1.70 (.509)	.228
		AHP	19	1.84 (.602)	
		Con	2	2.00 (.000)	
		NCHD	1	3.00	
		Other	39	1.67 (.530)	
I would actively encourage colleagues to get involved with the next stage (Phase 2) of the accreditation process	1.96 (.820)	Nurse	45	1.96 (.903)	.700
		AHP	19	1.95 (.621)	
		Con	2	2.00 (.000)	
		NCHD	1	3.00	
		Other	38	1.95 (.837)	
Contributing to accreditation is everyone's responsibility	1.53 (.636)	Nurse	45	1.62 (.650)	.083
		AHP	19	1.58 (.692)	
		Con	1	2.00	
		NCHD	1	3.00	
		Other	39	1.36 (.537)	

†Indicates statistical significance (2 tailed) at 5% level

While no specific comments were offered in relation to the explicit issue of commitment in the responses to the open-ended question, a rich and varied picture

was painted during the interviews conducted with the twenty-eight team members, which, in turn, serves to support the results from questionnaire 2 to a large extent. In the main, respondents indicated that they had had some degree of commitment to the accreditation process over the course of the self-assessment stage, although for many (nineteen respondents), this commitment had been varied at times, as illustrated in the following comments:

"I would love to say I would give it 100%, but because of other demands... maybe I'm being negative there"(SS).

"I'm a bit negative about it, but I said I was going to give it a chance, I went to every meeting, I attended every meeting"(SS).

"I would say that I am committed enough, I think that it certainly wavered when I had other things on. I felt that we were doing a lot and achieving very little" (CS).

"Yeah, I would be more committed to it towards the end of it definitely, but along the way it was difficult to be committed" (CS).

"Last year it was about 90%, but now it's down to about 40%" (CS).

However, for others, their commitment to accreditation had been lacking for a variety of reasons:

"Absolutely cat, absolutely cat, because of being on the wrong team it was hard to settle in, I felt I had been landed in a place for accreditation but I didn't understand what I was doing and I didn't get any information on it as such"(SS).

"I wouldn't say I was very committed. I think that at times I survived, I did enough to get by, a fair amount of that too was because the process turned me off"(CS).

Not withstanding these views, all respondents indicated that in general, they would be willing to be involved going forward with the process in phase 2, which also serves to reinforce the findings from questionnaire 2. However, this overall

willingness was also tempered by concerns that primarily related to the availability of time and the level of participation of other members:

"I would be reasonably excited about it if we bring up standards to recommendation level I would be excited about being involved with it"(SS).

"I look forward to it, again it's the little concerns… it's grand sitting here this morning thinking about it, but again when it comes down to it I will be concerned again about time"(CS).

"For me personally and the team, it would be to see that people were regularly in attendance, so I mean, a commitment from senior management to allow people the time to go at stated times and that if they do work outside of hours that they'll get that time back. I think that will be the most important thing to let it continue on, continuously with the same team"(CS).

Finally, while the results for questionnaire 2 suggested that respondents believed that accreditation was the responsibility of everyone in the hospital, whether all accreditation team members and the wider body of employees at the research site saw this as part of their work role, was also addressed with interviewees. In relation to all two hundred and four team members, the general consensus from respondents was that this was not the case, but there was an acknowledgement that those who had been actively involved probably now saw accreditation as part of their role:

"No, not with two hundred and four, I'd say you'd only get half of that"(SS).

"I'd say those who attended and who were involved probably do, but those who were on the list and didn't attend, they obviously have a different attitude or different thoughts on the whole thing anyway, I would say people who were committed to the first stage do see it as part of their role"(SS).

"I wouldn't say everybody really to be honest, I mean I wouldn't imagine so you may have all of those, if you got three quarters you would be lucky"(CS).

In relation to the wider employee group, interviewees seemed to be acutely aware that many individuals outside of the process were unlikely to view accreditation as part of their role:

“No I don't think they do, no, and I don't think there is enough awareness there for them to feel that. I think, you know, if you went around the hospital and did a survey or whatever, I’m sure you would find quite a number of people for who the process hasn’t touched them” (SS).

“No, my staff have no more interest in accreditation than they ever had” (SS).

“I think people who haven't been involved in the teams feel, a lot of them do feel very removed from it and that it had nothing to do with them” (CS).

“They have been told that they are responsible, or they have been told that the accreditation processes is for everybody, and that is heightened across the hospital, but I don't think with the everyday things, they actually see that accreditation is down to them” (CS).

6.3.4 Training

Table 6.46 summarises the data derived from the observational stage of the research, as it relates to training. The timing of training was raised in all five teams by the two Accreditation Managers, in particular with reference to that directly provided by IHSAB. This included informing members of the training session on the IHSAB standards and self-assessment and also the schedule for a mock-interview, where an IHSAB survey team would visit and two of the research site accreditation teams would go through a typical interview, while other team members would be given the opportunity to observe. In relation to the former, in a support services team, this became a topic of discussion, with many of the team members expressing the view that the training was being provided too late at seven months after the accreditation process had started at the research site.

In terms of the effectiveness of training, this also emerged as an issue in the team meeting environment and, in turn, presented both positive and negative assessments. At an early meeting of one of the clinical services teams, with reference to a training session that had been held a few weeks previously for all of the teams, aiming to provide a detailed overview of the accreditation process, one member remarked that:

"[The] XXX session was a disaster"(April 2004).

Table 6.46 - Summary of Key Training Observations

Team Number	Team Type	Number of Team Meetings Observed	Effectiveness of Training (Frequency)	Timing of Training (Frequency)
Team 1	**Clinical**	18	3	2
Team 2	**Clinical**	17	2	3
Team 3	**Clinical**	21	1	3
Team 7	**Support**	15	0	2
Team 8	**Support**	18	2	3

The effectiveness of the training provided by IHSAB on the standards and the self-assessment process was commented on in both a support services and clinical services team context. In both instances, the discussion amongst members appeared to suggest that many of them had got conflicting messages from the training in relation to the use of the standards in the accreditation process. Conversely, the mock - survey held prior to the IHSAB visit to the research site, was met with positive comments in three of the teams, having provided them with an insight into how their own survey interview might unfold.

The data arising from questionnaire 1 and 2 relating to training would appear to support the observational findings. In table 6.47, the results from questionnaire 1 for both the clinical services and support services respondents, indicate levels of disagreement towards having received sufficient training and support in order to fulfil their role in their accreditation team. Furthermore, this disagreement was higher amongst the clinical services responding group.

Table 6.47 - Comparison of Means for Training based on Team Type: Questionnaire 1

Questionnaire 1 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score, Standard Deviation and Weighted Mean	Team Type	N	Mean Score and Standard Deviation	P-Value
I received sufficient training and support in order to fulfil my accreditation team role	3.29 (1.080) 3.33	CS	62	3.45 (1.019)	.063
		SS	54	3.11 (1.127)	

* Indicates statistical significance (1 tailed) at 5% level

Table 6.48 provides an insight into the views of respondents on the sufficiency of training and support based on work role, with data derived from questionnaire 1. Reviewing this the responding Nurses and Consultants disagreed most with the statement, with the Non-Consultant Hospital Doctor recording the highest level of agreement.

Table 6.48 - Comparison of Means for Training based on Work Role: Questionnaire 1

Questionnaire 1 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score and Standard Deviation	Work Role	N	Mean Score and Standard Deviation	P-Value
I received sufficient training and support in order to fulfil my accreditation team role	3.29 (1.080)	Nurse	50	3.44 (1.146)	.550
		AHP	23	3.17 (.834)	
		Con	3	3.33 (1.155)	
		NCHD	1	2.00	
		Other	38	3.21 (1.143)	

†Indicates statistical significance (2 tailed) at 5% level

The comments offered by respondents to the open-ended question also suggested that, based on their experiences, the level of training provided for the process had been to some extent inadequate and that this, in turn, had generated confusion and had resulted in a general absence of understanding about how the accreditation process worked. This is reflected in the following comments:

"We needed much education and time to do justice to this project, and we received neither" (CS).

"Need more education from teams who have been through accreditation process" (CS).

"I do not fully understand the accreditation process the only knowledge I have is what I have accessed myself" (CS).

"Found the initial briefing sessions too complicated - large numbers attended I did not gain understanding of the process prior to commencement"(CS).

Moreover, one team member additionally noted the absence of any team building training to support the functioning of the teams themselves, and the impact that this had had in their own team:

"Team building is an important part of the process when undertaking a project like accreditation. I think this important aspect of our group formation was left out and has not been addressed. It has inhibited the team members from 'jelling' to the level we need to work together" (SS).

Training as an issue, was also addressed again in questionnaire 2, after first phase of accreditation had been completed, and the mean scores in table 6.49 indicate that assessments made against this statement had improved. Support services respondents indicated a level of agreement, with clinical services respondents returning a mean score reflecting a degree of uncertainty in relation the statement (3.08). Table 6.49 also addresses the effectiveness of the training provided directly by IHSAB. The results mirror those presented earlier, with support services respondents clearly indicating that they had found that the training provided a good understanding of the accreditation process (mean score 2.32), while the clinical services group achieved a mean score of 3.0 indicating that overall, their assessment of the effectiveness of the training was uncertain.

Table 6.49 - Comparison of Means for Training based on Team Type: Questionnaire 2

Questionnaire 2 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score, Standard Deviation and Weighted Mean	Team Type	N	Mean Score and Standard Deviation	P-Value
I received sufficient training and support in order to fulfil my accreditation team role	2.75 (1.116) 2.81	CS	59	3.08 (1.134)	.000*
		SS	46	2.33 (.944)	
The Irish Health Services Accreditation Board training sessions provided a good understanding of the accreditation process	2.70 (1.035) 2.75	CS	55	3.00 (1.018)	.000*
		SS	44	2.32 (.934)	

*Indicates statistical significance (1 tailed) at 5% level

Where the issues of training from questionnaire 2 were explored based on work role, a varied assessment was made and these are summarised in table 6.50. The responding medical groups (Consultants and NCHDs) registered the greatest levels of disagreement in relation to the sufficiency of training, while negative and uncertain assessments of the IHSAB training provision, were made by the NCHD and Consultant groups, respectively.

Table 6.50 - Comparison of Means for Training based on Work Role: Questionnaire 2

Questionnaire 2 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score and Standard Deviation	Work Role	N	Mean Score and Standard Deviation	P-Value
I received sufficient training and support in order to fulfil my accreditation team role	2.75 (1.116)	Nurse	44	2.91 (1.158)	.070
		AHP	19	2.68 (1.108)	
		Con	2	4.50 (.707)	
		NCHD	1	4.00	
		Other	39	2.49 (.997)	
The Irish Health Services Accreditation Board training sessions provided a good understanding of the accreditation process	2.70 (1.035)	Nurse	42	2.81 (1.018)	.134
		AHP	18	2.94 (.998)	
		Con	1	3.00	
		NCHD	1	4.00	
		Other	37	2.41 (1.040)	

†Indicates statistical significance (2 tailed) at 5% level

The comment of one respondent to the open-ended question served to reinforce both the observational data and also the overall evaluation made of the IHSAB training, as expressed in the quantitative data:

"The mock Accreditation interviews were particularly helpful" (CS).

However, this was countered in the observations of other team members that the sufficiency of training relating to the accreditation process and to the functioning of the team itself, had been somehow lacking:

"More training should be given" (CS)

"Needed ongoing education on quality improvement" (CS)

"The process required team-building exercises to enhance working relationships" (CS).

"Team building activities at the beginning of the process would be helpful to team members who are reluctant to speak in groups, ground rules would also have a positive effect on the members affording the members the confidentiality and safety they required to actively participate" (SS).

"I felt that the initial education session in the XXX hotel was not beneficial" (SS).

"There was not enough education provided at a basic level at an early enough stage" (SS).

The interviews with team members enabled the exploration of a number of specific issues relating to training. Addressing the quality management and continuous improvement knowledge base that team members had commenced accreditation from, a mixed set of responses were relayed. For several respondents (thirteen), knowledge had been gained by previous academic study or from involvement in work-related projects both within, and outside of, a healthcare environment:

“I think I probably would because through my own study, I mean I previously lectured so I did, and sure I would have lectured on quality and even I suppose from previous experience working elsewhere in the world, working in Australia and in the North, I suppose the whole area of quality assurance and evaluating quality and evaluating care and evaluating what it is you do would have been very integral so I probably would have been very familiar with the process. It came as a bit of a shock when I came into the hospital the first time, it was really only starting to be initiated here” (SS).

“Well about a year and a half ago I just finished a degree in healthcare management with the IPA, so I suppose that's where I learned, because I would have had to cover modules in that stuff, in issues around quality in healthcare, and that's where I learnt about it” (CS).

However, for the remaining interviewees, they appeared to be commencing accreditation with a level of knowledge of the general quality area that at best, seemed to be minimal:

“I'd say maybe not at the very, very beginning”(SS).

“I would have to acknowledge from my own perspective, probably not”(SS).

“Definitely not, no” (CS).

Whether team-building training would have been a useful exercise at the start of the accreditation process was an issue also broached with respondents. Just over half the interviewees (fifteen) agreed that they and their team would have benefited from this as a means of improving initial team functioning and cohesiveness and also the potential to positively impact on the participation rates of all team members:

“Yes and I would have felt that back on numerous occasions. It is just totally part of the work I do all the time with team building and forming relationships and putting people together to work, so I just feel the fact that we never went through a team

building process we couldn't have performed at the end. I just feel that it was such a valuable thing to have missed" (SS).

"Yep, yeah I think that would have, I think it would have. I think it would have jelled the team together"(CS).

"Certainly, certainly. People would have been less inclined to take that step back if there was some sort of team-building exercise initiated earlier on in the process"(CS).

"Yes, because I know when I went to my first meeting with the team I didn't know who anybody was, what their background was, what their role was, and that was difficult because I probably spent the first few meetings trying to decide that and where people were coming from. So I think it would have benefited and a lot of people who were on my particular team work in isolation, specialist practitioners who work in isolation, so they wouldn't, this wouldn't be something that they would be used to. I think we would've all benefited, yes" (CS).

Team building was not, however, an activity that was viewed as potentially being useful by the other interviewees. For them, already working in close proximity to most, if not all, of their fellow team members negated the usefulness of the exercise at the initial stage of the process:

"In my own particular team I don't think so, the simple reason being that I would have had a lot in common with certain members within the department and we would have worked very, very closely because we worked with the same department" (SS).

"The XXX team - the care group, I think you know they probably were a team already"(CS).

Respondents also offered a number of insights into training that serve to confirm both the findings from the observational and questionnaire stages of the research. The format and the effectiveness of the initial accreditation training met with wide-scale criticism and was viewed as being instrumental in creating a level of confusion

and a general lack of understanding of the process and what was also required from the individual team members operating within it. In turn, this was additionally seen as having contributed to time being wasted in the first few months of the self-assessment phase:

"That exercise we did in the XXX Hotel just really wasted time because you were sitting there hearing information and you couldn't actually speak on it because it was all a new language and there was nothing really to ask, whereas if it had been broken down to small tables with facilitators at each table, a process that involves all participants and exchange of information and then a gathering of all views and a feedback of that. I think that's what needs to happen" (SS).

"I think that maybe it was fundamentally flawed because of the very low knowledge or level of knowledge that we had of basic quality and we never learnt, through it we didn't learn anything more about quality" (SS).

"I think the introductory training down in the XXX Hotel didn't give, I don't think it gave enough of a picture of what we were facing into. I think it gave a picture, but I mean even coming into the first meeting as a team I don't think any of us had any idea of what we were really facing into. I felt that at stages we were going through and we hadn't got a clue, well I definitely didn't anyhow" (CS).

"I mean we had the day in the XXX Hotel and I was out at that and even I couldn't understand. I could understand where they were talking about quality and linking it altogether, but it was like they came and said 'you have all the standards, get on with it'"(CS).

One respondent further noted that the timing of the training from IHSAB had been an problem for them - *"If I had us back again I would of preferred to have the training from outside earlier on, it might have been more beneficial. I don't know, but I think it might have been. It's a general complaint from around the country" (SS).* However, and as also reported in the observational research, the mock-survey training that IHSAB provided towards the end of the first phase of accreditation was viewed as having been beneficial -*"I thought the, the day down in XXX Hotel when*

we did, when the groups were in the trial run, the mock survey, I thought that was excellent" (CS).

6.3.5 Teams

Various aspects of the operations and functioning of the accreditation teams were examined via the three research methods deployed during this study. A summary of the observational findings is presented in table 6.51.

Table 6.51 - Summary of Key Teams Observations

Team Number	Team Type	Number of Team Meetings Observed	Effectiveness of Team Meeting (Frequency)	Team Member Open Dialogue (Frequency)
Team 1	**Clinical**	18	25	23
Team 2	**Clinical**	17	16	16
Team 3	**Clinical**	21	22	22
Team 7	**Support**	15	18	15
Team 8	**Support**	18	19	20

The effectiveness of the team meetings, reflected in the extent to which these focused on, and subsequently progressed, the relevant issues, was recorded over the observational period and a varied picture emerges. The meetings of Team 7 were conducted on the whole in a 'business-like' manner and progressed the discussion and review of the standards and the associated activities in a systematic way, despite, like all the teams that were observed, not achieving full attendance. In only one of the meetings, did the author note what they described as 'cross-talking' - multiple conversations about different, and often unrelated, topics to accreditation which, in this instance, lasted for some ten minutes. Similarly, the observational results indicate only one instance of a meeting for Team 7 finishing ahead of its one and a half hour slot, albeit forty-five minutes early.

Likewise, the effectiveness of the meetings for Team 8 was also assessed in positive terms. Most of the meetings where conducted with a definite sense of purpose, and achieved in the main, progress through the agenda items. Episodes of 'cross-talking' were recorded (six times) but for the most part, the team leader and the Accreditation

Manager working with the team, were instrumental in bringing the discussion back to the issues in hand.

The clinical services teams also demonstrated effectiveness in many of their meetings, but this was also coupled with episodes where the meetings appeared to lack focus and subsequently seemed to accomplish very little. The discussions during the meetings were often littered with numerous conversations about a variety of subjects, much of which seemed to bare little relevance to accreditation. This was particularly apparent in Team 2, where this assessment was made of seven of the sixteen meetings that were observed (one was cancelled due to poor attendance). Furthermore, over the course of the observations, a number of the meetings finished early for the clinical services teams. In terms of meetings being terminated more than twenty minutes ahead of schedule, for Team 1, three instances were recorded; for Team 2, four and finally for Team 3, early cessations arose on three separate occasions.

The level of open dialogue within the team meetings was also noted during the observations conducted over the course of first phase of accreditation. The aim was to record the extent to which discussion of issues took place across the entire team and its members who were actually present. For the most part, a level of open dialogue was achieved in the teams and during most of the meetings, although looking specifically at Team 3, in five of the meetings that were observed, intermittent Consultant domination of the discussion was noted, where they appeared to effectively rule and almost singularly drive the dialogue for more than ten minutes.

In progressing the examination of the findings further, and drawing from both the questionnaires and the semi-structured interviews, the following sections address the teams aspect under the sub-themes of team meeting effectiveness and team meeting environment.

6.3.5.1 Teams: Team Meeting Effectiveness

The questionnaire findings, collected five months into the self-assessment phase and immediately post-IHSAB survey, presents an overall positive picture of the ‘teams’ aspect of the conceptual framework for this research and, as such, reflects to a large extent those outlined in the observational results. The data for questionnaire 1, based on team type and outlined in table 6.52, captures respondents experiences of several aspects of the team meeting process and its effectiveness. The first three items explore direct assessments of the meetings and the results indicate, for the first two items, agreement from both the clinical services and support services responding groups, that the meetings had both worked well and were characterised by progress being made. In relation to the third item, clinical services respondents registered minor disagreement (mean score 3.15) in their views of the extent to which meetings provided an indication of progress with the process across the hospital, as compared to support services respondents who indicated some level of agreement (mean score 2.95). However, responding team members from both groups allowed that at the end of a team meeting, they knew where they were with the accreditation process in their team, although the mean score for the support services team group was higher (2.72) than that for clinical services (2.49).

The issue of team members taking deadlines seriously was also posed in questionnaire 1. The results indicate that both groups registered some level of agreement that members did take the deadlines seriously, with mean scores of 2.92 and 2.50 for the clinical services and support services groups respectively, although differences between the groups are statistically significant. Having sufficient time within the meetings to address all the relevant issues, was met with a minor level of disagreement by the clinical services group and only marginal agreement by support services respondents (mean scores 3.30 and 2.97 respectively) and statistically significant differences also arise. This is particularly interesting given that the result arising from the observational data indicate that a number of meetings for the clinical services teams had finished early. This, by default, reduced the amount of time team members had available to them within the scheduled meetings to discuss the standards, evidence of compliance and the quality improvement plans, which are the pillars of the self-assessment process.

The final two items in table 6.52 also present a reasonably optimistic assessment from respondents in terms of their awareness of what was expected of them for the next team meeting, whether they had been in attendance at the meeting or not. In both instances, the mean scores for the clinical services group are higher than those for support services and in relation to the second item these differences are statistically significant.

Table 6.52 - Comparison of Means for Teams based on Team Type: Questionnaire 1

Questionnaire 1 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score, Standard Deviation and Weighted Mean	Team Type	N	Mean Score and Standard Deviation	P-Value
The formal team meetings work well	2.39(.794) 2.39	CS	61	2.38 (.778)	.386
		SS	58	2.41 (.817)	
We make definite progress in the formal team meetings	2.56 (.801) 2.56	CS	60	2.55 (.852)	.450
		SS	58	2.57 (.752)	
Each meeting gives me a clear indication of overall progress with the accreditation process in the hospital	3.05 (.908) 3.08	CS	60	3.15 (.917)	.061
		SS	57	2.95 (.895)	
At the end of each formal team meeting, I know where we are with the accreditation process in our team	2.61(.820) 2.57	CS	59	2.49 (.796)	.082
		SS	58	2.72 (.833)	
Team members take the agreed deadlines seriously	2.71 (.922) 2.77	CS	61	2.92 (.971)	.007*
		SS	58	2.50 (.822)	
We have sufficient time in the formal team meetings to address all the relevant issues	3.14 (1.004) 3.18	CS	60	3.30 (1.046)	.032*
		SS	58	2.97 (.936)	
At the end of each meeting I know what is expected of me for the next meeting	2.42 (.839) 2.46	CS	61	2.56 (.975)	.078
		SS	58	2.28 (.643)	
If I don't attend a formal team meeting, I still know what is expected of me for the next meeting	2.56 (.926) 2.61	CS	61	2.74 (1.031)	.033*
		SS	58	2.38 (.768)	

*Indicates statistical significance (1 tailed) at 5% level

An alternative view of the data from questionnaire 1 relating to team meeting effectiveness, is based on work role and is summarised in table 6.53. Again, the items explore various facets of the team meeting process and overall reflect a varied assessment by individual team members. The responding Consultants were the only group to register disagreement with the statements relating to the meetings working well and the progress made within these. However, the extent to which the meetings provided an indication of progress with the accreditation process in the hospital was

met with levels of both disagreement (Nurses, AHPs and Consultants), and agreement (NCHDs and Others), and record statistically significant differences between the groups.

Table 6.53 - Comparison of Means for Teams based on Work Role: Questionnaire 1

Questionnaire 1 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score and Standard Deviation	Work Role	N	Mean Score and Standard Deviation	P-Value
The formal team meetings work well	2.39(.794)	Nurse	51	2.35 (.796)	.360
		AHP	24	2.42 (.776)	
		Con	2	3.50 (.707)	
		NCHD	1	2.00	
		Other	40	2.40 (.810)	
We make definite progress in the formal team meetings	2.56 (.801)	Nurse	50	2.58 (.906)	.251
		AHP	24	2.67 (.816)	
		Con	2	3.50 (.707)	
		NCHD	1	2.00	
		Other	40	2.42 (.636)	
Each meeting gives me a clear indication of overall progress with the accreditation process in the hospital	3.05 (.908)	Nurse	50	3.26 (1.046)	.034†
		AHP	24	3.13 (.797)	
		Con	2	3.50 (.707)	
		NCHD	1	2.00	
		Other	39	2.72 (.686)	
At the end of each formal team meeting, I know where we are with the accreditation process in our team	2.61 (.820)	Nurse	51	2.59 (.829)	.384
		AHP	24	2.71 (.908)	
		Con	2	3.50 (.707)	
		NCHD	1	2.00	
		Other	38	2.53 (.762)	
Team members take the agreed deadlines seriously	2.71 (.922)	Nurse	51	2.98 (1.029)	.122
		AHP	24	2.58 (.881)	
		Con	2	3.00	
		NCHD	1	3.00	
		Other	40	2.42 (.712)	
We have sufficient time in the formal team meetings to address all the relevant issues	3.14 (1.004)	Nurse	51	3.25 (1.036)	.441
		AHP	24	3.21 (1.103)	
		Con	2	3.00 (1.414)	
		NCHD	1	2.00	
		Other	39	2.95 (.887)	
At the end of each meeting I know what is expected of me for the next meeting	2.42 (.839)	Nurse	51	2.47 (.924)	.231
		AHP	24	2.42 (.776)	
		Con	2	3.50 (.707)	
		NCHD	1	2.00	
		Other	40	2.28 (.716)	
If I don't attend a formal team meeting, I still know what is expected of me for the next meeting	2.56 (.926)	Nurse	53	2.60 (1.044)	.386
		AHP	23	2.74 (.752)	
		Con	2	2.00 (.000)	
		NCHD	1	2.00	
		Other	39	2.41 (.850)	

†Indicates statistical significance (2 tailed) at 5% level

The position improves where team members were asked to assess if the meetings provided an indication of where the team was with the accreditation process and this is indicated in mean scores of less than 3.00 for four of the five groups, the exception being the responding Consultants (mean score 3.50). Similarly, some agreement is registered in relation to team members taking the deadlines seriously, with only the medical respondents (Consultants and NCHDs) taking an uncertain position. The results relating to having sufficient time to address relevant issues in the meetings, reveals a spectrum of views across the responding groups. Nurses and AHPs indicated a level of disagreement with the statement; Consultants were uncertain, while the NCHD and 'Other' groups both confirmed that there had been an adequate amount of time.

The remaining items on table 6.53 refer to whether team members were clear as to what they were required to do for the next meeting, having been in attendance or having been absent from that meeting. Broad agreement with both of these statements is achieved based on the data from questionnaire 1, the exception being the Consultant group who indicated some level of disagreement (mean score 3.50) with the item *"At the end of each meeting I know what is expected of me for the next meeting"*.

A number of responses (six) to the open-ended question in the initial questionnaire also provide further evidence of positive assessments of the overall team meeting process relating to accreditation. Within these, there was a general conclusion that the meetings were working well and that those present were contributing to the process:

"I think the formal meetings are working well" (CS).

"The tasks allocated to team members have been taken seriously. I think that there is good support among team members" (CS).

These views are, however, contradicted in the comments (eighteen in total) from other team members on their experiences of the team meeting process, where they

noted that amongst other things, meetings had often lacked structure; made slow progress and that agreed deadlines were often not met:

"Team meetings need to be more structured. People do not take work deadlines seriously" (CS).

"Team work is poor" (CS).

"I feel that one meeting per fortnight is too little for rapid progress to be made" (SS)

Furthermore, there were several (eighteen) suggestions for improving how the team process worked, which primarily related to individuals working on the same standards across the groups and also meeting as sub-groups within the teams:

"Those doing the same standard in each group should meet to reduce duplication of work" (CS).

"There is a lack of co-ordination between teams, and element of duplication being done and a lack of view of the overall picture and direction we are leading in" (SS).

The majority of the questionnaire 2 items relating to the team meetings reflect those included in the initial questionnaire. The results demonstrate an improvement in the assessments made by respondents post-IHSAB survey visit, as indicated in the overall mean scores contained in table 6.54. Positive assessments are made of all items relating to the team meetings, based on an analysis conducted on team type, with the exception of marginal uncertainly on the part of the clinical services group for the statement *"We had sufficient time in the formal team meetings to address all the relevant issues"*. For all items, the mean scores are higher (a lesser level of agreement) for the clinical services than the responding support services group and record statistically significant differences.

Table 6.54 - Comparison of Means for Teams based on Team Type: Questionnaire 2

Questionnaire 2 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score, Standard Deviation and Weighted Mean	Team Type	N	Mean Score and Standard Deviation	P-Value
The formal team meetings worked well	2.35 (.926) 2.41	CS	57	2.67 (.988)	.000*
		SS	46	1.96 (.665)	
We made definite progress in the formal team meetings	2.19 (.833) 2.22	CS	59	2.37 (.849)	.006*
		SS	46	1.96 (.759)	
Our team worked well together	2.03 (.760) 2.05	CS	58	2.14 (.760)	.038*
		SS	45	1.89 (.745)	
Team members took the agreed deadlines seriously	2.53 (1.024) 2.58	CS	58	2.79 (1.072)	.002*
		SS	46	2.20 (.859)	
We had sufficient time in the formal team meetings to address all the relevant issues	2.82 (1.073) 2.85	CS	58	3.02 (1.116)	.012*
		SS	45	2.56 (.967)	
At the end of each formal team meeting, I knew where we were with the accreditation process in our team	2.69 (.984) 2.72	CS	59	2.90 (1.012)	.007*
		SS	46	2.41 (.884)	

*Indicates statistical significance (1 tailed) at 5% level

Analysing the results from a work role perspective highlights the spread of assessments made by the five groups towards the questionnaire 2 items relating to team meetings. Table 6.55 provides an encouraging picture of the team meeting process, although the NCHD respondent returned an uncertain opinion in relation to whether progress was made in the team meetings and also to whether the team worked well together. Uncertainty was also expressed by the Consultant respondent, in relation to deadlines being taking seriously and disagreement with the statement on having sufficient time in meetings to discuss the relevant issues. Differences between the results for the groups for the first two items are also statistically significant.

Table 6.55 - Comparison of Means for Teams based on Work Role: Questionnaire 2

Questionnaire 2 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score and Standard Deviation	Work Role	N	Mean Score and Standard Deviation	P-Value
The formal team meetings worked well	2.35 (.926)	Nurse	44	2.52 (.976)	.010†
		AHP	19	2.74 (.933)	
		Con	1	2.00	
		NCHD	0		
		Other	39	1.97 (.743)	
We made definite progress in the formal team meetings	2.19 (.833)	Nurse	45	2.36 (.830)	.005†
		AHP	19	2.53 (.905)	
		Con	1	2.00	
		NCHD	1	3.00	
		Other	39	1.82 (.683)	
Our team worked well together	2.03 (.760)	Nurse	44	2.16 (.776)	.081
		AHP	19	2.16 (.765)	
		Con	1	2.00	
		NCHD	1	3.00	
		Other	38	1.79 (.704)	
Team members took the agreed deadlines seriously	2.53 (1.024)	Nurse	44	2.77 (.961)	.234
		AHP	19	2.47 (1.219)	
		Con	1	3.00	
		NCHD	1	2.00	
		Other	39	2.28 (.972)	
We had sufficient time in the formal team meetings to address all the relevant issues	2.82 (1.073)	Nurse	44	3.07 (1.108)	.152
		AHP	19	2.63 (1.012)	
		Con	1	4.00	
		NCHD	1	2.00	
		Other	38	2.61 (1.028)	
At the end of each formal team meeting, I knew where we were with the accreditation process in our team	2.69 (.984)	Nurse	45	2.78 (1.020)	.699
		AHP	19	2.79 (1.084)	
		Con	1	2.00	
		NCHD	1	2.00	
		Other	39	2.56 (.912)	

†Indicates statistical significance (2 tailed) at 5% level

Again, the qualitative data arising from the open-ended question provided a degree of confirmatory evidence that the team process had, in the opinion of some team members (twelve), been successful in that the team meetings had been effective and that deadlines had been adhered. However, an opposing view of the process was offered by a minority of (eight) individuals, who observed that in their experience, this had not been the case and for variety of reasons:

"I felt there was no thought given to who got what standard - very haphazard" (CS).

"Team meetings sometimes wandered around before dealing with the issues. So I would like to see more focused meetings or smaller sub-group meetings in place of full team meetings" (SS).

"I feel the meetings I attended (team meetings) could have been structured better and more could have been achieved" (SS).

Responses from the semi-structured interviews serve to shed further light on team members' experiences of the team meetings and their associated effectiveness and this, in turn, corroborates the findings from the other two data sources. For the most part, interviewees were of the opinion that the team meetings had worked well and had been reasonably productive:

"Relatively well from our perspective, in that you know we got a lot of good dialogue going" (SS).

"I think they worked fairly good, you know, they were, you know, they were structured and people knew what they had to do, what their role was, so I think overall they worked fairly well"(SS).

"They worked well when there was, you know, a good number of participants, it worked well, yes"(CS).

However, some respondents chose to qualify their assessments of the effectiveness of the team meetings:

"I mean there were days you when you'd go out and you thought 'Oh, XXX we didn't do anything', although you would have been doing things it didn't feel like you were getting anywhere. But no, on the whole, on the whole I felt the mix of the team, I thought that was very good, I think that's what progressed it" (SS).

"Some were good, some were bad, some were very… they were all enjoyable"(CS).

"I'm a bit concerned that the meetings aren't smart"(CS).

Finally, for three respondents, their evaluations indicated that in their view, the meetings had been frequently ineffective:

"There were just so many meetings really just covering the same ground that we just really didn't seem to move on. They just, they just kept going round in circles, it was like we never answered any questions properly"(SS).

"Not at all. No I really don't think they were"(SS).

"Towards the end, no they weren't structured at all. They were a waste of time"(CS).

6.3.5.2 Teams: Team Meeting Environment

The results summarised in table 6.56 also address aspects of the overarching theme relating to teams, in this instance, in relation to the team meeting environment. On all four items, a positive appraisal was given by both the clinical services and support services responding groups, in terms of encouragement to participate; opportunities to voice opinions; feeling part of the team and finally, in their views that work roles and hierarchies were not relevant within the meetings. In relation to the item, *"I feel part of my accreditation team"* however, it is the clinical services group, which registered the more positive assessment. This is in stark contrast to the majority of the results from both questionnaires and in this instance, does not support the acceptance of the result of the 1 tailed test.

Table 6.56 - Comparison of Means for Teams based on Team Type: Questionnaire 1

Questionnaire 1 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score, Standard Deviation and Weighted Mean	Team Type	N	Mean Score and Standard Deviation	P-Value
Everyone is encouraged to participate in the formal team meetings	2.04 (.767) 2.04	CS	61	2.03 (.836)	.292
		SS	57	2.05 (.692)	
Everyone has an opportunity to voice their opinions in the formal team meetings	1.86 (.695) 1.86	CS	60	1.88 (.739)	.426
		SS	58	1.83 (.653)	
I feel part of my accreditation team	2.22 (.842) 2.19	CS	60	2.08 (.829)	.018*
		SS	57	2.37 (.837)	
In our formal team meetings, work roles and hierarchies are not relevant	2.22 (.935) 2.24	CS	60	2.30 (1.030)	.282
		SS	58	2.14 (.826)	

*Indicates statistical significance (1 tailed) at 5% level

Reflective of the results analysed on team type, table 6.57 depicts an overall upbeat assessment of team members being able to participate and voice their opinions in the team meetings across the work role groups, and this was also the case for members feeling part of their accreditation team. Finally, the lack influence of work hierarchies on the team meetings was also met with agreement, with the exception of the Consultant group who recorded a mean score of 3.00.

