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Tools to Conduct Healthcare

Accreditation Research

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Centre for Clinical Governance Research

Australian Institute of Health Innovation



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1. Tools to Conduct Healthcare Accreditation Research

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1 ABBREVIATIONS

ACHS	Australian Council on Healthcare Standards
CCGR	Centre for Clinical Governance Research at University of NSW
EQuIP	Evaluation and Quality Improvement Program
UNSW	University of New South Wales

2 EXECUTIVE SUMMARY

Beginning in 2001, a partnership between researchers at the University of New South Wales and the Board and staff of the Australian Council on Health Care Standards was formed with the aim of conducting a series of studies into accreditation. The collaboration secured an Australian Research Council Linkage grant to implement the studies during 2005-2008 [Braithwaite et al., investigators and research staff, Australian Research Council grant LP0560737, 'A prospective, multi-method, multi-disciplinary, multi-level, collaborative, social-organisational design for researching health sector accreditation'.] The ACHS Evaluation and Quality Improvement Program (3rd edition) was used as an exemplar for the research. The findings have been presented at Australian and international seminars and conferences, and published in the academic literature. This report presents the rationale, understandings, methods and tools that were used to conduct the research studies.

3 THE RESEARCH COLLABORATION AND PURPOSE

3.1 The research collaboration

A collaborative research partnership was established by Professor Jeffrey Braithwaite, Centre for Clinical Governance Research (CCGR), University of New South Wales (UNSW), and Mr Brian Johnston, Chief Executive, the Australian Council on Healthcare Standards (ACHS) in the early 2000s. The collaboration was designed to build capacity for research into accreditation and over a four year period industry and academic interests were translated into research questions. The ACHS Evaluation and Quality Improvement Program (3rd edition) (EQuIP) was used as an exemplar to examine accreditation. Funding, in the form of an Australian Research Council Linkage Grant [LP0560737, 'A prospective, multi-method, multi-disciplinary, multi-level, collaborative, social-organisational design for researching health sector accreditation'], was received in late 2004. The study was conducted across four years, from 2005–2008. The necessity for research into accreditation has been argued by the collaboration (Braithwaite et al. 2008, 2010; Greenfield and Braithwaite 2008, 2009; Greenfield et al 2008a, b; 2009b, e; Lancaster et al. 2010; Nathan et al. 2008).

The inclusion of different interests and needs of the various stakeholders reinforced the collaboration and contributed to the progression of the research from idea to reality. The process of building and enacting the research capacity has been detailed previously; see Greenfield et al. (2007; 2009a). Preparedness and persistence to evolve the collaboration and the display of distributed leadership were necessary for the research to be successful. The inclusion of the ACHS executive as part of the research team was instrumental in enabling the research. Their participation engaged the organisation and its member health services to facilitate the implementation of the studies. The research questions, rationale, approach utilised and tools developed for the studies are products of this collaborative context.

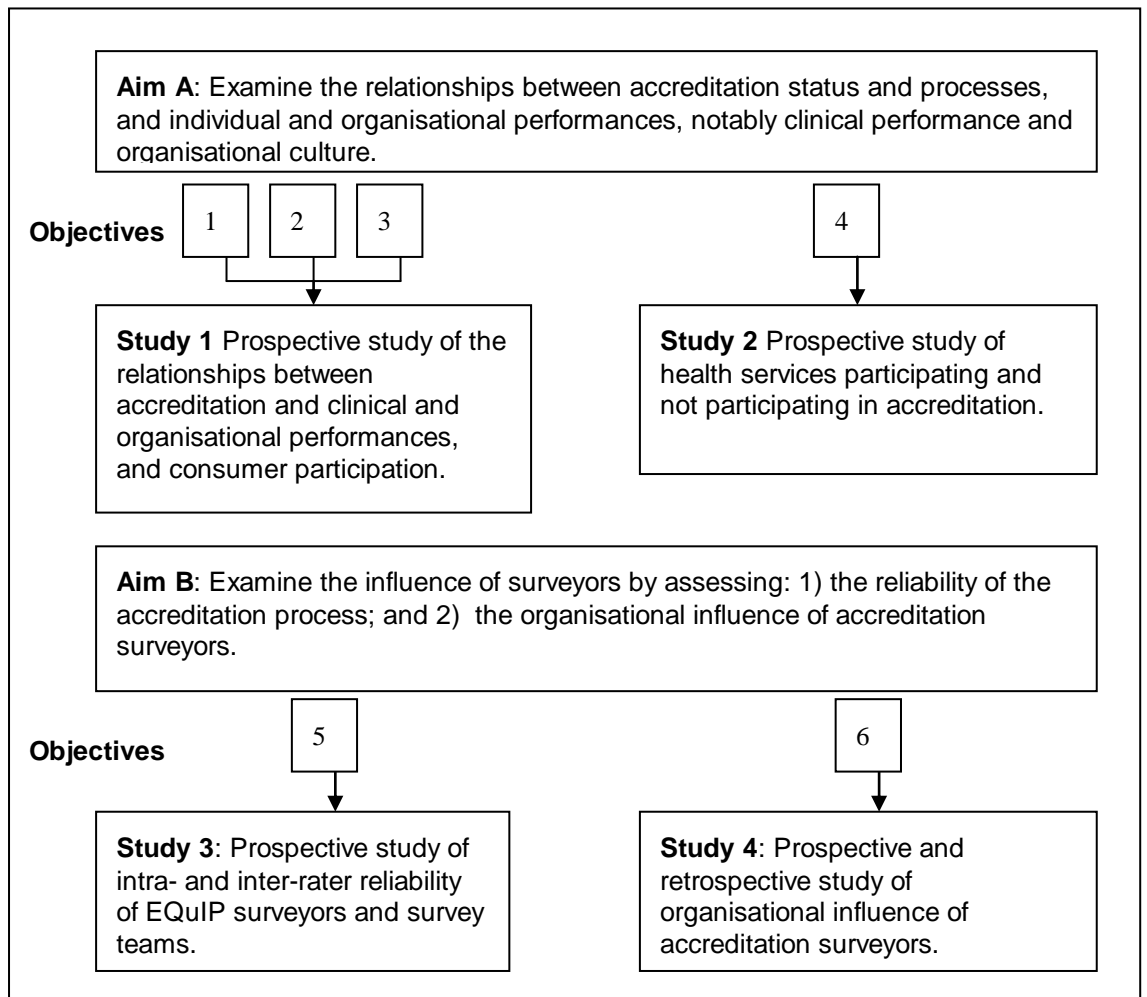
3.2 The research aims, objectives and studies

The collaboration developed a research program, published as a study protocol; see Braithwaite et al. (2006). The research program comprised two aims and six specific research objectives; see table 1. The relationships between the aims, objectives and studies are displayed in figure 1 below.

Table 1: Research aims and objectives

Research Aims	Objectives
Aim A: Examine the relationships between accreditation status and processes, and individual and organisational performances, notably clinical performance and organisational culture.	1. To determine whether there is a relationship between accreditation status (as measured by EQUiP) and organisational cultural characteristics.
	2. To assess the relationship between accreditation status and clinical performance.
	3. To analyse the associations between consumer participation, accreditation status and organisational cultural characteristics.
	4. To evaluate the relative performance, on quality of care measures, between health services participating in and not participating in accreditation.
Aim B: Examine the influence of surveyors by assessing: 1) the reliability of the accreditation process; and 2) the organisational influence of accreditation surveyors.	5. To appraise the intra- and inter-rater reliability of EQUiP surveyors and survey teams.
	6. To examine the relationship between accreditation status, clinical performance, organisational cultural characteristics and the number, network influence and characteristics of surveyors.

Figure 1: Schematic of the proposed research design



4 RESEARCH METHODS AND TOOLS

The research program comprised four studies. Study 1 investigated relationships between accreditation and clinical and organisational performances, and consumer participation. Study 2 was an examination of health services participating and not participating in accreditation. Studies 1 and 2 were linked to the same aim and overlapping in their focus, thus enabling the methods and tools developed for study 1 to be utilised for study 2. Study 3, which scrutinised intra- and inter-rater reliability of EQulP surveyors and survey teams, had a specific set of methods and tools developed for it. Similarly, the methods and tools for study 4, which explored the organisational influence of accreditation surveyors, were purpose developed. The methods and tools for the four studies are detailed below.

4.1 Study 1 and 2: Investigating relationships between accreditation and clinical and organisational performances, and consumer participation

4.1.1 Sampling strategies

The sample for study one was determined using a six step process; see figures 2-4. Steps one to three involved a structured sampling frame to identify appropriate health services from which a random sample for each jurisdiction would be drawn (figure 2). The division of the sample of health services into the selected Australian health jurisdictions (States and Territories) was step four (figure 3). Step five and six were the stratifying of each jurisdiction by health service size – large, medium or small, and a sample (a maximum of 3 from each State) was then randomly drawn (figure 4). Thus, the combined sample would comprise a maximum of 21 health services (seven jurisdictions x three health service sizes).

Figure 2. Step 1-3: process to identify the appropriate sample from which to draw the random sample.

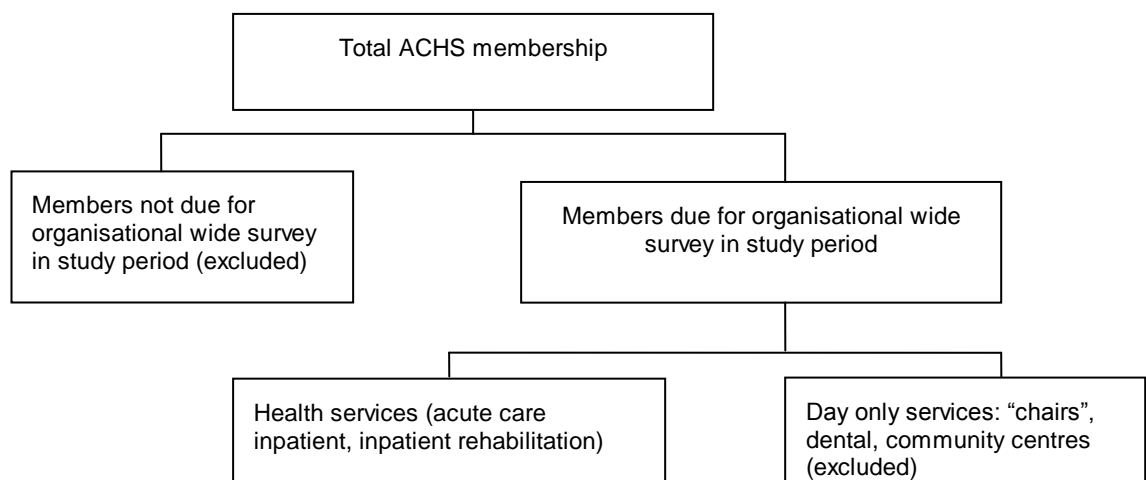


Figure 3. Step 4: stratification of sample by jurisdiction

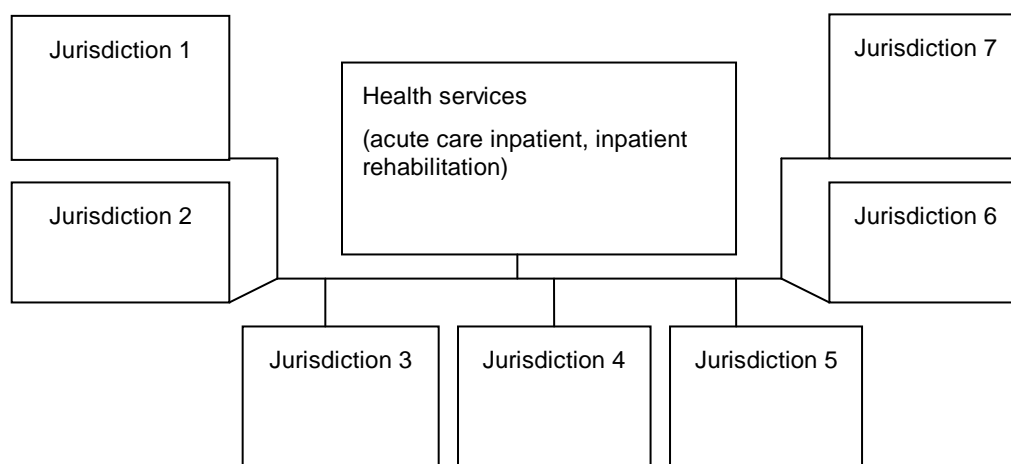
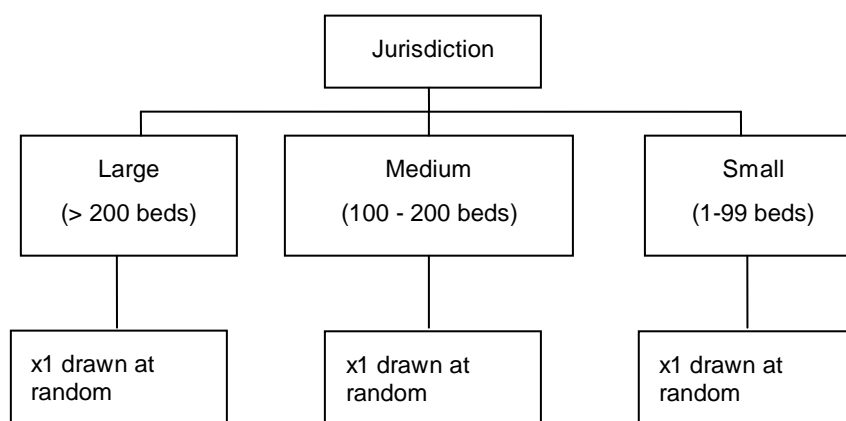


Figure 4. Steps 5 and 6: randomised jurisdiction sample stratified by size.



