

**Factors Affecting the Implementation of  
Joint Commission International Standards  
in United Arab Emirates Hospitals**

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## Abbreviations

CSA	Case study A
CSB	Case study B
DOHMS	Department of Health and Medical Services
EFQM	European Foundation for Quality Management
GCC	Gulf Cooperation Council
GDP	Gross domestic product
IOM	Institute of Medicine
ISO	International Organisation for Standardisation
JCAHO	Joint Commission on Accreditation of Healthcare Organisations
JCI	Joint Commission International
MM	Middle management
QMS	Quality management system
TM	Top management
TQM	Total quality management
UAE	United Arab Emirates
UK	United Kingdom
USA	United States of America

## **Abstract**

The implementation of quality management systems (QMSs) is a world-wide phenomenon, particularly in organisations in developing countries, which have used different QMSs to improve the quality of their goods and services. Joint Commission International (JCI) is an international body issuing healthcare standards following the principles of Total Quality Management to improve quality and patient safety.

The influence of the trend towards implementing QMSs by adopting an international framework has reached the Middle East through the continuous efforts of healthcare organisations to achieve international accreditation using JCI standards. The public sector hospitals are the leading hospitals in the United Arab Emirates (UAE) in achieving accreditation and meeting JCI standards. Indeed, many hospitals in the Middle East in general and in the UAE in particular are in the process of achieving JCI accreditation. This research examines how various factors affect the processes of implementing JCI standards in UAE hospitals.

The research is qualitative in nature, employing a case study approach and using semi-structured interviews as the main data collection tool within two hospitals in the Emirate of Dubai. Several other tools are used in order to achieve triangulation and to deepen the understanding of the factors identified.

Contributions to knowledge are made by the research, which represents the first attempt to investigate empirically the processes of implementing JCI standards in UAE hospitals. The original contribution of the research is in providing an in-depth understanding of the factors affecting this process. These factors are grouped into four main categories: organisational factors, human resource issues, cultural issues and technical factors. A unique contribution of the study is the identification of several new factors within the cultural context that could affect the implementation of the JCI standards.

## CHAPTER ONE

### Introduction

#### 1.0 Introduction

In such a highly competitive marketplace, undergoing dramatic changes in customers' expectations of value and affected by the dramatic revolution in information technology, excellence in quality has become a fundamental requirement for organisations in order to survive and succeed (Jagadeesh, 1999). Total Quality Management (TQM) is considered to be an essential way to achieve the required excellence in business practice, as it provides customer satisfaction through continuous improvement (Sayed, 2000). In hospital organisations, TQM is a promising management approach focusing on the customer, the improvement of structures and processes, and the outcome of healthcare services (Brown, 2006).

A review of the literature shows that it is very important for organisations involved in TQM projects to understand and manage the factors that have an impact on the implementation process. Research in the UK reveals that British firms are having problems with the implementation of TQM (Hill and Wilkinson, 1995). The principles and techniques of TQM have only recently been applied to UAE hospitals, where their implementation has encountered major challenges. No reference was found in the literature reviewed for the present study, however, to any research which has explored the factors particularly associated with the process of implementing TQM in UAE hospitals.

More than 3000 hospitals have been accredited since 1951 in the United States by the Joint Commission on Accreditation of Healthcare Organisations (now renamed 'the Joint Commission', but referred to throughout this thesis by its full abbreviation of JCAHO) (Joint Commission International, 2003). In the United Arab Emirates (UAE) six hospitals have achieved accreditation by the Joint Commission International (JCI) (Joint Commission International, 2007), which suggests that there are certain factors that affect the implementation of the JCI standards.

*"The philosophy of the JCI standards is based on principles of total quality management and continuous quality improvement"* (Joint Commission International, 2000, p1).



The JCI standards, which are the international version of the JCAHO standards, will be used as a TQM approach in this study, whose main aim is to identify and investigate the factors affecting the implementation of these standards in UAE hospitals.

### **1.1 Background**

In this new millennium, in a highly competitive modern business environment, with dramatic increases in customer needs and expectations of different services, the health industry represents a considerable economic weight. With demand continuing to grow year after year, health services remain one of the important potential needs for every member of the community. Costs in the healthcare sector have increased significantly throughout the past 25 years and this trend is expected to continue. Most of this cost arises in hospitals (Yang, 2003).

Health data published by the Organisation for Economic Co-operation and Development (2003), generated from a comparative analysis of 30 countries, shows that average healthcare expenditure in European countries was 8.4% of gross domestic product (GDP) in 2001. Health costs are also escalating in the United States, where Cowan *et al.* (2004) report that in 2002, expenditure on health care was \$1.6 trillion—a 93% increase on the previous year. In addition, GDP figures indicated that hospital spending was responsible for health spending growing faster than the overall economy for four consecutive years.

According to Sayed (1998), hospitals consume the largest share of public health resources; in developing countries, they absorb more resources than any other kind of recurrent government spending on health. Due to the nature of healthcare processes and customers, reducing errors and improving efficiency in hospitals will not only save money; it will also save lives, because the customers of the healthcare services are human beings. Brown (2007) believes that improving the outcome of healthcare services requires a continuous organisation-wide improvement in the processes of delivering them to patients and their families in an efficient and effective manner.

The concept of Total Quality Management, as advocated by management theorists and industrial engineers, has been adopted by health care leaders. It is a broad management philosophy espousing quality and leadership commitment that provides the energy and rationale for implementation of the process of continuous quality improvement as part

of an organisation-wide quality strategy in health care (Brown, 2007). On the other hand, Brown (2007) supports Donabedian's (1988) linking of the definition of quality in health care to compliance with preset standards: *"Standards are created when experts are able to understand what the right things are and how the right things are best achieved. Therefore, quality can be said to be compliance with standards"*.

Implementing TQM systems in healthcare organisations can improve patient safety, establish true economic effectiveness through vastly improved cost management practices and move the healthcare industry from its current low performance level to a new standard of excellence (Drago, 2002). The Institute of Medicine (1999) presents the results of two large studies of adverse events that took place in the early 1990s and indicating that 44,000 to 98,000 Americans die each year as a result of medical errors.

In addition, implementing TQM in health care, which is a patient-focused process, creates safe health services, effective patient care, improved health outcomes and improved patient satisfaction, provided that the processes are designed, implemented and consistently executed well (Schyve, 2000). The TQM approach has shown potential for enabling dramatic improvement in quality and cost in healthcare organisations, but has also been found difficult to implement. Healthcare managers must gain experience and training with a broad set of business management models (Trisolini, 2002).

In another study, Tamimi and Sebastianelli (1998) identify many problems that companies might experience while implementing TQM. Major problems cited by companies include failure to link management compensation to the achievement of quality goals, inadequate employee training and inadequate resources for employing quality management. However, the most important problems are a lack of top management commitment and a failure to focus on strategic planning.

## **1.2 The need for the study**

The importance of quality in the UAE service industries has grown in recent years. Decision makers in the country have started to believe that implementing quality systems is the key source of competitive advantage for all businesses, including healthcare providers. In his introduction to the Dubai Quality Award requirements, Sheikh Mohammed Al Maktoum, the Ruler of Dubai notes that *"the competitiveness of UAE companies against world class standards through adopting quality systems is one*

*of the most crucial necessities for accomplishing the country's mission, achieving the strategic objectives and contributing to the local economy" (Dubai Quality Award, 2004, p1).*

Many governmental awards have been established to recognize agencies and organisations that have achieved high quality levels in various industries, including health. Some healthcare organisations are beginning to adapt quality philosophies in their operations and administrative systems. This quality movement aiming at transforming the business environment and practices in the country requires scientific study, which will assist organisations to acknowledge and manage the factors that may have an impact on the implementation of quality management systems (QMSs). Healthcare organisations comprise a significant business area which will be part of adopting such systems to improve quality and patient safety.

It is very important for organisations embarking on a TQM journey to understand the factors associated with the implementation process. By understanding the potential severity of such factors, companies and organisations will be in a better position to anticipate and solve the problems that might otherwise inhibit successful TQM implementation. Finally, companies that spend more time in planning for the cultural aspects of implementing a TQM programme will improve their chances of a successful implementation (Gray and Fazel, 2000).

A detailed review of literature on implementing TQM and JCI standards in hospitals indicates that there is a gap in tackling the factors associated with their successful implementation in UAE hospitals. This research is a contribution to bridging this gap, so helping health professionals and managers to implement the JCI standards in successfully UAE hospitals. This research study discusses these factors with a focus on the public hospitals of the Department of Health and Medical Services (DOHMS), which runs publicly owned hospitals in the Emirate of Dubai.

Of 147 hospitals accredited by the JCI outside the United States before the end of 2007, 56 were in the Middle East. In the UAE, 13 hospitals are accredited to JCI standards. The five largest hospitals in the UAE, with a capacity of more than 200 beds, are governmental hospitals and all were accredited by the JCI between 2006 and 2007; three of these are DOHMS establishments. The American Hospital in Dubai was the

first to be accredited in the year 2000. Many other private and public hospitals in the Middle East in general and in the UAE in particular are in the process of implementing the JCI standards to achieve international accreditation. An overview of these accredited hospitals is presented as part of the literature review, in section 2.5.1.

### **1.3 The main features of UAE culture**

Since this study is set in the UAE and most of the literature originates in the West, this section examines the cultural aspects of the UAE which may be significant factors in the research. Hofstede (1997, p12) defines culture as *“the collective programming of the mind, which distinguishes the members of one category of people from another”*. It can be argued that the differences in work-related values are the result of an underlying difference in culture and that one of the major factors affecting the implementation of TQM and continuous quality improvement is the failure to consider the environmental and cultural situation of the workforce (Huq and Martin, 2000).

Hofstede (1980), for example, has suggested four dimensions of cultural difference between nations, clustering cultures according to whether they are high or low on each of these dimensions, which he labels as ‘power-distance’, ‘uncertainty-avoidance’, ‘individualism-collectivism’ and ‘masculinity-femininity’. In this research, the factors affecting the implementation of JCI standards will be explored within the environment and the cultural context of the UAE. The relevant aspects of the society and culture of the UAE are examined as part of the literature review, in sections 2.8.1 and 2.8.2.

### **1.4 The UAE healthcare system**

The investment in health care in the UAE has been very considerable since the discovery of oil in 1962, which led to a significant development in the healthcare system throughout the country, providing easy access to all kinds of medical care for the whole UAE population. The healthcare providers delivering these services include the Ministry of Health, the army, the Abu Dhabi Health Care Authority, the DOHMS, Dubai Health Care City and the private sector. The governmental healthcare services are available free to all UAE nationals and at low rates to expatriates who are resident in the country (Dubai Health, 2007).

Political and business leaders in the UAE in general and in Dubai in particular promote quality initiatives in all industries, including healthcare services, by encouraging

organisations to implement international standards. In response to this drive, and in an attempt to meet the requirements of the Dubai Government Excellence Programme, the DOHMS in Dubai decided in the year 2005 to adopt JCI standards in its facilities and to apply for JCI accreditation. The JCI standards were implemented and accreditation was granted in 2007 (Dubai Health, 2007). The healthcare system in the UAE is discussed in the literature review chapter, section 2.8.4.

## **1.5 Aim, objectives and research questions**

The aim of this research is to investigate and identify the factors that affect the implementation of JCI standards in UAE hospitals.

### **1.5.1 The objectives of the study**

- To identify the factors affecting the process of implementing JCI standards in UAE hospitals. These factors will be identified by reviewing the relevant literature.
- To investigate and analyse the factors affecting the implementation of JCI standards in UAE hospitals by conducting case study research.
- To categorise the common factors that affect the implementation of JCI standards in UAE hospitals.

### **1.5.2 Research questions**

The research questions, based on the above aim and objectives, are:

- What are the factors that affect the implementation of JCI standards in UAE hospitals?
- How do these factors affect the implementation of JCI standards in UAE hospitals?
- Why do these factors affect the implementation JCI standards in UAE hospitals?
- What are the factors that are unique to the UAE environment, if any, why are they different and how can they be categorised?

## **1.6 Originality and expected contribution of the research**

The significant contribution to existing knowledge made by this study and its originality will be achieved through an in-depth understanding of the factors affecting the implementation of JCI standards in UAE hospitals. The factors identified can be used to evaluate the process of implementation. The findings will strengthen the body

of knowledge and the existing literature on implementing QMSs in hospitals. More specifically, they will provide a clearer understanding of the implementation of JCI standards in UAE hospitals, including the categorisation of those factors that lead to achieving accreditation as a result of implementation. The need for such a study arises because there is no case study research in the published literature that investigates the process of implementing JCI standards in UAE hospitals.

### **1.7 Why the Joint Commission Accreditation Programme was chosen**

The following points explain why the JCI standards are taken in this research as the QMS whose implementation is investigated.

- **JCI standards are based on the principles of TQM.** As mentioned in the introduction to this chapter, the philosophy of the JCI standards is based on the principles of TQM and continuous quality improvement. According to Lin and Clousing (1995), the JCAHO has incorporated the concepts of TQM into its standards to implement change. The use of a TQM tool is a very important quality improvement approach for hospitals and it represents a fundamental paradigm shift in ideas about healthcare quality which can be used to correct the operation of an organisation (McLean, 2006). Hospital administrators have realised that if they do not take steps to correct their hospital problems, government or someone else will do it for them (Brashier *et al.*, 1996). Table 1.1 summarises some of the similarities between JCI and TQM.

- **The JCI standards consider the cultural and environmental contexts.** The accreditation programme emphasises the evaluation of the quality of services, education and training against internationally accepted standards (Sohail, 2003). JCI standards, as the international version of the JCAHO ones, are designed to meet the specific cultural and environmental needs of hospitals and other healthcare organisations wherever they may be in the world. Timmons (2007) states that

*“Joint Commission International standards account for countries’ and regions’ specific legal, religious, and cultural factors [as opposed to domestic US requirements]. We consider JCI’s standards to be optimal, achievable criteria for organisations dedicated to improving the quality of patient care, ensuring a safe environment, and continually working to reduce risks to patients and staff”.*

JCI accreditation is also considered to be an agent of change affecting all areas of the organisation and all actors (Pomey *et al.*, 2004).

**Table 1.1: JCI and TQM compared**

Principles of TQM	Principles of JCI
Deming (1986) believes that an important component of TQM implementation is the cooperation of the different functions and groups responsible for quality, including top management, workers, suppliers and customers.	Accreditation is considered an agent of change affecting all areas of the organisation and all actors (Pomey <i>et al.</i> , 2004). The JCI standards emphasise that providing excellent patient care requires effective leadership; in particular, leaders must identify the organisation’s mission and make sure that the resources needed to fulfil it are available (JCI, 2003, p121).
As a principle of quality management, Deming (1986) focuses on quality data and the use of statistical methods to analyse them. He also considers the redesign of the system or process itself as a fundamental element of the TQM approach and estimates that 85 to 95% of variation results from the system. He recommends statistical methods to understand common causes that will lead to their reduction.	The JCI follows the principles of TQM and continuous quality improvement (Brashier <i>et al.</i> , 1996). Quality improvement and patient safety are data driven. Because most organisations have limited resources, they cannot collect data to monitor everything they want to. Thus, each organisation must choose which clinical and managerial processes and outcomes are most important to monitor (JCI, 2003, p105).
TQM is a management philosophy that seeks to integrate all organisational functions to focus on meeting customer needs and organisational objectives (Hashmi, 2004).	According to JCI standards of governance, leadership and direction, leaders must work together well to coordinate and integrate all the organisation’s activities, including those designed to improve clinical services (JCI, 2003, p121).
Ennis and Harrington (1999) emphasise the importance of multidisciplinary teamwork as a basic prerequisite of TQM, where each member of the team has a role to play in the delivery of patient care. This will lead to a cross-functional approach, where no one person or department is superior to another as an integral part of TQM.	JCI quality improvement and patient safety standards focus on continuous quality improvement by following a multidisciplinary approach, which takes into account that most clinical care processes involve more than one department or unit and may involve many individual jobs, and that most clinical and managerial quality issues are interrelated (JCI, 2003, p97).

- Internationally recognized standards.** The JCAHO was established in 1951 and its long experience was utilized to build the international accreditation programme, which is recognized by the International Society for Quality Assurance (2007). Its standards are implemented in more than 100 countries all over the globe, including in Europe.

China, South America, East Asia, Africa and the Middle East. More than 300 hospitals in the international community have achieved the JCI accreditation (JCI website, 2008).

- **Healthcare-focused standards.** JCI standards are a combination of patient- and organisation-centred standards which help organisations to assure that all aspects of a patient's journey through a healthcare organisation are as safe and of favourable quality as possible. These standards focus on the structure, processes and outcomes of health care (JCI, 2003, p149).

- **Implemented in the UAE and Middle East.** JCI standards are widely implemented in the Middle East, where more than 50 organisations have achieved JCI accreditation to date. Six of these are in the UAE, and the numbers have grown year by year since the international version was published in 1999.

### **1.8 The rationale for choosing to study UAE hospitals**

There were two main reasons for conducting this research in UAE hospitals. First, the potential for future investment in the UAE healthcare industry is very high, as evidenced in the Dubai 2006-2016 strategic plan. The country is also undergoing a significant increase in population, at an annual rate of 5.2% (World Bank, 2005), which will affect the population's total healthcare needs.

The Emirate of Dubai spends around 17% of its healthcare budget to treat its nationals outside the country (DOHMS, 2006). One of the reasons for seeking overseas treatment which is always included in the application form that nationals have to complete to gain approval for such treatment is lack of confidence in the local healthcare services. Improving the quality of these services by implementing quality systems and meeting internationally recognised standards may improve the confidence of the community in using local services.

### **1.9 The research stages**

The research went through the following five stages.

#### **1.9.1 Stage one: Literature review**

Relevant literature on implementing quality and TQM in hospitals worldwide was reviewed. Many textbooks on research methodology were also consulted. The literature



review allowed the researcher to understand the concepts of TQM implementation in hospitals, to choose the appropriate research methodology for the current research and to generate the interview questions.

### **1.9.2 Stage two: Research methodology**

The research methodology is the processes and procedures followed in developing the research. Choosing the methodology entails identifying the need for the research, reviewing the related literature, developing the objectives and the research questions, then identifying the appropriate strategies to answer these questions. The research methodology also includes the tools used for collecting, analysing and presenting the data. It depends on the overall aim and scope of the research, the scope of data, the research questions and the proposal, as well as the constraints of the research (Yin, 1994).

The two broad research approaches, qualitative and quantitative, were studied and analysed to select the appropriate one to meet the objectives of this research and to answer the research questions. The qualitative approach was adopted because it allows the researcher to derive an in-depth understanding of the subject and to reach sound conclusions. Qualitative research is a source of well grounded, rich descriptions and explanations of processes in identifiable local contexts (Amaratunga *et al.*, 2002). This approach is related to the phenomenological paradigm, which is concerned with understanding human behaviour from the participants' frame of reference, giving due consideration to the subjective state of the individual by focusing on the meaning rather than the measurement of social phenomena (Hussey and Hussey, 1997).

The case study was chosen as the research design best able to meet the objectives by providing an in-depth understanding of the process of implementing JCI standards in UAE hospitals. The case study is the preferred strategy when 'how' or 'why' questions are posed (Yin, 2003). Two UAE public hospitals were chosen as the locations of the case studies. It is worth mentioning that the researcher works in case study hospital A. This situation facilitated data collection, including access to all the documents required to meet the aim and objectives of the research. On the other hand, the position of the researcher as a manager with responsibility for quality may have influenced the interview responses and so biased the results. The researcher addresses the issue of bias by triangulating the interview data in both case studies with material gathered from

official documentation and direct observation, as set out in section 3.5.2. Researcher bias is also discussed in section 3.8. A detailed discussion of the rationale for selecting the case studies is explored in the research methodology chapter.

### **1.9.3 Stage three: Data collection and analysis**

The researcher chose semi-structured interviews as the main data-gathering tool. These were conducted with the appropriate personnel: top managers, middle managers and frontline employees. This constituted the primary source of data collection, supported by secondary data from archives, quarterly and annual reports. Other relevant organisational documents were also reviewed and the researcher had the opportunity to collect further primary data through direct observation in both hospitals. The qualitative analysis of the data collected from the two case studies and the use of multiple sources to allow triangulation is discussed in the methodology chapter.

### **1.9.4 Stage four: Discussion**

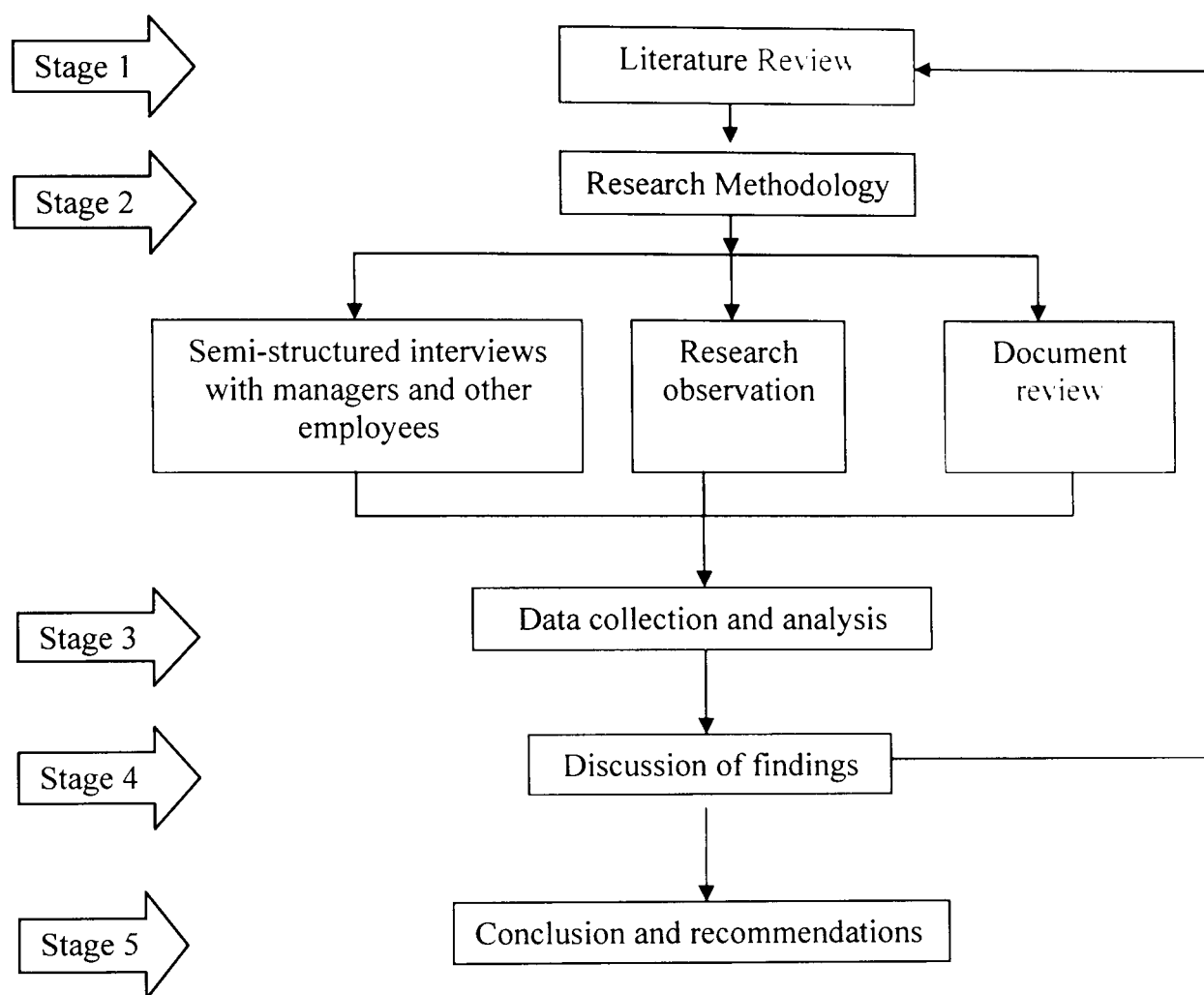
At this stage the researcher reviewed and discussed the data collected and analysed in stage three in order to identify and categorise the factors affecting the implementation of JCI standards in UAE hospitals and to relate these findings to those reported in the literature. The synthesis of findings from these two sources provided the basis for developing the categories and identifying the most common types of factors. This grouping and categorisation of the factors can be used by other researchers for further studies of JCI implementation in similar or different contexts. Some additional literature was identified and reviewed following the empirical stage of the research and during the discussion of the empirical findings of the two case studies. The justification of this review is to ensure that the field study results are thus discussed in the context of previous studies and of theoretical explanations.

### **1.9.5 Stage five: Conclusion and recommendations**

In the final chapter of this thesis, an overall conclusion is presented in relation to the research aim and objectives. The originality of the research and the contribution to knowledge are discussed and recommendations made for future research. Figure 1.1 depicts the research stages as discussed above.

### **1.10 Chapter summary**

This introductory chapter has offered an insight into the research study, presenting a brief overview of QMS implementation and its background. It has considered specifically the case of the UAE, justifying the need for the research, and has identified the research aim and objectives to be achieved. The contributions to knowledge have been identified and an indication given of the methodology to be adopted to secure these contributions. An outline of the research process has also been provided. As indicated in section 1.9, the following chapter will address the existing literature in the field of TQM and QMS implementation, with particular reference to JCI.



**Figure 1.1: The research process** (Source: Al-Haj, 2006)

## **CHAPTER TWO**

### **Literature Review**

#### **2.0 Introduction**

The purpose of this literature review is to investigate and understand the current knowledge of the principles, concepts and application of total quality management. The review will explain the implementation of a TQM approach in healthcare organisations. Its main aim is to identify the various factors that affect the implementation of the JCI standards in UAE hospitals in particular and the Middle East in general. It will also facilitate the process of identifying the appropriate research design and the development of the interview questions. Finally, the synthesis of the findings of the literature review with those of the field study will guide the researcher in categorising the factors that affect the implementation of the JCI standards in UAE hospitals.

The review will cover the following four main areas:

- A discussion of the principles and philosophies of quality, TQM, quality gurus and their contributions to TQM, and QMS.
- An introduction to the JCI standards, principles and components, highlighting similarities and differences with the International Standardization Organisation (ISO) and European Foundation for Quality Management (EFQM) equivalents.
- The factors that affect the implementation of JCI as a quality management system based on the principles of TQM in organisations in general and in hospitals in particular.
- The national culture, the UAE environment and the hospitals chosen for case study, which includes the definition of culture, the impact of cultural difference on management systems, the UAE economy, its healthcare system and quality trends in the UAE.

#### **2.1 Search strategy used in the literature review**

The following sections of this chapter review the literature on the five areas mentioned in the introduction to this chapter. The following points are considered in the literature review:

- In the discussion of the quality principles and the philosophy of TQM the researcher reviews the work of quality gurus like Deming, Juran, Crosby, Ishikawa and others because of their pioneering contributions to the literature

and body of knowledge in the field of quality management. The researcher noticed that some, including Deming, did not use the term TQM; however, the principles and philosophy of TQM were used as appropriate. The work of some other authors was reviewed in the field of quality definitions, principles, TQM implementation in general and health care in particular. The researcher found that research papers had been published on the implementation of quality systems and TQM as well as accreditation of hospitals by many authors, including Huq and Martin (2000) Yang (2003), Ruiz and Simon (2004) Pomey *et al.* (2004), Hendrich *et al.* (2007), Yu and Houston (2007) and Furman and Caplan (2007).

- In conducting the search the researcher reviewed only English literature and used the search terms ‘TQM implementation’, ‘TQM implementation in hospitals’, ‘JCI implementation’, ‘factors affecting the implementation of TQM’, ‘factors affecting the implementation of JCI in hospitals’ and ‘change and cultural management’. The Emerald and Epsco databases were mainly used to perform this search because the most relevant papers and journals could be found there. More than one thousand papers were found under the above keywords. Some of the journals reviewed in these databases contained literature specific to hospital management and the implementation of quality management systems in hospitals. Hundreds of these papers were relevant to this research. The remainder were eliminated and the researcher finally selected more than three hundred papers to be used directly in this research or to increase his knowledge of the topic. Table 2.6 summarises some of the research papers because they are particularly relevant to the factors affecting implementation of TQM, QMSs and JCI.
- Some additional literature was identified and reviewed following the empirical stage of research and during the discussion of the empirical findings of the two case studies. The justification for this review was to ensure that the fieldwork results could be discussed in the context of previous studies and theoretical explanations in order to identify the similarities and differences between factors identified in the literature review and the corresponding findings of the case studies. This will also provide opportunities to discuss any new issues that

emerge from the case study findings which were not predicted in the literature review.

- To evaluate the robustness of the literature reviewed and to differentiate between academic research papers and other levels of literature such as magazine articles, the researcher considered the following factors affecting the selection of literature: Is the article relevant to the topic under investigation? Is the article peer-reviewed? Is it based on empirical research with an appropriate methodology? If the information is based on opinion rather than empirical research, is the author a recognised, credible expert in the field? These points guided the researcher in identifying the factors that affect the implementation of JCI standards in hospitals. Table 2.7 lists some of the research papers and case studies reviewed and used to identify the factors that affect the implementation of JCI standards in hospitals. In some situations the researcher found references to relevant PhD theses or articles related to the findings of research papers and case studies in certain contexts. Many of these relevant PhD findings had not yet been published and it was necessary to consult the original thesis to find the data, even though the first choice of the researcher was published papers. There is an explanation in section 2.6 of this chapter of how the factors listed in Table 2.6 were identified and developed.
- The researcher used the literature on implementing TQM and QMSs in hospitals to identify the factors that affect the implementation of JCI standards because of the similarities in the principles of the TQM and JCI standards, as explained in Chapter One, section 1.7 and as detailed in Table 1.1. However, the researcher found that some of the literature referred to the implementation of JCI standards. Clearly the list of these reviewed research papers is given more importance and they are listed in Table 2.7. The researcher has been consistent, to ensure that whenever discussing any area of this study the priority is given to peer-reviewed research papers and to the contribution of the key authors whenever it is relevant, as mentioned above in this section. Similarly, in the process of identifying factors affecting the implementation of JCI standards the researcher ensured that any such factor had been mentioned in at least one of the reviewed research papers following the peer review process, including case studies. A list

of some of the peer-reviewed journals which were used to identify the factors that affect the implementation of JCI standards is given in Appendix 9.

## **2.2 Quality management**

This section covers the definition of quality, quality gurus and the principles of TQM.

### **2.2.1 Definition of quality**

The definitions of both quality and TQM have been debated for many years by quality management researchers. A number of definitions have emerged but there is still no universal agreement on them (Sila and Ebrahimpour, 2003). Huq (1996) states that many leaders of healthcare organisations define quality as continually improving services to meet and exceed the expectations of their customers. On the other hand, a number of definitions have been proposed by quality gurus. Deming (1986, p5) asserts that “*Quality should be aimed at the needs of the consumer, present and future*”, while Crosby (1996, p24) defines quality as “*Conformance to requirements and ... conforming to specification*”. The researcher believes that a combination of these two definitions is appropriate in the context of healthcare services, because it is important to meet the customer’s needs and please those who utilize healthcare services, while such services should also comply with recognised standards and requirements to ensure safety and avoid harming patients. The accreditation programme in hospitals emphasises the evaluation of the quality of the service, education and training against internationally accepted professional standards (Sohail, 2003).

Service in healthcare organisations is intangible and perishable. Healthcare organisations cannot produce their services prior to need—indeed, in most cases they must be provided within minutes of request—and most importantly, healthcare organisations deal with intangible, individual preferences, so implementing quality systems in these organisations is a particularly challenging task (Huq, 1996). According to the definition of the ISO, the quality system is the organisational structure, responsibilities, procedures, processes and resources for implementing quality management (ISO 8402, 1994).

Tannock and Krasachol (2002) observe that in developed countries such as the UK, USA and Japan, TQM has been an important issue for more than two decades in all business sectors, particularly manufacturing. In many developing countries, however,



TQM is a new and challenging management approach. More recently, the application of TQM practices has gained attention in the healthcare sector in many countries, including in Europe and America. However, it is necessary to implement advanced TQM if healthcare providers wish to resolve their problems effectively (Ching, 2003).

Dranove *et al.* (1999) observe that nearly all hospitals in the United States are involved in quality improvement programmes. They add that 98% of approximately 2000 hospitals in 1997 were using continuous quality improvement. In the Netherlands, Wagner *et al.* (2003) found that 71% of all healthcare organisations were training their employees in quality management. In Europe there was a significant rise in interest in implementing quality improvement initiatives in the last 15 years of the 20<sup>th</sup> century (Ovretveit, 2001).

### **2.2.2 Quality gurus**

Most of the contemporary TQM literature derives from the quality management principles and philosophies of quality gurus such as Crosby, Deming and Juran. These authors have been critical in the evolution of TQM frameworks with their principles (Sila and Ebrahimpour, 2003). Crosby (1979) recommended a 14-step programme to improve quality through defect prevention, then introduced the concept of Zero Defects (Crosby, 1980) to increase profitability. He is well known for his belief that quality is not a gift but is free; what costs money is a deviation from quality. Crosby describes quality as “*conformance to specifications*” (1996, p14), addressing it from the service provider perspective and stating that the role of the organisation is to deliver what it has promised. The way to achieve this is to have zero defects as a standard for performance and to deny that error is inevitable or that there should be an acceptable quality level (Hamali, 1999).

Deming (1986) believes that an important variable in the success of TQM implementation is the cooperation of the different functions and groups responsible for quality, including top management, workers, suppliers and customers. Deming focuses on quality data and the use of statistical methods to analyse these data, while considering the redesign of the system or process itself as a fundamental element of the TQM approach.

Deming (1986) made an important contribution to the science of improvement by recognizing that there are certain elements of knowledge that he called a “System of

Profound Knowledge.” The term ‘profound’ here denotes the deep insight that knowledge provides in making changes that will result in improvements in a variety of settings, while ‘system’ denotes an emphasis on the interaction of the components rather than on the components themselves. *“A system is a network of interdependent components that work together to try to accomplish the aim of the system”* (Deming, 1993, p50). The first step in the transformation is to learn how to change: that is, to understand and use his system of 14 points.

*“Adoption and action on the 14 points are a signal that the management intend to stay in business and aim to protect investors and jobs. [...] The 14 points apply anywhere, to small organisations as well as to large ones, to the service industry as well as to manufacturing. They apply to a division within a company”* (Deming, 1986, p23).

The second step in the transformation is to cure themselves of the five diseases which Deming lists as applying to organisations in all countries:

- Lack of constancy of purpose.
- Emphasis on short-term profits.
- Evaluation by (individual) performance ratings, which destroy teamwork.
- Mobility of management or ‘job hopping’.
- Running a company on visible figure alone.

The third step is a long-term commitment to new learning and the new philosophy. Deming’s 14 points and his System of Profound Knowledge, related to the science of improvement, constitute his novel philosophy.

Joseph Juran, one of the most influential of the quality gurus, defined TQM as a comprehensive management approach aiming at satisfying or delighting the customer. It is concerned with the quality assurance dimension of standardization of quality, but extends beyond it to include continuous improvement and total customer satisfaction, where customers are both internal and external to the organisation (Juran, 1989). Juran describes three quality management processes, known as the “Juran Trilogy”: quality planning, quality control and quality improvement. These provide a simple, logical model for understanding the whole of quality management (Brown, 2005). Indeed, Deming and Juran both contend that quality management concepts are universally applicable (Sila and Ebrahimpour, 2003).

For Feigenbaum (1991, p7), quality is *“The total composite product and service characteristics of marketing, engineering manufacture, and maintenance through which the product and services in use will meet the expectations of the customers”*. According to him, quality is produced not only by the production department, but also by marketing, research and development, finance, purchasing, or any other department. Feigenbaum (1991) sets out his approach in three stages:

- New Design Control: the techniques and documented procedures used to ensure that the customer’s requirements are fully understood and interpreted as manufacturing specifications with due consideration for all performance, safety and reliability-related requirements.
- Purchasing Control: the techniques to ensure that the quality of supplies consistently meets the specified requirements in terms of price, delivery, service and quality.
- Product Control: all the documented methods associated with ensuring that the product conforms to specified requirements, involving stages such as packing, installation and servicing.

Ishikawa (1989, p44) states that *“To practice quality control is to develop, design, produce and service a quality produce which is most economical, most useful, and always satisfactory to the customer”*.

Table 2.1 compares the approaches to quality management of the most important gurus.

### **2.2.3 Total quality management**

It is widely agreed that TQM is an integrated management philosophy (Kanji and Tambi, 1999) aimed at continuously improving the performance of products, processes and services in order to achieve and surpass customer expectations (Bayazit and Karpak, 2007).

**Table 2.1: The approaches to quality management of some quality gurus**

<b>Dimensions</b>	<b>Deming</b>	<b>Juran</b>	<b>Ishikawa</b>	<b>Feigenbaum</b>	<b>Crosby</b>
Top management support	No important differences	No important differences	No important differences	No important differences	No important differences
Customer relationship	No important differences	No important differences	No important differences	No important differences	No important differences
Supplier relationship	No important differences	He considers that for important purchases it is well to use multiple sources of supply.	He considers that the number of suppliers has to be two. Only one supplier can be dangerous.	The importance of long term relationships and reduction in the number of suppliers are not considered.	No important differences
Workforce management	Except for the importance of training, he scarcely considers this factor. For him, improvement is basically a manager's work.	No important differences	He emphasises the importance of quality circles.	Empowerment and teamwork are scarcely considered.	He does not consider empowerment.
Employee attitudes and behaviour	Motivational campaigns are useless.	Motivation does not assure zero defects production.	No important differences	No important differences	No important differences
Product design process	Not considered	No important differences	No important differences	No important differences	Not considered
Process flow management	He focuses on the need to maintain the process under statistical control. He criticises the zero defects approach and sampling inspection.	No important differences	No important differences	No important differences	He focuses on the need to achieve zero defects through prevention.
Quality data and reporting	Not considered	No important differences	No important differences	Not considered	No important differences
Role of the quality department	No important differences	No important differences	He emphasises the involvement of all employees in studying and promoting quality control. It has not to be an exclusive domain of specialists. He does not make any specific comment about quality departments.	He emphasises the need to have a management function whose only area of operation is in the quality control jobs. He considers that although quality is everybody's job, it may become nobody's job if this department does not exist.	No important differences
Benchmarking	Not considered	Not considered	Not considered	Not considered	Not considered

Source: Hamali (1999)

Hashmi (2004) states that “*TQM is a management philosophy that seeks to integrate all organisational functions to focus on meeting customer needs and organisational objectives*”, while according to Powell (1995), it can be generally described as the process of making quality the concern of everyone in the organisation, or as an organisational culture committed to customer satisfaction through continuous improvement. These two definitions are supported by Ennis and Harrington (1999), who emphasise the importance of multidisciplinary teamwork as a basic prerequisite of TQM, where each member of the team has a role to play in the delivery of patient care, leading to a cross-functional approach where no one person or department is superior to another.

Although there are countless definitions of TQM, what really matters is for the top management to apply the fundamental concepts in a way that is appropriate to its particular business conditions. Lua and Anderson (1998) offer a simplified digest of the main components of TQM from which a definition can be constructed, as shown in Table 2.2.

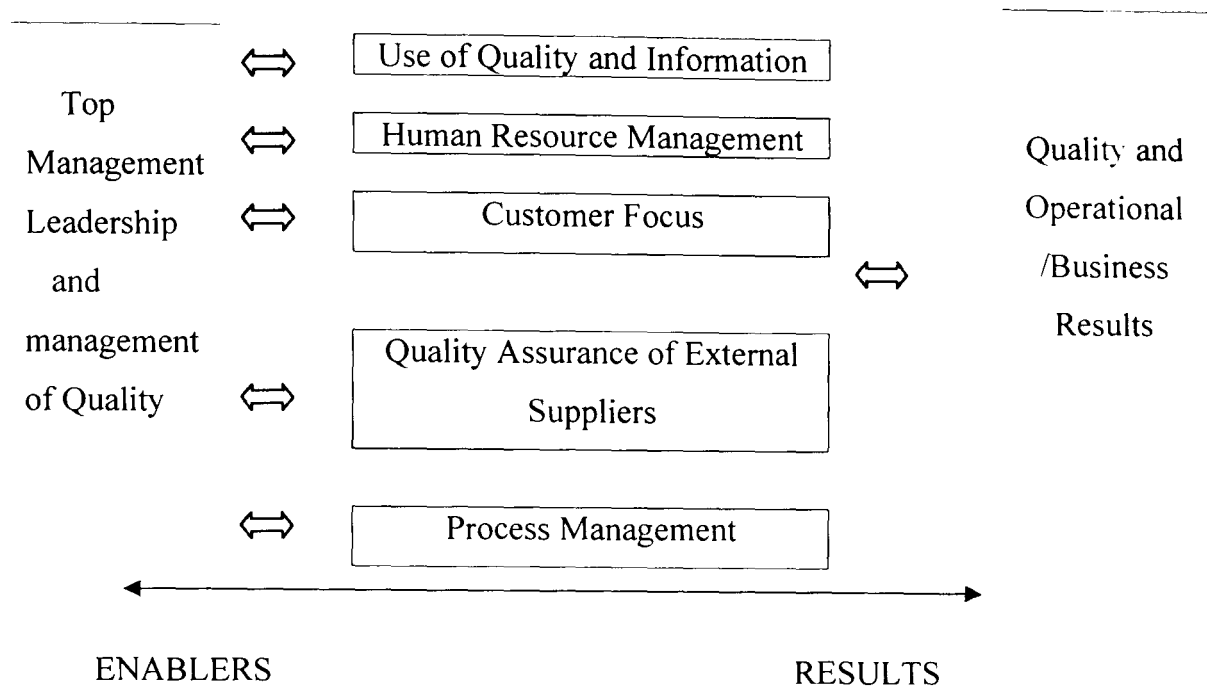
**Table 2.2: The major elements of TQM**

<b>Total (T)</b>	<b>Quality (Q)</b>	<b>Management (M)</b>
Require employee participation and teamwork	Customer driven (internal and external)	Require commitment from top management
Everyone must develop a sense of quality ownership	Emphasis on continuous improvement	Establish purposes and values for the company
Involve every level and function in the company	Technical issues: training for skills and knowledge	Leadership is critical
Apply system thinking	Human issues: encourage innovation	Make appropriate change in organisational culture

Source: Lua and Anderson (1998)

Sila and Ebrahimpour (2003) state that most definitions of TQM are not very different. For instance, most emphasise the concepts of continuous improvement, customer focus, human resource management and process management. This summary is supported by the model of the Malaysian Quality Management Excellence Award (QMEA) illustrated in Figure 2.1. Lee (1999) explains that empirical studies have identified, validated and established nine areas as the most important elements of TQM: customer focus, top management commitment, quality data and reporting, training, role of quality departments, employee involvement, process management, product/service design and

supplier quality management. The structure of TQM according to these definitions is illustrated in Figure 2.2.

