Hospital Accreditation: What Difficulties Does It Face in Iran?

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Abstract

Introduction: To determine if an established programme is achieving desired goals and objectives, in other words being effective, health-care policy makers need to recognise and cope with its challenges. This paper made an effort to pinpoint the main difficulties which appear on the way to successful implementation of the Iranian hospital accreditation programme, from perspective of hospitals medical and clinical staff, and accreditation authorities.

Material and Methods: applying a qualitative approach, we used semi-structured discussion guide in Focus Group Discussions (FGDs), as well as semi-structured In-Depth Interviews (IDIs) with purposively selected hospitals staff and accreditation programme authorities. Data collection was conducted in Iranian universities of medical sciences from June to September 2014. In order to analyse collected opinions, thematic content analysis was applied independently by two authors.

Findings: In addition to four independent FGDs with 27 participants, conducting seven individual IDIs were enough to reach data saturation. A total of 25 subthemes were emerged under five main themes. Participants were of the opinion that the accreditation problems include fundamental deficiencies in the Iranian healthcare system, poor design of the programme, deficiencies within hospitals, difficulties in surveyors and survey processes and negative impacts of the accreditation on hospitals.

Discussion: difficulties with the accreditation programme arise from a wide variety of sources. Decision-makers' achievements in the desired goals lie on recognizing and resolving them.

Keywords: accreditation, hospital, Iran, quality improvement, Focus Group Interview

1. Introduction

Throughout the world, healthcare industries show a strong tendency to implement Quality Improvement (QI) systems (Shekelle 2002). The necessity of efficiently managing of limited resources is the reason why those QI strategies are being used by healthcare systems (Boulkedid, Abdoul, Loustau, Sibony, & Alberti, 2011; K. Pongphirul, J. Sriratanaban, S. Asavaroengchai, J. Thammatach-Aree, & P. Laoitthi, 2006). One of those strategies is healthcare accreditation programme (Ahmadi, Khoshgam, & Mohammadpoor, 2008; El-Jardali, Jamal, Dimassi, Ammar, & Tchaghchaghian, 2008; Krit Pongphirul, Jiruth Sriratanaban, Santawat Asavaroengchai, Jadej Thammatach-Aree, & Poranee Laoitthi, 2006), which has its own origin from the U.S. (Alexander, 1985; David Greenfield & Braithwaite, 2008), and is defined as "usually a voluntary programme, sponsored by a Non-Governmental Agency (NGO), in which trained external peer reviewers evaluate a health care organization's compliance with pre-established   performance standards" (Rooney & Van Ostenberg, 1999).

Because of its widely used as a QI approach in many countries worldwide, a substantial number of authors have considered the effects of accreditation on healthcare quality and safety. Some studies have demonstrated the positive effects of accreditation on these key areas of healthcare systems (Alexander, 1985; El-Jardali et al., 2008; van Doorn-Klomberg, Braspenning, Wolters, Bouma, & Wensing, 2014). On the other hand, there are also

several studies that are skeptical about its beneficial effects on clinical processes and outcomes (Al Tehewy, Salem, Habil, & El Okda, 2009; Fairbrother & Gleeson, 2000; Heuer, 2004; Kwon et al., 2013; Ng, Leung, Johnston, & Cowling, 2013). For example, Fairbrother and Gleeson (2000) fund high levels of negative feedback on the accreditation among senior clinical and managerial staff at a teaching hospital in Sydney. Moreover, Kwon et al (2013) conducted a survey and showed that accreditation programme have not a noteworthy effect on decrease in inpatient mortality, readmissions and payments.

Regarding the fact that accreditation systems impose considerable costs on healthcare systems (Brasure, Stensland, & Wellever, 2000; Mihalik, Scherer, & Schreter, 2003; Rockwell, Pelletier, & Donnelly, 1993), and also due to these negative feedbacks about accreditation programme, its performance needs to be evaluated in case it may go beyond its initially established goals (Agrizzi, Jaafaripooyan, & Akbarihaghighi, 2010). In years 2012-2013, the Iranian Ministry of Health (MOH) released accreditation programme for evaluating and also improving the performance of hospitals. This study was conducted with the aim of identifying the major difficulties and challenges of hospital accreditation programme in Islamic Republic of Iran.