Study two was an examination of health services participating and not participating in accreditation. This required identifying and enrolling organisations that had not participated in an accreditation program and matching them, as closely as possible according to size and location, to organisations in study one. In Australia, which has a mature accreditation program for health organisations, this was a difficult challenge because most organisation participate in accreditation. The study participants became three matched pairs or six health organisations.

4.1.2 Evaluating accreditation performance

The accreditation performance for organisations was determined from the ratings they had been given by the ACHS survey teams. The ratings are categorical data which were transformed into numerical data by the research team. This enabled ranking of the health organisations, from highest to lowest. The ACHS survey teams rated each organisation using the EQUiP criterion and rating scale. EQUiP (3rd edition) is comprised of 19 mandatory and 24 non-mandatory criteria. Mandatory criteria are

those issues that organisations must perform well on, that is achieving a surveyor rating of moderate achievement or better, if they are to receive accreditation. The scale has five options: little achievement (LA), some achievement (SA), moderate achievement (MA), extensive achievement (EA) and outstanding achievement (OA). This scale, while effective for the purposes of ACHS, was not sufficient for the research study. Organisations with similar ratings could not be distinguished from one another. The UNSW research team developed a tool to address this issue - the 'Accreditation Research EQUiP Rating Form' (ARERF); see appendix 1. The ARERF, similar to the EQUiP, employs a five point scale; 1 represents a minimal meeting of the criteria through to 5 which represents strongly meeting the criteria. The combined use of the two tools enabled the survey teams to rate each criteria very specifically. For example, a standard could be rated as a MA 2 or MA 5, rather than just MA.

To create the categorical data from the EQUiP results, the LA to OA scale, were translated into a five point scale, from 1 to 5. Similarly, the data from the ARERF were assembled. An ARERF percentage figure was determined because the ARERF are designed to separate out the performance of different organisations relative to one another. The five point scale equates to numerical data as follows: 0.0 for 1, 0.2 for 2, 0.4 for 3, 0.6 for 4 and 0.8 for 5. For each standard the two figures were combined to give a score, for example an MA 2 equates to 3.2 and an MA 5 becomes 3.8. For each organisation the scores for the 43 criteria were summed to give their final result. The ordered list for EQUiP performance, or accreditation performance, was achieved by ranking the overall score for each individual organisation. The method for evaluating accreditation performance and results using this tool have been published and presented at international conferences – see Braithwaite et al. (2010) and Greenfield et al. (2009b).

4.1.3 Examining clinical performance

Clinical indicator data are provided by organisations to ACHS as part of their normal participation in the accreditation program. As a component of the accreditation process, organisations collect clinical indicator data and report these every six months. Organisations can select which indicators they will monitor from a pre-set list with associated measurement definitions provided by the ACHS. The ACHS provided the data to the research team. The clinical indicator data, corresponding to the time period for accreditation, were used to assess the relative clinical performance of the accredited organisations. In this case the indicator data between 2001-2005 were examined and performance on each indicator averaged across the five years. Clinical indicator data derived from all other accredited organisations in Australia were analysed in order to determine the national average performance on each clinical indicator for the 2001-2005 period. The clinical indicator performance of participating organisations was then compared against the national average performance for each indicator collected; if the outcome observed was better than the expected, it scored a "1", and if worse a "0". Organisations were subsequently ranked according to their proportion of clinical indicators that were better than the national average.

4.1.4 Investigating organisational performances

The research team examined the accreditation, organisational and health services literatures to identify significant topics related to organisational performance and accreditation. Ten issues were selected and conceptual understandings of these were created; see appendix 2. The issues are: organisational culture and organisational climate; staff well-being; communication; team climate; decision making; leadership and management; standard of care, quality and safety; consumer participation; and clinical indicators. Five of these issues – that is, staff well-being, communication, team climate, decision making and, standard of care, quality and safety – were combined together to construct the topic of ‘organisational culture’. This topic, along with organisational climate, leadership, and consumer participation became the four dimensions by which to investigate organisational performance.

Data relating to organisational culture, leadership and consumer participation topics were collected via interviews. The research team constructed a set of ‘guiding questions’ to examine each topic/issue. Together they were collated into one document to create an ‘Interview Book’; see appendix 3. The interview book was designed, piloted, revised and subsequently used across all organisations. Researchers who conducted interviews were trained in the use of the interview book. The book enabled the research team to conduct semi-structured interviews. This means, while substantially followed, the order of the topics and guiding questions for each interview was not prescriptive. The researcher had the freedom to cover the themes by following the direction and pace of the person(s) being interviewed. As necessary the questions were rephrased to suit the wording of the different researchers and participants, including using examples tailored to suit specific interviews. The prime focus was the topics not the particular wording of questions. Interviews were with a cross section of staff, including senior executives, managers, clinicians, administrative and corporate services staff. Individual and group interviews were carried out, depending on the position(s) of the individuals involved. Focus group interviews comprised staff in similar positions or roles, for example managers or clinicians but not together. The rationale for this was it would allow staff to speak more freely about organisational issues. In general, individual interviews lasted for one hour and focus groups for up to one and a half hours. All were conducted in an open manner; there was no attempt to hide the data collection and responses were hand written in the book.

Data relating to organisational climate were collected through observation. An ‘observation book’, equivalent to the interview book, was similarly developed, piloted, refined and then used across all organisations; see appendix 4. The observation book outlined the list of topics which structured and standardised the researchers’ observations of each organisation. Observations were carried out over the course of the visit period. The observations ranged from an hour through to three hours in a location. The observation sites included the hospital entrance, a ward, accident and emergency department, and the (staff) cafeteria. Hand written field notes were collected in an open visible manner. At no time did any researcher participate in delivering care to patients.

To collect the data, research teams, blinded to the accreditation results, visited each organisation. Research resources allowed for each visit to last for up to one week. Timetables, with interviews and observational periods, were negotiated through quality managers from the organisations. Following the visit, interview and observational field notes were transcribed and collated into the one document for each organisation.

Four separate, blinded expert panels, each with three panelists, were established to review the organisational culture, organisational climate, leadership, and consumer participation data. Panel members, blind to the accreditation and clinical performance data, assessed the organisational field notes. The RAND-UCLA phased method for analysing social data was used (Fitch et al., 2000). A similar process has been utilised in other research (McGory et al. 2006; Samama et al. 2006; Verkerk et al. 2006). Each panel member individually rated the organisations on their variable from highest to lowest. Members of each panel met and reconciled individual rating differences, creating a composite ranking.

4.1.5 Analysis of accreditation, clinical and organisational performances data

The research team collated the rankings for accreditation, clinical and organisational performances, and consumer participation for analysis. Relationships were examined through the application of four tests: Spearman's rank order correlations (ρ); Kendall's coefficient of concordance (W); the Mann-Whitney U test; and Kruskal-Wallis one-way analysis of variance. Spearman's rank order correlations were calculated between accreditation performance and clinical performance scores and the four other organisational variables. Rank order correlations were calculated between the organisational variables to determine their relationships to each other. Kendall's coefficient of concordance was computed to examine whether there was a significant relationship overall between the set of ratings of the five variables. The association of demographic variables (organisational size, health sector and geographic location) with accreditation ratings was investigated using the Mann-Whitney U test and Kruskal-Wallis one-way analysis of variance. Results from the studies have been published and presented at international conferences – see Braithwaite et al. (2008a, b; 2010), Greenfield et al. (2009b, c), Nathan et al. (2008) and Pawsey et al. (2007).

4.2 Study 3: Examining intra- and inter-rater reliability

The examination of intra-rater reliability necessitates a number of different and overlapping approaches. We report five strategies that were used to investigate the issue.

First, the research team undertook direct observation of an accreditation survey team *in situ*. To examine a survey team *in situ* the research team identified three criteria: a team with a minimum of three members (to see individual surveyor behaviour and

survey team interactions); an organisation that would consent to the accompanying researcher; and, researcher availability to undertake the observation. A researcher attended an accreditation survey and monitored individual surveyor and team behaviour to examine how they conducted their assessments. An open approach to the observation was taken, with the researcher recording the actions and behaviours of the surveyors. The analysis and categorisation of the data resulted in the construction of a surveyor styles typology – see Greenfield et al. (2008a).

Second, the research team carried out interviews and a survey with accreditation stakeholders about the issue of reliability. The ACHS surveyor workforce and personnel were invited to participate. Unstructured individual and group interviews were held to examine experiences, and structures and processes that promoted, or undermined, reliability in accreditation. To initiate discussion two questions were put to participants: What do you think influences the reliability of the accreditation process? What do you think influences the reliability of the surveying teams? A survey, using open ended questions based on a thematic analysis of the interview data, was distributed electronically to ACHS member organisations; see appendix 5. Results from the study have been published and presented at international conferences – see Braithwaite et al. (2008a, b) and Greenfield et al. (2008c; 2009c, d, e, g).

Third, a scenario exercise was conducted to examine inter-rater reliability. Scenarios, comprising written information and role plays, focusing on individual criteria were developed by the research team in collaboration with EQuIP members, surveyors and ACHS staff. See appendix 7 for an example of a scenario. The exercise was facilitated by the research team with selected surveyors acting out the scenarios to their colleagues. Surveyors voluntarily attended a workshop and were randomly allocated to teams and presented with the scenarios. Each team, using EQuIP (3rd edition), then discussed and rated the scenarios. Collectively the teams reviewed their ratings and decision making processes. The outcomes from the study have been presented at international conferences – see Braithwaite et al. (2008a, b) and Greenfield et al. (2008c, 2009c, d, f, g).

Fourth, a scenario exercise to investigate intra-rater reliability was performed. The research team drew upon ACHS records to develop matched pairs of case scenarios, focusing on individual EQuIP standards; the matched scenarios differed only in non-significant details. See appendix 6 for an example of a matched scenario pair. Using a web-based survey the first scenario of each pair was assessed by the ACHS surveyor workforce using the EQuIP rating scale; the second was then assessed three months later. The outcomes from the study have been presented at international conferences – see Braithwaite et al. (2008a, b) and Greenfield et al. (2008c, 2009c, d, f, g).

Fifth, an observational study of two teams surveying the same organisation was undertaken. The research team, participating organisation and ACHS negotiated a study protocol; see appendix 8. The protocol defined expectations, conduct prior to, during and post survey, and decision and information sharing processes. The accreditation, organisational and team working literatures were examined to identify issues for exploration in this study. The issues were collated and structured into books to standardise observations and interviews with organisational staff. The research

team piloted and revised the books prior to their finalisation; see appendix 9. Three researchers accompanied the teams during the survey. A researcher was allocated to each survey team and completed hand written field notes of observations. Additionally, the research coordinator liaised with the teams and interviewed organisational staff about their survey experiences. Field notes were electronically transcribed and collated for analysis. Study findings have been presented at international conferences – see Braithwaite et al (2008a, b) and Greenfield et al. (2009c, f, g).

4.3 Study 4: Probing surveyor organisational influence

An in-depth case study methodology has been used in study four. That is, a small sample of surveyors was selected for a detailed investigation of their organisational influence. The study examined and contrasted the perceptions of surveyors, and their colleagues within their organisation's socio-professional network, about how surveying experience influences quality and safety issues in their organisation. Participants were chosen according to three criteria. First, they have significant surveying experience, defined as a minimum of ten surveys. This was to allow a period of time and number of surveys for their surveying experiences to develop. Second, the surveyor needed to have their regular professional occupation as a senior executive in a health service, and therefore have the capacity to influence both organisational and clinical areas. Third, limited study resources required that the surveyors be easily accessible to the research team. Probing surveyor influence has been undertaken through the use of in-depth interviews. The accreditation, networking and quality and safety literatures were examined to identify issues for exploration. The questions were collated and structured into a book to standardise the interviews; see appendix 10. Using the book individual surveyors and their colleagues were interviewed and field notes recorded. The data have been subject to analysis using the 'framework approach', as detailed by Pope et al. (2000). Initial results have been published and presented at an international conference – see Lancaster et al. (2009; 2010).

5 CONCLUSION

The CCGR and ACHS collaboration successfully conceptualised, designed and implemented a program of accreditation research. The results from the collaboration's four studies, published and presented to international audiences, have added significantly to the evidence base for accreditation. This report has outlined the approach and tools used in the studies. In doing so, we make them available to other researchers and collaborations.