Table 6.57 - Comparison of Means for Teams based on Work Role: Questionnaire 1

Questionnaire 1 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score and Standard Deviation	Work Role	N	Mean Score and Standard Deviation	P-Value
Everyone is encouraged to participate in the formal team meetings	2.04 (.767)	Nurse	52	2.10 (.846)	.347
		AHP	22	1.95 (.722)	
		Con	2	2.50 (.707)	
		NCHD	1	1.00	
		Other	40	2.03 (.698)	
Everyone has an opportunity to voice their opinions in the formal team meetings	1.86 (.695)	Nurse	50	2.00 (.808)	.203
		AHP	24	1.67 (.565)	
		Con	2	1.50 (.707)	
		NCHD	1	1.00	
		Other	40	1.85 (.580)	
I feel part of my accreditation team	2.22 (.842)	Nurse	50	2.16 (.817)	.797
		AHP	24	2.13 (.741)	
		Con	2	2.50 (2.121)	
		NCHD	1	2.00	
		Other	39	2.36 (.903)	
In our formal team meetings, work roles and hierarchies are not relevant	2.22 (.935)	Nurse	51	2.33 (1.108)	.441
		AHP	24	2.08 (.584)	
		Con	2	3.00 (1.414)	
		NCHD	1	1.00	
		Other	39	2.15 (.844)	

†Indicates statistical significance (2 tailed) at 5% level

A single respondent remarked on the team environment issue in their comments to the open-ended question and noted that, in their experience, the team meetings had facilitated individuals articulating their opinions:

“The multidisciplinary approach to the make-up of team members works well and the majority of team actively participate in completing work required and expressing their views” (SS).

Similarly, only one comment was made to the contrary:

“I am disappointed that despite very excellent team leaders that I am still not that comfortable at the meetings. I find all the different disciplines in the large group very intimidating. When we break into the smaller groups the brainstorm is much better and more comfortable. I dread the meetings. I’m always afraid I’ll say

something stupid or that I'm not doing what's expected of me. I don't know if that's something within me or whether others feel the same"(SS).

The results based on team type from questionnaire 2, as summarised in table 6.58, indicate that in all cases, the overall mean scores had improved on those arrived at through questionnaire 1, while the clinical services responding group consistently achieved a higher mean score than the support services group. In relation to the item addressing whether everyone was encouraged to participate in meetings, there are statistically significant differences between the clinical services and support services responding groups.

Table 6.58 - Comparison of Means for Teams based on Team Type: Questionnaire 2

Questionnaire 2 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score, Standard Deviation and Weighted Mean	Team Type	N	Mean Score and Standard Deviation	P-Value
Everyone was encouraged to participate in the formal team meetings	1.96 (.861) 1.98	CS	60	2.07 (.861)	.049*
		SS	46	1.83 (.851)	
In our formal team meetings, work roles and hierarchies were not relevant	2.10 (1.064) 2.13	CS	59	2.24 (1.072)	.051
		SS	46	1.93 (1.041)	
Everyone had the opportunity to voice their opinions in the formal team meetings	1.70 (.679) 1.71	CS	60	1.77 (.673)	.075
		SS	46	1.61 (.682)	
I felt part of my accreditation team	1.84 (.810) 1.84	CS	59	1.83 (.647)	.237
		SS	46	1.85 (.988)	

*Indicates statistical significance (1 tailed) at 5% level

The final items relating to teams, as outlined in table 6.59, suggests that the responding work role groups viewed the team meetings as having fostered the encouragement of participation, the voicing of opinions and that within the context of the meeting themselves, work hierarchies were not relevant. Finally, across four of the five groups, there was agreement amongst respondents that they had felt part of their accreditation team, the exception to this being the sole NCHD respondent, who indicated that they were uncertain in their views in relation to this item.

Table 6.59 - Comparison of Means for Teams based on Work Role: Questionnaire 2

Questionnaire 2 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score and Standard Deviation	Work Role	N	Mean Score and Standard Deviation	P-Value
Everyone was encouraged to participate in the formal team meetings	1.96 (.861)	Nurse	45	2.07 (.939)	.379
		AHP	19	1.84 (.602)	
		Con	2	2.50 (.707)	
		NCHD	1	1.00	
		Other	39	1.90 (.882)	
In our formal team meetings, work roles and hierarchies were not relevant	2.10 (1.064)	Nurse	45	2.07 (1.031)	.508
		AHP	19	2.47 (1.172)	
		Con	1	2.00	
		NCHD	1	2.00	
		Other	39	1.97 (1.063)	
Everyone had the opportunity to voice their opinions in the formal team meetings	1.70 (.679)	Nurse	45	1.80 (.726)	.373
		AHP	19	1.63 (.597)	
		Con	2	2.00 (.000)	
		NCHD	1	1.00	
		Other	39	1.62 (.673)	
I felt part of my accreditation team	1.84 (.810)	Nurse	45	1.76 (.645)	.401
		AHP	19	2.05 (.970)	
		Con	1	2.00	
		NCHD	1	3.00	
		Other	39	1.79 (.894)	

†Indicates statistical significance (2 tailed) at 5% level

The interview findings are consistent with those already presented relating to the team meeting environment. Twenty-seven of the twenty-eight respondents indicated that they had felt comfortable and free to participate in the team meetings, although as one interviewee commented, this was not without its challenges:

"Yes, sometimes there were difficult things but you knew they had to be said" (CS).

The remaining interviewee presented an opposing view of their experiences of the team meeting environment and the extent to which they felt they were able to voice their opinions, which, in their view, had resulted from being a member of the incorrect team:

"No because I was on the wrong team - what could I contribute? What could I input? I was embarrassed" (SS).

6.3.6 Reward

The broad area of reward was explored by all three research methods utilised during the study. The availability of reward itself was only voiced once during the observations of the team meetings (see table 6.60), within a support services team context, when a member, in what seemed to be a joking manner, commented in relation to completing the IHSAB standards:

"We should get paid extra for having to deal with this stuff!" (October 2004)

On a limited number of occasions, the issue of recognition was raised in a number of the teams and the frequencies relating to this are presented in table 6.60. Comments relating to the absence of recognition emerged at later stages of the self-assessment process and hence the observations. As one clinical team member observed at a meeting, where only three members had turned up:

"We've done all the work and are getting no recognition for it"(January 2005).

Similar frustration was expressed within a different clinical services team, again where only four team members were present:

"I don't know why I'm even bothering to do this...no else is bothered and I don't even get so much as a 'thank you'"(February 2005).

Table 6.60 - Summary of Key Reward Observations

Team Number	Team Type	Number of Team Meetings Observed	Reward (Frequency)	Recognition (Frequency)
Team 1	**Clinical**	18	0	5
Team 2	**Clinical**	17	0	4
Team 3	**Clinical**	21	0	2
Team 7	**Support**	15	0	0
Team 8	**Support**	18	1	2

The questionnaire data would appear to concur with the observational findings. In questionnaire 1, questions were posed to individual team members relating to reward and within this, recognition. Table 6.61 outlines whether the prospect of reward was

a reason for becoming involved with the accreditation process, to which only 1.6% of respondents confirmed that it was. Of the two respondents, one was from a clinical services team (a Nurse) and the other from a support services team and tables 6.62 and 6.63 summarise the data relating to this.

Table 6.61 - Reasons for Becoming Involved with the Accreditation Process: Reward Questionnaire 1

I got involved as I expected to be rewarded financially		Number of Respondents	%
Valid	Yes	2	1.6
	No	125	98.4
Total		127	100.0

Table 6.62 - Cross-tabulation of Reasons for Becoming Involved with the Accreditation Process based on Team Type: Reward Questionnaire 1

Questionnaire 1 Item I got involved as I expected to be rewarded financially	Team Type	Number of Respondents and % Yes	Number of Respondents and % No	Total Number of Respondents and %	P-Value
Valid	CS	1 (1.5)	65 (98.5)	66 (52.0)	.478
	SS	1 (1.6)	60 (98.4)	61 (48.0)	
		2 (1.6)	125 (98.4)	127 (100.0)	

*Indicates statistical significance (1 tailed) at 5% level

Table 6.63 - Cross-tabulation of Reasons for Becoming Involved with the Accreditation Process based on Work Role: Reward Questionnaire 1

Questionnaire 1 Item I got involved as I expected to be rewarded financially	Work Role	Number of Respondents and % Yes	Number of Respondents and % No	Total Number of Respondents and %	P-Value
Valid	Nurse	1 (1.9)	52 (98.1)	53 (42.1)	.956
	AHP	0	25 (100.0)	25 (19.8)	
	Con	0	4 (100.0)	4 (3.2)	
	NCHD	0	1 (100.0)	1 (.8)	
	Other	1 (2.3)	42 (97.7)	43 (34.1)	
		2 (1.6)	124 (98.4)	126 (100.0)	

†Indicates statistical significance (2 tailed) at 5% level

Items in questionnaire 1 also explored explicit issues around recognition and sources thereof. Table 6.64 presents the mean scores, based on team type, for recognition for contribution to the accreditation arising from both work colleagues and the team member's line manager. For both items, the results indicate that clinical services

team respondents felt that there was a degree of absence of recognition from these sources. This absence is also reflected in the results for the first item - recognition from work colleagues - for the support services team respondents. In the case of the second item, this group is more positive and achieves a mean score indicating a level of agreement with the statement (2.64). For both items, the differences between the two groups are statistically significant.

Table 6.64 - Comparison of Means for Reward based on Team Type: Questionnaire 1

Questionnaire 1 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score, Standard Deviation and Weighted Mean	Team Type	N	Mean Score and Standard Deviation	P-Value
I get recognition from my work colleagues for my contribution to the accreditation process	3.61 (1.013) 3.64	CS	60	3.73 (1.056)	.047*
		SS	53	3.47 (3.47)	
I get recognition from my line manager for my contribution to the accreditation process	2.91 (1.127) 2.97	CS	60	3.15 (1.205)	.012*
		SS	56	2.64 (.980)	

*Indicates statistical significance (1 tailed) at 5% level

Addressing the results at the work role level, the results in table 6.65 indicate that medical staff (Consultants and Non-Consultant Hospital Doctors) and Nurses are the three groups who disagree most with the statement relating to recognition from their work colleagues, and this pattern is also reflected in the item relating to line manager recognition. This result is perhaps not surprising for the Consultant respondents, given that there was no clear line of reporting and accountability for this group at the research site and hence no obvious line manager.

Table 6.65 - Comparison of Means for Reward based on Work Role: Questionnaire 1

Questionnaire 1 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score and Standard Deviation	Work Role	N	Mean Score and Standard Deviation	P-Value
I get recognition from my work colleagues for my contribution to the accreditation process	3.61 (1.013)	Nurse	50	3.68 (1.133)	.143
		AHP	22	3.32 (.945)	
		Con	3	4.67 (.577)	
		NCHD	1	4.00	
		Other	36	3.58 (.874)	
I get recognition from my line manager for my contribution to the accreditation process	2.91 (1.127)	Nurse	51	3.10 (1.253)	.158
		AHP	22	2.50 (.673)	
		Con	3	4.00 (1.000)	
		NCHD	1	3.00	
		Other	38	2.82 (1.111)	

†Indicates statistical significance (2 tailed) at 5% level

Reward and recognition were further explored in the second questionnaire, giving an indication of team members' views on the issue, post-IHSAB survey. The data presented in table 6.66 captures three items. The first two repeat the statements from the initial questionnaire and demonstrate an improvement in respondents' views relating to recognition from both colleagues and line managers. For both items, the mean scores for support services team respondents indicate that recognition was forthcoming from these sources, while for clinical services teams this had occurred only from line managers, with the group recording an overall uncertain position with reference to recognition from work colleagues (mean score 3.00).

Both groups were in agreement with the statement that those contributing to phase 1 of accreditation should be rewarded. Additionally, the mean score for the clinical group was lower than for support services group, indicating a stronger level of agreement with the item and moreover, this difference is statistically significant. As with an earlier item, this is counter to the majority of the results from both questionnaires and, in this instance, does not support the acceptance of the results of the 1 tailed test.

Table 6.66 - Comparison of Means for Reward based on Team Type: Questionnaire 2

Questionnaire 2 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score, Standard Deviation and Weighted Mean	Team Type	N	Mean Score and Standard Deviation	P-Value
I got recognition from my work colleagues for my contribution to the accreditation process	2.84 (1.178) 2.87	CS	59	3.00 (1.232)	.064
		SS	46	2.63 (1.082)	
I got recognition from my line manager for my contribution to the accreditation process	2.62 (1.100) 2.62	CS	59	2.69 (1.149)	.574
		SS	45	2.51 (1.036)	
Those who contributed to Phase 1 of the accreditation process should be rewarded	2.18 (1.072) 2.14	CS	59	1.98 (.974)	.020*
		SS	46	2.43 (1.148)	

*Indicates statistical significance (1 tailed) at 5% level

Exploring the data in terms of work role as presented in table 6.67, Consultants again show the greatest level of disagreement with the first item, amongst the five groups, with the NCHD group being uncertain in terms of their views in relation to recognition from work colleagues. All groups indicated that they agreed that they had received recognition from their line manager for contributing to the accreditation process, with the exception of the Consultant group, where both individual respondents returned uncertain replies to the statement. The final item addressing reward for contribution to the process yielded the greatest level of agreement, reflected in the mean scores, from the nursing and the NCHD groups, while the Consultant respondents again indicated that they were uncertain in their views towards the statement (3.00).

Table 6.67 - Comparison of Means for Reward based on Work Role: Questionnaire 2

Questionnaire 2 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score and Standard Deviation	Work Role	N	Mean Score and Standard Deviation	P-Value
I got recognition from my work colleagues for my contribution to the accreditation process	2.84 (1.178)	Nurse	45	2.84 (1.261)	.975
		AHP	19	2.84 (1.015)	
		Con	2	3.50 (2.121)	
		NCHD	1	3.00	
		Other	38	2.79 (1.166)	
I got recognition from my line manager for my contribution to the accreditation process	2.62 (1.100)	Nurse	45	2.44 (1.099)	.543
		AHP	19	2.63 (.955)	
		Con	2	3.00 (2.828)	
		NCHD	1	2.00	
		Other	37	2.81 (1.101)	
Those who contributed to Phase 1 of the accreditation process should be rewarded	2.18 (1.072)	Nurse	45	1.98 (.988)	.497
		AHP	19	2.32 (1.108)	
		Con	2	3.00 (1.414)	
		NCHD	1	2.00	
		Other	38	2.32 (1.141)	

†Indicates statistical significance (2 tailed) at 5% level

Questionnaire 2 also provided qualitative data through the open-ended question on the general issue of reward, although from only two respondents who were both members of clinical services teams. Their comments clearly suggest that their participation in accreditation should have been met with reciprocal reward and recognition from their employer:

"Would like official acknowledgement and a reward for my work - deserve a bonus and additional day, annual leave" (CS).

"Some concrete recognition for the time and commitment given by team members e.g. a good will gesture or some time in lieu for meeting attendance" (CS)

The semi-structured interviews allowed for the further development of these issues and in doing so, provided greater insight into team members views on, and experiences of, the reward and recognition connected to their participation in the self-assessment stage of accreditation. Addressing general reward in the first instance, and in results that are seemingly at odds with those derived from

questionnaire 2, twenty of the twenty-eight respondents were adamant in their views that team members should not be rewarded for their participation, with three of these additionally identifying that health service organisations did not have a culture where reward for this type of participation was promoted. It is perhaps worth noting that during the interviews, some further clarification was required of the term ‘reward’, which stemmed from the fact that interviewees initial interpretation of this saw reward as having some fiscal element attached to it:

“I feel very strongly on this, I have an issue on this rewarding, you know people are paid to do a job and they do the job well and if you do your job well you get a lot of personal satisfaction out of doing it well”(SS).

“No I think that getting the accreditation is actually reward enough isn’t it?”(SS).

“The idea of giving people fiscal or monetary rewards…no because accreditation is only one of the sort of quality developments in the health system and it would be unfair to single out the people involved in ethics meetings and doing things and voluntary groups and support groups and I don’t think you should single us out, I don’t think there should be any source of fiscal or monetary sort of recognition for it” (CS).

“I don't think so, certainly there was no indication that money or any other kind of broader reward would have been any more motivational”(CS).

The remaining eight interviewees (two support services and six clinical services), all confirmed that an additional reward should have been forthcoming by virtue of their participation in the accreditation process, although the composition of this primarily related to additional time off:

“I suppose maybe a day off” (SS).

“Definitely I think they should…I do think you're making a big contribution towards it”(CS).

"Maybe if after the process is finished, people were entitled to an extra half a day or something like that as a gesture, more than remuneration"(CS).

"I think definitely when you're putting in that much time you need to get time back from that"(CS).

"Well I mean maybe they could give you an extra day off, or something to say 'you know you've put a lot of work into this, you have come in on your time off and, you know, we are going to give you an extra two days annual leave'"(CS).

However, when the notion of recognition (as a facet of reward) for participation in accreditation was addressed, all interviewees indicated that this should be in evidence as part of the overall accreditation process, although two acknowledged that this too was not without its problems:

"I think more like recognition than a reward. I don't agree with reward, I personally think recognition that could be something else, maybe a big dinner in the cafeteria for everyone who was involved and not to forget the others that weren't directly involved, those thirteen hundred filled in the gaps, while the other two hundred were involved...So it's not just that the accreditation people, the hospital should celebrate...and I think recognition...just the simple things, it's gone out there already, like the thank-yous from the hospital manager and with my team I did my own few bits on it, that's what people want, most people, that's all they want. It is just recognition"(SS)

"I think probably recognition certainly, yeah. I think if people start getting the night out it's going to cause a lot of bad feeling because if people weren't involved whatever. But yeah I think certainly just acknowledging, well in some way that these people were involved" (CS).

"I think recognition is always very difficult when you're in amongst peers to be recognised. I think the biggest reward for me would be to know that what I'm doing is good"(CS).

In the experiences of many respondents (twenty-two), it became evident that there had been some manifestation of recognition during and after the self-assessment process had been completed. This was explored with respondents in terms of whether they had felt valued for their contribution to accreditation and this appeared to surface from three key sources - themselves, other team members and those external to the team:

"I would have been known to the support team that I was on, to a lot of the members of that and I know that they value my contributions around stuff. So yes I know those people valued me" (SS).

"The team leader for a start and then I think people like XXX [Accreditation Manager] and people in those roles, in the lab, in the hospital management roles, they certainly did yeah and I think that was acknowledged in the closing stages of the first process when the assessors were here and at the final wrap-up meetings it was very well acknowledged I thought"(SS).

"Just my own pat on the back" (CS).

"In the final hurdles in the last sort of few months, the value and respect we had for each other and with all the value we got back, it was brilliant, people could see that you were delivering, you were achieving and you were able to help other people through" (CS).

"I think so, yeah... I suppose the team valued each other more in the end because you could see that the work had to be done and people got more and more into it and you want to do your unit proud so that was the value, it was the team. I would say that the letters from XXX [Hospital Manager] were great… I mean XXX is somebody who I think values people anyway, you know and I would have felt that from them"(CS).

For the remaining respondents, in their experience, they had not felt valued in any particular sense for their contribution to accreditation, and for one, this was particularly evident in their comments:

"Even though people might say thank-you for it and everything, fundamentally you are not being valued, you're being more… fundamentally it's really just more work" (CS).

As the final issue explored during the interviews on the theme of reward, respondents were asked if they were able to offer an explanation for a key finding from questionnaire 2. The last item on table 6.66 - *"Those who contributed to Phase 1 of the accreditation process should be rewarded"* - generated a particularly interesting result, as this represented one of only a minority of instances throughout the entire questionnaire data, where the clinical services team respondents had been more in agreement with a statement than the support services responding group, as reflected in the mean scores. While six respondents indicated that they were unable to explain the reasons behind the results, the remaining interviewees provided a number of insights as to why this might be, which included issues relating to resources, the work roles themselves and the culture within the hospital:

"I think that clinical people think that they are beaten into the ground at the moment. I suppose, by comparison with other hospitals of this size and activity we have much less qualified staff on the ground in relation to nursing staff... I think maybe they feel because they may have to replace sick leave on the ground, or replace maternity leave without being replaced, that then they are being pulled and dragged from every quarter, and that may be why they might feel that they have to be rewarded... coming out of that and then they have to go into another hour for accreditation and this is on top of what I already have to come back to"(SS).

"I would think that's probably a culture thing really... I think that's the life and the union involvement that if we do anything we must get rewarded but what they fail to see is that they got the reward"(SS).

"I think that's the nature of the beast…clinicians as a group, we would tend to say my area of responsibility is my ward or my clinic, and if you take me away from it I expect reward" (CS).

"I can understand why that is coming across and I suppose Brigid, people feel pretty hard done by, it's so difficult, people are really, really stretched and inviting them to something for the hospital is stretching them big-time, on a voluntary capacity that can be just too much sometimes" (CS).

"I think it goes back to the same thing we said before, that the support services are maybe not under as much pressure when they are attending the meetings as the clinical people, because they you see, in those type of jobs you don't run, they walk, whereas clinical people actually run and that's the difference, you know what I mean?"(CS).

This section has sought to present the findings arising from the six themes - leadership; communications; involvement and participation; training; teams and reward - relating to the accreditation implementation process, as depicted in the conceptual framework for this study. The next section seeks to explore the results relating to the experiences of respondents in terms of the impacts from accreditation.

6.4 Accreditation Impacts

In examining the findings based on accreditation impacts, the following sections aim to address these in terms of those that arise at the individual and organisational levels.

6.4.1 Individual Impacts

The impacts arising from the accreditation process, at an individual level, emerged to some extent during the observations of the accreditation team meetings. This was primarily evident in the role conflict experienced by team members in terms of having both the time to attend the meetings and to complete accreditation tasks required by virtue of their membership, and the competing demands of their normal work roles. These issues have been addressed in the previous section relating to involvement and participation. The only other instances of references to individual impacts being made were in Team 2 (clinical services) and Team 8 (support services). In the former, a team member comment early on in the process served to

suggest that getting away from the work environment was seen as positive aspect of attending an accreditation meeting:

"It's great to get away from the ward for a bit and to get a sit down. It's sweltering up there" (June 2004).

In the support services team, the scope for individual development arising from participation in the process, was also acknowledged by a team member:

"In fairness, I think I've learned quite a lot. I've got a better handle on how this place works than I had a year ago" (April 2005).

Questionnaire 1 also sought to explore various issues in relation individual impact, framed within the context of reasons for involvement. Table 6.68 addresses four items: only 15% of respondents indicated that involvement in accreditation would contribute to their career advancement, although this increases markedly in relation to contributing to personal development (34.6%). The use of involvement as an opportunity to remove themselves from the immediate work environment, was confirmed by only 3.9% of respondents, while 38.6% responded that their involvement would provide the opportunity to reflect on work practices.

Table 6.68 - Summary of Responses to Reasons for Becoming Involved with the Accreditation Process: Individual Impact Questionnaire 1

Questionnaire 1 Item I felt involvement would contribute to my career advancement		Number of Respondents	%
Valid	Yes	19	15.0
	No	107	84.3
	Total	126	99.2
Missing		1	.8
Total		127	100.0
Questionnaire 1 Item I felt involvement would contribute to my personal development		Number of Respondents	%
Valid	Yes	44	34.6
	No	83	65.4
Total		127	100.0
Questionnaire 1 Item I saw it as an opportunity to remove myself from my immediate work environment		Number of Respondents	%
Valid	Yes	5	3.9
	No	122	96.1
Total		127	100.0
Questionnaire 1 Item I wanted to reflect on my work practices		Number of Respondents	%
Valid	Yes	49	38.6
	No	78	61.4
Total		127	100.0

A cross-tabulation of these items is presented in table 6.69 based on team type. In relation to the career advancement item, there is relative consistency between the percentage responses of the two groups. The issue of personal development yields ‘Yes’ responses from 31.8% of clinical services respondents and 37.7% from support services. Distinct differences (although not statistically significant), arise between the two groups in relation to involvement in accreditation as an opportunity to leave the immediate work environment, as reflected in 1.5% of clinical services respondents confirming that this was their view, compared to 6.6% of the support services group. The final item - reflecting on work practices - provides relatively consistent results across the two groups, with 37.9% of the clinical services and 39.3% of the support services group indicating that this was their reason for involvement.

Table 6.69 - Cross-tabulation of Responses to Reasons for Becoming Involved with Accreditation Process based on Team Type: Individual Impact Questionnaire 1

Questionnaire 1 Item I felt involvement would contribute to my career advancement	Team Type	Number of Respondents and % Yes	Number of Respondents and % No	Missing	Total	P -Value
Valid	CS	10 (15.2)	55 (83.3)	1 (1.5)	66 (52.0)	.325
	SS	9 (14.8)	52 (85.2)	0	61 (48.0)	
		19 (15.0)	107 (84.2)	1 (.8)	127 (100.0)	
Questionnaire 1 Item I felt involvement would contribute to my personal development	**Team Type**	**Number of Respondents and % Yes**	**Number of Respondents and % No**		**Total**	**P-Value**
Valid	CS	21 (31.8)	45 (68.2)		66 (52.0)	.243
	SS	23 (37.7)	38 (62.3)		61 (48.0)	
		44 (34.6)	83 (65.4)		127 (100.0)	
Questionnaire 1 Item I saw it as an opportunity to remove myself from my immediate work environment	**Team Type**	**Number of Respondents and % Yes**	**Number of Respondents and % No**		**Total**	**P-Value**
Valid	CS	1 (1.5)	65 (98.5)		66 (52.0)	.072
	SS	4 (6.6)	57 (93.4)		61 (48.0)	
					127 (100.0)	
Questionnaire 1 Item: I wanted to reflect on my work practices	**Team Type**	**Number of Respondents and % Yes**	**Number of Respondents and % No**		**Total**	**P-Value**
Valid	CS	25 (37.9)	41 (62.1)		66 (52.0)	.432
	SS	24 (39.3)	37 (60.7)		61 (48.0)	
					127 (100.0)	

* Indicates statistical significance (1 tailed) at 5% level

Table 6.70 presents the same four items as a cross-tabulation, but analysed on work role. For the first three items, both medical groups (Consultants and NCHDs) provide ‘No’ responses, while for the final item, only one Consultant respondent (25%) saw involvement in accreditation as an opportunity to reflect on work practices.

Table 6.70 - Cross-tabulation of Responses to Reasons for Becoming Involved with Accreditation Process based on Work Role: Individual Impact Questionnaire 1

Questionnaire 1 Item: I felt involvement would contribute to my career advancement	Work Role	Number of Respondents and % Yes	Number of Respondents and % No	Missing	Total	P -Value
Valid	Nurse	8 (15.1)	44 (83.0)	1 (1.9)	53 (42.1)	.969
	AHP	4 (16.0)	21 (84.0)	0	25 (19.8)	
	Con	0	4 (100.0)	0	4 (3.2)	
	NCHD	0	1 (100.0)	0	1 (.8)	
	Other	6 (14.0)	37 (86.0)	0	43 (34.1)	
		18 (14.3)	107 (84.9)	1 (.8)	126 (100.0)	
Questionnaire 1 Item: I felt involvement would contribute to my personal development	**Work Role**	**Number of Respondents and % Yes**	**Number of Respondents and % No**		**Total**	**P-Value**
Valid	Nurse	20 (37.7)	33 (62.3)		53 (42.1)	.578
	AHP	9 (36.0)	16 (64.0)		25 (19.8)	
	Con	0	4 (100.0)		4 (3.2)	
	NCHD	0	1 (100.0)		1 (.8)	
	Other	15 (35.0)	28 (65.0)		43 (34.1)	
		44 (34.9)	82 (65.1)		126 (100.0)	
Questionnaire 1 Item: I saw it as an opportunity to remove myself from my immediate work environment	**Work Role**	**Number of Respondents and % Yes**	**Number of Respondents and % No**		**Total**	**P-Value**
Valid	Nurse	1 (1.9)	52 (98.1)		53 (42.1)	.749
	AHP	2 (8.0)	23 (92.0)		25 (19.8)	
	Con	0	4 (100.0)		4 (3.2)	
	NCHD	0	1 (100.0)		1 (.8)	
	Other	2 (4.7)	41 (95.3)		43 (34.1)	
		5 (4.0)	121 (96.0)		126 (100.0)	
Questionnaire 1 Item: I wanted to reflect on my work practices	**Work Role**	**Number of Respondents and % Yes**	**Number of Respondents and % No**		**Total**	**P-Value**
Valid	Nurse	18 (34.0)	35 (66.0)		53 (42.1)	.500
	AHP	13 (52.0)	12 (48.0)		25 (19.8)	
	Con	1 (25.0)	3 (75.0)		4 (3.2)	
	NCHD	0	1 (100.0)		1 (.8)	
	Other	16 (37.2)	27 (62.7)		43 (34.1)	
		48 (38.0)	78 (62.0)		126 (100.0)	

†Indicates statistical significance (2 tailed) at 5% level

Further insights into experiences of individual impacts were provided from the open-ended question data in the initial questionnaire. Of the eleven separate comments that were offered in a positive vein, these primarily related to accreditation providing an avenue for individual learning and increasing knowledge and understanding of the various functions and respective interactions across the research site. One support

services member commented that involvement in their accreditation team had improved their analytical ability and critical thinking skills, while for another the process had brought home to them the scope of their own work role:

"Participation in the accreditation process has made me more aware of my responsibilities as department head" (SS).

However, the process of working towards accreditation appeared to have already given rise to fundamental role conflicts for some individual team members. Both clinical and support services respondents (a total of eight and five respectively) volunteered that attending meetings and following up on the completion of standards and collecting the necessary supporting evidence, left them conflicted vis-à-vis the demands of their work role. This has been previously alluded to, in some respects, in relation to both the ability to leave the work environment to attend team meetings and the availability of time to participate in the accreditation process itself. Moreover, the scheduling of meetings was also problematic (as has been previously highlighted), particularly for those working in a clinical environment, and this is illustrated in the comments of two clinical services team members:

"Our meetings are scheduled at lunchtime which is totally inappropriate as the ward needs to be covered for lunch breaks and often staff members are on sick leave and not replaced so therefore I cannot attend"(CS)..

"Find it very difficult to get time to go to the meeting when I'm on day duty as there are two us going from the one area. So someone has to stay behind as we're generally on duty together" (CS).

Questionnaire 2 provided an additional opportunity to revisit a number of the individual impact issues, when the self-assessment stage had finally been completed. Table 6.71 provides an analysis of these based on team type and yields positive responses (varying levels of agreement) on all fronts, although this agreement is consistently stronger amongst the support services respondents. In addition, the differences between the two groups for the second item - involvement contributing to personal development - are statistically significant.

Table 6.71 - Comparison of Means on Individual Impact based on Team Type: Questionnaire 2

Questionnaire 2 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score, Standard Deviation and Weighted Mean	Team Type	N	Mean Score and Standard Deviation	P-Value
Involvement in Phase 1 of the accreditation process has allowed me to reflect on my work practices	1.89 (.734) 1.90	CS	60	1.95 (.675)	.070
		SS	46	1.80 (.806)	
Involvement in Phase 1 of the accreditation process contributed to my personal development	2.05 (.821) 2.07	CS	59	2.17 (.834)	.040*
		SS	47	1.89 (.787)	
Involvement in Phase 1 of the accreditation process contributed to my professional development	2.04 (.850) 2.06	CS	60	2.15 (.860)	.060
		SS	46	1.89 (.823)	
Involvement in Phase 1 of the accreditation process will contribute to my career advancement	2.64 (1.035) 2.64	CS	60	2.65 (1.071)	.462
		SS	46	2.63 (.997)	

*Indicates statistical significance (1 tailed) at 5% level

Addressing the items once more from the work role perspective, as illustrated in table 6.72, only the final item relating to career advancement, met with any disagreement and in this case, from the responding Consultant group (mean score 4.00). This is probably not surprising considering that, as Consultants, they have reached the most senior position in their profession and discipline. The sole NCHD respondent indicated that they were uncertain as to whether involvement in the self-assessment process would contribute to their career advancement.

Table 6.72 - Comparison of Means on Individual Impact based on Work Role: Questionnaire 2

Questionnaire 2 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score and Standard Deviation	Work Role	N	Mean Score and Standard Deviation	P-Value
Involvement in Phase 1 of the accreditation process has allowed me to reflect on my work practices	1.89 (.734)	Nurse	45	1.84 (.673)	.964
		AHP	19	1.95 (.705)	
		Con	3	2.00 (1.000)	
		NCHD	1	2.00	
		Other	38	1.89 (.831)	
Involvement in Phase 1 of the accreditation process contributed to my personal development	2.05 (.821)	Nurse	45	2.04 (.903)	.620
		AHP	19	2.26 (.733)	
		Con	3	2.33 (1.528)	
		NCHD	1	2.00	
		Other	38	1.92 (.712)	
Involvement in Phase 1 of the accreditation process contributed to my professional development	2.04 (.850)	Nurse	45	2.07 (.963)	.958
		AHP	19	2.11 (.658)	
		Con	3	2.33 (1.528)	
		NCHD	1	2.00	
		Other	38	1.95 (.769)	
Involvement in Phase 1 of the accreditation process will contribute to my career advancement	2.64 (1.035)	Nurse	45	2.49 (1.014)	.454
		AHP	19	2.68 (.749)	
		Con	2	4.00 (1.414)	
		NCHD	1	3.00	
		Other	39	2.72 (1.146)	

†Indicates statistical significance (2 tailed) at 5% level

The largely positive experiences of accreditation impacting at an individual level, as reflected in the quantitative results, were reinforced through the comments presented by team members to the open-ended question in the final questionnaire. Having then completed the first phase of accreditation - self-assessment - they were now positioned to reflect on their experiences of the process and to volunteer any benefits or problems that had arisen for them personally from involvement. In positive terms, some nineteen individual mentions were made within the data and examples of impacts included individual learning, providing an opportunity for self-analysis and reflection about practices in the specific work area, with a view to creating change and networking with staff from other disciplines and departments. These are, in turn, encapsulated in a sample of comments from two of the respondents:

"I did enjoy working as part of my care team. I got to know a wide spectrum of disciplines because of the team meetings and got a better understanding of the process involved in the care of the patient in XXX Hospital"(CS).

"In completing the first phase of the accreditation process, I have learnt that the importance of multidisciplinary involvement, and inter-agency contribution are hugely important in promoting best practice in the area of the welfare of children and their families. This process has highlighted for me the importance, among the professionals involved, of sharing information, in a co-ordinated response through good communication and feedback procedures. It has been a very well worth doing exercise and I feel it has enhanced my work practice within XXX Hospital"(SS).

This position was equally balanced (nineteen separate comments) by the problems relating to role conflict, which have been previously alluded to and had continued to be present for the remainder of the first phase of accreditation. Again, the tension that existed between attending team meetings and progressing related tasks and the requirements of busy work roles impacted on individual team members and spread, in some instances, to perceived impacts at the organisational level. These difficulties are expressed in the following sample of respondents comments:

"Huge time demands which left a lot of other necessary work undone" (SS).

"The amount of work involved in this process has meant that much of the 'day job' has been neglected we have fallen behind in very important issues. Protected time is required for this and this should be addressed" (SS).

"Very difficult to leave clinical area when ward busy, for team meetings" (CS).

"Time is a serious limiting factor. It is difficult to slot an extra ½ day per fortnight into an already stretched clinical workload, not to mention the extra paperwork, research etc (CS)".

"A lot of time was spent gathering information by staff with a clinical workload commitment. No extra hours were able to be allocated for same. Time spent on clerical/information gathering by staff with a clinical commitment takes time from patient care. This has to reduce the quality of care offered" (CS).

During the interviews, aspects of individual impacts also emerged when respondents where asked what they had personally derived from involvement with the first phase of accreditation. All twenty-eight confirmed that accreditation had been a positive vehicle for learning and development, despite the fact many of them had also been critical of aspects of the implementation process. The following extracts serve to demonstrate the strength of some of the views:

"Meeting and working with other people in the organisation, that is something, I mean there would be people that you would hear of, people on our team, or line managers, or whatever they were, and you'd vaguely know they were out there, whereas working with them on the team you would be a lot more aware of their role and what the issues are, so it's helpful" (SS).

