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Understanding the impact of accreditation on quality in healthcare: A grounded theory approach

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Abstract

Objective: To explore how organizations respond to and interact with the accreditation process and the actual and potential mechanisms through which accreditation may influence quality.
Design: Qualitative grounded theory study.
Setting: Organizations who had participated in Accreditation Canada's Qmentum program during January 2014–June 2016.
Participants: Individuals who had coordinated the accreditation process or were involved in managing or promoting quality.
Results: The accreditation process is largely viewed as a quality assurance process, which often feeds in to quality improvement activities if the feedback aligns with organizational priorities. Three key stages are required for accreditation to impact quality: coherence, organizational buy-in and organizational action. These stages map to constructs outlined in Normalization Process Theory. Coherence is established when an organization and its staff perceive that accreditation aligns with the organization's beliefs, context and model of service delivery. Organizational buy-in is established when there is both a conceptual champion and an operational champion, and is influenced by both internal and external contextual factors. Quality improvement action occurs when organizations take purposeful action in response to observations, feedback or self-reflection resulting from the accreditation process.
Conclusions: The accreditation process has the potential to influence quality through a series of three mechanisms: coherence, organizational buy-in and collective quality improvement action. Internal and external contextual factors, including individual characteristics, influence an organization's experience of accreditation.

Key words: accreditation, quality management, qualitative methods

Introduction

Accreditation involves the certification of a program, service, organization, institution or agency by an authorized external body using process to assess performance in relation to established standards in order to support continuous improvement [1, 2]. Despite widespread uptake of accreditation programs internationally, the process

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by which accreditation programs impact quality and outcomes is poorly understood. A systematic review of accreditation literature highlighted inconsistent findings, with conflicting evidence around organizational impact, financial impact, quality measures and program assessment [3]. Attempts to establish value have emerged in response to repeated calls for further evidence [4–6], albeit with limited success [5, 7, 8].

Before further attempts to evaluate effectiveness, there is a need to understand how accreditation could work to accomplish desired outcomes [6]. Establishing an underlying programme theory would clarify the links between the accreditation process and its anticipated effects [9], serving as a tool for clearly understanding the process (i.e. how the accreditation process should work and why) [10]. Elucidating a programme theory for accreditation could also support design, optimization of the process, identify contextual conditions necessary for its success and enhance learning [11–13]. Therefore, the objectives of this study were to explore (i) how organizations respond to and interact with the accreditation process and (ii) the actual and potential mechanisms through which accreditation may influence quality.

Methods

Study design

This study used a systematic grounded theory approach outlined by Corbin and Strauss [14]. Grounded theory is well-suited to the overall intention of the research to investigate a particular phenomenon across diverse circumstances in order to produce an explanatory model [15].

Setting

In Ontario, Canada, publicly funded health services include care provided (but not limited to): hospitals, long-term care, community support services, mental health and addition services, and community health centres (CHCs). CHCs deliver primary care services alongside health promotion and illness prevention services.

Accreditation Canada provides health services organizations with comprehensive accreditation services. Their Qmentum program is based on eight dimensions of quality [16, 17] and outlines a set of Required Organizational Practices (ROPs), which are evidence-based practices organized according to six patient safety goal areas [18]. The process involves a pre-survey period of self-assessment and preparation, an on-site survey, and post-survey reflection and modifications when necessary (https://www.accreditation.ca/qmentum).

Recruitment and data collection

To select participants, we identified a sample of 239 healthcare organizations in Ontario, Canada that had participated in Accreditation Canada's 'Qmentum' program during January 2014–June 2016. Nursing homes, organizations with academic affiliations, and organizations delivering a single specialty service (e.g. assisted reproductive technology or respiratory services) were excluded as these sectors involve a unique regulatory environment which may influence the experience of the accreditation process, which may include mandatory accreditation requirements or incentives (n = 124 excluded). The remaining organizations (n = 115) were a sample who pursued accreditation voluntarily, often in anticipation of future mandated requirements. A purpose sampling strategy was