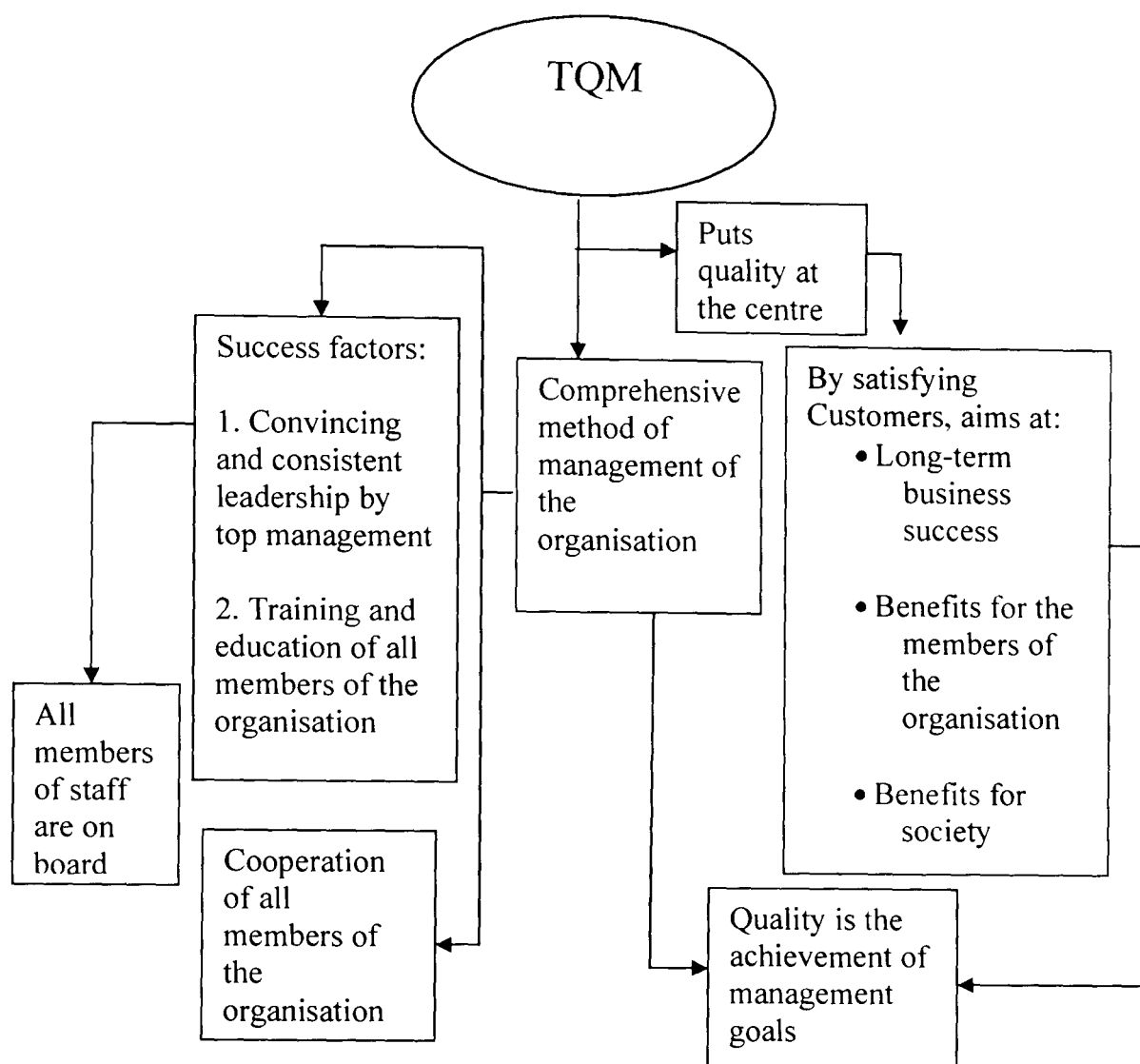


**Figure 2.1: QMEA framework**

Source: Malaysia Productivity Corporation (2003)

The application of TQM to the healthcare industry was limited when it was introduced in the late 1980s, for a number of reasons, such as the major cash flow problems of hospitals and cultural concerns; but the most significant barrier to the acceptance of TQM by the healthcare sector was a practical concern related to the lack of agreed standards to judge deviation and noncompliance (Mclean, 2006).

The value of TQM to clinical decision making and to the health services advanced significantly after the United States Institute of Medicine (IOM) launched the patient safety movement with its publication of “To Err Is Human” (Mclean, 2006). In that report, the IOM announced that as many as 98,000 Americans die each year due to preventable medical errors. In response, the senator and physician Bill Frist asserted that *“these deaths and the many errors that result in prolonged hospitalization, more misery, and greater cost can absolutely be prevented”*(Mclean, 2006). He was calling for the widespread application of TQM to the health care setting, because TQM has been demonstrated to reduce medical errors, thereby improving providers’ outcomes (Mclean, 2006).



**Figure 2.2: The foundation of TQM**

Source: Karaszewski (2004)

The IOM, however, states that health care today harms too frequently and routinely fails to deliver its potential benefits (Institute of Medicine, 2001).

In the five years since the IOM report it has been demonstrated that as many as 85 percent of all malpractice cases are not due to bad physicians. Rather, the malpractice occurred because the hospital where the physician worked had a faulty or nonexistent quality management system (McLean, 2006). If hospitals want to solve their problems more effectively and practically, it is necessary to implement TQM (Kim and Johnson, 1994; Short and Rahim, 1995).

### 2.3 Quality management systems

A quality management system is defined by NEPCon (2004) as a tool that enables every organisation to achieve better quality in its products or services through continual improvement of methods and means of performance. Similarly, Howcroft and Mite (2000) define a QMS as a system that ensures that all activities address the needs and expectations of the customers and the community, while the goals of the organisation are satisfied in the most efficient and cost-effective way by maximizing the potential of all employees.

According to Oakland (2003), the purpose of adopting an appropriate QMS is to ensure the realisation of an organisation's objectives cited in its quality policy. Other authors define a QMS as a framework for implementing a quality programme and emphasise the importance of achieving consistency through establishing a quality system in the organisation. For example, Dale (1999) states that the purpose of a quality management system is to establish a framework of reference points, to ensure that every time a process is performed, the same information, methods, skills and controls are used and applied in a consistent manner. Alternatively, Poksinska *et al.* (2006) suggest that a QMS relates to the system of processes by which the product is developed and distributed to customers, while Ivanovic and Majstorovic (2006) state that a quality management system is a strategy for the improvement of efficiency and effectiveness in organisations.

TQM was discussed and defined in section 2.2.3, where it is noted that Hashmi (2004) refers to it as seeking *"to integrate all organisational functions to focus on meeting customer needs and organisational objectives"*. Previously, Oakland (2000) had explained that TQM is about integrating organisational functions to prevent product defects through an emphasis on quality of design, meeting internal and external customer needs within a management environment that supports the development of good relationships between employees, suppliers and customers.

Table 1.1 sets out the relationship between TQM and JCI and indicates that the TQM approach and JCI standards both focus on integrating all organisational functions and activities to meet the objectives of the organisation and to improve customer satisfaction (Hashmi, 2004; Pomey *et al.*, 2004). Similarly, the relationship between QMS and JCI is consistent with the purpose and the definition of QMS as constituting an organisation-



wide framework to promote consistency and to meet organisational objectives and customers' needs (Oakland 2003; Dale, 1999).

In summary, TQM and QMSs, including JCI and other quality management systems, are used as frameworks to integrate all organisational functions and activities, to meet organisational objectives, to promote continuous improvement and to ensure customer satisfaction.

The JCI standards can be considered as a QMS followed by healthcare organisations to improve quality and patient safety through emphasizing consistency of care. Dale (1999) explains that the purpose of a quality system is to establish a framework to promote consistency in the organisation. As stated by the JCI (2003), the following are some of the important features of its standards as a quality framework which can be used by healthcare organisations:

- It requires leadership commitment and the involvement of all healthcare providers and administrative staff in the implementation process.
- It is assessed by external auditors who are not familiar with the system used by the organisation.
- Continuous self-assessment is encouraged to ensure the consistency of implementation of the standards.
- Internal and external benchmarks are used to compare each organisation's performance with its own and best practice levels of performance.
- Internal audits of the medical documentation and records of healthcare providers should be conducted to identify areas for improvement.

These features are similar to those listed by Oztas *et al.* (2007) as useful for organisations to assess the progress and effectiveness of their QMSs:

- Reference to internal benchmarks such as scrap costs, quality costs and customer complaints. Quality can then be expressed in numbers.
- Self-assessment of internal performance, i.e. critical self-assessment of the organisation's activities and results against a specific set of criteria.
- General comparison of the level of QMS activity with those of other organisations of high standing, using published information, visits to counterparts and discussions with managers.

- Analysis of internal and external audit results and assessments by people external to the company. This will mainly concern reports and comments on systems, planning carried out, attitudes of management, training undertaken and customer awards.
- Attempting to understand how the organisation might be seen by an independent observer who is not necessarily knowledgeable about QMS, who will have different criteria and whose judgment will probably be subjective.

According to Lua and Anderson (1998), the Malcolm Baldrige National Quality Award, which is a quality framework and annual award that recognizes US organisations in all businesses including health care, adopts the principles of TQM in its criteria. Black and Porter (1996), having examined the criteria of the Baldrige Award and the published TQM literature, identify ten critical factors to prove the similarities between the two systems. On the other hand, there is a correlation between JCI standards and the Baldrige criteria; although the latter are broader in scope, there are many similarities, for example in quality management and improvement, governance, leadership and direction, staff qualification and education, and management of information standards (Joint Commission International 2003, p173). Based on the above discussion, the similarities between the TQM principles and the Baldrige Award criteria, and those between the latter and the JCI standards, support the contention that the JCI standards are based on the principles of TQM.

Another example of a QMS is the EFQM Excellence model, which is a framework for organisational management systems, promoted by the European Foundation for Quality Management (EFQM) and designed to help organisations in their drive towards being more competitive. It is seen by McAdam *et al.* (2002) as an overall integrative quality framework for organisations. As there are common features linking TQM and Baldrige to JCI, there are similar linkages between the JCI standards, the EFQM model criteria and the ISO principles; according to Murray and McAdam (2007), the ISO 9000 series can act as a company framework for quality management to direct quality efforts on a long-term basis without any loss of compliance. The EFQM model takes a holistic approach, covering all aspects of an organisation's activities and results, without being overly specific. Key processes in the JCI standards are linked with the EFQM standards, so that although many of the former are more detailed than the latter, especially related to medical record content, infection control and the management of buildings, the spirit

of the EFQM criteria reflects many of the JCI standards (Joint Commission International, 2003, p173).

The similarities between the JCI and ISO models include adopting a quality approach, aligning policies and procedures with performance, using statistical techniques and defining management responsibility. On the other hand, the main difference is the focus of the ISO standards on adhering to specific requirements and then assessing that conformity, while JCI standards focus on assessing organisational performance and stimulating continuous improvement to achieve optimum outcomes (Joint Commission International, 2003, p173). Donahue and van Ostenberg (2000) state that the JCI model provides a comprehensive framework for quality management in an organisation, expanding the boundaries of the quality leadership and management found in the EFQM model, and beyond the quality control of the ISO model.

According to McFadden *et al.* (2006), the JCI standards constitute a quality management framework for hospitals with strong emphasis on the implementation of patient safety initiatives. The implementation of patient safety refers to the process of carrying out certain initiatives or approaches such as open discussion of errors, education and training, and system redesign, with the aim of reducing medical errors and eliminating patient harm. Hospital accreditation has been increasingly tied to intervention and the prevention of hospital errors. It is imperative that hospitals develop effective solutions to reduce medical errors in order to strengthen quality of patient care. Thus, according to McFadden *et al.* (2006), patient safety is one of the components of JCI standards and a tool to promote quality of care in hospitals.

According to Conway (2008), the leaderships of healthcare organisations are the entities most responsible for promoting quality and patient safety. It is suggested that the leaders of hospitals should demonstrate their role in promoting patient safety by setting an annual patient safety aim, collecting data and hearing stories about patient safety, changing the environment, promoting a safety culture, facilitating learning and training on patient safety issues and establishing executive accountability.

When reviewing the literature related to the investigation of factors that affect the implementation of quality systems including ISO and EFQM, the researcher found that many authors use the term 'implementation' to refer to the process of carrying out or

acting on the requirements of a specific quality framework and performing all the activities required to build a quality system in an organisation (Ennis and Harrington, 1999; Bauer *et al.*, 2005; Mellahi and Eyuboglu, 2001; Short and Rahim, 1995; Ovretveit, 2000). The present study adopts the understanding of these authors related to the concept of implementation, using it to refer to the process of carrying out or implementing all requirements of the JCI standards in order to build a quality framework in the hospital which will operate after the process has been completed.

## **2.4 Joint Commission International**

This section examines the principles and components of the JCI standards.

### **2.4.1 Introduction**

The mission of the JCAHO is to improve continuously the safety and quality of care provided to the public through the provision of healthcare accreditation and related services (Brown, 2007). JCI is a wholly controlled not-for-profit affiliate formed by the JCAHO to provide leadership in healthcare accreditation and quality improvement for organisations outside the United States. The traditional approach to external evaluation of health care organisations began when the American college of surgeons established the hospital standardisation programme in 1917. In 1950 the growing number and complexity of hospitals required revision of the standards and support of the entire medical and hospital field, originating in the foundation of the JCAHO in 1951 (Roberts, 1996).

The goal of JCI, as reflected in its Accreditation Standards for Hospitals (JCI, 2003, p1), is *“to stimulate demonstration of continuous, sustained improvement in health care organisations by applying international consensus standards and indicators”*. Some countries and healthcare organisations outside the United States are seeking its services and applying their standards in an attempt to improve the quality of their services to meet international standards. Its mission is to improve the quality of care in the international community through the provision of accreditation and consultation services. JCI is designed to respond to a growing demand around the world for standards-based evaluation in health care (ibid). According to the World Health Organisation (WHO) (2008), JCI leaders work with the WHO to promote quality and patient safety practices around the world by introducing patient safety solutions which give countries around the world the opportunity to translate them into tangible actions

that actually save lives and challenge them to do so. Smits *et al.* (2008) state that the Joint Commission standards consider the dimensions of quality, goal attainment, adaptation to the external environment and values in a balanced approach. On the other hand, Pasternak (2008) found that the main emphasis of the JCI standards was always on quality of patient care and reduction of safety risk to patients. Similarly, Phelps and Hyman (2007) emphasise that JCI standards support patient safety and managing risks in hospitals through specific requirements of the standards. According to JCI standards, hospitals should proactively seek to identify and reduce risks to the safety of patients and so to prevent adverse events, rather than simply reacting when they occur. According to Poe and Brannan (2006), the JCI patient safety website supports patient safety initiatives by providing nurses and patients with accurate and balanced information to increase public awareness and to demonstrate commitment to consumer safety advocacy.

#### **2.4.2 JCI standards**

The JCI standards were developed with the help of an international task force and were designed to accommodate the legal, religious and cultural factors within a country. The standards focus on adaptability to local needs, the quality of patient care and safety. The standards are cross-referenced to ISO and EFQM (JCI, 2003).

The JCI (2007) organises its standards into “functional chapters” around those functions found to be common to all healthcare organisations. In addition, the JCI has requirements related to promoting safe practices which it calls international patient safety goals and whose purpose is to promote specific improvements in patient safety. These goals highlight problematic areas in healthcare organisations and describe solutions based on expert consensus. The goals cover the following areas:

- Goal one: identifying patients correctly.
- Goal two: improving effective communication.
- Goal three: improving the safety of high-alert medications.
- Goal four: ensuring correct-site, correct-procedure and correct-patient surgery.
- Goal five: reducing the risk of healthcare-associated infections.
- Goal six: reducing the risk of patient harm resulting from falls.

A summary of each chapter of the standards is given below. The standards are classified as patient-centred and organisation-centred (Joint Commission International, 2007).

#### **2.4.2.1 Patient-centred standards**

The patient-centred standards include access to care and continuity of care, patient and family rights, assessment of patients, care of patients, anaesthesia and surgical care, medication management and use, and patient and family education.

##### **2.4.2.1.1 Access to care and continuity of care**

A healthcare organisation should consider the care it provides as part of an integrated system of services, healthcare professionals and levels of care, which make up a continuum of care. The goal is to correctly match the patient's healthcare needs with the services available in the organisation, then plan for discharge and follow-up. The result is improved patient care outcomes and more efficient use of available resources (Joint Commission International, 2007, p39).

##### **2.4.2.1.2 Patient and family rights**

Each patient is unique, with his or her own needs, strengths, values and beliefs. Healthcare organisations work to establish trust and open communication with patients and to understand and protect each patient's cultural, psychosocial and spiritual values. Patient care outcomes are improved when patients and—as appropriate—their families or those who make decisions on their behalf are involved in care decisions and processes in a way that matches cultural expectations.

To promote patient rights in a healthcare organisation, one starts by defining those rights, then educating patients and staff about them. Patients are informed of their rights and how to act on them. Staff are taught to understand and respect patients' beliefs and values and to provide considerate and respectful care that protects patients' dignity (Joint Commission International, 2007, p53).

##### **2.4.2.1.3 Assessment of patients**

An effective patient assessment process results in decisions about the patient's emergency or immediate treatment needs and continuing treatment needs, even when the patient's condition changes. Patient assessment is an ongoing, dynamic process that takes place in many settings and departments. Patient assessment is appropriate when it

considers the patient's condition, age, health needs and requests or preferences. These processes are most effectively carried out when the various health professionals responsible for the patient work together. Organisations should have processes in place to ensure that assessment is based on collecting and analyzing information and performing appropriate diagnostic tests or procedures. Assessment should lead to a care plan for each patient (Joint Commission International, 2007, p71).

#### **2.4.2.1.4 Care of patients**

A healthcare organisation's main purpose is patient care. Providing the most appropriate care in a setting that supports and responds to each patient's unique needs requires a high level of planning and coordination. Certain activities are basic to patient care. These include:

- Planning and delivering care to each patient;
- Monitoring the patient to understand the results of the care;
- Modifying care when necessary;
- Completing the care; and
- Planning the follow-up.

Many medical, nursing, pharmacy, rehabilitation and other types of healthcare providers may carry out these activities. The care may be preventive, palliative, curative or rehabilitative and may include anaesthesia, surgery, medication, supportive therapies, or a combination of these. The delivery of the services must be coordinated and integrated by all individuals caring for the patient (Joint Commission International, 2007, p 95).

#### **2.4.2.1.5 Anaesthesia and surgical care**

The use of anaesthesia, sedation and surgical intervention are common and complex processes in a healthcare organisation. They require comprehensive assessment, integrated care planning, continued patient monitoring and criteria-determined transfer for continuing care, rehabilitation and eventual transfer and discharge. The organisation should ensure that all patients are assessed physically before going through the processes of anaesthesia or moderate and deep sedation (Joint Commission International, 2007, p107).

#### **2.4.2.1.6 Medication management and use**

Medication management encompasses the system and processes an organisation uses to provide pharmacotherapies to its patients. This is usually a multidisciplinary, coordinated effort by the staff of a healthcare organisation, applying the principles of effective process design, implementation and improvement to the selection, procuring, storing, ordering, prescribing, preparing, dispensing, administering, documenting and monitoring of medication therapies. While healthcare providers' roles in medication management vary greatly from one country to another, sound medication management processes for patient safety are universal (Joint Commission International, 2007, p117).

#### **2.4.2.1.7 Patient and family education**

Patient and family education helps patients better participate in their care and make informed care decisions. Many different staff members in the organisation educate patients and families. Education takes place when the patient interacts with his or her physician or the nursing staff. Others provide education as they provide specific services, such as rehabilitation or nutrition therapy, or prepare the patient for discharge and continuing care. Because many staff members help to educate patients and families, it is important that they coordinate their activities and focus on what patients need to learn.

Effective education thus begins with an assessment of the patient's and family's learning needs. This assessment determines not only what needs to be learned, but how the learning can best occur. Learning is most effective when it suits an individual's learning preferences, religious and cultural values, and reading and language skills, and when it occurs at appropriate points in the care process.

Education includes both the knowledge needed during the care process and the knowledge needed after the patient is discharged to another care site or home. Thus, it can include information on community resources for any additional or follow-up care required and how to access emergency services if necessary (Joint Commission International, 2007, p131).

#### **2.4.2.2 Organisation-centred standards**

The organisation-centred standards cover quality improvement and patient safety, prevention and control of infections, governance, leadership and direction, facility



management and safety, staff qualifications and education, and management of information and communication.

#### **2.4.2.2.1 Quality improvement and patient safety**

Quality improvement and patient safety standards describe a comprehensive approach to quality improvement. Integral to overall improvement in quality is the ongoing reduction in risks to patients and staff. Such risks may be found in clinical processes as well as in the physical environment. This approach includes the following processes:

- Designing new clinical and managerial processes well;
- Monitoring how well processes work through indicator data collection;
- Analyzing the data; and
- Implementing and sustaining changes that result in improvement.

Both quality improvement and patient safety programmes are leadership driven; seek to change the culture of an organisation; proactively identify and reduce risk and variation; use data to focus on priority issues; and seek to demonstrate sustainable improvements. Quality and patient safety standards emphasise that continuously monitoring, analysing and improving clinical and managerial processes must be well organised and have clear leadership to achieve maximum benefit. This approach takes into account that most clinical care processes involve more than one department or unit and may involve many individual jobs. It also recognises that most clinical and managerial quality issues are interrelated. Thus, efforts to improve those processes must be guided by an overall framework for quality management and improvement activities in the organisation (Joint Commission International, 2007, p139).

#### **2.4.2.2.2 Prevention and control of infection**

The goal of an organisation's infection surveillance, prevention and control programme is to identify and reduce the risks of acquiring and transmitting infections among patients, staff, doctors, contract workers, volunteers, students and visitors. The infection control programme may differ from organisation to organisation, depending on the organisation's geographic location, patient volume, patient population served, type of clinical activities and number of employees. Effective programmes have in common identified leaders, appropriate policies and procedures, staff education and coordination throughout the organisation (JCI, 2007, p155).

#### **2.4.2.2.3 Governance, leadership and direction**

Providing excellent patient care requires effective leadership, which comes from many sources in a healthcare organisation, including governing leaders, clinical and managerial leaders, and others who hold positions of leadership, responsibility and trust. Each organisation must identify these individuals and involve them in ensuring that the organisation is an effective, efficient resource for the community and its patients.

In particular, these leaders must identify the organisation's mission and make sure that the resources needed to fulfil it are available. For many organisations, this does not mean adding new resources but using current ones more efficiently, even when they are scarce. Leaders must also work together well to coordinate and integrate all the organisation's activities. Over time, effective leadership helps to overcome perceived barriers and communication problems between departments and services in the organisation, so that it becomes more efficient and effective, while services become increasingly integrated. In particular, the integration of all quality management and improvement activities throughout the organisation results in improved patient outcomes (Joint Commission International, 2007, p167).

#### **2.4.2.2.4 Facility management and safety**

Healthcare organisations work to provide safe, functional and supportive facilities for patients, families, staff and visitors. To reach this goal, the physical facilities, medical and other equipment and people must be effectively managed. In particular, management must strive to reduce and control hazards and risks, prevent accidents and injuries and maintain safe conditions. Effective management includes planning, education and monitoring (Joint Commission International, 2007, p181).

#### **2.4.2.2.5 Staff qualifications and education**

A healthcare organisation needs an appropriate variety of skilled and qualified people to fulfil its mission and meet patient needs. The organisation's clinical and administrative leaders must work together to identify the number and types of staff needed, based on the recommendations from department and service directors.

Recruiting, evaluating and appointing staff are best accomplished through a coordinated, efficient and uniform process. It is also essential to document applicant skills, knowledge, education and work experience. It is particularly important to

carefully review the credentials of medical and nursing staff, because they are involved in clinical care processes and work directly with patients. Healthcare organisations should provide staff with opportunities to learn and advance personally and professionally. Thus, they should be offered in-service education and other learning opportunities (Joint Commission International, 2007, p195).

#### **2.4.2.2.6 Management of communication and information**

Providing patient care is a complex endeavour that is highly dependent on information. To provide, coordinate and integrate services, healthcare organisations rely on information about the science of care, individual patients, care provided, results of care and their own performance. Like human, material and financial resources, information is a resource that must be managed effectively by the organisation's leaders. Every organisation seeks to obtain, manage and use information to improve patient outcomes and both individual and organisational performance. Although computerisation and other technologies improve efficiency, the principles of good information management apply to all methods, whether paper based or electronic. These standards are thus designed to be equally compatible with non-computerised systems and future technologies (Joint Commission International, 2007, p213).

### **2.5 Benefits of implementing JCI standards**

TQM can have a dramatic impact on the performance and culture of the organisation (Deming, 1986). However, few published studies have measured the impact of accreditation on hospitals and on the healthcare system where it is implemented (Pomey *et al.*, 2004). Achieving the voluntary accreditation of healthcare organisations represents a necessary recognition by service payers of the safety and suitability of such organisations as providers of healthcare services (Ruiz and Simon, 2004). Therefore, it seems that finding the appropriate management systems for healthcare organisations is a high priority to improve patient safety and minimise the possibility of medical errors (Ruiz and Simon, 2004).

McFadden *et al.* (2006) found in an extensive survey of data from 250 US hospitals that implementation of patient safety initiatives were associated with benefits to the hospital in areas such as medical error reduction, cost reduction and patient satisfaction. Yang (2006) notes that the successful implementation of TQM can also lead to an increase in customer satisfaction, so benefiting corporate image, and can improve the satisfaction

and quality awareness of employees. In Canada, studies have demonstrated that accreditation served to improve communication processes and, to a lesser extent, clinical practices (Beaumont, 2002).

### 2.5.1 JCI implementation in hospitals

JCI accreditation began at the end of 1999 and the first hospital accredited outside the USA was the Israelita Albert Einstein in Brazil, while the American Hospital in Dubai was the first in the Middle East, in 2000. The total number of hospitals accredited outside the USA up to the end of 2007 was 147 and the number of accredited hospitals reached 197 at the end of 2008 (JCI, 2008). Table 2.3 shows the number of accredited hospitals outside the USA by region and year of accreditation.

**Table 2.3: Number of JCI accredited hospitals by region, 1999-2007**

Regions	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total
Africa	0	0	0	0	0	0	1	0	0	1
Asia including the Middle East	0	2	1	6	3	2	14	32	33	93
Europe	1	2	2	13	1	3	7	4	7	40
South America	1	0	1	1	0	1	0	2	7	13
Total JCI accredited per year	2	4	4	20	4	6	22	38	47	147
Cumulative total	2	6	10	30	34	40	62	100	147	

Source: JCI (2007).

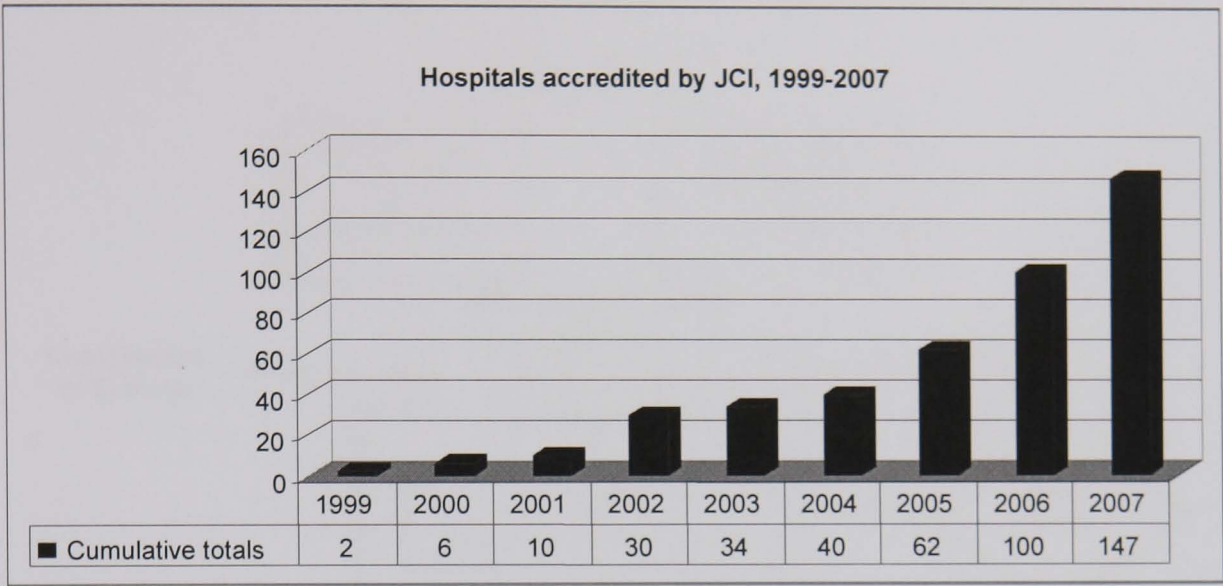
In the Middle East there were 56 hospitals accredited as of 2007, of which 13 were in the UAE; seven of these were public hospitals, the largest in the country in terms of bed capacity. Table 2.4 shows the number of accredited hospitals in the Middle East for the years 1999 to 2007. The number of accredited hospital in the middle east reached 80 at the end of 2008 (JCI, 2008).

**Table 2.4: Number of JCI accredited hospitals in the Middle East, 2000-2007**

Countries	1999	2000	2001	2002	2003	2004	2005	2006	2007	%
Egypt							1			2
Jordan								1	1	4
Saudi Arabia		1	1	3				6	5	29
Lebanon									1	2
Qatar								5		9
Turkey				2	1	1	4	5	5	32
UAE		1						2	10	23
Total JCI accredited per year		2	1	5	1	1	5	19	22	100
Cumulative total		2	3	8	9	10	15	34	56	

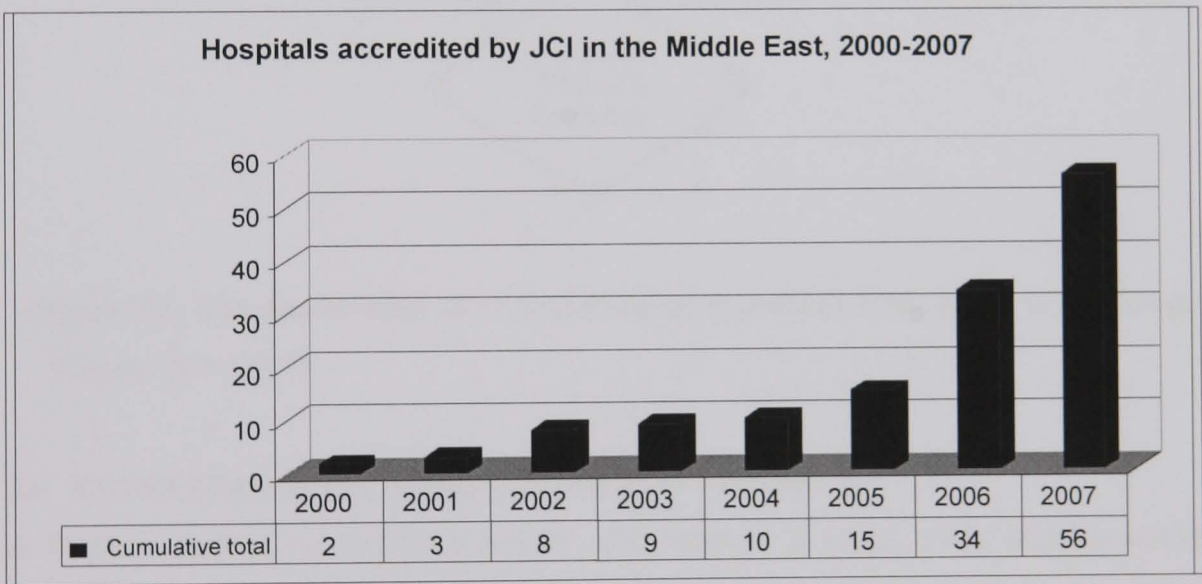
Source: JCI (2007).

Figures 2.3 and 2.4 illustrate the positive trend by showing both of the above cumulative totals graphically.



**Figure 2.3: Cumulative total of hospitals accredited by JCI, 1999-2007**

Source: JCI (2007)

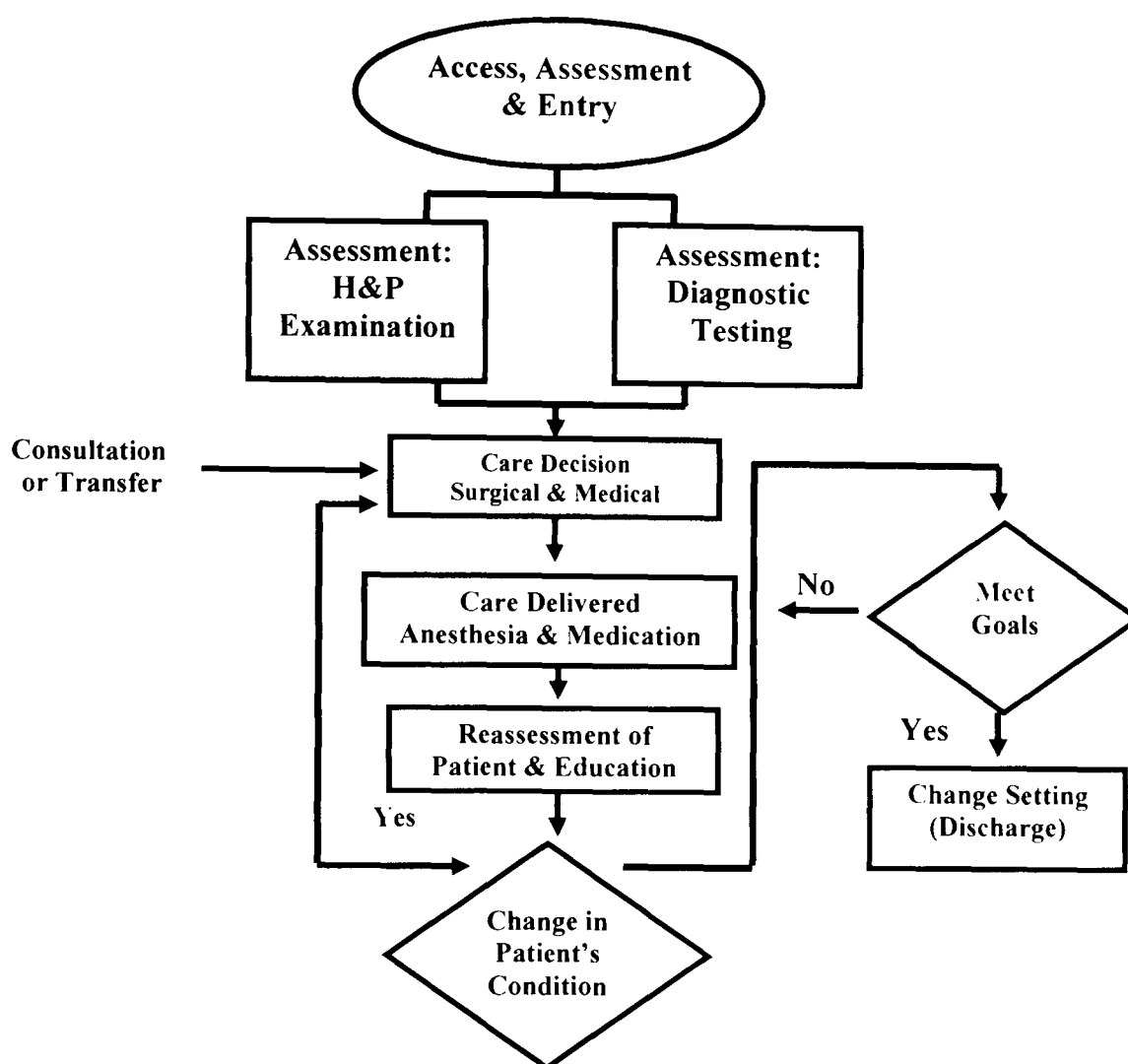


**Figure 2.4: Number of hospitals accredited by JCI in the Middle East, 2000-07**

Source: JCI (2007)

After the literature review had been completed, another 50 hospitals were accredited during 2008, of which 24 were in the Middle east and three in the UAE.

Figure 2.3 is a flow chart showing the process of applying the JCI patient-focused standards from the point of entry to the hospital by the patient until he or she is discharged.



**Figure 2.5: The application of patient-focused standards from entry to discharge**  
Source: JCI (2007)

## 2.6 Factors affecting the implementation of JCI standards

A factor is defined as an influence that contributes to a result, while implementation means the act of carrying out, performing or implementing (Oxford Dictionary, 2001). Some authors, including Mellahi and Eyuboglu (2001), Sila and Ebrahimpour (2003) and Ennis and Harrington (1999) have studied the factors that influence the implementation of TQM in organisations. However, there is a paucity of knowledge in the literature regarding the factors that affect the implementation of JCI standards in hospitals in general and in those in the UAE or the Middle East in particular. The researcher was nevertheless able to find some literature dealing with factors that affect the implementation of TQM or other QMSs in organisations, some referring specifically to hospitals. Al-Haj (2006) notes a shortage of work on barriers to the implementation

of ISO 9001:2000 standards in earlier studies, especially as regards research conducted in organisations in the Arab countries.

The researcher started the process of identifying the factors that affect the implementation of JCI standards in hospitals by taking notes from the relevant literature about these factors, as mentioned above. These notes were organised into patterns and then into categories. The researcher reviewed the literature more than once when appropriate to gain a better understanding of these factors and to categorise them appropriately. Table 2.6 summarises these factors with authors' names and the year of publication of their papers, as well as the country where the studies were conducted. It is worth mentioning that the researcher did not consider the number of times a factor was mentioned in these sources but did consider whether the paper was a research report or a case study when acknowledging the existence of a specific factor.

Subsections 2.6.1 to 2.6.20 examine a number of such factors, including reasons for seeking JCI accreditation, identified in the Arabic and Western literature. These factors are summarised at the end of this chapter in Table 2.6.

### **2.6.1 Reasons for seeking JCI accreditation**

Greenfield and Braithwaite (2008), who conducted a study in Australia to identify and analyse research into the accreditation processes of different national and international agencies, found that views about the benefits and the impact of the accreditation process varied between negative and positive among the stakeholders, being influenced by ideology or preference and driven by such biases. According to the authors, the impact and effectiveness of accreditation with these different views can be classified into the following ten categories:

- Professionals' attitudes to accreditation
- Change and professional development
- Organisational impact
- Financial impact
- Quality measures
- Programme assessment
- Patient satisfaction
- Public disclosure

- Professional development
- Surveyors' (assessors') issues.

More specifically, in relation to hospital accreditation, El Jardali *et al.* (2008) conducted a study in Lebanon to assess the perceived impact of accreditation on quality of care through the lens of healthcare professionals—specifically nurses—and found that nurses from Lebanon considered hospital accreditation to be a good tool for improving quality of care. Nurses perceived improvement in quality during and after the accreditation process, especially in areas related to leadership commitment and support, use of data, quality management and staff involvement. In another study conducted in Canada into the effects of the accreditation process on quality management practices, Paccioni *et al.* (2008) found that it encouraged the medical staff to use the consultation mechanism, improving the assessment of client satisfaction, while accreditation had little effect on the perception of employees not directly involved in the process. Ennis and Harrington (1999), argue that implementing quality programmes is seen as the solution for all challenges facing hospitals in the Irish healthcare system. Taylor and Adair (1993), Brashier *et al.* (1996), Lee (1999) and Kollberg *et al.* (2005) found that leaders of organisations were motivated to implement quality management systems because they were convinced that the effective implementation of quality improvement practices would lead to improvements in organisational performance in terms of both productivity and profitability.

Balding (2005) states that improving the day-to-day performance of doctors and nurses was one motivator to implement organisational quality improvement in Australia. This finding is supported by Mo and Chan (1997), Tsiotras and Gotzamani (1996). Ovretveit (2001) and Fuentes *et al.* (2000), who argue that one of the main reasons for implementing quality systems is to attain internal organisational improvement, such as establishing a formal system in an organisation, improving performance and simplifying procedures, as a contract with clients. Lin and Clousing (1995) found that many hospital leaders were motivated to implement TQM principles to reduce costs and to improve quality of patient care.

A number of other studies conducted in Arab countries by Magd *et al.* (2003), Al-Khalifa and Aspinwall (2000), Tayyara *et al.* (2000) and Aspinwall (2000) found that implementing quality management systems was seen as a marketing tool to improve



productivity, raise revenue and minimise production costs. Naylor (1999) reports that the EFQM model was implemented in the Royal Bolton Hospital in the UK because of its emphasis on improving quality and efficiency. Fuentes *et al.* (2000) state that many organisations are motivated to implement quality management systems to improve organisational communication, to enhance employees' involvement and satisfaction, and to minimise production costs. Similar reasons for implementing quality systems were found by Ab Rahman and Tannock (2005), Tayyara *et al.* (2000), Taylor (1995) and Tang and Kam (1999).

James and Hunt (1996) state that some organisations seek the accreditation of their hospitals to have their healthcare services compared to those of other organisations and to use quality as a catalyst for change, i.e. to mobilise the organisation towards the goal of quality improvement.

### **2.6.2 Leadership commitment and involvement**

One of the most important factors affecting the implementation of TQM by organisations is said by quality gurus like Deming, Juran and Crosby to be leadership commitment (Tari, 2005). Ennis and Harrington (1999) found that top and middle management commitment, teamwork, staff reward, managing the organisational culture and the availability of financial resources were important factors in implementing a quality programme in the Irish healthcare system. In their study of TQM best practices in Malaysian companies, Ab Rahman and Tannock (2005) found genuine top management commitment to be one of the most important components. Top managers must play a very important role in promoting quality at every level in a company. They and the CEO need to be "champions of quality" and be seen to lead from the front. This finding is supported by a survey study in India which covered different service industries including health care.

According to Brashier *et al.* (1996), when an organisation starts the implementation of a quality programme it should be remembered that the focus is the customer and the most critical factors to be considered are top management commitment, employee interest, physician support and involvement, good planning and cost management.

Balding (2005), Banerji *et al.* (2005), Ruiz and Simon (2004), Mellahi and Eyuboglu (2001), Kohli *et al.* (1995), Short and Rahim (1995) and Cheung and Koch (1994)

conclude that leadership and senior management play critical roles in promoting and facilitating the implementation of TQM. In particular, leadership was found to motivate the implementation of TQM by linking profitability to quality. Sultani (2005), Taylor and Wright (2003), Chen *et al.* (2004), Ovretveit (1997; 2000; 2001) and James and Hunt (1996) argue that the commitment of leaders and all hospital staff at different levels is important when implementing quality programmes and achieving hospital accreditation. Weeks and Helms (1998) state that if top management provides weak or no support to the TQM effort, the process is likely to fail.

Martin and Ruiz (1995) review the implementation of quality systems in 262 hospitals in 15 European countries and conclude that the commitment of the top management of hospitals is needed to achieve an integrated approach to quality activities. This finding is supported by Schubert (1999), who studied quality management practices in German hospitals and found that significant factors for success in the implementation process were the active support of top and middle management and a combination of radical changes in selected problem areas and continual incremental improvements on a broad base. In another study, Schubert (1999) found that the influence of leadership, the use of strict accountability and the effect of staff education and training were factors underlying the success of TQM implementation.

According to Kanji (1998), senior management must be actively involved in creating a total quality culture with a clear vision to adopt the following leadership roles:

- To define a mission, vision and goals that promote a quality culture;
- To establish a set of shared values;
- To define a quality strategy;
- To better coordinate the use of resources in order to improve financial performance;
- To establish goals and systems to enhance customer satisfaction;
- To establish effective information systems and to use objective data;
- To promote the development of human resources training and recognition;
- To communicate, define and motivate continuous improvement.

Similarly, Czuchry *et al.* (1997) quote Latham (1995) as arguing that vision is an essential element in organisational success, adding that management should motivate

the employees to believe in the vision of the organisation as a key to successful change effort. Many other authors, such as Thorsteinsson and Hage (1991), Campbell (1995), Mostafa (2004), Davis *et al.* (1997), Hoffman (2002), Chua and Goh (2002) and Sharp *et al.* (1997), have emphasised the importance of the clear communication of the organisation's vision to obtain the support and involvement of the staff in implementing quality systems or introducing change to the organisation.

The findings of Kanji are supported by Ashire and O'Shaughnessy (1998), who note that top management must not just adopt slogans of improving quality but should become involved in quality efforts at planning, implementing and monitoring phases. Top management commitment encourages managers, supervisors and employees in an organisation to invest more fully in the particular elements for which they are responsible, thereby increasing their impact on the quality of products. Leaders should translate their commitment into a set of actions aimed at enhancing the ability to compile and effectively analyse relevant information of customer focus, benchmarking and supplier QMS. Without the support of management, the behaviour of the personnel is difficult to change.

Munro-Faure and Munro-Faure (1992), Sila and Ebrahimpour (2003) and Yang (2003) assert the importance of management commitment. Goetsch and Davis (2000) also advocate the need to publicise and communicate the benefits of the system to the employees for continuous improvement. Moreover, Beer (2003) asserts that TQM implementation will succeed only if top management requires and ultimately institutionalises an honest organisation-wide conversation that yields valid data about the quality of management in each unit and subunit of the organisation and leads to changes in management quality or replacement of managers. The implementation of the technical methods and principles of TQM requires a quality of management, managerial values, attitudes, skills and behaviour that will enable TQM to flourish over time. In addition to the immediate problems of closing the gap between rhetoric and reality, TQM will only persist and become a way of life if management deals with a number of fundamental dilemmas that are likely to unfold if the TQM implementation succeeds.

On the other hand, Sharif (2005) and Al-Haj (2006) warn that top managers should be fully aware of their responsibility to facilitate the implementation of quality management systems in organisations. Abd Manaf (2005) argues that management

commitment is an essential factor for implementing quality management programmes in the Malaysian public healthcare system.

McFadden *et al.* (2006) emphasise the role of leadership commitment in implementing quality and patient safety initiatives in US hospitals, concluding that the greater the commitment, involvement and emphasis placed on quality and patient safety initiatives by the hospital and patient safety leaders, the more likely the hospital is to actually implement them.

In conclusion, there is a lot of evidence that top management commitment and involvement is an important factor to avoid failure in implementing quality management systems.

### **2.6.3 Organisational culture**

A commonly-used definition of organisational culture is that it is a set of values shared among organisational members (Chatman and Jehn, 1994; O'Reilly *et al.*, 1991). The values can be grouped into seven dimensions: innovation, stability, respect for people, outcome orientation, detail orientation, team orientation and aggressiveness (Liu, 2004).

According to Anwar and Jabnoun (2006), the total success of TQM implementation is only possible when all its components are implemented effectively, including the availability of the resources and managing the organisational culture, which is part of the national culture; this can be done by adopting appropriate strategies. Horng and Huarng (2002) found that organisational identity and citizenship behaviour could promote a degree of TQM implementation by hospitals in Taiwan. On the other hand, Beer (2003) argues that TQM will persist only if the leadership institutionalises an honest organisation-wide teamwork culture which promotes transparent and effective communication, especially in relation to quality management data.