"I think it has probably been one of the big learning things for me anyway…that I acquired huge learning, huge learning really from the whole process"(SS).

"The positive thing was that you got to meet people you wouldn't have met before. I got to find out what they were doing, which as I say, is good in a place like this that has never attempted to do that before"(SS).

"I wouldn't have had a clue of half of what was going on in XXX Hospital, but I learned a lot of what is going on there, there is a whole lot more going on here than I anticipated"(SS).

"Well I learned how lots of different services run in the hospital that I wasn't aware of"(CS).

"I went to the accreditation meetings, at a fair few of those accreditation meetings I often wondered if I was working in the same hospital as everybody else, by the end of that time I was pretty sure that I was working in the same hospital as everybody else and I knew an awful lot more about the support services, but more about what policies and procedures and protocols were out there"(CS).

Moreover, three clinical services respondents additionally highlighted the benefits that might accrue from involvement, in terms of seeking other employment and career progression:

"Well I suppose it would be if I was looking for, you know, promotion, certainly it would be very beneficial to have that on your CV that you're involved in it"(CS).

"For employment or jobs it's good for the CV. It's also very good at an interview to show that we actually understand the mechanisms and we understand what it's about" (CS).

"It would be nice for your résumé"(CS).

In spite of these assessments, the interview results further confirm what has already been identified through the other data collection mechanisms - that respondents had experienced role conflict by virtue of participating in accreditation, arising from demands of their work role and the requirements of being a team member. Only one interviewee (support services) indicated that that they had been able to effectively manage the prioritisation of accreditation meetings and tasks, while for majority, the difficulties seemed to be acute and, in particular, for those in clinical services teams:

"I found that difficult myself because sometimes to get to the meetings was difficult because of other commitments…I suppose at times I felt guilty that I should have been there more often, I should have been contributing a bit more"(SS).

"It was a significant contribution in terms of time and a burden on everyone in addition to what they were doing, without any, how should we say, consideration to what they were doing in their alternative work and I think that was particularly significant"(SS).

"I felt that some days you were coming down from the areas that you knew were understaffed to kind of like talk about all the things you did, and quality seemed to be so detached from what was actually happening in reality on the wards, and sometimes I used to come into meetings and I used to be just like ' what am I doing

this for when there is so much to be done up there' and you go down and it all sounds like everything is wonderful down there, you're doing this and you're doing that, and actually the reality is so different"(CS).

"I'm thinking of nursing staff and numbers are low and there is a patient on the ward needing a lot of attention, it's very difficult, you know, to the point that it is not feasible"(CS).

"The fact that you were taking time and walking off, walking away from clinical areas, people just got so annoyed with you the whole time, it was palpable the annoyance, so you really had to put your head down and just go, and quite often you wouldn't even say where you were going, you would just say I have to go to a meeting, eventually they knew where you were going, but people got very annoyed at you walking off and leaving them with the workload"(CS).

6.4.2 Organisational Impacts

The experiences of individual team members in terms of organisational impacts, reflects the remaining theme under which the results from this aspect of the research are presented. The observational data is limited in its reference to this area (only three recorded observations of this issue being discussed) and suggests that some team members viewed the accreditation process, and its potential to impact in a positive sense at the research site, with some degree of reservation. This was particularly brought home in the comment from a clinical services team member, during a discussion on risk assessment:

"Maybe we should do a risk assessment to find out whether accreditation is worth doing" (November 2004).

Despite these reservations, a potential benefit of accreditation was acknowledged by another clinical services team member early on in the process:

"Even without accreditation, the review needed to be done" (May 2004).

Results from the questionnaires provide a more detailed assessment of the organisational impact of accreditation based on the views and experiences of team members. Tables 6.73 summarises the responses reflecting the reasons for team member involvement with the accreditation process, with reference to organisational impacts, arising from the initial questionnaire. While 65.4% of respondents indicated that they wanted to make a contribution that would improve standards and delivery at the hospital level, this was markedly lower at 51.2% in relation to improving the operation of their immediate work environment.

Table 6.73 - Summary of Responses to Reasons for Becoming Involved with Accreditation Process: Organisational Impact Questionnaire 1

Questionnaire 1 Item: I wanted to contribute to improving the standard and delivery of healthcare in the hospital		Number of Respondents	%
Valid	Yes	83	65.4
	No	44	34.6
Total		127	100.0
Questionnaire 1 Item: I wanted to contribute to improving the way in which my immediate work environment operates		Number of Respondents	%
Valid	Yes	65	51.2
	No	62	48.8
Total		127	100.0

A richer level of analysis of these issues is presented in the cross-tabulation based in team type, outlined table 6.74. The results illustrate some degree of consensus between both the clinical services and support services team types on the first item (65.1% and 65.6% respectively). In relation to the second item, small differences arise, with 53% of clinical services team respondents specifying that a reason for involvement was the potential to improve upon how their immediate work environment operated, in comparison to 49.2% of those respondents in the support services responding group.

Table 6.74 - Cross-tabulation of Responses to Reasons for Becoming Involved with Accreditation Process based on Team Type: Organisational Impact

Questionnaire 1 Item: I wanted to contribute to improving the standard and delivery of healthcare in the hospital	Team Type	Number of Respondents and % Yes	Number of Respondents and % No	Total	P-Value
Valid	CS	43 (65.1)	23 (34.9)	66 (52.0)	.273
	SS	40 (65.6)	21 (34.4)	61 (48.0)	
		83 (65.3)	44 (34.7)	127 (100.0)	
Questionnaire 1 Item: I wanted to contribute to improving the way in which my immediate work environment operates	**Team Type**	**Number of Respondents and % Yes**	**Number of Respondents and % No**	**Total**	**P-Value**
Valid	CS	35 (53.0)	31 (47.0)	66 (52.0)	.393
	SS	30 (49.2)	31 (50.8)	61 (48.0)	
		65 (51.2)	62 (48.8)	127 (100.0)	

*Indicates statistical significance (1 tailed) at 5% level

Viewing the same two items from the work role perspective allows for an alternative view of the data to be reached and this is presented in table 6.75. In relation to the first item - involvement to improve the standard and delivery of healthcare in the hospital - yields the lowest percentage to 'Yes' from the Consultant group (25%). With reference to improving the operation of the immediate work environment, the position changes, with only 44.2% of the 'Other' group indicating that this was their reason for involvement with the accreditation process.

Table 6.75 - Cross-tabulation of Responses to Reasons for Becoming Involved with Accreditation Process based on Work Role: Organisational Impact

Questionnaire 1 Item: I wanted to contribute to improving the standard and delivery of healthcare in the hospital	Work Role	Number of Respondents and % Yes	Number of Respondents and % No	Total	P-Value
Valid	Nurse	34 (64.2)	19 (35.8)	53 (42.1)	.197
	AHP	19 (76.0)	6 (24.0)	25 (19.8)	
	Con	1 (25.0)	3 (75.0)	4 (3.2)	
	NCHD	0 (-)	1 (100.0)	1 (.8)	
	Other	28 (65.1)	15 (34.9)	43 (34.1)	
		82 (65.0)	44 (35.0)	126 (100.00)	
Questionnaire 1 Item: I wanted to contribute to improving the way in which my immediate work environment operates	**Work Role**	**Number of Respondents and % Yes**	**Number of Respondents and % No**	**Total**	**P-Value**
Valid	Nurse	27 (50.9)	26 (49.1)	53 (42.1)	.317
	AHP	17 (68.0)	8 (32.0)	25 (19.8)	
	Con	2 (50.0)	2 (50.0)	4 (3.2)	
	NCHD	0 (-)	1 (100.0)	1 (.8)	
	Other	19 (44.2)	24 (55.8)	43 (34.1)	
		65 (51.6)	61 (48.4)	126 (100.0)	

†Indicates statistical significance (2 tailed) at 5% level

The analysis of responses based on a comparison of means, outlined in table 6.76, presents a breakdown based on team type for the Likert items from questionnaire 1. For both statements, clinical services respondents offered more negative responses to the constructive impact of accreditation, both in their immediate work environment and across the hospital, than their support services counterparts and these are reflected in the mean scores which are consistently greater than 3.00. In relation to the second item, these differences are statistically significant. Overall, these results might not be considered to be surprising given that the accreditation process had only been underway for five months at the point at which the questionnaire was administered.

Table 6.76 - Comparison of Means on Organisational Impact based on Team Type: Questionnaire 1

Questionnaire 1 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score, Standard Deviation and Weighted Mean	Team Type	N	Mean Score and Standard Deviation	P-Value
Accreditation has already improved the standard and delivery of healthcare within my immediate work environment	3.33 (1.006) 3.36	CS	62	3.45(1.066)	.077
		SS	58	3.19 (.926)	
Accreditation has already improved the standard and delivery of healthcare within the hospital	3.32 (.889) 3.38	CS	62	3.55 (.918)	.002*
		SS	58	3.07 (.792)	

*Indicates statistical significance (1 tailed) at 5% level

The results based on work role, as presented in table 6.77, similarly reflect the level of negativity towards both items, with the medical respondents (Consultants and NCHDs) indicating the greatest level of disagreement.

Table 6.77 - Comparison of Means on Organisational Impact based on Work Role: Questionnaire 1

Questionnaire 1 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score and Standard Deviation	Work Role	N	Mean Score and Standard Deviation	P-Value
Accreditation has already improved the standard and delivery of healthcare within my immediate work environment	3.33 (1.006)	Nurse	52	3.30 (1.034)	.012†
		AHP	24	3.08 (.929)	
		Con	2	4.50 (.707)	
		NCHD	1	4.00	
		Other	40	3.03 (.920)	
Accreditation has already improved the standard and delivery of healthcare within the hospital	3.32 (.889)	Nurse	52	3.58 (.893)	.001†
		AHP	24	3.00 (.780)	
		Con	2	5.00 (.000)	
		NCHD	1	5.00	
		Other	40	3.05 (.749)	

†Indicates statistical significance (2 tailed) at 5% level

However, the comments from the open-ended question within the questionnaire did confirm that many respondents recognised the potential of accreditation to impact at the organisational level and the qualitative analysis yielded thirty-eight positive comments (nineteen from clinical services and nineteen from support services team members) from those who choose to input to this part of the questionnaire. A range of benefits were highlighted including enabling the identification of current

weakness in the system; formalising policies to improve consistency and move towards standardisation; reducing duplication; enhancing communication between disciplines and departments and improving multidisciplinary working. As one support services respondent summed up:

"The process of accreditation has brought members from all disciplines together to share a focus in improving standards in healthcare. The experiences within the team are widespread which allows a difference of opinion and different perspectives in the overall view. This difference in outlook should be a positive influence to appreciate the problems and strengths within the health care system. The sharing of information has opened a better forum for communication with colleagues and an appreciation of other roles".

This encouraging position was, however, countered in the views expressed by other respondents, which suggested both doubt and cynicism about the real impact that accreditation might make across the organisation. A number of remarks (five from a total of eleven) articulated the view that accreditation was nothing more than a paper exercise, whose recommendations would not be followed through with the necessary resources. The process was also described as being too vague to have any real relevance and impact and that any policies and protocols that would arise might not be actually adhered to. The reservations of one clinical services team member, at this five-month stage of the process, are clearly represented in the following comment:

"If the outcome is positive and achieves what it has set out to achieve then the many hours it took away from our ordinary duties, to research and collate the data will have been worthwhile. However I am sceptical about how many of the recommendations will actually be implemented mainly due to a shortfall in resources. We will just continue to have to prioritise and be selective".

Table 6.78 indicates that an improvement in views on the impacts arising from accreditation had occurred by the end of phase 1 of the accreditation process, as derived from questionnaire 2 and based on team type. The initial two items from questionnaire 1 were repeated and these yield results that indicate that accreditation had impacted positively, in both the immediate work environment of respondents and

also across the hospital. Clinical services and support services respondents also agreed that the process had enhanced both working relationships and the level of multidisciplinary working. As to whether accreditation was deemed to be a worthwhile process in the views of the staff within the hospital, the mean scores for the responding groups are somewhat lower than for the other items relating to organisational impact. In all instances, the mean scores for the support services group are more positive (i.e. higher levels of agreement) than those for clinical services and with the exception of the first item relating to the enhancement of working relationships with immediate work colleagues, there are statistically significant differences between the two groups.

Table 6.78 - Comparison of Means on Organisational Impact based on Team Type: Questionnaire 2

Questionnaire 2 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score, Standard Deviation and Weighted Mean	Team Type	N	Mean Score and Standard Deviation	P-Value
Accreditation enhanced my relationships with my immediate work colleagues	1.89 (.858) 1.89	CS	58	1.93 (.722)	.087
		SS	47	1.83(1.007)	
Accreditation has improved the level of multidisciplinary working in the hospital	2.15 (.922) 2.19	CS	59	2.37 (.945)	.002*
		SS	45	1.87 (.825)	
Accreditation has improved the standard and delivery of healthcare within my immediate work environment	2.56 (.943) 2.59	CS	59	2.76 (.989)	.011*
		SS	42	2.29 (.805)	
Accreditation has improved the standard and delivery of healthcare within the hospital	2.52 (.831) 2.55	CS	59	2.69 (.915)	.019*
		SS	47	2.30 (.657)	
Accreditation is a worthwhile process	1.83 (.910) 1.86	CS	59	2.00 (1.00)	.023*
		SS	47	1.62 (.739)	
Staff in the hospital believe that accreditation is a worthwhile process	3.01 (.830) 3.04	CS	60	3.18 (.833)	.015*
		SS	47	2.79 (.778)	

*Indicates statistical significance (1 tailed) at 5% level

A final review of the organisational impacts arsing from accreditation is made in table 6.79, based on work role. The first five items were all assessed in positive terms, with the exception of the single NCHD respondent on item three and item five. However, the final item, where the issue of accreditation being a worthwhile process from the hospital staff perspective, is posed to respondents, was met with

either uncertainty or a level of disagreement by four of the five groups, the exception being 'Other'.

Table 6.79 - Comparison of Means on Organisational Impact based on Work Role: Questionnaire 2

Questionnaire 2 Item (1 - strongly agree, 2 - agree, 3 - uncertain, 4 - disagree, 5 - strongly disagree)	Overall Mean Score and Standard Deviation	Work Role	N	Mean Score and Standard Deviation	P-Value
Accreditation enhanced my relationships with my immediate work colleagues	1.89 (.858)	Nurse	45	1.89 (.775)	.727
		AHP	19	2.00 (.745)	
		Con	2	2.00(1.414)	
		NCHD	1	2.00	
		Other	38	1.82(1.010)	
Accreditation has improved the level of multidisciplinary working in the hospital	2.15 (.922)	Nurse	45	2.31(1.041)	.140
		AHP	19	2.37 (.955)	
		Con	3	1.67(1.155)	
		NCHD	0		
		Other	37	1.89 (.658)	
Accreditation has improved the standard and delivery of healthcare within my immediate work environment	2.56 (.943)	Nurse	45	2.62(1.007)	.265
		AHP	19	2.74 (.806)	
		Con	3	2.33(2.309)	
		NCHD	1	4.00	
		Other	33	2.36 (.742)	
Accreditation has improved the standard and delivery of healthcare within the hospital	2.52 (.831)	Nurse	45	2.67 (.977)	.139
		AHP	19	2.68 (.582)	
		Con	3	2.67(1.528)	
		NCHD	1	3.00	
		Other	38	2.24 (.634)	
Accreditation is a worthwhile process	1.83 (.910)	Nurse	45	1.87 (.944)	.900
		AHP	19	1.84 (.958)	
		Con	2	1.50 (.707)	
		NCHD	1	5.00	
		Other	39	1.72 (.724)	
Staff in the hospital believe that accreditation is a worthwhile process	3.01 (.830)	Nurse	45	3.16 (.852)	.229
		AHP	19	3.00(.816)	
		Con	3	3.00 (1.000)	
		NCHD	1	3.00	
		Other	39	2.85 (.812)	

†Indicates statistical significance (2 tailed) at 5% level

The seemingly general acknowledgement of the positive impact of accreditation at the organisational level, is also reaffirmed in the views expressed in the responses to the open-ended element of questionnaire (a total of forty comments) and largely reflected the comments arising from the previous questionnaire. Benefits included an increased understanding and recognition of the roles that different disciplines played in delivering care; providing the opportunity to review, evaluate and revise service provision in a work area, in line with best practice; developing a central bank of

documents; improving communication across the hospital; facilitating multidisciplinary working and being the basis for justifying and reinforcing already existing claims for further resources. As one support services respondent observed:

"The accreditation process has presented an invaluable opportunity for each head of service to stop review, evaluate and revise their service provision to the betterment of the healthcare provision. The accreditation process will fortify the need for 'already justified resources' and will serve as a vehicle to develop and progress areas which have that justified need".

However, despite the encouraging quantitative and qualitative results from the post-IHSAB survey questionnaire, cynicism and doubt were still in evidence in the comments to the open-ended question and were, in the main (eleven of the thirteen total comments), offered by respondents from the clinical services teams. Negativity surrounded what was felt to be the superficiality, short-termism and lack of real commitment on the part of management to the process and that this might suggest that respondents felt there had been no positive impact from accreditation. This is reflected in the comments from three different clinical services team members:

"It appears like a last minute tidy up while the improvements were not sustained. Management appeared to be concerned only with getting it 'right on the day' not looking at ways to improve patient care".

"The accreditation day gave a very unrealistic and tainted version of this hospital. Ongoing problems were hidden and covered up".

"The hospital 'fixed up' for accreditation survey. Will there improvements continue, or will there be another fix up rush prior to survey no. 2 ?".

Concerns were also highlighted about the amount of time that had been spent on accreditation and that, as a consequence of no extra resources being allocated to the process, it was suggested that this had detracted from ultimately sustaining service provision and had, in turn, potentially impacted negatively on patient care. As a clinical services respondent noted:

"Leaving the area understaffed to attend meetings is an issue of great relevance to client safety, staff well-being. A major concern for those leaving the area, as well as those staying behind"(CS).

Similar disquiet was also in evidence in the remarks of a support services team member:

"A Senior Manager attending the very first briefing session on Accreditation saw how many staff were present and was heard to comment 'is no work being done in the Hospital this afternoon'. In a situation where Departments and disciplines are unable to do all that needs to be done for patient care due to chronic on-going lack of resources, the fact that management is seeking accreditation which would give the appearance that everything is fine can only be regarded as an attempt to 'paper over the cracks'. We have been given no sense at all that, if deficiencies are identified, solutions will be adequately and appropriately resourced in a targeted way"(SS).

This spectrum and balance of views was also reflected in the responses from the twenty-eight interviewees. Most respondents were able to acknowledge the positive benefits of the process to the organisation:

"I believe there was no sort of system or review of documentation or any thing of sort up 'til that" (SS).

"I think that it was good for morale in the hospital in general"(SS).

"I do think that it was a good thing, I still think it's a good thing. I mean I think there has been a bit of cynicism from some people who sort of feel that 'Oh well we got the walls painted' or 'we got this done' or 'we're getting policies done because accreditation is happening '. If no other reason it's been a good thing to get those things done, you know it made people are much more aware of what we're doing, and maybe how we're seen, you know, what we're doing in the sense that, you know, we all feel we're giving lots of information to patients, but then you're asked how do you verify it, can you document what you are giving to people" (CS).

"I felt that there was improvement around the place"(CS).

"My opinion on the accreditation end of things, it's very beneficial. The overall objective is for change, change for the better, you know, I would like to see that as being the outcome of accreditation after phase 1"(CS).

Moreover, a number of other specific and positive impacts were volunteered by respondents, which, in turn, serve to reinforce the findings from the other data sources. In the first instance, the scope for developing standards for processes and practices across both clinical and support services activities was highlighted as being a beneficial outcome from accreditation:

"The other benefit is that when we introduce new people, new employees, to our department what happens then automatically is we can focus them towards the relevant standards in this department and say this is what is done. It dismisses this prospect of learning by word of mouth from their colleagues" (SS).

"I suppose in a way it was something that needed to be done. It was definitely beneficial because I think it gave a formal standard to our services and we have committed to other plans"(SS).

The improvement in multidisciplinary working was also noted as having arisen from the self-assessment process:

"I think what I got out of it probably, and probably it was the most beneficial thing we got out of it, was the fact that groups of people who would not normally have had the opportunity to get together now found themselves working together and sharing their knowledge, sharing their expertise, and that's sowing the seeds to me for an awful lot greater things to come"(SS).

"It even brought the team together a bit closer and the multidisciplinary team working on the ward, that we actually probably would work better together now

because you even get to know people on a personal level, you know, which makes it a little bit easier when you're in your workplace"(CS).

Finally, accreditation was recognised as being a vehicle for improving communication in the hospital:

"I didn't get a sense that people were running around excited because accreditation was going on, they were seeing accreditation as a means to highlight issues that they had themselves on the ground"(SS).

"You know even if nothing comes out of it, that in itself is something that is very valuable for the whole hospital, that people even know who they are talking to"(CS).

"I think overall it was a positive exercise I think, overall, for the rest of the people in it, it was good, I mean we wouldn't have had direct contact with the public health, well I would have now being the ward sister or whatever, like I still have that level of engagement now because I can meet them now or I can ring the pharmacist and sort out issues on the phone. It's much easier to talk to them now. Certainly the communication with the public health and community care has improved"(CS).

However, two responses serve to illustrate separately on one hand, what was viewed as a lack of positive impact from accreditation at the research site and on the other, what might be a prevailing view amongst the wider body of staff:

"I don't think accreditation overall made a huge difference. I'm not saying that when the next phase comes I'm going to refuse to take part, because I will participate. Because it is a lovely thought, it would be a good thing to have, but I don't know if it is achievable, I really don't. I think the nature of the hospital and as I said there is a lack of continuity in the staff, with them coming and going all the time in every area, and the workload on people, it seems to be getting more and more and the staffing is not being increased, everybody is just so busy trying to do what they have to do that all those extras are not going to, you know, get done or make a difference" (SS).

"I think there would definitely be people who would still see this as a paper exercise, definitely. I think it's getting that message out there that it isn't a paper exercise in the sense that it will benefit each and every one of us who work in the organisation and strengthen reputation with the service users that we look after and care for every day of the week, but it is getting that message out there that I think it is difficult"(SS).

6.5 Respondent Explanations of Differences between Clinical Services and Support Services Findings

This final section presents the findings arising from the semi-structured interviews in terms of respondents' explanations for what has been, in the main, an overall pattern in the questionnaire findings i.e. that the support services responding group were more positive in their assessments of their experiences of the accreditation implementation process and impacts, than their clinical services counterparts.

Six of the twenty-eight interviewees were unable to offer any insights into the trend in the questionnaire results. For the remaining twenty-two, their explanations reflected a range of issues. Several respondents indicated that clinical services staff, were in their view, more operational and were thus further removed from the strategic and wider environmental drivers for implementing accreditation, and hence saw it as less relevant:

"I would say that you know that would be quite apparent because on the clinical teams they are operational on the ground and they don't, they are not always aware of why something is happening so they perceive a lot more barriers than on the support team. The people on the support team, they know what the policies and strategies are all about, we are exposed to them so therefore we know why we are implementing something and we are much more aware, but that's the only difference"(SS).

"The support team are strategic, in that they can, they view things strategically, they base themselves strategically, they look at the national direction, they look at the regional, that's all done in their day to day work, in their day to day practice, sort of the way they operate. A lot of clinicians work very much within their own bubble,

that's as that may be, I myself, I'm a very good nurse at looking after my patients, but they don't recognise the influences or the demands even that may be coming from the wider hospital, yes all the stuff that's driving change, that's effecting change"(CS).

The lack of multidisciplinary participation in the clinical services teams, was also noted by another respondent as an explanation:

"I'd say from the care teams' perspective one of the big, one of the big downfalls was that they weren't completely multidisciplinary, really if you were to be true to yourself it wasn't. The whole process required much more support from our medical colleagues and I know some of the teams did get the support, and true support, but I know some of the teams didn't, and I think really the care teams would have had to have been multidisciplinary and I don't think the whole issue of getting staff released from all wards, from very busy wards, and trying to cover their shifts etc., would be easy"(SS).

The resource constraints under which clinical services team members were particularly perceived to be working, featured heavily in the exploration of this issue, highlighting that staffing levels, the needs of patients and the lack of personal discretion over time allocation in the working day, had exacerbated team members ability to fully participate, which, in turn, had influenced their assessments of the process:

"You have an awful lot of independent people within the non-care teams and maybe they have a level of control over where they are at a particular point, where the people on the care team are typically out there and it's very hard to separate them from the ward... I think much more difficult for them. While the others are busy, they have more of an element of self-control about where they are at any particular time…whereas the others are trying to get a care person to be released, it's much harder for them to extract themselves from that, you know, so I would say that is a key factor in that"(SS).

"I said it really angrily, you know I was thinking 'I am so stressed here' and you know 'it's all right for ye guys to sit around' and just thinking ' I haven't got time for this' and I know a lot of my colleagues would have felt the same, and that would be really because you can't put, and maybe we're wrong, but I just thought I can't put people on hold, if something happens it's too late when you go back up, or you know the way, so I can totally understand that that pattern would be there, yeah I would have found that very difficult. Both have a different focus too you know, depending on what service you're in, I mean clinical people are very clinically focused, they're there and they're hands-on people and their priority really is the patients. So there is a difference"(CS).

"A lot of those support services teams are away from the coalface and I think that when you are away from the coalface you are often buffered by the fact that, from the reality of what's going on at the coalface. From the management point of view, to be able to see everything is great and there's all this going on, whereas they are not eyeballing it in every day, they don't actually see the reality as the public do, and the staff on the front line see every day... now I suppose that's the judgment I'm making, but I suppose the clinical people they are on the floor, support services are under no pressure"(CS).

"I would imagine that the people in the clinical areas are a lot more frustrated than people in support services. It is a lack of resources, what they should be doing, what they feel, the care that they could be giving, that there were other resources put in place. I'd say it was perceived as another drain on their time, yes"(CS).

"With it being clinical, you're little more...you see the patient, I don't know if this is answering your question, but so you can be a lot more dissatisfied and maybe have a little bit more of a negative outlook on where accreditation and the process is going"(CS).

"Yes, because they're not dealing with people, I think that's the main one, they're not actually dealing with people, human emotions, if you like the foibles of people, the differences and they literally weren't. It did rankle me a couple of times when people would say 'the support services are much better than the clinical services', they just

didn't understand it all at all how difficult that is to deal with the demands. If you have to give a service, you really have to give time, time being money, We have enough people on the ground to barely give the service"(CS).

6.6 Conclusion

This chapter has presented the findings arising from the three research methods deployed during this study on hospital accreditation. In doing so, it has focused on the themes integral to the implementation process, individual and organisational impacts and differences in individual experiences, based on team type and work role, as reflected in the conceptual framework. Chapter 7 now moves to address the interpretation of these findings and their meaning in the context of the literature review.

Chapter 7: Discussion

7.0 Introduction

Forming the penultimate chapter within this thesis, the approach taken is to provide an opportunity to examine the findings from Chapter 6 and to interpret these, with reference to both the literature review, as presented in Chapters 3 and 4 and the wider healthcare context, as discussed in Chapter 2. For the purpose of ensuring continuity and moreover, to make an explicit link to the conceptual framework and stated objectives for this research, this discussion is structured as follows:

- Background - Previous Involvement with Quality and Accreditation;
- Accreditation Implementation Process (leadership; communications; involvement and participation; training; teams; reward);
- Accreditation Impacts (individual and organisational);
- Respondent Explanations of Differences between Clinical Services and Support Services Findings.

Furthermore, particular account is taken of the arguments made by Katz & Kahn (1978), Beer & Spector (1993), Schonberger (1994), Hill & Wilkinson (1995), Yong & Wilkinson (1999) and Chang (2005) as to the interconnectedness of the activities associated with change and quality implementation. Thus, the treatment of the discussion extends beyond the specific boundaries of the results based on the individual themes and, as depicted in the conceptual framework, to the exploration of related evidence elsewhere in the body of findings.

7.1 Background

The primary research (questionnaire 1) provided background data on the extent of the prior involvement of respondents with both quality initiatives and accreditation in a healthcare context and serves as an indication of the experience base from which team members commenced the self-assessment process. These results demonstrate that only a limited body of responding accreditation team members had had this type of exposure (37% and 18.1% respectively) previously, although a higher percentage of clinical services team members had gained experience with accreditation (19.7%) than support services (16.7%). For accreditation in particular, this experience had

been gained not only in Ireland but also internationally, and was not exclusively with approaches that were directly comparable to the IHSAB scheme, as team members included involvement with ISO 9000 and the WHO baby friendly hospital award in their responses.

The results from this research clearly support the position that has been previously presented in Chapter 2, in that within the context of Irish public sector and healthcare, in particular, the actual implementation of quality approaches and, specifically, accreditation would appear to be in its early stages (Boyle & Humphreys 2001;PA Consulting Group 2002;National Economic and Social Forum 2006). This may also be viewed with reference to the fact that the SMI and DBG were implemented more than a decade ago, as vehicles for reform and within this, as a means of heightening the quality agenda. Furthermore, *Shaping a Healthier Future* (Department of Health 1994) was launched in 1994 as an attempt to develop and promote quality in the provision of health services in Ireland. As such, the findings from this study may also serve as a further indication that progressing the NPM, public sector reform and quality agendas, has been slow within an Irish context and is thus supportive of the assessments made by Boyle & Humphreys (2001), PA Consulting Group (2002), Wren (2003) and Tussing & Wren (2006).

As further evidence of this, the findings from the Ennis & Harrington (1999b) study on quality in Irish healthcare indicated that only 25% of responding hospitals had developed any degree of involvement with quality approaches. The manifestation of this would therefore be the likely restriction of respondents within this study's ability to gain such experience within an Irish context. The results also contribute to confirming that accreditation, at the time of the study, was in the early stages of adoption, having only been rolled out in the major academic teaching hospitals in 2002 and then to the remainder of the acute-care sector, in subsequent years. In the context of the research site, the implementation of organisation-wide quality approaches appeared to be in its infancy, confirmed by the comments of one support services respondent: *"It came as a bit of a shock when I came into the hospital the first time, it was really only starting to be initiated here" (SS).* As a result, there would have been limited opportunities for respondents to become involved with an accreditation process, unless it had been at one of the initial teaching hospital sites, in

a private hospital context, for example implementing the JCI scheme or alternatively, in hospitals abroad.

7.2 Accreditation Implementation Process

The following sections seek to explore the six themes relating to the implementation process of accreditation and in doing, address the following research objectives:

> *To explore the experiences of individual team members with reference to the implementation process surrounding the first phase of accreditation;*
>
> *To establish the extent of, and reasons for, any differences between individual team members, in terms of their experiences of the implementation process and individual and organisational impacts associated with the first phase of accreditation, based on team type and work role.*

7.2.1 Leadership

The central role that leadership plays in the management of change and, within this, the implementation of an organisation-wide quality approach, has been recognised in the review of the literature in the area (Weisbord 1976a;Pettigrew, Ferlie, & McKee 1992;Hamzah & Zairi 1996a;Shortell, Bennett, & Byck 1998;Gustafson et al. 2003;Buchanan & Fitzgerald 2007). For Burke & Litwin (1992), leadership supplies the direction to the change and implementation process. Moreover, Woodward & Hendry (2004) note that the leadership during implementation will be subjected to constant scrutiny and evaluation by employees. With reference to the findings, on one hand these have presented a relatively positive assessment of the leadership associated with the implementation of the first phase of accreditation at the research site. The observations noted evidence of providing direction, motivating the team and focusing the team members on the timelines for the self-assessment. At the same time, both the quantitative and qualitative questionnaire data and the subsequent interview responses have further reinforced this position, based on the assessments of the respondents, and in the view of one *"The encouragement given by XXX and YYY was exceptional. Their leadership was without fault" (SS).* Further insight into the extent and efficacy of the leadership associated with the implementation process

may, however, also be gained when viewed in the context of Cummings & Worley's (2001) five major leadership activities associated with managing change. This, in turn, may serve to demonstrate the spread and influence of leadership across other aspects of the implementation process, which is evidenced in other facets of the research findings.

Looking first at the extent that the leadership for accreditation was successful in motivating and creating readiness and acceptance of the need to change, as previously acknowledged, the observational findings have confirmed that there was some demonstration of this during the accreditation team meetings. However, accepting that communication is a vehicle by which this motivation, readiness and acceptance may be achieved (Ford & Ford 1995;Lewis 1999;Kitchen & Daly 2002), the evaluations of the initial and on-going communications associated with the process would suggest that this had not been fully realised. At stages within the self-assessment process, there was evidence that team members did not fully understand the process, their role within it and the relevance of accreditation to the hospital itself. In the words of one team *member "I get the impression that this accreditation model is definitely a Beaumont Hospital type of thing. I can't see how it applies to us"*. Moreover, the challenge to the leadership of the process at the research site in engaging team members, was also demonstrated in the findings, where the motivation of team members towards the process would appear to have wavered over the course of the self-assessment, as indicated in both respondents assessments of their commitment to accreditation and also in the level of general attendance and hence involvement and participation at team meetings.

The results would also suggest that, based on the experiences and views of respondents, the development of the motivation for, and readiness and acceptance of, accreditation as an organisation-wide quality approach is unlikely to have been fully internalised by the wider body of employees at the research site, despite the initial communications efforts and the additional media that were introduced by the Accreditation Managers. This is contrary to the position advocated in the literature, which underlines the significance of, and necessity for, every employee in the organisation to acquire an understanding of the purpose, necessity and implications

of the quality approach and also their role and contribution to it (Milakovich 1991;Alexander 1997;Jackson 2001;Caluwe & Vermaak 2003).

Cummings & Worley's (2001) second leadership activity - creating a vision for change - has already been alluded to. The communications and the linked training sessions conducted at the early stages of the self-assessment process would appear to have struggled to achieve this, as demonstrated in the findings. Only towards the end of the first phase did a fuller understanding of the scope and impact of accreditation materialise, although as reported by respondents, this was not surprisingly more with those directly involved with the process (the team members), than the wider employee population.

The third activity associated with leadership during the implementation of change, as advocated by Cummings & Worley (2001), involves harnessing the political support of powerful groups and individuals. Securing this support and also key stakeholder involvement during the change and quality implementation process, is widely acknowledged in the literature as being a priority which if not successfully actioned, may have the potential to undermine the achievement of the change itself (Black & Porter 1995;Fernandez & Rainey 2006;Soltani, Lai, & Mahmoudi 2007;Oakland & Tanner 2007). Within a public sector context, employees have been recognised as a powerful stakeholder group (Fernandez & Rainey 2006;National Economic and Social Forum 2006;Soltani, Lai, & Mahmoudi 2007), while in a healthcare and more specifically, a hospital environment, doctors are seen as both individuals and collectively as a group, as having the capacity to exert their influence throughout the organisation and in doing so, resist change and quality implementation (Weisbord 1976b;Mintzberg 1989;Zabada, Rivers, & Munchus 1998;Boaden 2006).

With reference to this study, harnessing the support of powerful groups would seem to have posed a serious challenge for the leadership of the accreditation process at the research site. The problems associated with low levels of team meeting attendance have been highlighted in the findings, while the level of both attendance and associated involvement of doctors has been singled out for particular comment in the responses of team members, who recognised, as reflected in the literature, that as a group, clinicians' contribution to quality approaches and within this accreditation,

is an imperative (Duckett 1983;Berwick, Godfrey, & Roessner 1990;Redmayne et al. 1995;Gandhi et al. 2000;Ham, Kipping, & McLeod 2003;Pomey et al. 2005). For Alexander et al. (2006), the function of leadership is to positively influence doctor participation, which in this instance may not been fully achieved and the implications of this are also recognised in the findings, where clinical services respondents, in particular, noted that the completion of the IHSAB standards and the collation of supporting evidence of compliance had been hampered by the lack of input from clinician colleagues. As such, the findings from this study resonate with those of Duckett (1983), Redmayne et al. (1995) and Pomey et al. (2004). In particular, Duckett (1983) noted in his research that the self-assessment stage of accreditation had been severely hindered by medical staff that he described as being *"…uncooperative and uniformed"* (p.1577), a view that is also echoed in the study by Redmayne et al. (1995).