Table 1 Participant characteristics

Study ID	Study phase	Organization	Role	Participated in validation
1	Primary	CMH Organization 1	Director of Quality	Yes
2	Primary	CMH Organization 1	Board Chair	Yes
3	Primary	CMH Organization 1	Chief Executive Officer	Yes
4	Primary	CMH Organization 1	Manager of Safety	No
5	Primary	CMH Organization 1	Clinical Program Manager	No
6	Primary	CMH Organization 1	Clinical Program Manager	No
7	Primary	CMH Organization 1	Chief Financial Officer	No
8	Primary	CMH Organization 1	Director, Support Services	No
9	Primary	CMH Organization 1	Director, Clinical Services	Yes
10	Secondary	CHC Organization 2	Accreditation Coordinator	Yes
11	Secondary	CHC Organization 2	Chief Executive Officer	No
12	Secondary	CHC Organization 2	Director, Primary Care	No
13	Secondary	CHC Organization 2	Board Chair	Yes
14	Secondary	CHC Organization 3	Chief Operating Officer	Yes
15	Secondary	CHC Organization 3	Director, Corporate Affairs	No
16	Secondary	CHC Organization 3	Clinical Program Manager	No
17	Secondary	CMH Organization 4	Quality Lead	No
18	Secondary	CMH Organization 4	Risk Manager	No
19	Secondary	Acute Care Organization 5	Quality Coordinator	No
20	Secondary	Acute Care Organization 6	Quality Coordinator	Yes
21	Secondary	Acute Care Organization 7	Director of Clinical Services	No
22	Secondary	CMH Organization 8	Clinical Program Manager	No
23	Secondary	CMH Organization 9	Quality Coordinator	Yes
24	Secondary	Acute Care Organization 10	Chief Information Officer	No

CHC, Community Health Centre; CMH, Community Mental Health.

Note: The primary phase aimed to achieve a depth of exploration within a single organization to identify core constructs relevant to the study objectives. The secondary phase involved theoretical sampling to further develop the properties of each construct and identify the relationships between emerging themes. Several participants assisted with validation, whereby a summary of the results was sent to participants for feedback to ensure the final themes and resulting theory reflected their individual experiences.

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used to identify a subset of eligible organizations (n = 22), selected to achieve a variation in sampling characteristics (e.g. sector, size and geography), in order to generate insights across a range of settings. An initial invitation email was sent by Accreditation Canada to the accreditation contact at each organization. Individuals were instructed to contact a member of the research team (LD) if they were interested in participating. Participants were initially selected based on their engagement with the accreditation process, creating an initial pool of participants with in-depth personal experience of the phenomenon under study.

A purposive sampling strategy was used in the primary phase to achieve a depth of understanding from within a single organization (refer to Table 1). The invitation to participate in an interview was extended to employees from a single organization (Organization 1) with executive, managerial, and/or direct care experience, representing those most directly interfacing with the accreditation process and its implications for care delivery. The purpose of these interviews was to identify topics that participants considered centrally relevant to either accreditation or providing quality services. Once these topics were identified, further theoretical and purposive sampling strategies were used for the second stage to further develop themes and ensure variation across sectors, including organizations providing acute, community based and mental health services (Organizations 2–10). Following the identification of core constructs (primary phase), theoretical sampling was used to further develop the properties of each construct and identify the relationships between emerging themes.

Participants completed a semi-structured interview with a member of the research team (LD), who conducted all interviews to ensure consistency and familiarity with the data. Interview questions initially followed a semi-structured interview guide (available from the authors upon request), and then pursued topics that participants identified as crucial to either accreditation or providing quality services. Observation notes were taken during each interview to be used during data analysis. All interviews were audio-recorded and transcribed by a third party. Recruitment, data collection, and analysis were continued until conceptual saturation was reached, meaning no new experiences relating to the accreditation process or managing quality were emerging and concepts were fully developed. Interviews were conducted between July and October 2016.

Data analysis

Interviews from both phases were included in data analysis, which began immediately after completion of the first interview, and continued throughout the data collection process. An inductive approach was used using three stages of open, axial and selective coding and the constant comparative technique [14]. First, one coder (LD) reviewed the transcripts to identify and extract text segments relevant to: (i) participant views and/or experiences of the accreditation process or (ii) factors that impact the quality of services provided by the organization.

Memos were created for each segment to identify the underlying ideas and processes. The segments (n = 80) were combined into groups based on similarities and then labeled with a thematic category, resulting in a list of themes (n = 8) and subthemes. Transcripts were then re-read to ensure all relevant themes were captured. Using constant comparison, preliminary links between themes were defined and overlapping themes were integrated. Axial coding was used to identify the causal, contextual and intervening conditions. During selective coding, the core category, which is the primary driver of influence in the pattern of the data analysis and has a systematic relationship with the remaining constructs, was presented as the central category within the overall theory (refer to Fig. 1). These categories were synthesized from the themes emerging from the data, and were subsequently mapped to constructs outlined in Normalization Process Theory (NPT) [19] due to their conceptual similarity.