6 REFERENCES

- Braithwaite, J., J. Westbrook, M. Pawsey, D. Greenfield, J. Naylor, R. Iedema, B. Runciman, S. Redman, C. Jorm, M. Robinson, S. Nathan and R. Gibberd (2006). "A prospective, multi-method, multi-disciplinary, multi-level, collaborative, social-organisational design for researching health sector accreditation." BMC Health Services Research **6**: 113.
- Braithwaite, J., D. Greenfield, B. Johnson, E. Scrivens and C. Shaw (2008a). "Workshop on recent results analysed from large accreditation studies with new research results on accreditation, standards and surveying.", Twenty-fifth International Safety and Quality Conference: Healthcare quality and safety: meeting the next challenges, International Society for Quality in Health Care, Copenhagen, Denmark.
- Braithwaite, J., D. Greenfield, B. Johnston, E. Scrivens and C. Shaw (2008b). "Recent results analysed from large accreditation studies with new research results on accreditation, standards and surveying.", Twenty-fifth International Safety and Quality Conference: Healthcare quality and safety: meeting the next challenges, International Society for Quality in Health Care, Copenhagen, Denmark.
- Braithwaite, J., D. Greenfield, J. Westbrook, M. Pawsey, M. Westbrook, R. Gibberd, J. Naylor, S. Nathan, M. Robinson, B. Runciman, M. Jackson, J. Travaglia, B. Johnston, D. Yen, H. McDonald, L. Low, S. Redman, B. Johnson, A. Corbett, D. Hennessy, J. Clarke and J. Lancaster (2010). "Health service accreditation as a predictor of clinical and organizational performance: a blinded, random, stratified study." Quality and Safety in Health Care **19**: 14-21.
- Fitch, K., Bernstein, S., Aguilar, M., Burnand, B., LaCalle, J., Lazaro, P., van het Loo, M., McDonnell, J., Vader, J. and Kahan, J. (2000) The RAND/UCLA Appropriateness Method User's Manual, RAND Health, Santa Monica CA.
- Greenfield, D. and J. Braithwaite (2008). "Health sector accreditation research: a systematic review." International Journal for Quality in Health care **20**(3): 172-183.
- Greenfield, D., J. Braithwaite and M. Pawsey (2008a). "Health care accreditation surveyor styles typology." International Journal of Health Care Quality Assurance **21**(5): 435-443.
- Greenfield, D., J. Braithwaite, M. Pawsey and J. Travaglia (2008b). "Accreditation literature and research: an overview and significant issues.", Fourth International Conference on Quality in Primary Healthcare - Quality Carnivale, Melbourne, Australia.
- Greenfield, D., Pawsey, M. and Braithwaite. J. (2007) "Mobilising academic, industry and government stakeholders in collaborative research partnerships for improved patient safety through accreditation research.", Proceedings of the Patient Safety Research Conference: Shaping the European Agenda: #52, Porto Portugal, 24-26 September.
- Greenfield, D., M. Pawsey, J. Naylor and J. Braithwaite (2008c). "Improving the reliability of an accreditation program: using research to educate and to align practice.", Twenty-fifth International Safety and Quality Conference: Healthcare quality and safety: meeting the next challenges, International Society for Quality in Health Care, Copenhagen, Denmark.

Greenfield, D. and J. Braithwaite (2009). "Developing the evidence base for accreditation of healthcare organisations: a call for transparency and innovation." Quality and Safety in Health Care **18**(3): 162-163.

Greenfield, D., J. Braithwaite, M. Pawsey, B. Johnston and M. Robinson (2009a). "Distributed leadership to mobilise capacity for accreditation research." Journal of Health Organisation and Management **23**(2): 255-267.

Greenfield, D., M. Pawsey and J. Braithwaite (2009b). "Are accredited organisations different from those not accredited.," Bridging the gap: The Seventh Australasian Conference on Safety and Quality in Health Care, Australasian Association for Quality in Health Care, Sydney, Australia: 7-9 September.

Greenfield, D., M. Pawsey and J. Braithwaite (2009c). "Maintaining the standard: what are the options?," ISQua 2009, Twenty-sixth International Safety and Quality Conference: Designing for Quality, International Society for Quality in Health Care, ISQua Accreditation Symposium, Dublin, Ireland: 11-14 October.

Greenfield, D., M. Pawsey, J. Braithwaite and H. McDonald (2009d). "Intra-rater reliability: to what extent does this hold amongst accreditation surveyors?," Bridging the gap: The Seventh Australasian Conference on Safety and Quality in Health Care, Australasian Association for Quality in Health Care, Sydney, Australia: 7-9 September.

Greenfield, D., M. Pawsey, J. Naylor and J. Braithwaite (2009e). "Are healthcare accreditation surveys reliable?" International Journal of Health Care Quality Assurance **22**(2): 105-116.

Greenfield, D., M. Pawsey, J. Naylor, H. McDonald and J. Braithwaite (2009f). "Designing quality in accreditation programs by researching the reliability of survey teams: lessons learnt when things went awry.," Twenty-sixth International Safety and Quality Conference: Designing for Quality, International Society for Quality in Health Care, Dublin, Ireland: 11-14 October.

Greenfield, D., M. Pawsey, J. Naylor, J. Travaglia and J. Braithwaite (2009g). "Designing quality into healthcare accreditation surveyor performance: strategies for professional development.," Twenty-sixth International Safety and Quality Conference: Designing for Quality, International Society for Quality in Health Care, Dublin, Ireland: 11-14 October.

Lancaster, J., J. Braithwaite and D. Greenfield (2010). "Benefits of participating in accreditation surveying." International Journal of Health Care Quality Assurance **23**(2): 141-152.

Lancaster, J., D. Greenfield and J. Braithwaite (2009). "Beyond accreditation: the benefits of surveying.," Twenty-sixth International Safety and Quality Conference: Designing for Quality, International Society for Quality in Health Care, Dublin, Ireland: 11-14 October.

McGory, M. L., P. G. Shekelle, et al. (2006). "Development of quality indicators for patients undergoing colorectal cancer surgery.," J. Natl. Cancer Inst. **98**(22): 1623-1633.

Nathan, S., K. McLure, D. Greenfield, M. Pawsey and J. Braithwaite (2008). "Taking our first steps together: involving 'consumers' in a national study of health service accreditation.", Involving People in research Conference of the National Health and Medical Council Health Issues. Perth, Western Australia.

Pawsey, M., Gibberd, R., Westbrook, J., Braithwaite, J. Greenfield, D. and Naylor, J. (2007) "The relationship between accreditation criteria results and clinical indicators: do health services with superior survey results have better clinical performance as measured by clinical indicators, and vice versa?", Proceedings of the 5th Australasian Conference on Safety and Quality in Health Care, Brisbane Convention Centre, 6-8 August.

Pope, C., Ziebland, S. and Mays, N. (2000), "Analysing qualitative data." (2000), BMJ 320:114-116.

Samama MM, Dahl OE, Mismetti P, Quinlan DJ, Rosencher N, Cornelis M, de Vries H, van Beusekom I, and Kahan JP (2006) "An electronic tool for venous thromboembolism prevention in medical and surgical patients.", Haematologica **91**(1):64-70

Verkerk, K., H. Van Veenendaal, et al. (2006). "Considered judgment in evidence-based guideline development.", Int J Qual Health Care **18**(5): 365-369.

7 APPENDICES

7.1 Appendix 1: accreditation research rating tool

THE UNIVERSITY OF
NEW SOUTH WALES



Centre for Clinical Governance Research in Health

ARC Linkage Accreditation Research

EQuIP Rating Form

Periodic Review

Dear Survey Coordinator,

The UNSW research team is endeavouring to understand in greater detail the ratings that the survey teams assign during the accreditation survey process. To this end we have developed a tool to capture more of the complexity of the discussion and ratings by the survey teams. The form was developed through discussion with several survey coordinators, and the rating system is similar to the risk rating process that surveyors currently use in EQulP.

The data in this tool will be available only to the research team and not to the ACHS. It will also be kept blinded from the researchers performing the cultural assessments so that the analysis of their assessments is not influenced by the EQulP performance.

Instructions:

When the team is completing its final decision about the EQuIP ratings please complete the expanded ratings for each criterion. For example:

When considering the “Continuum of Care” the survey team discusses standard 1.1 beginning with criterion 1.1.1; the team decides on MA. You decide from the team discussion that the organisation has done really well in some areas but there are a number of areas that were not so good though still within an MA performance. In your judgement of the team discussion the rating would be below average for this criterion. Please then complete the form, rating the MA against the research scale –

1. Minimum
2. Less than average
3. Average
4. Better than average
5. Maximum

We also understand that time constraints often make it impossible to discuss each criterion as a team. It is important to the research to understand if the rating was a team or individual rating - could you therefore select either the “I” (individual) or “T” (Team) to indicate the rating decision. Please note that the tool is to be returned to the UNSW research team at ACHS via Marjorie Pawsey and will not be available to the ACHS.

Standard	Criterion	Team or Individual	EQuIP rating	Rating						
				Min	Av	Max				
1.1										
	1.1.1	T I	LA SA MA EA OA	1	2	3	4	5		

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Centre for Clinical Governance Research in Health

ARC Linkage Accreditation Research

EQUIP Rating Form

Date: _____

Size of survey team: _____

Name of Coordinator: _____

Health organisation: _____

Continuum of Care

Standard	Criterion	Team or Individual	EQuIP rating	Research Rating					
1.2				Min	Av	Max			
	1.2.1	T I	LA SA MA EA OA	1	2	3	4	5	
1.3									
	1.3.1	T I	LA SA MA EA OA	1	2	3	4	5	
1.4									
	1.4.1	T I	LA SA MA EA OA	1	2	3	4	5	

Leadership & Management

Standard	Criterion	Team or Individual	EQuIP rating	Research Rating					
2.1				Min	Av				Max
	2.1.2	T I	LA SA MA EA OA	1	2	3	4	5	
	2.1.5	T I	LA SA MA EA OA	1	2	3	4	5	
2.2									
	2.2.1	T I	LA SA MA EA OA	1	2	3	4	5	
2.3									
	2.3.1	T I	LA SA MA EA OA	1	2	3	4	5	
2.4									
	2.4.2	T I	LA SA MA EA OA	1	2	3	4	5	

Human Resource Management

Standard	Criterion	Team or Individual	EQuIP rating	Research Rating				
3.1				Min	Av	Max		
	3.1.2	T I	LA SA MA EA OA	1	2	3	4	5

Information Management

Standard	Criterion	Team or Individual	EQuIP rating	Research Rating				
4.1				Min	Av	Max		
	4.1.1	T I	LA SA MA EA OA	1	2	3	4	5

Safe Practices & Environment

Standard	Criterion	Team or individual	EQuIP rating	Research Rating				
5.1				Min	Av		Max	
	5.1.1	T I	LA SA MA EA OA	1	2	3	4	5
	5.1.2	T I	LA SA MA EA OA	1	2	3	4	5
	5.1.3	T I	LA SA MA EA OA	1	2	3	4	5
	5.1.4	T I	LA SA MA EA OA	1	2	3	4	5
	5.1.5	T I	LA SA MA EA OA	1	2	3	4	5
	5.1.6	T I	LA SA MA EA OA	1	2	3	4	5
	5.1.7	T I	LA SA MA EA OA	1	2	3	4	5
	5.1.8	T I	LA SA MA EA OA	1	2	3	4	5
	5.1.9	T I	LA SA MA EA OA	1	2	3	4	5

7.2 Appendix 2: accreditation research conceptual understandings

The research team examined the accreditation, organisational and health services literatures to identify significant topics related to organisational performance and accreditation. Nine issues were selected and conceptual understandings of these were created. The issues are:

- organisational culture and organisational climate;
- staff well-being;
- communication; team climate;
- decision making; leadership and management;
- standard of care, quality and safety;
- consumer participation; and,
- clinical indicators.

7.2.1 Organisational culture and organisational climate

Organisational culture is defined as a set of shared values and norms held by employees that guide their interactions (Svyantek and Bott 2004). Organisational climate can be understood to be a manifestation of culture (Schein 2004). Organisational climate is behaviourally oriented, it is the actions of people on a daily and ongoing basis (Svyantek and Bott 2004).

Organisational culture has been shown to affect quality and safety in health organisations (Boan and Funderburk 2003; Braithwaite et al. 2005; Gillett and Stenfert-Kroese 2003; Kralewski et al. 2005), and other industries (Cox and Cheyne 2000; Feldman 2004). There exists a range of instruments by which health care culture and climate can be assessed (Gershon et al. 2004; Hofstede et al. 1990; Kralewski et al. 2005). Organisational culture has also been shown to influence staff wellbeing (Hatton et al. 1999; Klein et al. 1995) and organisational performance (Homburg and Pflesser 2000).

Our position on culture and climate

There is a long tradition of research into both culture and climate with differences, agreement, confusion and contestation recorded between the individuals. For example, Kroeber and Kluckholm (1952) (in Braithwaite et al. (2005)) identified 164 definitions of culture and Scott et al. (2003) discusses research identifying multiple elements that comprise climate. In short, there is considerable contestation about culture-climate notions, what elements comprise them, how the availability of resources to undertake study affects the notion researched and the intended use of results (Scott et al. 2003). This consideration is compounded by the fact that the two terms are used interchangeably at times (Boan and Funderburk 2003; Gershon et al. 2004) and then dichotomised at other times (Parker et al. 2003; van den Berg and Wilderom 2004; Patterson et al. 2005). In the ongoing debate about the similarities and differences between the two Scott et al. (2003) makes the point that the primary problem is that both are metaphors that evoke different images and understandings. Climate is a meteorological metaphor and culture is an anthropological one. The research adopted the perspective that cultures are socially constructed (Meyerson and Martin 1987; Wenger 1998), and organisations are cultures (Meyerson and Martin 1987). But it also takes the view that the broader environment within which cultures, and micro-cultures, operate is usefully described by the term climate.