The development of a plan for implementation (Cummings & Worley 2001) had clearly been delivered upon by the leadership for the accreditation process and this is outlined in Chapter 1. However, one element of the activities associated with this was the timing of training, which the literature argues is an important consideration in managing change and quality implementation (Motwani, Frahm, & Kathawala 1994;Brashier et al. 1996;Redman & Mathews 1998;Vermeulen & Crous 2000). The results indicate that there were concerns amongst respondents, in particular about the stage at which the external IHSAB self-assessment training would be, and actually had been, provided, although to what extent the leadership for the accreditation process would have been in a position to influence this is unknown.

The final leadership activity associated with implementing change, as advocated by Cummings & Worley (2001), concerns sustaining the momentum through competency and skill development and the provision of resources. In relation to the direct leadership brief at the research site, this related both to the extent of, and perceived efficacy of, the training associated with the self-assessment stage, which would support the development of the necessary knowledge, skills and competencies of participants. The literature presents an unambiguous argument in favour of providing effective and timely training to those directly participating in change and quality implementation (Beer, Eisenstat, & Spector 1990;Motwani, Frahm, &

Kathawala 1994;Black & Porter 1995;Nwabueze 2001;Daily & Bishop 2003;Buchanan & Fitzgerald 2007). Moreover, this also extends to providing team building training to support the development of the functioning and cohesiveness of the groups who are central to the quality approach (Snape et al. 1995;Smith et al. 2004). As previously recognised, this was an area of the findings where the concerns of a number of respondents were voiced. Comments extended to both the initial accreditation training and furthermore, included some focus on the absence of team building training. This, in turn, was perceived to have contributed to a lack of understanding of the self-assessment process and the standards on which it is founded. Moreover, a lack of clarity around how team members should progress their responsibilities and tasks was viewed as having hindered the pace at which the self-assessment process had developed.

The issues raised in the findings in relation to the lack of time for participation, could also be interpreted in terms of some degree of failure to secure resources on the part of the leadership for the process. This is contrary to what has been argued in the literature - for example, by Shaw (2004) - who has advocated that ‘protected time’ (i.e. providing dedicated time during normal working hours) be made available for those participating in accreditation.

The aforementioned assessment suggests that the leadership associated with accreditation at the research site had only been partially realised on the five key leadership activities, as advocated by Cummings & Worley (2001), which, in turn, are likely to have influenced other aspects of the implementation process. Despite the many positive evaluations of leadership, as demonstrated in the results, there is also recognition in the findings of the scope for further leadership, which may be reflected in the more critical assessments made of the leadership associated with the accreditation process. This particular issue is illustrated in the following comment: *“I feel the accreditation process was not implemented well - the process is worthwhile but was lacking in leadership” (CS).*

It is necessary however, to consider the overall evaluations of leadership in the context of the allocation of the limited time and resources of the two Accreditation Managers, who were both seconded on a part-time basis to the accreditation process.

Shortell, Bennett, & Byck (1998) have argued that the implementation of quality approaches requires constant attention by leadership and the findings have noted in the views of a number of respondents, whether this was able to be fully achieved by two individuals who were simultaneously carrying senior management responsibilities. In turn, this was also seen to represent an under-resourcing of the accreditation process itself by some respondents. In relation to this, the leadership issue was further extended in the findings to the scope for a dedicated, full-time accreditation leadership role to be created. The views expressed in the findings suggests that this role would give further direction, coordination and be able to influence involvement and participation of key individuals and groups to the process, which clearly resonates with the arguments made in the literature in the area, where these are seen to be central activities of effective leadership for change and quality implementation (Berwick, Godfrey, & Roessner 1990;Pettigrew, Ferlie, & McKee 1992;Lammers et al. 1996;Siegal et al. 1996;Ahire, Golhar, & Waller 1996;Wagar & Rondeau 1998;Ovretveit 1999;Gandhi et al. 2000;Ryan 2004;Pomey et al. 2005).

Overall, the leadership associated with the implementation process has been shown, on one hand, to be effective, as viewed by many respondents, who particularly acknowledged the constraints on the resources allocated to it. However, a deeper examination has also demonstrated the challenges presented to the leadership by other aspects of the accreditation implementation process. Moreover, this research has also shown there to be an acknowledgement by respondents that a dedicated leadership resource for accreditation might likely yield significant benefits for the process.

Finally, this aspect of the discussion may also need to be considered with reference to the organisational context itself, which Friedman & White (1999) have suggested, as a healthcare and hospital organisation, may have be naturally averse to change and quality implementation and hence may represent an unfavourable terrain for its achievement (Weisbord 1976b;Berwick, Godfrey, & Roessner 1990;Ham, Kipping, & McLeod 2003). This, in turn, may serve to exacerbate the efforts of those in leadership positions, who are charged with implementing what are often considered as management-driven, organisation-wide quality approaches (Milakovich 1991;Counte, Oleske, & Hill 1992;Degeling & Carr 2004;Boaden 2006), which may

be also viewed as a challenge to the prevailing ideologies, practices and control of those in more clinically orientated roles (Ferlie & Shortell 2001).

7.2.2 Communication

The body of literature examined has argued that initial and on-going communication is a key activity during the enactment of change and quality implementation, as it is the mechanism by which change is announced, explained, the vision created and also the means by which organisational members develop an understanding of any consequences of the change itself and furthermore, their roles within it (Black & Porter 1995;Ford & Ford 1995;Lewis 2000;Huq & Martin 2000;Kitchen & Daly 2002). As previously discussed, it is also an activity closely associated with the leadership for change and quality implementation. For those who are not directly involved with the implementation of change and, within this, quality, this communication is equally important as it also facilitates the development of individual meaning and an acceptance that they too are contributors to the process (Milakovich 1991;Alexander 1997;Jackson 2001;Squires 2003). Moreover, Ovretveit (1992) argues that communication has to reinforce that the quality approach has *"…something tangible in it for staff and managers"* (p.138).

The findings have presented a view of communications during the implementation of accreditation, as experienced by team members, on a number of levels. Within the team itself, there appeared to have been evidence of feedback to members on progress and the timelines for the process. This is further reinforced by the positive assessments made within the 'teams' section of the questionnaire findings. Here respondents indicated that at the end of a meeting, they knew where they were with the self-assessment process and moreover, if they were unable to attend a meeting, that they were aware of what was required of them for the next meeting. This suggests that at this level, the communications process associated with accreditation had been successful and is reflective of guidance offered by Stamatis (1996), Kia Liang Tan (1997), Alexander (1997), Balogun & Hope Hailey (1999), Lewis (2000) and Gollop et al. (2004), on communications during change and quality implementation.

However, the extent to which the communications process (and the associated training activity) had been instrumental in creating a complete understanding of accreditation, the standards and criteria contained therein and clarity in relation to individual team members roles, is questionable and further, is reflective of the findings of the study by Gollop et al. (2004) on quality implementation in the NHS. In this study a significant level of misunderstanding was found to have arisen with a quality approach, as a result of the initial communication and promotion associated with it, which, in turn, was seen as having undermined its implementation and moreover, as contributing to scepticism about the approach itself. Scrivens (1995b) has noted that the language of accreditation is *"…complicated"* (p.11) and that this should be recognised in the planning, content, delivery and media selection for communication. However, the results from this research have signalled that at the commencement and during the early stages of accreditation, this had not been fully realised, as reflected in the following comment: *"A greater understanding of the process developed as we progressed. A lot of time wasted initially trying to get to that level" (CS).*

In particular, criticisms have been levied at the efficacy of the initial communications sessions, as indicated in the following evaluation: *"I felt that the initial education session in the XXX hotel was not beneficial. At that stage, the Accreditation process was 'double dutch'"(SS).* These issues are further illustrated in terms of the development of a sufficient understanding of the process and the individual team member role within this, as made explicit in the observations of one team member: *"There doesn't seem to be a complete understanding, I don't know whether it is detailed enough and whether we are capturing everything we should be capturing" (SS).* While the results indicate that a more complete understanding of the accreditation process had evolved over the period of self-assessment, the implications of that early absence of understanding may have manifested itself in other ways. Thiagarajan & Zairi (1997) have argued that a product of unclear communication may be that those involved in quality activities end up focusing on the wrong priorities which represents wasted time, which, in turn, may contribute to disillusionment and loss of momentum with the approach. The findings would suggest that there had been some evidence of this at the research site, as reflected in

the following insight from a respondent: *"I felt communication was very poor, when you cannot grasp what its all about then your motivation is very low" (CS).*

The findings have also explored the extent to which the communications activity over the course of the first phase of accreditation had been successful in creating an awareness of the process across the entire hospital. As previously discussed, communication aims to create an understanding of the change and quality implementation and furthermore, its purpose, necessity, process and implications (Alexander 1997;Fletcher 1999;Caluwe & Vermaak 2003;Squires 2003). Moreover, for those not directly participating in the process, communication has further significance in that it enables the development of an understanding of their own role in supporting and assisting colleagues who are more integral to the implementation and creating an acceptance of this responsibility (Brown 1994;Redmayne et al. 1995;Close 1997;Higgins & Routhieaux 1999;Dale 2003c;Gollop et al. 2004;Huq 2005).

As to whether this had occurred at the research site, the findings would indicate that this had not been completely achieved. While respondents indicated that, in their experience, there was some degree of awareness that the process was taking place amongst the wider body of staff, this had not been achieved in relation to the specific aims of, and progress with, the implementation of the process. Other aspects of the findings (in particular under the theme of involvement and participation) extend the communications issue by providing further insights into whether accreditation was also seen by those directly outside the teams, as their responsibility. Acknowledging that communication has the potential to play a central role in achieving this, the findings would suggest that this acceptance had not been reached in the views of responding team members and is further reflected in the comment volunteered by one: *"I think people who haven't been involved in the teams feel, a lot of them do feel very removed from it and that it had nothing to do with them" (CS).* These issues are further reinforced within the findings in relation to the low level of interest expressed by team members' work colleagues as to progress with the accreditation process, despite what were indicated as additional communications efforts on the part of team members themselves. Moreover, and as another manifestation of this, the findings also indicate that colleague support and assistance to team members had been

somewhat lacking, although it should be noted that this position and also the interest expressed, improved over time.

The issues with communications may have, in turn, have contributed to an element of scepticism and cynicism with those outside the process. This is particularly acknowledged in the comment of one team member that is also reflective of some of the observations of Reichers, Wanous, & Austin (1997) and the findings in the study by Gollop et al. (2004), on influencing sceptical employees during organisational change and quality implementation: *"I think there would definitely be people who would still see this as a paper exercise, definitely. I think it's getting that message out there that it isn't a paper exercise in the sense that it will benefit each and every one of us who work in the organisation and strengthen reputation with the service users that we look after and care for every day of the week, but it is getting that message out there that I think it is difficult"(SS).*

Finally, the aforementioned interpretation and discussion of this specific facet of the communications findings, may also be viewed in the context of two other factors. Firstly, it must be acknowledged that Hillman (1991) has noted that some organisational members may be unreceptive to the content of quality-related communication or alternatively, not remember what they have received, irrespective of the efficacy of the communication and the supporting media. The findings have indicated that there may have been elements of this during the first phase of accreditation, as illustrated by the following comments: *"I think some people are just not willing to actually hear that there is something else going on, because it is something extra"(CS)* and with particular reference to the accreditation newsletter: *"I think the people who read that were the people involved in accreditation, you know, and a lot of people would have, sort of, pulled them off and said 'well that has nothing to do with me' and put it in the bin" (CS).* Furthermore, the discussion has already noted that the work colleagues of team members had expressed limited interest with the progress of accreditation in its early stages. Secondly, and as a possible reflection of the issue of receptiveness, only eight hundred of the total fifteen hundred staff at the research site had been party to the initial organisation-wide communication sessions, which would appear to be contrary to the position taken in the literature, which underlines the necessity for communication to reach

every employee (Milakovich 1991;Alexander 1997;Fletcher 1999;Ennis & Harrington 1999a;Jackson 2001;Caluwe & Vermaak 2003;Squires 2003).

In summary, the initial and on-going communication associated with the implementation of phase 1 clearly struggled to develop the initial understanding of the specifics of the process for those directly involved and the findings have shown that this may have both frustrated individual team members in their accreditation roles and the self-assessment process itself. Furthermore, and with an acknowledgement of the potential for the total employee body to have represented an unreceptive audience for accreditation information, the communication efforts were challenged in their ability to achieve organisational penetration, to further develop a hospital-wide understanding of accreditation and, in turn, to gain an acceptance that accreditation was the responsibility of everyone at the research site.

7.2.3 Involvement and Participation

Recognising the number of facets of involvement and participation that have been explored in both the literature review and the findings, the following sections will address these based on various sub-themes.

7.2.3.1 Involvement and Participation: How and Why?

The findings have identified the mechanism by which responding team members became involved with the accreditation process, in terms of either volunteering or being asked. Boaden & Dale (1993) and Dale (2003a) have argued that consideration should be given to whether participation in a quality approach is either voluntary or mandatory. In relation to the research site, accreditation was promoted as a voluntary process in terms of individual involvement, but the findings indicate that only 14.2% of respondents volunteered to join a team. Almost 80% confirmed that they had been asked to participate but within this, there may be some possibility that it was not mandatory for individuals, as reflected in the following interview findings: *"…certainly you ask them, if they don't want to participate sure there's not a lot you can do"(SS)* and *"I think you would definitely approach people, but you would approach people that you would feel would have something to offer the process, but their participation has to be completely voluntary" (CS).*

Furthermore, the findings need to be also reflected upon with reference to the fact that almost 24% of respondents had indicated that they felt pressurised to get involved with accreditation. This has been additionally evidenced by the fact that a small number of respondents had indicated that they had felt that they had no choice and had effectively been 'ordered' to join a team. This position would appear to be contrary to the stance taken by Dale (2003a) who argues that involvement should not be a product of coercion and that individuals should come to the process as willing participants. Moreover, this might also be an indication of some of the individual leadership and management styles across the site, which could be interpreted in terms of controlling as opposed to supporting, the latter being advocated as a requirement for effectively managing change and quality implementation (Feinberg 1996;Zabada, Rivers, & Munchus 1998;Degeling & Carr 2004;Buchanan & Fitzgerald 2007;Lagrosen, Backstrom, & Lagrosen 2007).

In terms of why respondents became involved with accreditation, only 53.5% of respondents to questionnaire 1 indicated that they had done so because they saw it as part of their overall work role and, of particular note, of these, only 43.9% of clinical services respondents, as compared with almost 64% of the support services group, confirmed this as their reason for participation. The literature has argued that quality is, in effect, the responsibility of every organisational member and, likewise, its implementation (Ovretveit 1992;Counte, Oleske, & Hill 1992;Close 1997;Shin, Kalinowski, & El-enein 1998;Dale 2003c;Scrivens 2005;Pomey et al. 2005;Boaden 2006). Moreover, quality implementation also requires the integration of every aspect and every role within the organisation (Close 1997;Gandhi et al. 2000;Book, Hellstrom, & Olsson 2003). However, the findings suggest that many respondents and, in particular, those in clinical services teams, did not come to the process with that mindset. This position might be explained by the issues that have been previously alluded to. With specific reference to the communication associated with the implementation, this may not have reinforced any existing understanding of this, or alternatively, have developed an initial appreciation of the critical contribution that respondents would play in implementing a quality approach such as accreditation and additionally, that this was integral to each individuals existing work role. These findings may also be examined with reference to the NPM literature and might be interpreted as some indication of an unwillingness to accept the employee

empowerment that the paradigm argues in favour of (Pollitt 1995;Dent, Chandler, & Barry 2004). However, it is worth noting that by the end of the accreditation process, the results from questionnaire 2 indicated that there had been an acknowledgement that accreditation was everyone's responsibility and that respondents viewed future involvement as part of their work role.

The specific differences between the clinical services and support services groups is marked and is further reinforced by the findings that only 25% of responding Consultants and 43.4% of responding Nurses became involved with the first phase of accreditation because they saw it was part of their overall work role. The literature has highlighted that those in clinical roles may be somewhat indifferent to organisation-wide quality approaches, viewing them as yielding minimal benefits and moreover, see the management of quality as being driven from, and residing solely within, their own domain (Duckett 1983;Wakefield & Wakefield 1993;James & Hunt 1996;Kennedy 1998;Gaster & Squires 2003a;Boaden 2006). The interview findings did attempt to provide further insight into the reasons behind the differences and these too would appear to lend further support to the stance taken in the literature, as illustrated in the following explanation offered by one interviewee respondent: *"A lot of clinicians work very much within their own bubble, that's as that may be, I myself, I'm a very good nurse at looking after my patients, but they don't recognise the influences or the demands even that may be coming from the wider hospital"(CS).* This would, in turn, suggest that the way in which quality and accreditation approaches are promoted and communicated to those in clinical roles needs to focus on providing appropriate and practical information about the approach, while still making the relevant links to the wider organisational and health service issues. This, as result, may provide further encouragement to engage with the process (Gollop et al. 2004), which may not have been in evidence over the course of this study.

7.2.3.2 Involvement and Participation: Attendance

Attendance at team meetings has been demonstrated through the findings to be problematic over the course of the self-assessment at the research site and this had further exacerbated other aspects of the implementation process, and furthermore, the comprehensive completion of the IHSAB standards. Dale (2003a) has argued that

once the individual involvement of team members has been secured, then they should attend all quality-related meetings as required, other than in exceptional circumstances. This is further reinforced by Huq & Martin (2000) who posit the position that in support of securing employee participation and attendance, there is a need for personal responsibility and accountability. Without full involvement, a quality approach runs the risk of being implemented without complete and on-going representation to facilitate the comprehensive review of existing practices and proposals for improvement (Berwick, Godfrey, & Roessner 1990;Beer, Eisenstat, & Spector 1990;Motwani, Frahm, & Kathawala 1994;O'Leary 2000;Nwabueze 2001). Furthermore, sporadic or non-existent attendance may have the effect of negatively influencing the motivations of other team members (Weller Jr 1995;Hearnshaw et al. 1998;Woodward & Hendry 2004), may frustrate the meetings process and adherence to timelines (Stamatis 1996;Colquitt 2004) and moreover, may mean that for those that do attend, they carry the workload of their absent colleagues (Higgins & Routhieaux 1999). As Pascale, Millemann, & Gioja (1997) have noted, the numbers of individuals 'committed' to a quality approach across the organisation may, in reality, be too small.

The composite findings in this study that focus on this issue, confirm that lack of attendance at accreditation team meetings has manifested in all of the above and furthermore, there is a suggestion that there had been an absence of accountability. In the first instance, there has been a clear demonstration, based on the experiences of individual team members, that both the comprehensive completion of the standards and the collection of the supporting evidence of compliance were significantly hampered over the course of the self-assessment process, as a result of attendance issues. This was particularly problematic for the clinical services teams, where the absence of doctors from team meetings and their lack of contribution to the completion of the standards, was particularly felt. In the words of one respondent: *"Lack of Consultant/Medical team participation was a huge loss, it inhibited the process, the findings and in part the overall aim of Accreditation" (CS).*

Overall, these findings are not necessarily at odds with those presented in the literature. If attendance is interpreted to some extent as a proxy for 'buy-in' and commitment to the quality process, then this may have not necessarily been achieved

and may serve as a reflection of the observations of Wilkinson & Brown (2003) who have argued that the challenges associated with harnessing this, are frequently understated and underestimated. Furthermore, and as previously alluded to, galvanising the support and active participation of the medical profession may be extremely problematic (Duckett 1983;Berwick, Godfrey, & Roessner 1990;Redmayne et al. 1995;Shortell, Bennett, & Byck 1998;Ham, Kipping, & McLeod 2003;Pomey et al. 2005) and this has been shown in other studies to have hindered quality approaches such as accreditation (Duckett 1983;Redmayne et al. 1995;Hearnshaw et al. 1998;Higgins & Routhieaux 1999;Pomey et al. 2004;Gollop et al. 2004). Overall, the lack of attendance by some team members might be interpreted as passive resistance or overt opposition to the accreditation process, which is reflective of the findings of the study by Milakovich (1991) on the Joint Commission scheme in the US.

The findings have also provided some evidence that the motivation of individual team members may have been adversely influenced by the poor attendance at team meetings of their colleagues and which may have, in turn, given rise to resentment, as evidenced in the remarks of one respondent: *"Resentment towards those who haven't attended regularly" (CS).* This position mirrors the findings of Hearnshaw et al. (1998), who found that the sporadic attendance of doctors in particular, had the effect of negatively influencing the motivation and commitment of other team members.

The impact of poor attendance on the motivations of team members might also be explained by the fact that as a result of the high task interdependence (Stamatis 1996;Cacioppe 1999;Colquitt 2004), progress in meetings and the self-assessment process itself was often inhibited, as noted in the findings. Moreover, a further explanation may be that for those that did attend, their motivation was also affected by having to complete more work, by virtue of the absence of other team members. This particular issue surfaces in the literature, where Weller Jr (1995) argues that this will result in feelings of 'inequity', which, in turn, may be detrimental to an individual's motivation. Finally, Higgins & Routhieaux (1999) demonstrate in their study that this decline in motivation may further exacerbate existing problems with attendance, as others may also remove themselves from the team environment.

Overall, the extent of involvement and participation, as indicated by the tangible level of attendance at team meetings, may serve as an indicator of the extent to which the motivation for, and acceptance of, change had been fully achieved.

However, there is also some necessity to view the aforementioned discussion within the context of the challenges that have been highlighted in other facets of the findings, with reference to the difficulties that respondents had reported in relation to attending meetings. In particular, the absence of 'protected' or 'release' time (Higgins & Routhieaux 1999;Shaw 2004) would appear to have frustrated some team members attendance, which can be further appreciated in the reports of role conflict, where individual respondents noted the demands of trying to fulfil their work role and in doing so, contribute to maintaining the service within the hospital, vis-à-vis the requirements of being a team member. For the clinical services team respondents, the findings would suggest that their priority was the former and overall, the findings reflect the tensions identified by Pettigrew, Ferlie, & McKee (1992) in simultaneously attempting to enact change, while maintaining organisational operations.

7.2.3.3 Involvement and Participation: Equity and Fairness

The findings from all three research methods have served to demonstrate that there were issues surrounding the equity and fairness associated with individual team member participation in the self-assessment stage of accreditation and these have been alluded to, to some extent, in previous discussion. As Cacioppe (1999) has recognised, participation means *"…completing one's share of the work and facilitating the work of other group members"* (p.324) but where this is compromised, violation of equity and fairness within the team may occur, which may result in individuals experiencing decreased motivation and discontentment with both the team and the quality approach (Weller Jr 1995;Rollinson & Broadfield 2002;Woodward & Hendry 2004;Buchanan 2004).

The results from the two questionnaires indicate that while respondents recognised that there had been a fair and equitable distribution of tasks amongst those that did attend the meetings, this had not been the case with respect to those that were listed as team members but who did not attend with any regularity, a position that was

whole-heartedly reinforced by all interview respondents. Moreover, on both issues, the position would have appeared to have deteriorated over time and this is further noted in the more negative assessments made by clinical services team members and the Nurse, AHP and Consultant responding groups. This is likely to be explained by the fact that the impact of non-attendance was felt to an even greater extent as the accreditation process progressed and the requirements to complete the standards and provide supporting evidence became more pressing. As a result, feelings of inequity may have surfaced and this may have been exacerbated further by the fact that the clinical services teams were also required to complete more standards than their support services counterparts. The following observation from a clinical services respondent illustrates the overall view on equity and fairness: *"A lot of team members did not participate or did not complete tasks given to them. Nobody appeared to challenge these issues. The remaining members were expected to take up the slack" (CS).* As previously noted, the manifestation of this may be the decline in the motivation of those who remain and even their withdrawal (Weller Jr 1995;Stamatis 1996;Johnson & Johnson 1997;Gordon 2002;Woodward & Hendry 2004) and with reference to this study, there may have been evidence of this, reflected in the varying levels of commitment towards accreditation over the course of the self-assessment process, reported by respondents.

The final element of equity and fairness, relating to the support received from colleagues and also from line managers outside the team, has been previously addressed and the literature in the area argues that quality is responsibility of everyone in the organisation (Milakovich 1991;Dale 2003c) and that communication is a key mechanism by which this understanding and acceptance is reached (Redmayne et al. 1995;Higgins & Routhieaux 1999;Dale 2003c;Gollop et al. 2004;Huq 2005). As previously highlighted, this is one area where the results demonstrated that the position improved over the course of phase 1 of accreditation, as depicted in the differences between the two sets of questionnaire results, where respondents indicated the extent of the support they had received.

7.2.3.4 Involvement and Participation: Time

Insufficient time for team members to both attend team meetings and complete accreditation tasks, has been a prominent feature of the findings of this study. The literature acknowledges that quality approaches such as accreditation are demanding of participants time, which may in turn, present a challenge to, and a resultant conflict with, the daily demands of individuals work roles (Pettigrew, Ferlie, & McKee 1992;James & Hunt 1996;Shortell, Bennett, & Byck 1998;Gandhi et al. 2000;Eggli & Halfon 2003;Berwick, James, & Coye 2003;Weiner et al. 2006). The significance of the issue is recognised to such an extent that the World Health Organisation, in their guidelines for resources to support the implementation of national programmes for hospital accreditation in a European context (Shaw 2004), have recommended that organisations ensure that protected time is set aside for those who are actively involved with the process. This is furthermore reflective of the earlier stance adopted by Hearnshaw et al. (1998) and Higgins & Routhieaux (1999), where their studies have demonstrated the challenges presented to successful quality implementation in healthcare by an absence of dedicated participant time. Finally, Hurst (1997) develops the argument that by devoting resources (including time) to accreditation, there is the potential to uncover unsafe and inefficient practices in a healthcare environment.

With reference to the research site, no official provision for protected time was made, although as a policy this would not appear to be contrary to the position taken in other organisations as reported by James & Hunt (1996). One explanation might be that providing protected time is likely to have resource and hence cost implications for the change and quality implementation process as a whole, as identified by Ovretveit (1999), Hope Hailey & Balogun (2002) and Todnem By (2005). Given the context of publicly-funded healthcare in Ireland and the pressures and debate on the funding and effectiveness of health services (Wiley 2001b;Department of Finance 2002;Harney 2006a;Harney 2006b), it may have been deemed inappropriate to implement accreditation with supporting protected time, given the potential resource implications. Furthermore, this decision may also be viewed with reference to the argument made by Ovretveit (1997), who suggests that the criticisms as to the lack of time for participation are, in fact, symptomatic that participants in quality approaches in healthcare context, actually do not view this as integral to their daily work, which

has been demonstrated to some extent in this study via the results obtained, in particular, from questionnaire 1.

However, at the same time, these positions need to be considered in terms of the suggestion that emerged in the findings of the research site being under-resourced, in particular on the clinical side, and moreover, that some team members felt that they were already ‘stretched’ in their work roles. These views are depicted in the following extracts from respondents: *“…people feel pretty hard done by, it's so difficult, people are really, really stretched and inviting them to something for the hospital is stretching them big-time, on a voluntary capacity that can be just too much sometimes” (CS)*, while in the views of another, the appropriateness of the implementation itself and the extent of any positive resourcing outcomes from accreditation was challenged: *“In a situation where Departments and disciplines are unable to do all that needs to be done for patient care due to chronic on-going lack of resources, the fact that management is seeking accreditation which would give the appearance that everything is fine can only be regarded as an attempt to ‘paper over the cracks’. We have been given no sense at all that, if deficiencies are identified, solutions will be adequately and appropriately resourced in a targeted way”(SS).*

Notwithstanding this, the problems associated with the reported absence of protected time appear to have hampered the self-assessment process and have impacted negatively on individual team members and potentially, on the wider organisation itself. In the first instance, the findings have shown that team members found it both difficult to leave their immediate work environment and also to meet other team members for accreditation purposes. Furthermore, some frequently arrived late to meetings as a consequence and, moreover, the problems relating to time may have had a resultant knock-on effect on attendance. In the word of one respondent: *“Building time into the day/week rota to release people to the meetings would help greatly. It would relieve the pressure felt by those going to the meeting at leaving busy clinical areas behind, and also the pressure felt by those staff left behind”(CS).* The findings suggest general dissatisfaction arising from the scheduling of meetings at lunchtime for some teams. For clinical services respondents, this had caused problems with providing cover for colleagues to facilitate their breaks, but even more fundamentally that lunchtime represented personal time and also, as acknowledged

by one respondent, was legally (under the Organisation of Working Time Act 1997) a period of rest.

Secondly, the absence of protected time meant that for some team members, the completion of accreditation tasks was done in their own leisure time. This clearly resonates with the findings from the James & Hunt (1996) study on accreditation, which focused on this particular issue and who also note that this practice by participants is unlikely to be sustained over time. Thirdly, the findings have indicated that in some instances, the standards themselves were not completed on time and that this had frustrated the meetings process, which suggests that accreditation was viewed as secondary in relation to other priorities (James & Hunt 1996;Ovretveit 1997). Fourthly, the literature has suggested that line managers have a significant role to play in facilitating the participation of their staff in quality approaches (Boaden & Dale 1993;Greig 1993;Harrington & Williams 2004;Lakshman 2006) and, in particular, Feinberg (1996) has noted that their non-support may manifest in not actively accommodating individuals attendance at team meetings and not providing time for associated quality tasks outside these. In relation to this research, the findings from questionnaire 2 and the semi-structured interviews may provide some positive indication of this support, where there is evidence that respondents' line managers had both assisted and supported them in completing accreditation tasks, although as with the majority of the findings, this was less so for those in clinical services teams.

Finally, the findings demonstrate the time required for individual participation in accreditation at the research site, resulted in impacts at both the individual and organisational levels. In relation to the former, and as previously alluded to, this emerged in terms of the role conflict experienced by individual team members between the requirements of their work and their accreditation roles. This issue has been acknowledged in the literature (Redmayne et al. 1995;Lam 1995;Gandhi et al. 2000;Steensma & Tetteroo 2000;Francois et al. 2003;Lagrosen, Backstrom, & Lagrosen 2007) and in the experiences of the responding team members, was evident over the self-assessment period, as illustrated in the responses from one interviewee, who found making time for accreditation particularly difficult: *"I'm thinking of*

nursing staff and numbers are low and there is a patient on the ward needing a lot of attention, it's very difficult, you know, to the point that it is not feasible"(CS).

At an organisational level, being absent from the workplace as a result of participating in accreditation, may serve to potentially impact negatively on the provision of the overall service itself (Boaden & Dale 1993;Redmayne et al. 1995;James & Hunt 1996;Ovretveit 1999;Gandhi et al. 2000;Francois et al. 2003;Book, Hellstrom, & Olsson 2003) and it has been suggested that, based on the experiences of respondents in this study, this may have arisen. A number of respondents indicated that giving time to accreditation had left other work undone, while for some clinical services respondents, the impact was suggested to be potentially on the care and safety of patients and the well-being of colleagues.

7.2.3.5 Involvement and Participation: Commitment to Involvement and Participation

The results from questionnaire 2 and the semi-structured interviews have suggested that, for the most part, respondents had been committed to accreditation and to their team and as previously highlighted, saw on-going involvement in phase 2 as part of their work role. At the same time, the findings have also acknowledged that this commitment wavered and that future involvement might be tempered by the availability of time. The literature on employee involvement in change and quality implementation argues that a necessity exists to harness participation, and an accompanying commitment, to both this and the quality approach itself, in order to maximise the potential gain from implementation (Ovretveit 1992;Ennis & Harrington 1999a;Wilkinson & Brown 2003;Taylor & Wright 2003;Lagrosen, Backstrom, & Lagrosen 2007). Furthermore, it has already been acknowledged that the efforts in securing this may be underestimated (Wilkinson & Brown 2003) and this may be evidenced in the findings, where respondents identified that they believed that not all listed team members nor the wider employee body, now saw accreditation as part of their work role suggesting that, despite efforts in the area, commitment was not wide-spread.

In summary, the discussion of involvement and participation has served to demonstrate the complexities, interplays and many conflicts of the different facets

within this theme of the accreditation implementation process, as experienced by individual team members. As such, they are reflective of the findings from the study by Pongpirul et al. (2006) who identified that lack of participation was seen as both a problem and a barrier to the implementation of hospital accreditation. When considered in the context of the literatures in the area, the results suggest that the level of the 'supports' (attendance; equity and fairness; time and commitment) that underpin the initial and on-going involvement may not have been fully present over the course of the self-assessment process. These, in turn, may have served to hinder other aspects of the implementation and furthermore, may have impacted negatively, both individually and organisationally.

7.2.4 Training

Previous discussion has already demonstrated the low levels of experience of healthcare quality initiatives and specifically, accreditation, that questionnaire 1 respondents had at the commencement of accreditation at the research site. Moreover, the interview findings have further indicated that more than half the respondents felt that they did not have a sufficient knowledge of quality and continuous improvement at the start of the process. Within this context, both the efficacy and the timing of training would be expected to assume a heightened priority during the accreditation implementation process.

The literature argues that for change and quality implementation to be fully realised, there is a requirement for the development of the necessary competencies and knowledge of those who are central to the process and that the key mechanism for this is training (Shortell et al. 1995;Black & Porter 1995;Gustafson et al. 2003;National Economic and Social Forum 2006;Rad 2006;Buchanan & Fitzgerald 2007;Soltani, Lai, & Mahmoudi 2007). The literature also argues that for training to be effective, it needs to be sufficient, well designed and delivered, demonstrate the relevance to day-to-day activities and focus on equipping individuals with both the understanding and the tools and techniques that are required for participation in a quality approach. Furthermore, such training should be delivered in a timely manner (Motwani, Frahm, & Kathawala 1994;Brown 1994;Brashier et al. 1996;Kennedy 1998;Redman & Mathews 1998;Vermeulen & Crous 2000). Where this is not achieved, it has the potential to both undermine and affect subsequent participation in

the approach (Ovretveit 1996). Finally, Daily & Bishop (2003) posit the view that training will further add to creating an awareness of the relevance and significance of the quality approach to the organisation. All this needs to be considered with reference to a factor that has already been alluded to - that the language of accreditation is considered to be complicated (Scrivens 1995b).

When viewed in the context of the guidance offered in the literature, the findings present a mixed picture of the training associated with the first phase of accreditation at the research site. The previous discussion on communications has indicated that many respondents struggled with developing an understanding of accreditation and their role within it, which, in turn, may have hampered the process and moreover, wasted time. This position is also likely to be reflective of the sufficiency and efficacy of the initial training for self-assessment.

The initial questionnaire results suggest that respondents did not feel that they had received sufficient training to fulfil their accreditation role (in particular, those in clinical services teams), while the qualitative findings further reinforce this position and present a critical assessment of its efficacy, as reflected in the following comment: *"I think the introductory training down in the XXX Hotel didn't give, I don't think it gave enough of a picture of what we were facing into. I think it gave a picture, but I mean even coming into the first meeting as a team I don't think any of us had any idea of what we were really facing into. I felt that at stages we were going through and we hadn't got a clue, well I definitely didn't anyhow" (CS).* However, the findings do demonstrate that the position improved, as reflected in the post-IHSAB survey questionnaire results. In particular, they recognise that the mock-survey training provided in May 2004 by IHSAB had been particularly useful. In the words of one respondent: *"…when the groups were in the trial run, the mock survey, I thought that was excellent" (CS).* Notwithstanding this, there is still a necessity to acknowledge that the sufficiency and effectiveness of the training provided at the start of the accreditation process had been questioned. Coupled with communications, this is likely to have represented some of the first exposure to the language and concepts of accreditation, which may, in turn, have influenced team members' perception of it. As such, the findings from this research clearly echo those of Wright (1997), Hearnshaw et al. (1998) and particularly Rad (2006), who

established in his research undertaken across a number of hospitals, that a lack of training represented a significant barrier to the implementation of an organisation-wide quality approach.