Boaden (1997) views TQM as one element of cultural change, along with human business process reengineering, Boaden's view was supported by Scheuermann *et al.* (1997) and Mellahi and Eyuboglu (2001) who stated that for a TQM programme to be successful, factors such as management commitment, organisational cultural management, employee involvement and training must be implemented in the organisation. In their study of the implementation of quality business excellence in UK

organisations, Bauer *et al.* (2005) found that organisations with simple and informal organisational structures encountered fewer problems when implementing business excellence than those with complex and formal organisational structures. According to Atchison (1992), the functional nature of hospitals can create a negative or positive organisational culture in the workplace; a negative culture exists in hospitals when people spend a lot of time guarding and defending themselves, while a positive culture is one where employees experience pride in their work, where everyone is involved in and committed to continuous improvement, where people freely help each other to achieve goals and have fun during the process, where people feel appreciated and the action follows the suggestion.

Some other authors, like Claver *et al.* (2000), mention the negative impact of bureaucratic culture in organisations and state that a bureaucratic culture causes many problems for organisations, such as lack of employee involvement, insufficient investment in technology, hierarchical levels, inappropriate planning, inappropriate business alliances and an inability to adapt to the market. On the other hand, Awan and Bhatti (2003) found that the lack of a quality culture, centralised decision making and high turnover were inhibiting factors to starting the QMS process in Pakistan. Moreover Chen *et al.* (2004) report that inability to change organisational culture is considered one of the barriers to implementing TQM in healthcare organisations.

In a Middle East context, Al-Khalifa and Aspinwall (2000) explored the bureaucratic culture prevalent in Qatari organisations, where cultural change and employee resistance to change were the major cultural obstacles encountered in implementing QMS standards. In the same context Al-Kazemi and Ali (2002) found that the nationalities and backgrounds of employees affected their working beliefs, values and attitudes; for example, Kuwaiti nationals lacked technical competence, proper work values and career orientation. They conclude that Kuwaiti staff members preferred to work in government departments because they could rely on non-national staff to fulfil the requirements of the organisation and because they enjoyed flexible compensation packages, high job security and less demanding work.

Short and Rahim (1995) found that the most difficult barrier to implementing TQM in hospitals was their traditionally bureaucratic, complex and highly departmentalised structure with its related culture and leadership style. Yang (2003) agrees that the major

barriers to TQM implementation remain connected to the traditional culture of hierarchical structures. According to Isouard (1999), TQM involves a major paradigm shift in the organisational culture; there are innate difficulties in the development of a quality culture, which will not happen without changing the behaviour and attitudes of all employees and ensuring the direct support and involvement of the leadership. Similarly, Wilson (1997) emphasises that major behavioural and attitudinal changes are required by the entire hospital system if quality management programmes are to be successfully implemented.

Yong and Wilkinson (1999) believe that the issue of organisational cultural change plays a key role in determining the success of quality management implementation, but because of the competitive push for the adoption of TQM and the pervasiveness of prescriptive market-driven consultancy packages, some managers have largely neglected to tailor quality initiatives to suit their own organisational cultures.

Willoughby and Wilson (1997), in their report of a survey carried out at the Cowie Group in the UK, identify the following cultural barriers:

- The workers see the quality management system as a tool that management could use to punish them. Therefore a deep resentment is created towards the quality system.
- Quality is a swearword in the language of many workers.
- Fear of admitting error is the greatest barrier to effective logging of complaints.

Conversely, a good system is enhanced by sensitivity to the values, expectations, behaviours and relationships that exist within any organisation (Pheng and Alfelor, 2000). The movement towards continuous improvement is accompanied by a need to change the way of thinking and the way of working through the total commitment of management.

Twati and Gammack (2006, p3) cite Cameron and Quinn (1999) as stating that numerous studies identify the most frequent reason given for the failure of planned organisational change as a neglect of the organisational culture. Up to 75 percent of re-engineering, total quality management, strategic planning, technology adoption and downsizing efforts have failed or created serious problems by not recognising that organisational culture is a key to organisational success and that effective leadership is

the means by which the culture is created and managed. Schneider (2000) explains that understanding organisational culture is an important activity for managers, because it affects strategic development, productivity and learning at all levels.

Successful implementation of TQM requires that the values of the organisation are changed so as to harmonise them with the values of TQM. Changing the values of an organisation is, however, not an easy task, since values are deeply grounded in the organisational culture. Many scholars hold that implementing quality management systems must involve the cultural transformation of the organisation (Deming, 1986; Drummond, 1992; Schildknecht, 1992). This section of the literature review therefore considers the effect of culture on change management.

According to Raju *et al.* (2008), promoting transparency is considered an important pillar of the quality and patient safety culture in hospitals; although there will be some technical and human challenges, organisations' leaders are encouraged to consistently promote a culture of transparency, which will lead to a better outcome.

#### **2.6.4 Human resources and staffing**

Jun *et al.* (2004) and Sila and Ebrahimpour (2003) identify some human resource functions like training processes, incentive systems and reward tools as critical success factors for implementing TQM in organisations. Most organisations attribute their success to their employees and hence consider the workforce as of paramount importance. Because the staff members of any organisation are a real asset, they are essential to achieve organisational objectives. However, some other organisations ignore their people in terms of training, development, compensation and rewards. According to Holton and Baldwin (2003), in many organisations employees are treated as consumable resources to be used and disposed of as the organisation sees fit. As a result of this approach, many of an organisation's best people leave, seeking opportunities for growth, development and appreciation elsewhere. Holton and Baldwin (2003) argue that in order to overcome this problem, organisations need to create a developmental culture within their human resources practices which will affect their improvement and change.

Yang (2006) conducted a study into the impact of human resource practices on the implementation of TQM, confirming that human resource management significantly

affects TQM practices. He concludes that human resource practices play a key role in the implementation of TQM. According to Yang (2003; 2006), the practices of “training and education”, “incentive compensation” and “employee development” produced the greatest influences on TQM implementation. He adds that successful implementation can lead to an increase in customer satisfaction and so benefit corporate image. It can also improve the satisfaction and quality awareness of employees. Enterprises that devote themselves to the implementation of TQM also need to perform human resource management aggressively, if they are to increase the firm’s performance significantly.

Again, Holton and Baldwin (2003) state that the primary purpose of creating a developmental culture is to provide a work climate that encourages change within individuals. Another is to create conditions where continuous growth and development are encouraged. Furthermore, they argue that a developmental culture needs leaders who appreciate the value of employees’ contributions.

Appropriate recruitment of employees is an important component of the human resource function to ensure that competent and qualified staff are selected to perform a task or fill a post. Some managers may appoint their relatives and friends to positions for which they are not suitable, hence reducing labour efficiency. Similarly, Glover and Siu (2000) criticise the featherbedding system, which results in organisations being overstaffed, with low levels of productivity, managers promoted not on merit but according to allegiance, a reduction in the level of management skill, a fear of losing face and the avoidance of responsibilities. Similarly, some other Arab researchers have found that organisational bureaucracy and political structures lead to inappropriate recruitment of national staff; for example, Sharif (2005) found that the political structure of Libyan organisations resulted in overstaffing (featherbedding) among an unskilled Libyan workforce because of the policies imposed by the government to reduce the unemployment rate. This is supported by Al-Haj (2006), who reports that UAE nationals are inappropriately selected and are in the wrong positions due to poor recruitment.

One of the human resource factors affecting the implementation of any QMS is finding the best qualified staff to perform the job, including by moving staff from one department to another to help in performing certain difficult tasks. This is emphasised by Boiral and Roy (2007), who quote Briscoe *et al.* (2005), Gustafsson *et al.* (2001) and



Fuentes *et al.* (2000) as finding that the mobilisation of human resources appears to be both one of the main difficulties associated with implementing the standard and a key factor in any successful certification process. Collins *et al.* (2005) state that the structured clinical audits programme at the Queen Victoria hospital, East Grinstead, UK faced a problem regarding unfinished projects when trainees and staff moved to other hospitals, so arrangements had to be made to solve this problem.

### **2.6.5 Training**

Regarding training and development, Hayes (2002) states that organisational change is typically associated with some degree of individual change, which is often the outcome of training and development programmes. Therefore, training intervention is required in order to help individuals develop new knowledge, skills, attitudes and behaviour. Radovilsky (1993) found that components of an effective TQM programme consisted of training of all employees and managers, in addition to significant improvement in communication methods between the various departments implementing TQM.

Taylor and Wright (2003), Chua and Goh (2002), Chen *et al.* (2004), Mellahi and Eyuboglu (2001), Isouard (1999), Ovretveit (1997; 2000), Kivimaki *et al.* (1997), Huq (1996), Short and Rahim (1995) and Cheung and Koch (1994) emphasise the need for training and involving all employees in healthcare organisations in the implementation of TQM programmes. Similarly, Ruiz and Simon (2004) found that human resource training and involvement were key to implementing quality principles in Spanish hospitals. Kohli *et al.* (1995) consider training and employee empowerment to be important factors in the application of TQM in casualty and pathology departments in US hospitals.

McFadden *et al.* (2006) emphasise the importance of staff training, the availability of resources and the promotion of safety culture to implement patient safety initiatives in US hospitals. Ab Rahman and Tannock (2005) assert that since staff are the greatest company asset, not only must all key employees receive effective, targeted training in quality techniques and awareness, but for this to be efficient and effective, it should be based on employees' needs. In some countries, however, staff training is often not based on the learning needs of staff, as pointed out by Al-Khalifa and Aspinwall (2000), who found that a lack of human resource management systems meant that the provision of QMS-related training was based on nationality rather than staff needs and qualifications

in Qatari organisations. On the other hand, Zairi (1996) reports that many Middle Eastern countries put more emphasis on training in QMS certification than on any other quality initiative. These are not surprising findings, since the quality movement in the Arab world has a short history and has had very little success.

Some researchers have linked employee's training to their skills. Zhao *et al.* (1995) report that poor quality management practices in India, China and Mexico, such as lack of training, meant that unskilled employees and insufficient technology were challenges to QMS implementation in these countries. Tayyara *et al.* (2000) and Quazi and Padibjo (1998) studied QMS implementation and found that human resources and lack of training programmes were barriers to applying the desired standards. Najmi and Kehoe (2000) cite Laza and Wheaton (1990), Boyett *et al.* (1992), Brown (1993), Goodman *et al.* (1994), Zangwill (1994), Dale and Cooper (1994) and Tatikonda and Tatikonda (1996) as stating that training of employees without specific purposes and lack of effective human resource functions are some common barriers to the implementation of QMS standards. Balzarova *et al.* (2002) report that some of the organisational barriers encountered in some UK firms were poor teamwork, absence of team development and lack of training and learning.

#### **2.6.6 Physician and employee involvement**

According to Elangovan and Karakowsky (1999), job involvement is the degree to which employees are involved in their jobs. These researchers state that employees with high job involvement are more concerned about performing their jobs well and will therefore seek ways to improve their performance. Kollberg *et al.* (2005) found that top management commitment, change management, involving and training the employees were important components in implementing a quality initiative and a performance measurement system in the Swedish healthcare system. Kivimaki *et al.* (1997) and Ennis and Harrington (1999) emphasise the importance of employees' empowerment to focus on customers and their involvement in implementing TQM culture in healthcare organisations. Abd Manaf (2005) found that teamwork, employee involvement and training were essential factors in implementing a quality management programme in Malaysian public health care.

Similarly, Lagrosen (2000) found that employee empowerment and involvement were important factors in implementing TQM in health services in Sweden. Ovretveit (2001)

states that involving all hospital staff at different levels is important when implementing quality programmes and achieving hospital accreditation. This is supported by Taylor and Wright (2003), who argue that employee involvement is essential for success when implementing TQM in organisations.

In their study of Malaysian companies, Ab Rahman and Tannock (2005) reinforce the conclusion that TQM cannot be successfully introduced or practiced unless staff at all levels are informed, involved and committed. They assert that every employee should understand company policy, vision, standards and procedures. This is supported by Taylor and Wright (2003), Dory and Lewis (2002), Weeks and Helms (1998) and Ashire *et al.* (1996), who emphasise the importance of involving everybody in the organisation in implementing quality systems.

Sharif (2005, p213) states that “*management should adopt a teamwork approach to involve [the] workforce*” in improving processes and solving problems. Furthermore, other researchers have suggested that lack of employee involvement is a barrier to implementing quality management systems. For example, Park *et al.* (2007) report a lack of employee involvement in South Korean manufacturing companies. Senior managers were not personally involved, nor were any of the lower level employees, regarding the principles of the QMS, which was maintained by the quality department alone.

Godfrey (1999) believes that one of the critical factors in the development of a quality management environment for pathology services is the emphasis placed by the pathology project’s TQM Team on continually providing feedback to staff. Feedback in the form of process reports and minutes from meetings were regarded as important measures in ensuring cooperation and continued participation in the change process. Keeping staff informed of quality improvement efforts would minimise resistance to the proposed changes.

According to Huq (1996), most effective problem solving will occur when the people who own the process are given the responsibility to recommend and implement changes. This includes physicians, nurses and staff-level employees. To the physician, TQM can be presented as an extension of the medical profession’s current use of the scientific approach. Huq (1996) argues that separation of the common and the special

causes of errors in diagnosis and treatment can help physicians to improve patient care. The focus should be on the system, not on a retrospective review of individual providers. Physicians may participate more enthusiastically if they realise that the focus is not on them but on systemic causes of variation.

Moreover, Huq (1996, p75) asserts that “*Barriers to physician involvement in TQM may be the single most important [obstacle to] success in implementing TQM in hospitals*”. He emphasises that lack of physician involvement in implementing TQM is related in many hospitals to communication gaps, to the busy schedules of physicians and to the fact that the system in most hospitals is biased towards meeting physicians’ desires; therefore it is no wonder that doctors do not feel obligated to comply with a programme not initiated by them. According to Giraud (2001), doctors have often been the missing link in healthcare quality assurance systems because their definition of quality in medicine differs from that adopted by regulators and managers. For doctors, improvement in medical quality consists in the accomplishment of medical progress through clinical research.

John (1997) similarly reports that the involvement of physicians appears to be the most important single factor affecting successful implementation of TQM programmes in hospitals and one of the most difficult challenges. A hospital quality strategy has to use different methods to ensure that physician managers understand and lead the quality programme, with due regard for professional sensitivities. This should include physicians in formal positions, as well as respected and influential physician “opinion-formers”. Methods to ensure that all physicians are involved in the programme include training, educational activities, incentives and motivation.

Many other studies conducted in Western and in Islamic and Arab countries have identified lack of employee involvement as a barrier to the implementation of new quality standards. Examples of such studies in Islamic countries are those by Awan and Bhatti (2003) and by Amar and Zain (2002), and in Western countries by Dickenson *et al.* (2000) and by Claver *et al.* (2000). On the other hand, Amar and Zain (2002) state that a centralised approach to implementing new quality standards inhibits the involvement of staff members in the accreditation process.

#### **2.6.7 High cost**

A barrier facing most organisations is the relatively high cost of certification, arising from training, time, consultants' fees, the registration fee itself, etc. High consultancy fees to facilitate the registration process is a key factor in the cost of certification (Stevenson and Barnes, 2001). Likewise, Dickenson *et al.* (2000), Al-Haj (2006) and Mostafa (2004) found that the cost of consultation, implementation and third party certification fees were very high in Russia. Additionally, the cost of upgrading the infrastructure to meet international standards and the development costs of certification hindered QMS implementation in Russia. According to Fuentes *et al.* (2000), lack of financial capacity to meet the implementation costs and maintain a QMS was one of the barriers affecting implementation of ISO 9000 standards by Spanish organisations.

Quazi and Padibjo (1998) and Amar and Zain (2002) report that lack of financial support is a barrier to QMS implementation by manufacturing organisations in Singapore and Indonesia respectively. Lack of financial support was a barrier experienced by small and medium-sized manufacturing organisations in Australia attempting to implement quality system standards (Mo and Chan, 1997). Similarly, Lee *et al.* (1999) found that lack of financial support was a common barrier encountered by small and medium-sized manufacturing organisations in Hong Kong. James and Hunt (1996) state that the cost of accreditation or of implementing a quality programme depends on the time required to achieve accreditation or implement the programme. According to Gough and Reynolds (2000), cost is one of the important factors to be considered in the process of accrediting clinical laboratories in the UK.

Magd (2006) found that in Egypt, the most important problem with QMS implementation facing manufacturing organisations and registration agencies was the high costs associated with the auditing process. Sharif (2005) reports that the high cost of certification was a barrier facing most organisations in Libya and that this high cost came mostly from training, consultancy fees, registration fees and the cost of upgrading the infrastructure to meet international standards and requirements. Naylor (1999) found that availability of resources is very important factor for implementing EFQM in Royal Bolton hospitals of UK.

Finally, Fuentes *et al.* (2000) quote Moreno-Luzon (1993), Toemeier (1997), Axland (1992), Barrier and Zuckerman (1994) and Dale (1994) as identifying a lack of financial resources as a barrier to QMS implementation.

### **2.6.8 Time**

According to Pomey *et al.* (2004), the process of preparation to achieve accreditation is time consuming; for example, self assessment is an exercise that is very time intensive for staff and has an impact on hospital costs as well. It certainly represents a considerable sum that can be justified only by a significant return on investment. Balzarova *et al.* (2002) report that time taken to spread a new way of dealing with responsibilities and tasks within an organisation was a barrier to successful QMS implementation in some UK firms. Similarly, Withers and Ebrahimpour (2001) reveal that implementation time was one of the most common obstacles faced by the eleven different European organisations in their study. This was confirmed by Sharp *et al.* (2003), who found that a failure to allow sufficient time for evolution was a barrier to successful implementation of ISO 9001-2000 by organisations in the UK.

Stevenson and Barnes (2001) add that the amount of time needed to become certified is usually about a year or two, depending on the organisation's size, its current level of quality, the extent of documentation, the complexity of its production process and the strength of management commitment. Dory and Lewis (2002) quote Cole (2002), who found that organisations need time to successfully implement the quality methods and processes that are necessary to achieve significant improvements. Learning how to overcome existing institutional barriers and to apply a new system or new organisational routines is a slow process. However, Berggren *et al.* (2001) note that a plan for implementing a quality management process is one way to set time limits for the different steps.

### **2.6.9 Communication**

Communication plays a very important role in the implementation of quality management systems, but it has often been found to be poorly managed in Swedish organisations (Carlsson and Carlsson, 1996). Similarly, Al-Zamany *et al.* (2002) found that in Yemeni public organisations, there was a lack of effective communication from top to bottom and vice versa, because of a lack of trust and the difficulty for employees in having a discussion or debate with their managers about quality issues. Jun *et al.* (2004) state that lack of appropriate communication, lack of effective employee training and lack of employee involvement have been found to be barriers to the successful implementation of TQM. Weeks and Helms (1998) argue that a communication

programme is needed to help managers and employees communicate their perceptions of the process of implementing TQM in hospitals.

According to Lipshutz *et al.* (2008), communication with the staff concerned and providing them with feedback on progress in implementing quality initiatives is essential for the successful implementation of PDSA quality initiatives in a critical care setting. They also report that direct feedback and the celebration of success played a positive role in implementing quality initiatives in critical care units at the University of California San Francisco Medical Center. In their examination of the critical factors of TQM implementation across countries, Sila and Ebrahimpour (2003) found that communication played an important role in its success. They emphasise the importance of effective communication across functions and work units to ensure that customer requirements are addressed and that an environment of trust and knowledge sharing is created. This communication includes cultural communication, transmission of information to the customer, effective top-down and bottom-up communication, and organisational learning and communication. The authors also emphasise the importance of communicating and sharing improvement information among all the staff as a factor promoting the implementation of TQM principles.

Reason and Hobbs (2003) indicate that addressing coordination problems such as misunderstandings, poor teamwork or communication is very important to promote the implementation of quality systems. In many cases, coordination breaks down when people make unspoken assumptions about a job and fail to communicate with one another to confirm the situation. Authors including Mjema and Mweta (2003) and Cholasuke *et al.* (2004) mention that information technology is very important in promoting communication during quality system implementation and very helpful in minimising communication problems. Kivimaki *et al.* (1997) emphasise the importance of open communications among all employees for promoting TQM culture in healthcare organisations.

Al-Khalifa and Aspinwall (2000) consider regular and effective communication to be necessary for all phases of the change process. This is supported by Henderson *et al.* (1999) and Pupius (2002), who emphasise the importance of effective communication during the implementation of quality systems or other similar changes.

#### **2.6.10 Continuous quality improvement**

In his study of the development of a culture of quality within a UK healthcare trust, Stahr (2004) asserts that the approach of using the EFQM as quality management system to develop a culture of excellence helped to stimulate staff into establishing their own improvement projects and to be willing to share them with others within the trust. However, in order to maximise the potential of using the EFQM model, the trust concerned had to ensure that the quest for excellence was relentless if there was to be a sustainable culture of improvement. Stahr emphasises the importance of adopting a continuous improvement culture, putting quality at the heart of day-to-day decision making. This is supported by Ruiz and Simon (2004), who emphasise the importance of adopting a hospital-wide quality improvement approach to the implementation of a quality programme in Spanish hospitals, and by Abd Manaf (2005), who found that maintaining continuous quality improvement was an essential factor in implementing a quality management programme in Malaysian public health care. Banerji *et al.* (2005) found that top management commitment, continuous quality improvement activities, employee involvement and training were essential factors in implementing quality management practices in India.

Similarly, Sila and Ebrahimpour (2003) and Chua and Goh (2002) emphasise the importance of improving the quality of service in organisations during the process of implementing TQM. Employee motivation usually improved when the result of their contribution improved the service provided to the internal and external customers.

Focusing on the importance of process management, Bamber *et al.* (2000) note that part of the success of any organisation depends on how effectively its managers manage business processes. On the other hand, Kollberg *et al.* (2005) state that focusing on quality improvement activities is an important element in implementing a quality initiative and a performance measurement system in the Swedish healthcare system. Additionally, Al-Haj (2006) reports that one of the main points found in some UAE companies was poor process management and a lack of process improvement, arising from a too heavy bureaucracy. The decision making in most departments was over-centralised.



### **2.6.11 Effective steering committees**

According to Ab Rahman and Tannock (2005), a steering committee is an effective mechanism to coordinate and manage quality development activities and to resolve conflicts. If the members of the steering committee do not demonstrate their commitment to and involvement in the TQM programme, then this is at risk. It is essential that all key players support the proposed TQM implementation and quality activity programme. Navaratnam and Harris (1995) see the steering committee as representative of the management team of the organisation and responsible for setting the vision, mission, objectives, policies, plan and critical success factors of TQM implementation. Establishing a shared vision of the organisation's future with all its stakeholders will reduce resistance to the change initiative (Balzarova *et al.*, 2002).

### **2.6.12 Empowerment, reward and recognition**

According to Ab Rahman and Tannock (2005), a well-designed staff and team recognition system is an effective factor in continuously encouraging and reinforcing the desired behaviour toward proposed changed, supporting morale and motivating employee involvement. They found that the associated staff rewards (in terms of money, certification and promotion) assisted quality activity achievement and encouraged commitment in shop-floor workers and junior staff, giving them a sense of belonging and a feeling of pride. This finding is supported by McFadden *et al.* (2006), who declare that as one of the possible actions to improve TQM implementation, hospital administrators should focus on breaking down the barriers to implementation. Possible actions may include providing incentives for reporting errors, increasing employees' knowledge and understanding of errors, increasing leadership support and improving the empowerment and recognition of their staff.

Inconsistent reward systems and lack of recognition are other obstacles to implementing ISO 9000 standards in many organisations; they increase the difficulty of consolidating the implementation of the new managerial approach and associated quality practices (Marcedo-Soares and Lucas, 1996; Ngai and Cheng, 1997). Low and Ling-Pan (2004) also found that recognition, respect and reward for a good job done were important factors in assuring effective implementation and maintenance of quality management systems in Singaporean organisations. Similarly, Balding (2005) and Sultani (2005) argue that employee empowerment, training and reward are important factors in implementing organisational quality improvement activities.

This is consistent with the findings of Ashire *et al.* (1996) that employee empowerment increases participation and awareness of responsibility among employees. Empowerment not only shifts the responsibility for quality decisions to employees, but entails providing necessary resources and technical support to assist them in such decision making. Many researchers have indicated that for cross-functional quality improvement teams to be successful in the TQM journey, their performance should be linked with rewards and recognition (Denison and Hart, 1996; Tippet and Peters, 1995).

### **2.6.13 Understanding of TQM principles**

According to Arasli and Ahmadeva (2004) and Taylor and Wright (2003), one of the important factors in implementing TQM in hospitals is to understand and adopt the principles as well as the philosophy of TQM. These should become the basis of all changes in the hospital, thus creating a system of evaluation of the final product in hospital services. Taylor and Wright (2003) consider that understanding the quality principles, focusing on the customer needs and the commitment of the top management are essential for the success of implementing TQM in organisations. According to Percarpio *et al.* (2008), one of the quality improvement tools whose use is encouraged by JCI is root cause analysis, which should be conducted when a serious and unexpected medical error take place in a hospital. Hospital staff members in the USA find some difficulty in performing this task because of lack of experience and of available literature on the effectiveness of this tool in preventing future errors.

Al-Zamany *et al.* (2002) report that the level of awareness of quality management issues in Yemeni organisations was very low and there was a poor understanding of the importance of quality in international trade and the globalisation of world markets. Such a lack of awareness was also a factor inhibiting the start of the ISO 9000 process in Pakistan (Awan and Bhatti, 2003). Similarly, Al-Haj (2006) found that in lower-level staff, limited understanding of quality and an incomplete recognition of its benefits inhibited successful implementation.

Rohitratana and Boon-itt (2001) found that among the obstacles to the process of QMS implementation were a lack of knowledgeable specialists in this subject matter, poor understanding of the details of quality standards from the enterprises' point of view, which caused delay in implementation process and inadequate support and co-operation

from the staff, invariably resulting in resistance. On the other hand, Costa and Lorente (2007) found that not all auditing and consulting companies had the same ways of understanding the standards, and some of them had flexible procedures for auditing or implementing the quality management system. This means that two organisations in the same sector certified by different companies could be applying the standard in very different ways.

#### **2.6.14 Teamwork and interdepartmental relations**

McFadden *et al.* (2006) quote Flynn and Saladin (2001) as stating that an important factor in the success of TQM implementation is the cooperation of the different functions and groups responsible for quality, including top management, workers, suppliers and customers. This is consistent with the observation of Godfrey (1999) that effective teamwork was an important factor in developing the TQM environment in hospital pathology services. All staff members involved in the process of clinical pathology servicing were encouraged by the Project TQM Team to contribute to the improvement process. He adds that employees were empowered to identify problems and become involved in process change. During the first few months, the team leader and the quality advisor focused particularly upon team building among the various service partners. Such strategies attempted to break down long-standing departmental barriers, thereby requiring staff to work as a team. Several medical staff members participated actively in the project. Their enthusiasm and responsiveness grew as the project progressed successfully.

It is emphasised by Abd Manaf (2005), Yang (2003), Mellahi and Eyuboglu (2001), Ovretveit (2000), Ennis and Harrington (1999) and Isouard (1999) that having a qualified team to introduce TQM to organisations and to provide assistance during and after TQM implementation is essential to the success of the programme. They also report that assistance with TQM implementation has been identified as another key determinant of success. A final factor is a highly educated management team that is not only aware of the skills and behaviour required to implement TQM, but also able to introduce the necessary practices that will develop these skills and elicit these behaviours.

### **2.6.15 Focus on the customer**

Godfrey (1999) found that fostering the attitude that the customer comes first was one of the critical factors in the development of a TQM environment. This was demonstrated in the following actions:

- Customers and providers were identified and had representation during the project to develop the TQM environment.
- The relationships between customers and providers were improved through the encouragement of closer communication and joint problem solving.
- Customer needs and requirements were determined and plans developed to meet them. Systems were developed to evaluate how customer needs were being met.

As outlined by Quazi *et al.* (2002) and Fuentes *et al.* (2000), the following are some important customer-related barriers having an impact on the successful implementation of quality management systems:

- Lack of commitment to satisfy customers;
- Lack of integration of customer satisfaction in an organisation's goals and vision;
- Lack of knowledge of customer needs and expectations;
- Lack of cooperation from customers;
- Lack of usage of customer feedback in new service and goods design;
- Inappropriate monitoring of customer satisfaction;
- Ineffective response to customer complaints.

Similarly, Tayyara *et al.* (2000) and Al-Zamany *et al.* (2002) found that the absence of the customer's voice and lack of alternatives for the customer to accepting or rejecting the product were barriers to QMS implementation in Syrian and Yemeni public sector manufacturing organisations.

Measurement of customer satisfaction is an important factor in the determination of the effectiveness of QMS implementation, according to the JCI standards. Regarding customer satisfaction requirements in these standards, top management should ensure that all the employees concerned in the hospital are aware of patient and family rights as well as the requirements of patient education. The JCI standards also require the top management to ensure that customer feedback is measured and improvements initiated accordingly.

### **2.6.16 Resources**

Arasli and Ahmadeva (2004) conducted a study of the local TQM formula for health promotion in Cyprus, finding that the following resources were critical in supporting its implementation:

- The appointment of qualified and competent managers who were involved in quality programmes and successfully contributed to changes in hospital policy;
- The extended use of a well designed, integrated information system to meet safely the health information needs of doctors, nurses and others in the hospital.

In a comparative study of quality management procedures in six UK general hospitals, Hore (1994) found that problems related to the implementation of quality initiatives were felt to be mainly due to lack of finance and time, many hospitals feeling that they were being asked to do too much in a relatively short period at a time when posts were being frozen and the numbers of staff generally reduced. Some individuals complained of having to do more than one job; in effect, the quality assurance co-ordination was being “managed” in addition to their other roles and responsibilities. Resources were short, with hospitals having to borrow money from other budgets to carry out their existing quality initiatives. Many felt that additional funding was necessary to employ staff to assist with auditing and to meet properly the requirements of the Department of Health purchasers.

Similarly, Amar and Zain (2002) found that a lack of financial support was a barrier to the implementation of a quality management system in manufacturing organisations in Indonesia. According to Griffin (2007), the implementation of a quality initiative to reduce methicillin-resistant *Staphylococcus aureus* infections required many resources in order to achieve and maintain good results. Some of these resources were related to hand hygiene, medical disposables, single use devices and the training and education of employees. The author also emphasises the value of a multidisciplinary and teamwork approach to implementing this quality improvement initiative.

### **2.6.17 Harmonization and sharing of data and information**

According to Sila and Ebrahimpour (2003), studies of the critical factors affecting the implementation of TQM in Italy, Spain, Canada, the UK and Qatar showed that process measurement, sharing quality information, quality data feedback and management by fact were very significant for success. Moreover, Ab Rahman and

Tannock (2005) emphasise the importance of sharing informative data with all of an organisation's members to promote a successful implementation of quality programmes, so it is necessary to gather and analyse information for effective quality improvement. Tools that are suitable for sharing such information include the basic quality improvement tools based on the simple concept of the PDCA improvement cycle.

On the other hand, Ruiz and Simon (2004) state that professionals' willingness to establish a valid information system to share quality data is an important factor in the implementation of a quality programme in Spanish hospitals. Previously, Lagrosen (2000) found that the foremost success factors in implementing TQM in health services were sufficient information, commitment by the management and the evaluation of operations, while Chen *et al.* (2004) state that for successful TQM implementation data must be credible and reliable, and the measurement process must be consistent.

Some other researchers have found that poor availability of information or information systems is a barrier to QMS implementation in certain countries. For example, Amar and Zain (2002) identified lack of quality information as such a barrier in Indonesian manufacturing organisations, while Al-Khalifa and Aspinwall (2000) report that a lack of information in Qatari organisations retarded their implementation of ISO 9000 standards.

In his study of the barriers to implementing ISO 9000 in the UAE, Al-Haj (2006) found that the main aims of the information system were to facilitate information gathering and to make it available across departments, thus giving individuals and groups the tools needed for better environmental action and achievement of the vision of the company. He adds that absence of these tools or lack of involvement of the end users in purchasing the appropriate information systems are considered to be barriers to successful QMS implementation.

Hammer and Champy (2001) and Ross (1999) show that IT investment can have a positive impact on organisational performance as a result of better coordination in the value chain. However, putting such a high level of collaboration into practice is not easy. Both information quality and relationship commitment play important roles in helping to improve information management in the organisation. Similarly, Yu and

Houston (2007) found that computerised healthcare processes in hospitals, such as electronic medical records, facilitated the effective and efficient implementation of the quality programme and promoted patient safety.

In a study to consider how information and information systems could be used to support improved in-patient flow in acute hospitals, Proudlove and Boaden (2005) found that the effective management of the components of the patient journey required integration of the use of information systems. This is supported by Sanders and Premus (2002), who argue that information systems should support the integration of inter-organisational processes.

Huq (1996) emphasises the involvement of staff and physicians in decisions related to their work in hospitals as an effective problem-solving strategy, asserting that most effective problem solving will occur when the people who own the process are given the responsibility to recommend and implement changes. This includes physicians, nurses and staff-level employees.

Lurie *et al.* (2008) found that a major challenge to implementing quality initiatives related to the national health plans in the USA had been to find ways to efficiently translate those data into actionable knowledge that could be understood by all stakeholders. One of the strategies used to manage this challenge was to present the data by using appropriate quality tools such as Pareto charts. This strategy improved stakeholders' understanding of the data in relation to quality improvement initiatives.

#### **2.6.18 Staff awareness**

Al-Zamany *et al.* (2002) quote Wong (1998), who indicates that the implementation of quality programmes in developing countries may fail due to a lack of awareness and understanding of TQM. The failure of some organisations to gain accreditation or certification is caused by a poor understanding by top management and other concerned managers of the requirements of quality management standards and the implementation process. Also, Withers and Ebrahimpour (2001) indicate that one of the most common obstacles faced by eleven European organisations in their study was difficulty in interpreting the ISO 9000 standards. Thus, top managers should educate themselves before taking action to seek QMS certification (Lee, 1999).

In the USA, Hendrich *et al.* (2007) found that one of the main barriers to implementing quality activities at Ascension Health to achieve zero errors was lack of administrative staff awareness of patient safety issues in hospitals; the administrative staff rating of the safety climate was three times higher than that of clinical staff, due to lack of awareness and differences in the perception of patient safety issues.

This is supported by Pomey *et al.* (2004) and Chua and Goh (2002), who argue that awareness among all hospital staff of the quality improvement principles and accreditation process is one of the conditions for a successful implementation process. One of the important strategies to improve such awareness among staff in hospitals is to gain their support for the accreditation process via self-assessment, which is usually conducted by trained quality department staff.

Many authors, including McFadden *et al.* (2006), Ngai and Cheng (1997), Rohitratana and Boon-itt (2001), Bhanugopan (2002), Masters (1996), Amar and Zain (2002), MacDonald (1992), Walsh *et al.* (2002), Al-Khalifa and Aspinwall (2000) and Salegna and Fazel (2000), have argued that lack of knowledge and understanding of the quality management system and a lack of awareness or a misunderstanding of its benefits could work as barriers to its implementation or that of other quality initiatives.

#### **2.6.19 Documentation**

Yahya and Goh (2001) quote Quinlan (1996) as stating that 80 per cent of the failure of organisations in certification audits is caused by barriers such as the wrong documents and poor control of documents and data. Beskese and Cebeci (2001) point out that the difficulty most frequently encountered during the certification process in Turkish organisations was in controlling documentation. One of the common difficulties that faced QMS implementation in Hong Kong was too much documentation and too many records (Tang and Kam, 1999). According to Ennis and Harrington (1999), “documentation-driven” improvements in Irish hospitals can restrain staff from adopting the process of quality improvements. Pomey *et al.* (2004) emphasise the importance of documenting all hospital clinical and administrative work to promote the implementation of the quality programme.

Another insight is given by Tayyara *et al.* (2000), who report that the difficulty of setting up a quality manual and the difficulty of writing up procedures and work



instructions were barriers to QMS implementation in Syrian organisations. Brashier *et al.* (1996), Mo and Chan (1997), Carlsson and Carlsson (1996) and Lee *et al.* (1999) also found that failure to control documentation was a barrier to implementing a QMS.

#### **2.6.20 Resistance to change**

Resistance to change was found by Al-Zamany *et al.* (2002) to be a barrier to the implementation of a Western quality management model by Yemeni organisations, because tensions arose between European and local cultures. Similarly, Sanders and Scott (1997) advocates integrating quality initiatives into organisational culture, creating a quality steering committee and investing in planning and education, which are essential for quality implementation in healthcare organisations. Stebbing (1993) concurs that the most common cultural cause of implementation setback is employee resistance and suggests that to remedy resistance, retraining with the use of a third party would be an effective solution. It is certainly true that the development and application of a quality assurance system helps companies to better organise and synchronise their operations by eliminating ambiguities and clearly defining duties and responsibilities among employees and departments.

Moser and Bailey (1997) found that lack of employee motivation, resistance to change, additional workload from the quality management system and opposition to bureaucratic management impeded QMS implementation. According to Ennis and Harrington (1999), organisational culture, resistance to change and employee resistance were considered important factors in implementing quality programmes in Irish hospitals, while Glover and Siu (2000) found that avoidance of responsibilities acted as resistance to change in Chinese organisations. Similar findings were made in Western countries by Fuentes *et al.* (2000), Brashier *et al.* (1996), Tsim *et al.* (2002), Moser and Bailey (1997) and McAdam (1996), who report that employees had a strong feeling of being controlled by the quality system and so avoided undertaking more responsibility as the quality system required.

Sharp *et al.* (2003) found resistance to change to be a barrier to successful implementation of ISO 9000 in some UK organisations, while Raymond (2002) summarises the common reasons for people resisting change as:

- Fear of the unknown – not understanding what is happening or why;

- Disrupted habits – feeling upset when old ways of doing things cannot be followed;
- Loss of confidence – feeling incapable of performing well under the new way of doing things;
- Loss of control – feeling that things are being done to them, rather than by them or with them;
- Poor timing – feeling overwhelmed or that things are moving too fast;
- Work overload – not having the physical or mental stamina to handle the change;
- Lack of purpose – not seeing a reason for the change or not understanding its benefits;
- Economic loss – feeling that their pay and benefits may be reduced or that they may lose their jobs.

According to Raymond (2002) and Paton and McCalman (2000), resistance to change can be overcome in the following ways:

- Communication: The management should provide enough information in advance to employees, regarding the need for the change, its nature and the planned timing. This can reduce fear of the unknown and change team behaviour.
- Participation by employees in developing and implementing change can reduce fear of the unknown and lead to commitment.
- Guarantees: Management should assure employees that they will not be disadvantaged by engaging in any change activities such as training.
- Certainty: It is better to let people know exactly where they stand and to detail what is going to happen and when.
- Counselling: Non-threatening discussions can help to eliminate negative feelings and facilitate acceptance of change.
- Negotiation gives a margin of flexibility to all parties.
- Reward: Managers and employees who contribute to the successful introduction of change should be motivated.
- Coercion usually involves the use of threat or punishment against those resisting change, such as loss of promotion, transfers, poor performance rating, pay cuts and termination.

Tushman and Anderson (1997) state that managing change involves moving an organisation from its current state to its desired state via a transition period. For quality standard registration, this may mean moving from a quality management system that is inadequate (current state) to one that meets quality standard requirements (future state). This view is supported by Mohammed (2005), for whom change can be described as a transfer from one case to another through transitional stages.

Paton and McCalman (2000) emphasise the importance of managing the driving and restraining forces while managing change. Driving forces are all the factors that facilitate the occurrence of change, while restraining forces are the factors or situations that play a role in resisting it. Driving forces may include customer satisfaction, resource availability, worldwide competition, technology awareness and high demand for a service or product. Some restraining forces are cultural effects, unclear vision, lack of confidence, lack of sufficient resources, poor job design and lack of training.

Given these driving and restraining forces, Paton and McCalman (2000) offer three basic strategies for achieving change: increase the driving forces, reduce the restraining forces, or both. These apply to any example of organisation-wide change, which might include a change in mission, restructuring operations, new technologies, mergers, major collaborations, “rightsizing” and new programmes such as implementing TQM.

Hayes (2002, p64) believes that *“recognising the need for change is an essential step in starting the change process. A leader might want to reflect on his own experience and consider how good his unit or organisation has been at recognising the need for change”*. Allan *et al.* (1998) assert that most managers and executives would agree that change has become a constant phenomenon which must be attended to and managed appropriately if an organisation is to survive. They add that changes in technology, the marketplace, information systems, the global economy, social values, workforce demographics and the political environment have significant effects on the processes, products and services produced.

Further, Brawn and Harvey (2001, p165) emphasise the purpose of change as being *“to increase organisational effectiveness or even to ensure survival”*. They add that in the future, the only winning organisations will be those that respond quickly to change. Preparing managers to cope with today’s accelerating rate of change is the essential

concern of these organisations. The modern manager must not only be flexible and adaptive in a changing environment, but also be able to diagnose problems and implement change programmes. Most organisations today are under severe pressure to proceed with the organisational transformation needed in order to cope with increasing rates of environmental change and turbulence.

As noted above, Tushman and Anderson (1997) state that managing change involves a transition from a current to a desired state. Similarly, for Mohamed (2005), quality standard registration may mean moving from a current to a future QMS that meets quality standard requirements, so it is important to understand how implementing such changes could affect quality management.

Raymond (2002), Paton and McCalman (2000), Pomey *et al.* (2004), Ngai and Cheng (1997) and Campbell (1995) have suggested some strategies to overcome resistance to change, including effective communication, participation, teamwork and proper performance evaluation systems, while Oakland (1997) suggests seven steps in the integration of change management and quality management:

- Gaining commitment to change;
- Developing a shared mission or vision of the desired change;
- Defining measurable objectives;
- Listing the critical success factors of the mission;
- Understanding the key processes;
- Breaking down the key processes into sub-processes;
- Monitoring and adjusting the processes.

Furman and Caplan (2007) found that transparent discussions and continuous feedback had helped to promote staff acceptance and participation in applying a quality initiative to reduce medical errors in an ambulatory healthcare service setting. Introducing new standards of practice in hospitals will affect and may change the behaviour of healthcare providers in these hospitals. Considering the change management techniques and how to deal with resistance to change, as mentioned in section 2.6.2, will facilitate the implementation process.

## **2.7 National culture and the UAE environment**

This section of the literature review discusses the definition of culture and national culture, cultural differences between nations and the UAE environment.

### **2.7.1 Definition of culture**

According to Hofstede and Hofstede (2005), managers and leaders of organisations, as well as the people they work with, are part of national societies. Therefore, in order to understand them one must understand their societies. Moreover, culture is always a collective phenomenon, because it is at least partly shared with the people who live or have lived within the same social environment. This is supported by Nicholls *et al.* (1999), in a study of self-managed teams in Mexico, which found that many Mexican workers were driven by the national culture to obey norms which include collectivism and strong uncertainty avoidance, making them reluctant to confront people openly and disagree with each other.

Furthermore, Hofstede and Hofstede (2005) assert that culture consists of the unwritten rules of the social game. They state that four terms can be used to describe the manifestations of culture, as follows:

- Symbols, which are words, gestures, pictures, or objects that carry a particular meaning only recognised as such by those who share the culture.
- Heroes, who are persons, alive or dead, real or imaginary, who possess characteristics that are highly praised in a culture and thus serve as models for behaviour.
- Rituals, which are collective attitudes, technically superfluous to reaching desired ends, but which are considered socially essential within a culture.
- Values, which are the core of culture. Values are broad tendencies to prefer certain states of affairs over others. They are feelings with a positive or negative evaluation and are acquired early in our lives.

Adler and Jelinek (1986) see culture as a set of taken-for-granted assumptions, expectations or rules for being in the world. Hofstede (1991) suggests that culture is the collective programming of the mind which distinguishes the members of one group or category of people from another. Leininger (1995) declares that a world view is the way that individuals or groups look at the universe to form values related to their lives and

the world around them. Culture furnishes the beliefs and values that give individuals a sense of identity, self-worth and belonging, as well as providing the rules for behaviour.

Beardwell and Holden (2001) state that culture consists of explicit and implicit patterns of behaviour acquired and transmitted by symbols, constituting the distinctive achievement of human groups, including their embodiment in artefacts. For them, the essential core of culture consists of traditional (i.e. historically derived and selected) ideas and especially their attached values. Cultural systems may be considered both as products of action and as conditioning elements of future action.

Culture is not limited to religious beliefs, communal rituals or shared traditions; Sherman and Katzenbach (1995, p25) state that *“Culture is an integrated phenomenon and by recognizing and accommodating taboos, rituals, attitudes toward time, social stratification, kinship systems and many other components, modern managers will pave the way toward greater harmony and achievement in the country in which an multinational business operates”*. Although not discarding the importance of a person’s cultural inheritance of ideas, values, feelings, ways of relating and behaving and practices, we must also acknowledge that culture is dynamically affected by social transformation, social conflicts, power relationships and migration (Good, 1994). However, there is still the danger of perceiving culture as static.

