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Health worker perceptions towards safe-care accreditation and quality of care - a case of the Ruaraka Uhai Neema Hospital, Nairobi, Kenya

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HEALTH WORKER PERCEPTIONS TOWARDS SAFECARE ACCREDITATION AND QUALITY OF CARE: A CASE OF THE RUARAKA UHAI NEEMA HOSPITAL, NAIROBI, KENYA

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DECLARATION

I declare that this work has not been previously submitted and approved for the award of a degree by this or any other University. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made in the thesis itself.

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ABSTRACT

Hospital accreditation is a process where hospitals meet the highest peer-agreed standards. Staff buy-in is a key factor for the success of the accreditation. This study aimed to explore perceptions of healthcare workers towards SafeCare accreditation and quality of care and to propose a model for effective inclusion of healthcare workers in the accreditation process.

The study was done at the Ruaraka Uhai Neema Hospital, a SafeCare certified hospital located in Nairobi, Kenya. The study adopted a case study method using qualitative method of data collection using semi-structured interview technique. A total of six in-depth interviews and three focused group discussions were held with persons purposively selected from among 202 hospital staff. Data was audio-recorded and notes of important events written down. The results of the interviews were transcribed and thematically analyzed using grounded theory to identify patterns and themes.

Overall, healthcare workers at Ruaraka Uhai Neema hospital indicated receiving support during the accreditation process. They noted that staff resistance may be a barrier especially when staffs are not adequately involved, but that the resistance can be overcome by proper training, involvement and management support. While accreditation may improve services sustainably, it faces certain threats, including poor implementation due to staff turnover. Accreditation was seen to promote staff satisfaction and improve communication and work processes. Managers thought accreditation benefits outweighed costs involved.

Based on the study participants' views and opinions, accreditation can contribute to better quality of care and promote learning and development of professional skills. It may also improve cost management, processes, communication and safety culture.

The Policy implication of this study is that healthcare organizations require a clear strategy of retaining personnel and reduce turnover, accreditation organization to support facilities undergoing accreditation from a needs-based perspective and stimulate awareness to create buy-in and demand for accreditation, and the need to educate the public on accreditation. Future studies should look at other accreditation models available and the effect that the different approaches may have on staff and the organizations in general.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

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To my family your prayers and encouragement kept me going, your support morally and psychologically kept me strong. My friends for the many times I kept a distance from your company! Thank you for your understanding and encouraging me during the whole process of the study.

DEFINITIONS

Accreditation body: The organization that is mandated with the responsibility of implementing the accreditation program and granting the accreditation status

Accreditation standards: Set of procedures to determine the degree of conformity to accreditation requirements at the hospitals or organizations.

Accreditation: An internationally established process intended to improve quality and safety

Assessment: The process where certified or trained persons evaluate a process using set standards and give a score for compliance

Certification: A process of awarding recognition for compliance to set standards in a certain discipline or recognition for completion of a process.

Expectations: Belief about service delivery that functions as standard or reference point against which performance is judged

Hospital accreditation: A self-assessment and external quality review mechanism that checks a hospital's conformity with established standard

Perception: A state or process of being aware of something through the senses

Service quality: An assessment of how well a service conforms to the client expectation

Healthcare workers: staff working in the healthcare organization

LIST OF ABBREVIATIONS

5S	Sort, strengthens, shine, standardize and sustain
COHSASA	Council for Health Service Accreditation of Southern Africa
FGD	Focused group discussion
HCO	Health care organization
ISO	International Organization for Standards
ISO	International Organization for Standardization
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCI	Joint Commission International
JHOM	Journal of Health Organization and Management
KEBS	Kenya Bureau of Standards
KENAS	Kenya Accreditation Service
KHS	Kenya health sector Report
KQM	Kenya Quality Model
KQMH	Kenya Quality Model for Health
MOH	Ministry of Health
NGO	Non-governmental organization
NHIF	National Hospital Insurance Fund
PHC	Primary health care
QI	Quality improvement
QSR NVIVO	Qualitative data analysis computer software package
RUNH	Ruaraka Uhai Neema hospital
UHC	Universal health coverage
WHO	World Health Organization

CHAPTER ONE: INTRODUCTION

1.1 Background of the study

Accreditation is an external quality assurance process that helps to improve quality and safety (Montagu, 2003);(Braithwaite et al., 2010). Other researchers in the field of health accreditation Greenfield, Pawsey, Hinchcliff, Moldovan, & Braithwaite (2012) defined accreditation as a formal declaration by a designated authority that an organization has met predetermined standards. The World Health Organization defines external quality assessment as processes through which external organizations assess facilities for compliance to pre-determined standards (WHO/ISQUA, 2003).

Accreditation dates back to as far as 1860, when Nightingale developed a system for collecting hospital statistics which she used to explain variation in quality from one hospital to another using mortality rates (L.S., R.G., Hanold, Koss, & Loeb, 2000) thereby underpinning healthcare quality assurance. Worldwide, accreditation focuses on promoting continuous improvements, applying standards and providing feedback as the main objectives (Bogh et al., 2018).

Accreditation processes are applied through assessing and recommending ways to improve healthcare services. They entail a complex mix of interventions that typically include audit of healthcare providers, assessment of performance, and finally, award of the accreditation. Such processes are increasingly being applied by healthcare funders, who are more likely to make funding available (or less likely to withdraw funding) if standards are met and healthcare professionals and the public can have confidence in the standards of care provided (Jirovsky, Hoffmann, Maier, & Kutalek, 2015).

Studies have shown accreditation result in improved teamwork, improved access to care, increased awareness to patient safety, improved practice systems and care process that lead to quality of care (M. et al., 2013). Accreditation also focuses on promoting continuous improvement, applying standard and providing feedback (Campbell, Roland, & Buetow, 2000)

According to a study by Greenfield and Braithwaite's (2008) on health professional perceptions, attitude and beliefs they found contrasting views of health workers, some supported the process and found it as an effective strategy for quality while others had critical perspective. Doctors perceived accreditation as irrelevant while nurse managers and allied administrative managers perceived accreditation favorably as it promoted safety, improved decision making and increased compliance to clinical guidelines resulting to significant quality improvement.

According to a report by the World Health organization, (WHO, 2003) Sub- Saharan Africa faces a critical shortage of healthcare workers making implementation of effective clinical supervision programs challenging, in an effort to improve compliance to standards many Sub-Saharan counties are establishing national facility accreditations programs. However, (Bukonda, Tavrow, Abdallah, Hoffner, & Tembo, 2002)noted that noted that in resource limited settings, feedback from external assessments can also be critical in increasing the efficient use of scarce facility resources.