There is also a requirement to reflect on the timing of training. Once the self-assessment process had commenced and with the initial training having been provided, the findings have indicated that there were concerns about the timing of the subsequent training that would be supplied by IHSAB. The first session by IHSAB took place some seven months after the first phase had started at the research site, which was deemed as being organised too late in the process. As one respondent noted: *"If I had us back again I would of preferred to have the training from outside earlier on, it might have been more beneficial. I don't know, but I think it might have been. It's a general complaint from around the country" (SS).* As previously acknowledged, with reference to the leadership associated with the accreditation process, to what extent this could have been influenced at the research site is unknown.

The final issue relating to the theme of training, is that which supports the formation and cohesiveness of the team itself i.e. team building training. The position taken by Snape et al. (1995) and Smith et al. (2004) is that central to the successful implementation of a quality approach, is the development of behavioural and non-technical skills to support team working. Team building training is one means of achieving this. The findings have recorded that no team building training was provided at the commencement of the first phase of accreditation or at any other stage within the self-assessment process. This absence was noted in the qualitative data from both questionnaires and also by interviewees, of which more than half indicated that they would have found this type of training beneficial and who further acknowledged this may also have had a positive influence on retaining the participation of team members. Not surprisingly, the remainder of the interview respondents felt that by already working in close proximity to other accreditation team members, team building training would not have been a particularly useful exercise.

In summary then, when viewed within the context of the literature in the area, the findings show that the implementation of the training associated with the accreditation process may have presented shortcomings in aspects of its sufficiency, efficacy and timing, which are likely to have had wider implications for the implementation of accreditation itself.

7.2.5 Teams

Teams represent the vehicle for involvement and participation during change and quality implementation (Schonberger 1994;Black & Porter 1995;Daily & Bishop 2003;Dale 2003a;West et al. 2004;Gowen III, McFadden, & Tallon 2006) and are the central means by which quality issues are identified, managed and improved upon (Morris, Haigh, & Kanji 1994;Joss & Kogan 1995). Multidisciplinary accreditation teams embody a parallel and complementary structure to that of the organisation proper and are central to the implementation of accreditation (IHSAB 2004). The findings have sought to address the effectiveness and the environment of the forums in which these teams met i.e. the team meetings, as a means of exploring the internal processes of the accreditation team structure (Cohen & Bailey 1997;Dale 2003a).

The findings have painted a varied picture of the effectiveness of the team meetings. On one hand, the quantitative results indicate that in the experiences of respondents, the team meetings were deemed to be largely effective, as measured by the Likert items. This is further supported by qualitative data that also confirmed this assessment and in the view of one respondent, the meetings had worked *"Relatively well from our perspective, in that you know we got a lot of good dialogue going" (SS).* In contrast, the findings have provided an alternative perspective on the meetings process, where it is suggested that they often lacked structure and focus; ran behind schedule; that deadlines were not adhered to and that progress with the self-assessment was not made, as reflected in the following comment: *"There were just so many meetings really just covering the same ground that we just really didn't seem to move on. They just, they just kept going round in circles, it was like we never answered any questions properly"(SS).*

This latter assessment is counter to what is widely advanced in the literature, where Berwick, Godfrey, & Roessner (1990) have argued that effective meetings are seen

as central to the timely completion of quality-related projects and furthermore, to creating both enthusiasm and an acceptance of mutual responsibility amongst team members. Moreover, Kanter (1983) has noted that where team meetings are perceived as failing to progress a change process, there is the risk that scepticism may ensue and there is some evidence of this, both within this specific aspect of the findings and also elsewhere, for example, in relation to the views expressed about the potential for positive organisational impacts and follow-on resources for quality improvements. Finally, both Reeves & Bednar (1993) and Higgins & Routhieaux (1999) concluded in their respective studies that where quality team meetings were conducted in a 'dysfunctional' manner not dissimilar to that described above, that this hindered not just the team but also the quality implementation itself.

The other facet of the findings relating to teams, is the environment of the team meetings themselves. The composite results present an overall encouraging depiction of the environment within the team meetings, although one respondent did acknowledge, in a view reflective of the observations of Wiener (2000), the content and nature of those discussions was sometimes difficult but necessary: "*Yes, sometimes there were difficult things but you knew they had to be said" (CS).*

The findings also indicate that respondents had felt that both they and other team members had been encouraged to participate in, and to voice their opinions in, the team meetings and furthermore, that they individually, had also felt part of their accreditation teams. These results, in turn, provide positive evidence of the arguments made by Johnson & Johnson (1997), Huq & Martin (2000), Sheard & Kakabadse (2002) and Caluwe & Vermaak (2003), who advocate that the team environment will influence the scope for capitalising on the synergistic benefits of teamwork. Of interest, in relation to the Likert item on feeling part of their accreditation team, this represents one of the few instances within the quantitative data where clinical services respondents are more positive in their views than the support services responding group. As previously alluded to, this might be explained by the fact that a number of the members of individual clinical services teams were likely to be already working in close proximity to each other and hence may have already identified themselves as part of that team, as suggested in the following

interviewee response: *"The XXX team - the care group, I think you know they probably were a team already"(CS).*

Finally, the extent to which the influence of work roles had been brought to bear on the meetings process was also addressed in the findings and it would appear that the team meetings did not succumb to the dynamics organisational hierarchy, a risk which is highlighted by Kanter (1983) and Hearnshaw et al. (1998) as having the potential to detract from the effectiveness of the team process itself. With particular reference to the clinical services teams, the results from the questionnaires on this issue might not be considered surprising, given that the findings have already indicated that there was a distinct absence of senior doctors i.e. Consultants at the accreditation team meetings and any influence by virtue of their seniority, would not have been felt.

In summarising this aspect of the discussion relating to the teams element of the implementation process, it has been highlighted that one perspective presented in the findings, is that team meetings were viewed as effective and appeared to be functioning in such a way that reflected the position on good practice advocated in the literature. The alternative perspective is counter to this and suggests that there may have existed some degree of faulty meeting processes, which the literature argues may undermine the implementation of an organisation-wide quality approach. The environment of the team meetings has been assessed as largely 'healthy', which again, the literature has argued is a necessity for effective team working. However, there has also been an acknowledgement that the almost complete absence of Consultants from the meetings process, may have served to create an environment where work hierarchies were not deemed to be relevant.

7.2.6 Rewards

The final theme of the accreditation implementation process, as reflected in both the conceptual framework and the findings, is the issue of reward. The literature has acknowledged that there is no consensus on whether those directly involved in quality approaches should be rewarded (Boaden & Dale 1993;Hackman & Wageman 1995;Redman & Mathews 1998;Tari & Sabater 2006), although the argument made in favour of its provision takes the position that reward serves to determine support,

incentivise and reinforce individual involvement in implementing change and quality approaches. Conversely, Gaster & Squires (2003a) venture that, with particular reference to employee involvement in external assessment in healthcare, it is often assumed that reward is unnecessary and that increased job satisfaction and better results will be the main incentives for participation

At the same time, there has been an acknowledgement that the term 'reward' is broad in scope and encompasses both financial and non-financial elements, which, in turn, may take many forms including pay, extra holidays, learning and development and recognition (Weisbord 1976a;Weisbord 1987;Pettigrew, Ferlie, & McKee 1992;Burke & Litwin 1992;Balogun & Hope Hailey 1999;Gustafson et al. 2003;Armstrong 2007). Moreover, for public sector organisations, there is likely to be little scope to exercise discretion in reward for participation that has a financial dimension to it (Balogun & Hope Hailey 1999;Boyne 2002;Kelman 2005) and given the current funding climate for healthcare in Ireland, this is likely to be particularly restrictive (Department of Finance 2002;Wiley 2005;Harney 2006a;Harney 2006b).

The findings have captured a number of issues relating to the general area of reward, in the context of the implementation of accreditation at the research site. The results from questionnaire 1 demonstrate that the prospect of financial reward had not provided the motivation for involvement with the process for the majority of respondents. Elsewhere in the findings, there is also an acknowledgement by some respondents that it is not the culture of health service organisations in Ireland to promote reward for this type of participation. However, despite this, and contrary to the prevailing culture and the inability of public sector organisations to exercise discretion, as outlined above, there is still evidence in the findings that suggests that some respondents believed that they should have received a reward with a financial element to it, as reflected in the following statement: *"Would like official acknowledgement and a reward for my work - deserve a bonus, and additional day, annual leave" (CS).* This issue was further developed in questionnaire 2, where there was a strong indication (from the clinical services respondents, in particular) that those who had participated should be rewarded. This was, in turn, revisited during the interviews, which presented a variety of positions, largely mirroring the debate in the literature on the issue of financial reward and recognising on one hand, that many

individuals had made a significant contribution and were therefore deserving, while on the other, suggesting that participation in accreditation was actually part of team members work roles and hence financial reward was inappropriate.

The findings have also illustrated that recognition, as part of reward, was widely viewed by respondents as being of value to the accreditation implementation process, although the results also demonstrate that it may have not always been forthcoming from a variety of sources. The significance of recognition, as an element of reward, is widely acknowledged in the literature (Crosby 1984;Juran 1992;Ovretveit 1992;Reeves & Bednar 1993;Huq & Martin 2000) and of particular importance, it is seen as being instrumental in ensuring on-going participation in quality approaches, through the enhancement of motivation and commitment towards the process (Koch & Sabugeiro 1992;Schonberger 1994;Hill & Wilkinson 1995;Higgins & Routhieaux 1999). Given some of the previous discussion - for example in relation to commitment - in the context of this study, the absence of recognition early on in the implementation process may have been a contributory factor in exacerbating attendance issues. However, it should be noted that arising from the questionnaire results, the level of recognition from work colleagues and line managers, as experienced by responding team members, improved over time. This was also confirmed by a number of interviewees, who indicated that they had felt valued for their participation and where the source of this value had been from themselves, other team members or those external to the team.

Finally, Hamzah & Zairi (1996b), while extolling the benefits of recognition, also underline that it needs to be managed fairly, in terms of equal treatment for equal contribution, which in the context of this study would need to acknowledge the varying levels of participation and contribution amongst team members and also their colleagues and line managers. Moreover, it has also been noted in the findings that recognition for accreditation participation in the form of a ‘celebration’ would have the potential to be divisive vis-à-vis those who were not directly involved with the process, as illustrated in the following comment from a respondent: *“I think probably recognition certainly, yeah. I think if people start getting the night out it’s going to cause a lot of bad feeling because if people weren't involved whatever. But yeah, I*

think certainly just acknowledging, well in some way that these people were involved" (CS).

As the final theme within the implementation process, the findings from the reward element of the study demonstrate that, when viewed from a financial perspective, the absence of reward is consistent with both the literature on change and quality implementation in public sector organisations and the health service context in Ireland. This is despite an expectation to the contrary being articulated by a minority of responding team members. In relation to recognition, the results suggest that although being absent on occasion (in particular, during the early stages of self-assessment), the position improved over time.

The examination and interpretation of the findings relating to the accreditation implementation process for this study have been facilitated by the development of the conceptual framework, which itself is founded on an organisational change model that both allows for the identification of *"…what is"* and *"…what ought to be"* (Weisbord 1976a p.435) and moreover, is seen to encompass the factors that target change management activities (Armenakis & Bedian 1999). In summarising the discussion on the implementation process, the overall interpretation of the findings would suggest that specific aspects of the six constituent themes that have been addressed, had not been fully realised over the course of the first phase of accreditation at the research site and, as such, may be interpreted in terms of lack of supports or resources for the process. Overall, what this may amount to is a *"…partial"* (Hill & Wilkinson 1995 p.10) implementation process for accreditation in the context of this study, which Hill & Wilkinson (1995), Yong & Wilkinson (1999) and Chang (2005) argue represents a fragmented and *"…piecemeal"* (Yong & Wilkinson 1999 p.157) strategy for adopting organisation-wide quality approaches.

Furthermore, the interconnectedness of each of the themes has surfaced, where difficulties relating to one area have been shown to manifest elsewhere in the implementation process. This clearly supports the arguments made by Katz & Kahn (1978), Beer & Spector (1993), Schonberger (1994), Hill & Wilkinson (1995), Yong & Wilkinson (1999), Rollinson & Broadfield (2002) and Chang (2005) who suggest

that the successful implementation of organisational change and quality approaches requires the effective integration of a number of separate but related activities.

The implications of implementation in this vein may mean that the quality approach runs the risk of never being fully developed in the organisation (Hill & Wilkinson 1995;Yong & Wilkinson 1999;Chang 2005). This position is further reinforced elsewhere in the literature on change and quality implementation. In the first instance, Burnes (2000) purports that employees experiences of change and their views of any outcomes, will be influenced by the way in which it is implemented, a position also supported by Ghobadian & Gallear (2001), who further note that participants early experiences are particularly important as they will influence attitudes and behaviours towards the process. In addition, Ovretveit (1999) and Pomey et al. (2005) argue that quality approaches and specifically accreditation, will fail in their ability to actually generate organisational change and quality improvement, where there are weaknesses in implementation. Finally, Alexander et al. (2006) have demonstrated that implementation and its supporting process and infrastructure will determine the embeddedness and diffusion of a quality approach in a hospital context.

However, in arriving at this overall assessment, cognisance also needs to be taken of the suggestion that over the course of the first phase of accreditation, the organisational context in which the implementation of accreditation had occurred, was viewed by many respondents as being under-resourced and those working within it 'overstretched', which, in itself, may have exacerbated aspects of the process. In terms of the secondary sources of data reviewed during this research, the recent statistics provided by the OECD (2006) and Central Statistics Office (2007) suggest that despite the growth in healthcare expenditure in Ireland, spending based on GDP is still below both the OECD and EU 25 averages. Furthermore, the translation of this expenditure into resources on the ground demonstrates that the number of acute-care beds also is significantly below the OECD average, as is physician density, while population growth (Department of Health and Children 2001;Colgan & Tubridy 2001;Quinn 2005) and increased activity rates (ESRI 2006) may be instrumental in creating greater pressure on service provision. As a result, this data

may provide evidence to support the views expressed by respondents during this research, as to the resourcing issues at the research site.

7.3 Accreditation Impacts

The discussion now turns to the interpretation of the findings relating to the impacts associated with the accreditation process. Reflecting the previous structure adopted in this thesis, these are dealt with in terms of those arising at the individual and organisational levels and furthermore, make explicit reference to the relationship with the aforementioned findings from the implementation process, where appropriate. In doing so, this aspect of the discussion seeks to address the following research objectives:

> *To identify the experiences of individual team members in terms of impacts at both the individual and organisational levels arising from the first phase of accreditation;*
>
> *To establish the extent of, and reasons for, any differences between individual team members, in terms of their experiences of the implementation process and individual and organisational impacts associated with the first phase of accreditation, based on team type and work role.*

7.3.1 Individual Impacts

The findings have presented an assessment of the impacts experienced at the individual level that largely concur with those articulated in the literature in the area. The results demonstrate that opportunities for learning, development and reflection were both the initial motivation for many respondents involvement and had, in turn, become the main benefit from participation in accreditation and a self-assessment team, which mirror the observations made in the literature by Cole, Bacdayan, & White (1993), Hackman & Wageman (1995), Iles & Sutherland (2001) and Alexander et al. (2005). As Daily & Bishop (2003) note *"…working in teams can be instrumental in employees developing comprehensive and in-depth views of organizational issues and institutions through the pooling of knowledge"* (p.398) and there is clear evidence of this in the findings, in particular, those from the semi-

structured interviews. Furthermore, these findings are consistent with those reported by Joss & Kogan (1995) and Pomey et al. (2004) on the implementation of an organisation-wide quality approach and accreditation respectively, in healthcare contexts, where they have also noted that involvement had been developmental for participants and had also improved their understanding of the strategic issues in the organisation.

To a lesser extent, career advancement is presented in the findings as being a reason for involvement and an individual impact associated with participation in accreditation, as viewed by respondents. While Ahire, Golhar, & Waller (1996) and Cacioppe (1999) have identified this as a potential outcome, Lam (1995) found in his study that opportunities for advancement were ranked low as a perceived change arising from the implementation of an organisation-wide quality approach. In relation to this study, only 15% of questionnaire 1 respondents indicated career advancement as a reason for involvement and ranked it below opportunities for personal development and reflection on work practices. While the findings from questionnaire 2 have positively assessed involvement as contributing to career advancement, the results have also demonstrated that the mean scores are also higher (viewed less positively) than contributing to professional and personal development and allowing for reflection on work practices. Finally, career advancement and promotion as an individual impact arising from accreditation, were mentioned by only a minority of respondents during the semi-structured interviews. This trend would suggest that the findings from this study are consistent with those of Lam (1995).

The remaining element of the individual impacts associated with accreditation explored during this study, concerned the experiences of role conflict, as seen by respondents. This issue has previously been alluded to in relation to the problems associated with the absence of time for involvement and participation in accreditation. The literature acknowledges that individual involvement in quality approaches has the potential to add to existing work roles and associated workloads (Lam 1995;VanRooyen et al. 1999;Yeh 2003) and to fundamentally overstretch existing internal resources (Steensma & Tetteroo 2000;Berwick, James, & Coye 2003;Weiner et al. 2006), which, in turn, may give rise to role conflict (Katz & Kahn 1978). However, it should also been acknowledged that work role expansion can in

itself be developmental (Cooney & Sohal 2004). At the same time, it has also been recognised in the literature that line managers (as leaders) are charged with facilitating the participation of their staff and where employees experience difficulties or 'conflicts', then this might be interpreted in terms of their lack of support for both the individual participant and the quality approach (Feinberg 1996;Lakshman 2006).

The findings have provided clear evidence of role conflict over the course of the first phase of accreditation at the research site and this was particularly apparent for those contributing to the clinical services teams. Here the conflict was, for the most part, between providing care to patients and attending accreditation team meetings and completing associated tasks, where the latter was viewed as detracting from doing what may be perceived as the *"…'real job'"* (Gaster & Squires 2003a p.87), in what has already been suggested to be an under-resourced environment. Moreover, the results additionally capture that a further manifestation of this conflict may have been between the individual team member themselves and those colleagues remaining behind in the work environment, which is reflective of the observations made by Steensma & Tetteroo (2000) in the literature, where tensions are purported to be a negative outcome from participation in quality teams. This particular issue is reflected in the following interviewee response:*"The fact that you were taking time and walking off, walking away from clinical areas, people just got so annoyed with you the whole time, it was palpable the annoyance, so you really had to put your head down and just go, and quite often you wouldn't even say where you were going, you would just say I have to go to a meeting, eventually they knew where you were going, but people got very annoyed at you walking off and leaving them with the workload"(CS).*

Overall, the findings from this research would appear to be consistent with those reported by Redmayne et al (1995), James & Hunt (1996), Gandhi et al.(2000), Francois et al. (2003) and Book, Hellstrom, & Olsson (2003), where role conflict was reported to be experienced by respondents participating in the implementation of quality approaches (including accreditation), where the demands of their quality roles presented a challenge to that of their normal work.

In summary, this aspect of the discussion has demonstrated that in terms of the individual impacts associated with accreditation, the findings from this study are largely consistent with both the arguments and empirical findings presented within the literature. While the findings have shown that role conflict has been reported to be extensive and is related, in part, to aspects of the implementation process, the results have also demonstrated the significant benefits that have accrued at the individual level. These have principally been in providing enhanced scope for learning and development and to a lesser extent, the opportunity for career advancement.

7.3.2 Organisational Impacts

Both the literature and the findings have highlighted a range of organisational impacts associated with the implementation of quality approaches, including accreditation. Whether wanting to improve the standard and delivery of healthcare in both the hospital and the immediate work area provided the initial motivation for involvement, was addressed in questionnaire 1, where only 65.4% and 51.2% of respondents respectively indicated that it was. These results on one level might be considered surprisingly low, particularly if examined with reference to the observations made by Gaster & Squires (2003a), who have noted that it is often assumed that better results and increased job satisfaction will be the main incentives for participation in quality approaches in healthcare contexts. However, if the findings are viewed in the context of communication, they may reflect the 'disconnect' between the objectives of accreditation and the individual understanding of the process itself, as previously addressed in this chapter. However, countering this, the findings (likewise from questionnaire 1) also suggest that respondents indicated that they had a clear understanding of how accreditation could improve the standards and delivery of healthcare in the hospital, at the start of the self-assessment process.

Another possible explanation may lie with respondents views of whether they saw involvement as part of their overall work role. As previously noted, the level of agreement on this issue in the results from questionnaire 1, was also low and suggests that many team members failed to see accreditation as part of their role and may, as a result, have been unlikely to be motivated to become involved by the

prospect of improving the standards and delivery of care. Finally, the results also need to be considered in the context of how respondents actually became involved as a member of an accreditation team. Previous discussion has noted that some respondents may have come to the accreditation process as unwilling participants, which, in turn, may have negated any alternative motivations for involvement, such as improving overall standards and delivery of healthcare at the research site.

The literature argues that quality approaches have the potential to improve quality of care and Shortell et al. (1995) have demonstrated this in their study in terms of enhanced clinical efficiency and patient outcomes. The quantitative questionnaire findings have provided an evaluation of whether, in the views of the respondents, positive impacts had been achieved at the organisational level. This particular aspect of the questionnaires sought to address respondents assessments of whether accreditation had improved the standards and delivery of healthcare, in both their immediate work area and also within the hospital itself. Not surprisingly, the interim questionnaire findings, providing a view of the organisational impact at only five-months into the process, indicated that this had not occurred. However, the post-IHSAB survey results paint a distinctly different picture, where agreement is shown on these items (but again less so for clinical services team respondents), suggesting that the benefits of self-assessment had taken time to materialise. Furthermore, the qualitative findings have also indicated that tangible outcomes were seen in terms of moving towards standardisation of practice, the development of protocols, the updating of documentation and formally institutionalising the review of work processes. As such, these were viewed as positive developments which would, in turn, contribute to better and safer practices for both patients and those working within the organisation. In the words of one respondent *"I believe there was no sort of system or review of documentation or anything of sort up 'til that" (SS).*

This assessment of the organisational impacts concurs with those highlighted in the literature and within this, with other studies in the quality and accreditation implementation area (Duckett 1983;Steiner, Scrivens, & Klein 1995;Hearnshaw et al. 1998;Pomey et al. 2004;Lagrosen, Backstrom, & Lagrosen 2007). In particular, the study by Steiner, Scrivens, & Klein (1995) highlighted that accreditation implementation had actively facilitated the transition towards a standards-based

organisation culture and the findings from this research would suggest that this journey had commenced at the research site by the end of the first phase of accreditation. The more recent study by Pomey et al. (2004) also demonstrates that accreditation had been instrumental in developing a *"…writing culture"* (p.121), where work practices and information about patients started to be ritually written down as opposed to relying on word of mouth. Again, there is also evidence of this in the findings from this study and in the view of one respondent *"The other benefit is that when we introduce new people, new employees, to our department what happens then automatically is we can focus them towards the relevant standards in this department and say this is what is done. It dismisses this prospect of learning by word of mouth from their colleagues"(SS).* This obviously has the potential to contribute to both reducing the risks for patients and staff and, in turn, to developing more consistent work practice, which may ultimately result in a positive impact on the quality of care.

Other benefits deemed to have arisen at the organisational level were enhanced levels of communication, multidisciplinary working and improved relationships. Looking first at communication, the body of literature recognises this as one of the central and most positive outcomes from quality and accreditation implementation (Duckett 1983;Berwick, Godfrey, & Roessner 1990;Brown 1994;Redmayne et al. 1995;Steiner, Scrivens, & Klein 1995;Nwabueze 2001;Francois et al. 2003;Cooney & Sohal 2004). Pomey et al. (2005) further argue that the impact of improved communication arising from accreditation, actually outweighs any improvement in terms of healthcare practices, as the process develops a forum to discuss knowledge and values amongst healthcare professionals. The findings from this study have provided evidence that communication across the organisation had improved as a result of accreditation implementation and that associated with this, relationships between different functions and disciplines had also been strengthened as a result of both direct interaction and a greater appreciation of each other's roles.

Likewise, quality and accreditation implementation are also seen to give rise to enhanced levels of multidisciplinary working (Counte, Oleske, & Hill 1992;Redmayne et al. 1995;Joss & Kogan 1995;Pomey et al. 2005), where participating in quality teams brings individuals together who otherwise might never

directly or indirectly interact (Berwick, Godfrey, & Roessner 1990). The findings from this study lend support to this claim and, in particular, those from questionnaire 2. Of specific interest with this aspect of the findings, are the differences in the assessments made by the clinical services and support services respondents where, as has been the case with the majority of the questionnaire findings, the clinical services group are more negative in their views. In this particular instance, these results might be explained by the lack of attendance at the team meetings by doctors which may, as a result, have hindered the extent to which the clinical services teams could achieve full multidisciplinary working, which was also suggested in the results from the semi-structured interviews.

As previously acknowledged, the scope for enhanced relationships is also cited within the literature as a positive outcome associated with quality and accreditation implementation and is related to both improved communication and multidisciplinary working (Duckett 1983;Morris, Haigh, & Kanji 1994;Nwabueze 2001;Pomey et al. 2005). The findings from this study demonstrate that relationships with immediate work colleagues and also those in different functions, at both the research site and in the wider regional and health board/network structure, improved as result of accreditation. These reflect those reported by Lam (1995), Steiner, Scrivens, & Klein (1995) and, in particular, Pomey et al. (2004) who posit that in their study, accreditation implementation had been shown to have created social capital, where new networks of relationships developed up, down, across and outside of the organisation and that these were, in turn, seen to have had a positive impact of the process of delivering care. In the context of this research, this particular point is illustrated in the following comment: *"I can meet them now or I can ring the pharmacist and sort out issues on the phone. It's much easier to talk to them now. Certainly the communication with the public health and community care has improved"(CS).*

Finally, the interview results, in particular, have shown that some respondents had recognised a number of other positive impacts and benefits arising from accreditation. These included improving morale at the research site, enhancing the reputation of the hospital amongst service users and fundamentally creating organisational change. As such, these findings echo the positions presented in the

literature, in particular those by Duckett (1983), Scrivens (1995b), Steiner, Scrivens, & Klein (1995), Bohigas et al. (1996), Bruchacova (2001), Schyve (2000) and Pomey et al. (2005).

Despite the aforementioned positive impacts associated with accreditation implementation, the findings also provide an alternative perspective on the outcomes at the organisational level. Sewell (1997) has argued that accreditation has the potential to develop into a 'paper-chase' exercise, with no guarantee that quality of healthcare services will actually improve, while Pomey et al. (2004) have also noted that as a quality approach, accreditation has the potential to become bureaucratic and will resultantly fail to deliver a comprehensive review and improvement in the structures, processes and outcomes of care. Based on the results from this research, there is the suggestion that this was the experience and view of some responding accreditation team members, where doubts and, moreover, cynicism were articulated about the process and any tangible and long term benefits that it might accrue from it, as evidenced in the following comment: *"It appears like a last minute tidy up while the improvements were not sustained. Management appeared to be concerned only with getting it 'right on the day' not looking at ways to improve patient care"(CS).* Furthermore, Pomey et al.(2004) have argued that the strength of accreditation is that it has the potential to arrive at a global assessment of a healthcare organisation. In this study, the findings have recorded the reservations of a minority of respondents, in whose view, the self-assessment process had provided an unrealistic and incomplete picture of the research site and who additionally believed that any improvements made as a result of this, might not be sustained within the organisation.

As the final issue for discussion in relation to organisational impacts, the implementation of quality and accreditation approaches have been recognised as having the potential to impact unfavourably on the organisations and services they are seeking to improve (Boaden & Dale 1993;Higgins & Routhieaux 1999). The previous discussion around the issue of time for involvement and the role conflict arising from participation, has acknowledged that the findings in this study have shown that, in the experiences and views voiced by a number of respondents,

implementing accreditation may have left other work undone and was also seen to be potentially impacting on colleagues and service users.

In summarising the organisational impact aspect of the discussion, both positive and negative assessments of the outcomes of accreditation have been addressed. On one hand, the results have provided strong evidence that communication, multidisciplinary working and work relationships had improved as a result of the first phase of accreditation at the research site, positions that are also reflected in the literature. However, this has been countered by an alternative evaluation, that proposes that the process was viewed as a 'paper-chase' exercise, that provided an incomplete view of the organisation and any benefits from which would be unlikely to be sustained in the long term. Moreover, there has also been the suggestion in the findings that the implementation of accreditation may, in fact, have represented a challenge to the provision of service within the hospital, arguments which have been also made within the body of literature in the area. Finally, what this aspect of the discussion has also demonstrated is that, despite the difficulties with the implementation process itself (as identified in earlier sections of this chapter), positive organisational impacts have still been generated, which concurs with the position taken by Greig (1993), Redmayne et al. (1995) and Ennis & Harrington (1999a) in the literature.

7.4 Respondent Explanations of Differences between Clinical Services and Support Services Findings

This final area of the discussion seeks to address the differences in the individual experiences of both the implementation process and the individual and organisational impacts that may have arisen within this study, based on team type and work role. As such, it focuses on the following research objective:

> *To establish the extent of, and reasons for, any differences between individual team members, in terms of their experiences of the implementation process and individual and organisational impacts associated with the first phase of accreditation, based on team type and work role.*

The literature has argued that those in clinical roles and disciplines may view quality approaches, and any potential and resultant impacts, less favourably than those in management, administrative and support roles within a healthcare organisation (Duckett 1983;Wakefield & Wakefield 1993;James & Hunt 1996;Pomey et al. 2004;Gollop et al. 2004;Hazilah & Manaf 2005;Boaden 2006;Gollop & Ketley 2007).

In this study, team type and work role have been used as a proxy for work role or discipline, as described in the literature. Both the findings themselves and previous sections of this discussion, have acknowledged that for the majority of the questionnaire data arising from this study, the results have shown clear support for the stance taken, and findings reported, within the literature. The clinical services respondents have been, in the main, more negative in their assessments of their experiences of the process and any impacts arising, than the support services repondents and this has been further borne out in the findings presented based on work role, where the responding group 'Other' have been largely more positive in their views. The other areas of the findings have also reinforced this trend and, in particular, issues surrounding involvement and participation, role conflict and the views voiced in relation to the potentially negative organisational impacts, have captured the challenges, dilemmas and sometimes cynicism and scepticism of those working in clinical services roles.

This research has also sought to address the reasons behind these differences and the semi-structured interviews have been the main source of evidence on this issue. Three separate explanations emerged from the data. First, it was suggested that those working in clinical services areas were more operational and, as a result, saw accreditation as less relevant to their day-to-day work. This position would appear to concur with the literature in the area, where organisation-wide quality approaches such as accreditation have been reported to be viewed as lacking application and yielding minimal benefits by those in clinical roles (Duckett 1983;Wakefield & Wakefield 1993;James & Hunt 1996;Kennedy 1998;Boaden 2006).

Secondly, and as previously alluded to, it was suggested that the failure to achieve full multi-disciplinary working in the clinical services teams may also have

influenced respondents views and reported experiences of the accreditation process and impacts, as reflected in the following comment from an interviewee: *"I'd say from the care teams' perspective one of the big, one of the big downfalls was that they weren't completely multidisciplinary, really if you were to be true to yourself it wasn't. The whole process required much more support from our medical colleagues"(SS).* The literature argues that where the involvement of all relevant parties to a quality approach is not achieved, this may impact on both the motivation of other participants, their perceptions of the process and also on the ability of the quality approach itself to make a positive impact in the organisation (Ovretveit 1992;Redmayne et al. 1995;Weller Jr 1995;Hearnshaw et al. 1998;Ennis & Harrington 1999a;Taylor & Wright 2003;Lagrosen, Backstrom, & Lagrosen 2007) and there would appear to be evidence in this study to support this view.

Finally, the reported resource constraints within the working environment of clinical services respondents may have served to influence and exacerbate their experiences of the accreditation implementation process and their assessments of the individual and organisational impacts. In the words of one interviewee respondent, those in the clinical services teams were working at the *"…coal face" (CS)*, while it was also reported by others that they viewed themselves as already 'stretched' in their roles and subjected daily, to the shortcomings in resources and the demands being placed on the service itself. This was furthermore offered as an explanation for why clinical services respondents were more of the view that they should be rewarded for their involvement in the first phase of accreditation.

7.5 Conclusion

This chapter has offered an interpretation of the findings arising from this study with reference to both the body of literature in the area and also to the wider context of public sector and healthcare reform. In terms of the implementation process, the discussion has identified that while a number of positive evaluations of individual experiences have been recognised, so too have a variety of shortcomings, which has led the author to assess the accreditation implementation process at the research site as one that has been 'partial'. At the same time, by virtue of the interconnectedness of each of the themes within the implementation process, it has been shown that their

influence may have extended to other aspects of the process and also to the individual and organisational impacts of accreditation. However, this study has also demonstrated that at the research site, despite these reported difficulties, the implementation of accreditation still gave rise to impacts that were beneficial at both the individual and organisational levels, although the problematic nature of other outcomes must also be acknowledged. Chapter 8, therefore turns to the conclusions and associated recommendations that may be drawn from this research exercise, set within an appropriate recognition of the overall limitations associated with this study.

Chapter 8: Conclusions, Recommendations and Limitations

8.0 Introduction

This chapter presents the conclusions that have been arrived at from conducting this doctoral study on the implementation process and impacts associated with acute-care hospital accreditation. The particular focus of this under-researched area has been the experiences of the individual members of the accreditation teams, which were formed at the commencement of the first phase of accreditation at the research site. Reflecting the structure adopted elsewhere in this thesis, the chapter addresses the conclusions in terms of the implementation process, individual and organisational impacts and differences arising within these based on team type and work role. The contribution made by this study, underpinned as it is by a robust evidence base, to knowledge and understanding, is also discussed with particular reference to the gaps in the literature, which were identified at the outset of this thesis in Chapter 1. Recommendations for practice, policy and future research are recognised and, where possible, specified. Similarly, the limitations and restrictions that are inherent within this study are identified and discussed.

8.1 Research Question and Research Objectives

Chapter 1 has served to demonstrate the paucity of literature and empirical studies in the field of accreditation implementation and impacts. Furthermore, demand for robust research in this area, in particular that which focuses on bespoke methodologies, with a high degree of emphasis on those who are directly involved with implementing quality approaches in healthcare settings, has also been acknowledged. This demand, coupled with the fact that accreditation has only recently been adopted as an organisation-wide approach for managing and improving quality in publicly funded acute-care hospitals in Ireland, has provided the major driver and key justification for this study. With this in mind, this research has sought to answer the following research question:

> *What are the experiences of individual team members in terms of the accreditation implementation process and the individual and organisational impacts associated with this, in a large acute-care hospital context?*

Furthermore, a number of specific research objectives have been addressed as a result of this:

(i) To review and synthesise themes within the existing literature in the area of organisational change and quality implementation and impacts, with particular reference to quality in healthcare and hospital accreditation;

(ii) To explore the experiences of individual team members with reference to the implementation process surrounding the first phase of accreditation;

(iii) To identify the experiences of individual team members in terms of impacts at both the individual and organisational levels arising from the first phase of accreditation;

(iv) To establish the extent of, and reasons for, any differences between individual team members, in terms of their experiences of the implementation process and individual and organisational impacts associated with the first phase of accreditation, based on team type and work role.

The following sections will identify the conclusions that have been arrived at as they relate to both the research question and the specific objectives.