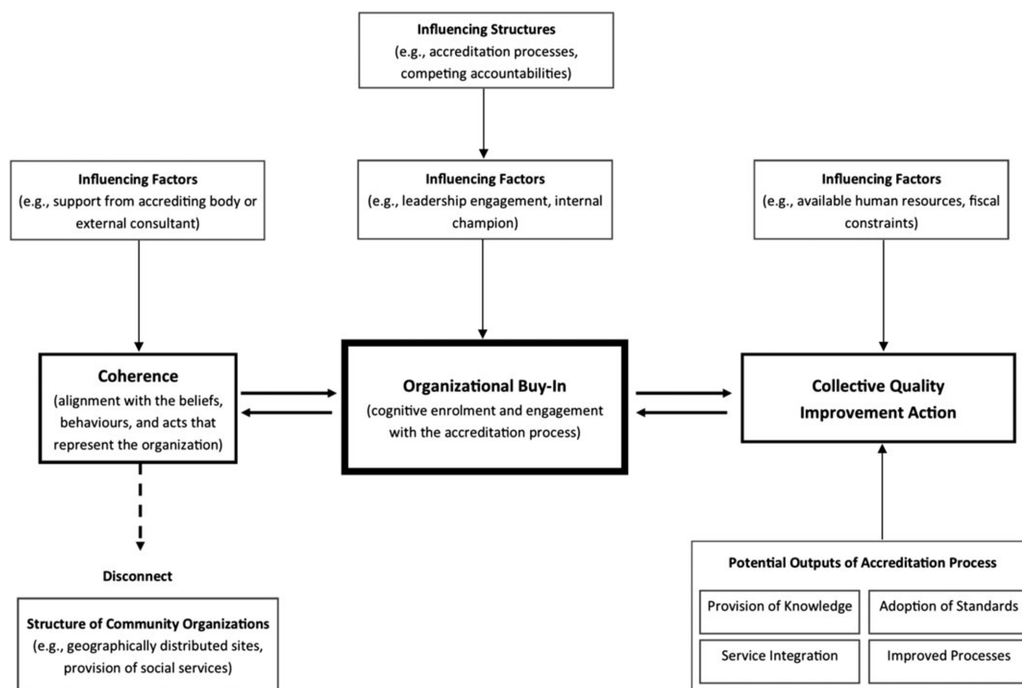

Figure 1 NPT explains the potential mechanisms by which accreditation can impact quality.

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NPT is a sociological theory used to understand the implementation, embedding and integration of new approaches in healthcare settings [20]. It accounts for how people understand and make sense of an approach (Coherence), engage and participate with it (Cognitive Participation), distribute work (Collective Action) and reflect or appraise its effects (Reflexive Monitoring) [19]. NPT extends beyond the initial introduction of a new approach to investigate the processes by which it may become embedded in practice and routine care. It can explain and guide implementation processes [21] and has been used in previous qualitative research to study new ways of working in healthcare.

Qualitative Rigour

Rigour of our study was ensured through the use of constant comparison, long transition times between interviews, member checking and peer checking, based on best practices in grounded theory methodology. The study team included expertise in qualitative methods (LD and JS), health policy (JS and JM), quality improvement (LD, JM, and NI) and accreditation (JM). Constant comparison was utilized to confirm the codes and themes, and the new groups were developed with a recursive approach. The coded constructs and resulting theory were reviewed by nine participants to ensure fidelity and verify whether the findings were in line with their experiences (member checking). A second member of the research team familiar with grounded theory (JS) independently read a selection of transcripts to ensure the themes and resulting theory were grounded in the data (peer checking).

Results

A total of 24 interviews were conducted across a sample of ten organizations (Table 1, participant characteristics). Interviews ranged from 20 to 70 min each (average = 39 min). Participants' experience of the accreditation process depended largely on organizational culture and the attitudes of senior leaders within the organization. The findings describe the underlying organizational realities that explain variations in experience and outcomes (Table 2, data underlying analytic statements). The overarching process linking accreditation to (potential) impact on quality is composed of three primary categories: coherence, organizational buy-in and collective quality improvement action (refer to Fig. 1).