7.2.2 Staff wellbeing

Staff wellbeing encompasses what an individual perceives and how they feel about their colleagues and the organisation. It involves their overall experience of work, their attitude and level of commitment to the organisation.

Staff wellbeing is important because

it has been shown to directly influence the quality of patient care (Firth-Cozens 2001; Smith 2001). Furthermore, research has shown that the more employees experience purpose and meaning at work, more committed they are to the organisation (Milliman et al. 2003). "Meaning at work" is itself a multidimensional concept which includes ability to realise one's potential, being associated with good or ethical organisation, interesting work, having good colleagues, and providing service to one's community (Mitroff and Denton 1999).

7.2.3 Communication

Communication covers the means, habits and participation by which people in organisations exchange knowledge, information, attitudes and beliefs with one another (Tukiainen 2001). Employees through their communication behaviours construct, or undermine, identity, commitment and trust in one another and the organisation (Elving 2005) and promote or hinder the provision of healthcare (Schoop 1999). Other research has termed an exploration of communication behaviours a “communication audit” (Tourish and Hargie 1998).

Communication means are understood to be how individuals communicate with each other, be that personal or through technology. This includes personal interactions, whether direct face-to-face or by telephone, and those mediated through technology such as paper (books, forms, memo’s, or reports) and computers (emails).

Communication habits are understood to be the interactions that occur. These can be individual or group interactions and formal meetings or informal discussions.

Communication participation concerns individuals’ access to information. That is, whether people have the information to fulfil their responsibilities in a timely manner, whether they receive information indirectly, including having to seek out information, or are excluded.

7.2.4 Team climate

Team climate focuses attention upon how the organisational actors understand and approach the provision of care. That is, do they work cooperatively and collaborative with their colleagues or do they view their tasks and responsibilities as independent from their colleagues. A key aspect of the team climate being the presence, or absence, of shared commitment (Katzenbach and Smith 1993). Team work has been shown to positively affect wellbeing (job satisfaction) (van Mierlo et al. 2005) and to be necessary to provide complex health care (Flin, O’Connor and Mearns 2002; Hall and Weaver 1991; Harolds 2005).

7.2.5 Decision Making

Decision making examines the inclusion or exclusion of individuals, teams, and patients in both the organising of and the provision of care. The influence and control organisational actors experienced in their work is explored, as well as how decisions made by others impacted on them.

Inclusion of staff in decisions has shown to improve patient care (Cook and Clarke 2001; Gair and Hartery 2001), team work (Cook and Clarke 2001), and trust and commitment to the decisions, managers and the organisation more broadly (Korsgaard, Schweiger and Sapienza 1995).

7.2.6 Leadership and Management

Leadership has a longer term focus whilst management is more concerned with the immediate, but they come together through a focus of how an organisation shifts from the here and now into the future. Leadership is about the process of influence and management is about planning, organisation and control.

Leadership and management are about negotiation, about working with people in a collaborative way to see what can be achieved (Heifetz and Laurie 2001; McAreavey, Alimo-Metcalfe and Connelley 2001). Taking this approach the tasks are about including, valuing, supporting and encouraging; not inspiring the follower (Alimo-Metcalfe and Alban-Metcalfe 2001). Such actions creates trust, exposes and deals with conflict, gets people to assume responsibility, instils confidence in people, and gives voice to people below (Heifetz and Laurie 2001).

Leadership and management are not separate roles but rather interrelated activities (Nadler and Tushman 1990; Yukl 1999; Hay and Hodgkinson 2006). A separation of leadership and management has been noted in the orthodox management literature (Watson 2002) and criticised as misrepresenting the complexity of organisational behaviour (Mangham and Pye 1991; Schruijer and Vansina 2002).

7.2.7 Standard of care, quality and safety

Standard of care, quality and safety explored how staff understood and enacted these issues in their work. That is, what assessment did they make about the care they and their colleagues provided, and did they review and improve their services? Explicit attention was directed to whether staff perceived their organisation had enacted a safety culture.

Organisations with a safety culture have been shown to perform highly on safety issues (Hudson 2003; Nieva and Sorra 2003). However it has been noted that poor quality care exists in all part of the health system (Hindle, Braithwaite and Iedema 2005). Similarly, other research has highlighted that health organisations need to make improvements in safety culture (Singer et al 2005). Comparisons of professionals and patients views of the standard of care is consistent overall, although differing in the details (Durieux et al. 2004).

7.2.8 Consumer participation

Consumer participation explored the role of patients, their families and the broader community in the planning, organising, and delivery of the services provided by a health organisation. Also, at a service level how care and treatment was explained to individual consumers and their role in the health care process.

Consumer's participation in their own health care has been linked with improvements in a range of factors; these include, compliance with treatment (Epstein, Apler and Quil 2004), the quality of health care, quality of life outcomes (Frewer, Slater and Lambert 2001; Janz et al. 2004) and treatment outcomes, reduced hospital and medical visits (Bechel, Myers et al. 2000; Glasby and Littlechild 2001). However, even where information is provided the quality and accessibility of information for the patients remains limited (Winterbottom et al. 2007). Similarly, health professionals' treatment discussions with patients do not typically cover all relevant information (Clarence et al. 1997).

In contrast to the emerging body of evidence which supports participation of patients in their own care, there has been little research undertaken which has investigated quality of care and other health service outcomes and their relationship to broader system level consumer and community participation processes (Crawford, Rutter et al. 2002). However, there is a body of normative literature, including many guidelines and toolkits that outline processes and attributes within organisations that are likely to enable influence by consumer or community members in decision-making (Carr 2001; CHF 2001; van Wersch and Eccles 2001; Church, Saunders et al. 2002).

7.2.9 Clinical indicators

The ACHS understanding of clinical indicators has been adopted, that is,

“Clinical indicators are one type of performance measure and relate to specific clinical issues. A clinical indicator is a measure of the management or outcome of care. It is an objective measure of either the process or outcome of care in quantitative terms.” (ACHS 2002)

Clinical indicators have been adopted widely and are used to show improvements in care (Gabriele et al. 2006; Silver, Geis and Bateman 2004; VanSuch et al. 2006; Williams et al. 2005; Williams et al. 2006) or review behaviours by patients (Bismark et al. 2006).

However, the comparative use of clinical indicators is recognised as problematic (Gibberd et al. 2004; Gross et al. 2000; Loeb 2004). Similarly, caution and further understand of clinical indicators in relation to accreditation has also been call for (Chen et al. 2003; Miller et al. 2005). No relationship is generally found between a specified quality measure and accreditation outcome (Dean Beaulieu and Epstein 2002; Grasso, Rothschild, Jordan and Jayaram 2005; Griffith, Knutzen and Alexander 2002; Miller et al. 2005).

References

- ACHS (2002). The Equip Guide: A Framework to Improve Quality And Safety in Healthcare. Sydney, Australian Council on Healthcare Standards.
- Alimo-Metcalfe, B. and J. Alban-Metcalfe (2001). "The development of a new transformational leadership questionnaire." Journal of Occupational and Organisational Psychology **74**(1): 1-27.
- Bechel, D. L., W. A. Myers, et al. (2000). "Does patient-centered care pay off?" Journal of Quality Improvement **26**(7): 400-409.
- Braithwaite, J., M. Westbrook, et al. (2005). "A tale of two hospitals: clinical service structures as an expression of different organisational cultures." Social Science & Medicine **60**(5): 1149-1162.
- Boan, D. and F. Funderburk (2003). Healthcare Quality Improvement and Organizational Culture, Delmarva Foundation.
- Bismark, M. M., T. A. Brennan, et al. (2006). "Relationship between complaints and quality of care in New Zealand: a descriptive analysis of complainants and non-complainants following adverse events." Quality and Safety in Health Care **15**(1): 17-22.
- Carr, B. J. (2001). "Making the best of consumer participation." Journal of Quality in Clinical Practice **21**(1-2): 37-39.
- Chen, J., S. S. Rathore, et al. (2003). "JCAHO accreditation and quality of care for acute myocardial infarction." Health Affairs **22**(2): 243-254.
- Church, J., D. Saunders, et al. (2002). "Citizen participation in health decision-making: past experience and future prospects." Journal of Public Health Policy **23**(1): 12-32.
- Clarence, H. B., D. F. Stephan, et al. (1997). "How doctors and patients discuss routine clinical decisions: informed decision making in the outpatient setting." Journal of General Internal Medicine **12**(6): 339-345.

- Cook, G. and K. Clarke (2001). "Decision-making in teams: issues arising from two UK evaluations." Journal of Interprofessional Care **15**(2): 141-151.
- Cox, S. and A. Cheyne (2000). "Assessing safety culture in offshore environments." Safety Culture **34**: 111-129.
- Crawford, M. J., D. Rutter, et al. (2002). "Systematic review of involving patients in the planning and development of health care." BMJ **325**(7375): 1263.
- Dean Beaulieu, N. and A. M. Epstein (2002). "National Committee on Quality Assurance health-plan accreditation: predictors, correlates of performance, and market impact." Medical Care **40**(4): 325-37.
- Durieux, P., A. Bissery, et al. (2004). "Comparison of health care professionals' self-assessments of standards of care and patients' opinions on the care they received in hospital: observational study." Quality and Safety in Health Care **13**: 198-202.
- Elving, W. (2005). "The role of communication in organisational change." Corporate Communications: An International Journal **10**(2): 129-138.
- Epstein, R. M., B. S. Alper, et al. (2004). "Communicating evidence for participatory decision making." JAMA **291**(19): 2359-2366.
- Feldman, S. P. (2004). "The culture of objectivity: quantification, uncertainty, and the evaluation of risk at NASA." Human Relations **57**(6): 691-718.
- Firth-Cozens, J. (2001). "Interventions to improve physicians' wellbeing and patient care." Social Science and Medicine **52**: 215-222.
- Flin, R., P. O'Connor, et al. (2002). "Crew resource management: improving team work in high reliability industries " Team Performance Management **8**(3-4): 68-78.
- Frewer, L. J., B. Salter, et al. (2001). "Understanding patients' preferences for treatment: the need for innovative methodologies." Quality and Safety in Health Care **10**(90001): 50i-54.
- Gabriele, P., G. Malinverni, et al. (2006). "Are quality indicators for radiotherapy useful in the evaluation of service efficacy in a new based radiotherapy institution?" Tumori **92**(6): 496-502.
- Gair, G. and T. Hartery (2001). "Medical dominance in multidisciplinary teamwork: a case study of discharge decision-making in a geriatric assessment unit." Journal of Nursing Management **9**(1): 3-11.
- Gershon, R., P. Stone, et al. (2004). "Measurement of organisational culture and climate in healthcare." JONA **34**(1): 33-40.

- Gibberd, R., S. Hancock, et al. (2004). "Using indicators to quantify the potential to improve the quality of health care." International Journal of Quality in Health Care 16(suppl_1): i37-43.
- Gillett, E. and B. Stenfert-Kroese (2003). "Investigating organizational culture: a comparison of a 'high'- and a 'low'- performing residential unit for people with intellectual disabilities." Journal of Applied Research in Intellectual Disabilities 16: 279-284.
- Glasby, J. and R. Littlechild (2001). "Inappropriate hospital admissions: patient participation in research." British Journal of Nursing 10(11): 738-41.
- Grasso, B. C., J. M. Rothschild, et al. (2005). "What is the measure of a safe hospital? Medication errors missed by risk management, clinical staff, and surveyors." Journal of Psychiatric Practice 11(4): 268-73.
- Griffith, J. R., S. R. Knutzen, et al. (2002). "Structural versus outcomes measures in hospitals: a comparison of Joint Commission and Medicare outcomes scores in hospitals." Quality Management in Health Care 10(2): 29-38.
- Gross, P., B. Braun, et al. (2000). "Comparison of clinical indicators for performance measurement of health care quality: a cautionary note " Clinical Performance and Quality Healthcare 8(4): 202-211.
- Hall, P. and L. Weaver (2001). "Interdisciplinary education and teamwork: a long and winding road." Medical Education 35(9): 867-875.
- Harolds, J. (2005). "Effective radiology teams." Journal of the American College of Radiology 2(2): 151-8.
- Hatton, C., M. Rivers, et al. (1999). "Organisational culture and staff outcomes in services for people with intellectual disabilities." Journal of Intellectual Disability Research 43(3): 206-218.
- Hay, A. and M. Hodgkinson (2006). "Rethinking leadership: a way forward for teaching leadership." Leadership and Organisational Development Journal 27(2): 144-158.
- Heifetz, R. and D. Laurie (2001). "The work of leadership." Harvard Business Review 75(1): 124-135.
- Hindle, D., J. Braithwaite, et al. (2005). Patient Safety: A Review of Key International Enquiries. Sydney, Clinical Excellence Commission.
- Hofstede, G., M. N., et al. (1990). "Measuring organisational cultures: a qualitative and quantitative study across twenty cases." Administrative Science Quarterly 35(2): 286.