8.2 Conclusions: Accreditation Implementation Process

This research has addressed the implementation process associated with accreditation under six individual themes. The overall conclusion drawn within the context of the first phase of accreditation and based on the experiences of individual team members, is one of partial implementation being achieved. This view is based upon an assessment emerging from the research data and findings, that the actions and activities that constitute the process of accreditation have fallen short of expectations, to the extent that their implementation has not been fully realised. If these are, in turn, interpreted in terms of resources and supports, this may be a further regarded as a possible failure to position quality and accreditation strategically within the

organisation, which is an observation that aligns closely with the perspective that pervades the quality implementation literature (Berwick, James, & Coye 2003). Furthermore, the integration of the separate aspects of the implementation process, in concert, has been shown to have not been entirely achieved. This suggests fragmentation in terms of the implementation, which, in turn, may have influenced the extent to which accreditation has been fully developed at the research site, an argument that is also presented in the literature (Hill & Wilkinson 1995;Yong & Wilkinson 1999;Chang 2005;Alexander et al. 2006).

Finally, this study has also demonstrated, through its findings, that a further implication arising from partial implementation may have been the manifestation of detrimental impacts at the individual and organisational levels. Such negative factors identified included role conflict and the associated perception amongst the research respondents that the process of engaging with accreditation could potentially have some bearing on their ability to deliver healthcare services.

However, such conclusions and moreover, the totality of those drawn from this research, have been arrived at with a particular appreciation of the specific resourcing issues that have been suggested existed at the research site over the course of this study. Both the findings and the discussion chapters have both acknowledged that these may have served to exacerbate both the implementation process and, furthermore, may have contributed to impacts at the individual and organisational levels that were undesirable and potentially unanticipated. As such, it would appear reasonable to posit a view that the organisational context and the level of resourcing therein, represents an important consideration in the overall implementation of accreditation.

With reference to the conclusion arrived at in relation to the leadership aspect of the process, as previously acknowledged, elements of the findings from this study have revealed the many positive features of the leadership associated with accreditation implementation. However, the results from this study have also demonstrated that the spread and influence of leadership may, in turn, have contributed to issues and problems with other aspects of the implementation process and furthermore, to some of the unintended individual and organisational impacts. In particular, problems with

the efficacy of communications; the absence of key contributors from the self-assessment process; a lack of protected time; individual role conflict and perceived problems with maintaining service delivery, have all been shown to bear some relationship to leadership. As such, the conclusion drawn in relation to the leadership aspect of this study, is that, despite the efforts of those individuals within the roles, and being cognisant of the perceived resource issues at the research site, that the leadership has struggled to develop the necessary promotion, support and direction to the first phase of accreditation. Finally, this study has further demonstrated, as reflected in the literature in the area (Joss & Kogan 1995;Shortell, Bennett, & Byck 1998;Samson & Terziovski 1999;Weiner et al. 2006;Lakshman 2006), the significance of leadership to quality in healthcare and specifically to accreditation, and has additionally underlined the centrality of a dedicated leadership role as a key resource for the implementation process.

This research has confirmed that the communications associated with accreditation implementation exist at a number of levels within the organisation and this reflects the key arguments made in the literature (Lewis 1999;Elving 2005;Lewis 2006). In this study, communications at the team level has been shown to be instrumental in supporting the functioning of the accreditation team, in terms of providing feedback on progress, timelines and required actions to the individual team members. However, what has also been established is that the communications efforts, and in particular those at the commencement of the process, struggled to develop the fundamental understanding required by team members in order to fulfil their accreditation roles. The implications of this have been shown to have extended to an influence on participant motivation and may, in turn, have affected the level of attendance of the individuals listed as being involved with the first phase of accreditation. Moreover, the findings have also suggested that the absence of this understanding may have additionally impacted negatively on progress with the self-assessment process itself.

Developing an organisation-wide understanding of accreditation and the role that every employee plays in supporting and contributing to it, is also revealed by this research as a function of the communication process. This study has shown that the communication efforts were challenged from the outset in their ability to create the

initial and on-going awareness amongst the general body of employees at the research site. At the same time, evidence has also been presented to support the conclusion that these may have, to some extent, represented an unreceptive audience, which the literature has argued may be characteristic of healthcare and specifically, hospital organisations (Berwick, Godfrey, & Roessner 1990;Hillman 1991;Shortell et al. 1995;Friedman & White 1999;Walshe & Smith 2006).

The multifaceted nature of involvement and participation has been highlighted in this study and a number of specific conclusions can be drawn from the findings. Firstly, while this research has recognised the imperative for the involvement of those in key roles with accreditation, the process is unlikely to function adequately if it is reliant solely on those individuals who come forward as volunteers for the process, despite the fact that it was promoted as a voluntary activity. This research has revealed that the majority of team members had been asked to join an accreditation team, although the findings have suggested that there may have existed a degree of individual choice in relation to participation and moreover, that this was the preferred mode of involvement. However, what has also been shown is that for some team members, this was not the case and that they experienced individual pressure to become involved with accreditation, a practice which is actively discouraged in the literature in the area (Boaden & Dale 1993;Dale 2003a) and which may have contributed to disengagement with the process during the first phase of accreditation.

Secondly, this study has also demonstrated that at the start of the first phase of accreditation, many team members did not view involvement with accreditation as part of their work role and this was particularly apparent for those in clinical services teams and roles. While a greater level of acceptance had been reached by the end of the process, this research has demonstrated the challenges associated with successfully eliciting the participation of individuals to organisation-wide quality approaches in healthcare. Furthermore, it has also highlighted the difficulty in gaining an acknowledgement that accreditation is an integral part of daily work. The findings from this study also underline the fact that the initial communication efforts in particular, are likely to be instrumental in creating either an initial awareness or providing a timely reminder to all employees, including direct accreditation participants, that managing and improving quality, through the accreditation

approach, is everyone's responsibility, as advocated in the literature (Ovretveit 1992;Close 1997;Shin, Kalinowski, & El-enein 1998;Scrivens 2005;Pomey et al. 2005).

The final conclusion to be drawn from this specific aspect of the research relates to the level of active participation in the self-assessment process. In this study, this was interpreted as being reflected in the level of attendance at team meetings. In relation to this, a strong theme emerged that suggested that on-going absences from these meetings served to hamper the process of accreditation. This study has explicitly illustrated the consequences arising from the non-participation of key contributors, and specifically, the medical profession, to an organisation-wide quality approach. In particular, it has illustrated the potential that exists for the completion of the accreditation standards and the compilation of evidence of compliance, to be hindered in advance of a third-party accreditation survey, which is an issue that has previously been noted in the literature (Duckett 1983;Berwick, Godfrey, & Roessner 1990;O'Leary 2000;Nwabueze 2001). Furthermore, it has been demonstrated that this absence from the accreditation process may additionally contribute to frustration, de-motivation and feelings and perceptions of inequity amongst many team members and, in turn, adversely influence their commitment to the process, as has been recognised in the literature (Weller Jr 1995;Hearnshaw et al. 1998;Higgins & Routhieaux 1999;Woodward & Hendry 2004). However, involvement has also been shown to have been challenged by an absence of a policy to formally provide 'protected time' for individual team members, despite this being an explicit recommendation of the World Health Organisation (Shaw 2004) for the implementation of accreditation.

The findings from this study have also served to reaffirm the importance of the content and timing of training, as articulated in the literature (Motwani, Frahm, & Kathawala 1994;Black & Porter 1995;Redman & Mathews 1998;Vermeulen & Crous 2000), to the quality and accreditation implementation process. In particular, the significance of the initial training has been demonstrated as the means, in conjunction with communication, by which accreditation participants develop their knowledge and understanding of the process. Furthermore, the consequences of a

delay in specific external training (by IHSAB) may have been felt in terms of additionally impeding the development of these.

Accreditation teams are at the core of the accreditation process and this study has sought to evaluate the effectiveness and operational environment of the team forums - the bi-weekly meetings - as a vehicle for exploring internal team processes. In relation to the meeting effectiveness, a mixed assessment has been arrived at. This is based on an acknowledgement that the findings have presented a varied picture of team members experiences, with the more negative views being contrary to the practice for meeting management advocated within the literature on organisational change and quality implementation (Kanter 1983;Berwick, Godfrey, & Roessner 1990;Reeves & Bednar 1993;Higgins & Routhieaux 1999). In relation to the team environment, the conclusion drawn from the findings is that the team meetings actively encouraged and facilitated the participation and articulation of the views of team members. As further evidence of this 'healthy' team environment, there appeared to be little manifestation of the influence of work hierarchies, which is cautioned upon in the literature (Kanter 1983;Hearnshaw et al. 1998;Huq & Martin 2000), although it is also recognised that the majority of senior members of the medical staff were absent from these meetings and hence arguably, did not pose a risk to the dynamics of these forums.

The final theme within the accreditation implementation process associated with this study, relates to the area of reward. This study has demonstrated that recognition, as an element of reward and a means of acknowledging involvement and contribution, was viewed by team members as being of value to the accreditation implementation process. Furthermore, it has been demonstrated that recognition of individual team members had been largely forthcoming, from a variety of sources, over the course of the first phase of accreditation at the research site. However, in keeping with the public sector context and reflective of the literature in the area (Balogun & Hope Hailey 1999;Boyne 2002;Kelman 2005), the scope for reward with some financial element attached to it, was recognised within the majority of the findings in this area, as being both beyond the remit, and inconsistent with the prevailing culture, of organisations of this type.

Finally, this study has focused on the experiences of individual team members with reference to the implementation process over the course of the first phase of accreditation. As such, this research has been conducted from a longitudinal perspective and has demonstrated on one hand, that individual experiences of several of the themes and the specific elements within these, developed in a positive sense over time, suggesting an evolutionary and essentially developmental process. As examples of this, individuals understanding of the accreditation process; their evaluations of the training provided and the level of recognition received from colleagues all exhibited improvement by the completion of the self-assessment stage.

In contrast, the findings have also highlighted that the specific problems associated with the equity and fairness of accreditation task allocation, became more pronounced as the self-assessment progressed and as a result, individuals reported more negative experiences of this over time. Overall, the totality and implications of these trends may be fully appreciated when considered with reference to the change and quality implementation literatures (Burnes 2000;Ghobadian & Gallear 2001). It is here that the argument has been made that suggests that individuals views of implementation and associated outcomes will be influenced by their early experiences of it, which, in turn, may serve to affect attitudes and behaviours towards the quality approach itself going forward.

8.3 Conclusions: Accreditation Impacts

The impacts associated with the first phase of accreditation at the research site have been addressed in terms of those occurring at the individual and organisational levels. This study has evidenced and concluded (to some extent, paradoxically), that despite the problems identified within the implementation process itself, in the experiences of team members, a number of positive impacts have emerged from the first phase of accreditation. From an individual perspective, this study has demonstrated that accreditation provided opportunities for reflection, contributed to learning and development and, to a more limited extent, may have served to further future career progression. However, the reported experiences of team members has also shown that involvement in the process had also given rise to fundamental conflicts between the demands of work roles and those of being an accreditation

team member. These appear to have been particularly acute for those in the clinical services teams, most of whom were directly at the front line of patient care. Moreover, this conflict was seen to be rooted in both an absence of protected time and a lack of healthcare resources, such as additional staff. Overall, the conclusions drawn in relation to individual impacts in this research are reflective of those presented in the literature in the area (Redmayne et al. 1995;Hackman & Wageman 1995;Lam 1995;James & Hunt 1996;Book, Hellstrom, & Olsson 2003;Pomey et al. 2004;Alexander et al. 2005).

A number of explicit and beneficial organisational impacts arising from accreditation have been made apparent within this study, which has also illustrated that, as a consequence of the longitudinal nature of the research base, that these had taken time to emerge at the research site. Enhanced communication, multidisciplinary working and relationships, a move towards a standards-based culture and improved delivery of healthcare services, have all been shown as positive impacts associated with the first phase of accreditation, which are also consistent with other empirical studies in the quality and accreditation implementation areas (Duckett 1983;Redmayne et al. 1995;Steiner, Scrivens, & Klein 1995;Shortell et al. 1995;Hearnshaw et al. 1998;Pomey et al. 2004;Lagrosen, Backstrom, & Lagrosen 2007). Likewise, but to a somewhat lesser extent, improved morale, the enhanced reputation of the research site and the creation of the momentum for organisational change more generally, have also been identified by respondents within this study as constructive developments arising from accreditation implementation. Again, such outcomes are acknowledged in the body of relevant literature in the area (Steiner, Scrivens, & Klein 1995;Scrivens 1995b;Bohigas et al. 1996;Schyve 2000;Bruchacova 2001;Pomey et al. 2005). At the same time, this study has also shown that, based on the experiences of team members, the implementation of accreditation has the potential to unfavourably impact on the provision of health services themselves. As such, there is significant congruence between the conclusions arrived at from this research and the arguments and findings reported in the literature (Boaden & Dale 1993;Higgins & Routhieaux 1999).

8.4 Conclusions: Explanations of Differences between Clinical Services and Support Services Findings

This study has sought to establish the extent of, and reasons for, any differences between individual team members in terms of their experiences of accreditation, based on team type and work role. In particular, it has aimed to address these experiences with reference to the six themes within the implementation process and those relating to individual and organisational impacts. Based on the majority of the findings arising from this research, the conclusion reached in relation to the extent of any differences, concurs with those previously drawn within the literature (Duckett 1983;Wakefield & Wakefield 1993;James & Hunt 1996;Pomey et al. 2004;Gollop et al. 2004;Hazilah & Manaf 2005;Boaden 2006;Gollop & Ketley 2007). Here, it is argued that those working in clinical roles or disciplines will view quality and, specifically accreditation, approaches and any associated positive impacts, less favourably than their administrative or support services colleagues and through the adoption of team type and work role as a proxy for discipline or work role, this study has lent further weight to this position.

In relation to the reasons for these differences, this research concludes that these lie with three principal explanations. Firstly, that by virtue of their operational orientation, those in clinical services disciplines see accreditation as less relevant to their roles, a view which is also reflected in the literature (Duckett 1983;Wakefield & Wakefield 1993;James & Hunt 1996;Kennedy 1998). Secondly, the failure to achieve full multidisciplinary working with the clinical services accreditation teams negatively influenced the experiences and views of those individuals participating in them, a conclusion that is also supported in the literature in the area (Ovretveit 1992;Redmayne et al. 1995;Hearnshaw et al. 1998;Lagrosen, Backstrom, & Lagrosen 2007). Finally, the perceived resourcing issues at the research site and the existing demands reported to be made on those in clinical roles, is concluded to have negatively influenced their experiences of the accreditation implementation process and impacts.

At the outset of this study, the author posed the following research question: *What are the experiences of individual team members in terms of the accreditation implementation process and the individual and organisational impacts associated*

with this, in a large acute-care hospital context? Based on the conclusions drawn from this research, the answer would appear to suggest that these experiences have been 'varied'. The findings have highlighted a number of effective and beneficial aspects to both the implementation process and the individual and organisational impacts. However, notwithstanding these, this study has also demonstrated the varied challenges, problems, conflicts and detrimental outcomes experienced by individual accreditation team members over the course of the first phase of accreditation.

8.5 Contribution of the Research

This study was initiated as a response to the identified gaps in the literature on healthcare accreditation. Furthermore, it has also sought to heed a number of calls that have been made for further research in the area of quality and accreditation implementation and impacts, both generally and specifically, within a healthcare context, for bespoke methodologies to explore these and finally, for empirical research to target respondents who are actively engaged with implementation.

With reference to the specific area of accreditation, the study has responded to the opportunities identified by a number of researchers and commentators in the quality in healthcare field, who have recognised the limited body of literature examining this particular quality approach (Walshe et al. 2001;Ovretveit & Gustafson 2002;Braithwaite et al. 2006). Furthermore, acute-care accreditation has been acknowledged to be a relatively new phenomenon in an Irish, publicly funded hospital context (IHSAB 2004;Sweeney 2004). As such, this study has provided both a unique and timely insight into the implementation process and impacts associated with its adoption, as experienced by individual accreditation team members, and contributes to both knowledge and practice in the area.

In relation to the implementation process, this study has incorporated the 'soft' aspects of quality implementation with the Weisbord (1976a) content model of organisational change, as the basis for exploring this aspect of the research and in recognition that change and quality implementation are inextricably linked. As such, this represents a innovative use of the Weisbord (1976a) model and has introduced a formal boundary to the 'people' elements of quality. This, in turn, has facilitated the

in-depth examination of key implementation activities in a robust and integrated manner, based on the experiences of those central to the process - the accreditation team members.

Resulting from this decision, the research makes an explicit rejoinder to the observations of Ghobadian & Gallear (2001), Grol, Baker, & Moss (2002), Ovretveit & Gustafson (2002;2003), Edwards & Sohal (2003) and Rijinders & Boer (2004), who have noted the absence of empirical studies that have both adequately addressed the implementation process in a comprehensive and meaningful way and additionally, approached this with a particular emphasis on the 'people' or 'human' side of quality. Furthermore, this research study has been descriptive in nature and therefore has been instrumental in identifying, describing and subsequently interpreting, the activities and actions that support or hinder the accreditation implementation process. This, Ovretveit & Gustafson (2002;2003) argue, has particular merit in that it has the potential to enhance knowledge, understanding and also to influence, in a positive sense, future implementations of quality approaches, such as accreditation. As such, the author believes that this study has made a significant contribution to knowledge, understanding and practice relating to the accreditation implementation process.

This study has also sought to identify the impacts associated with accreditation and has explicitly addressed these in terms of those arising at the individual and organisational levels. This aspect of the research was progressed as a result of the positions posited by Walshe et al. (2001) and Adinolfi (2003), and more recently reiterated by Braithwaite et al. (2006), who have identified the necessity for the development of a deeper understanding of the impacts of organisation-wide quality approaches such as accreditation, through more extensive research. With this in mind, this study has both identified and provided an in-depth examination of the beneficial and unfavourable individual and organisational impacts of the first phase of accreditation, as experienced by team members. In doing so, it has contributed to the existing knowledge and understanding of these issues, while, in turn, enhancing an appreciation of the accreditation approach itself, an issue that has also been acknowledged by Walshe et al. (2001). Furthermore, the author believes that this

new contribution has the potential to enhance the existing levels of practice associated with implementing and managing quality and accreditation approaches.

No particular calls were initially noted for research relating to the exploration of differences in experiences of, and views on, quality approaches, based on work role or discipline in the organisation. However, pursuing this course of enquiry has provided a logical and significant extension to the aforementioned research focus on the implementation process and impacts relating to accreditation. Based on an acknowledgement that relatively few studies had previously reported on this issue and moreover, that none of these had addressed this with reference to acute-care accreditation in an Irish context, progressing the research in this vein, was deemed a worthwhile activity. This study has as a result, provided a valuable insight into the differing individual experiences of the accreditation implementation process and the associated individual and organisational impacts. As such, the author believes that the findings from this study serve to add to the existing knowledge of these issues and to the understanding of the difficulties associated with involvement in accreditation (and specific reasons for these) as experienced, in particular, by those in clinically-orientated roles. Moreover, informed by this knowledge, those charged with leading accreditation may be better positioned to anticipate and manage the challenges, dilemmas and conflicts arising for specific groups within the context of accreditation implementation.

This research has adopted a descriptive case study research design, which, in turn, integrates three individual, but complementary research methods, as a response to the opportunities highlighted by Grol, Baker, & Moss (2002) and Ovretveit & Gustafson (2002) for alternative and bespoke methodologies. Being cognisant of the call made for in-depth studies, with a qualitative focus (Grol, Baker, & Moss 2002), this research has combined non-participant observation, questionnaires and semi-structured interviews to explore, in detail, the experiences of individual team members, over the course of the first phase of accreditation. There has also been originality to the sequencing of these methods and the related data collection activity, which has facilitated the achievement of a deeper understanding of the implementation process and impacts. Moreover, the research instruments - individually or collectively - may serve to provide the foundation for future research

studies in the area. Finally, from a practice perspective, the questionnaire instruments in particular, have the potential to be used in their entirety or in an abridged format, as a useful diagnostic tool to identify problems and issues surfacing during implementation.

The scope for research studies to incorporate respondents who are actively involved with quality implementation, was acknowledged in Chapter 1 of this thesis. This has been particularly recognised by Grol, Baker, & Moss (2002), Ovretveit & Gustafson (2002) and Adinolfi (2003), who have suggested that the literature in the area under-represents these key stakeholders in quality implementation. This study has sought to redress this issue, by targeting accreditation team members and in doing so, has provided an in-depth insight into their experiences of accreditation. From a practice perspective, this should additionally alert those managing quality and accreditation approaches to the key issues and potential problems faced by those individuals who are pivotal to implementation - the accreditation team members.

The conceptual framework for this study has sought to encompass the aforementioned research area on the implementation process and impacts and the respondents for this study, in an integrated and holistic approach. As a result, this conceptualisation may offer a future research framework for other researchers in the healthcare quality and accreditation field.

This research has also produced what the author understands to be the first study of its kind to address the accreditation implementation process and impacts in the context of a publicly funded acute-care hospital in Ireland. As such, this represents a particularly significant contribution to the literature on quality and accreditation implementation. Furthermore, Ovretveit (2003b) has noted that much of the existing research on quality implementation in healthcare has been conducted within the United States and additionally within a private healthcare/hospital context. As such, he has cautioned on the extent to which the conclusions drawn may be transferred to European and publicly funded health service organisations. In acknowledging this, the author believes that this specific study may be making a particular contribution to the European body of knowledge and understanding relating to quality and accreditation implementation and impacts.

Finally, this research has also enhanced the understanding and knowledge of the wider issues of public sector and healthcare reform in Ireland and, within this, the challenges posed to progressing the change and quality agenda, which underpin the NPM paradigm. This study has provided a unique insight into an acute-care hospital environment and has highlighted many of the issues and dilemmas experienced by those working within healthcare and likewise for those charged with implementing the quality approaches that are integral to the process of reform.

8.6 Recommendations

A number of recommendations for practice, policy and further research have emerged from this study on hospital accreditation. In relation to practice, these include a number of specific actions and activities that may contribute to enhancing the effectiveness of accreditation implementation, while those aimed at policy address accreditation in the wider context of healthcare in Ireland. As such this study recommends:

(i) The reassessment of the strategic positioning of the IHSAB accreditation process and ensuring its future implementation progresses in an integrated and holistic manner;

(ii) The creation of a dedicated leadership role for the accreditation process in the form of a full-time Accreditation Manager. Given that part of this role will be to elicit the participation of key and often challenging groups of stakeholders within the organisation, there is a likely requirement for this to be positioned at a senior level in the organisation, in order to be able to extend a degree of influence over the process;

(iii) The review of the initial and on-going communications activity associated with accreditation. This should be undertaken with a view to redesigning the communication content and the media selection to provide the key messages about accreditation to every employee, with a particular emphasis on the benefits to the hospital, to individual employees and to

their immediate work areas, which, in turn, may contribute to improved engagement with the process. Furthermore, the content of these communications should seek to remind all employees that they too are responsible for accreditation and, as such, that they will be expected to support their colleagues who are more actively involved with the process;

(iv) Gaining an explicit undertaking from accreditation team members to attend all team meetings, other than in exceptional circumstances and ensuring that there is accompanying accountability to this;

(v) The initiation of targeted efforts to engage key stakeholders, in particular Hospital Consultants, in accreditation and to elicit their commitment to participate fully and actively within the process. This might include specific communications sessions and/or individual discussions in order leverage this involvement;

(vi) Making a particular effort to communicate with, and to gain the support of, line managers and, in particular, those in clinical services areas. This should seek to ensure that they commit to reviewing and reallocating where possible, in a resource neutral mode and with no disruption to services, the workloads of individual accreditation team members in order to facilitate their full participation in accreditation. As such this would represent 'protected time'. In doing so, line managers should be encouraged to review the requirements for service provision and from this identify more innovative ways of providing this within the existing complement of staff resources. These communication efforts should also reinforce the message that line managers play a central role in facilitating accreditation and that they, and their staff, are also essential to its successful achievement;

(vii) Reviewing the content, provision and timing of training to ensure that it meets the requirements for providing the knowledge and skills necessary for individuals participating in an accreditation team. Training sessions - both internally and externally provided - should also be regularly

evaluated to facilitate their continuous review and improvement. Explicit commitments from IHSAB should also be gained relating to the timely delivery of externally provided training and this should be appropriately scheduled over the course of the implementation process. Additionally, further training should be provided at the commencement of the accreditation process in the areas of team building for entire teams, and also meeting management skills for team leaders, to promote team cohesiveness and to contribute to the effectiveness of meetings respectively;

(viii) Ensuring that those who are actively involved with accreditation receive recognition for their contribution to the process. Consideration should be given to instituting some form of certification, which would also formally record and recognise the continuing professional development associated with participation;

(ix) From a policy perspective, the Department of Health and Children should seek to ensure that expenditure on publicly provided healthcare services in terms of GDP meets, at a very minimum, the OECD and EU 25 averages and also commit to its translation into the required resources on the ground. Moreover, the Department (as policy makers), in conjunction with the Health Services Executive, should continue to promote and encourage the use of accreditation and should also explore the scope for linking accreditation reports and ratings to organisational funding, as the basis for both incentivising its implementation and what is the fundamental objective of the approach - ensuring the continuous pursuit of, and improvement in, the quality of healthcare services.

A number of opportunities for further research have become made apparent during the course of, and upon completion, of this study:

(i) A logical course of future academic effort would be to continue to study the accreditation process at the research site to investigate the extent to which the issues and problems that have been identified during this study, continue to persist in further cycles of accreditation. Progressing this might also provide a useful insight into issues of sustainability, which Idris & Zairi (2006) have very recently noted is a growing concern for organisation-wide quality approaches;

(ii) As this research has been limited to a single site, clearly there is scope to extend this to other acute-care hospitals to explore the extent to which the issues that have been uncovered in this study are mirrored elsewhere in similar organisations, both within Ireland and also in other countries. In doing this, it might also be useful to adopt a research design incorporating multiple case studies to facilitate cross-case comparison. Furthermore, Shortell et al. (1995) have argued that hospital size may influence the extent of successful organisation-wide quality implementation and, as such, there may be additional scope to incorporate this into the criteria for case study selection. However, in order to replicate this study across a number of research sites, it is also necessary to acknowledge the likely requirement for the involvement of a number of researchers;

(iii) Given that this research has addressed accreditation during its initial implementation at the research site, it may be valuable to conduct similar research in environments where accreditation has had a longer history of implementation, for example, in the major academic teaching hospitals. Pursuing research in this vein, may serve to provide an insight as to how these organisations have approached the implementation of accreditation and whether the issues that are reported in this study, in terms of the process and impacts, also exist in organisations where accreditation, as a quality approach, might logically be expected to be more embedded and

advanced. This might also provide further understanding of the previously considered sustainability issue;

(iv) There is scope to migrate the central foci of this study, set in an acute-care context, to other healthcare environments. As an example, IHSAB introduced accreditation standards for palliative care (hospice-type organisations) in 2005 and now as part of HIQA, the boundaries of accreditation may extend to other sectors of the Irish health services. With this in mind, research in these domains may provide an interesting insight into the experiences of the implementation process and impacts in different organisational settings;

(v) There may also be merit in focusing on the experiences of Accreditation Managers of the implementation process. This research has served to reiterate the arguments presented the literature, which underlines their centrality in terms of leadership, to implementation. With this in mind, it may be valuable to explore their perceptions of the issues, challenges and barriers to successful accreditation implementation. Furthermore, it might be particularly useful to progress research that would lead to a formal competency framework for Accreditation Managers that could form the foundation for the selection, development and performance management of individuals appointed to these roles;

(vi) There may be value in exploring views of accreditation with those in medical roles, with the particular objective of identifying any barriers or impediments to their active participation. However, in attempting to progress research in this specific area, it should also be acknowledged that eliciting the involvement of doctors in research on accreditation may prove challenging, as has been the case during this study;

(vii) Addressing a wider range of stakeholders may also provide alternative perspectives on a number of issues relating to the accreditation process, its implementation and associated impacts. These might realistically include senior managers at both hospital and HSE levels; inputs from

representatives of HIQA; senior Civil Servants and also the Minister for Health and relevant Ministers of State within the Department of Health and Children;

(viii) Finally, at the time of writing, Ireland is experiencing a growth in the number of private hospitals providing services within the State. This is likely to continue given that government has now committed to a policy of co-location, where privately owned and operated facilities will be built within the grounds of publicly funded acute-care hospitals. As such, private hospitals may elect to adopt alternative accreditation schemes such as that offered by the JCI, which other similar organisations in Ireland have already implemented. With this in mind, the private hospital context may provide an additional and also a comparative environment, in which to conduct research on the accreditation implementation process and associated impacts.

8.7 Limitations

There are a number of limitations inherent within this research. While these have already been addressed in previous chapters, as this thesis now draws to a close, this presents a timely opportunity for them to be restated:

(i) The author has been singularly responsible for undertaking all aspects of this study and, as such, has been subject to the limitations of their time and personal resources. Without this constraint, or alternatively working with other researchers, there may have been scope to collect further data, in particular, in terms of conducting non-participant observations across all ten accreditation teams;

(ii) In conducting a single case research design, this research has thus potentially limited the scope for the generalisability of the findings to other organisations and other instances of accreditation implementation;

(iii) The validity and reliability of the observational element of this research may also have been compromised. Despite the best efforts to limit the observer effect and the reactivity of team members to the author's presence and moreover, to ensure the consistent use of the observation schedule, there remains an inherent risk from these within this study;

(iv) The reliability of the questionnaires was not fully demonstrated based on an inability to conduct the test-retest exercise and also in relation to Cronbach's alpha values obtained for some of the question groupings. In terms of the response rates across the five work role groups, very few completed questionnaires were received from those in the Consultant and the Non-Consultant Hospital Doctor groups. As a result, statistical significance has mostly been influenced by the other three dominant groups, despite the fact that, as an example, Consultants were often more negative in their responses to the Likert items. Furthermore, the inability to arrive at an accurate picture of the work role demographics for the entire team member population, has frustrated the calculation of the questionnaire response rates based on work role;

(v) In relation to the semi-structured interviews, there is also an inherent threat of respondent bias. Despite the efforts of the author to both prepare for, and manage the interview process effectively, there remains the possibility that the responses provided an inaccurate reflection of interviewees experiences of the accreditation implementation process and associated impacts;

(vi) Finally, this research has risked exposure to the preconceptions, personal and professional values and potential biases that the author themselves may have brought to the process. While every effort has been made to negate these through the careful and systematic planning and execution of this study, it is appropriate to acknowledge that these in themselves may represent a limitation within this research, which has addressed the implementation of acute-care hospital accreditation in an Irish context.

8.8 Conclusion

This chapter has presented the range of conclusions that have been drawn from this study. It has also offered a number of recommendations for practice, policy and further research in the area, while at the same time acknowledging the limitations inherent within the research exercise itself. Finally, this chapter has served to highlight the contribution that this study has made on a number of fronts to knowledge and understanding of the accreditation implementation process and associated impacts.

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Appendix A: The IHSAB Accreditation Standards and Process

IRISH HEALTH SERVICES
Accreditation
BOARD

Second Edition

Acute Care Accreditation Scheme
A Framework for Quality and Safety

3.0 THE ACUTE CARE ACCREDITATION SCHEME (ACAS)

3.1 THE ACAS PHILOSOPHY, PURPOSE AND PRINCIPLES

Philosophy of the ACAS

The ACAS is designed:

- to be patient/client focused
- to demonstrably contribute to the quality of healthcare service delivery to patients/clients and ensure that patients/clients derive benefit there from
- to promote continuous quality improvement in the health system through regular evaluation of its structure, process and patient/client outcome

Purpose of the ACAS

The purpose of the ACAS is:

- to provide an environment in healthcare entities which assures safety for patients/clients, staff and the public, within a framework of continuously improving quality of care
- to promote a quality culture in participating healthcare entities and place quality at the core of service delivery
- to encourage attainment of best practice in participating healthcare entities
- to promote a patient/client-centred organisation and delivery of services

Principles of the ACAS

- Participation in the ACAS is voluntary
- The ACAS distinguishes between good and poor practice
- Honesty and integrity are fundamental underlying features of the ACAS
- Standards relate directly to the patient/client/public
- The ACAS must remain internationally recognised and accepted
- The ACAS is based on standards of excellence, promotes continuous quality improvement and promulgates best practice

Care/Service Standards facilitate assessment of performance with respect to provision of healthcare and/or service to patients/clients. They are founded on a population health approach which emphasises the aspiration of healthy populations. Seamlessness/integrated care across the continuum linking primary care, acute care, long term care, rehabilitation, home care etc. is also advocated. In addition the standards follow the patient's/client's journey i.e. from access to care/service through assessment, planning of care/treatment etc. and implementing care/service to transfer, discharge and follow-up.

Environmental and Facilities Management Standards provide the basis for an organisation to assess and evaluate its performance in all areas pertinent to management of its physical surroundings and equipment. The standards cover, inter alia, the planning and development of environment management services, managing physical diagnostic and therapeutic resources, minimising adverse events, the impact of the organisation on the environment etc.

Human Resources Management Standards provide the basis for an organisation to assess and evaluate its performance with respect to its human capital. These standards emphasise the human resource function across the organisation, rather than the Human Resources Department or its equivalent. The standards cover, inter alia, issues such as selection and recruitment of personnel, enhancing personnel performance and provision of a healthy work environment.

Information Management Standards pertain to the information management function across the organisation. The focus is not purely IT/IS based. They facilitate an organisation in assessing and evaluating planning, obtaining, management and security of data and information provisions.

(b) Quality Dimensions and Descriptors

The ACAS has been developed to provide organisations with a framework for improving quality. But what is quality? What should an organisation be aiming to achieve from accreditation?

Within the accreditation standards quality is represented by four Quality Dimensions. These Quality Dimensions form the basis of the structure of the standards.

By linking each criterion to a Quality Dimension the organisation is able to get a broad overview of how it is performing under each dimension. This information will be reflected within the Peer/Service User survey report. For example, the organisation will know how "responsive" it is to its patients/clients and the community.

Each criterion is linked to one of the following quality dimensions:

- ◊ Responsiveness
- ◊ System Competency
- ◊ Patient/Client/Community Focus
- ◊ Work Environment

Descriptors assist in describing each of the Dimensions.

DIMENSION	DESCRIPTORS
RESPONSIVENESS The organisation anticipates and responds to changes in the needs and expectations of the (potential) patient/client and/or community/ population(s), and to changes in the environment.	*Availability* • service(s) and resources (e.g. financial, human, information, equipment) are available to meet the needs of the patient/client and/or community population(s) *Accessibility* • the patient/client and/or community easily obtains required or available services in the most appropriate setting *Timeliness* • services are provided and/or activities are conducted to meet patient/client and/or community needs at the most beneficial or appropriate time *Continuity* • co-ordinated services are provided across the continuum, over time *Equity* • decisions are made and services are delivered in a fair and just way

DIMENSION	DESCRIPTORS
SYSTEM COMPETENCY The organisation consistently provides service(s) in the best possible way, given the current and evolving state of knowledge. The organisation achieves the desired benefit for patients/clients and/or communities, with the most cost-effective use of resources.	*Appropriateness* • services meet the needs of the patient/client and/or community population(s), achieve the organisation's goals, are proven (evidence-based) to produce benefits, and are based on established standards *Competence* • an individual's knowledge, skills, and attitudes are appropriate to the service provided *Effectiveness* • services, interventions, or actions achieve optimal results *Safety* • potential risks and/or unintended results are avoided or minimised *Legitimacy* • services and/or activities conform to ethical principles, values, conventions, laws, and regulations *Efficiency* • resources (inputs) are brought together to achieve optimal results (outputs) with minimal waste, re-work, and effort *System Alignment* • The mission, vision, goals and objectives are clear, well-integrated, co-ordinated and understood both internally and externally. These are reflected in organisation plans, delegations of authority, and decision-making processes.