Sub- Saharan Africa struggles with budget shortages, poorly maintained facilities, inadequate sanitation, regular drug and essential supplies stock-outs with such a health system accreditation is not considered a priority (Bateganya, Hagopian, Tavrow, Luboga, & Barnhart, 2009). Here in Kenya the National Health Insurance Fund (the insurer) manages accreditation using standards, known as the Kenya Quality Model, that were developed by a broad coalition of professionals outside of the Insurance Fund supported by the Ministry of Health (Ministry of Healtha & Ministry of Healthb 2014).

1.1.1 SafeCare

In 2010 the Pharmaccess Foundation of the Netherlands, the Joint Commission International (JCI) and the Council for Health Service Accreditation of Southern Africa (COHSASA) developed a quality assessment tool called SafeCare which entails basic health standards to support healthcare providers in resource-restricted settings to go through step-wise structured improvement programs to deliver safe and quality-secured care to their patients. The tool enables health facilities to measure and improve the quality, safety and efficiency of their services. It also allows for rating and benchmarking of providers across the health system. Several facilities in

Tanzania, Kenya, Nigeria and Ghana are undergoing SafeCare accreditation and have been awarded certificates that mark their progress towards achieving excellence. SafeCare certification is based on levels; level I show very modest quality, with continued need for periodic technical support, level II indicates modest quality strength, requiring medium technical assistance at this level, healthcare quality is likely to fluctuate, level III; medium quality strength, acceptable but vulnerable to changing environment, level IV; strong quality systems in place, but high-risk areas still in need of attention, level V demonstrates long-term commitment to continuous quality improvement, ready for accreditation programme and self sufficiency of continuous quality improvement SafeCare, 2018).

1.1.2 Kenyan health system

The Kenyan healthcare system is divided into three subsystems namely the public sector which is the largest in number of facilities available and is owned by the government, the commercial private sector that is owned by several stakeholders including Non-Governmental Organizations (NGOs), commercial enterprises and private individuals and the Faith Based Organizations (FBOs) owned by religious institutions (Government of Kenya, 2016).

Kenya's healthcare system is structured in a hierarchical manner. The following six levels make up the healthcare system; Level 1: Community, Level 2: Dispensaries, Level 3: Health centers, Level 4: Primary referral facilities, Level 5: Secondary referral facilities, Level 6: Tertiary referral facilities (Kenyan Ministry of Health, 2014). Kenya's health care system is structured in a step-wise manner so that complicated cases are referred to a higher level. Gaps in the system are filled by private and church run units (Kenyan Ministry of Health, 2014).

The Kenyan health sector faces several challenges: shortage of staff, lack of resources and poor quality of care with reports in mainstream and social media indicating several deaths caused by negligence and lack of quality standard (Government of Kenya, 2016). While there has been an increase in developing country organizations pursuing accreditation, there is minimal evidence on how effective it is, as a tool for promoting quality of care and patient safety (Smits, Supachutikul, & Mate, 2014). Previous studies have had mixed results, with authors pointing at a

need for additional assessments. Achieving and maintaining accreditation requires a significant investment of resources. It is a rigorous process, it can be expensive and it is demanding on both individuals and organizations. There may be a question as to whether accreditation is worth the time, effort and cost, and whether it shows demonstrable improvement on patient outcomes (Braithwaite et al., 2010); (Devkaran & O'Farrell, 2014).

Developing countries (including Kenya) have recently started using hospital accreditation as a means of guaranteeing quality and patient safety and also as a strategy for improving basic health services. Through accreditation quality services can be achieved through independent professional surveys helping to ensure that financing from public and private sources only goes to facilities that meet a certain standard of care (Smits et al., 2014).

There is a shortage of institutions and standards that can ensure objective measurement and rating of the level of quality of basic health care facilities in Africa. As a result, quality levels of providers are not transparent, benchmarking is not possible and patients face uncertainty with regard to the quality of health care they seek (Smits et al., 2014). Just like the rest of Africa, there are very few accreditation institutions in Kenya; the costs of the accreditation process are also prohibitive, locking out majority of the hospitals from international accreditation or certification (Smits et al., 2014).

ISO 9000 series certification is one of the accreditation organizations that operate in Africa. It is an internationally recognized set of standards and evaluation process used mainly to assess management competencies and documentation ("Quality and accreditation in health care," 2003). Another International accreditation organization working in Kenya is the Joint Commission International which identifies measures and shares best practices in quality and patient safety. JCI accredits hospitals and other health care organizations and so far only two hospitals in Kenya are JCI accredited. The national hospital insurance fund (NHIF) manages a basic accreditation mechanism for purposes of empanelment. The NHIF uses its own standards, which are operationalized through a basic checklist that mainly focuses on the facilities' readiness to provide key services, and meet the other goals of NHIF, including patient satisfaction (NHIF, 2014). The standards were partly informed by the Ministry of Health's Kenya Quality Model (KQM). The Kenya quality model for health (Kenya & Kenya., n.d.)Replaced the KQM and is

the overall framework guiding quality management and continuous quality improvement activities within the Kenyan health care system. The KQMH defines health care standards for facilities offering various services using the 5'S' and the Kaizen model however this model has not been fully operational (Kenya & Kenya., n.d.).

1.1.3 Ruaraka Uhai Neema Hospital

The study was carried out in Ruaraka Uhai Neema Hospital (RUNH), located in Nairobi County. The hospital had recently attained SafeCare Level Five certification which was awarded in November 2018. The Hospital was founded by World Friends in partnership with the Catholic Church under the Archdiocese of Nairobi with the aim of offering quality healthcare at affordable prices to Nairobi residents. The hospital provides comprehensive services which include General outpatient clinic; maternal-Infant Clinic; gynecology; pediatrics; maternity services; Diagnostics services including laboratory tests, radiography and echography; accident & Emergency including minor surgery and day care; HIV testing and treatment; Physiotherapy and Occupational Therapy; Pharmacy; Ambulance services; and Training Services.

RUNH is a 50 bed capacity hospital. The hospital is headed by administrator clinical services headed by a medical officer, all staff total to 202. The hospital serves a catchment area of approximately 750,000 people in Nairobi. In 2018 the hospital attended to approximately 80,000 people.