- Homburg, C. and C. Pflesser (2000). "A multiple-layer model of market-oriented organizational culture: measurement issues and performance outcomes." Journal of Marketing Research **37**(4): 449-462.
- Hudson, P. (2003). "Applying the lessons of high risk industries to health care." Quality and Safety in Health Care **12**(Suppl 1): i7-i12.
- Janz, N. K., P. A. Wren, et al. (2004). "Patient-physician concordance: preferences, perceptions, and factors influencing the breast cancer surgical decision." Journal of Clinical Oncology **22**(15): 3091-3098.
- Katzenbach, J. and D. Smith (1993). The Wisdom of Teams: Creating the High-Performance Organisation. New York, Harper Business.
- Klein, A. S., R. J. Masi, et al. (1995). "Organisation culture, distribution and amount of control, and perceptions of quality: an empirical study of linkages." Group Organization Management **20**(2): 122-148.
- Korsgaard, M., D. Schweiger, et al. (1995). "Building commitment, attachment, and trust in strategic decision-making teams: the role of procedural justice." The Academy of Management Journal **38**(1): 60-84.
- Kralewski, J., B. Dowd, et al. (2005). "Measuring the culture of medical group practices." Health Care Management Review **30**(3): 184-193.
- Kroeber, A. L. and C. Kluckhohn (1952). "Culture: a critical review of concepts and definitions." Papers of the Peabody Museum of American Archaeology and Ethnology, Harvard University **47**(1).
- Loeb, J. M. (2004). "The current state of performance measurement in health care." International Journal of Quality in Health Care **16**(suppl_1): i5-9.
- Mangham, I. and A. Pye (1991). The Doing of Managing. Oxford, Blackwell.
- McAreavey, M., B. Alimo-Metcalfe, et al. (2001). "How do directors of public health view leadership." Journal of Management in Medicine **5**(6): 446-62.
- Meyerson, D. and J. Martin (1987). "Cultural change: an integration of three different views." Journal of Management Studies **24**(6): 623-647.
- Miller, M., P. Pronovost, et al. (2005). "Relationship between performance measurement and accreditation: Implications for quality of care and patient safety." American Journal of Medical Quality **20**(5): 239-252.
- Milliman, J., A. Czaplewski, et al. (2003). "Workplace spirituality and employee work attitudes: an exploratory empirical assessment." Journal of Organisational Change Management **16**: 426-47.

- Mitroff, I. and E. Denton (1999). "A study of spirituality in the workplace." Sloan Management Review **40**(4): 83-92.
- Nadler, D. and M. Tushman (1990). "Beyond the charismatic leader: leadership and organisational change." California Management Review **32**(3): 77-97.
- Nieva, V. F. and J. Sorra (2003). "Safety culture assessment: a tool for improving patient safety in healthcare organisations." Quality and Safety in Health Care **12**(90002): 17ii-23.
- Parker, C., B. Baltes, et al. (2003). "Relationship between psychological climate perceptions and work outcomes: a meta-analytic review." Journal of Organisational Behavior **24**: 389-416.
- Patterson, M., M. A. West, et al. (2005). "Validating the organisational climate measure: links to managerial practices, productivity and innovation." Journal of Organizational Behavior **26**: 379-408.
- Schein, E. (2004). Organisational Culture and Leadership. San Francisco, Jossey-Bass.
- Schoop, M. (1999). "An empirical study of multidisciplinary communication in healthcare using a language-action perspective." Proceedings of the Fourth International Workshop on the Language Action Perspective on Communication Modelling (LAP 99). Copenhagen: 59-72.
- Schruijer, S. and L. Vansina (2002). "Leader, leadership and leading: from individual characteristics to relating in context." Journal of Organisational Behaviour **23**(7): 869-74.
- Scott, T., R. Mannion, et al. (2003). "Does organisational culture influence health care performance? A review of the evidence." Journal of Health Services Research and Policy **8**(2): 105-117.
- Silver, M., M. Geis, et al. (2004). "Improving health care systems performance: a human factors approach." American Journal of Medical Quality **19**(3): 93-102.
- Singer, S., D. Gaba, et al. (2003). "The culture of safety: results of an organisation-wide survey in 15 California hospitals." Quality & Safety in Health Care **12**(2): 112-118.
- Smith, L. (2001). "Working time, stress and fatigue.", in C. Vincent (Ed.), Clinical Risk Management (pp. 319-340). London: BMJ Books.

- Svyantek, D. and J. Bott (2004). "Organisational culture and organisational climate measures: an integrative review.", in Comprehensive handbook of psychological assessment: Industrial and Organisational Assessment. J. Thomas. Hoboken, NJ, Wiley. 4: 507-524.
- Tourish, D. and O. Hargie (1998). "Auditing staff-management communication in schools: a framework for evaluating performance." International Journal of Educational Management 12(4): 176-182.
- Tukiainen, T. (2001). "An agenda model of organisational communication." Corporate Communications: An International Journal 6(1): 47-52.
- van den Berg, P. and C. Wilderom (2004). "Defining, measuring and comparing organisational cultures." Applied Psychology: An International Review 53(4): 570-582.
- van Mierlo, H., C. G. Rutte, et al. (2005). "Self-managing teamwork and psychological well-being: review of a multilevel research domain." Group Organisation Management 30(2): 211-235.
- VanSuch, M., J. Naessens, et al. (2006). "Effect of discharge instructions on readmission of hospitalised patients with heart failure: do all of the Joint Commission on Accreditation of healthcare organisations heart failure core measures reflect better care?" Quality and Safety in Health Care 15(6): 414-417.
- van Wersch, A. and M. Eccles (2001). "Involvement of consumers in the development of evidence based clinical guidelines: practical experiences from the North of England evidence based guideline development programme." Quality in Health Care 10(1): 10-6.
- Watson, T. (2002). Organising and Managing Work. London, Prentice Hall.
- Wenger, E. (1998). Communities of Practice: Learning, Meaning and Identity. Cambridge, Cambridge University Press.
- Williams, C., S. Schmaltz, et al. (2005). "Quality of care in US hospitals as reflected by standardised measures, 2002-2004." New England Journal of Medicine 353: 255-64.
- Williams, S. C., A. Watt, et al. (2006). "Assessing the reliability of standardised performance indicators." International Journal for Quality in Health Care 18(3): 246-55.
- Winterbottom, A., M. Conner, et al. (2007). "Evaluating the quality of patient leaflets about renal replacement therapy across UK renal units." Nephrology Dialysis Transplantation 22(8):2291-2296.

**7.3 Appendix 3: accreditation organisational performance assessment tool:
interview book**

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**Centre for Clinical Governance Research
in Health**

**ARC Linkage Project -
Researching Accreditation**

Interview Book

Name of Health Service: _____

Date of Organisational Assessment: _____

Researcher: _____

Workbook and interview instructions:

This book is designed to assist the researcher when undertaking the interviews during the organisational assessment. The interviews are defined as “semi-structured”, which means the order of the themes and guiding questions for the interview is not prescriptive. The researcher has the freedom to cover the themes by following the direction and pace of the person being interviewed. As necessary the questions can be rephrased to suit the wording of each researcher, including using examples tailored to suit the specific interview, as the prime focus is the issue not the wording as set out here.

To enhance the quality of the interview researchers are encouraged to become familiar with the themes/ questions prior to beginning the interviews. The book provides space to make notes for 5 interviews.

The themes to be covered are:

1. General inquiry, incorporating values
2. Communication
3. Team climate (individual/ team)
4. Decision making
5. Leadership/ management
6. Standard of care/ quality and safety
7. Consumer involvement

List of Interviews

Interview #	Interviewee	Role	Page #
1.			5
2.			23
3.			41
4.			59
5.			77

Organisational Data

What State/ Territory of the organisation?

What is the location of the health service?

Metropolitan	
Regional/ rural	
Remote	

What is the size of the health service?

Large hospital/ health service (> 200 beds)	
Medium hospital/ health service (100 – 200 beds)	
Small hospital/ health service (< 100 beds)	

Is the health service public or private?

Interview # 1

Date/ time of interview:

Name of interviewee:

1) What sex are you? Male Female

2) How old are you?

3) What is your professional background?

4) What is your highest qualification?

5) Do you have a speciality?

6) What is your job?

7) Do you have a clinical role? Yes No

8) Do you have a management role? Yes No

9) Length of time working in your current job?

10) Length of time working in the organisation?

11) Length of time working in health industry?

Issues to cover:

1. General inquiry regarding the organisation, incorporating values

The intention here is to ask the interviewee a general non-specific question to open up their views about their organisation. For example:

Tell me what this organisation is like to work in?

Do you think there is a culture of safety or a culture of blame in this organisation?

What do you think are the values that this organisation promotes/ enacts?

Where is the balance between individual responsibility and system failure?

What are the good things about working here?

What are the not so good things about working here?

How does the health service celebrate it's achievements?

2. Communication

The focus here is the interaction between staff across the organisation, and the mixture of personal and technological mediated interactions. The issues to consider include:

How do staff communicate with one another? (in person/ phone/ email/ memo?)

How is clinical care communicated/ organised within professions?

How is clinical care communicated/ organised between professions?

How is clinical care communicated/ organised between departments?

Do and/ or how do the senior management communicate to staff?

What is the tenor of communication? Aggressive/ passive/ assertive/ blaming/ emotional etc?

3. *Team climate (individual – team)*

How people approach their work is under consideration – what is the approach to organising care – is it focused on individual/ group/ collaborative team? Issues under consideration include:

What teams exist in the health service?

What sort of teams are they? (Collaborative/ hierarchal/ single-dual-multi professional?)

How is conflict resolved by the team?

Do staff receive training to work as members of team?

How are team leaders chosen?

How is the functioning of teams reviewed?

Is care planning undertaken by a multi-disciplinary team?

Are consumers members of teams?

How do people provide services – individually/ working in parallel with others/ in a collaborative negotiated manner?

Do people ask for help within/ across professions?

How are consultations requested? via phone/ in person/ in notes/ through technology (electronic system)/ via a third party (dr tells nurse to arrange)?

4. *Decision making*

The focus is to understand how people are included-excluded in participating in decisions throughout the organisation. Issues under consideration include:

Consider how the following questions may apply to your –

- ▶ Ward/ service/ unit
- ▶ Profession
- ▶ Health service

How are decisions made? Top-down, inclusive, collaborative?

Who makes them?

Are you involved in decisions that affect you?

What is the management/ decision making structure for the organisation? Who's included and excluded?

5. *Leadership - management*

Here the focus is on examining the displays of leadership and management. The issues under consideration include:

Who demonstrates leadership in the organisation?

What are they doing that stands out?

Are there leaders that are not managers?

Are there managers who are not leaders?

To whom, and how do, senior managers relate to others in the organisation?

What do supervisors/ managers do?

Is there a separation of the organising of work and the doing of the work?

6. *Standard of care/ quality and safety*

The focus is to understand how, or even if, the organisation ensures appropriate standards of care and quality. Issues under consideration include:

How is quality understood in the organisation?

How is quality reviewed/ measured/ monitored?

How is responsibility for standards and quality enacted?

How are standards reviewed/ benchmarked?

Is there an organisational approach or is it fragmented?

What occurs when problems are identified?

How are professionals responded to when they raise concerns?

What happens when poor quality is identified?

Is quality reported upon at team meetings/ Departmental meetings/ Divisional meeting?

7. *Consumer involvement*

The focus is to explore the role of consumers when they access the services of the organisation, how the organisation incorporates consumer representatives/ advocates and what the organisation says (written documentation) and then staff do in relation to them. Issues under consideration include:

Are consumers active/ passive when receiving care?

Are consumers informed of their rights? How?

Do consumers exercise their rights?

How are consumers involved in care planning?

How are consumers responded to when they raise a concern/ complaint?

Are consumers represented on committees/ focus groups/ on the hospital board?

What does the organisation document about consumer involvement in care plans/ minutes/ annual reports?

Are consumers consulted with when the organisation developed/s a strategic plan/ policies?

**7.4 Appendix 4: accreditation organisational performance assessment tool:
observation book**

THE UNIVERSITY OF
NEW SOUTH WALES



**Centre for Clinical Governance Research
in Health**

ARC Linkage Project – Researching Accreditation

Observation Book

Name of Health Service: _____

Date of Organisational Assessment: _____

Researcher: _____

This book is designed to be used when a researcher is undertaking the non-participant observation during the organisational assessment.

The book sets out the themes to be focused upon during the observation period, however the order of the themes does not represent any significance; all are as important as each other.

During the observational period the researcher needs to cover the themes for each department/ clinical area/ professional group they observe. To enhance the quality of the observations the researcher is encouraged to become familiar with the themes and guiding questions prior to beginning the site visit.

The book provides space to make notes for 5 different observations during the site visit.