DIMENSION	DESCRIPTORS
PATIENT/CLIENT/ COMMUNITY FOCUS The organisation strengthens its relationship with the patient/client and/or community. The organisation does this by encouraging community participation and partnership in its activities.	*Communication* • all relevant information is exchanged with the patient/client, family and/or community in a manner that is ongoing, consistent, understandable and useful *Confidentiality* • information to be kept private is safeguarded *Participation and Partnership* • the patient/client and/or community actively participates as a partner in decision-making, and in service planning, delivery, and evaluation *Respect & Caring* • politeness, consideration, sensitivity and respect are incorporated into all interactions with the client and/or community *Organisation Responsibility and Involvement in the Community* • the organisation supports and strengthens the community and its development, and contributes to its overall health

DIMENSION	DESCRIPTORS
WORK ENVIRONMENT The organisation provides a work atmosphere conducive to performance excellence, full participation, personal/ professional and organisational growth, health, well-being, and satisfaction.	*Open Communication* • the organisation fosters a climate of openness, free expression of ideas, and information sharing *Role Clarity* • staff have clearly defined job scope and objectives, and these are aligned with team and organisation goals *Participation in Decision-making* • staff input is encouraged and used in decision-making *Learning Environment* • Staff creativity, innovation and initiative is encouraged. The necessary training and development, to attain organisational goals and personal/professional development objectives, is provided. *Well-being* • the organisation provides a safe, healthy, and supportive environment, recognises staff contribution, and links staff feedback to improvement opportunities

(c) Intent Statements

In order to explain the aim of each of the standards, an Intent Statement has been included as part of the guidelines. The intent statement is designed to clarify the purpose of each standard (e.g. EF 1.0, EF 2.0, etc.) and to provide further explanation as to the aim of each criterion.

(d) Guidance for Evidence of Compliance (EOC)

Self assessment is undertaken by an organisation to help improve care/service (see also 3.6(b) Self Assessment). As part of the self assessment process, the self assessment teams must identify evidence which exists to justify their evaluation of the care/service they provide. This evidence is then utilised to determine the level of compliance to the criterion they are assessing.

Guidance has been provided to assist in determining what types of evidence may be necessary to show compliance to each of the criteria. The Guidelines for Evidence of Compliance are provided for each criteria and should be used as a prompt for compiling evidence. The Guidelines for Evidence of Compliance list is not exhaustive, rather they should be seen as indicators of the type of evidence which should be considered.

The Guidelines for Evidence of Compliance are structured under headings of:

- Structure
- Process
- Outcome

These headings are discussed in detail in 2.1(a) Structure, Process, Outcome.

Common terminology is utilised throughout the guidelines to provide a clearer understanding. These include:

- Details of . . .
  (A list of particulars, facts, processes, and/or information, etc., e.g. community partners, education programmes etc.)
- Documented process(es) for . . .
  (Physical polices, procedures, guidelines, protocols or other appropriately documented process(es).)
- Evaluation of . . .
  (Appraisal/assessment of the effectiveness, efficiency and value of . . .)
- Resultant action(s) and feedback and quality improvement plan
  (Evidence of actions taken as a result of evaluations carried out and how this information is communicated to all concerned and also incorporated into a quality improvement plan.)

(e) Patient/Client Safety Criteria ✪

In order to provide quality care/service, an organisation must ensure that there is a continual focus on the safety and well being of the patient/client. In this regard, core patient/safety criteria have been identified within the standards to help the organisation prioritise areas which relate specifically to patient/client safety. These criteria address a broad range of clinical and non-clinical issues which should be considered by an organisation providing patient/client care.

Approximately 35% of all criteria, across the five standard groupings, have been identified as patient/client safety criteria. These criteria have been developed through an evaluation of international best practice as well as a detailed review by multi-disciplinary health professionals and most importantly, users of the health services.

The patient/client safety criteria are clearly identified within the standards by use of a ✪ symbol. To emphasis the importance of a patient/client safety focus within the accreditation process, the ratings of these criteria are given primary consideration when determining an accreditation award (see also 3.6(c) - Accreditation Decision).

Education & Support

The IHSAB run four education sessions for applicant organisations. These sessions are designed to support and foster an understanding of the accreditation process within the applicant organisation. The IHSAB's Client Services Liaison works with the Accreditation Co-ordinator to assess the education needs of staff and education programmes are tailored to meet those needs.

The four education sessions are as follows:

Education Session One – Introduction to Accreditation

The purpose of this education session is to introduce participants to the accreditation scheme and components of accreditation. The session is aimed at patients/clients, self assessment teams, all staff, board of management, the public and volunteers.

Education Session Two – Standards Framework

The purpose of this education session is to provide an introduction to the provision of Evidence of Compliance to the standard. The session is aimed at self assessment team members along with the Accreditation Co-ordinator.

Education Session Three – Self Assessment Process

The purpose of this education session is to educate the self assessment team on how to complete the self assessment. A workshop on self assessment exercises is also facilitated. This session is aimed at self assessment team leaders and one to two team members.

Education Session Four – The Role Play Interview

The purpose of this education session is to educate the self assessment teams on the structure, process and content of an accreditation survey interview. This is achieved through a mock self assessment team interview in a role play context with two self assessment teams. Feedback is provided to teams on their performance at the interview. Teams will not receive feedback on the content of their self assessment responses. This session is aimed at self assessment team members not involved in the role play exercise.

Self Assessment Teams

Self assessment allows an organisation to examine its everyday activities and assess them against the accreditation standards. It allows for an examination of where they have been, where they are now and where they need to go next. It also allows them to realise what they do well and the areas they need to improve on (see also 3.6 (b) Self Assessment).

In order to comprehensively self assess an organisation, self assessment teams must be established. The membership of the self assessment teams should reflect the interdisciplinary approach to providing seamless, integrated care within the organisation. Membership should be reflective of staff knowledge, not necessarily the position they hold.

Inter-disciplinary self assessment teams should include front line direct and indirect care/service providers and professionals, organisation leaders (management and/or governance), community partners, patients/clients, volunteers, etc. Direct and indirect care/service may include such areas as anaesthesia, pain control, radiology, laboratory, pharmacy and infectious diseases, physiotherapy, clinical dietetics, pastoral care, audiology, podiatry/chiropody, speech/language therapy, social work, bio-engineering, occupational therapy etc. In relation to non-clinical support services personnel this should include, for example, household, catering and administration.

The self assessment teams must be reflective of both the services provided within an organisation and the structure of the ACAS. It is important to note that the self assessment team reflects requirements of the standard and not a department, e.g. the Human Resources *Management self assessment team should be reflective of the Human Resource Management Standard and not just the Human* Resources Department in the organisation. A care/service self assessment team should also reflect the patient/clients journey of care through the organisation, not just one department, e.g. a Trauma Care/Service Team should be reflective of other departments and staff not just A&E.

Self assessment teams, which must complete a self assessment, include the following:

- Care/Service Teams
- Environmental and Facilities Management Team
- Human Resources Management Team
- Information Management Team
- Leadership and Partnerships Team

It is recommended that there be an average of 10 to 20 members on each team. The number of care/service teams is dependant on the care/services offered by the organisation. Care/Service teams should be established based on the patient's journey. Examples of care/service teams include:

- Trauma/Elective
- Cardiac: could include Cardio-Vascular, Cardiology
- General Medicine: could include Endocrinology, Gastroenterology, Rheumatology, Respiratory Care, Infectious Diseases, Immunology, Dermatology, Rehabilitation
- General Surgery: could include Anaesthesia, ENT, Gynaecology, Vascular, Ophthalmology, Urology
- Geriatric/Care of the Elderly: could include Geriatric Rehabilitation
- Neuro-Sciences: Neurology and Neuro-Surgery
- Obstetrics/Gynaecology
- Oncology/Cancer Care: could include Immunology, Haematology, Palliative Care
- Paediatrics
- Psychiatry/Mental Health
- Nephrology/Endocrinology

Training in self assessment techniques are provided by the IHSAB to the organisation as part of the overall accreditation process.

(b) Self Assessment

How to Self Assess

The true value of accreditation lies in the self assessment process that an organisation must undergo. Self assessment is undertaken by an organisation to help improve care and service delivery. It enables the organisation, and more specifically the self assessment teams, to identify what they are doing and how well they are doing it. This allows teams to consider where they have been, where they are now, and where they need to go. The accreditation standards and criteria provide a framework for teams to ensure that key aspects of the care and service they deliver are included in their assessment.

The self assessment process is carried out by the self assessment teams over an average period of 6 months (see also 3.6 (a) Timeframes - Development of a Critical Path). During this period the teams meet on a regular basis. Experience has shown that the team meetings vary greatly, from teams meeting once a week for one or two hours, to teams meeting for a half day once a month. Whatever structure is employed it is necessary for the self assessment teams to follow some key steps in the process. These are:

- Education
- Discussion
- Agreement of areas of compliance and opportunities for improvement
- Compilation of Evidence of Compliance
- Rating & Risk Assessment
- Acreditation Process Management System
- Identification of supporting onsite documentation

Education

Before the beginning of their self assessment each team member should have a good understanding of their role and the aims and objectives of the self assessment process. The IHSAB provides specific education sessions for members of the self assessment teams (see also 3.6 (a) Education and Support). In addition, the members should read all of the accreditation standards and criteria, not just those specific to their team, to get a clear understanding of what each area covers. The intent statements assist in explaining the aim of each standard (see also 3.5 (c) Intent Statements).

Discussion

The discussions and debate which occur as a self assessment team examines their activities are core to the added value of the accreditation process. Through the encouragement of open discussions, the team can answer key questions such as:

- What activities do we carry out in relation to this criterion?
- What do we do well?
- Where could we improve?
- Are we doing anything about it?
- Do we have any evidence to validate what we are doing?
- Who else should we ask to get a clearer picture of how we are doing? Staff? Partners?

Within each criterion there are guidelines for the provision of evidence of compliance. These guidelines should help to provide a starting point for teams during their discussions.

Agreement of areas of compliance and opportunities for improvement

Throughout the discussions the team should be attempting to identify how its activities comply with the individual criteria. In instances where it does not comply with a criterion, i.e. an opportunity for improvement, the team should identify what action is being taken. It is necessary for the team to agree and record these findings as it is this information that forms the basis of the completed self assessment documentation.

Compilation of Evidence of Compliance

Following on from the team's determination of its compliance with each criterion, it must then identify what evidence can be provided to back up its claim. It is this evidence which is examined during the survey to allow the survey team validate the self assessment team's findings. When providing evidence of compliance, the self assessment team should give consideration to what can be provided under the headings of structure, process and outcome (see also 2.1(a) Structure, Process and Outcome). Where opportunities for improvement have been identified, evidence of progression, e.g. a quality improvement plan, should also be acknowledged.

Rating and Risk Assessment

The final stage of the self assessment process is the rating of the team's level of compliance and, where applicable, the level of risk related to the criteria.

Rating Scale

The rating of individual criterion is designed to assist self assessment teams, and the organisation in general, to prioritise areas for development. To rate its level of compliance against a criterion, the team must first ask itself what would constitute a 100% compliance to the criterion, i.e. what structures, processes and outcomes would have to exist for full compliance. The team must then determine what level of compliance they adhere to. The rating for the criterion can be determined based on this percentage level of compliance.

- **Structure**
  - ◊ Identified structures are in place to comply with the standard criterion
- **Process**
  - ◊ Systems have been developed and are consistently implemented
- **Outcomes**
  - ◊ Evaluation of the results of the process
  - ◊ Action is taken, based on the evaluation, to improve the quality of the process or related structure
  - ◊ Continuous Quality Improvement Plan to continuously enhance care/service is developed and pursued.

NB. All three headings may not be applicable to all criteria as some criteria may relate specifically to structure and/or process and/or outcome. (See also 2.1(a) Structures, Process & Outcome).

The rating scale utilised by the ACAS is a simple 5 point scale:

A	B	C	D	E	N/A
Exceptional Compliance >90%	Extensive Compliance 66-90%	Broad Compliance 41-65%	Minor Compliance 15-40%	Negligible Compliance <15%	Not Applicable

Evidence of Compliance

The degree of compliance with a standard criterion requirements is determined based on the evidence provided under the following headings:

Interpretive guide to the Rating Scale:

A Exceptional Compliance

- There is evidence of greater than 90% compliance with the standard criterion provisions.
- There is a comprehensive and systematic approach to quality improvement and evaluation of the process and this information is used to make and sustain improvements.
- There is evidence that the process is achieving the expected outcomes.

B Extensive Compliance

- There is evidence of compliance to a level of between 65% and 90% with the standard criterion provisions.

C Broad Compliance

- There is evidence of compliance to a level of between 40% and 65% with the standard criterion provisions.

D Minor Compliance

- There is evidence of compliance to a level of between 15% and 40% with the standard criterion provisions.

E Negligible Compliance

- There is evidence of less than 15% compliance with the standard criterion provisions.

N/A Not Applicable

- The standard criterion does not apply to the area of care/service covered by the Self Assessment Team. Rationale must be provided.

Risk Assessment

Where a self assessment team has identified relatively weak compliance to a criterion it must consider the possibility of related risks with regard to the patient/client, staff or the organisation. To help identify these risks and prioritise those that are identified, the self assessment team must carry out a risk assessment.

A risk assessment must be carried out by the self assessment team where a criterion has received a D or E rating. Where a criterion has received a C rating the need to carry out a risk assessment is at the discretion of the self assessment team. Risk assessments will be validated by the survey team as part of the survey process.

The report is structured as follows:

General Summary;

- Progress from the previous survey (if applicable)
- Areas of excellence/compliance in the organisation
- Opportunities for improvement
- Quality improvement initiatives in the organisation

Team Specific Summary;

Assessment of each team's performance against the standards criteria under the following headings:

- Areas of excellence/compliance identified
- Opportunities for improvement
- Areas for priority action
- Overall feedback on performance

Risk Ratings and Recommendations

Quality Dimensions Analysis

Accreditation Award/Decision

Areas for Priority Action

An organisation's report may include several recommendations which should be acted on by the organisation. To assist in prioritisation of these findings the accreditation report specifically identifies areas for priority action. The areas relating to the safety of patients/clients should receive primary focus.

The action taken based on these recommendations should be prioritised based on the risks associated with them, which will depend on the potential for adverse event, the potential impact of it and the urgency of action associated with it. The quality improvement plan should include how each of these recommendations and issues will be progressed and should include a corresponding timeframe in which to address them.

Where an immediate and significant threat to patients/clients, the public and or staff has been identified, the IHSAB will automatically seek to urgently discuss the issue with the Chief Executive of the organisation and request immediate remedy of the threat.

Accreditation Awards

A healthcare organisation which achieves an accreditation award has demonstrated to the IHSAB that it has:

- An extensive organisation-wide risk management process to ensure maximum patient/client safety
- A comprehensive quality system which actively seeks to identify problems within the provision of care and rectify them
- That it is predominately compliant with all of the key aspects of health provision as identified by the IHSAB

An accredited healthcare organisation is recognised as a centre of excellence in the specific areas of patient/client care/service that it provides. An accreditation award is granted for a period of three years.

Organisations who achieve accreditation status will be informed as to the level of achievement they reached. These levels are based on the overall results of their accreditation survey (see also 3.6 (c) – Accreditation Decisions). These are:

- Accreditation Level 1
- Accreditation Level 2
- Accreditation Level 3

Accreditation Denied

Where an organisation does not fulfill the requirements to achieve an accreditation award the organisation will be provided with an indicator of its current stage of development (see also 3.6 (c) Accreditation Decisions). These are:

- Pre Accreditation Level 1
- Pre Accreditation Level 2

Where an organisation receives pre-accreditation the organisation, in agreement with the IHSAB, may re-apply for survey at an earlier than normal stage.

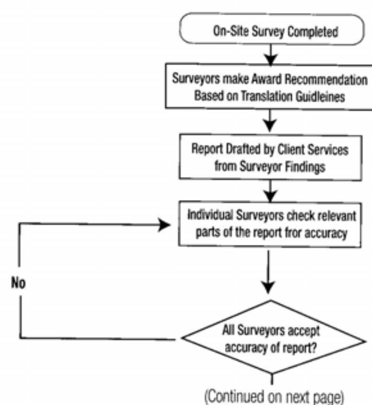
Use of Focused Visit or Report

The IHSAB reserves the right to award any of the accreditation levels, including pre-accreditation, with an additional requirement which must be fulfilled by the applicant organisation. These are:

- A report to be provided to the IHSAB within a determined timeframe, to clarify or indicate how specific improvements will be made, or
- A focused visit, at a determined time, to review an activity currently under development or required to be implemented.

Accreditation Award Decision

The accreditation award outcome for an organisation is determined by the Accreditation Award Decision Process:



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Accreditation Awards

Accreditation - Level 1

Translation Rules:

Patient/Client Safety Criteria Ratings

- Greater than 10% of patient/client safety criteria must have achieved an A rating, with no patient/client safety criteria achieving less than a rating of B, and

Criteria Ratings

- Greater than 51% of criteria must have achieved a rating of A, with no criteria achieving less than a rating of C, and

Risk Ratings

- No criteria have received a risk rating of greater than 4, (where a risk rating of High = 3; Medium = 2; Low = 1).

Accreditation - Level 2

Translation Rules:

Patient/Client Safety Criteria Ratings

- All patient/client safety criteria must have achieved a B rating or greater, and

Criteria Ratings

- Greater than 10% of criteria must have achieved a rating of A, and
- Greater than 51% of criteria must have achieved a rating of B or higher, with not greater than 2% of criteria achieving a rating of D or E, and

Risk Ratings

- No criteria have received a risk rating of greater than 5, (where a risk rating of High = 3; Medium = 2; Low = 1).

Accreditation - Level 3

Translation Rules:

Patient/Client Safety Criteria Ratings

- Greater than 10% of patient/client safety criteria must have achieved an B rating, with no patient/client safety criteria achieving less than a rating of C, and
- No patient/client safety criteria must have received a risk rating of greater than 4, (where a risk rating of High = 3; Medium = 2; Low = 1), and

Criteria Ratings

- Greater than 51% of criteria must have achieved a rating of B or higher, with not greater than 5% of criteria achieving a rating of D or E, and

Risk Ratings

- No criteria have received a risk rating of greater than 7, (where a risk rating of High = 3; Medium = 2; Low = 1).

Accreditation Denied

Pre - Accreditation - Level 1

Translation Rules:

Patient/Client Safety Criteria Ratings

- Greater than 65% of patient/client safety criteria must have achieved a C rating or higher and

Criteria Ratings

- Greater than 65% of all criteria must have achieved a rating of C or higher, and

Risk Ratings Score

- Less than 5% of criteria have received a risk rating of greater than 7, (where a risk rating of High = 3; Medium = 2; Low = 1),

Pre - Accreditation - Level 2

Translation Rules:

Accreditation may be denied in the following instances:

- Requirements for Accreditation or Pre-Accreditation Level 1 have not been achieved, or
- An immediate and significant threat to patient/clients, public or staff exists, or
- Pre-Accreditation Level 1 has been awarded in two consecutive accreditation surveys

Accreditation Award Announcement

Information on the details of an organisation's current accreditation status is made publicly available on the IHSAB website only with the expressed written permission of the organisation's Chief Executive.

Where an organisation wishes to promote its accreditation outcomes the IHSAB offers to work with them in communicating its results to the public.

Use of the IHSAB Accreditation Logo

Organisations that achieve on accreditation award from the IHSAB are granted permission to utilise the IHSAB "Accredited Logo".

The use of this logo provides the organisation with a distinctive recognition of the level of care and service they provide.

The logo maybe utilised on letterheads, signs and other publications. All use of the logo must be approved by the IHSAB prior to implementation. The logo may only be used by an organisation while it maintains a current accreditation award.

(e) Continuous Assessment

Quality Improvement Report – 12 months

Continuous quality improvement is a foundation feature of the ACAS. To facilitate its establishment and promulgation within an organisation, the ACAS contains provisions for formal continuous assessment:

Organisations which have undergone an accreditation survey must submit a progress report to the IHSAB outlining progress with implementation of quality and safety improvement 12 months post survey.

The Report should clearly outline the plan developed and implemented to address a number of principal issues as documented in the organisation's Survey Report, including:

- Areas of significant risk
- Quality improvement plan
- Self assessment team recommendations

The IHSAB review the Quality Improvement Report and provides feedback regarding its contents to the organisation.

Review Visit – 18 Months

In organisations which have undergone an accreditation survey, a continuous assessment review visit is carried out by the IHSAB 18 months post survey. The aim of the review visit is to assess progress in:

- Areas of significant risk
- Implementation of the quality improvement plan.

The review visit is undertaken by the IHSAB surveyors. The methodologies utilised within the review visit is similar to an accreditation survey, e.g. interviews, document review etc. The proceedings of the review visit follow a pre-determined schedule as determined by the Client Services Liaison in agreement with the organisation.

A report of the surveyors findings is submitted to the IHSAB. The IHSAB review the report and provides details of the findings to the organisation.

(f) Special Revisit

Provision for a Special Revisit to an organisation applies where:

- The IHSAB has reason to believe that there is serious breach of the ACAS Accreditation Standards in the organisation, or
- The organisation has undergone major changes with regard to ownership, control, merger and/or level or type of services provided, or
- The organisation is experiencing multiple and/or recurrent issues of quality/safety concerns
- There is significant complaint from patients/clients, the public or other users of the service regarding the organisation's performance

The IHSAB inform the organisation of the need for a special revisit. Surveyors visit the organisation and a report of their findings is submitted to the IHSAB. The IHSAB reviews the report and provides details of the findings, as well as any action to be taken with regard to its accreditation status, to the organisation.

Appendix B: Team Meeting Observation and Analysis Templates

Accreditation Team Meeting Observation Schedule
Phase 1 (Self Assessment)

Date:_____________ Location:____________________________________

Team:____

Time Started:_________________ Time Finished:_____________________

"+" - Positive towards element "-"Negative towards element
"( )" Incidence of element > 1

Theme	Frequency	Comments
Leadership		
Promoting the accreditation process		
Giving direction		
Motivating team		
Commitment to resolve resource issues		
Focus on plan and timelines		
Other		
Communication		
Understanding and awareness of accreditation process within the team		
Understanding and awareness of accreditation process across hospital		
Feedback to team on progress with accreditation process		
Communication methods and media to support accreditation process		

Other		
Involvement and Participation		
Attendance less than 80%		
Attendance less than 50%		
Meeting cancelled due to poor attendance		
Meeting started more than 10 minutes late		
Team member attendance and participation		
Doctor attendance and participation		
Colleague support		
Team member completion of tasks		
Team member fairness and equity		
Time to attend meetings and complete tasks		
Other		
Training		
Effectiveness of training		
Timing of training		

Other		
Teams		
Effectiveness of team meeting		
Team member open dialogue		
Other		
Reward		
Reward		
Recognition		
Other		
Individual Impact		
Role Conflict		
Other		
Organisational Impact		
Quality of Care		
Other		

Other Comments:

Team Meeting Observation Analysis - Team XXX: Clinical Services

"+" - Positive towards element "-"Negative towards element "( )" Incidence of element > 1

	Leadership					Communication				Involvement and Participation										Training		Teams		Reward		Ind. Impact	Org. Impact
Meeting Observation Date	Promoting the Accreditation Process	Giving Direction	Motivating Team	Commitment to resolve resource issues	Focus of plan and timelines	Understanding and awareness of the Accreditation Process within Team	Understanding and awareness of the Accreditation Process across Hospital	Feedback to Team on Progress with Accreditation Process	Communications Methods and Media to support Accreditation Process	Attendance less than 80%	Attendance less than 50%	Meeting cancelled due to poor attendance	Meeting started more than 10 minutes late	Team Member Attendance and Participation	Doctor Attendance and Participation	Colleague Support	Team Member Completion of Tasks	Team Member Equity and Fairness	Time to Attend Meetings and Complete Tasks	Effectiveness of Training	Timing of Training	Effectiveness of Team Meeting	Team Member Open Dialogue	Reward	Recognition	Role Conflict	Quality of Care

Appendix C: Reflections on the use of NVivo

During this study, the author utilised the software QSR NVivo, Version 7 to support the analysis of qualitative data derived from the primary research stage. Reflecting back on using NVivo, the author now has mixed views as to its effectiveness based on a number of observations. Firstly, there is a significant amount of data preparation required prior to commencing data analysis in NVivo. This principally lies in ensuring that each question, sub-question or data category is assigned the correct heading level in MS Word. If this is not addressed comprehensively and consistently, NVivo will fail to pick up coded data accurately and may well omit important sections of text.

Secondly, the author struggled, although eventually succeeded, to extract the data in the required format. In particular, a significant amount of time was devoted to ensuring that the coded data was ‘cut’ to reflect respondents based on team type. Thirdly, progressing straight to data analysis with NVivo risks sacrificing getting close to the data itself. During this study, the author ensured that they reviewed the data itself in detail and made preliminary notes prior to progressing to coding in NVivo. Without this, the author believes that the data analysis may have been less robust. Finally, while NVivo has the functionality to facilitate content analysis, the author found this difficult to execute and instead resorted to a manual count.

Overall, the author acknowledges that NVivo probably has significant potential for researchers, particularly those with larger volumes of data than that associated with this study and also for those who are more computer literate. However, reflecting back on using NVivo during this study, the author wonders whether the same outcomes could have been achieved by using the ‘cut and paste’ facilities in MS Word to systematically code and group the data as part of the analytical process.

Appendix D: Questionnaire Documents

Our ref: CD

Dear Colleagues,

As you are aware Waterford Institute is working with us on Accreditation for research purposes. Central to this is your experiences of being involved in the process. Ms. Brigid Milner whom you know from her attendance at team meetings, has designed a questionnaire to record your experiences to date. I sincerely urge you to take the ten minutes or so it will take to fill it in. She will share the findings with us all.

This is of great value to us in evaluating the process on an ongoing basis. The key learning from this for us will help us structure our support, coaching and facilitation to meet your needs as best we can and as resources allow.

I will continue to attend team meetings as required and to support you and in this extremely arduous but rewarding process. Well done on your work to date we are doing well and within our time- frames.

Kind Regards,

Regional Quality/Accreditation Manager
General Hospital

Waterford Institute *of* Technology WIT

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9th August 2004

Re: IHSAB Accreditation – XXX Hospital

Dear Accreditation Team Member

As you may be aware, the Centre for Management Research in Healthcare in WIT is currently undertaking a number of large-scale research projects in conjunction with the XXX Healthboard and XXX Hospital. **One of these studies is being undertaken by myself and aims to explore the experiences of accreditationn teams as they move towards the implementation of the IHSAB Acute Care Hospital standards**. It is hoped that the research findings and process will create a greater understanding of accreditation initiatives and will also allow for the dissemination of key learning points to other hospitals in the region who are considering embarking on the process.

The accreditation exercise has now been underway for several months and with this in mind, I am particularly interested in eliciting your views on your experiences to date as an accreditation team member. I attach a questionnaire which covers a range of issues surrounding the process and I am particularly keen to get your views on what you feel is working well with the team process and what you would like to see changed (this is dealt with in the final section of the questionnaire). In total, the questionnaire should take no longer than 10 minutes to complete. Please place your completed questionnaire in the attached envelope and return to myself by the 30th August.

Please be assured that your responses will be treated as confidential and that the results will be generated in aggregate form only.

Your contribution to this research project is greatly appreciated and if you have any queries, please don't hesitate to contact me.

Yours faithfully

Brigid M. Milner
Lecturer in Human Resource Management
Centre for Management Research in Healthcare
School of Business

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August 2004

Re: IHSAB Accreditation –XXX Hospital

Dear

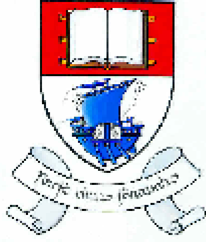
I am sorry to have missed you at your accreditation team meeting today.

During this session, I distributed the attached questionnaire. **This questionnaire is aimed at eliciting your views as a team member on the accreditation process to date** (please see attached covering letter). In order gain the fullest understanding of the exercise to date in XXX Hospital, I hope that you will be able to take the time to complete the questionnaire and return it to me in the pre-paid envelope at your earliest convenience and no later than 30th August.

Your contribution to this research project is greatly appreciated and if you have any queries, please don't hesitate to contact me.

Yours sincerely

Brigid M. Milner
Lecturer in Human Resource Management
Centre for Management Research in Healthcare
School of Business



Healthboard Logo

XXX Hospital

Irish Health Services Accreditation Board – Acute Care Standards Implementation

Accreditation Team Questionnaire - Interim

Instructions for Completion

This questionnaire aims to elicit your views on your experiences of the accreditation process to date in XXX Hospital.

Please complete all sections and questions. Where appropriate, please circle or tick √ your response in the relevant box.

All your responses are confidential and will be used to generate *aggregate data only.*

Please place your completed questionnaire in the prepaid envelope attached and return it to *Brigid Milner, Centre for Management Research in Healthcare and Health Economics, Waterford Institute of Technology* by 30th August 2004.

Your contribution to this exercise is greatly appreciated.

You and Your Accreditation Team

1. Please indicate your team role

Team Member 1 ☐ Team Leader 2 ☐

2. Please indicate your team type

Clinical Services Team 1 ☐ Support Services Team 2 ☐

3. Your Work Role | **4. Your Work Role**

Nurse	1☐	**Brief Description**
Allied Health Professional	2☐	________________
Consultant	3☐	________________
NCHD	4☐	________________
Other (brief description)	5☐	

____

5. Your Work Location

XXXH 1 ☐ Health Board Headquarters 2 ☐ Other (please state)3__________

____

Getting Involved with Accreditation

6. Please indicate <u>how</u> you became involved with the accreditation process

I volunteered to join a team 1 ☐

I was asked to join a team 2 ☐

Other (please explain)3____

Please indicate <u>why</u> you got involved with the accreditation process (*please place Y for "Yes" and N for "No" in the appropriate box*)

7. I wanted to contribute to improving the standard and delivery of healthcare in the hospital ☐

8. I wanted to contribute to improving the way in which my immediate work environment operates ☐

9. I saw it as part of my overall work role ☐

10. I felt involvement would contribute to my career advancement ☐

11. I felt involvement would contribute to my personal development ☐

12. I saw it as an opportunity to remove myself from my immediate work environment ☐

13. I got involved as I expected to be rewarded financially ☐

14. I wanted to reflect on my work practices ☐

15. I felt pressurised to get involved ☐

16. Other ☐

17. Please explain your answer to Question 16

____

____

Previous Involvement in Quality Initiatives

18. Have you had any previous involvement with quality initiatives in either XXXH or any other healthcare setting?

Yes 1 ☐ No 2 ☐

19. If yes, please describe briefly the initiative and your role____

____

20. Have you had any previous involvement with a healthcare accreditation process?

Yes 1 ☐ No 2 ☐

21. If yes, please give a brief description of the accreditation initiative and your role

____

____

Starting the Accreditation Process The following series of statements relate to **your understanding of both what was entailed in the accreditation process and the commitment required from you as a team member, *prior to commencing accreditation.*** ***Please indicate either by circling or ticking √ the appropriate number whether you strongly agree, agree, are uncertain, disagree or strongly disagree with each statement.***	**Strongly agree**	**Agree**	**Uncertain**	**Disagree**	**Strongly Disagree**
	1	2	3	4	5
22. Prior to joining the team, I had a sufficient understanding of the accreditation process	1	2	3	4	5
23. Prior to joining the team, I had a sufficient understanding of what would be expected of me as a team member	1	2	3	4	5
24. The communication sessions on the accreditation process gave me a clear understanding of what was involved	1	2	3	4	5
25. I received sufficient training and support in order to fulfil my accreditation team role	1	2	3	4	5
26. At the start of the accreditation process I clearly understood how accreditation could improve the standard and delivery on healthcare in the hospital	1	2	3	4	5
27. When I started the accreditation process I was aware of the time commitment associated with being a team member	1	2	3	4	5

Accreditation Team Meetings

28. Please indicate the approximate percentage of formal team meetings that you have attended to date

100% ☐ 90% ☐ 80% ☐ 70% ☐ 60% ☐ 50% ☐ 40% ☐ 30% ☐ 20%☐
10% ☐ None ☐

Accreditation Team Meetings The following series of statements relate to **your experiences as an accreditation team member**. ***Please indicate either by <u>circling</u> or <u>ticking</u> √ the appropriate number whether you strongly agree, agree, are uncertain, disagree or strongly disagree with each statement.*** (The term "formal team meetings" refers to the two-weekly scheduled meetings that take place in Room YY in XXXH)	Strongly agree	Agree	Uncertain	Disagree	Strongly Disagree
	1	2	3	4	5
29. The formal team meetings work well	1	2	3	4	5
30. We make definite progress in the formal team meetings	1	2	3	4	5
31. Each meeting gives me a clear indication of overall progress with the accreditation process in the hospital	1	2	3	4	5
32. Everyone is encouraged to participate in the formal team meetings	1	2	3	4	5
33. Everyone has an opportunity to voice their opinions in the formal team meetings	1	2	3	4	5
34. I feel part of my accreditation team	1	2	3	4	5
35. In our formal team meetings, work roles and hierarchies are not relevant	1	2	3	4	5
36. At the end of each formal team meeting, I know where we are with the accreditation process in our team	1	2	3	4	5
37. Team members take the agreed deadlines seriously	1	2	3	4	5
38. We have sufficient time in the formal team meetings to address all the relevant issues	1	2	3	4	5
39. At the end of each meeting I know what is expected of me for the next meeting	1	2	3	4	5
40. Formal team meetings are scheduled at appropriate times	1	2	3	4	5
41. I have no difficulty leaving my immediate work environment in order to attend a formal team meeting	1	2	3	4	5
42. Tasks are shared fairly and equitably between team members who attend the formal meetings	1	2	3	4	5
43. Tasks are shared fairly and equitably between all team members who are listed as being part of the team	1	2	3	4	5
44. If I don't attend a formal team meeting, I still know what is expected of me for the next meeting	1	2	3	4	5
45. I get sufficient time to meet with other team members to complete the agreed tasks	1	2	3	4	5
46. Accreditation has already improved the standard and delivery of healthcare within my immediate work environment	1	2	3	4	5
47. Accreditation has already improved the standard and delivery of healthcare within the hospital	1	2	3	4	5

Awareness of the Accreditation Process The following series of statements relate to **your views about the general level of awareness and interest in the accreditation process by those staff who are NOT accreditation team members.** ***Please indicate either by circling or ticking √ the appropriate number whether you strongly agree, agree, are uncertain, disagree or strongly disagree with each statement.***	Strongly agree	Agree	Uncertain	Disagree	Strongly Disagree
	1	2	3	4	5
48. Staff in the hospital are aware that the accreditation process is taking place	1	2	3	4	5
49. Staff in the hospital are aware of the progress made to date by the accreditation teams	1	2	3	4	5
50. Staff in the hospital are aware of the aims and objectives of the accreditation process	1	2	3	4	5
51. Patients are aware that the accreditation process is underway	1	2	3	4	5
52. Other associated healthcare organisations in the region are aware that the accreditation process in the hospital is underway	1	2	3	4	5
53. I actively update my colleagues in my immediate work area on my team's progress with the accreditation process	1	2	3	4	5
54. Those in my immediate work area express interest in my team's progress with accreditation	1	2	3	4	5
55. My work colleagues, who are not team members, assist and support me in completing my accreditation tasks	1	2	3	4	5
56. I get recognition from my work colleagues for my contribution to the accreditation process	1	2	3	4	5
57. I get recognition from my line manager for my contribution to the accreditation process	1	2	3	4	5

58. Please comment generally or specifically on the accreditation process, highlighting any activities that you feel are working particularly well and/or any changes that you would like to see made.