### **2.7.2 Cultural differences and their effect on management systems**

Al-Khalifa and Aspinwall (2000) assert that the national culture represented by the shared values of a society or country influences organisational culture and thus affects QMS implementation. Elashmawi and Harris (cited by Al-Khalifa and Aspinwall, 2000), compare the most important cultural values of the US, Japan and the Arab countries, while Table 2.3 shows that for the UK, Japan and the Arab world, the priority of cultural values differs from one culture to another. This can affect technology transfer, managerial attitudes and employees’ performance.

Hofstede (1980; 1991) suggests four dimensions of cultural difference between nations and clusters cultures according to these dimensions: “power-distance”, “uncertainty avoidance”, “individualism-collectivism” and “masculinity-femininity”.

- Power-distance is the extent to which the less powerful people in a society accept inequality in power and consider it normal.

- Uncertainty avoidance indicates the extent to which people are made nervous by situations which they consider as unstructured or unclear and the extent to which they try to avoid such situations by adopting strict codes of behaviour and a belief in absolute truths. Burgmann *et al.* (2006) state that uncertainty avoidance describes a lack of tolerance for uncertainty and ambiguity. Hofstede (2001) explains that people in such cultures look for structure in their organisations, institutions and relationships, which make events clearly interpretable and predictable.
- Hofstede (2001) describes the dimension of individualism and collectivism as the relationship between the individual and the collectivity that prevails in a given society. Following on from this, the dimension characterises collectivist cultures as relationship- and group-oriented. In contrast, individual-oriented cultures are those in which people are expected to take greater responsibility and where attention is drawn towards the individual.
- Masculine cultures are seen by Hofstede (1991) as having vastly different social roles for the sexes, whereas in feminine cultures social roles overlap significantly.

**Table 2.5: Priorities of the top 10 cultural values**

United Kingdom	Japan	Arab Countries
1. Individualism	1.Belonging	1. Family security
2. Independence	2. Group harmony	2. Family harmony
3. Freedom	3. Collectiveness	3. Parental guidance
4. Openness	4. Age/seniority	4. Age
5. Self-reliance	5. Group consensus	5. Authority
6. Competition	6. Cooperation	6. Compromise
7. Equality	7. Quality	7. Devotion
8. Time	8. Patience	8. Patience
9. Directness	9. Indirectness	9. Indirectness
10. Efficiency	10. Go-between	10. Hospitality
Note: “1” represents the most important cultural value, “10” is the least		

Source: Hofstede (1997)

In summary, the national culture refers to shared values, beliefs and the way of life of a society, a country or a nation where people live together. Similarly, those people who work in organisations live in an organisational culture which is related to the beliefs, values, perceptions and what is accepted or not within the organisation. Therefore, in order to understand them one must understand their societies (Hofstede and Hofstede, 2005).

### **2.7.3 The UAE environment**

The following subsections offer an overview of the UAE environment with a focus on the following:

- The United Arab Emirates and the Middle East
- Culture and Society
- Economy
- Healthcare system
- Quality trends.

#### **2.7.3.1 The UAE and the Middle East**

The United Arab Emirates is an oil-rich desert country situated in the eastern part of the Arab world, in the south-east of the Arabian Peninsula, overlooking the Gulf of Oman to the East and the Arabian Gulf to the North, with Saudi Arabia to the south and west. It is thus positioned at an important location in the world of trade. In 1971, the former Trucial States of the Persian Gulf coast—Abu Dhabi, Ajman, Fujairah, Sharjah, Dubai and Umm al Qaiwain—merged to form the United Arab Emirates and were joined by Ras al Khaimah in 1972.

The UAE is the third largest oil producer in the Gulf after Saudi Arabia and Iran (Al-Haj, 2006). Ojaili (2000) claims that virtually no country in world history has matched the UAE's rapid development; its skyscrapers, landscaped gardens, desert farms and modern schools and hospitals give no indication that for many centuries this had been a desert land.

The UAE is a federation of the seven separate emirates listed above. Specific powers are delegated to a central government, while other powers are reserved for the individual member emirates. The hereditary rulers of each individual emirate make up the Supreme Council of Rulers, which is responsible for electing a president every five years. The late Sheikh Zayed bin Sultan al-Nahayan, ruler of Abu Dhabi, was president of the UAE from 1971 to 2004 and was succeeded by his son, Sheikh Khalifa bin Zayed al-Nahayan. The federal structure includes a Federal Judiciary and the Federal National Council, comprising 40 members from the seven emirates, which cannot initiate legislation, but advises the other councils (Al-Sereni, 2005).



The UAE is a member of OPEC and of the Gulf Cooperation Council (GCC), which is increasingly concerning itself with regional economic collaboration with the neighbouring Arab nations. Plans to establish a customs union among the six member states of the GCC are well advanced and the GCC has sought advice from the EU on the creation of a single currency. Imports into the UAE are dominated by the Japanese (the main buyer of the Emirates' oil and gas), followed by the USA, the UK, Germany and Korea.

The public administration in the UAE is adapting itself to the economic globalisation needs of the 21<sup>st</sup> century. The UAE is a member of the World Trade Organisation (WTO) and its laws and regulations have been reviewed in order to abide by the WTO's terms and conditions. Although the current law encourages foreign investment and allows the activities of transnational companies, there is a continuous review of those laws to remove obstacles encountered by foreign investors. In addition, free trade zones have been established to attract foreign investment (Ojaili, 2000).

According to 2004 estimates, the UAE population was around 4.3 million, including about 3 million expatriates. The UAE has one of the most diverse populations in the Middle East, consisting mainly of native nationals (19%), other Arabs and Iranians (23%) and South Asians (50%), the remaining 8% being Westerners and East Asians. According to 2006 population estimates, there were approximately 1.2 million Indians and 300,000 Pakistani residing in the UAE, making them the largest expatriate community in the country. One of the interesting demographic features of the UAE is that almost 70% of the population is estimated to be male and 30% female because most of the male expatriates leave their families in their home countries due to the high cost of living in comparison to their income. The population growth rate of the UAE is currently estimated at around 1.6 % per annum (UAE, 2006).

Dubai is the most populous city, with approximately 1.2 million people (2006 estimates), followed by Abu Dhabi with 1 million people (UAE, 2006), Al Ain, Sharjah and Fujairah. The United Arab Emirates is also one of the most urbanized nations in the world, with about 88% of its population living in cities and large towns. The remaining 12% live in small towns and desert oilfield camps scattered throughout the country (UAE, 2006). Islam is the official religion of the UAE and Muslims constitute around 96% of the total population. Among these, 85% are Sunni and 15% are Shia. Christians,

Hindus and other religious groups form just 4% of the UAE population, but have been granted freedom to practice their religious and cultural practices. While Arabic is the official language of the UAE, English and several Asian languages are widely spoken and understood (UAE, 2006).

#### **2.7.3.2 Culture and society in the UAE**

Cultural identity in the UAE is a rich blend of traditional Arab, Islamic and contemporary elements. Following the foundation of the state and the increased availability of educational opportunities, private and public cultural centres and libraries began to spring up around the country, helping to promote cultural awareness and assisting in the preservation of the country's heritage.

The tribe has been the principal building block of UAE society since successive waves of migration, beginning in the middle of the first millennium BC, brought Arab tribes to the region. The largest tribe, the Bani Yas, roamed the vast sandy areas which cover almost all of the emirates of Abu Dhabi and Dubai. Other tribes, too, such as the Awamir and Manasir, shared this challenging environment for numerous generations. All the subtribes and clans were accustomed to wander great distances with their camels in search of grazing, moving as entire family units. Almost all Bani Yas families, with the exception of fishing groups like the Al Rumaithat, returned to a home in one of the oasis settlements at certain times of the year. Much-prized date gardens were cultivated in the hollows of the huge dunes at Liwa, tapping the water trapped beneath the absorbent sands. In Al Ain and other oases, the luxuriant date gardens were watered by an efficient traditional irrigation system bringing water from aquifers in the mountains, while in the narrow mountain valleys, watercourses were used to irrigate terraced gardens tended by extended families (Jamal. 2001).

Under the patronage of the late Sheikh Zayed, the UAE witnessed a dramatic change in lifestyle from that of a tribal nation thriving on fishing and pearls to a highly developed one. The national workforce has been a part of all government organisations and very much involved with the growth of private companies, free trade zones and other government projects. The emirates of Dubai, Abu Dhabi and Sharjah have witnessed strong growth in all sectors, especially public services, banks, aviation, technology, insurance, trade and commerce.

### **2.7.3.3 The UAE economy**

The United Arab Emirates boasts one of the most dynamic economies in the Gulf. With oil revenues and proceeds from free trade zones leading the way, the UAE is making a concerted effort to meet its 20-year economic diversification plan. The plan has been pursued because, in the past, a fluctuating oil price has influenced the UAE's economy. Numerous construction projects, free trade zones and new intellectual property rights laws are testament to the government's long-term commitment to improving the economy (Salloum, 2002). Diversification of the economy and expansion of the non-oil sector should ensure that this area will continue to grow as the Gulf region's centre of trade. These efforts are especially evident in Dubai (Porter, 2001).

Since 1970, the UAE has provided various job opportunities for many expatriates, as noted above. At present, there are more than 150 nationalities in the UAE, dominated by Asians and Arabs but including Africans, Europeans, Australians, Canadians and Americans. Many expatriates, especially those coming from developing countries, repatriate part of their income, which has effectively contributed to their national income and helped in socio-economic development. The development and training of the UAE's national workforce is a major focus of government policy. A third of the UAE population is under 18 years old and most of these are UAE citizens, so there is an urgent need to create employment opportunities for them. This is coupled with a recognition that high quality training is essential if the country's growth is to continue. Besides conventional training opportunities in institutes of higher education, industry-based training is growing rapidly in the oil industry and other organisations. A special cabinet manpower committee supervises the development of the UAE's human resources, with the objective of maximising local employment and reducing dependence on expatriate labour (Ministry of Labour, 1999).

### **2.7.3.4 The UAE healthcare system**

The UAE has a comprehensive, government-funded health service and a developing private health sector. The average child mortality rate is 9 per 1000, comparable to most developing countries. Life expectancy is 76 years for women and 74 years for men. Endemic diseases have been eradicated. The focus of a network of government primary healthcare centres is maternal and child welfare, while school health and health education are considered important services in the UAE. The public hospitals offer specialized services, including telemedicine links with major hospitals abroad and state-

of-the art surgery. The healthcare infrastructure is upgraded regularly, with a central database project being prepared. There are plans to double bed capacity in public hospitals over the next ten years to meet the significant growth in the population. The government finances more than 75% of the cost of health care, but several initiatives towards privatization have been launched recently (UAE, 2006).

The UAE is listed as the fourth most developed Arab state according to the Human Development Index, which measures overall achievements in a country in three basic areas of human development: life expectancy, education and general standard of living. Preventive medicine campaigns, which have been launched to combat and control more than 36 infectious diseases in the UAE, have had a major impact on life expectancy and constitute a key element of healthcare strategy (UAE, 2006).

Healthcare infrastructure has kept pace with other developments over the past 28 years to ensure that adequate services are provided in the Emirates. For example, the number of government hospitals has risen to 30, with 4,681 beds, compared with only seven hospitals and 700 beds in 1971. The number of physicians has also risen to 1,535 and nursing staff to 4,664. These hospitals are furnished with the latest medical equipment. More than 85% of the labour force in the healthcare sector is expatriate (UAE, 2006).

#### **2.7.3.5 Quality trends in the UAE**

In the United Arab Emirates, there is an official top-level drive to apply quality initiatives and quality systems in both government and private institutions, including healthcare organisations. In 1998 the Crown Prince of Dubai ordered the establishment of the Dubai Government Excellence Programme, with the aim of developing the public sector and increasing its efficiency by providing incentives and work conditions to encourage fruitful cooperation and positive competitiveness. The Sheikh Khalifa Excellence Awards were launched in 2001 to recognize the achievements of those organisations which can demonstrate that their total quality has contributed significantly to improved performance. Organisations are beginning to realise that in order to survive they must pay greater attention to quality management and business excellence. Quality awards, most of which are based on the EFQM, are adopted in UAE organisations as a framework to implement TQM. Implementing these quality awards in the UAE supports the promotion of a national quality culture. These awards are listed in Appendix 1.

**Table 2.6: Factors affecting the implementation of JCI standards according to the literature reviewed**

Reason for seeking accreditation		✓			✓		✓	
Leadership commitment		✓	✓	✓	✓	✓	✓	✓
Organisational culture	✓	✓					✓	
Human resources and staffing								
Training		✓	✓	✓	✓	✓	✓	
Physician and employee involvement			✓	✓	✓		✓	
High cost								
Time				✓				
Communication				✓				
Improving of quality & continuous improvement			✓			✓	✓	
Effective steering committee				✓				
Empowerment, reward & recognition		✓		✓	✓			✓
Understanding of TQM principles								
Teamwork & interdepartmental relationships			✓					
Focus on the customer				✓				
Resources	✓	✓		✓				
Harmonization and sharing data & information			✓	✓				
Staff awareness		✓						
Documentation								
Resistance to change								
Country	Kuwait	USA	Malaysia	Malaysia	Australia	India	Sweden	UK
Year	2006	2006	2005	2005	2005	2005	2005	2005
Author(s)	Anwar and Jabnoun	McFadden <i>et al</i>	Abd Manaf	Ab Rahman & Tannock	Balding	Banerji <i>et al.</i>	Kollberg <i>et al.</i>	Sultani

Table 2.6 continued

Reason for seeking accreditation					✓			
Leadership commitment			✓			✓	✓	✓
Organisational culture		✓	✓		✓		✓	
Human resources and staffing				✓		✓		✓
Training			✓	✓	✓			✓
Physician and employee involvement				✓	✓	✓		
High cost								
Time					✓			✓
Communication				✓			✓	✓
Improving of quality & continuous improvement						✓		
Effective steering committee								
Empowerment, reward & recognition								✓
Understanding of TQM principles	✓					✓		✓
Teamwork & interdepartmental relationships							✓	
Focus on the customer								
Resources	✓							
Harmonization and sharing data & information			✓			✓		✓
Staff awareness					✓			
Documentation					✓			
Resistance to change					✓			
Country	Cyprus	UK	Taiwan	Mexico	France	Spain	USA	Across country
Year	2004	2004	2004	2004	2004	2004	2003	2003
Author(s)	Arasli and Ahmadeva	Bauer <i>et al.</i>	Chen <i>et al.</i>	Jun <i>et al.</i>	Pomey <i>et al.</i>	Ruiz and Simon	Beer	Sila and Ebrahimpour

Table 2.6 continued

Reason for seeking Accreditation						✓		
Leadership commitment	✓	✓	✓		✓	✓		✓
Organisational culture		✓		✓	✓			
Human resources and staffing		✓						
Training		✓	✓		✓			
Physician and employee involvement	✓		✓			✓		✓
High cost							✓	
Time								
Communication								
Improving of quality & continuous improvement			✓					
Effective steering committee								
Empowerment, reward & recognition								✓
Understanding of TQM principles	✓		✓					
Teamwork & interdepartmental relationships		✓			✓			
Focus on the customer								
Resources								
Harmonization and sharing data & information								✓
Staff awareness			✓					
Documentation								
Resistance to change								
Country	UK	Taiwan	Singapore	Taiwan	Turkey	Japan	UK	Sweden
Year	2003	2003	2002	2002	2001	2001	2000	2000
Author(s)	Taylor & Wright	Yang	Chua and Goh	Hong and Huang	Mellahi and Eyuboglu	Ovretveit	Gough and Reynolds	Lagrosen

Table 2.6 continued

Reason for seeking accreditation		✓			✓				
Leadership commitment	✓	✓				✓		✓	✓
Organisational culture		✓	✓	✓					✓
Human resources and staffing									
Training	✓		✓	✓			✓	✓	✓
Physician and employee involvement		✓				✓	✓	✓	✓
High cost					✓				
Time									
Communication				✓		✓	✓		✓
Improving of quality & continuous improvement									
Effective steering committee									
Empowerment, reward & recognition		✓	✓				✓		
Understanding of TQM principles									
Teamwork & interdepartmental relationships	✓	✓	✓						
Focus on the customer							✓		
Resources									
Harmonization and sharing data & information									
Staff awareness									
Documentation		✓							
Resistance to change		✓							
Country	Europe	Ireland	Australia	Greece	UK	USA	Finland	Europe	USA
Year	2000	1999	1999	1999	1999	1998	1997	1997	1997
Author(s)	Ovretveit	Ennis and Harrington	Isouard	Lipovatz	Naylor	Weeks and Helms	Kivimaki <i>et al.</i>	Ovretveit	Scheuermann <i>et al.</i>



**Table 2.6 continued**

Reason for seeking accreditation	✓				✓		
Leadership commitment	✓		✓	✓		✓	✓
Organisational culture						✓	
Human resources and staffing	✓		✓				
Training	✓	✓		✓			✓
Physician and employee involvement	✓	✓			✓	✓	
High cost	✓		✓				
Time							
Communication							
Improving of quality & continuous improvement							
Effective steering committee							
Empowerment, reward & recognition				✓			
Understanding of TQM principles		✓					
Teamwork & interdepartmental relationships							
Focus on the customer	✓						
Resources							
Harmonization and sharing data & information		✓					
Staff awareness							
Documentation	✓						
Resistance to change	✓						
Country	USA	USA	UK	USA	USA	Canada	Hong Kong
Year	1996	1996	1996	1995	1995	1995	1994
Author(s)	Brashier <i>et al.</i>	Huq	James & Hunt	Kohli <i>et al.</i>	Lin & Clousing	Short and Rahim	Cheung and Koch

**Table 2.7: Some of the research papers and case studies reviewed and used to identify the factors that affect the implementation of JCI standards in hospitals**

Authors	Year	Country	Type of Paper (all peer reviewed)
Anwar and Jabnoun	2006	Kuwait	Not a research paper
McFadden <i>et al.</i>	2006	USA	Research
Abd Manaf	2005	Malaysia	Research
Ab Rahman & Tannock	2005	Malaysia	Research
Balding	2005	Australia	Research
Banerji <i>et al.</i>	2005	India	Research
Kollberg <i>et al.</i>	2005	Sweden	Research
Sultani	2005	UK	Research
Arasli and Ahmadeva	2004	Cyprus	Research
Bauer <i>et al.</i>	2005	UK	Research
Chen	2004	Taiwan	Research
Jun <i>et al.</i>	2004	Mexico	Research
Pomey <i>et al.</i>	2004	France	Research
Ruiz and Simon	2004	Spain	Research
Beer	2003	USA	Research
Sila and Ebrahimpour	2003	Across Countries	Research
Taylor & Wright	2003	UK	Research
Yang	2003	Taiwan	Research
Chua and Goh	2002	Singapore	Research
Hong and Huarng	2002	Taiwan	Research
Mellahi and Eyuboglu	2001	Turkey	Research
Ovretveit	2001	Japan	Research
Gough and Reynolds	2000	UK	Research
Lagrosen	2000	Sweden	Research
Ovretveit	2000	Europe	Not a research paper
Ennis and Harrington	1999	Ireland	Research
Isouard	1999	Australia	Research
Lipovatz	1999		Research
Naylor	1999	UK	Research
Weeks and Helms	1998	USA	Research
Kivimaki <i>et al.</i>	1997	Finland	Research
Ovretveit	1997	Europe	Research
Scheuermann <i>et al.</i>	1997	USA	Research
Brashier <i>et al.</i>	1996	USA	Research
Hug	1996	USA	Research
James & Hunt	1996	UK	Research
Kohli <i>et al.</i>	1995	USA	Research
Lin & Clousing	1995	USA	Research
Short and Rahim	1995	Canada	Not a research paper
Cheung and Koch	1994	Hong Kong	Research

## 2.9 Chapter summary

This chapter has reported an extensive review of the literature intended to facilitate a deep understanding of issues related to the current knowledge, principles and concepts

of the JCI, TQM and the implementation of quality management systems in Arab, Western and Asian countries. The factors identified as affecting the implementation of TQM or QMSs like JCI are summarised in Table 2.6.

The understanding provided by the literature review helped the researcher to formulate the questions for the interview protocol. These questions are listed with the related references in Appendix 4.

Chapter three, which follows, presents the methodology adopted to conduct the empirical work.

## **CHAPTER THREE**

### **Research Methodology**

#### **3.0 Introduction**

This chapter describes and discusses the research methodology, considering in turn the philosophy, approach and strategy, then the detailed research design, the rationale for adopting it and its limitations. It also addresses ethical considerations and methods of data analysis. It is intended to show how the choices made help to meet the objectives of this research.

#### **3.1 Research methodology**

According to Adam and Healy (2000), the research methodology is the overall approach and within that the individual research methods and tools used to meet given research objectives. A clear and unambiguous statement of the research objective is therefore necessary, to enable the selection of an appropriate research methodology and data collection techniques. Zickmund (2000) views methodology as the procedures for collecting and analysing required information. It depends on the overall research aim and scope of the thesis, the scope of data, the research questions and the proposal, as well as the constraints of the research (Yin, 1994).

In short, the research methodology is the process and the procedures followed by the researcher in developing his research. The process includes identifying the need for the research, reviewing the related literature, developing the objectives and the research questions, then identifying the appropriate strategies to answer these questions. The research methodology also includes the tools used for collecting, analysing and presenting the data and information.

#### **3.2 Research philosophy**

According to Easterby-Smith *et al.* (1994), there is a long-standing debate within the social sciences about the most appropriate philosophical stance to take, from which the research methods should be derived. There is an absence of consensus about which position is best to help a novice researcher make simple choices in deriving methods to conduct the work. On the other hand, it is essential to have a clear understanding of the philosophical basis for the selection of a research strategy and this helps to provide the researcher with clarification, focus and consistency of research design. Thus, it is

important for all researchers to have a clear understanding of the most appropriate philosophical position from which to derive a suitable research method.

Philosophers of science and methodologists have been engaged in a long-standing epistemological debate about how best to conduct research. This debate has centred on the relative value of two fundamentally different and competing schools of thought or inquiry paradigms (Amaratunga *et al.*, 2002):

- Logical Positivism uses quantitative and experimental methods to test hypothetical deductive generalisations. Positivism follows the traditional scientific approaches to developing knowledge, research strategies, methods and interpreting results.
- Phenomenology (interpretive science) uses qualitative and naturalistic approaches to understand human experience inductively and holistically in specific contexts or settings. This approach tries to understand and explain a phenomenon, rather than search for external causes or fundamental laws (Easterby-Smith, *et al.*, 1994). Ideas are developed through inductive reasoning. The task of social scientists is *“to appreciate different constructions and meanings that people place upon their experience”* (Easterby-Smith *et al.*, 1994).

Based on the strengths and weaknesses of the two types of research philosophy and the nature of this research, the phenomenological paradigm was chosen here. It is considered more suitable because the objectives of the study demand in-depth understanding of change processes and of the meanings and understanding ascribed by people to the implementation of JCI standards and the accreditation process in UAE hospitals.

### **3.3 Research approach**

Concerning data collection methods, there are two research approaches: qualitative and quantitative. Qualitative research is a source of well-grounded rich descriptions and explanations of processes in identifiable local contexts (Amaratunga *et al.*, 2002), focusing on words rather than numbers, while quantitative research is where the researcher emphasises careful control and measurement by assigning numbers to measurements (Hussey and Hussey, 1997). *“Qualitative methods are therefore more suitable when the objectives of the study demand in-depth insight into a phenomenon”*

(Ghauri *et al.*, 1995, p86). Qualitative research can also be attuned to change, sequences of events and behaviour, and the transformation of culture (Dayman and Holloway, 2002). In order to allow a comparison between these two research approaches, their key features and characteristics are documented in Table 3.1.

The differences between qualitative and quantitative research which are listed below helped the researcher to decide on the appropriate approach to meet the objectives of the present study.

- The rejection of quantitative, positivist methods by qualitative researchers.
- Qualitative researchers believe that they can get closer to the actor’s perspective through detailed interviewing and observation.
- Qualitative researchers are more likely to confront the constraints of everyday life, while quantitative researchers tend to abstract themselves from this world and consequently seldom study it directly.
- Qualitative researchers tend to believe that rich descriptions are valuable, while quantitative researchers are less concerned with such detail (Naslund, 2002).

**Table 3.1: Comparison between quantitative and qualitative research**

Item	Quantitative	Qualitative
Role of qualitative research	Preparatory Means to	exploration of actor's
Relationship between researcher and subject	Distant	Close
Researcher’s stance in relation to what is being researched	Outsider	Insider
Relationship between theory / concepts and research	Confirmation	Emergent
Research strategy	Structured	Unstructured
Scope of findings	Nomothetic	Ideographic
Image of social reality	Static and external to actor	Processual and socially constructed
Nature of data	Hard and reliable	Rich and deep

Source: Bryman (1998)

According to Rossman and Raillis (1998), the characteristics of qualitative research and the qualitative researcher are the following:

### **Qualitative research**

- Takes place in the natural world
- Uses multiple methods that are interactive and humanistic
- Is emergent rather than tightly prefigured
- Is fundamentally interpretive

### **Qualitative researcher**

- Views social phenomenon holistically
- Systematically reflects on who she is in the inquiry
- Is sensitive to her personal biography and how it shapes the study
- Uses complex, multifaceted reasoning.

Based on the above characteristics and the objectives of this study, the qualitative research approach was chosen. In particular, this was because it is very closely related to the phenomenological philosophy and allows the researcher to explore the subject deeply.

There are two general approaches which may result in the acquisition of new knowledge, namely inductive and deductive reasoning. Inductive reasoning is a theory-building process, starting with observations of specific instances and seeking to establish generalisations about the phenomenon under investigation, while deductive reasoning is a theory-testing process which commences with an established theory or generalisation and seeks to discover whether it applies to specific instances (Hyde, 2000). The researcher selected the inductive approach for this work, as it is very powerful for giving insights into results, making inferences and drawing conclusions.

### **3.4 Research design**

The research design is the logic that links the data to be collected and the conclusions to be drawn to the initial questions of the study Yin (2003). Thus, the main aim of the research design is to answer the research questions and to satisfy the aim and objectives. Research design is a model of proof that allows the researcher to draw inferences concerning causal relations among the variables under investigation. Qualitative researchers consider that it is not possible to assign meaning to a phenomenon (or behaviour) without describing the context and understanding the position of the people who affect or are affected by the phenomenon. Consequently, a qualitative investigator

is interested in distilling meaning and understanding. Qualitative research is not concerned with the measurement and quantification of the phenomenon but acquiring an understanding of it in its natural setting through observation (Weick and Daft, 1983). This view is supported by Ennis and Harrington (1999), who note that qualitative research is an in-depth study which seeks to capture employees' views and identify possible challenges and tensions inherent in the quality management implementation process. It is also emphasised by Adinolfi (2003) that qualitative methodology allows one to investigate TQM within its real-life context, to incorporate archival data critically and to understand the ways in which complex factors interact and generate real-life outcomes, as the subjective perspectives of the various organisational factors.

Yin (2003) states lists different types of research design: experiment, survey, archival, history and case study. The situations for which these are appropriate are summarised in Appendix 2.

Qualitative enquiry often takes the form of a case study, which represents not so much a single qualitative method as an approach to research. Case study is simply an in-depth study of a particular instance or a small number of instances of a phenomenon. According to Yin (1994), case study is the preferred research approach when 'how' or 'why' questions are being posed—in other words, questions of process. Qualitative methods search beyond mere snapshots of events, people or behaviours. Case study is the design to be preferred under certain circumstances and for certain research problems.

According to Mellahi and Eyuboglu (2001), a case study approach is appropriate in the early development of a field of enquiry, such as research into TQM implementation in developing countries, which is still at an early development stage.

The great strength of the case study method is that it allows the researcher to focus on a specific instance or circumstance and to attempt to identify the various interactive processes at work. It is also appropriate for individual researchers, since it gives a chance for one view of a problem to be studied in depth within a limited time scale (Bell, 1999). Another strength of the case study is its ability to deal with a full variety of evidence—documents, artefacts, interviews and observations—beyond what might be available in a conventional historic study. On the other hand, critics of the approach



draw attention to some disadvantages, such as the fact that generalisation is not usually possible, and question the value of the study of single events (Blau *et al.*, 1996).

From the present researcher's point of view, as this is an exploratory and explanatory study, following Paulin *et al.* (1982), the most appropriate research design is the case study, since it can provide good empirical evidence. Robson (1998) suggests the use of this method to achieve a rich understanding of the context of the research and the processes being enacted. This is relevant to one of this study's objectives, which is to investigate and analyse the factors affecting the process of implementing JCI standards in UAE hospitals. As the research question is in the form of 'why', the use of the case study is pertinent (Yin, 2003). Furthermore, Hakim (2000) notes its usefulness for research into both public and private organisations. For the present study, the hospitals were all selected from the public sector, because the six largest hospitals in the UAE in terms of bed capacity, all of which happen to be public ones, were leading the process of accreditation in the country. As mentioned in section 2.5.1, seven of the thirteen accredited hospitals in the UAE were public, according to 2007 data at the time of planning the research design and the data collection process. These seven are the largest in terms of bed capacity and arguably the most advanced and sophisticated hospitals in the healthcare system of the UAE.

A further discussion surrounding the case study methodology involves the selection of either a single case study or multiple cases, and numerous levels of analysis (Eisenhardt, 1989; Yin, 1994). In designing case research a key question is the number of respondents. The single case can be used to determine whether a theory or proposition is correct or whether some alternative set of explanations may be more relevant. It is also appropriate to use this strategy when the case represents an extreme or unique case (Yin, 1994). Multiple case studies aim to reach more generalisable conclusions than those provided by a single case. The main restrictions imposed by the qualitative method in this research were the time and resource factors; therefore the extent of data collection was influenced by the amount of time available in which to collect meaningful data. In consideration of these points, and in particular to enhance the generalisability of the research findings, Perry and Coote (1994) state that the literature on the issue of case study sample size varies significantly, so that the number selected is at the discretion of the researcher. One approach is to aim for saturation, continuing to

collect data to the point of redundancy. Therefore, as there is no rule for the selection of a sample size in qualitative research, each scenario needs to be considered in context.

Yin (1994) suggests the following criteria for selecting the cases for study:

- Every case has to demonstrate prior to final case selection the occurrence of exemplary outcomes. The basic replication question would then be whether similar events within each arrangement could account for these outcomes.
- The study's policy concerning some of the arrangements would have a federally supported type of organisation at its centre, but other arrangements would have it in a more peripheral relationship.

Yin (2003, p53) states that when the researcher has the choice, multiple-case designs may be preferred over single-case designs, and that even two cases are better than one as regards "*the possibility of direct replication [and] more powerful analytic conclusions*". Bryman (1998) is of the same view, noting that multiple case studies provide rich data and a potentially enhanced understanding of the subject, while comparisons allow the special features of cases to be identified much more readily.

The researcher chose two recently accredited public hospitals in the UAE to conduct the case studies. The rationale for choosing accredited hospitals was that it could be assumed that their staff and managers would have encountered the factors that affected the implementation of the JCI standards throughout the process of accreditation, from planning and design to full implementation. On the other hand, these two hospitals had been accredited recently, so the experience was still fresh in the minds of the participants.

### **3.5 Data collection methods**

There are many methods that can be used to collect research data. Oppenheim (1992) defines research methods as those used for data collection and generation. The data collection methods and sources used in the present research are discussed in this section.

To satisfy the requirement for research validity, multiple sources of evidence were used. Marshall and Rossman (1999) suggest that a researcher using the case study approach can use six major sources of evidence: documentation, archival records, interviews,

direct observation, participant observation and physical artefacts. The same sources are listed by Yin (2003), whose assessment of their strengths and weaknesses is set out in Table 3.5. According to Yin, multiple sources of evidence give multiple measures of the same phenomenon. *“The various sources are highly complementary and a good case study will therefore want to use as many sources as possible”* (2003, p85).

**Table 3.2: Six sources of evidence – strengths and weaknesses**

Source of evidence	Strengths	Weakness
<b>Documentation</b>	<ul style="list-style-type: none"> <li>•Stable- can be reviewed repeatedly.</li> <li>•Unobtrusive- not created as a result of the case study.</li> <li>•Exact- contains exact names, references and details of an event.</li> <li>•Broad coverage- long span of time, many events and many settings.</li> </ul>	<ul style="list-style-type: none"> <li>•Retrievability- can be low.</li> <li>•Biased selectivity, if collection is incomplete.</li> <li>•Reporting bias- reflects (unknown) bias of author.</li> <li>•Access- may be deliberately blocked.</li> </ul>
<b>Archival records</b>	<ul style="list-style-type: none"> <li>•Same as above for documentation.</li> <li>•Precise and quantitative.</li> </ul>	<ul style="list-style-type: none"> <li>•Same as above for documentation.</li> <li>•Accessibility due to privacy reasons.</li> </ul>
<b>Interviews</b>	<ul style="list-style-type: none"> <li>•Targeted- focuses directly on case study topic.</li> <li>•Insightful- provides perceived causal inferences.</li> </ul>	<ul style="list-style-type: none"> <li>•Bias due to poorly constructed questions.</li> <li>•Response bias.</li> <li>•Inaccuracies- interviewee gives what interviewer wants to hear.</li> </ul>
<b>Direct observation</b>	<ul style="list-style-type: none"> <li>•Reality- covers events in real time.</li> <li>•Contextual- covers context of event.</li> </ul>	<ul style="list-style-type: none"> <li>•Time-consuming.</li> <li>•Selectivity- unless broad coverage.</li> <li>•Reflexivity- event may proceed differently because it is being observed.</li> <li>•Cost- hours needed by human observers.</li> </ul>
<b>Participant-observation</b>	<ul style="list-style-type: none"> <li>• Same as above for direct observation.</li> <li>•Insightful into interpersonal behaviour and motives.</li> </ul>	<ul style="list-style-type: none"> <li>•Same as above for direct observation.</li> <li>•Bias due to investigator’s manipulation of events.</li> </ul>
<b>Physical artefacts</b>	<ul style="list-style-type: none"> <li>•Insightful into cultural features.</li> <li>•Insightful into technical operations.</li> </ul>	<ul style="list-style-type: none"> <li>•Selectivity.</li> <li>•Availability.</li> </ul>

Source: Yin (2003, p86)

For the purpose of meeting the objectives of this research within the case studies, interviews and documentation review were selected as the main primary and secondary sources of data respectively. The use of semi-structured interviews is supported by Yin (1994). Direct and participant observation were also used to complement the data collection process.

### **3.5.1 Interviews**

Hussey and Hussey (1997) define an interview as a method of collecting data in which participants are asked questions in order to find what they do, think or feel. It is a widely used method of data collection in social science in general, and in management and business research in particular (Yin, 1991).

Easterby-Smith *et al.* (1994) state that there are three types of face-to-face interviews: unstructured, structured and semi-structured. In a structured interview a set of prepared questions is asked and the responses are recorded on a standardised schedule; an unstructured interview is also called an in-depth interview and has no pre-determined list of questions or themes. Unlike the structured interview, it is non-standardised; the researcher has a list of themes or questions to cover during the interview, but these may vary from one interview to another depending on the organisational context and the interview conditions. The researcher has the flexibility to omit some questions in a particular interview or to add others to supplement or explore the research questions and objectives. Data collected by the interviewer are recorded by note-taking or tape-recording (Yates, 2004). Saunders *et al.* (2000) also note that semi-structured and in-depth interviews are used in qualitative research not only to reveal and understand the 'what' and 'how', but also to place more emphasis on explaining the 'why'.

Yates (2004) emphasises that the interview method allows the researcher to explore complexity, ambiguity, contradictions and processes which might be encountered by the interviewees. It gives the researcher the opportunity to explore and negotiate potential meanings of questions and answers as the interviewer explores the perspective of the respondent. On the other hand, this method is expensive and time-consuming, especially if there is a large number of respondents to be interviewed. Moreover, the interviewer may affect the validity and reliability of the questions as he/she influences the interaction with the interviewee, which will affect the interview process. Since the researcher in the present study is a DOHMS employee, it was relatively easy for him to

establish the rapport needed to make the interviewees feel comfortable, giving the potential for a high level of cooperation. This factor helped to reduce the time consumed in interviewing, since lines of communication already existed between the researcher and the interviewees, but also increased the potential for bias on the part of both parties. The question of bias is discussed further in section 3.11.

### **3.5.2 Documentation**

Documentary data were used to verify and supplement that obtained from interviews. Documentary information is likely to be relevant to every case study topic (Yin, 2003). This is a secondary tool for gathering data by reviewing documents such as quality manuals, policy and procedure manuals, internal audit and self-assessment reports, external audit and assessment reports, and committee minutes. These documents were chosen because most of them were available and accessible to the researcher as a DOHMS employee enjoying very good social relations with the top management in the two hospitals.

A list of all documents reviewed during the case studies appears in Appendix 3.

### **3.5.3 Justification of the interview method**

The use of interviews can help to gather valid and reliable data that are relevant to research objectives (Saunders *et al.*, 2000). This method is supported by Easterby-Smith *et al.* (1994), for whom it is one of the most useful data collection techniques in qualitative research, and by Yin (1991), who considers it the most important source of data in case study research. Hussey and Hussey (1997) note that an interview may allow a higher level of confidence than questionnaire responses, and can benefit from non-verbal communication.

Most qualitative researchers use in-depth interviewing, since when collecting information about people, the best way is to ask them (Yates, 2004). The present researcher encouraged interviewees to talk at length in their words and at their own level of understanding. Semi-structured interviews were conducted with top managers, middle management employees and general staff members. The use of semi-structured interviews allowed the researcher to obtain the required responses from interviewees or to phrase a question in a different way when an interviewee was reluctant to answer.

While interviews constituted the main source of data, this was triangulated with documentation and observation, as noted above, in order to obtain a wide variety of data on the same subject and to benefit from the strengths of each methodology to deepen the understanding of the subject.

### **3.6 Target interviewees**

Amaratunga *et al.* (2002, p4) quote Kvale as stating that the purpose of a qualitative research interview is “*to gather descriptions of the life-world of the interviewee with respect to interpretation of the meaning of the described phenomena*”. The top management interviewees in the present study included heads of department, section heads, senior managers and quality managers. Middle management respondents included supervisors, doctors, nurses-in-charge and heads of unit. General staff members were quality department staff and JCI committee members; these were expected to provide a large amount of data, due to their significant role and direct involvement in the implementation of JCI standards. Some of the JCI committee members were senior leaders, heads of section, supervisors and frontline staff, which enabled the researcher to collect valuable data about the implementation process.

The researcher began with a general idea of which people to interview and how to find them, but was willing to change the target after the initial interviews to meet the research objectives (Taylor and Bogdan, 1984). In deciding the appropriate number of interviews to gather the information required to meet the research aim and objectives, the plan was to conduct between 25 and 30 interviews in the first case study (A) and between 15 and 20 in the second (case study B). The difference in numbers was due to the difference in the size of the two organisations and in the complexity of their work. As Kvale (1996, p101) points out, one should “*interview as many subjects as necessary to find out what you need to know*”.

### **3.7 Developing the interview protocol**

Yin (1994) advises that the preparation for a case study includes the development of a case study protocol, an assessment of the prior skills of the investigator, the training and preparation for the specific case study and piloting of the protocols and data collection instruments. The review of relevant literature on implementing TQM in hospitals worldwide, presented in Chapter Two, allowed the researcher to understand the concepts of

implementing TQM and to generate an interview protocol appropriate to the research objectives.

A list of interview questions was thus prepared according to the factors that emerged from the literature review, as shown in Appendix 4. A draft of the interview protocol was then discussed and reviewed by the researcher's supervisors and some fellow PhD students to enhance the validity issues, some amendments were suggested and the draft was modified accordingly into the form adopted for the pilot study. Subsequent feedback from the pilot interviews resulted in some of the questions being further modified. The final two sets of interview questions are attached as Appendixes 5 and 6.

The two sets of interview questions were essentially designed to gather the information related to the aim and objectives of the research. Preliminary questions sought background information on each interviewee: his/her name, position, qualifications, date of employment and area of speciality. The researcher continued with an open-ended question: "*Why did your hospital decide to go for JCI accreditation*"? This was used to explore the reasons for implementing the JCI standards and to discover the beliefs of the hospitals leaders and managers about quality. The remaining questions constituted the main body of the interview protocol and were designed to obtain a clear picture of the process of implementing the JCI standards in the case study organisations and to achieve a deep understanding of the factors affecting implementation.

### **3.8 The fieldwork**

The initial stage of the fieldwork process was a personal visit to the executive team members of the two case study organisations. This visit, which was very important to build trust and rapport with the targeted respondents, was undertaken mainly to introduce the researcher and his study to the organisations and to present a letter requesting permission to conduct the research and asking the leaders of the two organisations to encourage respondents to co-operate during the data collection process. Appendixes 7 and 8 reproduce the replies from the directors of the two hospitals.

As mentioned in the introduction to this thesis (section 1.9.2), the researcher works in case study hospital A, which facilitated data collection—both the conduct of interviews and access to all the documents required to meet the aim and objectives of the research. On the other hand, the position of the researcher as a manager with responsibility for



quality may have influenced the interview responses and so biased the results. The researcher took the following steps to minimise bias:

- Introducing himself as a researcher working on meeting the research objectives.
- Using a neutral introduction at the beginning of the interview.
- Avoiding any unconscious signals or cues that guided respondents to give answers expected by the researcher (Miles and Huberman, 1994).
- Using standard interview questions.
- Applying Sekaran's (2000) advice by asking general questions and then narrowing them to specific areas.
- Summarising the responses of the interviewees at the end of each interview and confirming the understanding of the researcher of these answers.
- Addressing bias by triangulating the interview data with material gathered from official documentation and direct observation, as set out in section 3.5.2.

After permission was granted by the leadership of the two organisations, the researcher held discussions with the head of quality in hospital B to facilitate interviews with the personnel selected according to the process explained in section 3.6. In case study A, the researcher obtained approval from the hospital director to start the process of the interviews, as explained in section 3.6. A list of potential candidates for both the pilot and the actual interviews was then developed according to positions and roles within the organisation.

### **3.8.1 Ethical considerations**

The researcher followed the University policy regarding the granting of ethical approval before conducting the interviews. The interviews were conducted at a time most suitable to the interviewees, who were asked in advance about the most convenient times. The researcher adapted his schedule accordingly and made himself ready for each interview at the right place a few minutes before the planned time to save the time of the interviewee. The interviewees were informed of the general purpose of the research before they took part in interviews. They were told that the aim of the research was to investigate and identify the factors affecting the implementation of the JCI standards in UAE hospitals and were assured that any information they supplied throughout the research process would be treated as anonymous.



### 3.8.2 Conducting the pilot study

The main objective of conducting a pilot study is to help the researcher in refining the data collection plans in relation to the procedures to be followed and the content of the designed data collection tool (Yin, 2003). For Ghauri *et al.* (1995, p 66). *“a pilot study is the test that checks the understanding of the interviewee regarding the research problem and interview questions, and such pilot research also provides first-hand insight into what might be called the ‘cultural endowment’ of the informants”*. Brenner *et al.* (1985) state that the pilot study is carried out to ascertain the validity and credibility of the interview protocol questions.

Beside the above-mentioned objectives, the pilot study gave the researcher an idea of the clarity and length of the questions, the time required for the interviews and repetition within or between questions, allowing an opportunity for feedback if there was any misunderstanding of questions by respondents. This allowed him to review and modify the questions before they were used in the main case studies. Furthermore, the researcher believed that a pilot study would help to develop more accurate questions related to the research aim and objectives which could be used when conducting the case studies.

The researcher conducted eight pilot interviews, four in each case study organisation. The interviewees were top managers, middle managers, executives and frontline employees from the two hospitals. All the interview questions were designed and produced according to the literature review in Chapter Two after identifying the key areas of the research. The pilot study ran from the 15<sup>th</sup> to the 27<sup>th</sup> December 2007. No major problems were identified in the interview protocol, but the researcher considered the comments of the respondents related to lack of clarity in some of the questions, repetition of a few questions and the length of some of them, modifying some of the questions accordingly.

New factors related to implementing the JCI standards, not mentioned in the literature, were identified during the interviews. This suggests that these factors are specific to the UAE environment. The piloting of the interview questions helped the researcher to modify them and to cover most of the related literature review. A neutral introduction was also introduced in order to create a comfortable environment during the interview and to avoid any bias.

After completing the pilot interviews, the researcher spent a few days reading the responses, examining whether the questions were credible, sufficient and appropriate to collect the data required. This process served as an initial analysis of the responses, in which the research aims and objectives were continuously matched with them to ensure that enough data would be collected from the actual interviews.

### **3.8.3 Conducting the main case studies**

The researcher started the actual data collection on 15<sup>th</sup> January 2008, conducting a total of 28 semi-structured interviews in hospital A and sixteen in hospital B. The interviewing stage was completed at the end of May 2008.