1.2 Problem statement

Typically organization seek accreditation of their hospitals to have their healthcare services more marketable compared to those of other organizations and to use quality as a catalyst for change, that help them mobilize the organization towards the goal of quality improvement, while at the same time have favorable outcomes in healthcare including reduced morbidity and mortality and a general improvement in the state of health(Attal, 2009).However, there is limited evidence on the extent to which obtaining accreditation results in sustained changes and how staff perception influence accreditation seeking process, whether they feel that the accreditation has improved their ability to offer quality services. There is limited information on how healthcare providers perceive accreditation overall, drivers of its success in changing practice, and challenges that

come with implementing continuous quality improvement activities. Little research has gone towards understanding the accreditation-seeking process, how staff are involved, how it affects their environment and ability to offer quality services, and whether they feel, overall, that accreditation can allow them to practice in ways that improve outcomes (as opposed, for instance, to implementing quality improvement activities without necessarily seeking accreditation (Westbrook et al., 2012).

Accreditation is a supply side concept that is designed to communicate performance to the demand side at present there is lack of evidence on the efficiency and effectiveness of these Programmes and the factors which may affect successful implementation of accreditation (WHO 2003, Attal, 2009). Healthcare organization management use accreditation often as a marketing tool to the public and the main focus is customers or client seeking healthcare services (Attal, 2009); however there have been concerns expressed elsewhere that staff may not be fully convinced about its merits, and that this may result in poor sustainability of improvement activities. This may be a barrier in the model of implementation of accreditation process where staff involvement contributes to a feeling that accreditation is only a management issue and not a staff issue. The result can be catastrophic equilibrium where staff becomes spectators rather than actors.

This study sort to explore the role and experience of healthcare staff on accreditation and its role in continuous quality improvement at healthcare facilities using the SafeCare model, the study also explored the perception of staff-related factors that influence achievement of accreditation process, and understand their views on whether (and how) these processes translate into continuous quality improvement efforts that are sustainable and consistent, beyond the period of accreditation assessments.

1.3 Objectives of the study

1.3.1 General objective

To explore perceptions toward SafeCare accreditation and quality of care among healthcare workers at Ruaraka Uhai Neema Hospital

1.3.2 Specific objectives

3.1 To assess the experiences of healthcare workers during the process of pursuing SafeCare accreditation at the Ruaraka Uhai Neema Hospital.

3.2 To explore perceptions on factors that influence SafeCare accreditation process among health workers at Ruaraka Uhai Neema Hospital.

3.3 To explore perceptions on quality of care following SafeCare accreditation among healthcare workers at Ruaraka Uhai Neema Hospital.

1.4 Research questions

1. What is the role and experiences during the process of pursuing SafeCare accreditation among health workers at Ruaraka Uhai Neema Hospital?
2. What are the perceptions on factors that influence SafeCare accreditation process among health workers at Ruaraka Uhai Neema Hospital?
3. What are the perceptions on quality of care following SafeCare accreditation among healthcare workers at Ruaraka Uhai Neema Hospital?

1.5 Scope of the study

This study explored perceptions toward quality of care following SafeCare accreditation, factors that influence the accreditation process and the role and experiences of healthcare workers in the process of accreditation. This study was done at Ruaraka Uhai Neema hospital which is located in Nairobi County, the hospital is directly opposite Moi sports stadium Kasarani. The hospital is one of the four SafeCare level five certified, it was chosen purposively because of accessibility, ease of working with the facility and variety of services provided. The target population was healthcare workers of Ruaraka Uhai Neema Hospital.

1.6 Significance of the study

To accreditation bodies, the study will inform accreditation institutions on the critical areas where collaboration with HCO management and staff will bear more fruits and also which areas of the accreditation process will require re-evaluating to make the process more seamless for health workers. The study will impact some level of rethinking about the model of accreditation by in cooperating recommendations of street level bureaucracy where organizations can develop

simpler and practical ways of achieving and sustaining accreditation away from the rigid laid down protocol and processes.

Health facilities will also have better ways of synergizing the marketing accreditation as well as having strategies to compliment staff efforts to maintain and sustain accreditation. This study will benefit healthcare providers seeking accreditation as they will be able to navigate the hurdles related to staff perceptions toward accreditation.

To policy makers this study will unlock policy for areas for all stakeholders such as the government, private healthcare sector prayers, and non-governmental organizations on how to engage human recourses for health especially on areas like staff motivation, training, inclusion and involvement on accreditation process.

To the research community, the study will contribute to existing knowledge on accreditation and how it can be studies and improved.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter presents views of other researchers with a purpose to review and critically appraise the existing literature on perceptions of healthcare workers toward accreditation and quality of care in order to provide supporting information applicable to this research.

First, the chapter seeks to provide theoretical support for the study on the process of accreditation in healthcare and quality of care and how this link with healthcare workers perceptions, role and experiences.

The second part presents empirical review of literature published in the field of healthcare accreditation, concentrating particularly on the role, experiences, perception of health workers on quality of care during the accreditation process experience and lessons drawn by other researchers. Finally, literature summary at the end showing some gap in literature that this study aims to bridge.

2.2 Theoretical review

2.2.1 Donabedian model

Avedis Donabedian and colleagues at the University of Michigan conceptualized the original Donabedian model in 1966. The model is widely accepted and used in healthcare measurement models. According to the model, information about quality of care can be drawn from three categories: “structure,” “process,” and “outcomes (Donabedian, 1988).

Structure includes all of the factors that affect the context in which care is delivered. This includes the physical facility, equipment, and human resources, as well as organizational characteristics such as staff training and payment methods. These factors control how providers and patients in a healthcare system act and are measures of the average quality of care within a facility or system (Donabedian, 1988).

Process is the sum of all actions that make up healthcare. Processes can be further classified as technical processes, how care is delivered, or interpersonal processes, which all encompass the manner in which care is delivered (Donabedian, 1988). According to Donabedian, the measurement of process is nearly equivalent to the measurement of quality of care because process contains all acts of healthcare delivery. Information about process can be obtained from medical records, interviews with patients and practitioners, or direct observations of healthcare visits (A., 1988).

Outcome contains all the effects of healthcare on patients or populations, including changes to health status, behavior, or knowledge as well as patient satisfaction and health-related quality of life as well as support functions. Outcomes are sometimes seen as the most important indicators of quality because improving patient health status is the primary goal of healthcare (Donabedian, 1988).

The interest of the researcher in choosing this model is the fundamental themes involving Assessment and Quality in Health, which are the actual core of the Accreditation.

In the process of hospital accreditation, staff plays a fundamental role, actively participating in decision-making, strategizing, and assistance, as well as being part of the evaluation team. The perception of this team constitutes an important diagnostic in the search for excellence in safe, quality medical care provision.