2. Material and Methods

2.1 Research Design and Setting

Due to the fact that qualitative methods provide an effective way of exploring experience and opinions of people (Huhn et al., 2016), a qualitative, descriptive cross-sectional study was set out between June and December 2014 in the Iranian universities of medical sciences.

2.2 Sampling and Data Collection

Due to the fact that a FGD based method provides a wealth of detailed information and profound insight, experiences and opinions of stakeholders about the challenges of the accreditation programme were collected by means of Focus Group Discussions (FGDs). We also conducted one-on-one semi-structured interviews with stakeholders who were unable to participate in FGDs. Clinical and managerial staff of hospitals and also accreditation managers in offices of Vice-Chancellor in Treatment affair made up the study population. We purposively included those professionals who had active role in implementing the programme. In order to ensure that invited participants had necessary information about the subject, vice-chancellor's office in each university assumed responsibility to invite eligible participants. All the invited were issued by the letter of introduction of the study team and subject.

Discussions were conducted by a moderator (Ph.D. in healthcare management) experienced in healthcare research and administration and a note-taker (M.Sc. student of healthcare management) that were first and correspondent author of the study, respectively. At the time of the study, the moderator was an associate professor at the management and medical information science faculty and was also the president of University of Medical Sciences. The study team developed a discussion guide, which was pilot tested in a research workshop, to structure the meetings (Appendix 1). The facilitator explained the purpose of the study to the participants, asked open-ended questions and encouraged all the participants to explicitly explore topics in-depth at any point of debates. The FGDs were held in quiet university meeting rooms, but interviews took place in participants' workplace.

Conducting four FGDs with 27 participants and seven interviews was enough to achieve data saturation, which means when no fresh opinions or remarks arose from conversations. None of the participants were dropped out. Demographic data of the participants are shown in Table 1.

Table 1. Participants' demographic characteristics

Category	characteristic	N (%)
occupation	Nurse	9(26)
	Physician	4(12)
	Hospital administrative staff	11(32)
	Accreditation body manager	10(30)
gender	male	16(47)
	female	18(53)
Years in practice	5 to 10	3(9)

10 to 15	3(9)
15 to 20	14(41)
20 to 25	7(20.5)
25 to 30	5(14.5)
Over 30 years	2(6)

Discussions were in Persian language and were simultaneously transcribed and audio-recorded. Sessions were continued up to when the same responses were elicited repetitively in the various sessions and among the sessions. To make the debates thought-provoking, participants in each FGD were diverse in terms of gender and occupation.

The number of participants in each FGD was between six and eight persons, and sessions varied in length from 60-90 minutes.

2.3 Data Analysis

To analyze collected data, thematic content analysis was conducted independently by the same two authors. First, in order to immersion in the data, texts were read repeatedly and then fragmented into meaning units related to difficulties facing accreditation and then initial key sub-themes were developed. This process continued until reaching saturation. It was attempted to assign each data into only one sub-theme. Based on similarities between subthemes, main categories were identified. These findings were debated and finally were mutually agreed upon by authors.

2.4 Trustworthiness of Data

In order to raise trustworthiness, member check was used. Therefore, responses were sent back to the several participants and they were asked to approve or modify them.

2.5 Ethical Considerations

Ethical approval for the research was received from Tabriz University of Medical Sciences Research and Ethic Committee (no 5/4/8110) before conducting the research. All the participants gave verbal and written consent for participating in the discussions. They were allowed to withdraw from the study at any time they desired. They also gave their consent to have the interview taped. They were assured of not revealing their identities and dialogue.