Taylor and Bogdan (1984) state that qualitative interviewing is flexible and before commencing the study neither the number nor the type of participants needs to be specified. As Kvale (1996, p101) points out, *"To the common question, 'how many interview subjects do I need?' the answer is simply, 'interview as many subjects as necessary to find out what you need to know'"*.

Thus, Taylor and Bogdan (1984) argue that the sample size of an interview study should be determined toward the end of the research and that the depth of the interviews is dependent upon the number, adding that in theoretical sampling, the actual number of cases studied is less important than the potential of each case to yield theoretical insights into the area under investigation. In the same vein, Oberle (2002) states that the exact number of participants required for qualitative research can often not be specified before the study is conducted. Following these recommendations, the researcher started interviewing without knowing how many employees would be interviewed, continuing until he felt that most answers had become repetitive and that enough information had been collected to achieve the research aim and objectives.

Most of the interviews were conducted in offices or coffee shops in the hospitals concerned, in either the morning or the afternoon. The interviewees chose the place and time of their interviews. Five respondents (three in case study A and two in case study B) chose Saturdays, as they were too busy on weekdays. This gave the respondents the opportunity to answer any question put by the researcher without interruption. Most of the interviews were conducted in English, while some interviewees preferred Arabic, the researcher's mother tongue, which enabled him to understand each word and

expression during the interview. In the latter case, the researcher translated all the interview notes from Arabic into English. The translations were then revised by a professional English and Arabic translator and other Arabic linguists to ensure their correctness. During the interviews, the researcher took notes, because all the respondents refused to be tape-recorded, which is common in Arab societies, due to cultural issues, as reported by many authors (e.g. Al-Haj, 2006; Sharif, 2005; Elferis, 2005; Mohamed, 2005). After each interview the researcher thanked the respondent for his/her time and participation.

The average duration of each interview was one hour and ten minutes, some taking less than an hour and others as much as two. The average number of interviews undertaken per day was one, as sometimes the researcher had the opportunity to conduct three interviews, at other times only one and on some days none at all, due to the busy schedule of the interviewees. The researcher followed the guidance of Easterby-Smith *et al.* (1994) in leaving enough time between the interviews to write notes, think about data and possibly explore some issues raised. This required at least two hours after each interview, especially since, as mentioned above, there was no voice recording to rely on later. Since the researcher had taken handwritten notes, it was important to consider and supplement these immediately, in order not to forget vital information discussed during the interview. Each interview was transcribed as an MS Word document, a procedure supported by researchers such as Stake (1995) and Yin (1994).

During the interviewing process the researcher had an opportunity to collect other materials relevant to the study, such as hospital documents, archival records, technical and administrative quality policies and plans. Additionally, he took advantage of a great deal of co-operation in hospital B, where he found many people to be co-operative and supportive, sufficient to make him feel free to ask for any document. However, it is worth mentioning that some documents were available only for use inside the hospital, and in those situations the researcher made notes from them. Accessed to the required documents was easier in case study A, because the researcher dealt with these as part of his daily job. This gave him confidence in the accuracy of the interview process. Although it is difficult to evaluate the honesty and accuracy of the responses of interviewees, the overall impression gained was that they were generally intelligent, friendly and open, giving generously of their time and cooperation, and most seemed interested in the research. Building on Oberle (2002), privacy and confidentiality were

assured by the researcher to all the participants, either at the pilot stage or during actual interviewing.

### 3.9 Analysing data

Saunders *et al.* (2000) state that there is no standardised approach to the analysis of qualitative data. Phenomenologists, for instance, resist categorising or coding their data, preferring to work from the transcripts of interviews. Saunders *et al.* (2000) indicate that using the transcripts or notes of qualitative interviews or observations by thoroughly reading and re-reading them is one approach to analysing this type of data. The approach adopted in this study was to place the mass of qualitative data collected into meaningful and related categories. This allowed the researcher to rearrange and analyse the data systematically and rigorously (Saunders, *et al.*, 2000). Collis and Hussey (2003) explain how the responses are analysed and then categorised into distinct groupings.

Flick (2002, p176) distinguishes “*two basic strategies in handling texts: on the one hand the coding of the material with the aim of categorising and/or theory development; and on the other the more or less strictly sequential analysis of the text aiming at reconstructing the structure of the text of the case*”. Yin (2003) asserts that the overall goal of data analysis is to treat the evidence fairly, produce compelling analytic conclusions and rule out alternative interpretations. He states (*ibid*, p109) that “*data analysis consists of examining, categorising, tabulating, or otherwise recombining the evidence to address the initial propositions of a study*”.

Based on the above discussions, the researcher followed the steps below in conducting the data analysis:

- All information collected from the interviews, direct observations or original documents was properly referenced to the interviewees and labelled. The labelling included the date and time of the interview, the context and circumstances of data collection and the possible implications for the research.
- The researcher converted the interview responses into computerised documents, then grouped the data into categories according to the patterns or themes which emerged.

- In addition, the researcher transformed any oral notes into the form of written records and ignored all responses that had nothing to do with the objectives of the study.
- These labels were then organised into a pattern of concepts and categories in tables that sorted the information separately for each case study. At this stage, many factors were identified.
- The researcher read and reread the findings for better understanding, then wrote details of his findings and used them to construct an in-depth understanding with which he could confront the existing literature.
- The researcher restructured and rebuilt the factors thus identified into various patterns and categories based on his in-depth understanding. This allowed him to delete, combine, rearrange and reorganise the factors in order to put them into the appropriate categories and to analyse them systematically and rigorously.
- The researcher listed the factors identified in the course of the literature review and the unique factors found in the two case studies. He was then able to identify those factors that were discussed in the literature review but not found to be applicable to the case studies (Tables 5.1 and 5.2).

### **3.10 Difficulties in conducting the fieldwork**

During the fieldwork the researcher encountered a number of difficulties, one being the fact that managers were extremely busy and it was hard to secure appointments. To accommodate their availability, the researcher had to invest a great deal of time; for instance, it was necessary to schedule some of the interviews late in the evening, early in the morning or during weekends. Another problem was that a few appointments were cancelled because the interviewee found him/herself needed in other meetings or had to undertake some urgent travel. In addition, the researcher was often kept waiting for a scheduled appointment, thereby wasting valuable time.

Finally, some cultural difficulty was encountered, since the data were sometimes collected during times when many Emiratis were likely to be praying in the mosque. Therefore, it happened more than once that the interview was interrupted for prayers and continued after the interviewee and the researcher had returned from the mosque. This reflects the Emirati collectivist culture, as stated by Hofstede (1981).

### **3.11 Limitations of the research approach**

It is important to recognise and reiterate the limitations of the research methods used. The major limitation was the absence of literature related to quality and TQM in health care and to Joint Commission accreditation in general and in the Arab world in particular. The data collection was likely to be prone to observer bias, to recording errors, memory lapses and errors in interpreting activities, behaviours, events and nonverbal cues (Sekaran, 2003). In particular, the use of the semi-structured interview tool is likely to have led to bias on the part of both researcher and interviewees. This limitation was addressed by comparing the results with official documentation (manuals, minutes of committee meetings related to Joint Commission accreditation, audit reports and quality manuals) and with direct observation during the two case studies. Researcher bias was also reduced by using a neutral introduction and standard interview questions, as noted in section 3.8.

### **3.12 Chapter summary**

This chapter has introduced the methodology adopted to pursue the aim and objectives of the study. It has explained the choice of the phenomenological paradigm, a qualitative approach and the semi-structured interview technique, fully rationalised by reference to the nature of the objectives to be realised and the character of the research population involved. A full description of the fieldwork has been presented and clear information given regarding how the data were collected and analysed. The next chapter discusses the findings that emerged from the analysis.

**CHAPTER FOUR**  
**Research Findings**

**4.0 Introduction**

This chapter presents and analyses the data collected during the two case studies. As noted in Chapter 3, semi-structured interviews were the main source of data, supplemented by participant observation and by consulting documents such as minutes of meetings, newsletters and various reports in order to support and verify the interview data. The findings of this triangulation of three methods are presented to meet the aim, objectives and research questions set out in Chapter One. The rationale for using interviews as the main tool to collect the data was discussed in Chapter Three, section 3.7. As discussed in Chapter 3, the researcher conducted 28 interviews in case study A and 16 in case study B, reflecting significant differences in the number of staff and complexity of work between the two organisations: the former had around 2900 staff and 20 specialities, while the latter had 1400 staff and four medical specialities.

This chapter presents the case study findings, illustrated where appropriate with statements quoted from the interviews to clarify certain points concerning the factors affecting the implementation of JCI standards in UAE hospitals.

**4.1 Interview results**

The interviews were conducted during the period from 15<sup>th</sup> January to the end of May 2008. Their average duration was 70 minutes. In presenting the data, the following abbreviations are used: CSA = case study A / hospital A, CSB = case study B / hospital B, TM = top management and MM = middle manager. The responses of all interviewees are discussed in chapter 5. In CSA the researcher interviewed 8 members of TM, 12 MMs and 8 frontline employees, while in CSB the numbers were 5 from TM, 6 MMs and 5 frontline employees, as shown in Table 4.1.

**Table 4.1: Numbers of interviewees in the two case studies**

<b>Staff Category</b>	<b>Number of interviewees in case study A</b>	<b>Number of interviewees in case study B</b>
Top management	8	5
Middle management	12	6
Frontline staff	8	5
Total	28	16

The researcher chose to interview the staff primarily responsible for quality initiatives in the respective categories by focusing on the quality coordinators or facilitators in each category, because of the likelihood of them being aware of all aspects of the accreditation process. The interview questions were designed to collect in-depth information on the following key areas:

1. The reasons for and benefits of the implementation of JCI standards;
2. The awareness and understanding of JCI requirements;
3. Factors affecting implementation and accreditation.

#### **4.1.1 Interview results in case study A**

CSA is the busiest hospital in Dubai in terms of number of patients attending the emergency department (ED) and in terms of the variety of medical specialties and services available. An average of 400 patients attend the ED daily and a total of 140,000 patients did so in 2007. The hospital, which was established in 1972, has a capacity of 480 beds and 20 medical specialties. It makes 35-40 admissions and 35-40 discharges each day. CSA is considered the main trauma centre in Dubai; all accident and emergency cases are brought to the hospital for treatment and management. The total number of staff is around 2900. The hospital is considered one of the most important in the UAE because of the role that it plays in case of emergencies or natural disasters in the country.

The hospital is led by a hospital director, assisted by four other directors, for medical services, nursing, finance and administration, and clinical support services. The head of quality in the hospital is a member of the executive team and reports directly to the Hospital Director.

It is worth mentioning that some departments of the new extension to the hospital which was opened in September 2006 are run by a contracting company, which was asked to manage the healthcare services by recruiting the managers for the following departments: Emergency Department, Operating Theatre, Surgical Intensive Care Unit and General Surgical Ward. The managers of these departments from the contracting company report, according to the organisational structure, to the Hospital Director through the main administrator. The contracting company recruited the main administrator to oversee the work in the above-mentioned four departments. All frontline staff members are recruited by the hospital. Figure 4.1 shows the



organisational structure of CSA. The researcher will highlight any significant findings related to the presence of the contracting company, especially as the managers and leaders of the contracting company are all from a Western culture and background.

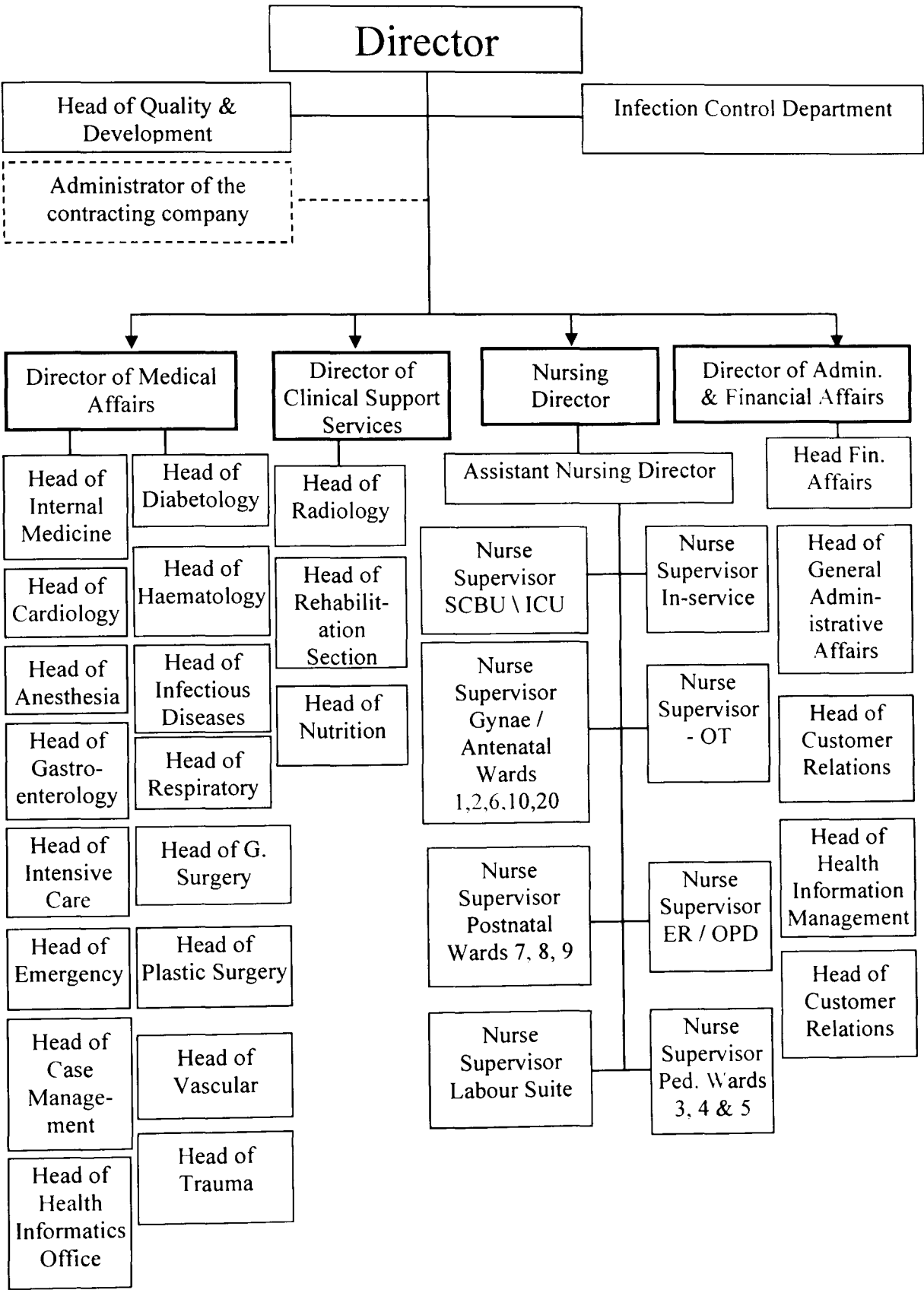
The hospital started the implementation of JCI standards in February 2006. It was accredited in October 2007, which means that it took around one and a half years to achieve accreditation. To prepare it for achieving accreditation, the Hospital Director established twelve teams, each responsible for one chapter of the JCI standards. The Patient Care team covered the medication management, surgical and anaesthesia standards.

The chairpersons of the eleven teams formed the JCI Steering Committee, chaired by the Hospital Director. The requirements of the international patient safety goals were not assigned to any of the teams but were led by the Quality Department, because this was considered a hospital-wide function not specific to any team. The main responsibility of the JCI Steering Committee was to oversee the process of accreditation in the hospital and to follow it with every team. The JCI teams met weekly at the beginning and at the end of the accreditation process, because of the intensity and load of the requirements, to ensure first that the process was well established and then that all the requirements were met before the date of the survey. In the mid-period of the process they met twice a month because the workload was reduced.

Sections 4.1.1.1 to 4.1.1.13 present the results of CSA, which include the reasons for achieving and implementing the JCI standards in the hospital, the awareness and understanding of the JCI requirements, and the factors affecting the implementation of the JCI standards.

#### **4.1.1.1 Reasons for seeking JCI accreditation**

All the leaders, managers and supervisors who were interviewed stated that JCI accreditation was sought in response, in one way or another, to a hospital initiative and desire, but they differed as to whether this initiative was based on instruction or advice from the higher authority of the DOHMS or the Dubai government.



**Figure 4.1: Organisational structure of CSA**

Some respondents, especially from the MM, mentioned that the government of Dubai had an important impact on encouraging the hospital leaders to seek accreditation. Other respondents from the MM and frontline staff stated that the Central Office of the

DOHMS had decided that all governmental hospitals in Dubai had to achieve international accreditation in three years and before the end of 2009.

The Director of the hospital viewed the JCI accreditation as a tool to improve quality, patient safety and patient satisfaction, as well as to improve the image of the hospital in the UAE in general and Dubai in particular. On the other hand, he emphasised the role of the Dubai government strategic plan (2007-2010) in motivating hospitals to achieve accreditation. He claimed that JCI accreditation would improve the overall performance of the hospital and the level of patient satisfaction by enhancing quality and patient safety.

There was agreement among the four directors in the hospital (the medical, nursing, clinical support, and finance and administration directors) that improving quality and patient safety was one of the strategic goals of the hospital's strategic plan for 2007-2010) and that this was why they had decided to seek JCI accreditation. They felt that JCI accreditation contributed to achieving the goal of improving quality and patient safety in the hospital. The Director of the hospital claimed that he used the accreditation requirements and demands to obtain approval for implementing many positive initiatives in his hospital, because the DOHMS authorities would approve the requirements of JCI accreditation without much discussion in comparison to other routine requirements. One of the TM interviewees said that things usually took time to be approved by the higher DOHMS authorities, because of protracted review and approval procedures, while JCI requirements were approved more rapidly. However, the TM of the hospital believed that the process of approving the hospital's requirements by the DOHMS was still slower than it should have been. One top manager explained that this delay caused the late completion of many projects in the hospital.

Table 4.2 shows the views of top and middle managers on reasons for seeking JCI accreditation.

To investigate the level of understanding of quality management systems, through achieving the JCI standards, the interviewees were asked to identify the major differences made by JCI to the hospital as compared to the prior state

**Table 4.2: Top and middle management views on reasons for JCI accreditation**

Top management responses (10)	Middle management and frontline staff responses (18)
It is a hospital initiative to improve quality and patient safety	On advice from the DOHMS Central Office
To meet international standards	On instruction from the Dubai government
To meet the requirements of the Dubai government strategic plan.	To improve customer and patient satisfaction
To improve the image of the hospital	It was considered a quality improvement project by itself to improve the services in the hospital
To improve systems and processes in the hospital	It was a customized quality system for the healthcare industry
Used as a tool to implement many improvement initiatives in the hospital	It was a tool for recognition by Dubai government and the community

All CSA respondents saw a significant difference; they believed that the implementation of JCI standards had contributed significantly to the improvement of communication between departments in the hospital and between different categories of staff. This happened because of frequent meetings between departments and between different categories of staff; and it also happened because of the availability of policies and procedures that facilitated communication between members of hospital staff. On the other hand, the respondents emphasised that the implementation of the JCI standards improved the service in general and patient care in particular. Only four of the 28 interviewees asserted that the implementation of the standards had improved the process of rewarding and recognizing the hospital staff, while twenty-four believed that the JCI standards had had a minimal impact on the staff reward and satisfaction. However, most of the respondents felt that the implementation of JCI standards had made the staff more aware of what they should do in relation to their work assignments to promote quality and patient safety.

Many respondents from all three categories said that they believed that the implementation of standards had improved staff empowerment and enabled them to take decisions in better way regarding their work. They added that the implementation of JCI standards provided the staff with a clear understanding of their work and allowed them to review what they were doing. This stimulated the staff's analytical thinking and self-monitoring of their performance. All TM, MM and frontline interviewees believed that

the implementation of JCI standards in general was a very good tool to improve all the hospital's activities, because the standards viewed the hospital as one integrated system consisting of many departments and processes.

Some respondents from each of the three categories believed that the implementation of JCI standards improved the reporting and management of medical and nonmedical errors, which usually happened due to deficiencies in the hospital systems and processes. These respondents felt that the JCI requirements encouraged the leadership of the hospital to promote a positive culture of accountability rather than a punitive culture of blame. They emphasised that in the last few months of achieving accreditation and after the award of accreditation, the focus of managers and supervisors when errors were reported was to identify the root cause and to focus on areas for improvement in the system, rather than blaming or punishing people. Most of the frontline staff agreed that this improvement had occurred in the culture, but in some situations they were not convinced that the 'blame-free' culture was always consistent, due to differences in the interpretation of the concept among managers and supervisors. The researcher reviewed the numbers of errors and incidents reported to the Quality Department before and after implementation of the JCI standards and found that there was an increase of 20% corresponding with the establishment of the blame-free culture. This meant that the hospital staff had started to feel more comfortable in reporting incidents without fear of punishment, as was stated by the Quality Department staff and some frontline employees.

#### **4.1.1.2 Top management commitment and involvement**

The researcher investigated the level of top management commitment and involvement by asking a direct open-ended question in relation to the factors affecting implementation. Most interviewees from the three categories believed that the TM of hospital A were very committed to and involved in achieving JCI accreditation. However, some of the MM and frontline interviewees mentioned that the top managers' commitment and involvement had become obvious only in the last few months of the process, because the vision of the leadership was not clear to all staff at the beginning of the accreditation process, due to the challenges that they had in relation to support from higher authority within the DOHMS.

On the other hand, most interviewees felt that the commitment and involvement of the top management of the hospital was more consistent than that of the DOHMS. The Director of the hospital said:

*“The Engineering, Purchasing and Human Resource departments belong and report to the headquarters of DOHMS, so the top management of the hospital has no authority over them, even if there was a delay in doing what they were supposed to do to support the implementation of the JCI standards”.*

Most of the challenges related to the commitment and involvement of top management were related to these central departments, as was clearly emphasised by the interviewees. The most important challenges related to the DOHMS headquarters, mentioned by most of the TM and MM interviewees, were the imposition of too much paperwork, heavy bureaucracy and delays in making decisions. A few MM interviewees thought that the reason for this over-bureaucratic approach to decision making at DOHMS headquarters was that most of its leaders were national staff who were very relaxed at work and did not show much commitment to quality and improvement. The interviewees commented on this as a leadership issue, related to ensuring that all staff members were treated equally and expected to meet their work requirements, regardless of nationality or any other external factors. This issue will be discussed in the next chapter.

The JCI steering committee was chaired by the Hospital Director and its members included the directors of medical services, nursing, clinical support, and finance and administration, as well as most of the heads of department in the hospital. The Quality Improvement Committee was chaired by the Clinical Support Director and consisted of the Nursing and Administration Director and some heads of department. The researcher reviewed the minutes of meetings of both committees and found that the directors and heads of department had attended most of them and participated actively in discussions.

The top management of the hospital were asked about their commitment to and support for quality, patient safety and implementing the JCI standards. Most of them answered that they strongly supported the process of improving the quality of care and patient safety and believed that JCI accreditation was not a goal in itself, but a tool to build the quality system of the hospital. They declared that they were committed to quality and patient safety in spite of all the challenges they faced, whether within the hospital or

related to external factors. One of the frontline interviewee from the Quality Department said:

*“Most of the leaders and managers were committed and involved in the implementation of the JCI standards, especially at a later stage of the implementation process after they had seen that the director of the hospital was very serious and very committed to the process... But some of the heads of departments did not pay the required attention to the requirements of the JCI standards and they considered these requirements as extra work for their employees. Some of those heads felt uncomfortable when they were asked to change what they used to do to meet the requirements of the standards”.*

#### **4.1.1.3 Staff awareness and knowledge of quality and JCI standards**

In response to the question *“Did you receive training on quality and JCI standards throughout the process of achieving the accreditation?”* all respondents agreed that their knowledge and that of the hospital staff concerning quality and JCI standards was very limited when they started the process. They reported that they had attended many lectures and presentations on quality and JCI standards as well as on the implementation process after the JCI project had started. Four of the 20 TM and MM interviewees said that they had received structured training in the JCI standards, delivered through a well established plan including objectives, contents, methods of training and evaluation strategies. The other 16 management interviewees and all frontline employees said that they had received no structured training in quality and JCI standards, but they had attended lectures on the same as part of departmental in-service education activities, in their orientation programmes or during the weekly hospital meetings designed to allow staff to discuss issues related to quality and JCI standards.

Three of the MM interviewees reported that there was a well structured training programme on quality and JCI accreditation but that they were not included in it because the priority for training was for national staff, especially as it was costly.

#### **4.1.1.4 Employee involvement in implementation**

Nine of the twelve MM and seven of the eight TM interviewees explained that all staff members from different departments and categories were involved in the implementation process, because they were the people who did the work and without them accreditation could not have been achieved. The chief operation officer said:

*“Our role as leaders is to provide resources for the staff to do the job; they are the real people behind achieving the accreditation”.*

The head of the Emergency Department reported that

*“As a leader, I focused on involving the frontline staff, because one of our success strategies is to involve frontline staff in whatever we do to improve quality and patient safety and because the assessment and evaluation of the surveyors is focused on the frontline staff and most of the questions will be directed to them during the assessment process”.*

Three of the MM interviewees mentioned that they had trained link nurses in different units to encourage all the staff in their unit to become more involved in the implementation process. The Director of the hospital emphasised the role of the quality staff in involving the majority of the hospital staff in the implementation process through developing multidisciplinary accreditation teams, each covering one chapter of the JCI standards. Three of the TM interviewees said that one of the strategies the leadership decided to follow in order to involve all hospital staff was to upload onto the hospital intranet the quality plan, policies, procedures and other important documents related to accreditation. The leadership of the hospital made sure that this strategy was implemented well. However, the Medical Director admitted that

*“At the beginning of the process it was very difficult to involve doctors and technicians in the process, because they were very busy in their daily and routine work. They did not have enough time to attend training and to get involved in the process. However, after the real implementation of hospital plans, policies and procedures it was not avoidable to involve all medical staff in this process. [...] One of the very important motivators for different medical staff to get involved in the process is the presentation of data and information which used to be collected by quality departments about the compliance of every medical department with the requirements of the standards.”*

#### **4.1.1.5 Human resource issues**

Several MM interviewees reported that human resource issues had had a very clear impact on staff motivation and involvement in JCI accreditation. One of them said:



*“While some of the staff members were involved and motivated to participate in the process, others felt that they were not appreciated by the Human Resource Department, so why be positive toward hospital initiatives?”*

Two TM interviewees stated that the lack of motivation of some of the expatriates was obvious after the implementation of the new human resource rules and regulations adopted by the DOHMS on the advice of the Dubai government. The Director of Clinical Support Services said:

*“The new human resource rules and regulations were developed at the international level and were very objective with all staff regardless of their nationalities. They were built on the principles of fairness and equal job opportunities among national and non-national staff, but the problem is in interpreting these new rules and regulations by the Human Resource Department at DOHMS”.*

Several frontline interviewees complained that the human resource policies and procedures did not support them during the accreditation process. One of them said:

*“I can’t understand that I am paid less than my colleague who is working with me in the same department and doing the same job although I have more qualifications and experience. When I asked about that, I was informed that it was because of the differences in the salary scale between national and non-national staff. How do you want me to be motivated to do extra work or attend more meetings in order to achieve the JCI for the hospital?”*

The Director of the hospital explained:

*“I always try my best to be fair with all the staff but most of the time we can’t change these rules and regulations”.*

The Director of Nursing emphasised the positive role of the nursing staff in achieving JCI accreditation. She claimed that it was crucial in the accreditation process; however, most members of the nursing staff were not happy about the new human resource rules because of the way they were interpreted by the Human Resource Department at DOHMS. The Director of Nursing explained that

*“More than 98% of the nursing staff in the hospital are expatriates. They contribute more than 42% of the total number of hospital staff, so I focused*

*on their personal experience and exposure to the accreditation process to promote their motivation and maintain their positive morale.”*

Three MM interviewees admitted that poor selection of employees based on the promotion of localisation was not always safe for patient care. In some situations this had affected the process of promoting the quality and patient safety negatively. One interviewee said:

*“Having a national ward clerk to organise and manage the medical records of patients in a clinical unit without having proper qualifications or training is very unsafe for patient care because these mistakes are always critical. The national staff will face a lot of challenges to meet the JCI requirements because they are not qualified enough to do the job and in most cases she can't write or speak good English which is the official medical language in the hospital. [...] The job of the ward clerk was managed better a few years back, by qualified expatriate staff.”*

However, the Finance and Administration Director explained that

*“Certain positions have to be covered by national staff only, as per the instructions of the higher authority of DOHMS to promote localisation. This means that for certain administrative positions like ward clerk, all expatriate staff members have to be replaced by national staff on an annual basis”.*

#### **4.1.1.6 Training issues**

All the TM interviewees agreed that there were many issues related to training at their hospital in general and in relation to implementing the JCI standards in particular. On one hand, they considered training to be a very important success factor in improving the understanding of all hospital staff about the JCI accreditation process, while on the other hand they felt that the training process should be improved to meet the learning needs of the staff and should be integrated with the hospital strategic goals. The Medical Director claimed that appropriate structured training on JCI accreditation for doctors could improve the acceptance of the process and minimise resistance among doctors. Several expatriate MM interviewees claimed that most of the higher level training was provided to national leaders and managers, especially when it took place overseas or outside Dubai. One TM expatriate said:

*“I could not attend the specialised training on leadership competencies which was planned and delivered by Harvard Business School instructors to DOHMS leaders and managers in one of the prestigious five stars hotel outside Dubai because this training course was only for national leaders and managers”.*

Several MM interviewees claimed that providing more training to national staff than to expatriates had a negative impact on the latter’s motivation to support quality initiatives in the hospital, including the JCI accreditation process. One of the nursing managers stated the view that the DOHMS was unique among government departments in Dubai because expatriates constituted more than 70% of its total staff, compared with less than 10% in most other departments. The low percentage of national staff in the health field is due to a lack of national nurses and doctors, so excluding expatriates from certain types of training within DOHMS meant that 70% of the staff were excluded, which the interviewees felt would have a major impact on the organisation’s performance in general. One of the frontline staff said:

*“My application to attend training related to JCI in Abu Dhabi was rejected; I was told that the priority was for national staff, as this course was very costly ...”.*

#### **4.1.1.7 Cultural issues**

Most TM and MM interviewees emphasised that the working environment was encouraging and supportive, and that there was much co-operation among the employees during the implementation of the JCI standards. Such an environment was said by all respondents to be common in the healthcare field. However, an experienced middle manager stated that

*“The atmosphere fluctuated, and there was some conflict within the administrative jobs between the experienced managers of the hospital and some new managers who are working in the emergency department, operation room and surgical critical care unit... [...] This conflict happened between the two groups of managers because the new managers in these departments report to the contractor company which manages them under contract with DOHMS.”*

This type of conflict took place during the preparation of the JCI accreditation process. One of the senior managers with the contractor company said:

*"I couldn't adapt easily to the current culture in this organisation because I expected different organisational values and work principles. For example, I used to attend meetings on time but I am usually the first one to show up in meetings, while it is found to be normal for most members to come fifteen minutes after the planned start time."*

The hospital leaders acknowledged that there were some gaps and differences which lead to diversity in the organisational culture, due to the different backgrounds of the hospital employees. The Hospital Director said:

*"We have some differences in the culture and work values among our staff due to their different backgrounds. All the contractor company managers who manage some of the departments in the new extension of the hospital are from a western cultural background, while their staff in the same departments, as well as other managers from other departments, are from Asian or Arab cultural backgrounds."*

The Chief Operations Officer of the hospital reported that

*"A conflict happened between the leaders and managers of the contractor company on one side and the hospital leaders and managers on the other side. This conflict took place due to the differences in the priorities of the contractor company and the priorities of the hospital leaders in relation to the plans of the hospital activities. One of the hospital's top priorities was to achieve JCI accreditation, while the top priority for the contractor company in the first few months of their contract was to get all the resources in place to run their departments effectively as per their contract."*

One of the senior managers observed that some members of hospital staff had tried to interpret the JCI standards, policies and procedures according to their past experience in their countries of origin, which would not help the organisation to maintain quality and consistency of care. He added:

*"I promote the hospital culture as designed by the hospital leaders. I will not promote individual culture because we have employees from more than thirty-five countries and from different backgrounds, so we can't have thirty-*

*five ways of doing things. All the staff in the hospital should follow the approved policies and procedure which are developed through involving all concerned staff members, and based on the evidence-based practice.”*

Regarding the frontline staff respondents, a strong majority stated that they found their working environment encouraging and co-operative, as did the middle managers, who described the cultural situation in the hospital as very positive and professional. Only a few frontline staff complained of a discouraging and unsupportive work environment, one stating that many managers would not accept employees with higher qualifications than them. Such managers were usually seen as hostile to people holding high qualifications because they believed these better-qualified employees were a threat to them. Another frontline staff member claimed that the work environment was discouraging mainly because

*“the expatriate staff in general work and produce more than national staff in the same position, while the salary of the national staff is very high for less work”.*

The Director of Nursing emphasised her efforts during the JCI accreditation process to have all the staff working together to achieve accreditation and understand their individual differences and backgrounds without affecting the work:

*“This is the only way to do it, because if we open the door for enforcing individual experience of nursing staff based on the employees’ backgrounds and exposure in their home countries we will not be able to achieve our goal, but will be tied up in non-value-adding activities.”*

#### **4.1.1.8 Use of technology in providing services and information**

Most of the TM and MM interviewees emphasised that using technology was critical in providing good information for the healthcare providers in the hospital in order to provide good patient care. The Hospital Director declared:

*“Because we believe in the positive impact of information technology in supporting patient care and meeting international standards, we established a health information unit in the hospital to make the life of all healthcare providers easier in the hospital by using technology. The main role of this unit is to provide training and continuous technology support for all hospital staff.”*

One TM interviewee reported that the hospital leadership had started the process of introducing electronic health information to promote quality and patient safety and to meet the JCI accreditation standards, but that there were many challenges. Some of the MM interviewees were of the view that information technology was critical to achieving JCI accreditation, because many of the processes could be designed to maintain patient confidentiality, control access of user groups and develop a certain format with mandatory fields to guarantee that the requirements of JCI standards were always met and maintained.

Some other managers mentioned that they faced some challenges in implementing the electronic pharmacy system for ordering and administering medication in the hospital because it was not consistently compatible with the hospital's health information system. One of the senior doctors explained:

*"Doctors and nurses were not involved in purchasing the pharmacy electronic system; they were just asked to attend the training for implementing the system. I strongly believe if the system was designed in a better way to meet the end users' needs, we could promote patient safety and meet the JCI standards with fewer challenges".*

The Director of Finance and Administration had a more positive assessment:

*"Implementing the electronic patient complaint system helped the leadership of the hospital, managers and the staff to track all patients and customer complaints and follow up the action plans to meet patient needs. This helped me and my staff to meet the requirements of JCI in a better way and the surveyors were satisfied with the system during the final survey as far as the standards are concerned."*

An MM interviewee said that the electronic information system had added significant value in collecting data related to clinical and administrative key performance indicators, most of which are required by the JCI standards. However, the appropriate software program was not available in the hospital to support the analysis of these data and to extract the required information in an efficient manner.

One of the Quality Department staff who was working on key performance indicators mentioned reported the following difficulties:

*“I am facing a lot of challenges in analysing the data because some software programs are not available in the hospital’s information technology system. I used to take the hospital data home, because I can use my personal software to finalise the key performance indicator monthly reports. I repeat this process every month. When I asked for the software to help me in doing my job more efficiently, I was told that the Central Information Technology Department in DOHMS didn’t approve my request”.*

#### **4.1.1.9 Planning and working on more than one project at the same time**

TM and MM interviewees were concerned about the role of the Quality Department in developing a reasonable project plan for achieving the JCI standards. They agreed that assigning different quality teams in the hospital to work on specific requirements of the JCI standards was a very good approach. The Chief Operations Officer said:

*“I do believe that one of the success factors for our achievement of the JCI accreditation was the team structure which was developed by the Quality Department and approved by the hospital leaders. This structure made the responsibilities and accountabilities very clear to achieve the accreditation, especially the establishment of the JCI Steering Committee, which was a very good tool to follow up progress on a regular basis.”*

Several TM and MM interviewees reported that one of the challenges that they faced was related to the issue of working on more than one major project while preparing for JCI implementation. The Hospital Director said:

*“The experience of our hospital during the preparation to achieve JCI accreditation was different from other DOHMS hospitals because we were opening the new trauma centre and renovating some old departments. At the same time we were working on the accreditation process. This was a big challenge for everybody in the hospital, to work on more than one major project at the same time as implementing the JCI standards”.*

The Clinical Director of the Trauma Centre emphasised the importance of appropriate planning before starting the accreditation process. He believed that the outcome could be better if the focus in the hospital was only the JCI standards for at least one and a half years. He said:

*“Commissioning the trauma centre, renovating some old departments and launching the electronic radiology and pharmacy systems during the preparation for the JCI accreditation were distracting for the focus and concentration of the staff. It also took a lot of time and effort.”*

#### **4.1.1.10 Communication**

Respondents in all three categories referred to the importance of communication in implementing the quality system and achieving JCI accreditation. Several TM interviewees mentioned that like any other organisation, their hospital had room for improvement regarding communication. They also believed that communication was the backbone component to promote a culture of quality and safety in the hospital.

The Director of Clinical Support Services declared that

*“The quality department did a fantastic job by having the JCI campaign as a very good communication tool among all hospital staff. This campaign improved the awareness of people about the requirements of the JCI and the role of every individual in meeting the standards”.*

The Hospital Director agreed with the other interviewees that communication lay at the heart of promoting quality and patient safety and improving the awareness of the staff concerning the requirements of the JCI standards. He said:

*“One of the very effective tools that we used to promote communication among the staff in general and during the JCI accreditation in particular was the one hour general staff meeting for all hospital staff every Thursday. All the appropriate staff members were asked to attend these meetings every week. In this meeting we discussed issues related to staff awareness regarding JCI requirements to achieve the accreditation”.*

The Director asked the Quality Department to maintain this weekly meeting after he found it very effective in promoting communication among the hospital staff.

Several MM and frontline interviewees emphasised the importance of meetings between the Quality Department staff and certain critical departments in the hospital. They felt that these meetings played a very important role in disseminating the culture of quality



and improving the knowledge of the departments concerned about the requirements of JCI in their departments. One of the quality coordinators said:

*“The regular meetings of our departments with medical, nursing and some other services were a very helpful tool to answer the questions and inquiries of these departments in relation to their departments’ role in the JCI accreditation process”.*

The Head of the Health Information Unit explained its role in promoting communication within the hospital, especially during the JCI accreditation process, by using information technology:

*“We used our hospital intranet to make all the required policies, procedures and plans available online for the staff to access. We also uploaded all JCI-related material, questions and answers, presentations and some of the reports for the hospital staff to access them when the need arises”.*

Some of the MM and frontline staff considered that the bimonthly intranet newsletter was a very effective and efficient tool to improve their awareness and knowledge of the JCI accreditation process, because it could be accessed easily at convenient times. The manager of the surgical ICU said:

*“I liked the idea of the newsletter because it was a very good tool to update me and my staff about the JCI accreditation progress. I used to print out the electronic version and make sure that all the staff in the surgical ICU read it regularly”.*

#### **4.1.1.11 Time**

The TM and MM interviewees considered time to be one of the challenging factors during the JCI accreditation process, because the contract between the DOHMS and JCI specified that the hospital had to complete the project within eighteen months. The timeframe of the contract was decided on the basis of advice from the Dubai government, whose strategic plan emphasised the importance of providing public and private healthcare services which met the international standards. A related constraint, according to some TM and MM respondents, was that many JCI requirements concerned matters under the control of DOHMS central departments over which the hospital leaders had no control. According to these interviewees, DOHMS often took

more time than expected to approve or meet these requirements, some of which were related to the engineering, human resources and purchasing departments.

The Director of Nursing gave the following example of a time-related difficulty:

*“We struggled with one of the outsourcing companies which was appointed by DOHMS to verify the certificates and experiences of healthcare providers from the primary source of the academic institutions concerned or previous employers. In other words, this contractor had to communicate with different universities and hospitals around the world to make sure that these documents were authentic. The appointed company could not meet this commitment on time. A few weeks before accreditation, we worked very hard within our hospital resources and assigned a member of nursing staff on a full-time basis to complete this verification process as one of the important requirements for the JCI accreditation survey”.*

Most of the MM and some of the TM interviewees mentioned that the lifestyle of UAE nationals and expatriates had a real impact on the JCI accreditation process, especially during summer holidays and the holy month of Ramadan. In June, July and August most of the national staff leave UAE for Europe, Asia or elsewhere in the Middle East for their annual holidays. According to the admission statistics provided in documents reviewed for this study, the number of patients in hospital A, including the outpatient clinics, falls by more than 35% during the summer and school holidays. This happens because most of the residents of Dubai and other emirates return to their home countries in summer. According to the Dubai Municipality and the annual DOHMS statistics, expatriates comprise more than 80% of the population of Dubai (UAE, 2006).

A senior manager said:

*“We are very flexible in permitting the hospital staff to go for their holidays during the summer because there are fewer patients in the hospital”.*

The Chief Operations Officer reported a related difficulty:

*“We couldn’t plan staff leave very well during the accreditation process, because demand is greater in winter and lower in summer, so a lot of the staff should go for their annual holidays during the summer to manage the supply*

*and demand formula very well. That's why I am admitting that the process of JCI accreditation during summer was very slow".*

A Quality Department interviewee confirmed this:

*"Most of the JCI committees were not meeting regularly during the summer, because some of the key members were on their annual holidays, and this was a big challenge for us to meet the JCI requirements and to achieve the JCI accreditation on time".*

The Senior Quality Coordinator said:

*"To compensate for delays due to summer holidays we tried to work very hard and very fast immediately after the summer holidays were finished, but we faced another big challenge in terms of the habits and lifestyle of people during Ramadan, when people tend to work less".*

Indeed, many TM, MM and frontline interviewees mentioned the factor of Ramadan, which is related to lifestyle and to time. People usually fast all day, eating and praying at night. Therefore the working day is reduced from eight and a half to six hours per day during Ramadan, for both fasting and non-fasting staff.

The Director of the hospital explained that

*"We can't ask our staff in the hospital to work harder in the holy month of Ramadan, but we can do that in other months of the year, because we understand that they are fasting. They don't eat, they don't drink water or any fluids during the daytime, and they are usually awake most of the night praying, eating and socializing. This was one of our big challenges during the preparation for the JCI. In our case, during 2007 the situation was more difficult because Ramadan happened to be immediately after the summer holidays and our JCI accreditation survey date happened to be one month after Ramadan. We tried to change the survey date, but JCI would not approve it for us due to their planned commitments in other countries. I would not recommend any hospital in a similar situation to go for accreditation after summer or after Ramadan".*

#### **4.1.1.12 Cost of accreditation**

According to the Finance and Administration Director, the cost of the JCI accreditation process was related to the readiness of the hospital when that process began. He also stated that

*“JCI accreditation in general is costly because there are a lot of costs related to logistical support for the consultants and surveyors of the JCI, especially as most of them travel from the United States in business class and stay in five-star hotels”.*

Three of the TM interviewees said that they were more confident as a result of having the JCI consultants visiting the hospital regularly during the preparation process, but that they found it costly. The Chief Operations Officer emphasised that the cost of JCI accreditation was considered an investment to promote quality and patient safety. Nevertheless, he believed that the consultation could have been done by non-JCI consultants at a much lower cost.