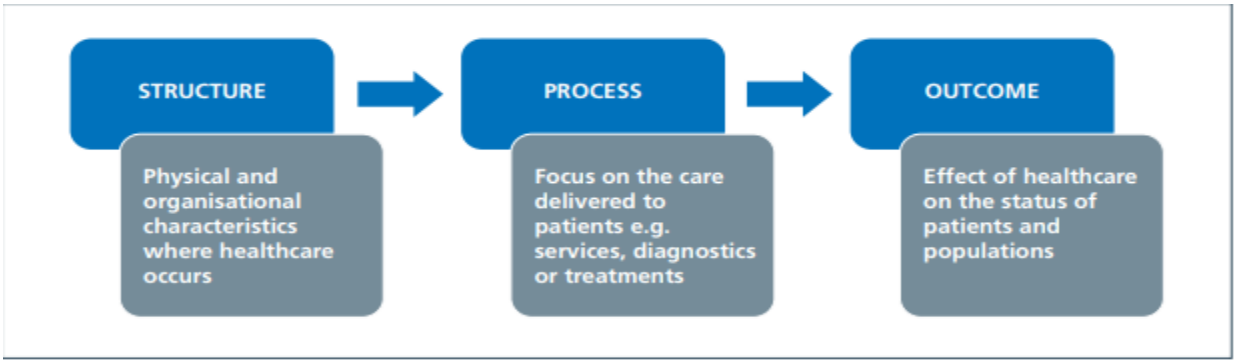

Figure 2.1 Donabedian model for quality of care (van Lerberghe, 2008).

2.2.2 Understanding frontline staff involvement: street-level bureaucracy theory

The concept of street-level bureaucracy was popularized by Michael Lipsky in 1980, who argued that "policy implementation in the end comes down to the people who actually implement it" (Lipsky, 2010).

According to (Goldner & Lipsky, 2006) street level bureaucracy (SLB) refers to the frontline workers in government agencies, for instance, teachers, nurses and police officers, who regularly interact directly with citizens in discharging their policy implementation duties and who have some discretion over which services are offered, how services are offered, and the benefits and sanctions allocated to citizens. This discretion is linked to one of the key propositions of street-level bureaucracy theory: the idea that the decisions and actions of street-level bureaucrats become the policies of the agencies they work for (Erasmus, 2014).

In his work Lipsky noted that this is so because citizens primarily experience policy as the street-level bureaucrat's decision about their case, the benefit allocated by the street-level bureaucrat or the sanction applied by the street-level bureaucrat. Given their discretion, street-level bureaucrats can ‘make policy’ in unwanted or unexpected ways that contradict formal policy directives or work against their agencies’ stated goals (Lipsky, 1980).

The theorist (Lipsky, 1980) identified the condition under which the street bureaucracies work under and the challenges they face as illustrated below.

Inadequate resources**;** the resources at their disposal are chronically inadequate relative to the tasks they are required to perform. This resource inadequacy can take various forms. There can be too few street-level bureaucrats for the number of cases or clients that require attention. A focus on administrative tasks, such as filling out forms, can limit the time they have for clients. Their inexperience or lack of training may mean that they lack the personal resources required for their jobs, including the resources to deal with the often stressful nature of their work. These limitations prohibit agencies from expanding or improving their programs to meet people’s needs. Shortages of staff create a situation where an employee has to deal with multiple tasks, job overlapping and overworking (Gilson, 2015).

An ever-growing demand for their services; the demand for government services tends to increase to match the supply of those services. If more services become available, they will be used. If the agency gets more money, there will be pressure to use it to offer additional services good example in the ever dynamic healthcare is the emergency of new diseases like Ebola, Avian flu e.tc.

Vague or conflicting organizational expectations; Government agencies often have ambiguous, vague or conflicting goals. For example: is it the role of the education system to teach certain values, certain basic skills or to meet employers' need for workers with specific training? What exactly does it mean to have the goal of good health? Goals may be vague, ambiguous or conflicting for many reasons.

Challenges of performance measurement; It is often difficult or impossible to measure the extent to which the performance of a street-level bureaucrat contributes to achieving their agency's goals. For example, if there is a lack of clarity or conflict about goals, how can performance measurements are operationalized? Street-level bureaucrats often change their behavior to reflect what is being measured.

Services for 'captive' clients; their clients, or recipients of services, often do not voluntarily choose the service they are attending and are mostly not a primary reference group for the bureaucracy. Therefore, it can be extremely difficult for clients to criticize or discipline street-level bureaucrats or their agencies. Often the agencies have little to lose if they fail to serve their clients well.

According to the theory of street-level bureaucrats their behavior is shaped by the nature of their work and conditions in which they operate. In response to the challenges they face, street-level bureaucrats often develop routines and simplifications in an attempt to reduce complexity, gain greater control over their work and manage stress, street-level bureaucrats exercise control over their clients through some action that help them to cope with the challenges that Lipsky described. These actions of street-level bureaucrats and reasons for them are listed below;

Distributing benefits and sanctions, including those of a psychological nature, for example health workers may behave with courtesy or rudeness to their patients.

Structuring the context in which clients interact with them. For example, health workers have control over the lay out and organization of a health facility, including how patient queues flow. This is controlling clients so that they can cooperate with procedure

Teaching clients how to behave appropriately in their roles as clients; For example, the organization of health facilities directs patients where to go to, and where to wait, to be seen by a health worker or to receive prescribed drugs; health workers also have expectations of patients in terms of the information they should provide in, and their behavior during, a consultation (Erasmus, 2014).

Rationing the services provided. This action is influenced by the high demand that street-level bureaucrats often experience for their services. Such rationing includes; imposing financial costs on clients (e.g. through fees for care), imposing time costs such as providing fast service for some clients and delaying others, providing information to some clients and not to others, imposing psychological pressures on clients, such as communicating disrespect, which discourages demand from clients, employing different queuing techniques, imposing waiting time or other costs, 'creaming', which involves choosing only those clients who are most likely to be successful in terms of what the government programme tries to achieve and acting on street-level bureaucrats' personal biases, for example by regarding some clients as more worthy than others (Erasmus, 2014).

In conclusion the term street-level bureaucrat refers to a specific group of frontline workers or policy implementers (Lipsky, 2010). They are often committed to providing good service and to doing socially useful jobs, but their jobs and the environments in which they work are such that it is not really possible to serve all clients as they ideally should be served. Instead, street-level bureaucrats develop patterns of practice, routines and simplifications that help them to deal with dynamics such as the chronic shortage of resources and the often high demand for their services. These patterns of practice will sometimes be in accordance with the stipulations of public policy and with what street-level bureaucracies seek to achieve (Erasmus, 2014). Perhaps most importantly, the routines and simplifications often create situations that are unintended by the agencies whose policies are being implemented and may even work against the objectives of such agencies and their policies (Erasmus, 2014).