The themes to be covered are:

1. Organisational environment
2. Communication
3. Team climate (individual/ team)
4. Decision making
5. Leadership/ management
6. Standard of care/ quality and safety
7. Consumer involvement

The following pages detail the guiding questions that expand upon the themes.

Themes and guiding questions.

1. *Organisational environment*

What is being focused upon here is how the organisation appears/ presents to those who work in it, to those who visit and how friendly-distant or easy/ difficult it is to access. Issues to consider include:

What is the physical presentation of the organisation like? (inside and out)
Is it easy to navigate the way around the organisation?
What is your initial observation of the organisation/ department?
How busy? noisy?
How many people?
Do they acknowledge you?
What is going on? What are they doing?
What can you see? hear? smell?
What are your feelings? impressions?
How do the staff present themselves? (dress/ name badges/ engage i.e. eye-contact, smiles etc)
When you first meet them how do they react/ respond?
If you ask for help how do they react?

2. *Communication*

The focus here is the interaction between staff across the organisation, and the mixture of personal and technological mediated interactions. The issues to consider include:

How do staff communicate with one another? (in person/ phone/ email/ memo?)
How is clinical care communicated/ organised within professions?
How is clinical care communicated/ organised between professions?
How is clinical care communicated/ organised between departments?
Do and/ or how do the senior management communicate to staff?
What is the tenor of communication? Aggressive/ passive/ assertive/ blaming/ emotional etc?

3. *Team climate (individual – team)*

How people approach their work is under consideration – what is the approach to organising care – is it focused on individual/ group/ collaborative team? Issues under consideration include:

What teams exist in the health service?
What sort of teams are they? (Collaborative/ hierarchal/ single-dual-multi professional?)
How is conflict resolved by the team?
Do staff receive training to work as members of team?
How are team leaders chosen?
How is the functioning of teams reviewed?
Is care planning undertaken by a multi-disciplinary team?
Are consumers members of teams?
How do people provide services – individually/ working in parallel with others/ in a collaborative negotiated manner?
Do people ask for help within/ across professions?
How are consultations requested? via phone/ in person/ in notes/ through technology (electronic system)/ via a third party (dr tells nurse to arrange)?

4. *Decision making*

The focus is to understand how people are included-excluded in participating in decisions throughout the organisation. Issues under consideration include:

Consider how the following questions may apply to a –

- ▶ Ward/ service/ unit
- ▶ Profession
- ▶ Health service

How are decisions made? Top-down, inclusive, collaborative?

Who makes them?

Are you involved in decisions that affect you?

What is the management/ decision making structure for the organisation? Who's included and excluded?

5. *Leadership - management*

Here the focus is on examining the displays of leadership and management. The issues under consideration include:

Who demonstrates leadership in the organisation?

What are they doing that stands out?

Are there leaders that are not managers?

Are there managers who are not leaders?

To whom, and how do, senior managers relate to others in the organisation?

What do supervisors/ managers do?

Is there a separation of the organising of work and the doing of the work?

6. *Standard of care/ quality and safety*

The focus is to understand how, or even if, the organisation ensures appropriate standards of care and quality. Issues under consideration include:

How is quality made visible?

How is quality talked about?

How is responsibility for standards and quality enacted?

How are standards reviewed/ benchmarked?

Is there an organisational approach or is it fragmented?

What occurs when problems are identified?

How are professionals responded to when they raise concerns?

What happens when poor quality is identified?

Is quality reported upon at team meetings/ Departmental meetings/ Divisional meeting?

7. *Consumer involvement*

The focus is to explore the role of consumers when they access the services of the organisation, how the organisation incorporates consumer representatives/ advocates and what the organisation says (written documentation) and then staff do in relation to them. Issues under consideration include:

Are consumers active/ passive when receiving care?

Are consumers informed of their rights? How?

Do consumers exercise their rights?

How are consumers involved in care planning?

How are consumers responded to when they raise a concern/ complaint?

Are consumers represented on committees/ focus groups/ on the hospital board?

What does the organisation document about consumer involvement in care plans/ minutes/ annual reports?

Are consumers consulted with when the organisation developed/s a strategic plan/ policies?

List of observation locations

Observation #	Location	Department/ clinical area/ profession	Page #
1.			7
2.			21
3.			35
4.			49
5.			63

Issues to consider:

Organisational environment

- ▶ Initial impression
- ▶ Physical presentation
- ▶ What's going on?
- ▶ Staff presentation/ reactions

Communication

- ▶ Method
- ▶ Within professions
- ▶ Across professions
- ▶ Tenor
- ▶ By management

Team climate (individual/ team)

- ▶ Teams exist?
- ▶ Sort (single/ dual/ multi –prof
- ▶ Conflict resolved?
- ▶ Training for?
- ▶ Leadership of?

Decision making

- For ward/ profession/ HS
- ▶ How are decisions made?
 - ▶ Who makes them?
 - ▶ Who's included/ excluded?

Issues to consider:

Leadership/ management

- ▶ Who demonstrates leadership?
- ▶ Leaders not managers?
- ▶ Managers not leaders?
- ▶ Organising and doing-separate?

Standard of care/ quality/ safety

- ▶ Made visible?
- ▶ Talked about?
- ▶ Whose responsibility?
- ▶ How organised?

Consumer involvement

- ▶ Active/ passive?
- ▶ Informed of rights?
- ▶ Exercise rights?
- ▶ How responded to?
- ▶ Involved in HS?

7.5 Appendix 5: survey questions for the examination of reliability issues with accreditation stakeholders

What do you think influences the reliability of the accreditation process?

What do you think influences the reliability of the surveying teams?

Why does your organisation undergo accreditation?

What are the benefits of accreditation for your organisation?

What are the costs of accreditation for your organisation?

Do the benefits outweigh the costs? That is, do you think that accreditation is value for money?

If you could change from ACHS to another accreditation agency would you?

Why or why not?

Any other comments...?

7.6 Appendix 6: accreditation research surveyor intra-rater reliability study

Scenario 1: Initial case

EQulP 4 Criterion 1.5.2

The infection control system supports safe practice and ensures a safe environment for consumers / patients and health care workers. (Please refer to EQulP Guide Part 1 for a description of the elements and guidelines)

Setting: Organisation – Wide Survey of a175 bed private hospital in a regional city.

Key improvements	Review of infection control procedures resulted in flash sterilisation just being ceased; policy written
Plans for improvement	Certification training of CSD staff (just booked)
Summary of supportive evidence	Infection control committee minutes; Report of Review of Infection Control Procedures, Flash Sterilisation Policy.
Self rating	SA

Surveyor findings

Surveyor preparation	Persons interviewed	Responses	Validation
Training programs for infection control Current infection control policies Practices –proof of processes in endoscope cleaning	Infection Control Practitioner Infection Control Committee	Flash sterilization ceased 6 weeks prior to survey; policy written but staff need training; no one yet certified – certification training booked Quality Manager is coordinating, through the Quality Review Committee, 2 projects: sharps in the clean up area; fast track project	Program for 2 day work shop booked for 6 months time to gain CSD certification
	CSD operator	External verification of practices – HICMR; Staff turnover in CSD; 50% in past year	Visit to CSD: Full theatre attire required; staff all protected; Followed instrument trail – all OK; Logs OK

Surveyor preparation	Persons interviewed	Responses	Validation
			Ultrasonic equipment: Question: How do you know it is working? Answer: BME checked and properly tagged; No foil test done. Soil removal – testing not done
	Operating Room Manager Contingency plans: <ul style="list-style-type: none"> • Evaluation • How to deal with doctors' own instruments • What system replaces the flash sterilization 	Surgeons told about the changed system one month previously. Not sure what to do with dentists and ophthalmic surgeons and non compliers with the sterilisation policy	

Rating

The UNSW research team is endeavouring to understand in greater detail the ratings teams assign during the accreditation survey process. A tool was developed through discussion with several survey coordinators to capture more of the complexity of the ratings by the survey teams. It has been used by survey teams in 2006 to assist the research. The rating system is similar to the risk rating process that surveyors currently use in EQUIP. Please expand your rating against the research scale –

6. Minimum
7. Less than average
8. Average
9. Better than average
10. Maximum

Please circle or shade your ratings

Standard	Criterion	EQUIP rating	Research rating
	1.5.2	LA SA MA EA OA	1 2 3 4 5

Comments

Scenario 1: Follow-up case

EQulP 4 Criterion 1.5.2

The infection control system supports safe practice and ensures a safe environment for consumers / patients and health care workers. (Please refer to EQulP Guide Part 1 for a description of the elements).

Setting: Periodic Review in a 180 bed private hospital in an outer metropolitan area.

Key improvements	Flash sterilisation just ceased after a review of infection control ; a policy has just been developed
Plans for improvement	Some of the staff of the CSD are booked for training to become certified
Summary of supportive evidence	Agenda papers and minutes of the Infection Control Committee; A documented review of Infection Control Practices across the organisation; the newly developed policy regarding flash sterilisation.
Self rating	SA

Surveyor findings

Surveyor preparation	Persons interviewed	Responses	Validation
<p>Infection control education programs</p> <p>Infection control policies</p> <p>Documented proof of the practices for cleaning endoscopes</p>	<p>Nurse responsible for Infection Control</p> <p>Members of the Infection Control Committee</p>	<p>Last flash sterilisation done six weeks before the survey; training sessions for staff on the flash sterilisation policy yet to be organised ; no CSD staff certified but training has been organised; The Quality Council is overseeing two projects being done by the Quality Coordinator - a review of sharps in the clean up area; developing fast tracking processes</p>	<p>Registration for CSD Certification Training Workshop (2 days) cited but the first available is in 6 months time.</p>
	<p>CSD officer-in-charge</p>	<p>External review of infection control practices had been conducted by an independent expert body; Staff turnover in CSD was a chronic problem - 50% in past year</p>	<p>Full theatre dress was required on the visit to the CSD and all the staff were protected; No problems identified in the tracking of an instrument through the CSD and logs were all</p>

Surveyor preparation	Persons interviewed	Responses	Validation
			completed; The Biomedical Department checked and tagged ultrasonic equipment; foil test not done; No testing of soil removal.
	Manager, Operating Rooms Questions re plans for: <ul style="list-style-type: none"> • evaluation • dealing with doctors' own instruments • replacement system for the flash sterilisation 	Surgeons had been notified of the cessation of flash sterilisation a month before. Dilemma about how to handle the dentists and ophthalmic surgeons and others who did not comply with the sterilisation policy	

Rating

The UNSW research team is endeavouring to understand in greater detail the ratings teams assign during the accreditation survey process. A tool was developed through discussion with several survey coordinators to capture more of the complexity of the ratings by the survey teams. It has been used by survey teams in 2006 to assist the research. The rating system is similar to the risk rating process that surveyors currently use in EQulP. Please expand your rating against the research scale –

- 11. Minimum
- 12. Less than average
- 13. Average
- 14. Better than average
- 15. Maximum

Please circle or shade your ratings

Standard	Criterion	EQulP rating	Research rating
	1.5.2	LA SA MA EA OA	1 2 3 4 5

Comments

7.7 Appendix 7: accreditation research surveyor inter-rater reliability study

Criterion 2.1.2

The integrated organisation-wide risk management policy and system ensure that corporate and clinical risks are identified, minimized and managed.

Key improvements	Root cause analysis of a medication incident.		
Plans for improvement	Development of computerised risk register		
Summary of supportive evidence	Corporate risk management planning strategies and activities; corporate data on risk. Organisation risk register with little activity;		
Self rating	MA		
Surveyor preparation	Persons interviewed	Responses	Validation
Corporate risk management plan	Risk Manager (part-time): Asked how the RM plan is operationalised; how liaison occurs with the Quality Manager (also part-time)	Refers continually to corporate RM plans. Talks about risk register, but states it is difficult to get the Executive to identify risks in a timely manner; data provided only relates to OHS, no clinical, HR etc Poor communication with the Quality Manager.	Strategic plan identifies some risks but some are obtuse eg need more midwives
Local risk management activity appears to demonstrate a disconnect between corporate and local	Department managers: Food Services Biomedical Engineering Engineering	Talks about food poisoning episode Talks about backs up and spares; Complains about poor power supply, old and unreliable generators	Food poisoning episode not on the risk register Failures are not logged
	CEO	No real knowledge of how RM concepts and how RM works in the organisation	
Presumed surveyor rating : SA			
Surveyor recommendation intent: Non integration of risk management of corporate and organisation programs; lack of evaluation at the local level			

Criterion 2.1.2

The integrated organisation-wide risk management policy and system ensure that corporate and clinical risks are identified, minimized and managed.

Key improvements	Root cause analysis of a medication incident.
Plans for improvement	Development of computerised risk register
Summary of supportive evidence	Corporate risk management planning strategies and activities; corporate data on risk. Organisation risk register with little activity;
Self rating	MA

7.8 Appendix 8: inter-rater reliability study protocol

Research Agreement for the inter-rater reliability of accreditation teams study.

This agreement is between the Centre for Clinical Governance Research in Health (CCGR), the Australian Council on Healthcare Standards (ACHS) and Hospital.