The Director of the hospital justified the expenditure and explained how the money was found:

*“I managed to arrange for the financial support to achieve the JCI accreditation through saving part of the hospital budget. Our hospital required a lot of renovation in relation to the buildings to meet the safety standards; for example, building four emergency exits on the first floor and integrating the fire alarm system in a systematic organised process were very costly too. I do believe the cost of the consultants was based on the number of days they usually spend in hospitals, while the cost increased and decreased based on the hospital's readiness at the starting point of the accreditation process. [...] Although the cost of the consultants was relatively high, arranging the money was not a problem for us in Dubai. I can and will raise money whenever needed to support quality and patient safety.”*

#### **4.1.1.13 Resistance to change**

All the TM interviewees in CSA mentioned resistance to implementation of the JCI standards as one of the challenges they faced, especially at the beginning of the process. The Medical Director of the hospital said:

*"At the beginning of the process it was very difficult to convince doctors and technicians to be part of the process of implementing the JCI standards in the hospital. Lack of involvement was one of the main reasons that the staff members were not very much interested in being part of the process. I worked with all the concerned parties in the hospital, especially the Quality Department, to make sure that all medical staff were involved in the process and were consulted well before the recommendation of any change was carried out in relation to their daily practice. [...] The direct involvement of the heads of the departments and the presentation of data about the performance of each department were two important motivators to encourage all the staff to be part of the process and to minimise the level of resistance to this change in the hospital".*

The director of Clinical Support Services shared this opinion:

*"I noticed that the resistance to the implementation of the JCI standards in the hospital was coming from the national staff more than the expatriate staff. I could not understand the reason behind that, but I think the expatriate staff members are in general more receptive to change in order to maintain the security of their jobs, while the national staff members challenge changes because they are more secure in their jobs."*

The Hospital Director said:

*"Some of the senior staff resisted the process of implementing the JCI standards by not attending required meetings or by not following certain policies and procedures in the hospital. However, I communicated with everybody in the hospital through general staff meetings that implementing the JCI standards and achieving accreditation was one of the leadership's priorities. Then the acceptance to the process was improved significantly because of our persistence and continuing support for the process"*

The administrator of the contractor company managing the Emergency Department, Operating Theatre and Surgical ICU admitted that

*"At the beginning of the process to implement the JCI standards, I was not able to give this process the required attention and support, because I was very busy ensuring that the resources required to run the departments which*

*are under our responsibility were available. My priority was to ensure that I would succeed in running these departments well before thinking about any other project. It is about priorities. Then late in the process I had to support the programme of implementing the JCI standards because achieving accreditation became one of the hospital's requirements, as advised by the Hospital Director”.*

The Chief Operations Officer confirmed that this contractor's staff did not support the process of implementing the JCI standards at the beginning of the process, so

*“The Director of the hospital advised the Administration Director of the contractor company that he had to work with his staff to support the JCI accreditation and to motivate them to get involved in the implementation process. The Director of the hospital realised that the support of the contract staff was very minimal at the beginning of the process, because the JCI was not their first priority”.*

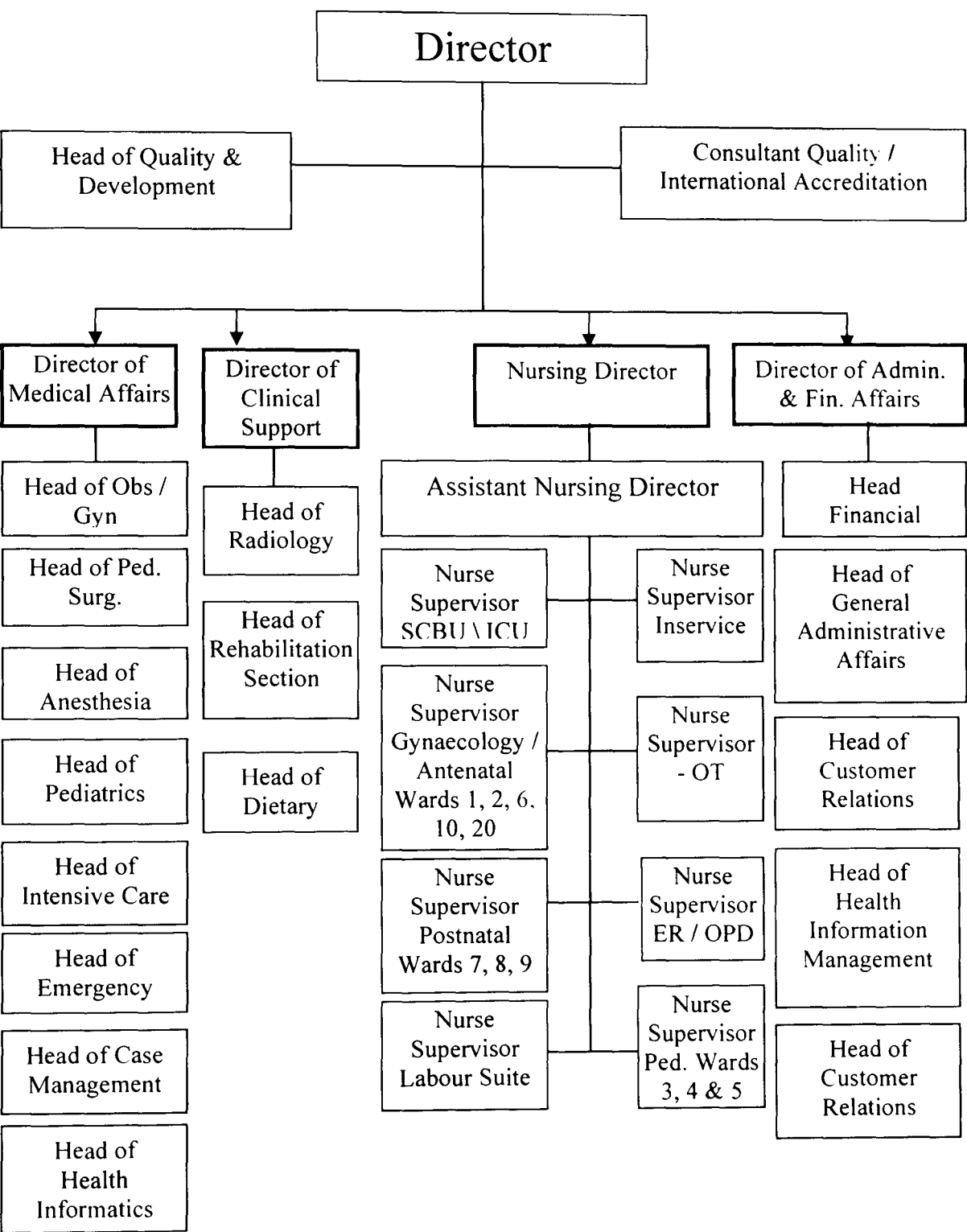
The following subsections report the findings of case study B.

#### **4.1.2 Interview results for case study B**

CSB is the women's and children's hospital in Dubai, most of whose patients are non-emergency cases; however, an average of 150 patients attend the ED each day and a total of 58,000 patients did so in 2007 (Hospital B Annual Report, 2007). The hospital, which was opened for patient care in 1986, has a capacity of 364 beds and makes an average of 7 admissions and discharges per day. It has a total of around 1400 staff members working in four main medical specialities. It is the largest hospital specialising in the care of women and children in Dubai. Like hospital A, it is led by a hospital director, assisted by directors of medical services, nursing, finance and administration, and clinical support services. The Head of Quality in the hospital is a member of the executive team and reports directly to the Hospital Director. Figure 4.2 shows the organisational structure of hospital B.

As mentioned in section 4.1, the researcher conducted 16 interviews in CSB: 5 with TM respondents, 6 with MMs and 5 with frontline employees. Fewer interviews were conducted than in CSA because the process in hospital B was less complex, it had only four medical specialities rather than twenty and it employed far fewer people. As with

CSA, different categories of staff were interviewed in order to explore all aspects of the implementation of the JCI standards and the factors that affected the process.



**Figure 4.2: Organisational structure of CSB**

The hospital started the implementation of JCI standards in February 2006. It was accredited in September 2007, which means that like hospital A, it took around one and a half years to achieve JCI accreditation. In another similarity with CSA, the hospital

established different teams to prepare for accreditation. Each was responsible for one chapter of the JCI standards, including the international patient safety goals. All these teams reported to the Quality Council, an entity which oversaw the whole process and was responsible for approving all policies, procedures, plans and any other documents required to meet the JCI standards. The Quality Council was chaired by the Hospital Director and consisted of various directors and leaders of the hospital to ensure that all aspects of the accreditation process and other quality and patient safety issues were well developed in the hospital. The Council and the JCI accreditation teams met weekly throughout the accreditation process.

The following subsections present the results of CSB, examining the reasons for seeking JCI accreditation and implementing its standards in hospital B, the awareness and understanding of the associated requirements, and the factors that affected the implementation of the JCI standards.

#### **4.1.2.1 Reasons for seeking JCI accreditation**

The reasons given by all interviewees in CSB for seeking JCI accreditation were similar to those reported in section 4.1.1.1 for CSA, i.e. that it was a hospital initiative and desire. However, there was in this case more emphasis on the role of the Dubai government and the higher authority of the DOHMS in influencing the hospital decision to seek accreditation. Several MM respondents stated that without the intention of Dubai government and the DOHMS to work with hospitals to achieve accreditation, the hospital would not have started this process, because the accreditation process had been started a few years earlier and stopped again by the DOHMS.

The Director of the hospital explained:

*"The process of working on the JCI accreditation was started for the first time in the year 2000. The leadership of DOHMS at that time were very keen to achieve international accreditation. Unfortunately this process was stopped when the leadership was changed a few months later. So I decided not to go for the accreditation in my hospital till I had seen a real intention from the Dubai government and the DOHMS authority to go through this process. In my hospital I started the process after the contract between DOHMS and JCI had been signed. I do believe that the JCI accreditation is a*



*tool to improve quality and patient safety as well as to improve the image of the hospital in the UAE in general and Dubai in particular”.*

Most of the leaders and managers who were interviewed in CSB emphasised the role of JCI accreditation in promoting quality and patient safety. A few leaders said that they had used accreditation as a tool to achieve excellence and to be the best government hospital in the UAE. One of the nursing leaders elaborated:

*“After we achieved accreditation we applied for the Dubai Government Quality Award because we believed that this award was the most powerful tool to recognize good performing hospitals in the UAE.”*

The researcher noticed that the remaining reasons for the hospital to seek JCI accreditation were similar to the findings in CSA. Table 4.2 summarises the responses of top management and others on this point.

**Table 4.2: CSB respondents’ views on reasons for seeking JCI accreditation**

Top management (5)	Middle management and frontline staff (11)
To meet the requirements of Dubai government and higher authority of DOHMS	On instruction from the higher authority of DOHMS
It is a hospital initiative to improve quality and patient safety	Some agreed that it was an instruction from the Dubai government.
A tool to apply for Dubai Government Quality Award	A tool to improve patient safety and quality of care
To provide healthcare services at international level	Most of the hospitals in UAE are going through this process
To be recognized as the best government hospital in the UAE	It is a set of healthcare-focused standards

The researcher asked the interviewees from different categories about the major differences JCI had brought to the hospital as compared to the prior state. As in CSA, all the respondents said that they saw a significant difference. They believed that the implementation of JCI standards had contributed significantly to the involvement of all staff members in the improvement process, especially in the administrative departments. One senior quality coordinator said:

*“The process of implementing the JCI standards encouraged the staff in the Customer Service and Public Relations Department to participate positively in the quality improvement process. I have personally seen the administrative*

*staff working on the JCI requirements in relation to their departments to make sure that they are playing a positive role in the accreditation process”.*

Several interviewees from different categories of staff expressed the view that the accreditation process had played a significant role in improving communication in the hospital, as well as improving the culture of quality and patient safety. One of the heads of the Medical Department gave details:

*“Some of the policies and procedures which were developed during the JCI accreditation process played a very important role in improving communication among all healthcare providers. For example, the verbal and telephone order policy encouraged doctors and nurses to write each order down and read it back before implementation. This process helped nurses and doctors to make sure that the information was understood correctly between different healthcare providers. This promoted patient safety in the hospital”.*

The researcher noticed that the other benefits of implementing JCI standards in the hospital mentioned by interviewees were similar to those given in CSA (see section 4.1.1.2). These benefits included the following:

- Improved reporting and management of medical and nonmedical errors;
- Improved awareness of the hospital staff toward quality and patient safety;
- Improved staff empowerment in relation to their work, enabling them to take better decisions;
- Stimulation of staff analytical thinking and self-monitoring of their performance;
- Encouraging the leadership of the hospital to promote a ‘no-blame’ culture of accountability instead of a punitive and blaming culture.

Most of the MM and frontline interviewees felt that one of the areas which was not covered well in the JCI standards was that of staff rewards and recognition. One of the senior managers said:

*“I do believe that one of the shortcomings of the JCI standards is the lack of acknowledgment of people’s rights while they are working in hospitals. When our staff asked questions in relation to their rights from the JCI standards point of view and how the implementation of the standards would improve their rewards, recognition and maybe compensation, I could not find direct and clear answers in the JCI standards to share with my staff”.*

#### **4.1.2.2 Top management commitment and involvement**

The researcher found that most of the interviewees from the three different categories believed that top management involvement and commitment was one of the critical factors in achieving JCI accreditation. It was very interesting to find that several MM and frontline interviewees mentioned that reliable commitment and involvement were forthcoming from the top management of the hospital but not consistent from the high authority of DOHMS, because this is a very similar finding to that in CSA, reported in section 4.1.1.2. The Head of the Quality Department explained:

*“We had previous experience with DOHMS about the process of accreditation, which was started earlier, in the year 2000, and then it was stopped due to some changes in the top management. This time we started the process after the contract was signed with the JCI because we wanted to make sure that DOHMS was serious about the process. We were not comfortable with the idea of starting the process, introducing the project and then stopping it again. It could be very embarrassing to the leadership of the hospital in front of the staff.”*

The Director of the hospital gave another example of difficulties related to the DOHMS:

*“One of the challenges we had throughout the process and especially in the beginning was related to the fire and safety requirements of the JCI standards. This service was provided to us through a central department in DOHMS. There was a lot of delay in getting things done and a lot of delay in providing all the requirements to meet the JCI standards. I do believe that if this service was decentralized at the hospital level we could improve our efficiency, our effectiveness and our performance.”*

The researcher found that most of the responses of CSB interviewees were very similar to the findings in CSA regarding top management commitment and involvement, reported in section 4.1.1.2.

#### **4.1.2.3 Staff awareness and knowledge of quality and JCI standards**

On the subject of staff awareness and knowledge of quality and JCI standards, the findings in CSB were again similar to those in CSA and reported in section 4.1.1.3. In particular, the researcher was told by many of the experienced managers and frontline

staff that such awareness and knowledge were not as good as they should be, because not all the staff had the chance to attend the training which was delivered by the JCI consultants. For example, a senior quality coordinator said:

*“A lot of the staff attended in-house training related to quality and accreditation, but I do believe that the awareness of the staff and their knowledge about the standards should be much better through involving them in the training process in an effective manner, for example to repeat the training regularly to give the training opportunity to all hospital staff, and to provide training to the staff at different times to make it more convenient for them.”*

#### **4.1.2.4 Involvement of employees in the implementation process**

The head of the Quality Department stated that she was the coordinator for the JCI accreditation process in the hospital.

*“The hospital staff members were involved in the preparation process through the participation in different JCI teams. However, due to the challenges that we faced to get things done by some of the departments, I encouraged the quality staff to do some of the work by themselves for these departments. This work included developing policies, procedures and plans to meet the JCI requirements in these departments on time.”*

One senior quality coordinator suggested that

*“The staff in different departments could be involved in better ways if all policies, procedures and other required documents were developed by them rather than by the Quality Department. Some of the staff in different departments started thinking that this preparation for the JCI accreditation was the Quality Department’s job and its project. It is not an organisation-wide project”.*

In another similarity with CSA, as reported in section 4.1.1.4, the Medical Director explained that

*“At the beginning of the process it was very difficult to involve all doctors, nurses, and technicians in the JCI accreditation process, because they were usually busy in their routine work. Attendance at the JCI training was very poor in the beginning by all healthcare providers. However, after the real*

*implementation of hospital plans, policies and procedures it was essential to involve all medical staff in this process”.*

The Head of Quality offered this opinion:

*“One of the very important motivators for different medical staff to get involved in the process was the encouraging feedback of the JCI consultants after their initial assessment and the progress that we achieved gradually throughout the JCI accreditation process.”*

#### **4.1.2.5 Human resource practices**

The implementation of the new HR law had a very negative impact on staff motivation and involvement in JCI accreditation, according to one of the experienced heads of the Medical Department:

*“After the implementation of the new HR law we found that a lot of our staff members were not motivated to participate actively in the JCI accreditation process, because they felt the implementation of this new HR law was subjective and not fair. It was very difficult for us to motivate them, because we didn’t have any control over this new HR law. It was implemented by the higher authority of the DOHMS”.*

One of the nurses who was interviewed said:

*“My active involvement and motivation to work on the JCI accreditation process was related to my personal interest to get this exposure and experience. It had nothing to do with my satisfaction at work”.*

The acting Director of Nursing gave her assessment:

*“Although the nursing staff members were not happy about the implementation of the new HR law, they still worked very hard to achieve JCI accreditation. The strategy we followed with nurses in our department was focusing on what is good for them in this process in relation to their career growth and development. It was very important for the nursing staff to have the experience of preparing their hospital to achieve the accreditation, because most nurses leave the hospital for the United Kingdom and United States after a few years of experience to work and live there. They leave*

*because the salary and the benefits are much better for them and they feel more secure in terms of job and family”.*

The researcher found in CSB that the main motivator for the staff to work on JCI accreditation was related to their individual benefits and professional growth, because they were not satisfied by their work itself. This lack of satisfaction was mainly related to the implementation of the new HR law. This was emphasised by the Director of Clinical Support Services, who agreed with the acting Director of Nursing that they were not able to involve the staff of the hospital in the process of JCI accreditation without focusing on the experience and the exposure that they would gain as motivating factors.

The other findings related to human resource issues were similar to those in CSA, such as the impact of having certain positions that had to be filled by national staff only, regardless of their qualifications, as reported in section 4.1.1.5.

#### **4.1.2.6 Training**

The researcher noticed that most of the findings regarding training issues were related to the fact that the majority of the training was provided for the national staff. The heads and managers were trying to find other ways to train the expatriate staff. While most of the interviewees recognised that the training was necessary to promote the JCI accreditation process, they believed that in some situations the process of training had a negative impact on motivating the expatriate staff, because it was not delivered according to the learning needs of the staff.

The head of the Clinical Support Departments complained that

*“DOHMS leaders were not generous in providing training to the expatriate staff to promote the process of JCI accreditation in the hospital. Most of the training was organised for national staff, while both expatriate and national staff were involved in the JCI accreditation process and maybe the expatriate staff were involved more”.*

The Deputy Director of Nursing focused on the internal training within the Nursing Department to ensure that all expatriate staff were involved in the training process and empowered to achieve JCI accreditation. She reported:

*"I trained a few people in each nursing unit and I asked them to train the remaining colleagues on issues related to JCI accreditation. I focused on policies, procedures, plans and other documents. On the other hand, I asked some of the active nursing staff to prepare some of the questions and answers related to JCI standards to test the knowledge of their colleagues in a very creative and interesting approach".*

#### **4.1.2.7 Cultural issues**

The researcher found that the organisational culture in hospital B was more unified and integrated than the situation apparent in CSA. The Director of the hospital said:

*"I did not agree to have any contractor company participating in managing the hospital, because this might lead to a lot of diversity and lack of understanding of what might work in our hospital and what might not work. This could have led to a conflict during our accreditation process".*

The Head of the Quality Department emphasised the importance of teamwork during the JCI accreditation process:

*"One of our success factors during the accreditation process was that we decided to work as one family, focusing on achieving accreditation. Although we had a lot of challenges related to the motivation of our staff due to issues in the human resource system of DOHMS, we decided to work as a team in our hospital, following our own systems and focusing on the hospital policies and procedures".*

The Head of Laboratory Services reported that the culture in the hospital was very supportive and cooperative in general, especially during the accreditation process. He considered that resistance was minimal at the beginning of the process and that after that people were very supportive of the process. The support of the staff improved after they saw that the project was successful, based on self-assessment and the feedback of the JCI consultants. The Head of Laboratory Services added that

*"The resistance was very low among expatriate staff in my department because their focus was on the work itself. They always follow the hospital policies and initiatives, and they are very keen to maintain their jobs".*

The hospital leaders in CSB acknowledged that one of the reasons that they did not have cultural diversity in the hospital was because most of the hospital staff were from similar cultures in the Middle East and Asia. They felt that this cultural similarity among the staff minimised the level of resistance to the JCI accreditation process.

#### **4.1.2.8 Use of technology in providing services and information**

Several interviewees from different categories reported that the use of technology in providing information was very supportive for the JCI accreditation process. The Medical Director of the hospital said:

*“Our hospital is used to implementing new projects on a pilot basis before full implementation in DOHMS hospitals, because it is a small hospital in comparison with the others. We have only four departments, in which we can facilitate any new process without a lot of challenges. The information technology system, pharmacy electronic system and laboratory electronic system were implemented and stabilised first in our hospital, so we did not face challenges in this regard during the JCI accreditation process.”*

The Clinical Support Director made a similar point:

*“The mission of the hospital is to provide healthcare services to women and children in Dubai, so we are very focused in our service. Using technology in providing information and services to our patients is always done without significant problems, because the challenges are always less than what other big hospitals usually face”.*

#### **4.1.2.9 Planning and working on more than one project at the same time**

Similar to the situation in CSA and reported in section 4.1.1.9, the Quality Department in CSB developed a very practical and achievable plan which helped the hospital to focus on the objective of achieving JCI accreditation. The researcher found that the hospital leaders did not face many challenges during the accreditation process regarding the planning issue, because they were very focused on accreditation. The TM and MM interviewees asserted that the hospital's experience regarding the project management plan was very successful because its leaders decided not to work on any other project during the preparation for JCI accreditation.



#### 4.1.2.10 Communication

The distinct position of the hospital regarding communication was explored by several CSB interviewees from the three categories, whose view was that the hospital's leaders could manage communication better than other hospitals in their weekly staff meetings. The Head of Quality and the quality staff stated that the communication issue was improved significantly throughout the accreditation process by using different effective communication tools.

One senior quality coordinator said:

*"The hospital newsletter played a significant role in promoting awareness among the staff regarding the JCI accreditation process. We used it as a tool to communicate with all hospital staff about our progress in the process."*

The Hospital Director said:

*"Our hospital is relatively small in comparison to other public hospitals in the UAE, so we could manage our communication issues in our weekly staff meetings during the accreditation process. We used that weekly meeting as a communication tool in a very family-type environment. We always promoted transparency in our communications."*

#### 4.1.2.11 Time

The TM and MM interviewees in CSB identified time as one of the challenging factors during the JCI accreditation process, because many of the requirements to meet the JCI standards were related to DOHMS central departments, so the hospital leaders had no control over them. Some of these requirements were related to the engineering, human resource and purchasing departments. The Head of the Quality Department gave an example:

*"We struggled with the outsourcing company which was appointed by DOHMS to verify the certificates and experiences of healthcare providers from primary sources. Because of this problem we were thinking of travelling to some countries like India and the Philippines to verify the certificates of our nurses ourselves, because the outsourcing company was not able to do so".*

The TM and MM interviewees saw time management as a very important factor in the JCI accreditation process because the initial date of the final survey was postponed twice by the JCI surveyors, as the Head of Quality explained:

*“The initial survey was delayed on two occasions. On the first occasion the surveyors’ schedule was full, and on the second occasion DOHMS did not pay the cost of the survey on time”.*

The Director of Clinical Support Services also mentioned the question of seasonal availability of staff:

*“When we planned our final survey, we avoided having it during the summer or during the holy month of Ramadan. We understood that summer was not a good time [...] because most of our staff usually go on annual leave, while Ramadan was not a good time to have our survey because people usually focus on their fasting and prayer rather than work. In this way we were able to minimise our challenges.”*

#### **4.1.2.12 Cost of accreditation**

The Finance and Administration Director considered that the cost of JCI accreditation for hospital B was relatively acceptable in comparison to other DOHMS hospitals, because the hospital was relatively small.

Similar to the situation in CSA, the Head of the Quality Department judged that

*“Most of the cost of the JCI accreditation process was related to the logistic support for the consultants and surveyors of the JCI, especially as most of them travelled from the United States in business class and stayed in five-star hotels”.*

The Director of the hospital made the following assessment:

*“The cost of the JCI accreditation process was relatively reasonable because our hospital was small and not very old. The building and the safety maintenance programmes are very efficient and effective. However, we postponed the planned date of the survey because staff in the DOHMS finance department were unable to pay the JCI 50% of the cost in advance of the survey.”*

#### **4.1.2.13 Resistance to change**

Similar to the situation in CSA, all TM interviewees in CSB identified resistance to implementation of the JCI standards as one of challenges that they faced in the process, especially at the beginning. The Head of Quality in the hospital explained:

*“Most of the staff who resisted the change to JCI standards at the beginning of the process were not happy with some of the rules and regulations in regards to implementing the new human resource system”.*

Similar to the findings in CSA, the Head of Laboratory Services stated that

*“The resistance existed at the beginning of the process of implementing the JCI standards, but a few months later the staff members in general were very supportive of the accreditation process, because they started to see that the implementation process was successful, based on the self-assessment and the feedback of the JCI consultants”.*

In remarks similar to those of the Clinical Support Director in CSA, the Head of laboratory services added:

*“Resistance to the implementation of the JCI standards was very low among expatriate staff in my department, because they tended to focus on the work itself. They always follow the hospital policies and initiatives and they are very keen to maintain their jobs. In general, I find the expatriate staff members more receptive to change than the national staff”.*

One significant difference between the two hospitals regarding resistance to change was that there were no staff members or managers working for external contractors in hospital B, unlike situation reported in CSA. The Hospital Director said:

*“One of the positive factors in the culture of the hospital is that we don't have any contracted company to participate in managing the hospital's operations. I strongly believe that the existing understanding and teamwork among our leadership team played a role in minimizing the resistance in the hospital because of the similarities in understanding the hospital's mission, vision and priorities”.*

## **4.2 Chapter Summary**

This chapter has presented the results of the semi-structured interviews carried out in both case study organisations. The analysis of data was undertaken by considering the raw data, categorising and presenting it under a number of themes. The choice of the case study as a strategy for this research and the use of the semi-structured interview as the main data collection tool has provided valuable in-depth information about the process of implementing the JCI standards in the two hospitals. To improve the internal validity, multiple sources of data such as documents, quality manuals, minutes of meetings, plans and minor observations were also used during the analysis.

In the following chapter the findings will be discussed.

## **CHAPTER FIVE**

### **Discussion of the Research Findings**

#### **5.0 Introduction**

This chapter will discuss the empirical findings of the two case studies, link these with the findings of the literature review and consider the research implications. The field study results are thus discussed in the context of previous studies and theoretical explanations in order to draw both practical and research implications. The basis of the discussion will be the similarities and differences between factors identified in the literature review and the corresponding findings of the case studies. This will also provide opportunities to discuss any new issues emerging from the case study findings and which were not predicted in the literature review.

In relating the findings to the previously-reviewed literature, a better understanding will be gained of the similarities and differences between hospitals in the UAE, as represented by the case studies, and hospitals and other organisations in Western environments. This will shed light on practices that may be common across different cultural contexts, and on problems that are unique to the case study organisations in the UAE.

The chapter is organised into two sections. Section one discusses the results in the context of previous research and theoretical explanations, including categorising the factors that affect the implementation of JCI in UAE hospitals, while section two considers implications for future developments, improvements of existing research and future research opportunities.

#### **5.1 Case study discussion**

The following subsections (5.1.1 to 5.1.13) present a discussion of the results of the research under the same headings as in the preceding chapter, considering the similarities and differences vis-à-vis the literature reviewed in chapter 2. Findings unique to the UAE environment will be highlighted.

##### **5.1.1 Reasons for seeking JCI accreditation**

This research has identified the reasons for seeking JCI accreditation in the two hospitals studied. The initial aim in CSA was to improve quality, patient safety and

satisfaction, as well as to improve the image of the hospital in the UAE in general and Dubai in particular. In CSB, the leaders placed more emphasis on the role of the Dubai government and the higher authority of the DOHMS in influencing the hospital's decision to seek JCI accreditation. Both hospitals' leaders and middle managers emphasised that the reason for seeking JCI accreditation was to achieve customer satisfaction through improving the quality of services and the processes inside the hospitals. This result is explained by many authors, as illustrated in the literature review. The huge gain cited for the implementation of a quality system or accreditation was based on the objective that specific minimum characteristics can be standardised, which can be considered as a significant benefit for the organisation as well as its customers.

Taylor and Adair (1993) and Lee (1999) believe that top management are convinced that the effective implementation of quality improvement practices leads to improvements in organisational performance in terms of both productivity and profitability.

Another reason which was emphasised by the leaders and managers in both case studies was the plan to standardise hospital operations with well established policies and procedures. They envisioned the quality manual to serve as a reference for carrying out the department's operations. Middle and top managers in CSA agreed that achieving JCI accreditation helped to ensure that the hospital's departments had specific well documented procedures in the design and delivery of their services. This reason agrees with the internal reasoning explained by Mo and Chan (1997), Tsiotras and Gotzamani (1996) and Fuentes *et al.* (2000) that one of the main reasons for implementing quality systems is to attain internal organisational improvement, such as establishing a formal system in the organisations, improving performance and simplifying procedures, as a contract with clients. It can be implied that these findings were similar to Arab, Western and Australian organisations. The other reason given by some of the leaders, middle managers and other staff was that JCI accreditation was just a marketing tool to improve the image of the accredited hospitals. This finding is consistent with Arab studies by Magd *et al.* (2003), Al-Khalifa and Aspinwall (2000) and Tayyara (2000). Al-Khalifa and Aspinwall (2000) found that certification was seen as a marketing tool and explained that it was the main reason for organisations to seek certification in the Gulf countries. The situation in the UAE is very similar to that revealed by studies in other

Arab countries that are mainly dependant on their national income, driven by the price of oil.

Another reason for seeking JCI accreditation revealed by the two case studies was to promote continuous improvement and meet the higher level of international standards within the organisations. As emphasised by the JCI standards, accredited organisations have to demonstrate their quality improvement process throughout the preparation for achieving JCI accreditation. Thus, accredited organisations have to show how improvement in their work processes has taken place in implementing and maintaining the accreditation process (JCI, 2003). This was not an obvious reason given by the TM and MM respondents in the case studies. The researcher believes that it can be implied that there was a lack of understanding of the purposes of the standards and this finding is similar to those of other studies carried out in Arab countries by Al-Khalifa and Aspinwall (2000). Many reasons for seeking certification that were mentioned in the literature review were not identified in this research, such as:

- To improve productivity, found by Arab researchers such as Al-Khalifa and Aspinwall (2000) and Tayyara (2000), and in Western countries by Fuentes *et al.* (2000) and Taylor (1995).
- To motivate an organisation's employees and to improve employee participation (Fuentes *et al.*, 2000).
- To minimise product or service cost (Santos and Escanciano, 2002; Fuentes *et al.*, 2000 and Devos *et al.*, 1996).
- To improve communication inside and outside the organisation (Tang and Kam, 1999; Fuentes *et al.*, 2000).

This leads to the conclusion that the TM in both case studies were not fully aware of the benefits of the standards but were obligated by the government to implement the system, leading some MMs not to cooperate fully with the process of implementing the system. This will be discussed in more detail in sections 5.3 and 5.4.

### **5.1.2 Top management commitment and involvement**

The responses in the two case studies indicated that leaders and managers were committed to and involved in the process and that this commitment was strengthened at later stages of the process. Most of the interviewees at all levels in both case studies believed that the top management were strongly committed to and involved in achieving JCI accreditation for their hospitals. This finding is supported by Ab Rahman and

Tannock (2005), who found in their study of TQM best practices in Malaysian companies that top management must play a very important role in promoting quality at every level in the company. Top management may go beyond the commitment to the quality programme in the organisation by being actively involved in the implementation process themselves. Such involvement will set a good example for others in the organisation, as leaders will be considered role models in this process. The impact of leadership involvement in implementing quality systems to create a TQM culture was explored in the reviewed literature. According to Kanji (1998), senior management must be actively involved in creating a Total Quality Culture with a clear vision through the following leadership roles:

- To define a mission, vision and goals that promote a Quality Culture;
- To establish a set of shared values;
- To define a quality strategy;
- To better coordinate the use of resources in order to improve financial performance;
- To establish goals and systems to enhance customer satisfaction;
- To establish effective information systems and to use objective data;
- To promote the development of human resources training and recognition;
- To communicate, define and motivate continuous improvement.

In the present study, some of the MM and frontline interviewees felt that the vision of the leadership regarding JCI accreditation was not clear to all the staff, which is related to the first point as emphasised above by Kanji (1998). Czuchry *et al.* (1997) quote Latham (1995) as asserting that vision is an essential element in organisational success. He adds that the management should motivate its employees to believe in the vision of the organisation as a key to successful change effort. According to Kanji (1998), Czuchry *et al.* (1997) and Latham (1995), motivating employees to believe in the vision of the organisation should then become the basis for the establishment of the organisation's vision and values, which was lacking at the beginning of the JCI accreditation process in both case studies. Top management, however, must accept responsibility for and commitment to the mission before communicating it to the rest of the workforce, as stated by the MM respondents. The problem that existed among the top managers is that they were not committed to quality implementation in the beginning because of the lack of support from the headquarters of the organisation. This



lack of commitment was reflected in participation in quality activities at the beginning of the implementation process.

It seemed that the top management did not communicate the organisation's vision very well to different categories of staff in either hospital; thus, the vision was not shared by the frontline employees who should have been involved. A head of department said,

*"I do not know what top management is thinking and what they need to do. Their objectives are not clear to us; they have not discussed the quality objectives with us, although we have responsible positions in our departments".*

This finding is consistent with those of many other authors, such as Thorsteinsson and Hage (1991), Campbell (1995), Mostafa (2004), Davis *et al.* (1997), Hoffman (2002) and Sharp *et al.* (1997), who all advocate that vision and mission should be very clear to all employees. Quazi and Padibjo (1998) found that lack of top management commitment was a barrier to the implementation of quality management systems in small and medium organisations in Singapore. Munro-Faure and Munro-Faure (1992) assert the importance of management commitment. Goetsch and Davis (2000) also advocate the need to publicise and communicate the benefits of the system to the employees for continuous improvement.

According to one of the leaders interviewed in CSB, the accreditation process was started in the year 2000 and then stopped because of some changes in the top management which affected the degree of commitment at all levels. This time the hospital started the process after the consultation contract for preparing the hospital to achieve the accreditation had been signed with the JCI, to ensure that the top management at DOHMS was serious about the process.

Most interviewees from different levels of both case studies agreed that at a later stage of the accreditation process the commitment of the leadership of both hospitals was improved, leading to an improvement in the availability of resources and in the progress of implementation. This finding is supported in the literature by McFadden *et al.* (2006), who emphasise the role of leadership commitment in a study of implementing quality and patient safety initiatives in US hospitals: the more commitment, involvement and emphasis the hospital and patient safety leaders place on quality and patient safety initiatives, the more likely the hospital is to actually implement them.

Because the top management at the headquarters were not committed to or involved in the process of achieving accreditation in the two hospitals at the beginning of the project, the staff working there suffered a lack of resources and support. The leaders and managers at the two hospitals faced many challenges from the central departments reporting to the headquarters leadership, due to this lack of commitment and involvement. Some of the leaders of the headquarters departments were committed to the process but were not fully aware of their responsibility to facilitate the implementation of JCI standards and achieve accreditation. This finding is consistent with those of Sharif (2005) and Al-Haj (2006).

### **5.1.3 Staff awareness and knowledge of quality and JCI standards**

The respondents in both case studies agreed that the knowledge and awareness of staff in their hospitals regarding quality and JCI standards were very limited when they started the process. Some staff members were able to attend the structured training in quality and JCI standards when the project was started, but most did not have access to the training because it was provided for UAE nationals only. The lack of knowledge and awareness among the staff was one of the challenges to the process of implementing the JCI standards. The reviewed literature emphasised the importance of staff training to support quality programmes, otherwise a lack of awareness may lead to a failure of implementation. For example, Al-Zamany *et al.* (2002) quote Wong (1998) as reporting that the implementation of quality programmes failed in developing countries due to a lack of awareness and understanding of TQM. The failure of some organisations to gain accreditation or certification was caused by poor understanding by the managers concerned of QMS requirements and implementation. Similarly, Withers and Ebrahimpour (2001) indicate that one of the most common obstacles faced by eleven different European organisations in their study was difficulty in interpreting the quality system standards. Thus, top managers should educate themselves before taking action to seek QMS certification (Lee, 1999).

Many studies have considered staff awareness of and training in quality principles to be one of the important factors in the successful implementation of quality systems. For example, Pomey *et al.* (2004) found that awareness among all hospital staff of the accreditation process was one of the conditions for a successful implementation process.

In case study B the leaders relied on self-assessment and intensive training within the organisation to cover the training needs of their staff, to improve awareness of quality and the JCI accreditation process, and to facilitate implementation. These leaders believed that inadequate awareness and training would be a barrier to good decision making, which is consistent with the findings of Ngai and Cheng (1997), Rohitratana and Boon-itt (2001), Bhanugopan (2002), Masters (1996), Amar and Zain (2002) and Macdonald (1992), who found that inadequate knowledge and understanding could work as a barrier to the implementation of quality management systems. Walsh *et al.* (2002), Al-Khalifa and Aspinwall (2000), Salegna and Fazel (2000) and Amar and Zain (2002) report that one barrier that an organisation may encounter in adopting a QMS is a lack of awareness and a misunderstanding of its benefits.

The medical staff interviewed in the two case studies felt that implementing the JCI standards was additional work. They had to fill in all the requirements of patient's history and physical examinations in the designated forms, as required by the JCI standards. They also had to update the patient's medical record following the physician's documentation policy, as per the requirements of the standards. For example, pain assessment had to be documented for all patients passing through emergency departments or outpatient clinics, or being admitted to the hospital. Physician's documentation had been very different before the JCI implementation process began. Staff were not required to complete all the components of assessment and physical examination, but were able to focus on the area of the patient's complaint. Some staff members, such as doctors, were very annoyed and felt that they were forced to do this work for the Quality Department, adding to their own daily workload. They felt that a predetermined system had been thrust upon them. These results agree with those of Moser and Bailey (1997), who found that additional workload from the quality management system and the opposition to bureaucratic management impeded QMS implementation.

Indeed, all the top management respondents were convinced that a quality system and JCI accreditation could not be forced onto the employees against their will.

Another group of administrative staff explained that JCI standards were nothing but unnecessary paperwork. These administrators were not happy about the requirements of documenting the job description in each staff personnel file and performing an annual

performance appraisal, as well collecting data related to their departmental performance indicators. The TM interviewees explained that this was one of the reasons for not being very enthusiastic initially about being involved in the implementation process. The researcher feels that this state of affairs arises from a lack of awareness of the process and lack of appropriate training for all categories of staff about the process and the need to implement a quality system in the organisations, as well as the benefits of achieving accreditation.

#### **5.1.4 Involvement of employees in the implementation process**

The involvement of employees in the accreditation process enhances their ability and willingness to improve their ways of working. This finding is supported by researchers who state that employees with high job involvement are more concerned about their jobs and performance, and will therefore seek ways to improve their performance by implementing the TQM principles. In their study of Malaysian companies, Ab Rahman and Tannock (2005) conclude that TQM cannot be successfully introduced or practiced unless staff at all levels are informed and committed. They state that every employee should understand company policy, vision, standards and procedures.

It appears from the responses in both case studies that the involvement of staff, especially physicians, was improved at a later stage of the accreditation process. At the outset, JCI teams were formed to prepare for the accreditation award, but not all the staff concerned, especially physicians, were involved or interested in joining these teams. The JCI teams were developed, structured and managed by the quality departments in the two hospitals. Case study B found lower levels of involvement of staff, especially among physicians, as highlighted by the leaders of the hospital. The reason for this lack of involvement was the physician's busy schedule and the fact that the quality staff did most of the work related to accreditation. This finding is supported by Huq (1996), who concludes that lack of physician involvement in implementing TQM is related in many hospitals to the communication gap and to the busy schedule of physicians; furthermore, the system in most hospitals is biased to meet physicians' wishes, so it is unsurprising that doctors do not feel obligated to comply with a programme that they have not initiated.

Some physicians in both case studies told the researcher that they were not very much involved in the accreditation process because the whole process was managed and

controlled centrally by the quality departments of the respective hospitals. This centralisation inhibited the involvement of different staff in the accreditation process. This finding is similar to that of Amar and Zain (2002), who conclude from a study conducted in an Islamic country that centralised decision making inhibits the implementation of new standards. Additionally, responses in the two case studies indicate that the involvement of the staff in teamwork, decision making and solving problems was not adequate because these tasks need more skilful and knowledgeable employees.

Respondents among the nursing staff in both case studies were much better involved in the process of accreditation because of the support of their leaders and managers, who encouraged them to be part of the process and to use accreditation as a tool to improve their work. Thus, it can be inferred that there was better involvement in the accreditation process among nurses in comparison to medical staff. This finding is in contrast with that of Dory and Lewis (2002), who assert that QM will be successful if the whole organisation becomes involved, and of Ashire *et al.* (1996), who identify several factors in favour of employee involvement: the extent to which quality teams and cross-functional teams are used, and encouragement for employees to make suggestions and to implement them. But the findings of the present study are similar to those of other studies in Islamic countries, by Awan and Bhatti (2003) and Amar and Zain (2002), and in Western countries, by Dickenson *et al.* (2000) and Claver *et al.* (2000), who report lack of employee involvement as a barrier to the implementation of new standards.

As was highlighted by the medical directors of both hospitals, feedback from the JCI consultants and the presentation of information about the compliance of every medical department with the requirements of the standards were considered to be very important motivators of involvement in the process. This finding is supported by Godfrey (1999), who found that one of the critical factors in the development of a quality management environment for pathology services was the emphasis placed by the pathology project TQM team on continually providing feedback to staff. Feedback in the form of process reports and minutes of meetings was regarded as important in ensuring cooperation and continued participation in the change process. Keeping staff informed of the quality improvement efforts also greatly minimised resistance to the proposed changes.

While the involvement of all staff in the organisation is very important in implementing a quality system and achieving accreditation, the involvement of physicians was particularly critical and indeed essential, because physicians are the healthcare team leaders and role models for other healthcare providers who support and believe in the scientific approach. Both case studies found that the process of implementing the JCI standards was improved and that the involvement of all staff was significant after physicians became involved in the process. Physicians may participate more enthusiastically if they realise that the focus of TQM activities is not on them but on systemic issues that cause variation. John (1997) found that the involvement of physicians appeared to be the most important single factor in the successful implementation of TQM programmes in hospitals and one of the most difficult challenges. A hospital quality strategy has to use different methods to ensure that physician managers understand and lead the quality programme, with due regard to professional sensitivities. This did include physicians in formal positions, as well as respected and influential physician “opinion-formers”. Methods to ensure that all physicians are involved in the programme include training, educational activities, incentives and motivation.

#### **5.1.5 Human resource issues**

According to interview responses and other sources of data such as the minutes of meetings of the Human Resource Department with other departments in both case studies, most of the human resource practices did not support the implementation of JCI standards. Some other data reviewed included documents related to the interpretation of the new human resource law. Several interviewees from different categories mentioned that human resource issues had had a negative impact on staff morale and on the process of implementing the JCI standards.

One of the unique findings of this study was that the expatriate staff members were demotivated regarding JCI implementation after the Human Resource Department of the DOHMS implemented a new human resource law which differentiated between UAE nationals and all expatriate staff, including Westerners, in terms of payment and compensation. Under this law, UAE nationals are entitled to higher salaries and better compensation for the same job.

Clearly, the majority of expatriate staff members were not happy with this new law and were not motivated to work on hospital initiatives after it was approved and implemented. Many wondered why their local colleagues were paid more than them for the same work in the same department, while in some situations the expatriate staff were better qualified and more experienced. This was confirmed by the Director of Clinical Support Services, who stated that the Human Resource Department had played a negative role in regard to staff motivation when implementing the JCI standards:

*“The negative impact of this new law would be less if it was implemented and interpreted in a better way by the Human Resource Department”.*

This issue of compensating the national staff more generously than expatriates with the same qualifications for the same work in the same department is a unique finding of this study. It is not reported in the existing literature, either globally or locally in the UAE, nor has it been researched before. Hence, further in-depth research is highly recommended in order to better understand this phenomenon.

Another interesting finding in regard to human resource practices is that many staff members in both case studies, especially in the nursing departments, were encouraged by their managers to become involved in the accreditation process by focusing on different ways of motivating them. As mentioned in the findings chapter, section 4.1.5, 98% of the nursing staff in the hospitals are expatriates, who comprise almost half of all hospital staff. The nursing leaders focused on the personal experience and the unique exposure to the accreditation process that the staff would gain to promote their motivation and maintain their positive morale. The nursing staff certainly responded positively to these motivators: the nursing leaders and managers affirmed that it was very important for the nurses to have this special experience in preparing their hospital for accreditation, because most would leave the hospital after a few years of experience to work and live in the United Kingdom or the United States. This exposure was thus a very good opportunity for career development and professional growth. They would leave the UAE hospitals because salaries and benefits were much better in Western countries and they felt more secure in terms of work and family.

The leaders in both hospitals accepted the fact of high turnover among nursing staff, because the human resource rules and regulations did not support staff retention; thus, they knew at the time of recruitment that nurses would leave after a few years to seek better opportunities abroad. This issue is tackled by Holton and Baldwin (2003), who

report that in many organisations employees are treated as consumable resources to be used and disposed of as the organisation sees fit. As a result of this approach, many of an organisation's best people leave, seeking opportunities for growth, development and appreciation elsewhere. Holton and Baldwin (2003) argue that in order to overcome this problem, organisations need to create a developmental culture within their human resource practices which will affect their improvement and change. This is supported by Yang (2006), who conducted a study into the impact of human resource practices on the implementation of total quality management and found that human resource management significantly affects TQM practices, concluding that human resource practices played a key role in the implementation process of total quality management. According to Yang, the practices of training and education, incentive compensation and employee development produced the greatest influences on TQM implementation. He adds that successful implementation of TQM can lead to an increase in customer satisfaction, to the benefit of the corporate image.