These two models were chosen because it was considered fundamental for the themes involving assessment and quality in health, which are core components of accreditation.

In the process of hospital accreditation, staff plays a fundamental role, actively participating in decision-making, strategizing, and assistance, as well as being part of the evaluation team. The perception of this team constitutes an important diagnostic in the search for excellence in safe, quality medical care provision, with integration of SLB on the accreditation process staff develop policies, adhere to raid down standards and processes while at the same time identifying and breaking down the bottle necks that hinder their successful achievement of objectives.

Lipsky points out that street-level bureaucrats operate in highly regulated environments that, paradoxically, encourage discretion and constrain hierarchical control just the same way accreditation is a process that is regulated however in order for resource constrained facilities to achieve accreditation there is need to formulate a framework anchored on realistic goals that can be applicable and adjusted to multiple setup to realize gains.

The study proposes a hybrid use of the Donabedian model and the street level bureaucracy theory to examine the accreditation processes from the view of the healthcare workers at a hospital.

2.3 Empirical review of literature

2.3.1 Experiences of healthcare workers towards accreditation

A survey of hospitals in turkey on perception of nurses on impact of accreditation on quality of care found that nurses had higher score for items concerning benefit of accreditation (Yildiz & Kaya, 2014). Accreditation provides an objective system of empanelment by insurance and other Third Parties by providing access to reliable and certified information on facilities, infrastructure and level of care (Diab, 2011).

According to (Devkaran & O'Farrell, 2014) increase in frequency and magnitude of medical errors raise concern about quality, escalating cost and government regulated accountability to

standards, as a result healthcare leaders are seeking scientific methods for improving healthcare quality making accreditation seeking behavior to increase.

Studies have suggested that accreditation enhances organizational reputation among consumer enhancing end- user's consciousness and perception of quality care (El-Jardali, 2007)*;* (Hinchcliff et al., 2016).

In a qualitative and cross-sectional study interviewing senior staff (n = 67) and surveying hospital staffs (n = 1693) of a French teaching hospital, 77% of participants viewed accreditation preparation as an important stage in the hospital's evolution while others 67% believed that the process touched all of the hospital's personnel and believed that irreversible changes occurred at the level of the hospital. However, 81% believed that the accreditation preparation process was experienced essentially as bureaucratic and prescriptive (Park, Jung, & Suk, 2017).

In a qualitative Australian study (n = 72) doctors were generally unaware of accreditation and skeptical of it. Their concern was on how quality of care was to be measured. Doctors felt accountable within a professional framework, to themselves, the patient and family, their peers and to their profession; but not to accreditation bodies (Alkhenizan & Shaw, 2012).

Accreditation is valued by the healthcare provider in the private sector as many insurance companies demand as a precondition a healthcare provider to be accredited before proving services to its members, insurance companies pay extra money as a reimbursement for services rendered in accredited organizations (Ghareeb, Said, & El Zoghbi, 2018). Examples here in Kenya Aga Khan Hospital which is JCI accredited or AAR clinics receive more reimbursement compared to non-accredited facilities.

Other conflicting views show that Owners of hospitals perceive accreditation as potential of being used as a marketing tool, while Health care professionals viewed accreditation programs as bureaucratic and demanding (Alkhenizan & Shaw, 2011).

While studies have showed that organizations benefit from accreditation process, staffs have reported that they develop certain skills that improve their abilities and become confident in providing services to their clients (Pomey et al., 2010).

In a study done in Lebanon where 1048 nurses from 59 hospitals were involved, the researcher concluded that hospital accreditation had a significant impact on hospitals' infection control infrastructure and performance scores improved from 2.8 points in 2004 to 3.2 points in 2005 after accreditation (Bogh et al., 2018). In another study where 638 hospitals were surveyed staff considered accreditation as a valuable tool for improving quality of care (Alkhenizan & Shaw, 2011).

Accreditation value is jeopardized by government pressure for organizations to fall into an accreditation program, this cause financial constrain to health care organizations as the process require resources and time however empirical, evidence-based research on accreditation has not been forthcoming, questions regarding the value and impact of accreditation continue to be raised (Øvretveit, 2009).

2.3.2 Perceptions on factors that influence attainment of hospital accreditation among healthcare workers

In a 2013 study carried out at health centers in Lebanon, staff resistance was identified as a major barrier towards attainment of accreditation (Jaafar et al., 2014).

According to Lebanese Ministry of Public Health study across 25 primary health care centers in 2012, staff reported that initially they perceived accreditation as vague concept and were anxious about being surveyed; they also reported that accreditation increased workload however this barrier can be overcome by training staff members on concepts of quality and accreditation (Jaafar et al., 2014). A number of studies have highlighted various challenges related to accreditation; cost either direct or indirect is a barrier towards attainment of accreditation (Alkhenizan & Shaw, 2012). Healthcare professional have also raised concerns regarding accreditation Programmes as been both time consuming and challenging (Alkhenizan & Shaw, 2012), Others have argued that perceived patient care benefit are minimal (Alkhenizan & Shaw, 2012);(Alkhenizan & Shaw, 2011). Healthcare staffs have also suggested that accreditation standard have a problem (Ng, Leung, Johnston, & Cowling, 2013); while others harbor perception that surveyors are inconsistent (Alkhenizan & Shaw, 2012).

In other studies, staff resistance, heavy workload, staff shortages and financial constrains have been acknowledged as barriers to accreditation of healthcare organizations (El-Jardali et al., 2014);(Jaafar et al., 2014);(Camillo et al., 2016).

A qualitative study by ((Attal, 2009) to understand factors that affect implementation of JCI standards in the United Arab Emirates come up with four main categories of barriers that include human resources issues, organizational, cultural and technical factors as what healthcare perceived as influencers to JCI accreditation.

According to (El-Jardali et al., 2014) in a study on impact of accreditation as perceived by healthcare workers found that Strategic Quality Planning, Customer Satisfaction and Staff Involvement were associated with a perception of higher Quality Results. Directors emphasized the benefits of accreditation with regards to documentation, reinforcement of quality standards, strengthened relationships between PHC centers and multiple stakeholders and improved staff and patient satisfaction however challenges encountered included limited financial resources, poor infrastructure, and staff shortages (El-Jardali et al., 2014).