3. Results

It should be noted that the presented themes in this paper generally reflect commonly perceived challenges, infrequently described perspectives were also included to avoid missing any important viewpoint. The analyzing process resulted in five main themes and 25 sub-themes as follows:

Theme 1: Challenges associated with the structure of the healthcare system

There was a growing body of opinions among participants in our discussions that showed there are numerous fundamental deficiencies in Iranian healthcare system that not only adversely affect the accreditation programme, but also negatively influence any QI programme that is chosen by the policy-makers. In terms of this main theme, five sub-themes distinguished as follows:

None-market based system

Participants felt that as a result of "not being market-based", the Iranian healthcare system lacks any complete competition among hospitals for improving quality of their services. They believed that hospitals are confident of being funded by the government and do not have to compete with each other for customers. As participant 8 said: *"Only market-based climate forces them (hospitals) to achieve high standards."*

Managerial instability

Participants thought that frequent managerial changes discourage executives from continuing implementation of any programme. As participant 5 put it: *"I think managerial changes in our hospitals are so frequent that there is even no time for managers to actively engage in it."* They also added that under this situation, newly recruited managers will be unaware of the QI programmes.

Temporary QI programmes

According to almost all participants, these kinds of QI programmes have a reputation for being temporary. They all agreed that the MOH has applied different QI systems within last several years, which none of them lasted long. Respondents took the view that the accreditation is a short-lived fad in the MOH. Participant 12 remarked: "*Staff don't seriously consider the approach of programme, seeing it as temporary.*"

MOH's failure to publicise physicians' competence

Most of the participants perceived that due to the profound influence physicians have on policy-making structure of the MOH, it cannot disclose their competence level. Respondents expressed that programmes like accreditation is not able to even examine specialists' competence, let alone publish it. The following quote from participant 19 illustrates this matter: "*because of doctors' political influence, patients are not given even basic information about doctors' competence. As a result, the accreditation makes no sense.*"

Limited power of executives

Participants mentioned that hospitals' managers cannot hold specialists in their executive power to instruct them to comply with accreditation standards. Participant 5 stated his view as follows: "*Physicians have never followed managers' instructions.*"

Theme 2: Challenges associated with the design of the accreditation

In this study, five sub-themes emerged that are directly relevant to the design of the accreditation programme itself.

Unfair design

We received some complaints that the current evaluation system is grossly unfair. Fundamental differences among hospitals, that certainly affect the compliance of the hospitals with the accreditation standards, have not been taken into account. Participant 2 confirmed that "*The resources that public and teaching hospitals may have, are not available to others.*" In participants view, this accreditation system will be to the disadvantage of poor and small hospitals.

Excessive emphasis on documentation

Participants thought that an inordinate emphasis is being placed on documentation of accreditation-related tasks, while real clinical aspects and performance related outcomes are not considered. Participant 6 elaborated: "*Given that the main focus is on documentation, hospitals only provide relevant documents to achieve perfect score.*"

Measures and standards

The common perception among the respondents was the fact that numerous measures and standards make the accreditation too complex and time-consuming both for staff and surveyors. Participant (5), who was a surveyor, stated his experiencethat "*One day I wanted to investigate one unit throughly. (…) it lasted until the evening.*"

Another concern expressed in this regard was repetitiveness of measures and standards.

The next very important issue was about the almost equal weight of factors with different levels of importance. The participants highlighted that policy-makers need to prioritize them. Participant 12 talking about the importance of prioritizing accreditation standards and measures said: "*You know the most important element in ICU is the presence of resident physician which affects the overall performance. In accreditation, however, Policy writing and presence of resident physician bare the same weight and value. This is totally wrong.*"

Incompatibility

It was perceived that the programme is modeled strictly based on foreign health systems and have not been adopted to the Iranian health system context. Participant 6 expressed the following: "*weaknesses of the programme weren't identified by policymakers. This is exact copy of foreign ones.*"

Dependency on the Ministry of Health

Participants thought that MOH acts in both service provider and service assessor roles. They viewed this as inconsistent with the principle of external assessment approach. Participant 25 commentedthat "*It makes no sense that Ministry of Health grades itself. This will cause some obvious bias.*"

Theme 3: Hospital-level difficulties

This theme reflects the opinions that there are several problems in hospitals that severely affect the accreditation programme. Under this theme, six sub-themes appeared as follows:

Man power shortage in hospitals

In the opinion of the participants, hospitals' workforce is insufficient, and with this limited workforce hospitals are hardly able to provide all necessary patients cares, let alone execute this intensive programme completely. This can be seen in the following quote from participant (14): *"To put this new programme into practice, hospitals are in urgent need of new human resources."*