Another significant unique finding of this study in regard to human resource issues is that there are certain positions which can be held by national staff only, as per the instruction of the higher authority of the DOHMS, to promote localisation. One of these positions is that of the ward clerk, who is usually responsible for organising and managing the medical records of patients in a clinical unit. Indeed, this position may have an impact on quality and patient safety, if the person selected to work in this position is not qualified to deal with patients' medical records and prepare lists of patients for operations or medical procedures. Many of the managers interviewed in both hospitals confirmed that most of the ward clerks were not adequately qualified and in some situations were unfamiliar with medical language, which might affect patient safety. The researcher confirmed that the medical English used in the records of the ward clerks was very poor. The researcher reviewed many documents and found many spelling and grammatical mistakes in these records. Moreover, the medical terminology used by doctors and nurses demands clerical staff with a good ability to speak and write English. This is a very significant patient safety issue, because mistakes in spelling or grammar or both may lead to very bad consequences related to patient treatment plans and in some situations to serious medical errors.

In CSA the Director of Finance and Administration stated that in order for UAE nationals to assume the required roles, some nationals had had to be recruited without



taking into consideration their education and skills. This issue of human resource practice in relation to the qualification of national staff in medical English is a unique finding that requires further investigation. However, some other Arab researchers have found that organisational bureaucracy and political structures lead to inappropriate recruitment of national staff; for example, Sharif (2005) found that the political structure of Libyan organisations resulted in overstaffing (featherbedding) among an unskilled Libyan workforce because of the policies imposed by the government to reduce the unemployment rate. This is confirmed by Al-Haj (2006), who reports that UAE nationals are inappropriately selected and are in the wrong positions due to poor recruitment. For example, the top management of the Sharja Electricity and Water Authority retained unskilled UAE nationals on very large salaries, while expatriates did more work for less pay. Al-Haj (2006) refers to this inappropriate selection in recruiting national staff by the Arabic word *wasta*, denoting the influence of personal relationships. Glover and Siu (2000) also point out that this featherbedding system can help to avoid unemployment but makes organisations overstaffed.

#### **5.1.6 Training**

One of the important requirements of the JCI standards is that organisations should provide training to all categories of staff according to their learning needs. However, the researcher noticed that most of the findings regarding training issues were related to the fact that the majority of the training was provided for the national staff. The heads and managers were trying to find other ways to train the expatriate staff. While most of the interviewees agreed that the training was necessary to promote the JCI accreditation process, they considered that in some situations the process of training had a negative impact on motivating the expatriate staff, because the training was not delivered according to their learning needs.

Many leaders and managers in different departments confirmed this finding. One of the directors in CSB said that most of the training was organized for national staff, while expatriates were involved in the JCI accreditation process equally or perhaps more. Some of the managers in both case studies said that they had designed some departmental training activities to ensure that all the expatriate staff were involved in the training process and empowered to achieve JCI accreditation. These managers used the concept of 'train the trainers' to ensure that the training was organisation-wide and comprehensive.

The training of employees based on their nationalities and not their learning needs is very dangerous in a healthcare organisation. The health team members, including doctors, nurses, pharmacists, nutritionists, physiotherapists, respiratory therapist, speech therapists and sometimes managers, work together to provide safe, high quality care to patients, but it will certainly not be safe if some of these categories of staff are not trained in certain competencies related to their duties, just because they are not of UAE nationality. This finding, that healthcare providers are not fully trained to meet their learning needs because they are not nationals, is unique to the present study. Some researchers outside the healthcare sector have, however, reported a bias in training based on staff nationalities. Al-Khalifa and Aspinwall (2000) found poor human resource management, training programmes regarding quality management systems and promotion based on nationality rather than qualifications in Qatari organisations. The nationality-based training in healthcare organisations is a very significant patient safety issue that requires further study to identify the consequences of insufficient training of expatriate staff for their performance and the impact on patient care and safety.

Another issue to be addressed in training is that of language. Although the JCI standards were implemented in both cases using English, there were some local employees whose reading, speaking and writing of English was inadequate, which was a real obstacle to implementing the system. Some employees did not admit to their poor level of English and insisted on attending training; the outcome was that the objectives of the training were not met, which made the implementation of JCI more challenging. The researcher recommends establishing an in-house English language learning centre and that all employees be made to take English language courses where necessary.

Another finding of this study related to training is that the human resource departments did not have comprehensive and mature training plans based on staff learning needs to enable employees to do their job better. While some departments had developed plans to provide training in JCI standards and quality-related issues, training plans based on individual staff needs were not consistently available. The researcher feels that the reason for this immaturity of training plans is related to the overall immaturity of the entire QMS, which respondents said they had just started to adopt in their organisations. Moreover, the researcher found that in both case studies there was much more training conducted by the quality departments on the JCI standards and on the principles of quality management in comparison to the relative paucity of job-related training. The

JCI standards require a clear plan for training according to the actual training needs of each department.

This finding is consistent with the work of Zairi (1996), who reports that many Middle Eastern countries put more emphasis on quality management system certification than on any other quality initiative. These were not surprising findings, since the quality movement in the Arab world has a short history and has had very little success.

#### **5.1.7 Cultural issues**

One of the main findings of case study A in regard to cultural issues is the variation in cultural background among staff, notably between the Western staff who were recruited through the management team of the Emergency Department and the local staff who had worked at the hospital for a long time. The work values and beliefs of Western staff who were recruited during the accreditation process were very different from those of the existing local staff. One of the senior Westerners confirmed that he had faced many challenges in adapting to the current working culture of the organisation. The most significant issue in this regard was that some doctors and nurses, as well as administrators, worked together in the same department but reported to different managers. Staff members who were recruited by the outsourced management team reported to the leadership of this team, while the other staff reported to the hospital managers and leaders.

Indeed, having staff of the same department and same speciality reporting to different managers, although they had the same title and position, created a lack of clarity. Some of the staff reported to the management team of the company that ran these departments, while others reported to the hospital management. This situation caused confusion among staff during the implementation of policies and procedures and during the preparation for the JCI accreditation process. The priorities among the staff of the management team was to ensure the availability of resources to meet the requirements of their contract with the DOHMS, which created some conflict with hospital managers and leaders when they started the process of implementing the JCI standards. Most of the staff members of the outsourced management team were Westerners and were very serious at work, focusing on customer needs and expectations, and showing enthusiasm to meet their managers' expectations in terms of completing the assignments on time and attending meetings on time. This is another unique finding of the present study, that

having staff with the same title in the same department reporting to different managers led to confusion among the staff.

Departmental and unit heads felt that some of the UAE national employees were not very serious about their jobs and their careers, preferring to spend most of their time in the office maintaining their good relations over a cup of tea or coffee or on the phone. This situation created frustration for employees who took their work seriously and were concerned to meet the hospital's mission and objectives while addressing customer needs and expectations. This is a unique situation in healthcare organisations, where two different sets of working values and attitudes exist in the same organisation or even the same department. The researcher observed during the process of conducting the interviews that customers were waiting for medical reports, while the staff concerned were not keen to respond promptly to their requests.

The researcher was informed by many managers that in many situations such medical reports are almost ready but waiting for input from a local member of staff to release them to the customer concerned. These managers added that in some other situations this delay and lack of commitment to work on the part of some of the national staff had a direct negative impact on patient safety. This barrier, of having different work values and attitudes among staff of the same department in the hospital, is unique to this research and has not been discussed before in the literature.

The researcher found that the direct managers and leaders were very reluctant to take decisions to replace, transfer or discipline any UAE staff when the need arose, because the culture and the rules did not support them. The researcher was informed by many of the top and middle managers in both case studies that it was very easy to take any decision related to one of the expatriate staff, but that the situation was very complicated in regard to national staff. They added that in case of expatriate staff the direct manager could take such a decision easily, while for the national staff the Director-General of the Dubai Department of Health and Medical Services would have to approve the decision. This situation certainly leads to a lack of empowerment for managers and may encourage poor work commitment among national staff. This is one of the reasons why there are many national staff in their current positions due to system and process related issues, which is very dangerous and may jeopardise patient safety. This issue of having double standards related to managing and leading staff in

healthcare organisations based on their nationalities is considered to be one of the significant findings of the case studies related to cultural and human resource issues. This finding is unique to this research and may require further investigation.

Another finding of both of the case studies in regard to cultural issues is related to the bureaucratic style of management at the head office. The decision making in the central departments which report to the head office was centralised within the departments and most of the work done by departments was paper based. These documents were shifted from table to table of various departments, so that final authorisation and decision making were very slow; indeed, in some situations papers were lost. Claver *et al.* (2000) report similar findings and state that a bureaucratic culture causes many problems for organisations, such as lack of employee involvement, insufficient investment in technology, hierarchical levels, inappropriate planning, inappropriate business alliances and not being able to adapt to the market. Awan and Bhatti (2003) also found that the lack of a quality culture, centralised decision making and high turnover were inhibiting factors to starting the QMS process in Pakistan. The director of hospital A mentioned that the Engineering, Purchasing and Human Resource departments reported to the head office of DOHMS. The most important challenge related to these departments was the imposition of too much paperwork and heavy bureaucracy, causing slowness in the decision-making process. This was confirmed by some other managers in CSB, who asserted that the reason for this bureaucratic approach to decision making was that most people in leadership positions at the DOHMS were national staff who were very relaxed at work and had little commitment to quality and improvement.

Al-Khalifa and Aspinwall (2000) explored the bureaucratic culture prevalent in Qatari organisations. Cultural change and employee resistance to change were the major cultural obstacles encountered in implementing QMS standards in Qatar. This element of bureaucracy was very much evident in the style of management of the DOHMS-related departments, as mentioned above in this section. The researcher understands the similarities between Qatar and UAE, as two GCC countries, which may lead to similarities in their organisational cultures. Many managers in both case studies emphasised the need for effective training programmes, more job awareness, quality orientation, internal workshops and quality reviews, which they said were not facilitated by the TM.

MM and TM interviewees in both case studies agreed on the existence of bias based on the nationality and origin of employees. One manager explained that employees at the same grade in the same departments were paid different salaries according to nationality and culture. Other managers also complained that employees of different nationalities were given different allowances and gratuities based on their culture and background. When the grading system and salary scales were reviewed by the researcher as part of the documentation review, he found evidence of a great deal of subjectivity in interpreting the system. MM and TM interviewees agreed that this bias had a significant negative impact on employees' involvement in and support for the accreditation process.

Support for this finding is provided by Al-Kazemi and Ali (2002), who found that Kuwaiti nationals lacked technical competence, proper work values and career orientation. They conclude that Kuwait was heavily reliant on imported, ready-made human capital of all types and skills to run and manage most of the technological and sophisticated operations, while Kuwaiti men preferred to work for state enterprises, which provided flexible compensation packages with high job security but less demanding work. This situation is very similar to the environment observed in the case studies, where there was also an unequal distribution of work to employees: expatriates were given more work than UAE nationals, leaving the latter time to look after their own businesses and social lives. This result was triangulated by reviewing a number of medical procedures and operations, as well as some administrative jobs, where the researcher discovered that the majority of work in both case studies was carried out by expatriate staff. This supports the assertion that the expatriate staff should be included in the training, as they were involved in doing a majority of the work.

It was explained by many interviewees that discrimination existed in the form of biased employment decisions, treatment or behaviour based on prejudice against a group because of their race, national origin, gender, age or disability, which affected the system in such a way that employees were demotivated and unwilling to perform better in their jobs; therefore no continuous improvement could be achieved.

Moreover, managers stated that in some situations certain staff did not report incidents, patients' problems, or sometimes medical errors, when the staff member involved was of the same nationality. This was confirmed by one of the frontline staff, who did not

feel able to report a medical error because the colleague involved was of the same nationality as him. The researcher strongly believes that this is a very serious issue where patient safety is affected by staff nationality. The leadership should tackle this situation and review the whole process in relation to equal treatment of all their staff based on performance in order to promote patient safety. This finding, that discrimination among hospital employees may have a negative impact on patient safety and the reporting improvement opportunities, was unique to this research; this issue has not been discussed in the reviewed literature.

#### **5.1.8 Sharing data and information**

The responses given in case study A indicated that an information system based on good technology had been implemented to make the necessary data and information accessible across the hospital to provide better patient care. The main aim was to ease the gathering, recording and sharing of information among all healthcare providers to ensure that all were able to access the information required to provide good, safe and high quality care to their patients.

The Hospital Director interviewed in CSA emphasised the importance of information technology in supporting patient care and meeting international standards. He said that he had invested in establishing a dedicated health information unit to make sure that all healthcare providers had access to the information they needed without significant challenges. In CSB, hospital leaders said that they had decided to use information technology to design the process of documenting patient information in an accurate and comprehensive manner while maintaining patient confidentiality. However, some managers in both case studies reported facing challenges in implementing their electronic pharmacy systems for ordering and administering medication, because they were not fully compatible with the hospitals' health information systems and were not designed to support mistake proofing. These systems had been purchased by the Pharmacy Department without involvement of others. Many challenges related to the health information system could be avoided if the doctors, nurses and healthcare providers were involved in the purchasing and selection process.

This finding is supported in the literature by many authors; for example, John (1997) found that the involvement of physicians appeared to be the most important single factor in the successful implementation of a TQM programme in hospitals and one of

the most difficult challenges. Huq (1996) supports the involvement of staff and physicians in decisions related to their work in hospitals as an effective problem-solving strategy, asserting that most effective problem solving will occur when the people who own the process are given the responsibility to recommend and implement changes. This includes physicians, nurses and staff level employees. As noted in the literature review chapter, section 2.6.5, Huq (1996) considers that a lack of physician involvement in implementing TQM is related in many hospitals to a communication gap, to the busy schedules of physicians and to the fact that the system in most hospitals is biased to meet physicians' wishes, so that doctors unsurprisingly do not feel obligated to comply with a programme that was not initiated by them.

One of the challenges related to information technology was identified in CSA by frontline staff in the surgical intensive care unit (SICU). They complained that the information technology system which they used in the SICU was not compatible with other systems in the hospital, which led to much frustration whenever a patient was transferred to another department, because of the duplication of work required at the time of transfer. Nurses were required to print out from the computer the entire documentation related to the patient concerned at the time of transfer to another department, because the healthcare providers there would not have access to the SICU health information system. This was considered a duplication of work for the nurses and doctors in the SICU. The researcher concluded that the health information system needed a proper review, evaluation and phased implementation so that regular day-to-day work would not be affected by training and implementation. This view is supported by the finding of Proudlove and Boaden (2005) that the effective management of the components of the patient journey requires integration to use the information system in improving in-patient flow in hospitals. Similarly, Sanders and Premus (2002) argue that information systems should support the integration of inter-organisational processes. Hammer and Champy (2001) and Ross (1999) show that IT investment can have a positive impact on organisational performance as a result of better coordination in the value chain. However, putting such a high level of collaboration into practice is not easy. Both information quality and relationship commitment play important roles.

The leadership discussed their plans regarding the role of electronic documentation and data management in improving the quality of documents and the speed of work, providing better financial controls and communication, and simpler access to common



data. However, the benefits of IT come at a cost, since the costs of doing business and the complexity of work, especially in healthcare organisations, have increased. The continual demand for upgrading and the greater know-how required are considered important challenges. The principal reasons for this have been a lack of agreed national standards, a failure of systems designers to examine the needs of users adequately, lack of end-user involvement and the profusion of different systems that do not communicate with each other. The delays in fixing the systems, including software and hardware needs analysis, the phasing and planned implementations of the IT systems, were identified as some of the major barriers to achieving organisational objectives.

This is consistent with some studies in the literature, such as that of Sila and Ebrahimpour (2003) on the critical factors affecting the implementation of TQM in Italy, Spain, Canada, UK and Qatar, which showed that process measurement, sharing quality information, quality data feedback and management by fact were very significant for the successful implementation of TQM.

One example given in CSA in relation to lack of systems communication was that the staff concerned were not able to retrieve key performance indicator (KPI) data required by JCI standards directly from the health information system, because the latter did not communicate with the KPI information system. The appropriate software was not available in the hospital to support the analysis of these data and to produce the required information in an efficient manner. This was seen as one of the challenges in providing the right information and data to the right staff in the hospital.

#### **5.1.9 Planning and working on more than one project at the same time**

The majority of respondents in both case studies reported that during the preparation for the JCI accreditation their organisation was working on more than one major project, for example, renovation of old units in the hospital, commissioning new departments in the trauma centre and introducing major pharmacy and radiology electronic projects. Several TM and MM interviewees identified working on more than one major project while preparing to apply JCI standards as one of the major challenges to gaining accreditation, because this situation led to a poor understanding of the hospital's vision and planning process. Moreover, working on more than one major project at the same time had a negative impact on the coordination and cooperation between some of the departments in the hospital, due to differences in their priorities.

It is necessary to develop a common understanding among managers and employees about the organisation's vision, planning and prioritization processes: the vision and planning process will guide the actions that should be taken in the organisation in a prioritised way. The importance of a clear vision and plan for the staff of an organisation while implementing quality systems is outlined by Campbell (1995), Mostafa (2004) and Hoffman (2002).

The researcher noticed that coordination and cooperation between the Trauma Department and other parts of hospital A was low. This was evidenced by the extent of communication between their staff and by information collected during the interviews. This lack of coordination was due to the differences in staff priorities across the hospital. The researcher was informed by the trauma centre staff that the main priority of the departmental staff was to ensure the availability of all equipment and resources required to maintain the commissioning of this new department, while the MM interviewees appeared more concerned with implementing the quality system and achieving the JCI standards as the priority for the hospital during the implementation of the programme. This difference in priorities between the trauma centre staff and others in the hospital had a negative impact on the relationship between the departments. The importance of coordination, cooperation and good relations between departments is addressed by many authors; for example, Ngai and Cheng (1997) and Amar and Zain (2002) consider interdepartmental relations one of the most important factors in the successful implementation of TQM in organisations.

One of the unique findings of this research in relation to future planning and working on more than one major project at the same time concerns the utilization of the budget of one project to support the other. In CSA the Hospital Director stated that he had managed to cover the cost of the accreditation process by using some of the budget allocated for renovating the old inpatients' units. He did so because of a budget shortfall in the last few months before the end of the accreditation project, which meant that he might not achieve accreditation on time. He said:

*"I can always get financial support from the top management at headquarters for renovating the old patient's units but I can't easily do the same to support the requirements for supporting the implementation of JCI standards".*

This lack of continuous financial support by top management at the headquarters is evidence of a lack of commitment from their side to support the implementation of the

JCI standards consistently. The Director of hospital A used some of the financial resources of other projects because he was committed to achieving JCI accreditation on time. The researcher suggests further study of this unique finding, which is not mentioned in the literature reviewed for this study.

#### **5.1.10 Communication**

The top management in both case study organisations believed that communication was the backbone component to promote the culture of quality and safety in their hospitals. Respondents in all three categories and both case studies referred to the existence of many activities and initiatives to improve all aspects of communication in the two organisations. These efforts included regular departmental and interdepartmental meetings, bimonthly quality newsletters to promote the quality improvement initiatives, and hour-long weekly open meetings for all concerned staff to discuss issues related to quality and accreditation. It was implied that there was a significant effort from the leadership of the two hospitals to promote good communication, but respondents identified many areas for improvement regarding communication, such as a lack of feedback during communication and a failure to ensure common understanding between all parties. This lack of common understanding had a negative impact on the quality of healthcare services and it may have affected patient safety in some situations.

Reason and Hobbs (2003) indicate that addressing coordination problems such as misunderstandings, poor teamwork or communication is very important to promote the implementation of quality systems. In many cases, coordination breaks down when people make unspoken assumptions about a job and fail to communicate with one another to confirm the situation.

Sila and Ebrahimpour (2003) found that communication played an important role in the successful implementation of TQM. They demonstrated the importance of effective communication across functions and work units to ensure that customer requirements were addressed and that an environment of trust and knowledge sharing was created, leading to common understanding across functions.

One of the significant findings in CSA in relation to communication concerns the regular weekly meeting for all hospital staff to discuss issues related to quality and patient safety. The Director of the hospital said:

*“One of the very effective tools that we used to promote communication among the staff in general and during the JCI accreditation in particular was the one hour general staff meeting for all hospital staff every Thursday”.*

The majority of respondents mentioned that this regular Thursday meeting had played a significant role in keeping them and their staff updated about the progress of the hospital toward achieving JCI accreditation. This finding is supported by Al-Khalifa, (2000) who considers regular and effective communication to be necessary for all phases of the change process. Many of the top management interviewees spoke of the impact of the Quality Department's role in promoting good and effective communication among the staff regarding the implementation of the JCI standards. The Director of Clinical Support Services considered that the JCI campaign which was organised during the implementation was a very good tool to promote communication among all hospital staff and to emphasise the understanding of the requirements of the standards. This is consistent with the findings of Henderson *et al.* (1999), Al-Khalifa and Aspinwall (2000) and Pupius (2002), concerning the importance of effective during the implementation of quality systems or other similar changes.

Another important point regarding communication in both case studies was that the health informatics units used information technology to facilitate and improve communication among hospital staff during implementation. Hospital intranets were used in both cases to communicate all the relevant policies, procedures and plans to the hospital staff. The heads of quality in both hospitals uploaded question-and-answer materials to the intranet to facilitate staff readiness and their understanding of the JCI requirements. Some frontline employees considered that the bimonthly intranet newsletter was a very effective and efficient tool to improve their awareness and knowledge of the JCI accreditation process, because it kept them up to date with its progress. Managers also used the intranet to obtain quick and regular access to information in relation to JCI requirements. This finding is consistent with the work of many authors who have stated that information technology is very important in promoting communication during quality system implementation (e.g. Mjema and Mweta, 2003; Cholasuke *et al.*, 2004).

Most of the medical, nursing and other healthcare providers from different categories interviewed during the case studies referred to facing a major challenge in complying with the documentation requirements of the JCI standards. One of the medical staff in

CSA reported that most doctors felt more comfortable relying on oral communication and spoken orders rather than written communications or orders to nurses or other staff members. Some other doctors found that meeting the requirements of documentation in the medical records of patients was the most serious challenge for the hospital in meeting the JCI standards. The researcher understood that it was part of the culture in both case study organisations that telephone communication was considered normal practice.

#### **5.1.11 Time**

TM and MM interviewees stated that a shortage of time was one of the challenging factors during the JCI accreditation process, because the contract between DOHMS and the JCI specified that the two hospitals had to complete the project within eighteen months. The timeframe of the contract was decided following advice from the Dubai Government, whose strategic plan emphasised the need to provide public and private healthcare services in Dubai at an international standard. This timeframe was supported by JCI consultants, but some TM and MM respondents in case study A considered it unrealistic because the leaders of the hospital were working on more than one major project at the same time, as noted above. The Director of hospital A said:

*“If I had know the challenges related to implementing the JCI standards I could have postponed some of the major projects that we worked on during the implementation process, [such as] renovation of old units and the implementation of an electronic pharmacy system. [...] Our hospital is big, busy and complex in terms of patient’s cases that we treat after significant traumas and injuries. I think we were in need of more time to achieve proper implementation of the JCI standards and to receive accreditation in the best way possible with less challenges”.*

The Director of Nursing in CSA considered that the timeframe was one of the significant challenges in relation to implementing the JCI standards:

*“A few weeks before the accreditation survey, we worked very hard and we assigned two nursing staff on a full-time basis to complete the verification process of the nurses’ certificates as the outsourcing company assigned to perform the primary source verification for the healthcare providers failed to do it according to the planned timeframe”.*

On the other hand, she felt that the challenging timeframe for such a large hospital had motivated the teams to work very hard to achieve accreditation on time.

Stevenson and Barnes (2001) identify a similar barrier and add that it usually takes from about a year to two years to become certified, depending on the organisation's size, current level of work quality, extent of current documentation, complexity of production process and management commitment. Sharp *et al.* (2003) found that a failure to allow sufficient time for evolution was a barrier to successful implementation of ISO 9001 (2000) by organisations in the UK. Following the work of many authors, the researcher concluded that the implementation period of any quality system, including JCI, should be sufficient to cover all aspects of work in each department.

Several TM and MM interviewees felt that the lifestyle of UAE nationals and expatriates had a real impact on the JCI accreditation process, especially during summer holidays and Ramadan. During the months of June, July and August most non-national staff leave for annual holidays abroad and the documents reviewed indicate a fall of more than 35% in admissions during summer and school holidays, when many expatriate residents of Dubai return to their home countries. This situation had a significant impact on the implementation of JCI standards, as most of the work was frozen or very slow during the summer holidays. An interviewee from the Quality Department said:

*"Most of the JCI committees did not meet regularly in summer, because some of the key members were on their annual holidays. This was a big challenge for us to meet the JCI requirements and to achieve accreditation on time".*

This reduced pace of work to implement the quality system for three months due to staff holidays is a factor unique to this research and is not reported in the literature.

Many TM, MM and frontline interviewees also identified Ramadan as another lifestyle and time-related factor affecting implementation, as fasting during the day and eating and praying at night reduces the working day from eight and a half to five hours. The Director of hospital A said:

*"The lack of work production and progress in relation to the preparation for the JCI during the month of Ramadan was one of the big challenges. The situation was very difficult because Ramadan happened to be immediately*

*after the summer holidays and our JCI accreditation survey date happened to be one month after Ramadan”.*

His counterpart at hospital B reported that this had been considered in advance:

*“We managed very well to achieve our survey and finish all our preparation before the month of Ramadan because we knew that the production and performance of staff in relation to work during this holy month is very low, because they fast in the daytime and pray at night”.*

Again, this reduction in the amount of work and a decline in performance in relation to implementing the quality system is a factor unique to this research and does not appear to be reported in the literature.

#### **5.1.12 The cost of accreditation**

According to the finance and administration directors in both case studies, the cost of the JCI accreditation process was closely related to the infrastructure of the two hospitals when they started their JCI accreditation process. The high cost of accreditation was generated in CSA by safety requirements, consultants’ fees and the cost of upgrading the infrastructure to meet international standards. For CSB, most of the cost was related to consultants’ fees, training and the engineering requirements of controlled negative pressure for isolation rooms. Interviewees in both case studies also mentioned logistical support for consultants and JCI surveyors, including travel and accommodation.

The directors of finance and administration in both case studies agreed that the challenge regarding the cost was to obtain funding on time from the DOHMS; however, the budget and financial support were available and approved by the Director General, so this was not an issue. On many occasions, requests for financial support for the accreditation process in both hospitals were approved but the release of money was slow because of heavy bureaucracy and delays in the decision-making process, as discussed in section 4.1.1.2. TM interviewees in CSA explained that they did not have the authority to make decisions on purchases very freely to meet the JCI requirements, because of the central control and difficulties of bureaucratic procedures. However, they were sometimes able to overcome that difficulty by communicating directly with the Director General of DOHMS or by finding alternative ways to meet JCI requirements.

Otherwise, the headquarters department concerned would be blamed by the hospital. The Hospital Director in CSA said:

*“Money is not a problem in our country for any project supported by the government. The problem sometimes is to get the money on time. I managed to arrange for the financial support to achieve the JCI accreditation through saving part of the hospital budget for the JCI accreditation cost”.*

The researcher verified by reviewing some documents that the important upgrading of the fire alarm system in hospital A was held up by a delay in the approval process for financial resources. As mentioned by many leaders and managers in both case studies, the cost of accreditation was relatively high, but it was emphasised that the significant challenge was to receive financial support on time.

The unavailability of qualified local people who could act as JCI consultants in preparing hospitals for accreditation added to the cost; the finance and administration directors in both case studies mentioned that most of the high cost was related to the consultants' expenses. This is consistent with findings of authors in other countries, such as Al-Haj (2006), Mostafa (2004), Fuentes *et al.* (2000) and Dickenson *et al.* (2000). However, in the two case studies the cost was not found to be an issue, while receiving the money on time was an issue, as clearly stated by the Director of hospital A.

#### **5.1.13 Resistance to change**

There was broad agreement among interviewees in both case studies that resistance to change at all levels of staff was particularly obvious at the beginning of the process. This was related to lack of information and awareness regarding the nature of the accreditation process. Later, however, any remaining resistance to change was related to human resource practices, culture, differences in priorities among departments, and staff motivation and morale. The director of hospital B said:

*“At the beginning of the process we had significant resistance from doctors, administrators and some of the nurses, because they believed that the process of implementing the new quality system in the hospital was going to increase the load of work on them. Doctors resisted the comprehensive documentation in the patients' medical records, nurses resisted reviewing and implementing*



*the new policies and procedures, and administrators resisted attending new training sessions at the beginning of implementing the JCI standards".*

Most TM interviewees in CSB emphasised that due to resistance from doctors, administrators and some other staff to implementation of the JCI standards, the leadership of the hospital supported the role of the Quality Department in developing policies, procedures, plans and other documents on behalf of those resisting departments. The head of the Quality Department in CSB said:

*"We developed ourselves in the Quality Department all the documents required to build the new quality system, because doctors, administrators and other health care providers did not have the time to do it, which made them resist this process at the beginning, due to the work associated with developing the system. At a later stage of the process the resistance to this change was very much less because of the good results that we had after we started the process of implementing the standards."*

It can be inferred that the management of hospital B wished all quality work to be carried out through the Quality Department and for employees to rely on it to take responsibility for quality. This indicates a lack of awareness by top management of the practicalities of implementing a quality system. McFadden *et al.* (2006) suggest that one of the possible actions to improve TQM implementation is by increasing leadership support and improving the empowerment and recognition of their staff.

The training of all staff was a challenge, because they were not involved in developing the required documents earlier in the process and because the Quality Department did some of the work on their behalf. Quality professionals in organisations can act as a resource for developing policies, procedures and documents for different departments, but not to develop these for them, because the staff members concerned in each department are most knowledgeable about their own work processes. On the other hand, involving different departments' staff in the preparation process will minimise the level of resistance and promote the ownership of the process.

The study has identified reasons for some of the departmental heads and middle managers not accepting the implementation of JCI standards. In CSA the leaders of the management team of the trauma centre stated that the hospital's priority should not be

JCI implementation but the availability of all items, equipment and medical consumables required to facilitate the opening of appropriate new departments in the hospital and so to ensure quality and patient safety. Some managers in CSB felt that the hospital was running satisfactory and that implementation of the new standard required significant changes in the entire organisation, obliging them to take new responsibilities and perform additional tasks. The managers were relatively happy with the existing organisational system and saw no need for changes. Some members of staff perceived the implementation of a new quality system as a tool for improving the service in general and to improve patient satisfaction, quality and safety, while some others saw it as a tool adopted by management for monitoring them, which caused resistance to change. For their part, managers treated the system as a quality improvement tool to promote quality and patient safety.

The researcher found in both case studies that some groups supported the implementation of JCI standards and others did not. The former had participated in the established accreditation teams, committees and plans to achieve accreditation, while those who resisted implementation from the beginning of the process complained about the additional responsibilities and tasks assigned, claiming that they could not fulfil JCI requirements because of their current workload. They felt that the work of implementing the JCI standards should be done by the Quality Department, because they were very busy treating patients and providing care for them. These results agree with those of Moser and Bailey (1997), who found that lack of employee motivation, resistance to change, additional workload from the quality management system and the opposition to bureaucratic management impeded QMS implementation.

It can be inferred that the employees wanted to escape from new responsibilities, despite quality being the responsibility of everybody in the hospital. Some employees were convinced that quality was not their responsibility, but that of the Quality Department. Employees avoided taking responsibility, which might give them trouble with other staff and more work without recognition. Extra work would mean people might have to learn more information or develop new knowledge and skills related to the implementation of the JCI standards. It was a kind of resistance to change. This finding is similar to those an Asian study by Glover and Siu (2000), who found that avoidance of responsibilities acted as resistance to change in Chinese organisations. Similar findings were made in Western countries by Fuentes *et al.* (2000), Tsim *et al.* (2002).

Moser and Bailey (1997) and McAdam (1996), who report that employees had a strong feeling of being controlled by the quality system and avoided undertaking more responsibility as the quality system required.

One of the significant and unique findings of the research in relation to resistance to change was that resistance to implementing the JCI standards was more obvious among national staff in comparison to expatriates in both case study organisations. This was confirmed by the directors of both hospitals, who stated that the nature of human resource process and DOHMS practices, as well as the status of nationals and expatriates in their hospitals made it easier for nationals to express their opinions openly and freely because the expatriate staff were more likely to follow the rules and regulations. A TM expatriate said in CSA:

*“In general expatriate staff members were more supporting of the process of implementing the JCI standards because they perceived the leadership instructions and initiatives more positively and strictly than the national staff usually do. The majority of the national staff members believe that because they are national, they are in a more appropriate position and status to decide what is good for them, for their hospitals and for their countries. [...] National staff are supported by the human resource processes and practices. For example, there are certain jobs assigned to national staff only, and in case of disciplinary action against a UAE national it has to be approved by the Director General of DOHMS, while for expatriate staff the line manager can take the disciplinary action.”*

This finding, that resistance to implementing the JCI standards was more obvious among national staff than expatriates in both case study organisations, was not found in the existing literature, either globally or locally in United Arab Emirates; nor has it been researched before. Hence, further in-depth research is highly recommended in order to better understand the situation.

The researcher found in some of the reviewed documents such as minutes of meetings and action plans that the leadership of both hospitals followed many strategies to minimise resistance to change. Some of these were:

- Hospital-wide newsletters to update the staff about the progress of the JCI implementation process.

- Regular meetings for all hospital staff with the leadership and quality coordinators in order to promote their involvement and to share with them the performance-related data of each department.
- Regular involvement of all the concerned medical, nursing and administrative staff.
- Communicating the new policies, procedures and plans via the hospital intranet.
- Producing booklets containing questions and answers about important issues in relation to the role of different staff members in the implementation of the JCI standards.
- Communicating with all staff some of the achievements and success stories as well as the positive feedback of the JCI consultants during their regular consultation visits.
- Continuous follow-up and being persistent in implementing the quality system by achieving JCI accreditation.
- Continuous evaluation of performance in relation to progress towards JCI implementation.
- Consistent training, orientation and knowledge transfer to employees.

Some of these strategies are supported by Raymond (2002), Paton and McCalman (2000), Ngai and Cheng (1997) and Campbell (1995), who explain that resistance to change can be overcome by effective communication, participation, teamwork and proper performance evaluation systems.

The following reasons for resisting change identified during the literature review were not found in the present research:

- Fear of the unknown: not understanding what is happening or why.
- Disrupted habits: feeling upset when old ways of doing things cannot be followed.
- Loss of confidence: feeling incapable of performing well under the new way of working
- Loss of face: feeling inadequate or humiliated because the 'old' ways are no longer perceived as 'good' ways.

As a summary of the unique findings discussed in sections 5.1.1 to 5.1.13, Table 5.1 lists those unique factors that were found to affect the implementation of JCI in UAE hospitals but which were not found in the reviewed literature. By contrast, Table 5.2 lists factors identified in the literature as affecting the implementation of QMSs but which were not found to affect the implementation of JCI standards in this research.

## **5.2 Categorisation of factors**

To categorise the factors that affect the implementation of JCI standards it is necessary to explore the common types of factors in terms of the findings of the study and of systematic patterns and themes identified through the data analysis. It is logical to describe and elaborate a network showing the variables relevant to the research context, and such variables are usually identified through interviews, observations and literature survey (Sekaran, 1992; 2000). This section considers the categorisation of factors suggested by previous studies in order to develop the groups and the common types of factors for this research. Some of the categories of factors found in the literature are shown below.

Fuentes *et al.* (2000) classify barriers to QMS implementation into four categories, similar to those of Ngai and Cheng (1997), as follows:

- Organisational barriers: difficulty in the communication of new tasks for each job at all levels, resistance to new responsibilities, difficulties in cooperation among middle managers over quality problems, lack of employee involvement and lack of top management involvement.
- Technical barriers: lack of communication routes through which necessary information could flow, lack of appropriate technical knowledge, lack of information and help from public organisations, and difficulty of access to test laboratories.
- Economic barriers: economic effort, lack of an external adviser properly qualified in a certain sector of activity and lack of training programmes related to quality.
- Vertical barriers related to the economic chain, lack of cooperation from customers and lack of cooperation from suppliers.

**Table 5.1: Unique factors affecting the implementation of JCI in UAE hospitals**

Factors	Researcher Comments
Different working values and attitudes among the staff who work in the same department (cultural issues)	Differences between permanent hospital staff and contract workers – section 4.1.1.7
Resistance to change is greater among local staff than expatriates (resistance to change)	National staff shows much more resistance to change in this study in comparison to expatriate staff. Presented and discussed in sections 4.1.1.13, 4.1.2.13 and 5.1.13
Differences in training opportunities between national and non-national staff (training)	National staff were given better training opportunities. Presented and discussed in sections 4.1.1.6, 4.1.2.6 and 5.1.6
Differences in payment and compensation between national and non-national staff (human resource issues)	National staff were paid better than expatriate staff. Presented and discussed in sections 4.1.1.5, 4.1.2.5 and 5.1.5
Differences in the grading system between national and non-national staff (human resource issues)	National staff were given better grades. Presented and discussed in sections 4.1.1.5, 4.1.2.5 and 5.1.5
Allocation of certain positions based on nationality, regardless of qualifications (human resource issues)	E.g. ward clerks should be nationals, presented and discussed in sections 4.1.1.5, 4.1.2.5 and 5.1.5
Differences in human resource rules based on nationality (human resource issues)	E.g. job security, presented and discussed in sections 4.1.1.5, 4.1.2.5, 4.1.1.13, 5.1.5 and 5.1.13
Lifestyle during summer and Ramadan (time)	Most staff are on holidays and working hours reduced. Discussed in sections 4.1.1.11, 4.1.2.11 and 5.1.11
Use of English and medical language by administrative staff (human resource issues)	E.g. ward clerks have to use medical terminology, while they are not qualified. Discussed in sections 4.1.1.5, 4.1.2.5 and 5.1.5
Working on more than one major project during accreditation (planning and working on more than one project at the same time)	E.g. opening the new trauma centre, electronic medication system. Discussed in sections 4.1.1.9 and 5.1.9

Another way of classifying the factors affecting the implementation of quality systems is proposed by Al-Zamany *et al.* (2002), who identify three main categories of difficulties in implementing ISO 9000 standards in public sector organisations:

- Government-related barriers, which include the selection and assessment of managers and lack of governmental support.
- Technical knowledge barriers, which involve lack of skilled persons to implement the activities related to the QMS, such as process management, data collection, data analysis and problem solving.



- Current organisational practices and barriers; for example, failure to focus on customers, poor ways of thinking, lack of total commitment by management, unacceptability of errors, employee empowerment and presence of fire-fighting management.

**Table 5.2: Factors identified in the literature and their relation to the research findings**

No	Factor	Relation to the findings in the research
1	Reasons for seeking accreditation	Found in same context. Discussed in section 5.1.1
2	Leadership commitment	Found in same context. Discussed in section 5.1.2
3	Organisational culture	Found in the study with some unique findings related to the organisational culture. Discussed in section 5.1.7
4	Human resources and staffing	Found in the study with some unique findings related to human resource issues. Discussed in section 5.1.5
5	Training	Found in the study with some unique findings related to human resource issues. Discussed in section 5.1.6
6	Physician and employee involvement	Found in the study in the same context. Discussed in section 5.1.4
7	High cost	Found in the study in a different context. Discussed in section 5.1.12
8	Time	Found in the study with some unique findings related to time issues. Discussed in section 5.1.11
9	Communication	Found in the study. Discussed in section 5.1.10
10	Improving of quality & continuous improvement	<b>Not found in this study</b>
11	Effective steering committee	<b>Not found in this study</b>
12	Empowerment, reward & recognition	<b>Not found in this study</b> as a separate factor but found in different context. Discussed in section 5.1.4 and 5.1.8
13	Understanding of TQM principles	Found in this study. Discussed in section 5.1.3
14	Teamwork & interdepartmental relationships	<b>Not found in this study</b>
15	Focus on the customer	<b>Not found in this study</b>
16	Resources	<b>Not found in this study</b>
17	Harmonization and sharing of data & information	Found in this study. Discussed in section 5.1.8
18	Staff awareness	Found in this study in the same context. Discussed in section 5.1.3
19	Documentation	<b>Not found in this study</b>
20	Resistance to change	Found in this study. Discussed in section 5.1.13

Al-Haj (2006) categorises barriers to implementing ISO 9000 (2000) in the UAE as follows:

- Organisational barriers: lack of sustained top management commitment, lack of resource optimization, poor training of employees, misinterpretation of quality system requirements, recruitment policies, lack of communication and coordination, and lack of employee empowerment.
- Governmental and external barriers: bureaucracy (excessive control), competition of ISO certification, lack of mission and vision, lack of performance indicators and lack of nationalisation policy.
- Cultural barriers: cultural mix, resistance to change, language, social relations, *wasta* and failure by managers to admit error.
- Technical barriers: documentation system, time of implementation, lack of customer satisfaction view, financial issues with suppliers, lack of use of information systems and poor knowledge of statistical techniques.

Another grouping is proposed by Sharif (2005), who categorises the barriers to implementing ISO 9000 (2000) in Libya as follows:

- External barriers: high cost of certification, unskilled workforce, lack of qualified consultants, instability of executives and unavailability of local calibration providers.
- Organisational barriers: lack of top management commitment, inadequate technology, lack of coordination between different departments and lack of financial resources.
- Cultural barriers: managers not admitting errors, high employee absenteeism and employees who do not serve the vision of the company.
- Technical barriers: lack of continuous training, difficulty in interpreting standards requirements, lack of identification and traceability system, and the existence of a quality control approach.

Based on the literature review in Chapter Two and the discussion of the findings, the researcher has derived the factors that affect the implementation of JCI standards in UAE hospitals. According to these categorisations and the groupings of other researchers mentioned earlier in this chapter and in Chapter Two, it is obvious that most authors have considered cultural and organisational factors as well as technical and human resource ones. The researcher categorises the factors that affect the implementation of JCI in UAE hospitals in Table 5.3 into four groups. This



categorisation helps in better understanding the themes underlying these factors and can be used by other researcher in further studies.

The organisational factors are created by the management of the organisation itself, such as issues related to reasons, drivers and motivators of the organisation for implementing the JCI standards, the benefits of doing so and the commitment of leaders and top managers to their implementation. The organisational factors include issues related to the knowledge of staff about JCI standards and quality improvement principles.

The human resource issues are those factors related to the rules, regulations, training, practices and human resources functions, and to the responses of the staff to these rules and practices. They also include the involvement of staff in the implementation process. The organisational culture issues are those factors that have been created by management and employee behaviour and attitudes towards the JCI implementation process, including issues related to the diversity of cultural background among the staff, social relations and their impact on the work process, different working values among the Western and non-Western staff, the bureaucratic style of central management, the culture of safety and the use of English by the administrative staff. The technical factors are those which represent the difficulties encountered by management and employees in understanding the JCI requirements as well as issues related to the communication systems and tools, to information management and to the resources used during the accreditation process. As discussed in relation to the interview responses, the researcher found that almost the same issues related to JCI standards applied to both hospitals. This means that the factors are similar in the two hospital environments.

### **5.3 Discussion of research methodology**

The researcher selected an appropriate research methodology based on the review of the relevant literature. The phenomenological philosophy and the qualitative approach were argued to be the best means to identify and obtain an in-depth understanding of the factors affecting the implementation of JCI standards, as discussed in sections 3.2 and 3.3. The research strategy chosen was the case study, which allowed the phenomenon to be explored in its real-life context from the viewpoint of the participants. Semi-structured interviews were supplemented by other sources of relevant data. As explained

in Chapter Three, section 3.4, it was considered that two cases were enough to provide the data required to answer the research questions and to meet the aim and objectives.

After reviewing the related literature, factors that affect the implementation of quality management systems like JCI were identified in section 2.6 of the literature review chapter and summarised in Table 2.4, which enabled the researcher to generate the interview protocol. To enhance its validity, this was finalised after it had been reviewed many times by the researcher's supervisors and by some PhD researchers, with some amendments being made accordingly. As a final step to guarantee the validity of the interview questions, a pilot study was carried out within the case study organisations. This was done to check whether the questions were clear and understandable by the interviewees.

The following approach was taken in analysing the data: the raw data which was collected from the interviews, documents and observations was categorised as indicated in the preceding section of this chapter. The synthesis of the findings of the literature review and of the empirical work was the basis for developing this categorisation. The key factors affecting the implementation of JCI standards were identified, including the factors unique to the UAE environment. The analysis of the data is discussed in section 3.9 of the methodology chapter.

#### **5.4 Limitations of the research**

The selection of the phenomenological philosophy is justified in section 3.2 as the most suitable research strategy. This philosophy is linked with a qualitative approach, where the case study is the appropriate research design, as identified by the researcher. Using a case study, the researcher could answer 'how' and 'why' questions, as was indicated in section 1.3.2. According to Bamber (2002), the intangible nature of these research elements, such as cultural elements, made the case study approach a suitable one for this research. The two case studies were chosen to provide a comprehensive understanding of the various issues.