According to a study of Jordanian hospitals both accredited and non-accredited hospitals showed that nurses were more aware of reporting incidences that physicians, this study showed that physicians were 50% less likely to report an incidence and the barriers included lack of feedback, fear of disciplinary action and believe that there was no point of reporting near misses (Abualrub, Al-Akour, & Alatari, 2015). However, this study did not show whether this were perceptual thought or were based on professional values, practice or were as a result of organizational culture.

According to (Alkhenizan & Shaw, 2012) concluded that several studies have shown that health care professionals were skeptical about accreditation because of concerns about its impact on the quality of health care services. Concerns raised about the cost of accreditation programs by health care professionals especially in developing countries were consistent. Healthcare professionals (especially physicians) have to be educated on the potential benefits of accreditation but also recommended further study for independent evaluation of the cost-benefit analysis of accreditation of health services.

2.4 Perception toward quality of care and accreditation

According to (UNDP, 2010) attaining millennium development goal in low income countries is a challenge because of understaffing in health facilities, demotivated health workers in adequate healthcare infrastructure and inadequate health sector human resources this leads to poor quality of care.

In a study by (Alkhenizan & Shaw, 2011) on impact of accreditation on quality of care which was a systemic review, they conclude that accreditation programs improve the process of care provided by healthcare services. Accreditation programs improve clinical outcomes of a wide spectrum of clinical conditions, as a tool it should be supported to improve quality of care. Study on association of accreditation on patient satisfaction to care involving 73 HCO by (Holtmann, 2018) showed perceptions towards quality of care were not associated to accreditation.

According to (Hayes, 2002) adopting a statement on quality of care that is relevant helps stimulate quality of care in HCO especially if professional bodies easily identify with this statement.

According to a study done in Ghana (Alhassan et al., 2013) on perception of quality of care in accredited primary health care center among health workers and client found that Logistics and human resource are usually cited as major constraints in meeting the demands or needs of clients in resource-poor settings in Africa while at the same time perception among health worker and clients vary based on information asymmetry.

A cross-sectional qualitative study done in 2013 in Tanzania on healthcare workers perception on quality of care in an outpatient clinic found that Multiple factors influencing perceived quality of health care at Mwananyamala hospital, factors identified include physical infrastructure, availability of medical equipment and essential medicines, staffing levels, remuneration and promotion (Njau & Cairns, 2016).

Several studies on perception of healthcare workers on quality have suggested help that policy makers can use to identify bottlenecks in the health system that will improve utilization and

sustainability of care in the general population (Lantis et al., 2002; (R.N., T.C., & I.C., 2006); (N.G., I., K.M., V., & A., 2012).

Findings in a study on successful implementation of accreditation showed how accreditation drives quality improvement and implication for various stakeholders (government, public, patients and healthcare workers) when it comes to embarking on accreditation exercise (Leung, et al, 2013). However, this study does not recommend a framework based on stakeholders engagement to show how health workers can break existing bottle necks that inhibit facilities to achieve accreditation status.

In another study on nursing perception towards JCI accreditation and impact of care in tertiary care hospital, central Saudi Arabia found that accreditation results predict quality of health care, and there was a positive trend between accreditation and quality of health care noted (Mostafa et al, 2014).

2.5 Research Gap

Based on the literature review, it appears there is limited evidence on healthcare workers and their role and experiences throughout accreditation processes in Kenya and similar countries. No study has been done on perception of healthcare workers towards SafeCare model. Some of the empirical gaps by other researchers include cost of accreditation, staff resistance and workload were highlighted in settings that have adequate resources while this study will be done in a resources restricted settings it would be important get from the perspective of health workers how this factors influence accreditation.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

This section describes the research methodology, including the design, study population, study population, sampling methodology, data collection and analysis and presentation of findings. The section ends with the ethical issues taken into consideration.

3.2 Study Design

This was a cross sectional exploratory case study design that used qualitative method of data collection to allow in-depth understanding of the phenomenon under study.

3.3 Target Population

Target population refers to an entire group of individuals having common observable characteristics (Mugenda, 1999). This study primarily targeted healthcare workers employed and working at RUNH the total was 202 at the time of the study as given by the human resource department of the hospital.

3.4 Sample Size and Sampling Procedure

Qualitative studies typically require a smaller sample size than quantitative analyses. Qualitative sample sizes should be large enough to obtain enough data to sufficiently describe the phenomenon of interest and address the research questions. The goal of qualitative researchers should be the attainment of saturation. Saturation occurs when adding more participants to the study does not result in additional perspectives or new information, (Glaser & Strauss, 1967)recommend the concept of saturation for achieving an appropriate sample size in qualitative studies. For phenomenological studies, (Creswell, 2003) recommends 5 – 25 and (Boyle, 1994) suggests at least six.

Convenience sampling was used to select FDG participant, non-probability sampling technique that involves using the most available people for participation in the study, and is considered a sampling method that is easy to implement in relation to cost and accessibility (Polit D.F. Beck

C.T., 2004). This method will involve small sample to ensure the researcher can form a more meaningful bond and establish rapport with the participants for a richer discussion and interview process. The chief executive officer, the administrator, chief medical officer, lab technologist, pharmacist and the Nurse Manager will be purposively selected and interviewed individually; Focused group discussion will be conducted with the nursing staff, support staff for collective discussion in order to understand opinion and to get a rich description of accreditation perspective, this group will be drawn for a collective discussion to understand circumstance, behavior and opinion because of homogeneity of the carder. Convenience sampling approach enables the researcher to achieve the sample size in a reasonably fast and inexpensive manner and most importantly this allowed the researcher to sample from each department at the organization and have an all-round representation and views.

3.5 Inclusion and Exclusion Criteria

3.5.1 Inclusion Criteria

Only staffs that volunteered to be interviewed and provided consent were enrolled in the study. Staffs were required to have worked in the facility for a period of 4 months to participate in the study. This ensured they were well orientated and acquainted with accreditation process in order to meet the aim of the study which was to explore perception towards accreditation and quality of care. Key informant each post was held by a single person, so there was no need to consider sampling. While FGDs participants were purposively picked since they met selection criteria.

3.5.2 Exclusion Criteria

Health workers on leave schedule, on off duty and those who decline consenting were exempted from participation. In addition, new employees and those with no direct involvement to accreditation process such as the interns and students on attachment will be excluded because they may not offer quality information.