Resistance against change

Participants stated that, inevitably, employees would resist against any changes like the accreditation that was made in their routine. Participant 5 said: *"We've seen a lot of resistance from many staff members."*

Low participation of non-nurse staff:

Almost all participants disliked the issue of low participation level of non-nurse staff. They reported that each QI programme involves only nursing staff. This is while other employees, especially physicians play no role in it. Participant 4 believed: *"They (physicians) just wait on the sidelines"*. Participants also pointed out that there is a wrong attitude that quality improvement unit is the only responsible unit for improving quality of services.

Lack of managers' commitment

Almost all stakeholders highlighted that managers are not eager to participate in the accreditation. The following comment from participant 6 makes it clear that hospitals' managers do not fully cooperate in implementing the programme: *"They (managers) sometimes even refuse to provide necessary workshops on the accreditation topics."*

Besides to the participants' belief on low commitment among hospital managers, they emphasised that senior managers of MOH and universities of medical sciences also do not demonstrate enough commitment to the programme. Participant 15 expressed the following: *"This meeting should have been arranged by ministry (of health) to hear us out. This is a vivid sign of lack of commitment."*

Poor training of hospitals staff and executives

Stakeholders believed that staff and also hospital managers lack both academic and in-service training related to the programme. Participant 15 elaborated: *"Staff don't know anything about what they should do."* In this regard participant 2 also commentedthat *"Managers have no idea about what they really should do."*

Copying off the documents

The fact that hospitals just illegally copy the documents from each other was repeatedly mentioned as a hurdle. They believed this is because of undue emphasis that is placed on documentation. Participant 24 said: *"One of the colleagues told me that: we have twenty copies of your documents. My mind is calm about obtaining full marks."*

Theme 4: Challenges associated with Surveyors and survey process

Stakeholders in this study mentioned some obstacles to the programme that are directly related to surveyors and survey process as follows:

Intermittent surveys

Participants remarked that in the accreditation, hospitals are surveyed intermittently instead of continuously. So, hospitals get ready for reviews merely in few days prior to it .Then after completing the survey, hospitals will be continuing their old routine. Participant 16 narrated as follows: *"In this intermittent system, all accreditation-related activities will be ceased after the completion of survey till next phase begins."*

Shortage of surveyors

  Participants thought that recruited surveyors in the accreditation are insufficient. Therefore, surveyors have little time to spare for assessing hospitals performance and documents. Participant 21 said: *"I think that the big problem of surveyor shortage, we face in this programme, is causing limited time for the surveyors to do well."*

Insufficient surveyor training

The view that surveyors are not given adequate training is commonly held by our respondents. Training courses for surveyors were too small in number and provided just before the programme commenced. They reported that even senior surveyors have not competence with the programme. Participant 23 stated: *"The only response they (senior assessors) give our questions is "I'll get back to you.""*

Superficial surveys

One of the repeatedly raised concerns was the fact that assessors do not examine documents thoroughly and only go over casually. Participant 4 said: *"Assessors give only brief glance over provided documents."*

Inadequate reliability

The majority of participants had little belief in reliability of the accreditation surveys, because they believed that in the accreditation reviews, appraisers assess each item from their own professional viewpoint. Participant 10 said: *"We are faced with inconsistency between assessors."*

Survey protocol

Describing the reason for the lack of reliability, one stakeholder said that detailed and practical guidelines were not given to surveyors. He was of the opinion that existing guideline is complicated and ambiguous. Participant 24: *"They (assessors) have not been given necessary guidelines and work protocols."*

Theme 5: Negative impacts on hospitals

Under this theme, three sub-themes emerged that describe the disadvantageous outcomes resulted from implementing the accreditation programme as follows:

Additional costs of the accreditation

Participants disapproved the costs that the accreditation programme incurs on hospitals. Participant 4 doubted if its benefits outweigh the costs in the long run: *"Have we reached any achievement without high costs being incurred? – no way!"*

Intense stress for staff

This was also a matter of concern that the accreditation puts considerable stress on staff, especially clinical staff. Hospitals' staff are worried about losing marks for poor documentation. Participant 21 said: *"The only result of this (programme) was staff suffering from stress."*

Additional staff workload

Respondents believed that the accreditation merely adds to personnel workload, especially for clinical staff. Increased workload gives rise to difficulties of staff shortage, and consequently, they disregard other essential tasks in order to prepare for review. Participant 13 said: *"I think if it goes on like this, quality of care will get worse and worse rather than the better"*.