Coherence

Coherence was established when an organization and its staff perceived that the accreditation standards and ROPs align with the organization's collective beliefs, context and model of service delivery. When coherence is not fully established, organizations fail to buy-in to the accreditation process beyond pursuing accreditation as an external 'stamp of approval'; successful accreditation or participation in the process was often cited as a required condition of certain funding streams.

The ability to achieve coherence was influenced by a variety of factors. Acute care organizations were consistent in their belief that accreditation requirements aligned with their model of service delivery leading to established coherence across these organizations, though they believed that immediate uptake of new standards was not feasible. Organizations in other sectors struggled to interpret and apply standards to their specific context, and experienced a varying degree of support from the accrediting body.

This was especially true for participants in community-based organizations, who reported feeling they are trying to apply a set of standards originally designed for acute care to a portfolio of services that often extend beyond clinical care to target social determinants of health. A supportive, flexible relationship with the accrediting body is a critical feature of the accreditation process that facilitates coherence.

Organizational buy-in

Organizational buy-in aligns with the NPT construct of cognitive participation 'at the organizational level' [19]. As participation in an accreditation process is mandatory in some sectors, organizations often progressed to organizational buy-in before coherence was fully established, and were therefore simultaneously engaged in both stages. This meant that the two processes influenced one another, but were nonetheless distinct.

Participants described that buy-in was established when there is both a conceptual champion and an operational champion [19]. When organizational buy-in is not established, organizations are unlikely to use the results of the accreditation process to inform quality improvement initiatives. The conceptual champion is often a credible leader within the organization, who clearly communicates the value of the accreditation, but may or may not be actively involved in preparing the organization for the accreditation process. In addition to supporting the process, the conceptual champion identified features of accreditation that resonated with organizational priorities.

The operational champion is responsible for liaising with the accrediting body and overseeing the individuals and processes involved in preparation for the on-site survey. Individuals in this role were described as actively supporting the progress of the organization's quality agenda; understanding the meaning behind accreditation standards and applying it to the context of the organization; and communicating the meaning behind the standards to individuals and departments across the organization, ensuring a consistent approach. The complexity of this task posed challenges, as highlighted in the supporting quotes.

Several contextual factors influenced whether and how organizations buy-in to the accreditation process (refer to Fig. 1). Internal factors reflected the influence of the unique characteristics of individuals, including communication processes and organizational strategies. Participants unanimously identified strong relationships as a key feature of internal context that facilitated organizational buy-in. This amplified the influence of the conceptual champion(s) and enabled the operational champion to engage staff, further contributing to cultural cohesion. When organizations did not have the resources to appoint a full-time operational champion, strong relationships with accreditation staff and surveyors played a critical role in providing the support required to create a consistent approach across the organization. When strong relationships were not present, organizations were less likely to achieve buy-in.

Participants described a range of external factors, including incentives and accountabilities, which compete with the accreditation process for attention. For example, participants highlighted the need to meet a range of quality requirements for different stakeholders. The structure of these requirements, most notably the definitions of quality indicators, could shape the way organizations think about quality care. Conceptualizations of quality were largely a product of the organization and its senior leadership, and centered on organizational performance and patient-centred outcomes

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Table 2 Participant quotes supporting qualitative themes