Thank you for taking the time to complete this questionnaire. The results will contribute to creating a greater understanding of the healthcare accreditation process.

Please place your completed questionnaire in the attached envelope and return to Brigid Milner.

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1st September 2004

IHSAB Accreditation Teams
XXX Hospital (XXXH)

Re: Reminder IHSAB Accreditation Team Questionnaire Completion

Dear Accreditation Team Member

You will recently have received the above questionnaire in either your accreditation team meeting or in the internal post in XXXH which aims to elicit your views on your experiences of the accreditation process to date. If you have already returned the questionnaire – sincere thanks for taking the time to work through it.

If you have not returned the questionnaire, I hope that you will consider completing it as your contribution will be invaluable and will assist in providing a fuller picture of team members experiences of accreditation. If you did not receive or have mislaid your original questionnaire, please feel free to contact me on 051 302629 or bmilner@wit.ie and I will be happy to forward you a copy. Please return the completed questionnaire in the prepaid envelope to me at the Centre for Management Research in Healthcare and Healthcare Economics at WIT, by **10th September**.

Please be assured that your responses will be treated as confidential and that the results will be generated in aggregate form only.

Your contribution to this research project is greatly appreciated and if you have any queries, please don't hesitate to contact me.

Yours faithfully

Brigid M. Milner
Lecturer in Human Resource Management
Centre for Management Research in Healthcare and Health Economics
School of Business

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Telephone [redacted]
Fax [redacted]

Dear Team Member,

Congratulations on completing the first phase for the Accreditation process and well done on all your hard work. It was an enormous undertaking and you have done yourselves proud.

As you are aware Bridget Milliner is researching the process and her work will be of considerable use to us and others undertaking the process, her observations and research to date has informed us in a number of areas. She has worked as an observer on a number of teams throughout the whole process. Well done Bridget!

You have completed a questionnaire when you commenced the process which you have had feedback on thank you. Now to complete this cycle Bridget needs you to complete a second questionnaire. I hope you will facilitate us in this, and having reviewed the questions your responses will be most useful as we move forward in the Accreditation process in [redacted] and the other hospitals in the [redacted].

Thank you for your time and effort in this.

Kind Regards

[redacted] Regional Quality/ Accreditation Manager.

Waterford Institute *of* Technology WIT

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Email: bmilner@wit.ie
Direct Line: 051 302629

June 2005

Re: IHSAB Accreditation: Phase 1 completion – Team Questionnaire

Dear Accreditation Team Member

Congratulations on completing your team survey interview and the final stage of Phase 1 of the IHSAB accreditation process!

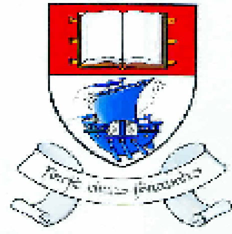
As part of the on-going study of the accreditation process in XXX Hospital (XXXH) in conjunction with the Centre for Management Research in Healthcare and Health Economics in WIT, I attach a questionnaire, which aims to **elicit your views on your experiences of the accreditation process to date**. It is hoped that the findings will contribute to a greater understanding of the team process in XXXH as Phase 2 of accreditation comes on stream and also provide insights for other hospitals within the regional network that are commencing the accreditation exercise.

The questionnaire should take no longer than 10 minutes to complete (please pay particular attention to the **final open-ended question**) and your responses will be treated as confidential. Please return it in the prepaid envelope attached by **Thursday 30th June 2005.**

On a personal note, I would like to take this opportunity to thank you for your on-going support for this study, which is also the basis for my postgraduate studies.

Yours faithfully

Brigid M. Milner
Lecturer in Human Resource Management
Centre for Management Research in Healthcare and Health Economics
School of Business



XXX Hospital

Irish Health Services Accreditation Board – Acute Care Standards Implementation

Accreditation Team Questionnaire – Phase 1 completion

Instructions for Completion **This questionnaire aims to elicit your views on your experiences of Phase 1 (February 2004 – June 2005) of the accreditation process in XXX Hospital.** Please complete all sections and questions. Where appropriate, please circle or tick √ your response in the relevant box. **All your responses are confidential** and will be used to generate *aggregate data only.* **Please place your completed questionnaire in the prepaid envelope attached and return it to *Brigid Milner, Centre for Management Research in Healthcare and Health Economics, Waterford Institute of Technology* by Thursday 30th June 2005.** *Your contribution to this exercise is greatly appreciated.*

You and Your Accreditation Team

1. Please indicate your team role

Team Member 1 ☐ Team Leader 2 ☐

2. Please indicate your team type

Clinical Services Team 1 ☐ Support Services Team 2 ☐

3. Your Work Role		**4. Brief Description**
Nurse	1☐	______________________
Allied Health Professional	2☐	______________________
Consultant	3☐	______________________
NCHD	4☐	______________________
Other	5☐	______________________

5. Your Work Location

XXXH 1 ☐ HSE Regional Offices 2 ☐ Other (please state) 3________________

6. Please indicate the approximate percentage of <u>formal team meetings</u> (April 2004 – May 2005) that you attended during Phase 1 of the accreditation process

100% ☐ 90% ☐ 80% ☐ 70% ☐ 60% ☐ 50% ☐ 40% ☐ 30% ☐ 20%☐ 10% ☐ None ☐

Looking back at Phase 1 of the Accreditation Process The following series of statements relate to **your views about the first stage (Phase 1, February 2004- June 2005) of the accreditation process** ***Please indicate either by circling or ticking √ the appropriate number whether you strongly agree, agree, are uncertain, disagree or strongly disagree with each statement.***	**Strongly agree**	**Agree**	**Uncertain**	**Disagree**	**Strongly Disagree**
	1	2	3	4	5
7. I received sufficient training and support in order to fulfil my accreditation team role	1	2	3	4	5
8. The Irish Health Services Accreditation Board training sessions provided a good understanding of the accreditation process	1	2	3	4	5
9. By the end of Phase 1, I had a good understanding of the accreditation process	1	2	3	4	5
10. There was sufficient leadership for the process	1	2	3	4	5
11. The overall accreditation process was well managed	1	2	3	4	5
12. The formal team meetings worked well	1	2	3	4	5
13. We made definite progress in the formal team meetings	1	2	3	4	5
14. Our team worked well together	1	2	3	4	5
15. Everyone was encouraged to participate in the formal team meetings	1	2	3	4	5
16. In our formal team meetings, work roles and hierarchies were not relevant	1	2	3	4	5
17. Everyone had the opportunity to voice their opinions in the formal team meetings	1	2	3	4	5
18. I felt part of my accreditation team	1	2	3	4	5
19. Team members took the agreed deadlines seriously	1	2	3	4	5
20. We had sufficient time in the formal team meetings to address all the relevant issues	1	2	3	4	5
21. I got sufficient time to meet with other team members to complete the agreed tasks	1	2	3	4	5
22. Formal team meetings were scheduled at appropriate times	1	2	3	4	5
23. I had no difficulty leaving my immediate work environment in order to attend a formal team meeting	1	2	3	4	5
24. At the end of each formal team meeting, I knew where we were with the accreditation process in our team	1	2	3	4	5
25. Everyone who was listed as a team member made a contribution to the accreditation process	1	2	3	4	5
26. Tasks were shared fairly and equitably between team members who attended the formal meetings	1	2	3	4	5
27. Tasks were shared fairly and equitably between all team members who were listed as being part of the team	1	2	3	4	5
28. I was fully committed to accreditation at all stages of Phase 1 of the process	1	2	3	4	5

Looking back at Phase 1 of the Accreditation Process - continued The following series of statements relate to **your views about the first stage <u>(Phase 1, February 2004- June 2005) of the accreditation process</u>** ***Please indicate either by <u>circling</u> or <u>ticking</u> √ the appropriate number whether you strongly agree, agree, are uncertain, disagree or strongly disagree with each statement.***	**Strongly agree**	**Agree**	**Uncertain**	**Disagree**	**Strongly Disagree**
	1	2	3	4	5
29. I was fully committed to my team at all stages of Phase 1 of the accreditation process	1	2	3	4	5
30. Accreditation enhanced my relationships with my immediate work colleagues	1	2	3	4	5
31. I actively updated my colleagues in my immediate work area on my team's progress with the accreditation process	1	2	3	4	5
32. Those in my immediate work area expressed interest in my team's progress with accreditation	1	2	3	4	5
33. My work colleagues, who were not team members, assisted and supported me in completing my accreditation tasks	1	2	3	4	5
34. My line manager assisted and supported me in completing my accreditation tasks	1	2	3	4	5
35. I got recognition from my work colleagues for my contribution to the accreditation process	1	2	3	4	5
36. I got recognition from my line manager for my contribution to the accreditation process	1	2	3	4	5
37. Involvement in Phase 1 of the accreditation process has allowed me to reflect on my work practices	1	2	3	4	5
38. Involvement in Phase 1 of the accreditation process contributed to my personal development	1	2	3	4	5
39. Involvement in Phase 1 of the accreditation process contributed to my professional development	1	2	3	4	5
40. Involvement in Phase 1 of the accreditation process will contribute to my career advancement	1	2	3	4	5
41. Those who contributed to Phase 1 of the accreditation process should be rewarded	1	2	3	4	5
42. Accreditation has improved the level of multidisciplinary working in the hospital	1	2	3	4	5
43. Accreditation has improved the standard and delivery of healthcare within my immediate work environment	1	2	3	4	5
44. Accreditation has improved the standard and delivery of healthcare within the hospital	1	2	3	4	5
45. Accreditation is a worthwhile process	1	2	3	4	5

Awareness of the Accreditation Process The following series of statements relate to **your views about the general level of awareness and commitment to the accreditation process by <u>those staff and patients who are NOT accreditation team members</u>**. ***Please indicate either by <u>circling</u> or <u>ticking</u> √ the appropriate number whether you strongly agree, agree, are uncertain, disagree or strongly disagree with each statement.***	Strongly agree	Agree	Uncertain	Disagree	Strongly Disagree
	1	2	3	4	5
46. Staff in the hospital are aware that the accreditation process is taking place	1	2	3	4	5
47. Staff in the hospital are aware of the aims and objectives of the accreditation process	1	2	3	4	5
48. Staff in the hospital believe that accreditation is a worthwhile process	1	2	3	4	5
49. Patients are aware that the accreditation process is underway	1	2	3	4	5
50. Other associated healthcare organisations in the region are aware that the accreditation process in the hospital is underway	1	2	3	4	5

Looking ahead to Phase 2 of the Accreditation Process The following series of statements relate to **your views on the next stage <u>(Phase 2) of the accreditation process</u>** ***Please <u>circle</u> whether you strongly agree, agree, are uncertain, disagree or strongly disagree with the statement.***	Strongly agree	Agree	Uncertain	Disagree	Strongly Disagree
	1	2	3	4	5
51. I have a clear understanding of what is involved in the next stage (Phase 2) of the accreditation process	1	2	3	4	5
52. I see on-going involvement in the accreditation process as part of my work role	1	2	3	4	5
53. I am happy to be involved as a team member in the next stage (Phase 2) of the accreditation process	1	2	3	4	5
54. I would willingly support colleagues who are involved in the next stage (Phase 2) of the accreditation process	1	2	3	4	5
55. I would actively encourage colleagues to get involved with the next stage (Phase 2) of the accreditation process	1	2	3	4	5
56. Contributing to accreditation is everyone's responsibility	1	2	3	4	5

57. Please comment generally or specifically on the accreditation process highlighting any activities that you felt worked particularly well and/or any changes that you would like to see made.

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Thank you for taking the time to complete this questionnaire. The results will contribute to creating a greater understanding of the healthcare accreditation process.

Please place your completed questionnaire in the attached prepaid envelope and return to Brigid Milner, Centre for Management Research in Healthcare and Health Economics, WIT.

If you are willing to share your views on accreditation in more detail, via a confidential interview, please provide your contact details below:

Name:____________________ Phone number:__________

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Email: bmilner@wit.ie
Direct Line: 051 302629

3rd July 2005

IHSAB Accreditation Teams
XXX Hospital

Re: Reminder IHSAB Accreditation: Phase 1 completion – Team Questionnaire

Dear Accreditation Team Member

Having now completed your IHSAB survey interview, you will have received a questionnaire to complete to provide your views on your experiences of Phase 1 of the accreditation process. If you have already returned the questionnaire – sincere thanks for taking the time to work through it.

If you have not returned the questionnaire, I hope that you will consider completing it as your contribution will be invaluable and will assist in providing a fuller picture of team members experiences of accreditation. If you did not receive or have mislaid your original questionnaire, please feel free to contact me on 051 302629 or bmilner@wit.ie and I will be happy to forward you a copy. Please return the completed questionnaire in the prepaid envelope to me at the Centre for Management Research in Healthcare and Healthcare Economics at WIT, by **Friday 15th July**.

Finally, congratulations again on completing Phase 1 of the accreditation process and your survey interview.

Yours faithfully

Brigid M. Milner
Lecturer in Human Resource Management
Centre for Management Research in Healthcare and Health Economics
School of Business

Appendix E: Questionnaire Question Groupings and Cronbach's Alpha Values

Table E1.1 - Question Grouping Based on Process and Impact Themes and Cronbach's Alpha Values[1] - Questionnaires 1 & 2

Theme	Questionnaire 1	Questionnaire 2
Background	*1. Please indicate your team role* *2. Please indicate your team type* *3. Your Work Role* *4. Your Work Role (description)* *5. Your Work Location* *18. Have you had any previous involvement with quality initiatives in either XXX RH or any other healthcare setting?* *19. If yes, please describe briefly the initiative and your role* *20. Have you had any previous involvement with a healthcare accreditation process?* *21. If yes, please give a brief description of the accreditation initiative and your role*	*1. Please indicate your team role* *2. Please indicate your team type* *3. Your Work Role* *4. Your Work Role (description)* *5. Your Work Location*
Theme - Process	**Questionnaire 1**	**Questionnaire 2**
Leadership		10. There was sufficient leadership for the process 11. The overall accreditation process was well managed ***Cronbach's Alpha - .838***
Communication	22. Prior to joining the team, I had a sufficient understanding of the accreditation process 23. Prior to joining the team, I had a sufficient understanding of what would be expected of me as a team member 24. The communication sessions on the accreditation process gave me a clear understanding of what was involved 26. At the start of the accreditation process I clearly understood how accreditation could improve the standard and delivery on healthcare in the hospital 27. When I started the accreditation process I was aware of the time commitment associated with being a team member 48. Staff in the hospital are aware that the accreditation process is taking place 49. Staff in the hospital are aware of the progress made to date by the accreditation teams 50. Staff in the hospital are aware of the aims and objectives of the accreditation process 51. Patients are aware that the accreditation process is underway 52. Other associated healthcare organisations in the region are aware that	9. By the end of Phase 1, I had a good understanding of the accreditation process 31. I actively updated my colleagues in my immediate work area on my team's progress with the accreditation process 32. Those in my immediate work area expressed interest in my team's progress with accreditation 46. Staff in the hospital are aware that the accreditation process is taking place 47. Staff in the hospital are aware of the aims and objectives of the accreditation process 49. Patients are aware that the accreditation process is underway 50. Other associated healthcare organisations in the region are aware that the accreditation process in the hospital is underway 51. I have a clear understanding of what is involved in the next stage (Phase 2) of the accreditation process

[1] Questions in italics were not subject to the Cronbach's Alpha reliability analysis.

	the accreditation process in the hospital is underway 53. I actively update my colleagues in my immediate work area on my team's progress with the accreditation process 54. Those in my immediate work area express interest in my team's progress with accreditation ***Cronbach's Alpha - .781***	 ***Cronbach's Alpha - .757***
Theme - Process	**Questionnaire 1**	**Questionnaire 2**
Involvement and Participation	*6. Please indicate how you became involved with the accreditation process* *9. I saw it was part of my overall work role* *15. I felt pressurised to get involved* *16. Other reasons for involvement* *17. Please explain your answer to Question 16* *28. Please indicate the approximate percentage of formal team meetings that you have attended to date* 40. Formal team meetings are scheduled at appropriate times 41. I have no difficulty leaving my immediate work environment in order to attend a formal team meeting 42. Tasks are shared fairly and equitably between team members who attend the formal meetings 43. Tasks are shared fairly and equitably between all team members who are listed as being part of the team 45. I get sufficient time to meet with other team members to complete the agreed tasks 55. My work colleagues, who are not team members, assist and support me in completing my accreditation tasks ***Cronbach's Alpha - .550***	*6. Please indicate the approximate percentage of formal team meetings (April 2004 – June 2005) that you attended during Phase 1 of the accreditation process* 21. I got sufficient time to meet with other team members to complete the agreed tasks 22. Formal team meetings were scheduled at appropriate times 23. I had no difficulty leaving my immediate work environment in order to attend a formal team meeting 25. Everyone who was listed as a team member made a contribution to the accreditation process 26. Tasks were shared fairly and equitably between team members who attended the formal meetings 27. Tasks were shared fairly and equitably between all team members who were listed as being part of the team 28. I was fully committed to accreditation at all stages of Phase 1 of the process 29. I was fully committed to my team at all stages of Phase 1 of the accreditation process 33. My work colleagues, who were not team members, assisted and supported me in completing my accreditation tasks 34. My line manager assisted and supported me in completing my accreditation tasks 52. I see on-going involvement in the accreditation process as part of my work role 53. I am happy to be involved as a team member in the next stage (Phase 2) of the accreditation process 54. I would willingly support colleagues who are involved in the next stage (Phase 2) of the accreditation process 55. I would actively encourage colleagues to get involved with the next stage (Phase 2) of the accreditation process 56. Contributing to accreditation is everyone's responsibility ***Cronbach's Alpha - .850***
Training	25. I received sufficient training and support in order to fulfil my accreditation team role	7. I received sufficient training and support in order to fulfil my accreditation team role 8. The Irish Health Services Accreditation Board training sessions provided a good understanding of the accreditation process ***Cronbach's Alpha - .680***

Theme - Process	Questionnaire 1	Questionnaire 2
Teams	29. The formal team meetings work well 30. We make definite progress in the formal team meetings 31. Each meeting gives me a clear indication of overall progress with the accreditation process in the hospital 32. Everyone is encouraged to participate in the formal team meetings 33. Everyone has an opportunity to voice their opinions in the formal team meetings 34. I feel part of my accreditation team 35. In our formal team meetings, work roles and hierarchies are not relevant 36. At the end of each formal team meeting, I know where we are with the accreditation process in our team 37. Team members take the agreed deadlines seriously 38. We have sufficient time in the formal team meetings to address all the relevant issues 39. At the end of each meeting I know what is expected of me for the next meeting 44. If I don't attend a formal team meeting, I still know what is expected of me for the next meeting ***Cronbach's Alpha - .792***	12. The formal team meetings worked well 13. We made definite progress in the formal team meetings 14. Our team worked well together 15. Everyone was encouraged to participate in the formal team meetings 16. In our formal team meetings, work roles and hierarchies were not relevant 17. Everyone had the opportunity to voice their opinions in the formal team meetings 18. I felt part of my accreditation team 19. Team members took the agreed deadlines seriously 20. We had sufficient time in the formal team meetings to address all the relevant issues 24. At the end of each formal team meeting, I knew where we were with the accreditation process in our team ***Cronbach's Alpha - .881***
Reward	*13. I got involved as I expected to be rewarded financially* 56. I get recognition from my work colleagues for my contribution to the accreditation process 57. I get recognition from my line manager for my contribution to the accreditation process ***Cronbach's Alpha - .694***	35. I got recognition from my work colleagues for my contribution to the accreditation process 36. I got recognition from my line manager for my contribution to the accreditation process 41. Those who contributed to Phase 1 of the accreditation process should be rewarded ***Cronbach's Alpha - .484***
Theme - Impact		
Individual	*10. I felt involvement would contribute to my career advancement* *11. I felt involvement would contribute to my personal development* *12. I saw it as an opportunity to remove myself from my immediate work environment* *14. I wanted to reflect on my work practices*	37. Involvement in Phase 1 of the accreditation process has allowed me to reflect on my work practices 38. Involvement in Phase 1 of the accreditation process contributed to my personal development 39. Involvement in Phase 1 of the accreditation process contributed to my professional development 40. Involvement in Phase 1 of the accreditation process will contribute to my career advancement ***Cronbach's Alpha - .833***

Organisational	*7. I wanted to contribute to improving the standard and delivery of healthcare in the hospital* *8. I wanted to contribute to improving the way in which my immediate work environment operates* 46. Accreditation has already improved the standard and delivery of healthcare within my immediate work environment 47. Accreditation has already improved the standard and delivery of healthcare within the hospital ***Cronbach's Alpha - .847***	30. Accreditation enhanced my relationships with my immediate work colleagues 42. Accreditation has improved the level of multidisciplinary working in the hospital 43. Accreditation has improved the standard and delivery of healthcare within my immediate work environment 44. Accreditation has improved the standard and delivery of healthcare within the hospital 45. Accreditation is a worthwhile process 48. Staff in the hospital believe that accreditation is a worthwhile process ***Cronbach's Alpha - .821***

Appendix F: Interview Documents

Waterford Institute *of* Technology WIT

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20th September 2005

Private and Confidential
To be opened by addressee only

Interviewee Name
Address
Address
Address
Address

Re: Confidential Interview- XXX Hospital IHSAB Accreditation Process

Dear XXX

Further to my call, I am writing to thank you for agreeing to participate in a confidential interview to discuss the accreditation process which you have been involved with over the last 18 months in XXX Hospital. As agreed, we are scheduled to meet on:

Date: Thursday 13th October 2005

Time: 12 noon

Location: Room 17, XXX Hospital

Duration: 1 hour 30 minutes (maximum)

During the interview, I hope that we will be able to explore your views on the IHSAB accreditation process. I am particularly interested in gaining your insights into the implementation of first phase of the exercise and what you felt were the impacts arising from involvement, both to you and to the hospital. In addition, I would also welcome any ideas for changes and additional supports for the process that you feel would be beneficial to the next phase of continuous improvement activity. Finally, I also hope to share with you some of the overall results from the post-IHSAB survey questionnaire which you kindly contributed to.

Your contribution to this exercise is greatly appreciated as it will assist in creating a greater understanding of the issues surrounding accreditation in the hospital going forward.

With sincere thanks

Brigid M. Milner
Lecturer in HRM
Centre for Management Research in Healthcare and Healthcare Economics

Waterford Institute *of* Technology WIT

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September 2005

Re: Standard Ethics Protocol – XXX IHSAB Accreditation Project

Dear Interviewee

Thank you for your willingness to participate in this research project on the Accreditation exercise that you have been involved with over the past eighteen months.

Before we start the interview, I would like to reassure you that as a participant in this project you have a number of options:

- Your participation in this interview is entirely voluntary;
- You are free to refuse to answer any question at any time;
- You are free to withdraw from the interview at any stage.

The contents of the interview will be kept **strictly confidential and anonymous**. Extracts from this interview may be included as part of the final research report, but under no circumstances will your name or any identifying characteristics be included. Any references to your name or team name will be deleted from the interview transcript. Any tape recording of this interview will be destroyed on transcription.

I would be grateful if you would sign this form to indicate that I have read you it's contents.

(Signed) ______________________ (Printed) ______________________

(Date) ______________________

Brigid M. Milner
Lecturer in HRM
Centre for Management Research in Healthcare and Health Economics
Email: bmilner@wit.ie

IHSAB Accreditation Implementation – Semi-Structured Interview Guide

Read Introduction

I am going to pose a range of questions under a number of headings that will require you, in the main, to reflect on your experiences as a team member of the accreditation implementation process in XXX hospital and any impacts that may have arisen for you, both as an individual and also at an organisational level. Some questions may also ask you to look to the future in relation to the accreditation process.

Please feel free to deviate from these questions if you deem relevant.

General

1. Looking back, what was your overall assessment of phase 1 of the accreditation process?

2. What factors may have influenced your view of the accreditation process?

3. The results from the two accreditation questionnaires which you may have contributed to, indicate, in the main, that the support services team members were more positive in their reports of their experiences of the overall accreditation process and any impacts arising, than those in the clinical services teams.

   Do you have any observations on why this might be?

4. Any other comments?

Communication

4. What is your assessment of the communication process across the organisation on the accreditation exercise and how the process was progressing?
5. What is your understanding of what is involved in phase 2 of the accreditation process?
6. Any other comments?

Training

7. Do you think an initial team building exercise would have benefited you and your team? Why?

8. Did you feel that you knew enough about general Quality Management and Continuous Improvement at the beginning of the process?

9. Any other comments?

Involvement and Participation

10. How would you regard your commitment to the accreditation process?

11. What factors influenced your commitment to the process?

12. What factors do you think influenced other team members commitment to the process?

13. Do you think that it is legitimate for line managers to ask their staff to get involved with accreditation or should the process be driven by volunteers to the exercise only?

14. The issue of non-attendance was a reoccurring issue in the questionnaire data. Did non-attendance impact on your team? If so, how?

15. What do you think could be done to manage attendance going forward?

16. One of the key concerns highlighted in the research data and in particular with the clinical services team members, was the low level of participation of Hospital Consultants. Do you anticipate that this will be an issue going forward?

17. What would you see as the potential impact of any specific employee group not participating in phase 2?

18. Do you think that all team members now see accreditation as part of their overall work role?

19. The results for the questionnaire statement *"**Tasks were shared fairly and equitably between all team members who are list as being part of the team**"* registered high levels of dissatisfaction, in particular for the clinical services team respondents. What are your views on this? How do you think this might be resolved going forward?

20. The results indicated that a number of team members were unhappy about the timing and scheduling of team meetings. What could be done to resolve this?

21. To what extent were you able to prioritise accreditation activities relative to your other work responsibilities?

22. Do you feel that your (i) line manager and (ii) your colleagues accommodated you in terms of working on accreditation tasks? Do you believe they will going forward?

23. Do you think that all employees in the hospital see themselves as being responsible for accreditation?

24. How do you feel about being involved in Phase 2 of the process?

25. Do you believe that you will be able to sustain the same level of input to accreditation going forward if your team operates in the same way and with the same levels of support outside the team?

26. Any other comments?

Teams

27. What are your views of how the team meetings worked? Any suggestions for changes?

28. Did you feel comfortable and free to participate in the meetings?

29. Any other comments?

Reward

30. One of the statements in the second questionnaire related to whether team members should be rewarded for their contribution to the accreditation process. What are your views on this?

31. Why do you think that the questionnaire results reflected greater agreement from the clinical services respondents than support services respondents, on the issue of being rewarded for contribution?

32. Do you feel you were rewarded any way, for example being given recognition, for your contribution to accreditation?

33. Did you feel valued for your contribution to the accreditation process? Who by?

34. Any other comments?

Leadership

35. What is your assessment of the overall implementation of accreditation? Please explain. Do you have any suggestions for changes that might be made going forward?

36. Do you feel that there were any factors that were not anticipated around the management and organisation of accreditation?

37. Would you like to see anything changed going forward in terms of how the accreditation process is organised and managed?

38. One of the suggestions arising from the questionnaire data was the appointment of a full-time Quality and Accreditation Manager for the Hospital. What are your views on this? How might they affect the process going forward?

39. Any other comments?

Impact - Individual

40. For you individually, what did you get out of involvement with the accreditation process?

41. Any other comments?

Impact - Organisational

42. What do you think accreditation should achieve overall in the hospital? In your immediate work area? Based on your experiences, did it achieve this?

43. Do you believe that accreditation will form the basis for securing more resources for the hospital and your immediate work area?

44. Looking back, do you think that accreditation is worth the effort?

45. Any other comments?

Looking Ahead

46. What types of supports would you like to have going forward with the next stage of accreditation? For you personally. For your team? For your immediate work area? Do you feel they will be forthcoming?

47. What factors present the greatest challenge to accreditation going forward?

48. Any final comments on the accreditation process?

Recap

Reiterate thanks for participation and reaffirm confidentiality.

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17th October 2005

Private and Confidential
To be opened by addressee only

Name
Address
Address
Address
Address

Re: Confidential Interview- XXX Hospital IHSAB Accreditation Process

Dear XXX

I am writing to thank you for your participation in the above interview process. I very much appreciate your willingness to share so freely your views on the accreditation exercise in the hospital and also for making the time in what I know is a hectic working day. Your input will help to create a greater understanding of the issues surrounding accreditation as the process moves forward in XXX Hospital and also for other hospitals in the network as they progress with implementing accreditation.

With sincere thanks

Brigid M. Milner
Lecturer in HRM
Centre for Management Research in Healthcare and Healthcare Economics

Appendix G: Non-Parametric Analysis Based on Willingness to be Interviewed

Questionnaire 2 Item	P-Value
APPROXIMATE PERCENTAGE OF MEETINGS ATTENDED	.077

Test Statistics [a]

	Asymp. Sig. (2-tailed)
I RECEIVED SUFFICIENT TRAINING AND SUPPORT IN ORDER TO FULFILL MY ACCREDITATION TEAM ROLE	.216
THE IHSAB TRAINING SESSIONS PROVIDED A GOOD UNDERSTANDING OF THE ACCREDITATION PROCESS	.930
BY TE END OF PHASE 1, I HAD A GOOD UNDERSTANDING OF THE ACCREDITATION PROCESS	.191
THERE WAS SUFFICIENT LEADERSHIP FOR THE PROCESS	.932
OVERALL THE ACCREDITATION PROCESS WAS WELL MANAGED	.694
THE FORMAL TEAM MEETINGS WORKED WELL	.723
WE MADE DEFINITE PROGRESS IN THE FORMAL TEAM MEETINGS	.736
OUR TEAM WORKED WELL TOGETHER	.497
EVERYONE WAS ENCOURAGED TO PARTICIPATE IN THE FORMAL TEAM MEETINGS	.870
IN OUR FORMAL TEAM MEETINGS, WORK ROLES AND HIERARCHIES WERE NTO RELEVANT	.432
EVERYONE HAD THE OPPORTUNITY TO VOICE THEIR OPINIONS IN THE FORMAL TEAM MEETINGS	.114
I FEEL PART OF MY ACCREDITATION TEAM	.165
TEAM MEMBERS TOOK THE AGREED DEADLINES SERIOUSLY	.770
WE HAD SUFFICIENT TIME IN THE FORMAL TEAM MEETINGS TO ADDRESS ALL THE RELEVANT ISSUES	.800
I GOT SUFFICIENT TIME TO MEET WITH OTHER TEAM MEMBERS TO COMPLETE THE AGREED TASKS	.091
FORMAL TEAM MEETINGS WERE SCHEDULED AT APPROPRAITE TIMES	.913
I HAD NO DIFFICULTY LEAVING MY IMMEDIATE WORK ENVIRONMENT IN ORDER TO ATTEND A FORMAL TEAM MEETING	.912
AT THE END OF EACH FORMAL TEAM MEETING, I KNEW WHERE WE WERE WITH THE ACCREDITATION PROCESS IN OUR TEAM	.933
EVERYONE WHO WAS LISTED AS A TEAM MEMBER MADE A CONTRIBUTION TO THE ACCREDITATION PROCESS	.543
TASKS WERE SHARED FAIRLY AND EQUITABLY BETWEEN TEAM MEMBERS WHO ATTENDED THE FORMAL MEETINGS	.184
TASKS WERE SHARED FAIRLY AND EQUITABLY BETWEEN TEAM MEMBERS WHO WERE LISTED AS BEING PART OF THE TEAM	.510
I WAS FULLY COMMITTED TO ACCREDITATION AT ALL STAGES OF PHASE 1 OF THE PROCESS	.076
I WAS FULY COMMITTED TO MY TEM AT AL STAGES OF PHASE 1 OF THE ACCREDITATION PROCESS	.505
ACCREDITATION ENHANCED MY RELATIONSHIPS WITH MY IMMEDIATE WORK COLLEAGUES	.347
I ACTIVELY UPDATED MY COLLEAGUES IN MY IMMEDIATE WORK AREA ON MY TEAM'S PROGRESS WITH THE ACCREDITATION PROCESS	.907
THOSE IN MY IMMEDIATE WORK AREA EXPRESSED INTEREST IN MY TEAM'S PROGRESS WITH ACCREDITATION	.325
MY WORK COLLEAGUES WHO WERE NOT TEAM MEMBERS, ASSISTED AND SUPPORTED ME IN COMPLETING MY ACCREDITATION TASKS	.267
MY LINE MANAGER ASSISTED AND SUPPORTED ME IN COMPLETING MY ACCREDITATION TASKS	.688
I GOT RECOGNITION FROM MY WORK COLLEAGUES FOR MY CONTRIBUTION TO THE ACCREDITATION PROCESS	.878
I GOT RECOGNITION FROM MY LINE MANAGER FOR MY CONTRIBUTION TO THE ACCREDITATION PROCESS	.951
INVOLVEMENT IN PHASE 1 OF THE ACCREDITATION PROCESS HAS ALLOWED ME TO REFLECT ON MY WORK PRACTICES	.717
INVOLVEMENT IN PHASE 1 OF THE ACCREDITATION PROCESS CONTRIBUTED TO MY PERSONAL DEVELOPMENT	.771
INVOLVEMENT IN PHASE 1 OF THE ACCREDITATION PROCESS CONTRIBUTED TO MY PROFESSIONAL DEVELOPMENT	.153
INVOLVEMENT IN PHASE 1 OF THE ACCREDITATION PROCESS WILL CONTRIBUTE TO MY CAREER ADVANCEMENT	.091
THOSE WHO CONTRIBUTED TO PHASE 1 OF THE ACCREDITATION PROCESS SHOULD BE REWARED	.218
ACCREDITATION HAS IMPROVED THE LEVEL OF MULTIDISCIPLINARY WORKING IN THE HOSPTIAL	.431
ACCREDITATION HAS IMPROVED THE STANDARD AND DELIVERY OF HEALTHCARE WITHIN MY IMMEDIATE WORK ENVIRONMENT	.845
ACCREDITATION HAS IMPROVED THE STANDARD AND DELIVERY OF HEALTHCARE WITHIN THE HOSPITAL	.115
ACCREDITATION IS A WORTHWHILE PROCESS	.171
STAFF IN THE HOSPTIAL ARE AWARE THAT THE ACCREDITATION PROCESS IS TAKING PLACE	.302
STAFF IN THE HOSPITAL ARE AWARE OF THE AIMS AND OBJECTIVES OF THE ACCREDITATION PROCESS	.641
STAFF IN THE HOSPITAL BELIEVE THAT ACCREDITATION IS A WORTWIHILE PROCESS	.688
PATIENTS IN THE HOSPITAL ARE AWARE THAT THE ACCREDITATION PROCESS IS UNDERWAY	.454
OTHER ASSOCIATED HEALTHCARE ORGANISATIONS IN THE REGION ARE AWARE THAT THE ACCREDITATION PROCESS IN THE HOSPITAL IS UNDERWAY	.405
i HAVE A CLEAR UNDERSTANDING OF WHAT IS INVOLVED IN THE NEXT STAGE(PHASE 2) OF THE ACCREDITATION PROCESS	.165
I SEE ON-GOING INVOLVEMENT IN THE ACCREDITATION PROCESS AS PART OF MY WORK ROLE	.113
I AM HAPPY TO BE INVOLVED AS A TEAM MEMBER IN THE NEXT STAGE(PHASE 2) OF THE ACCREDITATION PROCESS	.410
I WOULD WILLINGLY SUPPORT COLLEAGUES WHO ARE INVOLVED IN THE NEXT STAGE(PHASE 2) OF THE ACCREDITATION PROCESS	.945
I WOULD ACTIVELY ENCOURAGE COLLEAGUES TO GET INVOLVED WITH THE NEXT STAGE(PHASE 2) OF THE ACCREDITATION PROCESS	.637
CONTRIBUTING TO ACCREDITATION IS EVERYONE'S RESPONSIBILTY	.737

a. Grouping Variable: WILLINGNESS TO BE INTERVIEWED