1. Two accreditation survey teams will undertake the periodic review of the Hospital according to the arrangements negotiated by the Hospital and ACHS.
2. The ACHS will match the two teams to the organisation, as is the normal practice, and in addition the members of the two teams will be matched as closely to one another as is possible.
3. The ACHS will explain the study to the surveyors and agreement to survey the organisation includes agreement to participate in all research activities, prior to, during and after the survey, including completing research reflection forms.
4. The CCGR research team will be present during the survey to observe the activities of the survey teams. The CCGR research team will ensure their activities do not significantly affect the conduct of the survey or functioning of the teams.
5. The CCGR research team will brief and debrief the two survey teams about the research.
6. The ACHS will randomly select one survey coordinator to negotiate the survey timetable with the organisation.
7. For the integrity of the research and the ACHS accreditation process the two survey teams agree to not collaborate or discuss their survey findings during the survey period and until the accreditation decision has been made by ACHS.
8. Both survey teams will follow the established surveying practice as determined by the ACHS except that when undertaking interviews with health service staff, the surveyors from one team will alternate with the surveyors from the second team in asking questions. For example, in the first interview one team will ask all the questions and then in the interview with the next staff member the second team will ask all the questions.

9. Both survey teams will be expected to raise concerns or issues during the survey with the organisation as is normally the case. The Hospital will respond to any issue or concern raised by either team.
10. Prior to the summation conference the UNSW research team will flip a coin with the survey team coordinators to randomly select the official accreditation survey team. The selected survey team will make the summation presentation to the organisation.
11. The selected official accreditation survey team's assessment, recommendations, commendations and decision will be accepted by the Hospital and the ACHS as determining the accreditation outcome.
12. The second survey team, now termed the research survey team, will document their assessments, recommendations, commendations and decisions in the normal way, but these will have no bearing on the accreditation outcome and are for the CCGR research team's use.
13. The research survey team will participate in a debriefing with the CCGR research team. The CCGR research team will note any high priority recommendations, recommendations and commendations made by the research survey team. To avoid confusion with the language and status of recommendations and commendations made by the research survey team these will be redefined as follows:
 - Commendations will remain as commendations.
 - High priority recommendations will be termed important safety issues.
 - Recommendations will be termed as safety issues.
14. The ACHS and Hospital agree to the following process regarding the important safety issues and safety issues identified by the research survey team:
 - The Hospital and ACHS will negotiate in writing a strategy and appropriate timetable to address any important safety issues.
 - The ACHS will advise in writing the Hospital of any safety issues and the Hospital will respond to them as they deem appropriate.
15. The CCGR research team and the research survey team will report by telephone any important safety issues to the ACHS at the time of the debriefing.
16. The CCGR research team will provide a written report, within one week, to the ACHS and Hospital outlining any commendations, important safety issues and safety issues.

7.9 Appendix 9: observation and interview issues for reliability study of two survey teams

THE UNIVERSITY OF
NEW SOUTH WALES



**Centre for Clinical Governance Research
in Health**

ARC Linkage Project – Researching Accreditation

Study 3

Individual Surveyor Observation Book

Name of Health Service:

Researcher:

This book is designed to be used for study 3 of the CCGR research into accreditation. That is, the survey conducted by two teams at Nameless Hospital. This book provides a framework for gathering data about the conduct and interactions of a survey team.

We are seeking to understand the conduct of surveyors in interviews as part of the verification activities. This book sets out the issues to be focused upon during the observation of surveyors interviews, however the order of the issues does not represent any significance; all are as important as each other.

The issues to gather data upon are:

- Planned, spontaneous or a follow up interview
- Length of time engaged in the activity
- Any preparation undertaken for the interview – Is there an explicit structure / are the questions prepared or made up on the spot
- Is there a specific standard being focused upon
- Number of questions being asked
- The actual questions – topics being focused upon
- If any documents are being examined
- If the surveyor makes any notes
- Any problems or conflicts that occur during the interview
- The conduct of the interview – friendly, collegial, smooth or difficult, hostile, disjointed

Observe the following behaviours from the surveyor:

- What does the surveyor do to develop rapport with the interviewee?
- Does the surveyor engage in self disclosure / sharing personal experience?
- Does the surveyor add value by providing advice / making suggestions?
- Note the surveyor's body language and eye contact with the interviewee
- Note the surveyor's use of humour and how the interviewee responds to it
- Note how the surveyor is reacting / responding to what is being said
- Observe the surveyor's line of questioning and record:
 - The number and pattern of open questions
 - The number and pattern of closed questions
 - Questions seeking detail
 - Questions seeking general impressions
 - Questions to clarify what the interviewee has said
 - The use of silence

The issues to gather data upon are:

- Planned - spontaneous - follow-up interview;
- Length of time engaged in the activity;
- Any preparation undertaken for the interview – Is there an explicit structure / are the questions prepared or made up on the spot;
- Is there a specific standard being focused upon;
- Number of questions being asked;
- The actual questions – topics being focused upon;
- If any documents are being examined;
- If the surveyor makes any notes;
- Any problems or conflicts that occur during the interview; and
- The conduct of the interview.

Questions asked:

Observe the following behaviours from the surveyor:

- What the surveyor does to develop rapport with the interviewee;
- If the surveyor engages in self disclosure / sharing personal experience;
- If the surveyor adds value by providing advice / making suggestions;
- The surveyor's body language and eye contact with the interviewee;
- The surveyor's use of humour and how the interviewee responds to it;
- How the surveyor is reacting / responding to what is being said;
- Observe the surveyor's line of questioning and record:
 - The number and pattern of open questions
 - The number and pattern of closed questions
 - Questions seeking detail
 - Questions seeking general impressions
 - Questions to clarify what the interviewee has said
 - The use of silence

THE UNIVERSITY OF
NEW SOUTH WALES



Centre for Clinical Governance Research

ARC Linkage Project – Researching Accreditation

Study 3

Team Observation Book

Name of Health Service: _____

Researcher: _____

This book is designed to be used for study 3 of the CCGR research into accreditation. That is, the observation of two survey teams at Nameless Hospital.

The book sets out the themes to be focused upon with the organisational staff during the study, however the order of the themes does not represent any significance; all are as important as each other.

The themes to be covered are:

1. Organisation of the team
2. Leadership/ management
3. Coordination with the organisation
4. Communication
5. Decision making
6. Interpreting the standards
7. Documentation

Themes and guiding questions

1. Organisation of the team

What is being focused upon here is how the organisational staff perceive the team is organised and managed. Issues to consider include:

- Do you perceive the team to be well organised and that they know individually and collectively what they are doing?
- How does the team present themselves to the organisation? (ie. Use of titles and manner)
- Do the team members have credibility with the organisation?

2. Leadership - management

Here the focus is on how the organisational staff perceive the leadership and management of the survey team. The issues under consideration include:

- Do staff think the coordinator is effective?
- Do staff think the team is well managed?
- Have there been any challenges to the survey coordinator's leadership and how was it handled?
- Do surveyors display leadership for each other?

3. Coordination with the organisation

The focus here is the interaction between the survey team and the organisation, and how the work of the team is negotiated and arranged with the organisation. The issues to consider include:

- Do the survey team keep to the negotiated timetable?
- Do different surveyors follow up on the same issues / queries at a later time during the survey?
- Is the survey coordinator facilitating communication with the organisation?
- Who within the organisation is the survey coordinator primarily liaising with?
- What is the survey team asking of the organisation? (ie documentation)

4. Communication

The focus here is the communication and interactions between the team and the organisation. The issues to consider include:

- How do the surveyors communicate with organisational staff?
- Do the organisational staff feel they are able to explain their views effectively to the surveyors?
- Are there things staff wish they had said? Did they feel listened to and understood?
- What is the tenor of communication? Engaging/ Aggressive / passive / assertive / blaming?
- Is the communication clear or creating problems?
- How is conflict and / or differences of opinion resolved?
- Do the survey team provide feedback to the organisation throughout the survey or just at the end?

5. Decision making

The focus is how the organisational staff perceive how the survey team makes and communicates decisions with the organisation. Issues under consideration include:

- How does the organisation experience how the team makes decisions?
- How does the team involve the organisation in decisions?
- Is emerging assessment and decision communicated or just the final result?
- Does the team communicate their decision making rationale?
- How and when does the team communicate their decisions?
- Are team members asked to clarify or justify their thinking?

6. Interpreting the standards

The focus is how the organisational staff understand how individually and collectively the surveyors use and interpret the EQulP standards. The issues to consider include:

- Do surveyors refer to the ACHS EQulP standards (or they use their own tools) to explain their assessment?
- What level of specificity or literalness is used in applying the standards?
- What kind of discussion occurs between surveyors regarding the applicability of the standards within the context of the particular organisation?
- Is there any negotiation with the organisation?
- Is a broad or narrow focus taken by the surveyors?
- If the surveyor focused on a particular issue or topic, did the staff understand why?

7. Documentation

The focus is how the organisational staff understand how the survey team use the organisational documentation. Issues under consideration include:

- Do the surveyors communicate that they are aware of what is in the self-assessment report?
- What other organisational documentation do the surveyors access?
- Do organisational staff have documents they want to show the surveyors but do not have the chance to?

8. Accreditation

The focus here is to understand what the organisational staff think of the accreditation process and outcome. The issues to consider include:

- What do the organisational staff think of the accreditation process?
- Do they think survey teams are credible? Reliable?
- Are the right staff spoken to during a survey?
- Is preparing the self-assessment report useful for organisational staff?
- Does the organisation hide things from the survey team?
- How much time goes into preparing for a survey?

CONSIDER:

Organisation of the team

- Organisation
- Presentation
- Credibility

Leadership/ management

- Coordinator
- Management of the team
- Challenges
- Leadership behaviours

Coordination with the organisation

- Timetable
- Follow-up
- How/ who manages
- Requests

Communication

- What about
- Tenor or emotions
- Interview experience
- Feedback

THE UNIVERSITY OF
NEW SOUTH WALES



Centre for Clinical Governance Research

ARC Linkage Project – Researching Accreditation

Study 3

Interview Book for Organisational Staff

Name of Health Service: _____

Researcher: _____

The interviews with the staff were approached in an semi-structured informal manner, with the aim to capture the participant's views. That is, staff were asked an initial question about their views on the ACHS accreditation program and then the course of the interview followed their responses. In doing so the interviews covered many of the following themes:

- accreditation program
- the survey process
 - the preparation, including preparing documentation
 - the initial presentation
 - the interview process, both content and process
 - the summation by the survey team
 - the final report
- the conduct of individual surveyors

7.10 Appendix 10: questions to probe surveyor organisational influence

THE UNIVERSITY OF
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Centre for Clinical Governance Research in Health

**ARC Linkage Project -
Researching Accreditation**

Study 4 : Surveyor Influence and value to the organisation

Interview Book: Individual interviews with Surveyors

Topic : Influence of surveyors within the organisation

Place of Interview: _____

Name of Interviewee: _____

Position: _____

Date of Interview: _____

Researcher: _____

Workbook and interview instructions:

This book contains the questions to be posed to subject surveyors in the individual interviews conducted as part of the study of organisational influence of surveyors and the value of surveying within the organisation in which surveyors are regularly employed . The interviews are defined as “semi-structured”, which means the order of the themes and guiding questions for the interview is not prescriptive. The researcher has the freedom to cover the themes by following the direction and pace of the person being interviewed. As necessary the questions can be rephrased to suit the specific interview, as the prime focus is the issue not the wording as set out here.

The themes to be covered are:

8. General inquiry about what influence means and how it operates in the organisation
9. General inquiry about the organisation’s approach to quality and accreditation
10. General inquiry to identify what motivated the interviewee to become a surveyor and the beliefs held about the potential for surveying to provide value for the organisation
11. General inquiry about extent to which colleagues refer to the surveyor for guidance on quality issues and/or preparations for accreditation
12. General inquiry about the surveyor participant’s understanding of staff awareness of organisational expectations that surveyors should make particular contributions and or act as mentors in regard to quality improvement and/or preparation for accreditation in the organisation.
13. General inquiry to identify beliefs about the impact of surveying on the organisation’s expectations on the surveyor to contribute expertise acquired from surveying for the benefit of the organisation
14. Invitation to elaborate or comment on any issue the subject surveyor interviewee considers relevant to determining the influence she/he has in the organisation generally and the socio-professional network specifically and the perceived value to the organisation of having surveying expertise on staff
15. Invitation to identify colleagues within the socio- professional network who can contribute information about their interaction with the subject surveyor within the socio-professional network

List of Interviewees recommended by Surveyor

Interview #	Interviewee	Role	Page #
6.			
7.			
8.			
9.			
10.			
11.			

Organisational Data

What State/ Territory of the organisation?

What is the location of the health service?

Metropolitan	
Regional/ rural	
Remote	

What is the size of the health service?

Large hospital/ health service (> 200 beds)	
Medium hospital/ health service (100 – 200 beds)	
Small hospital/ health service (< 100 beds)	

Is the health service public or private?

Date/ time of interview:
Name of interviewee:

12) What sex are you?	Male	Female
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13) What is your age range?
25-40 40-55 over 55

14) What is your professional background?
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15) What is your highest qualification?
--

16) Do you have a speciality?