3.6 Data Collection Method and Research Instrument

Qualitative data collection occurred through face to face key informant interviews and focused group discussions; they were audio-recorded and guided by the interview schedule (APPENDIX

1). The interviews were pre-scheduled according to the availability of each participant/ group. The invitation to participate in the face to face interviews was arranged via a general invitation which was distributed by administrators and the chief nurse of the hospital. Prior to the start of each interview, the researcher explained the purpose of the study, what would happen during the interview and reminded participants that their participation was absolutely voluntary and they had the right to withdraw from the interview at any time and without giving any reason. This step was taken to encourage participation by removing any doubt as to the purpose and confidentiality of the interview. The interviews took between 30-40 minutes and took place in the hospital cafeteria which provided anonymity of the discussion while the FGDs took place in a quiet room provided by the management.

The researcher conducted two training interviews with his colleagues to familiarize himself with the interview process and make sure the questions were flowing in a logic sense. These two interviews were not included in the analysis.

Research Instrument

The researcher considered the interview which helps participants to explain their feelings, perception freely and provides more in-depth data without being restricted in selecting their answers (structured) nor left talking freely (unstructured) and possibly giving undesired data. The interview schedule (APPENDIX IV) was adopted, this was guided by topics drawn from the existing literature, and questions were included that allowed probing to enable interviewees to expand their answers and the same time a prompt was developed to further help in this. The final interview schedule was a tool adopted from (El-Jadari and (Alaradi, 2017), consisted of 13 questions divided into three sections each representing the study objectives aiming to examine the perceptions of healthcare workers towards SafeCare accreditation and quality of care. This method enables the researcher to attain equivalence of meaning rather than just wording questions (Ellis & Denzin, 2006). All interviews were audio recorded and important information as perceived by the researcher was recorded on a note book.

3.7 Data Analysis

The interviews were transcribed and subjected to Content Analysis, in the thematic code. The documents were also analyzed using N-Vivo. All data were examined in light of theoretical framework. Finally, the process of developing and refining the conceptual model was done in selective coding.

3.8 Research Validity

Face and content validity are qualitative measures of validity and secured using a panel of experts who judge the surveys appearance, relevance and representativeness of the items. Face and content validity are important first steps to establishing construct validity because they establish the accuracy and connection among the items and variables measured (Burton & Mazerolle, 2011). The study tool was peer reviewed by colleagues, who reviewed the items for understandability and clarity of the questions, and consistency in the terminology used in the questions and in healthcare settings, expert opining was sort from the review of my research supervisor.

3.9 Ethical Issues in Research

Ethical approval to conduct the study was sought and obtained from the Strathmore University Institutional Review Board (APPENDIX I). With the ethical approval letter from Strathmore University, permission to conduct the research within RUNH was sought from the chief executive officer of the hospital.

Participants in this research were required to give consent of their willingness to participate in the study based on the consent letter (APPENDIX II). They were also informed in advance of the objectives of the study and anonymity was maintained because they were not required to disclose their names. Audio recordings were transcribed, and data presented in codes to ensure that there is no linkage between specific data and individual respondents.

CHARPTER FOUR: DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.1 Introduction

This chapter presents key findings from the study. Table 4.1 shows the number and category of staff interviewed. A total of 6 in-depth interviews and 3 focused group discussions were conducted to answer the research questions.

Table 4.1 Interview schedule and interviewee codes

In-depth interview			**Focused group discussion**		
Category of staff	**No interviewed**	**Interviewee's codes**	**Category of group**	**No of participants**	**interviewee's codes**
CEO	1	R1	Nurses head of sections	5	D1,D2,D3,D4,D5
Admin	1	R2	Nursing officers	5	ND1,ND2,ND3,ND4,ND,5
Medical doctor	1	R3	Support staff	4	SD1,SD2,SD3,SD4
Laboratory technologist	1	R4	Total	14	
Pharmaceutical tech	1	R5			
Nurse manager	1	R6			
Total	**6**				

Respondents of the In-depth interviews were purposively selected to include management level staff who were directly involved in the SafeCare accreditation process. The interviewees cut across the different cadres in healthcare professions, bringing in diverse perspectives of the accreditation process. They also provided insights from lower level staff that they supervise.

The focused group discussions were held with front line staff, who were directly involved in the accreditation process. The respondents were drawn from the different healthcare professions', including nurses, front office staff, housekeeping staff, and cashiers

Results

This section presents finding of the interviews with the healthcare workers of RUNH who met the inclusion criteria. Data is presented as per the themes of each objective in a narrative approach that focuses on the story from the respondent. Verbatim quotes are used to illustrate the point made, and a short description of the category of respondent is given to aid interpretation of the findings.

4.2 Experiences Towards Safecare Accreditation Process

According to respondents their roles mainly included; coordinating the SafeCare process, reinforcement of quality standards and implementing the quality improvement plan.

SafeCare Process Coordination

Respondents in management positions were involved in coordinating the entire accreditation process, including coordination of staff within departments and communication with the accreditation body. Sensitization trainings were held with the health workers across the various departments to ensure the processes ran smoothly. The coordination processes also involved providing support for the departments. In coordinating the process support was provided and in some instances included financial resources.

"In terms of safe care you see the beauty of safe care is that it is a step wise kind of an improvement plan so my main task is to be able to get the QIP Quality Improvement Plan in order to identify which ones falls within particular department and the department that are affected we have to sit down and try to see is it a department or is it a committee. We kind of try to analyze the QIP and then make them understand what the QIP is all about." (R2)

"Well my role is to ensure that quality processes are maintained not necessarily by the nurses only but in the whole hospital." (R6)

"My role was to coordinate not only the management team but really safe care they told us to make sure everyone is embracing the culture of the SafeCare. Because when we had a meeting especially with the in charges of the departments, it was kind of; "this is for management, it is not for us, it is for the top one. So at the end we started sharing the information from SafeCare with all of them emails were copied. In the e-mail, then they started suggesting themselves that it was not impossible to do." (R1) This means that accreditation as a process has hierarchy and it's not a horizontal process but rather a vertical one with implementers and coordinators but must work in sync to succeed and avoid situation where workers can view the relationship as boss-servant relationship but equals with different roles to play.

An interviewer observed that coordinating the process was not easy, and that at some point, it become clear that everyone's support was necessary for the process to be successful, for a successful accreditation process all inclusivity is key.