Theme / Supporting Quotes
Coherence
'If it doesn't apply to your organization I think it would be great if there was a way to have that discussion, so that it relieves some anxiety and allows [the organization] to always focus on the [Required Organizational Practices] and the things that are actually relevant. I understand that the standards are never going to fit everybody, so that's fine, but I think that there should be a way of having those discussions so that it alleviates [that tension].' ID11
'Overall I think the feeling, and I think it's a pretty strong feeling, not just in our organization, is [accreditation] is a little bit more hospital focused and not as community focused. Some of the things don't make a lot of sense for us. Some of the safety standards, ours are quite different. You know, the hospital staff are not going out doing bed bug clean-up in people's homes. We're in people's homes all the time.' ID3
'[The health promotion piece] is an unmet need. I don't find it addressed it at all. Of course the Community Health Center (CHC) model in itself is so different from the hospital model, and when you're going across the CHC and you're looking at the programs- if you're expected to really look at the standards that the CHC as a whole is missing, there's some programs that are not reflected in those standards at all.' ID12
'Some of these initiatives are harder in the smaller hospitals. When you come out with [a required organizational practice] that has a big price tag like medication reconciliation or changing the way healthcare is done in a particular clinic, that's huge. [...] from a practice or financial perspective, I mean you need lag time.' ID22
Organizational buy-in
'I realized that [the accreditation process] isn't worth anything unless you truly believe in it. You truly believe in disclosure, you truly believe in reporting, you truly believe in suicide prevention, which is our big number 1 incident. You can't do it just to do it. You have to do it because you actually believe in it.' ID18
'[How the accreditation process is organized] very much needs to be strategically considered. It's not something you can just – that pockets of the organization can do [independently], it needs to be right across the breadth of the organization.' ID19
'I just can't tell you how important that was because there were things that I wasn't sure if we were meeting or if we had to look at it more. I could say to her, 'Here's what we're doing now. Is this what the standard is talking about?' And she'd say, 'Yeah,' or she'd say, 'Well it seems like maybe there might be some other things.' Not to tell us what to do but she was very good at that coaching. If there's something I wasn't sure about, I could check with her and when I was done with the conversation I pretty much knew if we were pretty good or if we had some work to do. That role is really important in the whole process.' ID23
'We know that good operations will make sure that we get to, or actually support, any change initiatives. We know that, but the process of accreditation and the processes that our funders require from us aren't actually aligned. [...] A lot of the accreditation standards that are related to clinical care are actually safety-oriented. They're not necessarily care-oriented, in the sense of increasing rates of cancer screening or all of that kind of stuff. And so what ends up happening is that we have a really good safety base, but a lot of the other things that are actually added value for primary care– they just don't make it. And that's actually where we're required to develop quality initiatives [for our funder]. We need to be increasing our rates of something, and accreditation process doesn't help us with that.' ID14
Collective Quality Improvement Action
'It's more like a quality assurance perspective instead of a quality improvement perspective. So it would've been helpful to give us some direction as to, 'Well this is the gold star way of doing it. You may want to model this or try this', but we had to go back and really look at our processes on our own, which wasn't a bad exercise. It made us think, and it pulled the team together so there was a lot of thinking and we actually got some clients' input, clients who went through our services and asked, 'What were your experiences?' They said, 'Well we had to...', and we said, 'So what if we changed this?' [...] When you read the standards, you don't see a heck of a lot about quality improvement. I don't know if I'm missing something. It's there but it's not as visible. If the intent is there, it's not as visible.' ID12
'All you're really doing is quality assurance. The rest of it was pointing out deficits in our own practice. So, for example, we never had a medication tracking sheet. We realized that we didn't actually track what was in and what was expiring and not, and that there were areas that were potentially, actually, dispensing expired medications. So we instituted some changes that have actually sort of stuck, which is really good. So that part has been the quality improvement part. Accreditation for me has been an assurance process.' ID16

(including access, experience and safety). These conceptualizations were formed independent of the accreditation process, as participants commented they were unaware of Accreditation Canada's definition of quality. Although each organization targets 'improved quality', varying conceptualizations of quality creates confusion and competing priorities for healthcare organizations when identifying relevant metrics to fuel quality improvement.

Collective quality improvement action

Quality improvement action occurs when organizations take purposeful action in response to observations, feedback or self-reflection resulting from the accreditation process. The accreditation process is viewed as an external audit by many participants, serving as a quality assurance process for the majority of organizations. These organizations use the accreditation process as a self-assessment to validate their efforts and demonstrate quality standards.

Participants outlined several outputs of the accreditation process that may act as a mechanism to stimulate quality improvement actions. The provision of knowledge through the accreditation process may draw attention to best practices. Macro-level feedback draws attention to opportunities for improvement across the organization, including greater service integration and strengthened processes. As a result, for some organizations participating in accreditation for the first time, the process may be perceived as more of a quality improvement endeavour as the organization attempts to align their operations with best practices. Among those organizations who had engaged in collective action, participants expressed a need to create an internal monitoring process to facilitate ongoing self-reflection and support improvement efforts within the organization.

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Discussion

Accreditation involves a process to assess performance in relation to established standards and to implement ways to continuously improve [2]. Given that the intention to both influence and support change within healthcare organizations, there is a need to understand the actual and potential mechanisms of change in order to better understand impact on quality. Communication, case complexity, work load, education and information systems can function as both barriers and facilitators to achieving quality [22]. The ability to attribute change to accreditation amid these contextual factors has been highlighted as challenging [4], most notably due to an apparent lack of literature exploring the potential links between accreditation and quality. The findings of this study suggest that context interacts, influences, modifies and has the potential to facilitate or constrain the implementation of the accreditation process and its effects.