4. Discussion

Using FGDs and interviews, this paper identified major difficulties and challenges facing the Iranian accreditation programme in different areas, from healthcare providers' and accreditation administrators' perspective. These FGDs' sessions made an opportunity for face to face interactions among the invited stakeholders. The results of this study that validate and augment on what has been found by other related studies, may be pertinent to other countries implementing healthcare evaluation systems.

Firstly, this study showed that the Iranian healthcare system is facing several structural issues that seriously affect the accreditation. As the most important disadvantage, Iranian healthcare system is not based on market. In this status, hospitals feel no need to get quality licences such as accreditation, and they would only adopt a passive role in QI programmes. Although, this finding differs from one published study by Devers, Pham, and Liu (2004) that found regulatory bodies (such as MOH), and not market forces only, have the most important impact on hospitals' effort to improve healthcare quality. Additionally, hospital managers have almost no power over physicians which makes it difficult to apply the programme. A recent study (von Knorring, de Rijk, & Alexanderson, 2010) suggested that this might be because physicians have high standing in healthcare systems' decision making structure. Chronic managerial instability is another contextual factor that was declared as a major hindrance to the QI efforts. But most importantly, participants perceived that policy-makers have second thoughts about the chosen QI strategies, and this status has served as a disincentive for hospitals staff to involve in them. In addition, they thought that Iranian health system has failed to give public recognition of good medical service providers due to structural deficiencies.

There are also a number of deep deficiencies in structural features of the accreditation. Accreditation is foreign in nature and needs to be tailored to the local situation. This finding corresponds closely with what other authors discovered that there is a critical need for alignment of standards with MOH (Bateganya, Hagopian, Tavrow, Luboga, & Barnhart, 2009). Our respondents also noted that the accreditation is an unjust system, because it does not treat different hospitals fairly. They believed that the programme designers should have taken into account differences which are beyond the control of the hospitals. The fact that the accreditation survey results are

heavily biased towards universities' hospitals was expressed as an important challenge too; because an independent organization was not identified as accreditation body. In other studies, this issue of Ministry of Health involvement has been seen as a paradox (Pomey, Francois, Contandriopoulos, Tosh, & Bertrand, 2005) and as a control knob to policy-makers (Nandraj, Khot, Menon, & Brugha, 2001). In regard to the accreditation structure, excessiveness and repetitiveness of measures and standards was mentioned as a big problem. As other studies revealed (Ammar, Wakim, & Hajj, 2007; Shekelle, 2002), the accreditation structure also has a major drawback of using structural and process-based standards rather than performance-based ones, that is far from patient-centered approach. The use of structural criteria is not a disadvantage, but a full concentration on them is.

There are also some difficulties that occur within hospitals. The most important one is the shortage of clinical labour that hinder the implementation of the programme (Bateganya et al., 2009; K. Pongpirul et al., 2006). As well as the study of NG et al (2013), resistance to the change among the personnel was considered to be impediment to the programme's success. Low participation of hospital departments, except nursing, is another important hospital-level obstacle. Physicians especially, do not involve themselves in the QI programmes and as outlined in a commentary by Shekelle, this will continue until they can notice its practical benefits (Shekelle, 2002). Moreover, it was seen as a serious problem that hospitals staff, particularly executives, feel no obligation to implement the accreditation. Furthermore, deficiencies of the accreditation-related training courses for staff and also executives were seen as an important constraint to the programme. Hospitals also duplicate each others' accreditation-related strategies and documents.