17) What is your job in this organisation?

18) Do you have an active clinical role?	Yes	No
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19) What is the level of your management role?	Yes	No
---	------------	-----------

20) Length of time working in your current job?
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21) Length of time working in the organisation?
--

22) Length of time working in health industry?

23) Length of time as a surveyor with ACHS?
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Issues to cover:

1. General inquiry about what influence means and how it operates in the organisation

The intention here is to ask general questions to elicit the subject surveyor's view about how influence operates in the organisation and how much influence he/ she has over quality issues:

Please describe what this organisation is like to work in?

Is communication and interaction an important issue in this organisation?

Do you think there ways to make things happen in regard to quality improvements?

Are senior staff members expected to take active steps to influence activities and /or decisions about which they have expert knowledge?

Are there any particular persons in the organisation (area or hospital) who you see as instrumental in affecting quality change or improvement?

Can you identify any persons at the area and/or hospital level who lead the process of preparation for accreditation. Are they the same as those just identified?

2. General inquiry about the organisation's approach to quality and accreditation

The intention is to identify the degree of importance the organisation places on planning for accreditation and the focus it places on interaction between staff across the organisation?

How is quality understood in the area and locally and is that consistent with the understanding in the individual hospitals?

How are standards reviewed/ measured/ monitored?

What happens when poor quality is identified?

Is quality reported upon at Area Executive/ Departmental meetings/ Divisional meetings?

Who or which groups have the major role in initiating and managing the organisation's preparations for accreditation?

How does this institution go about preparing for accreditation?

Is there an area organisational approach or is it individual to each hospital?

Do you have some thoughts on how the hospitals in your area are doing on EQUiP?

What common features can you identify about the way the hospitals in this area go about preparing for accreditation?

3. General questions to identify what motivated the interviewee to become a surveyor and the beliefs held about the potential for surveying to provide value for the organisation.

The intention here is ask interviewees general questions to identify if the surveyor feels she/he gains awareness of 'value-added' aspects from the experience of being a surveyor:

What influenced you to become a surveyor?

Is the experience you have gained from being a surveyor useful in your everyday work at this institution? Please describe the ways in which it has helped

If you identify a situation at either level that you believe should be addressed in a certain way do you see a role for yourself in influencing the outcome?

Do you believe you have influence over preparations for accreditation at either level?

If so,

- 1) can you describe the ways in which you exercise that influence?
- 2) would you trace the source of the influence to your expertise gained from being a surveyor or does it arise from other circumstances eg. senior position in the organisation, length of time engaged in particular area etc.?

Do you think you are consciously or sub consciously influencing or trying to influence quality in some way in your workplace?

Do you perform any particular role during preparations for accreditation in this organisation and can you name the ways you have an effect on this organisation's preparations for accreditation?

Do you think other colleagues believe either you or other surveyors influence the process of preparation for accreditation?

4. General inquiry about the extent to which colleagues refer to this surveyor for guidance on quality issues and/or preparation for accreditation in the organisation

The intention is to ask the surveyor general non-specific questions about the socio-professional network to elicit how surveyors communicate with colleagues and how their colleagues relate to them:

Do you consider yourself to be an expert open to give guidance on the accreditation process and quality issues in general? Please provide situational examples. Do your colleagues consider you an expert on these issues?

If so, to what do you attribute that?

If you were aware that certain colleagues were experiencing difficulties in preparing their part of what is required for accreditation would you offer any guidance?

Has the organisation got any rules or protocols setting out a distinct role or roles for surveyors in the institution's preparation for accreditation?

Do you play a leading role preparation for accreditation for any of the hospitals in this area health service?

5. General inquiry to identify the surveyor's views about whether the organisation has expectations that surveyors should make particular contributions and or act as mentors in regard to quality improvement and/or preparation for accreditation in the organisation

The intention here is to ask the interviewee/s a general non-specific question to elicit their views about their impression of the influence they believe they have and how it operates in their organisation:

Are senior staff members in the hospitals expected to take active steps to influence activities or decisions about which they have expert knowledge?

Do you have a designated role concerning the provision of information about accreditation and/or quality issues generally?

Are there informal channels through which this surveyor might have influence?

6. General questions to identify if the surveyor believes that her/his role as a surveyor has given rise to institutional expectations that particular contributions should be made by surveyor staff members to quality committees and preparation for accreditation in the organisation.

The intention here is to ask the surveyor a general non-specific question to elicit impressions of what the institutional expectations are concerning the utility the experience acquired from surveying should provide for the organisation and beyond

Do you think your colleagues in the Executive and throughout the hospitals expect you to be an expert on the accreditation process and quality issues in general?

If yes, do you respond to those expectations and if so, how?

Are you a member of any Key quality committees?

If so, how much influence do you have over keeping the committee/s informed about accreditation and/or quality issues generally?

Have you taken on any additional roles or duties in regard to quality improvement and/or preparation for accreditation since becoming a surveyor?

7. Invitation to elaborate or comment on any issue the interviewee considers relevant to determining the influence she/he has in the organisation generally and the socio-professional network specifically and the perceived value to the organisation of having surveying expertise on staff

8. Invitation to identify informed colleagues within the socio- professional network who can contribute information about their interaction with the subject surveyor within the socio-professional network

THE UNIVERSITY OF
NEW SOUTH WALES



Centre for Clinical Governance Research in Health

**ARC Linkage Project -
Researching Accreditation**

Study 4

Surveyor Influence and value to the organisation

Interview Book: Network colleague interviewees

**Topic : Influence of surveyors and value of surveying within the
organisation**

Place of Interview: _____

Name of Interviewee: _____

Position: _____

Date of Interview: _____

Researcher: _____

Workbook and interview instructions:

This book contains the questions to be posed to the network participant interviewees during individual interviews conducted for the study of the influence of surveyors and the value of surveying within the organisation in which surveyors are regularly employed. The interviews are defined as “semi-structured”, which means the order of the themes and guiding questions for the interview is not prescriptive. The researcher has the freedom to cover the themes by following the direction and pace of the person being interviewed. As necessary the questions can be rephrased to suit the specific interview, as the prime focus is the issue not the wording as set out here.

The themes to be covered are:

1. General inquiry about what influence means and how it operates in the organisation
2. General inquiry about the institution’s approach to quality and accreditation
3. General inquiry about colleagues’ awareness of surveyors on staff, the roles that perform as surveyors and the potential for surveying to provide value for the organisation
4. General inquiry about extent to which colleagues consider the surveyor a source of expertise on quality issues and/or preparations for accreditation
5. General inquiry about colleague awareness of ways in which the organisation benefits from having executive professional staff undertake surveying and whether that leads to them acting as mentors in regard to quality improvement and/or preparation for accreditation in the organisation
6. General inquiry to identify whether there are organisational expectations that surveyors will contribute expertise acquired from surveying for the benefit of the organisation
7. Invitation to elaborate or comment on any issue the interviewee considers relevant to determining the influence of the subject surveyor in the organisation generally and the socio-professional network specifically and the value of having surveyors on staff
8. Invitation to identify other potential participants within the socio-professional network of the subject surveyor

List of recommended colleague contacts

Interview #	Interviewee	Role	
1.			
2.			
3.			
4.			
5.			

Organisational Data

What State/ Territory of the organisation?	NSW
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What is the location of the health service?	
Metropolitan	
Regional/ rural	
Remote	

What is the size of the health service?	
Large hospital/ health service (> 200 beds)	
Medium hospital/ health service (100 – 200 beds)	
Small hospital/ health service (< 100 beds)	

Is the health service public or private?	Public
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Date/ time of interview:

Name of interviewee:

What sex are you?

Male

Female

What is your age range?

25-40

40-55

over 55

What is your professional background?

What is your highest qualification?

Do you have a speciality?

What is your job in this organisation?

Do you have a clinical role?

Yes

No

Do you have a management role?

Yes

No

Length of time working in your current job?

Length of time working in the organisation?

Length of time working in health industry?

Length of time working with the subject surveyor?

Type of professional relationship between you and the surveyor?

Issues to cover:

1. General inquiry about what influence means and how it operates in the organisation:

The intention here is to ask general questions to elicit the views of colleagues about how influence operates in the organisation and how much influence they believe the surveyor has over quality issues:

Please describe what this organisation is like to work in?

Is communication and interaction an important issue in this organisation?

Do you think there are ways to make things happen in regard to quality improvement?

Are there any particular persons in the organisation who you see as instrumental in affecting change or improvements in quality?

Can you identify any persons in the organisation who lead the process of preparation for accreditation. Are they the same as those identified above as leaders in affecting change?

2. General inquiry about the institution's approach to quality and accreditation

The intention is to identify the degree of importance the organisation places on planning for accreditation and the focus it places on interaction between staff across the organisation:

How is quality understood in the organisation?

How are standards reviewed/ measured/ monitored?

What happens when poor quality is identified?

Is quality reported upon at team meetings/ Departmental meetings/ Divisional meetings?

Who or which groups have the major role in initiating and managing the organisation's preparations for accreditation?

How does this institution go about preparing for accreditation?

Is there an area organisational approach or is it fragmented and individual to each hospital?

Are you aware of how your institution is doing on EQUiP?

What common features can you identify about the way the hospitals in this area go about preparing for accreditation?

3. General questions about colleagues' awareness of:

- **the surveyor's role as a surveyor**
- **what accreditation survey work involves**
- **beliefs about the amount of knowledge of quality issues the surveyor has acquired from the surveying process**
- **whether the expertise gained through surveying translates into a valuable additional resource in the organisation in which they are regularly employed**

The intention is ask interviewees general questions to identify what colleagues understand surveying to encompass and whether there are 'value-added' aspects they believe might translate into a valuable additional resource for the organisation:

Are you aware of this person's role as a surveyor?

If so:

- 1) Are you familiar with the processes involved in surveying?
- 2) Do you believe that provides this person with insights into quality issues generally and preparation for accreditation specifically?

Do you think other colleagues believe the surveyors on staff exercise influence over the process of preparation for accreditation and do they tap into her /his skill base?

Do you believe the surveyor colleague has influence over quality issues?

If so,

- 3) can you describe the ways in which she/he exercises that influence?
- 4) would you trace the source of the influence of this surveyor to her/his expertise gained from being a surveyor or does it arise from other circumstances eg. senior position in the organisation, length of time engaged in particular area etc.?

Does this surveyor consciously or sub-consciously influence quality in some way in your workplace?

4. General inquiry about extent to which colleagues refer to the surveyor for guidance on quality issues and/or preparations for accreditation in the organisation

The intention here is to ask the interviewee/s general questions to elicit their views about how they communicate with the surveyor colleague through the socio-professional network

If you encountered difficulties in preparing your part of what is required for accreditation would you consult with the surveyor/s on staff?

If a quality related situation arises that should be addressed in a certain way would surveyor/s be expected to influence the outcome?

Do the surveyors on staff, this surveyor in particular, perform any designated role during preparation for accreditation given to her because she has surveying experience?

If so, to what do you attribute that?

Do you consider this surveyor/colleague to have expertise in the area of accreditation and quality issues in general?

Has the organisation got any rules or protocols setting out a distinct role or roles for surveyors in the institution's preparation for accreditation?

5. General inquiry to identify:

- ***the extent to which any influence cast by this surveyor is linked to experience gained from surveying***
- ***the extent to which the institution encourages surveyors to act as mentors in regard to quality issues and preparation for accreditation***

The intention here is to ask the interviewee/s a general questions to elicit their views about their impression of the surveyor's influence, how it operates in their organisation and the value it might have for the organisatio:

Does this surveyor staff member perform any particular role during preparations for accreditation in this organisation and if so can you name them?

Are staff encouraged to refer their queries about quality and preparation for accreditation to surveyor colleagues, this surveyor colleague in particular?

Are there informal channels through which this surveyor might have influence?

Do you consider the experience acquired from surveying to provided a sound basis for surveyors on staff to be mentors on quality and preparation for accreditation in the organisation?

Is this surveyor considered to be a mentor within your community of practice?

6. General questions about whether there are organisational expectations that particular contributions should be made by the surveyor staff member and the value they believe surveying provides to the organisation

The intention here is to ask the interviewee/s general questions to elicit staff awareness of expectations that surveyors should utilise the experience acquired from surveying to the benefit of the organisation and beyond

To your knowledge, does the organisation have any expectation for surveyor staff members, this surveyor in particular, to contribute the insights and ideas they acquire from surveying by way of influencing quality improvements or preparations for accreditation?

Are you a member of any Key quality committees in common with this surveyor?

If so, how much is this surveyor relied upon for the purpose of keeping the committee/s informed about accreditation and/or quality issues generally?

Do you think your colleagues and/or the Executive expect this surveyor to be an expert on the accreditation process and quality issues in general?

Are you aware of how far this surveyor/colleague's influence might reach to others beyond the organisation?

7. Invitation to elaborate or comment on any issue the interviewee considers relevant to determining the influence the subject surveyor has in the organisation generally and the socio-professional network specifically and the value to the organisation of having surveyors on staff

8. Questions to identify colleagues whose close association with the subject surveyor provides them with an understanding of the value of surveyor skills within the socio-professional network