Successfully implementing new approaches is the product of continuous accomplishments that require constant work [23]. Our findings illustrate how organizational features have the potential to facilitate or constrain the accreditation process and potential downstream effects [24]. Thus, accreditation should be viewed as a platform for change, designed to create the conditions for change to happen, instead of being prescriptive [25, 26]. To optimize impact on quality, accreditation programs need to be flexible in their application and responsive to increasing variation in service delivery while ensuring that core standards of safety are embedded throughout the framework. Flexibility facilitates coherence [19] and allows for the consideration of context to ensure that individuals and organizations understand the value, benefits, and importance of the accreditation process. It is important to acknowledge that overly flexible approaches may negatively affect credibility, which was identified as a key feature organizational buy-in. The context in which accreditation takes place influences the type of change dynamics that occur [24], underscoring the need to further explore the tensions that exist and whether they vary across sectors.

Participation in accreditation was often cited as a mandatory requirement tied to funding, acting as an external driver of engagement. 'Buying in' to that practice, however, is an internal process that depends heavily on the organizational culture. This involves achieving shared beliefs across the organization about the value of accreditation and its standards within a network of existing practices [19]. Achieving buy-in is threatened by conflicting attitudes of staff, managers, and senior leadership with respect to the value of accreditation [27]. Motivation to introduce accreditation-related changes lessens following the first cycle of accreditation [24], suggesting that earlier cycles present the greatest opportunity to promote buy-in. Therefore, focusing on relationship development and providing tailored support to client organizations (especially where organizations do not have an operational champion) are potential strategies to employ during the early stages of accreditation in order to optimize impact.

It is important to note that although some organizations view the accreditation as a quality assurance process, our findings suggest it nonetheless stimulates quality improvement action [2]. Variable reports of effectiveness and impact may be explained by the degree to which modifications to processes and resources actually occur [25]. When accreditation processes fail to have an impact, it may be explained by differences in individual engagement or an organization's ability to mobilize resources. In contrast, failure to achieve impact may also be a product of the accreditation process itself, which may address deficiencies in outcome and process but fail to connect these deficiencies to a downstream impact on outcomes [28].

Once an organization progresses to collective quality improvement action, there is a need to encourage ongoing reflection and self-monitoring to create quality improvement capacity and ensure sustainability. Accrediting bodies are increasingly interacting with governments, regulators, and health insurers, presenting an opportunity for accreditation processes to encourage the creation of a common set of standards for data collection, which addresses sustainability within an organization while driving the ongoing assessment of system performance and public reporting [29, 30].

Given that this is the first study to explore potential mechanisms of impact, participation was limited to individuals familiar with the accreditation process who seemed best positioned to speak to topic as an initial point of exploration. Although this approach was necessary to establish an initial theory, this recruitment strategy introduced sampling bias by pre-defining the sample population. Future work should adopt a broader perspective, utilizing randomized recruitment that includes a range of direct care providers, patients and policy makers. Given that the significant interaction between context and experience, these results are not generalizable beyond the Canadian institutions that participated. However, the extensive use of NPT in understanding change in healthcare organizations [31–36] suggests that the utility of these findings in understanding when accreditation might and might not work is likely to apply to other contexts. Although, we reached thematic data saturation within our sample, more work is needed to seek out disconfirming cases [37] to further refine the theory. We excluded organizations for whom there was a clear regulatory requirement or funding incentive to participate in accreditation, however, our results suggest additional incentives and motivations exist and a more nuanced understanding is warranted. These exclusion criteria further contribute to sampling bias; therefore future work should explore whether mandatory participation or financial incentives influence how organizations interact with the accreditation process and its impact on quality. Finally, we deliberately avoided defining the concept of quality, allowing individuals to describe their own experiences and perceptions. Given that the variability in definitions of quality [38], it may be beneficial for future work to explore how healthcare organizations conceptualize quality, and the extent to which perspectives are variable.

Conclusion

Complex contextual factors and individual characteristics influence an organization's experience of accreditation. Understanding the mechanisms through which accreditation has an impact on quality will help to shape future evaluations of effectiveness to ensure they are measuring appropriate outcomes. This work adds key insights into the existing literature on accreditation by (i) demonstrating how organizations experience accreditation and (ii) suggesting opportunities to maximize impact of the accreditation on desired quality outcomes.

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