**Table 5.3: Categories of factors affecting JCI implementation in UAE hospitals**

<b>Organisational factors</b>	<b>Human resource factors</b>	<b>Cultural factors</b>	<b>Technical factors</b>
<p><b><u>Reasons for seeking the accreditation</u></b> This includes the drivers and motivators of the organisation for implementing the JCI standards and the benefits of implementing the standards.</p>	<p><b><u>Training</u></b> This includes issues related to differences in training opportunities between national and non-national staff.</p>	<p><b><u>Cultural issues</u></b> This includes issues related to the diversity of cultural background among the staff, social relations and their impact on the work, different working values among the Western and non-Western staff, the bureaucratic style of central management, the safety culture, the reporting of incidents and the poor level of English of administrative staff.</p>	<p><b><u>Sharing data and information</u></b> This includes issues related to the use of technology in providing the service and information, feedback and information sharing, and the inability of the health information system to support the integration of inter-organisational processes.</p>
<p><b><u>Top management commitment and involvement</u></b> This includes issues related to the commitment and involvement of hospital leaders and managers as well as the continuous commitment and support of the central office</p>	<p><b><u>Human Resource issues</u></b> This includes issues related to the differences in payment and compensation between national and non-national staff, the system of grading the staff, the allocation of certain positions to national staff and different human resource rules for national and non-national staff</p>	<p><b><u>Resistance to change</u></b> This includes stronger resistance to the implementation of JCI standards among national than non-national staff.</p>	<p><b><u>Communication issues</u></b> This includes issues related to lack of communication system and effective processes, publishing the newsletter and regular general staff meetings as communication tools.</p>
<p><b><u>Staff awareness of quality issues</u></b> This includes issues related to the knowledge of staff about JCI standards and quality improvement principles.</p>	<p><b><u>Involvement of employees in the implementation process</u></b> This includes the involvement and empowerment of all categories of staff, including medical and administrative staff.</p>		<p><b><u>Planning and working on more than one major project during accreditation</u></b> This includes working on all major projects in the hospital during the implementation of JCI standards.</p>
			<p><b><u>Time of implementing the standards</u></b> This includes issues related to working in the hospital during summer and Ramadan</p>
			<p><b><u>Cost of accreditation</u></b> This includes the approved financial resources.</p>

The researcher made all efforts during the period of this research to ensure the collection of high quality data. Nonetheless, every research study is limited by the constraints placed upon the researcher (Yin, 2003); thus, in this research effort, it was not possible to control all the influences that were likely to affect the quality of the research, since some were related to the case study organisations and others arose during the process of the research. As a result, the following limitations of this research can be identified.

- In 2005, when this research was started, there was a significant shortage of existing literature on the factors affecting the implementation of JCI standards, especially concerning empirical research into organisations in the Middle East and other countries that have a similar working environment to the UAE. Most of the available literature was about implementing other quality systems, like ISO 9001. The researcher therefore examined literature related to implementing quality systems such as ISO 9001 and TQM, because JCI standards have similarities with ISO 9001, as discussed in section 2.4.1 of the literature review chapter, and use the same principles as TQM, such as customer orientation, continuous improvement and human resource management. Sharif (2005) adopted a similar approach to his research.
- As the researcher was an employee in hospital A, there was a potential for bias during the interviews, on the part of the researcher and of the interviewees. The researcher took this into consideration by piloting the interview questions. This led to the inclusion of a neutral introduction while conducting the interviews. At the same time, the researcher used standard questions in the interviews. The most important tool used to reduce bias was the triangulation of the findings from the interviews with documentation and minor observation. Thus, the potential for bias was reduced. This limitation did not apply to the second hospital. The fact that the researcher was an employee of hospital A also presented an advantage, in that he could review documents very easily. He thus had easy access to large numbers of documents in CSA, but this was much more limited in CSB, where the researcher had to rely on the data gathered from the interviewees.

- The number of potential case study organisations was limited. From the researcher's knowledge of the sector, only a small number of UAE hospitals had attempted to implement the JCI standards at the time of starting this research. The researcher chose two public hospitals within the UAE to conduct the fieldwork, both having been recently accredited. They had thus already faced the factors that affected the implementation of the JCI standards throughout the whole process and the experience was still fresh in the minds of the interviewees. On the other hand, a limitation arising from the use of only two case studies is that the generalisation of the findings of the study is limited to the selected cases (Yin, 2003).
- It may be difficult to reconcile the differences between the respondents' answers and assess how representative they are (Saunders *et al.*, 2007). To overcome this, the researcher used other sources of information such as documents, reports and archives, in addition to minor observations, as mentioned above.
- Another limitation concerned the unwillingness of interviewees to allow audio recordings to be made of their evidence, due to cultural constraints, which may have led to the loss of important information. In order to tackle this limitation, the researcher tried to write as much as possible during the interview, and then immediately after each interview devoted time to recording all pieces of information and ideas while they were still relatively easy to recall (see section 3.8.3). The research strategy chosen was the case study, which allowed the phenomenon to be explored in its real-life context from the viewpoint of the participants. Semi-structured interviews were supplemented by other sources of relevant data.
- During the interviews the researcher may have given out unconscious signals or cues that guided respondents to give answers expected by the researcher (Miles and Huberman, 1994). This was avoided as much as possible by the researcher keeping himself neutral and giving the interviewees freedom to answer the questions (Saunders *et al.*, 2007). Also, to prevent bias in the interviewees' responses, the researcher applied Sekaran's (2000) advice by asking general questions and then narrowing them to specific areas, and by asking questions in an unbiased way in the two case studies, as mentioned in Chapter Four.

- During the data collection period the researcher was only able to make observations over a short time (only during the interviews); therefore, only minor observations were made while conducting the interviews.

### **5.5 Chapter summary**

In this chapter, the factors which emerged from the extensive review of the literature and from the research findings have been discussed in the context of the culture and environment of the UAE and DOHMS hospitals. Factors affecting the implementation of the JCI standards in the two case study hospitals were discussed in detail and a number of unique factors identified. These were classified into four main categories: organisational, cultural, human resources and technical. From the synthesis of the review of the literature and the findings of the empirical research into the factors affecting the implementing of JCI standards, the researcher extracted factors unique to DOHMS hospitals and categorised them as mentioned above. The chapter ended by discussing the research methodology and the limitations of the research.

The next chapter will summarise the content of this thesis, discuss the extent to which the aims and objectives of the study have been met, and make operational and general recommendations for further research.

## **CHAPTER 6**

### **Conclusions and Recommendations**

#### **6.0 Introduction**

This research has studied the implementation of the JCI quality management system. It aimed to investigate and identify the factors that affect the implementation of the JCI standards in UAE hospitals. The research methodology adopted in this study was based on the phenomenological philosophy, using a case study research design. The required data was collected in two main stages. The first stage was the secondary data collection method, an intensive literature review to understand the relevant aspects of quality implementation, in addition to the issue of change management. The second stage was the collection of primary data by in-depth, semi-structured interviews in two case studies, supplemented by a review of archival documents and minor observation to provide triangulation.

The analysis and discussion of the data collected were carried out to investigate and interpret the participants' responses and their implications in order to identify and understand in depth the factors affecting the implementation of JCI standards in UAE hospitals.

#### **6.1 Meeting the aim and objectives of the research**

Finally, through discussion of the research findings, the overall research questions were answered, thus achieving the aim of this study, which was to investigate and to identify the factors affecting the implementation of the JCI standards in UAE hospitals. Ultimately, this aim was achieved through the research objectives being fulfilled as follows:

- The first objective was to identify the factors affecting the process of implementing JCI standards in UAE hospitals. To achieve this objective, a critical literature review was conducted. The literature covered issues related to quality management principles, quality gurus, TQM, quality management models, JCI, change management and cultural issues. There was then a discussion of the factors that affect the implementation of JCI standards. These are summarised in Table 2.4.

- The second objective of this research was to investigate and analyse the factors affecting the process of implementing JCI standards by conducting case study research. To meet this objective, two case studies were conducted (section 3.4), to gather the required relevant information on JCI standards implementation within the two selected organisations. The primary data was collected from targeted respondents using semi-structured interviews. Other sources of data were documents such as archives, quality manuals and the minutes of meetings, supplemented by minor observations made during the data collection process. Thus the factors affecting JCI implementation were identified, investigated and analysed.
- The third objective was to categorise the common factors that affect the implementation of JCI standards in UAE hospitals. To do this, the researcher classified the factors into four main categories: organisational, cultural, human resources and technical, as shown in Table 5.3. The distinction was also made between factors common to the literature review and the case studies on one hand and others which were found to be unique to the present study, as discussed in section 6.2. and summarised in Table 5.1.

Thus, all three objectives of the study were met successfully.

## **6.2 Contribution to knowledge and originality of the research**

As noted above, the specific aim of this research was to investigate and identify the factors affecting the implementation of the JCI standards in UAE hospitals, the first time that such a study had been conducted in the UAE. Indeed, it became apparent from the literature review that there was very little material that dealt specifically with JCI standards. Most of the literature concentrated on implementing other quality systems such as ISO 9001 (2000) and particularly ISO 9001 (1994), especially when this research began. The researcher therefore decided to consider the factors identified in the literature related to the implementation of different quality systems as well as to the implementation of TQM, especially in healthcare organisations.

The literature showed that some of the main factors are related to the commitment and involvement of top management, awareness among managers, cultural influence on



individuals, as well as on the work processes. Of course, one of the main factors is related to resistance to change, which is in turn related to culture in general.

The social and cultural circumstances, particularly in the Middle East, have led to influence in the workplace, especially issues that are related to the cultural mix, lifestyle and social relations in the workplace. This research has raised some unanswered questions relating to implementing JCI standards in UAE hospitals and the factors that exist. Further study is therefore required both to extend this research and to help improve the implementation of JCI standards. Theoretically, the significance and importance of this research are clear, because the common factors affecting the implementation of quality management systems in an organisation have been identified in section 2.6 and summarised in Table 2.4.

Empirically, the importance of TQM in practice and the need to develop knowledge for the benefit of organisations in developing countries suggest that expanding the existing knowledge of quality management literature in these countries is a contribution. It should be noted that there is a lack of empirical studies of factors affecting the implementation of JCI standards in different countries in general and in Arab countries in particular. Therefore, this research contributes to this area by adding to the limited work that does exist (see Table 5.1). Many of the findings of this study are consistent with those of other studies conducted in different national contexts. Thus, this study has reinforced those previous results. This is the first study of the UAE healthcare industry focusing on quality management, the implementation of JCI and the factors affecting it. It has reduced the gap in knowledge in local studies in particular and in Arab studies in general (due to the similarity of the culture and environment context).

Additionally, the researcher identified some factors, listed in Table 5.1, which are unique to the UAE cultural context, because they have not been reported in the literature review as applying to other countries; these include differences in human resource practices and the provision of training based on the nationality of the staff. From the discussion of the findings of this research, it was concluded that although the two case study hospitals achieved international accreditation, maintaining their performance and the implementation of the standards after achieving accreditation were not addressed effectively in their daily activities.

Moreover, this research influences the direction of thoughts and activities in the field of implementing quality systems in healthcare organisations. Therefore, the research makes the following contributions:

- This is the first research conducted in the UAE into the implementation of JCI standards in a developing country. It uses the UAE as a lens through which to study and explore this phenomenon. It has brought together a large body of knowledge in relation to implementing a quality system in healthcare organisations in one of the Arab and GCC countries. The review of the literature in the field of implementing JCI standards identified gaps and the need for more empirical research; therefore, this research integrates and extends the studies conducted in this field.
- Since previous studies concentrating on implementing quality systems were mainly undertaken in different cultural contexts from that of UAE, another contribution to the literature has been made. The findings have added to the existing theories by extending the body of knowledge on implementing quality systems to a new culture.
- The research identified some of the unique factors affecting the implementation of JCI standards in the case study hospitals:
  1. Different working values and attitudes among the staff who work in the same department;
  2. Resistance to change being greater among local staff than expatriates;
  3. Differences in training opportunities between national and non-national staff;
  4. Differences in payment and compensation between national and non-national staff;
  5. Differences in the grading system between national and non-national staff;
  6. Allocation of certain positions based on nationality, regardless of qualifications;
  7. Differences in human resource rules based on nationality;
  8. The lifestyle during the summer and Ramadan;
  9. Competence in English and medical language by administrative staff;
  10. Working on more than one major project during accreditation.
- The research also corroborated the finding of other researchers in the Arab world such as Al-Haj (2006), Sharif (2005), Mohamed (2005), Al-Madi (2005) and Al-Zamany *et al.* (2002) regarding these factors:

1. Language
  2. Top management commitment
  3. Employee empowerment
  4. Training
  5. Resistance to change and
  6. Communication issues.
- This research has been conducted using a case study design, which has provided an in-depth understanding of JCI implementation in healthcare organisations. Indeed, this research is considered the first to use this approach and provide a richer appreciation of quality systems implementation.
  - This research is valuable in that it has been able to provide useful guidelines in the form of identifying the factors that could have a significant impact on the process of implementing JCI standards in healthcare organisations. It has categorised all the potential factors that might affect the process into a list of common types and groups (Table 5.3), which is useful for practitioners. Ultimately, these categories could be used by professionals as a guide when planning to implement the JCI standards in their healthcare organisations. Professionals can derive a better understanding of the process and what they need to focus on in order to improve implementation.
  - This study responds to the recommendations of researchers such as Sharif (2005), Mohammed (2005) and Al-Haj (2006), who began the research process in such environments and who have emphasised the need for more studies in the field of implementing quality systems in developing and Arab countries. While this research has brought to light points never previously discussed in the literature, it has also corroborated factors found by other researchers in the Arab world, such as Sharif (2005), Mohamed (2005) Al-Madi (2005) and Al-Zamany *et al.* (2002).

### **6.3 Recommendations for further research**

This research has not been entirely conclusive; many issues have emerged and this has raised some unanswered questions related to the implementation of the JCI standards in the case study organisations, within the DOHMS and by the government of Dubai more generally. Further studies are therefore required both to extend this research and to help to improve quality initiatives in the UAE. In regard to the significant development and growth of business-related activities, including healthcare services, in the UAE in

general and in Dubai in particular, the researcher suggests that additional research in the public sector in Dubai and the UAE could be interesting, in order to identify the changes that have occurred in these more open times, as more investment has been made in the healthcare industry in the UAE, especially during the last few years since this research began. Many Western companies have entered the UAE, especially Dubai and Abu Dhabi, as consulting companies to manage healthcare organisations, with a focus on the hospital sector. The effect that Western management practices might have on UAE government departments could be assessed to see if the exposure to these companies will add value to the country in the long term and to measure the impact on human resource development plans, including succession planning. On the other hand, the cultural issues and the difference in values may have an interesting influence on the culture and values of these healthcare organisations in the country. One of the interesting issues for potential further study is related to the impact of these Western companies on the factors that affect the implementation of quality management systems in the hospitals that they manage.

Therefore, in conclusion to this study a number of recommendations are presented for future research:

- Replication of this research in other sectors might yield insights into those factors which are specific to the healthcare sector and those that are culturally-conditioned.
- This research could be replicated with similar organisations in different developing countries such as other GCC or Arab countries in order to enhance the understanding of how sector-specific and cultural influences contribute towards the effective implementation of quality systems in healthcare organisations.
- One of the unique findings of this research as a factor which affects the implementation of JCI standards is that of differences in training opportunities, salary and compensation, and grading systems between national and non-national staff. Further research is recommended to investigate how these differences and other variations in human resource practices affect the implementation of quality systems in similar organisations.
- This study has revealed that there is a difference between local and expatriate staff in supporting the implementation of JCI standards; further research is

recommended to investigate how these differences affect the process of implementing quality systems in similar organisations.

- Due to the absence of evidence regarding the issue of cooperation among national and expatriate staff in the UAE, the researcher recommends further research to investigate the negative and positive perspectives, and to study the impact of the relationship between locals and expatriates on the process of implementing the JCI standards.
- Another interesting area of research is the role of consultants in implementing quality management systems in healthcare organisations. Therefore, further studies could be conducted to investigate the role of consultants in implementing the different quality management systems.
- The researcher recommends further research to study the phenomenon of implementing JCI standards from the perspective of certification or accredited bodies.
- Given the phenomenon whereby some organisations deteriorate in their performance after they achieve accreditation because they cannot maintain the requirements of the standards, the researcher recommends that further studies should be conducted to investigate this tendency.
- Finally, as the present study has identified the factors affecting the implementation of JCI standards in UAE hospitals, it would be very interesting and useful to study further how these can be dealt with and managed to overcome the challenges and barriers, by developing a suitable framework based on the findings of this thesis.

#### **6.4 Operational recommendations**

Based on the research findings and the discussion, this final section offers important recommendations for DOHMS hospitals in Dubai to improve JCI implementation, to manage the factors that affect the implementation process and to overcome barriers. In order to obtain sustained top management commitment, the DOHMS leaders and heads of department should become involved in the process through intensive orientation regarding the requirements of the JCI standards. Such an orientation exercise will give a clear idea of the requirements and the resources that are needed to apply the system throughout the implementation process. Thus, the department heads will be aware of the consequences of implementing the system. Furthermore, the continuous commitment of the headquarters leaders will facilitate the implementation process in the hospitals.

which will lead to a simplification of the process in the head office and eliminate inefficient bureaucratic steps.

One of the significant areas for improvement in the headquarters of the DOHMS in Dubai is related to its human resource practices, including the discrepancies and unequal opportunities among national and non-national staff in relation to the training, compensation and grading systems. The researcher recommends that DOHMS leaders should review the human resource practices and consider developing policies to promote equal job opportunities among all staff in the organisation, especially issues related to the training of expatriate staff. On the other hand, the researcher recommends that DOHMS leaders should develop a localisation plan to promote nationalisation in DOHMS departments and hospitals, as well as to facilitate change and quality initiatives among national and expatriate staff. Such a plan should cover the following components:

- Minimum qualifications for national staff to occupy certain positions. These should be equivalent to the qualifications of the expatriate staff in order to promote the principle of equal opportunity among the staff.
- On-the-job training for the national staff, to ensure that they are able to perform the tasks required of them in the workplace. The senior and qualified expatriate staff could be involved in training their national colleagues.
- Performance management and monitoring of the implementation of the localisation plan. This would open opportunities for the continuous process of implementing the plan.

The next recommendation is related to the maintenance of JCI standards following implementation. The researcher recommends that the leaders of the two case study hospitals should continue working on maintaining the implementation of the JCI requirements. One of the challenges related to the accreditation and certification of hospitals after they implement certain quality systems is maintaining the standards. Many organisations deteriorate in their performance after they achieve accreditation, then find it very difficult when the time comes for reaccreditation or recertification. The researcher wishes to emphasise the importance of using the accreditation process as a tool for improvement and not as a goal in itself.

Another operational recommendation is related to the process of introducing new software: the leaders of both case study hospitals should involve all end users before they decide to buy any new software. Many stand-alone programs have been introduced without the appropriate involvement of the end users concerned and it has been discovered later that they do not meet their needs.

As lack of performance indicators is one of the barriers to implementing quality systems, so it is suggested that the DOHMS hospitals should promote the use of key performance indicators and cascade them to the lower levels of the different departments. It is also important to have a systematic, objective and evidence-based process of individual performance appraisals. The key performance indicators, as well as the performance appraisal programmes, should be healthcare sensitive and appropriate to meet the unique needs of healthcare professionals. It would be very helpful for DOHMS hospitals to monitor the performance of suppliers based on agreed key performance indicators. These would serve as a tool of service-level agreements between hospitals and their suppliers. Delays in receiving services will affect the process of implementing the requirements of quality systems.

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## APPENDICES

### Appendix 1: Quality Awards in UAE

Award	Year	Purpose of the Award
The Zayed International Prize for the Environment	1991	Established by Sheikh Mohammed in recognition and appreciation of environmental achievements.
The Dubai Quality Award	1994	Launched by the Department of Economic Development in Dubai, of which Sheikh Mohammed is Chairman, it recognises role model organisations. It is also a process for providing organisations with a 'roadmap' to achieve excellence through the adoption of good practices and soundly-based approaches that are deployed systematically and are continuously measured and reviewed.
The Dubai Government Excellence Programme	1998	Recognises and rewards exceptional government employees, departments and initiatives.
The Sheikh Rashid Award for Academic Excellence	1998	Established under the patronage of Sheikh Maktoum bin Rashid Al Maktoum by the Dubai Cultural and Scientific Association in recognition of students who have achieved outstanding results at their respective levels.
Dubai International Holy Quran Award (DIHQA)	1998	Following instructions from Sheikh Maktoum bin Rashid Al Maktoum, Sheikh Mohammed sponsors the award in recognition of outstanding Muslim scholars who have been honoured with the duty of Islamic scholarship and culture.
The Ideal Arab Mother Award and the Ideal Family Award	2000	Established by Sheikh Mohammed as part of the Dubai Shopping Festival calendar in 2000. The theme of the Festival that year was "To Mother With Love".
The Ibda'a Media Student Awards	2001	Launched by Dubai Media City under the patronage of Sheikh Mohammed. <i>Ibda'a</i> means 'creativity' in Arabic.
Mohammed bin Rashid Al Maktoum Award for Arab Management	2001	General Sheikh Mohammed bin Rashid Al Maktoum, Dubai Crown Prince and UAE Defence Minister, established this annual award to recognize public and private sector organisations with the highest leadership and management standards in the Arab world.
Mohammed Bin Rashid Awards for Young Business Leaders	2002	Launched by the Mohammed Bin Rashid Establishment for Young Business Leaders to encourage and recognise exceptional entrepreneurs in the UAE.

The Sheikh Mohammed bin Rashid Al Maktoum Cambridge Awards	2003	A collaboration between Sheikh Mohammed and Cambridge International Examinations (CIE) to recognize those students in the UAE who achieve outstanding examination results in Cambridge IGCSE, AS Level and A Level examinations, students who have achieved academically whilst overcoming significant personal challenges and those who have contributed significantly to their school and local community.
The Young Arab Leaders Award	2005	Celebrates leadership and excellence in the Arab world by recognising those who serve as role models for the region's young people.
Mohammed Bin Rashid Al Maktoum (MRM) Business Award	2005	Recognises and rewards firms that contribute to the UAE's economic development.
Mohammed Bin Rashid Creative Sports Award	2007	Launched to uplift sportsmen and athletes through a solid base of principles that His Highness supports.
Arab Journalism Award	2008	Inspired by Sheikh Mohammed bin Rashid Al Maktoum's vision, Dubai Press Club launched the Arab Journalism Award to recognise and encourage journalistic excellence in Arabic media.

**Appendix 2: Features of Research Designs**

<b>Strategy</b>	<b>Form of research question</b>	<b>Requires control over behavioural events</b>	<b>Focuses on contemporary events</b>
<b>Experiment</b>	How, why	Yes	Yes
<b>Survey</b>	Who, what, where, how many, how much	No	Yes
<b>Archival analysis</b>	Who, what, where, how many, how much	No	Yes/No
<b>History</b>	How, why	No	No
<b>Case study</b>	How, why	No	Yes

Source: Yin (2003, p.5).

**Appendix 3: Documents reviewed during the interviews**

<b>Documents</b>	<b>Case Study A</b>	<b>Case Study B</b>
Quality manual	x	x
Clinical policy and procedure manual	x	x
Terms of reference for JCI committees	x	x
Minutes of meetings	x	x
Documentation audit reports	x	
Self-assessment reports	x	x
JCI consultants' reports	x	x
JCI implementation plan	x	x
Organisational structure	x	x
Quality plan	x	x
Facility management plans	x	x
Staffing plan	x	x



## Appendix 4: Interview questions, related factors and references

Question	Related Factors	References from the literature review
What is your knowledge of JCI standards? Have you been receiving any training related to JCI standards?	Training Understanding the principles of TQM	Pomey <i>et al.</i> (2004), Sila and Ebrahimpour (2003), Mc Fadden <i>et al.</i> (2006), Taylor & Wright (2003), Ruiz and Simon (2004)
Are the quality plan, policies and procedures identified and deployed in the hospital? How?	Physicians and employee involvement	Jun <i>et al.</i> (2004), Gough and Reynolds (2000), Sila and Ebrahimpour (2003), Ruiz and Simon (2004)
How are the responsibilities and authorities in the hospital defined and deployed?	Physicians and employee involvement	Jun <i>et al.</i> (2004), Gough and Reynolds (2000), Sila and Ebrahimpour (2003), Ruiz and Simon (2004)
Why did your hospital decide to go for JCI accreditation?	Human resources and staffing Organisational Culture & resistance to change	Sila and Ebrahimpour (2003), Ruiz and Simon (2004), Anwar and Jabnoun (2006), James & Hunt (1996), Sila and Ebrahimpour (2003)
How did your hospital implement the JCI standards?	Organisational culture and change resistance	Sila and Ebrahimpour (2003), Ruiz and Simon (2004), Anwar and Jabnoun (2006)
Are the purposes and the benefits of the JCI standards understood by the employees in the hospital during the implementation process? How? Why?	Training Understanding the principles of TQM	Pomey <i>et al.</i> (2004), Sila and Ebrahimpour (2003), Mc Fadden <i>et al.</i> (2006), Taylor & Wright (2003), Ruiz and Simon (2004)
Are all work polices and procedures identified? If not, why not?	Staff awareness	Mc Fadden <i>et al.</i> (2006), Pomey <i>et al.</i> (2004)
What are the factors that affected the implementation of JCI standards? How?	Physicians and employee involvement	Jun <i>et al.</i> (2004), Gough and Reynolds (2000), Sila and Ebrahimpour (2003), Ruiz and Simon (2004)
How did your hospital overcome the barriers and obstacles of implementing the JCI standards?	Organisational culture and change resistance	Sila and Ebrahimpour (2003), Ruiz and Simon (2004), Anwar and Jabnoun (2006)
What are the factors your hospital faced in maintaining the standards? How did they affect the maintaining of the standards?	All the listed factors	Ab Rahman & Tannock (2005), James & Hunt (1996), John Ovreteit (2001), Taylor & Wright (2003), Sila and Ebrahimpour (2003), Ruiz and Simon (2004), Anwar and Jabnoun (2006), Jun <i>et al.</i> (2004), Gough and Reynolds (2000), Sila and Ebrahimpour (2003), Ruiz and Simon (2004)
Do you think the internal audit and self assessment programmes in your hospital were effective? Why?	Improving of quality & continuous improvement	Abd Manaf (2005), Kollberg <i>et al.</i> (2005), Banerji <i>et al.</i> (2005)
What are the main issues raised while conducting the internal auditing and self-assessment activities?	Time, training, organisational culture and change resistance	Sila and Ebrahimpour (2003), Ruiz and Simon (2004), Anwar and Jabnoun (2006) Pomey <i>et al.</i> (2004) Ab Rahman & Tannock (2005)
How have the JCI standards influenced the hospital services overall?	Communication, Empowerment Reward & recognition Improving of quality & continuous improvement	Ab Rahman & Tannock (2005), Taylor & Wright (2003), Abd Manaf (2005)

How did you get the expertise to help you implement the standards?	Resources	Ab Rahman & Tannock (2005), McFadden <i>et al.</i> (2006)
What was the role of the experts in implementing the standards?	Resources	Ab Rahman & Tannock (2005). McFadden <i>et al.</i> (2006)
What was the role of the employees in helping to implement the standards?	Physicians and employee involvement	Jun <i>et al.</i> (2004), Gough and Reynolds (2000). Sila and Ebrahimpour (2003). Ruiz and Simon (2004)
What changes were required in your organisation to satisfy the requirements of the standards?	Training Communication Empowerment Reward & recognition	Ab Rahman & Tannock (2005), Taylor & Wright (2003), Abd Manaf (2005), Pomey <i>et al.</i> (2004), Ab Rahman & Tannock (2005)
Did you face any problems when making these changes? How ? Why?	Organisational culture and change resistance	Sila and Ebrahimpour (2003), Ruiz and Simon (2004), Anwar and Jabnoun (2006)
If you had to go through the implementation again, what would you do differently and why?	Time, training	Pomey <i>et al.</i> (2004), Ab Rahman & Tannock (2005)
What are the benefits that your department gained after implementing the JCI standards?	Communication, Empowerment Reward & recognition Improving quality & continuous improvement	Ab Rahman & Tannock (2005), Taylor & Wright (2003), Abd Manaf (2005)
Are there any other issues about implementing the JCI standards that you want to discuss?	Staff awareness	McFadden <i>et al.</i> (2006), Pomey <i>et al.</i> (2004)

**Appendix 5: Interview questions for middle managers and frontline employees**

**Middle management & frontline staff interview**

**Name .....Department.....**

**Your role in relation to JCI .....**

**Date of employment .....**

**Date ..... Length of the interview .....**

- 1. Why did your hospital decide to go for JCI accreditation?
- 2. How did your hospital implement the JCI standards?
- 3. Were the purposes and the benefits of the JCI standards understood among the employees in the hospital during the implementation process? How? Why?
- 4. What is your knowledge of JCI standards? Have you been receiving any training related to JCI standards?
- 5. Are the quality plan, policies and procedures identified and deployed in the hospital? How?
- 6. How are the responsibilities and authorities in relation to the JCI implementation defined and deployed?
- 7. Did your employees have a role in implementing the standards? If yes, could you please tell me how they had this role? And why this role was emphasised?
- 8. What were the changes required in your organisation to satisfy the requirements of the standards? Did you face any resistance when making these changes? Why did you face this resistance? How did your organisation overcome it?
- 9. What are the barriers that your organisation faced during the accreditation process? How did it overcome them?
- 10. What are the factors that affected the implementation of JCI standards? How did they affect it?

11. How did your organisational culture affect the implementation process in terms of accepting/rejecting the JCI standards?
12. How did the individual culture and the culture mix affect the implementation process?
13. Are the standards maintained in your organisation? If yes, how is maintenance facilitated? What are the main factors affecting maintenance and why? And what are the main issues raised, if any?
14. How do the JCI standards influence your department or the overall hospital services, such as: communication, empowerment reward & recognition, improving of quality & continuous improvement, etc?
15. Do you think the internal audit and self-assessment programme in your hospital is considered to be effective? Why?
16. What are the main issues raised while conducting the internal auditing and self assessment activities? How could the internal auditing and self assessment system be enhanced in your organisation?
17. If you were given another opportunity to implement the JCI standards, what are the main issues you would concentrate on? And why?
18. Are there any other issues about implementing the JCI standards that you want to discuss?

Thank you for your time and contribution

**Appendix 6: Interview questions for top managers**

**Top Management Interview**

**Name .....**  
**Department.....**  
**Your role in relation to JCI.....**  
**Date of employment .....**  
**Date ..... Length of the interview .....**

- 1. Why did your hospital decide to go for JCI accreditation?
- 2. How did your hospital implement the JCI standards?
- 3. Were the purposes and the benefits of the JCI standards understood among the employees in the hospital during the implementation process? How?
- 4. What is your knowledge of JCI standards? Have you been receiving any training related to JCI standards?
- 5. How did the hospital get the ability to find the financial and human resources which are necessary to implement and maintain the JCI standards?
- 6. How did you get the expertise to help you implement the JCI standards? What was the role of the experts in implementing the standards?
- 7. Did your employees have a role in implementing the standards? If yes, could you please tell me how they had this role? And why was this role emphasised?
- 8. What were the changes required in your organisation to satisfy the requirements of the standards? Did you face any resistance when making these changes? Why did you face this resistance? How did your organisation overcome it?
- 9. What are the barriers that your organisation faced during the accreditation process? How did it overcome them?

10. What are the factors affecting the implementation of the standards within your organisation and how?
11. How did your organisational culture affect the implementation process in terms of accepting/rejecting the JCI standards?
12. How did the individual culture and the culture mix affect the implementation process?
13. Are the standards maintained in your organisation? If yes, how is maintenance facilitated? What are the main factors affecting maintenance and why? And what are the main issues raised, if any?
14. What are the main issues raised during the management & leadership meeting/ steering committee? And how did you solve them?
15. How did the JCI standards influence the overall hospital services, such as communication, empowerment, reward & recognition, improving of quality & continuous improvement?
16. Do you think the internal audit and self-assessment programme in your hospital is considered to be effective? Why?
17. What are the main issues raised while conducting the internal auditing and self-assessment activities? How could the internal auditing and self assessment system be enhanced in your organisation?
18. If you were given another opportunity to implement the JCI standards, what are the main issues you would concentrate on? And why?
19. Are there any other issues about implementing the JCI standards that you want to discuss?

Thank you for your time and contribution

## Appendix 7

GOVERNMENT OF DUBAI  
DEPARTMENT OF HEALTH & MEDICAL SERVICES

دائرة الصحة والخدمات الطبية  
حكومة دبي

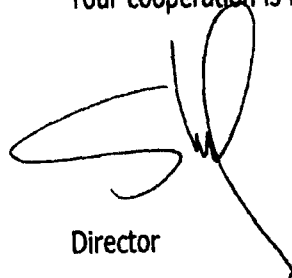
Date 15<sup>th</sup> December 2007

**Sub: Mr Zakaria Zaki Al Attal – Researcher for PhD – Salford University**

Dear All,

Reference to the above mentioned subject you are kindly requested to cooperate with Mr Zakaria Zaki AlAttal – PhD student at Salford University – UK by providing him with necessary information in order to meet his research objectives.

Your cooperation is highly appreciated.



Director

## Appendix 8

G O V E R N M E N T O F D U B A I  
DEPARTMENT OF HEALTH & MEDICAL SERVICES

حكومة دبي  
دائرة الصحة والخدمات الطبية

Date 21<sup>st</sup> December 2007

**Subject : Mr Zakaria Zaki Al Attal**  
**Researcher for PhD – Salford University**

Dear All,

Reference to the above mentioned subject you are kindly requested to cooperate with Mr Zakaria Zaki AlAttal – PhD student at Salford University – UK by providing him with necessary information in order to meet his research objectives. Mr. Zakaria research is about the factors that affecting the implementation of implementing the JCI standards in UAE hospital. He selected our hospital as one of his case studies for collecting his research information.

Your cooperation is highly appreciated.

Hospital Director





## Appendix 9

**A list of some of the peer reviewed journals which were used to identify the factors that affect the implementation of JCI standards**

### **1- Journal of Management Development**

#### **Reviewing process**

Each paper is reviewed by the Editor and, if it is judged suitable for publication, it is then sent to at least two referees for double blind peer review. Based on their recommendations, the Editor then decides whether the paper should be accepted as is, revised or rejected.

[http://info.emeraldinsight.com/products/journals/author\\_guidelines.htm?PHPSESSID=ooon1qslustuae969kj0n40sk6&id=jmd](http://info.emeraldinsight.com/products/journals/author_guidelines.htm?PHPSESSID=ooon1qslustuae969kj0n40sk6&id=jmd)

### **2- Quality Progress**

<http://www.asq.org/qualityprogress/information/AuthorGuidelines/review-process/index.htm>

### **3- International Journal of Operations and Production Management**

The International Journal of Operations and Production Management is a peer-reviewed academic journal published by Emerald Group Publishing Limited.

[http://en.wikipedia.org/wiki/International Journal of Operations & Production Management](http://en.wikipedia.org/wiki/International_Journal_of_Operations_&__Production_Management)

### **4- International Journal of Quality and Reliability Management**

#### **Reviewing process**

Each paper is first reviewed by the editor and, if it is judged suitable for this publication, it is then sent to two referees for double blind peer review. Based on their recommendations, the editor then decides whether the paper should be accepted as is, revised or rejected.

[http://info.emeraldinsight.com/products/journals/author\\_guidelines.htm?id=ijqrm](http://info.emeraldinsight.com/products/journals/author_guidelines.htm?id=ijqrm)

### **5- Academy of Management Journal**

The Academy of Management Journal is a peer reviewed journal focusing on management field.

[http://en.wikipedia.org/wiki/Academy of Management Journal](http://en.wikipedia.org/wiki/Academy_of_Management_Journal)

### **6- Journal of Quality in Maintenance Engineering**

#### **Reviewing process**

Each paper is reviewed by the Editor and, if it is judged suitable for this publication, it is then sent to two referees for double blind peer review. Based on their recommendations, the Editor then decides whether the paper should be accepted as is, revised or rejected.

[http://info.emeraldinsight.com/products/journals/author\\_guidelines.htm?id=iqme](http://info.emeraldinsight.com/products/journals/author_guidelines.htm?id=iqme)

### **7- Business Process Management Journal**

#### **reviewing process**

Each paper is reviewed by the editor and, if it is judged suitable for this publication, it is then sent to two referees for double blind peer review. Based on their recommendations, the editor then decides whether the paper should be accepted as is, revised or rejected.

[http://info.emeraldinsight.com/products/journals/author\\_guidelines.htm?id=bpmj](http://info.emeraldinsight.com/products/journals/author_guidelines.htm?id=bpmj)

### **8- European Management Journal**

The EMJ is a peer-reviewed journal, with a "double-blind" procedure involving at least two reviewers.

[http://www.elsevier.com/wps/find/journaldescription.cws\\_home/115/description#description](http://www.elsevier.com/wps/find/journaldescription.cws_home/115/description#description)

#### **9- Leadership and Organization Development Journal**

##### **reviewing process**

Double blind peer review, using two referees.

[http://info.emeraldinsight.com/products/journals/author\\_guidelines.htm?id=lodj](http://info.emeraldinsight.com/products/journals/author_guidelines.htm?id=lodj)

#### **10- Managing Service Quality**

##### **reviewing process**

Each paper is reviewed by the editor and, if it is judged suitable for this publication, it is then sent to two referees for double blind peer review. Based on their recommendations, the editor then decides whether the paper should be accepted as is, revised or rejected.

[http://info.emeraldinsight.com/products/journals/author\\_guidelines.htm?id=msg](http://info.emeraldinsight.com/products/journals/author_guidelines.htm?id=msg)

#### **11- Journal of Operations Management**

The **Journal of Operations Management** is a leading, peer-reviewed scientific journal that publishes original, high-quality research papers in the field of operations management. It is ideal for researchers and practitioners who want to keep abreast of the latest research in state-of-the-art operations management.

<https://enduser.elsevier.com/campaigntypes/specissue/index.cfm?campaign=operations&CFID=47313511&CFTOKEN=96042879>

#### **12- The International Journal of Human Resource Management**

##### **Peer Review Policy**

All review papers in this journal have undergone editorial screening and peer review.

<http://www.tandf.co.uk/journals/routledge/09585192.html>

#### **13- Academy of Management Executive**

##### **Availability**

Peer Reviewed: Yes

<http://www.acquirecontent.com/titles/the-academy-of-management-executive>

#### **14- Health Care Management Review**

**Health Care Management Review** is a peer-reviewed journal that publishes papers that apply practical frameworks and principles to health care management. Articles address issues that are timely, interest researchers, inform future research, and affect how health care facilities are organized.

<http://www.lww.com/product/?0361-6274>

#### **15- International Journal of Service Industry Management**

##### **reviewing process**

Each paper is reviewed by the editor and, if it is judged suitable for this publication, it is then sent to two referees for double blind peer review. Based on their recommendations, the editor then decides whether the paper should be accepted as is, revised or rejected.

<http://www.calpoly.edu/~eli/iceb/Guide-IJSIM.htm>

#### **16- Total Quality Management and Business Excellence**

##### **Peer Review Policy:**

All articles in this journal have undergone rigorous peer review, based on initial editor screening and anonymous double-blind review.

<http://www.tandf.co.uk/journals/titles/14783363.asp>

#### **17- Quality Management in Health Care**

This peer-reviewed quarterly journal provides a forum to explore the theoretical, technical, and strategic elements of total quality management in health care. Each issue of **Quality Management in Health Care (QMHC)** includes an in-depth interview with a health care attorney, information on basic quality management tools and processes, and articles to encourage informal....

<http://www.lww.com/product/?1063-8628>

#### **18- International Journal for Quality in Health Care**

This peer-reviewed journal is truly interdisciplinary and includes contributions from representatives of all health professions such as doctors, nurses, quality assurance professionals, managers, politicians, social workers and therapists, as well as researchers from health-related backgrounds.

<http://library.georgetown.edu/newjour/i/msg02702.html>

#### **19- Journal of Transcultural Nursing**

The **Journal of Transcultural Nursing** is the official journal of the Transcultural Nursing Society. It is a peer-reviewed, multidisciplinary journal with the mission to advance new knowledge about the relationship between.....

#### **20- Managerial Auditing Journal**

**You are a peer reviewed journal; what are your reviewers looking for?**

**PL:** In the first place we select the reviewers principally on our knowledge of their work and also on the assumption that they understand the style of the journal. So our reviewers will be looking for the intellectual rigour of the research, at the paper's structure, at the contribution to the literature, as well as making sure that the papers are within .....

<http://info.emeraldinsight.com/authors/interviews/maj.htm?PHPSESSID=000n1qslustuac969kj0n40sk6&>

#### **21- Journal of Controversial Medical Claims**

**Availability**

Peer Reviewed: Yes

<http://www.acquirecontent.com/titles/journal-of-controversial-medical-claims>

#### **22- International Journal of Productivity and Performance Management**

**Key benefits**

The journal includes both peer reviewed research papers and, a 'reflective practice' section which includes news, practical examples and case studies, together with personal viewpoints, to help set the developing body of knowledge within a context of practical application.

<http://info.emeraldinsight.com/products/journals/journals.htm?id=ijppm>

#### **23- International Journal of Productivity and Performance Management**

**Availability**

Peer Reviewed: Yes

<http://www.acquirecontent.com/titles/international-journal-of-production-economics>

#### **24- Journal of Quality in Maintenance Engineering**

**reviewing process**

Each paper is reviewed by the Editor and, if it is judged suitable for this publication, it is then sent to two referees for double blind peer review.

[http://info.emeraldinsight.com/products/journals/author\\_guidelines.htm?id=jqme](http://info.emeraldinsight.com/products/journals/author_guidelines.htm?id=jqme)

**25- International Journal of Physical Distribution & Logistics Management reviewing process**

Each paper is reviewed by the Editor and, if it is judged suitable for this publication, it is then sent to two referees for double blind peer review.

[http://info.emeraldinsight.com/products/journals/author\\_guidelines.htm?id=ijpdlm](http://info.emeraldinsight.com/products/journals/author_guidelines.htm?id=ijpdlm)

**26- British Food Journal reviewing process**

Each paper is reviewed by the editor and, if it is judged suitable for this publication, it is then sent to two referees for double blind peer review.

[http://info.emeraldinsight.com/products/journals/author\\_guidelines.htm?id=bfj](http://info.emeraldinsight.com/products/journals/author_guidelines.htm?id=bfj)

**27- Journal of Operations Management**

The Journal of Operations Management is a leading, peer-reviewed scientific journal that publishes original, high-quality research papers in the field of operations management.

<https://enduser.elsevier.com/campaigntypes/specissue/index.cfm?campaign=operations&CFID=47313511&CFTOKEN=96042879>

**28- Production and Inventory Management Journal**

The journal is peer reviewed and publishes high-quality original manuscripts relevant to professional leaders, educators, and business students in the operations and supply chain management field.

<http://list.informs.org/pipermail/msom-society/2008-August/000393.html>

**29- International Journal of Health Planning and Management**

The International Journal of Health Planning and Management operates an online submission and peer review system (ScholarOne Manuscripts, formerly known as Manuscript Central)

<http://www.wiley.com/bw/submit.asp?ref=0749-6753&site=1>

**30- Journal of Enterprise Information Management reviewing process**

Each paper is reviewed by the Editor and if it is judged suitable for this publication it is then sent to two referees for double blind peer review.

[http://info.emeraldinsight.com/products/journals/author\\_guidelines.htm?PHPSESSID=i4bav34sv9me0ai3jsmgt4hkb0&id=jeim](http://info.emeraldinsight.com/products/journals/author_guidelines.htm?PHPSESSID=i4bav34sv9me0ai3jsmgt4hkb0&id=jeim)

**31- Journal of European Industrial Training reviewing process**

Viewpoint articles will not necessarily undergo peer review.

[http://info.emeraldinsight.com/products/journals/author\\_guidelines.htm?id=jeit](http://info.emeraldinsight.com/products/journals/author_guidelines.htm?id=jeit)

**32- Industrial Management and Data Systems reviewing process**

Each paper is reviewed by the editor and, if it is judged suitable for the publication, it is then sent to two referees for double blind peer review.

[http://info.emeraldinsight.com/products/journals/author\\_guidelines.htm?id=imds](http://info.emeraldinsight.com/products/journals/author_guidelines.htm?id=imds)

**33- International Journal of Public Sector Management reviewing process**

Each paper is reviewed by the editor and, if it is judged suitable for this publication, it is then sent to two referees for double blind peer review.

[http://info.emeraldinsight.com/products/journals/author\\_guidelines.htm?id=ijpsm](http://info.emeraldinsight.com/products/journals/author_guidelines.htm?id=ijpsm)