The accreditation situation is complicated by several factors related to its surveyors and survey processes. First of all, accreditation surveys are conducted intermittently, which reduce continuance of the QI activities (Lewis, 2007). In this regard, a qualitative study by Walshe, Wallace, Freeman, Latham, and Spurgeon (2001) showed that rarely are the written portfolios and documents established after conducting accreditation process. We also found that the surveyor shortage of the programme causes multidimensional negative effects on its progress. One of these negative outcomes is the issue that surveys are carried out incomplete and cursory. The survey results, therefore, is not a true picture of what the actual situation is (Walshe, Wallace, Freeman, Latham, & Spurgeon, 2001). Although working as a surveyor requires a certain amount of knowledge and skill, these limited number of hired assessors had received no practical trainings, which has been pointed out by previous studies (Alexander, 1985; D. Greenfield, Pawsey, Naylor, & Braithwaite, 2009). The most serious setback that was considered in this regard, however, is inconsistency among surveyors in interpreting measures and criteria. Our findings also showed that without a standard guideline for assessors, the surveys would not be successful.

In the opinion of the accreditation stakeholders, the accreditation programme poses some considerable additional difficulties to the healthcare system and hospitals as well. One of these problems which was also reported in several other works is the increased assigned work involved in producing the evidences. This additional workload itself leads personnel, especially nurses, into high stress that is affiliated with compliance efforts (Bateganya et al., 2009; Fairbrother & Gleeson, 2000; D. Greenfield, Pawsey, & Braithwaite, 2011; Montagu, 2003; Touati & Pomey, 2009). Accreditation also adds to high costs of hospitals (Brasure et al., 2000; Mihalik et al., 2003; Rockwell et al., 1993). For example, Rockwell et al (1993) carried out a survey to estimate the costs of getting ready for and undertaking the 1989 accreditation survey and found this amount to be about 1 percent of the hospital's operating budget for that same year.

4.1 Study Limitation

Leaving aside the fact that we reached data saturation in our discussions, we consider that additional stakeholders need to be involved in discussions.

5. Conclusion

This study and also several other works already raise some concerns for stakeholders involved in accreditation programme. Our FGDs sessions made it clear that in this situation, patients and society, the end users of any healthcare programme, will not benefit. It is necessary that involved policy-makers should be aware of these challenges, discuss and finally overcome these issues.

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Competing Interests Statement

The authors declare that there is no conflict of interests regarding the publication of this paper.

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Appendix 1

Focus Group Discussion Guide

Introduction: We should like express our thanks for all of you for taking your time with us. I am Dr. Ali Janati and my assistant is Reza Ebrahimoghlu. Our research team conduct these Focus Group Discussion sessions with both hospital staff and the accreditation programme managers as part of a master's dissertation project at the Tabriz University of Medicine Science. As you were informed earlier, the main purpose of this convening is to identify the key issues that adversely affect the Iranian Hospital Accreditation Programme which make it difficult to achieve its major goals.

Before we start discussions, it would be better to have a look at the **ground rules** of the FGD sessions:

✓　The most principal rule is that merely one participant talks at a time.

✓　We do not seek right answers. We want you to express your real opinions and experiences related to the subject.

✓　There is not any particular order to speak.

✓　Please let us to hear what things you want to say. We want you to trust us.

✓　It is very important to us to obtain more and more opinion pieces.

✓　Does anyone questions?

Please complete these demographic forms (appendix 2) and let's begin.

Opening question:

You were given a couple of minutes to think and tell us what is the importance of an effective evaluation programme within the health systems?

Body questions:

What is the accreditation programme?

What are the main goals that healthcare policy makers are seeking in implementation of the accreditation programme?

Is the accreditation programme reach these goals?

What are your thoughts and opinions on the challenges and difficulties that are major hindrances to achieving these goals?

Concluding statement:

I will read you a quick and precise note of what you articulated in this FGD related to barriers that adversely affect the programme. Please listen carefully and see if there is anything you didn't mentioned during the discussion.

We would like to thanks you again for your time today.

God Lock!

Appendix 2

Demographic form

date/　　/　　　　　　　　　session …. of FGD/IDI						
demographic information						
first name	last name	occupation	years in service	phone number	Email	sign