"Very much let me say initially we had a few challenges because I think the way we approached the safe care journey was not clear to all the staff but over time with explanations from Pharmaccess engaging with the staff we came to a point where everyone accepted that yes we are on this journey for the good. So let me say it has really helped." (R6)

Implementing quality standards

Majority of respondents from various departments stated their biggest role was implementing quality improvement plans for areas that did not meet standards. They were required to work on developing and ensuring the standard operating procedures (SOPs) were followed in their various departments. Infection prevention was mentioned key; staff felt it was an important milestone they had achieved since starting the accreditation process, and that it was a collective role. The core of any accreditation process is geared toward quality improvement as shown by these responses. When SOPs are formulated they became the rule book for any organization and therefore form something to refer to and use in improvement and execution of tasks.

"But now when it comes to the nursing department it is more intense in the aspect of delivering care to the patients, how we are managing or how we are handling the patients, how we are performing our procedures are we able to maintain are we following the SOPs." (R6)

"After we have met some criteria's, maybe the infection prevention is up to the standard; we are following the SOP's, yeah."(D3)

"you know the creation of the SOPs they run for a period they keep on changing so I have to updated them"(R4)

"Then another thing is about hygiene, cleanliness of the hospital is a part of that because the moment you walk around, you will see this hospital is clean and we also maintain and follow infection prevention by using the color coded bins that is part of SafeCare." (SD 3) This shows the importance of accreditation HCO since its creates order and structures that can be used as reference points and to streamline operations using universally accepted standard operating procedures that brings out uniformity.

Reported experiences during the SafeCare implementation process included increased workload, improved revenues and improved work processes.

Increased workload

Majority of interviewees reported increased workload during the SafeCare accreditation process. They attributed this to the structured and detailed accreditation process. Specifically, some procedures that they would otherwise not have performed were now a requirement in the accreditation process. The increased quality of services also led to increased workload as clients who were happy with the services provided referred more patients to the facility. Result also show that some healthcare workers stated that while accreditation demanded for extra input in activities the staffing levels of the hospital remained the same therefore same staff required to put more extra in their work. High staff turnover without timely replacement also increased the workload as the few staff that remained at the facility had to cover for the staff that resigned. Increased workload could mean management fail to put mitigating factors early or do not recognize this as a problem.

"For example you have just heard me say I am almost going down, so there is increased work load. Because, Clients are many, but the staffing is low". (D5)

"As I am telling you one challenge we have always had I think it shouts most is our long queues because I think we have quite a number of patients I think this is a low season for some reason

but we have been having quite a number of patients so we find that with the current staffing we are not able to manage" (ND2)

"when we receive our supplies you will find cartons lying on the floor because we are few and have to continue with our daily work and still move them to the shelves" (R5)

Some respondents, especially those with managerial responsibility, attributed the increased workload to hospital growth and not just the accreditation. They pointed out that the hospital was executing a strategic plan concurrently, beyond the scope of accreditation.

"We are looking at offering more services to the community, we started some specialist clinics because our vision is health for all since we are not for profit everyone deserve quality services even if they come from the slum implementing this require finances which we may not have but with time we shall hire more staff as resources improve" (R1).

Workload resulting from accreditation process could be attributed to streamlined process, verifying procedures and also where the organization fails to recognize changes that come with accreditation and put corrective measures in place but rather continue to operate in the same way as before accreditation.

Improved revenue

Respondents agreed that they experienced improved revenue streams for the hospital mainly because of offering additional value-based services as a result of accreditation process. They also attributed this to prudent management of resources instigated by SafeCare process.

"The stakeholders so what the neighbor they think about you uum what we need to improve, there was the issue of incinerator, the incinerator, we need to reduce the pollution so we have to involve, NEMA. And then the company that is regulating the chimney, uum, okay that one is another expense. And then Nema to come here to approve the incinerator. In fact we have very few accelerators in Nairobi approved by NEMA and have a license. In fact we started the business also to bring the medical waste from other facility and to burn here."(R1)

"We now do strict waste segregation and all the waste papers are recycled in paper towels and tissue paper this never used to happen before accreditation but because of SafeCare we have realized this benefit that makes us money" (SD4)

This means that accreditation can be a tool to enhance business outcomes just the same way process and outcomes are improved. There is value addition and not necessarily an expense or time spent that has no return on investment.

Improved work processes

Healthcare workers observed that accreditation processes had made their work streams more efficient. The hospital had digitized records, resulting in a paperless process. Additionally, there was better time management; meetings were better scheduled, minutes recorded, and those with action points informed. Policies and work instructions were created to make processes smooth.

"When I came there was no this online now we have a system that is known as Med 360 it's available now but we just used to use files carrying files all over that's now an improvement"(R5)

"Management of patient has become easy now when you visit our clinical areas guidelines are available making reference very easy before you could be forced to look up a book or Google which is odd when you have a client" (D2)

Other experiences from the findings included improved communication among healthcare workers and management, issues were better responded to since management was supportive of the process and worked upon feedback more proactively.

The findings also showed that some staffs were not sure what their role was as far as SafeCare accreditation was concerned: -

"In fact that's what we could have started with, you know when we hear of level five [SafeCare accreditation Level], but I think this is an administrative thing that they are the senior people

who deals with this, we being juniors, we are just there to work. We only hear safe care were here so we don't know much about safe care. We might not know all be the same… some might be having little knowledge or we completely don't know."(SD4) This shows that accreditation sensitization and staff involvement should not be a discriminatory exercise but should involve everyone on a continuous basis. Accreditation should be anchored in the values of the organization to encourage staff to talk about and put seriousness in the process with the same weight as other organizational values.

4.3 Factors That Influence Progress towards Attainment of Accreditation

Interviewees identified the following as important factors that affected the process of SafeCare accreditation: training and capacity development, management support, staff response (acceptance/resistance), state of infrastructure and adequacy in staff numbers.

Staff response (acceptance/resistance)

Respondents observed that accreditation was a new concept, viewed as a management tool. They were not clear on its objectives. Others felt it would disrupt what they were used to or would come with additional demands. Respondents stated that at first it was a challenge and SafeCare was not a straightforward journey. Respondents also feared to fail and therefore adopted a wait and see attitude. Overall, it emerged that resistance reduced with continuous engagement.

"No, no, no. I think at the beginning there was a lot of resistance, It was a lot and to change the mind of the management team and sometime even myself because sometime you are really discouraged you think you are doing well but after the assessment you find yourself at the bottom, when you think your systems are serving you just fine you are told you have to adjust here and there" (R1)

"The other challenge which I may mention is with the staff some of them may have not embraced SafeCare in totality so there might be an issue…" (R2)

"You will have staff resistance because we perceive things differently. You may have very good intentions for initiating something but the way I perceive it…it depends so some will rebel but over time if the majorities are the ones for the change you will eventually embrace the change" (ND4) staff resistance only appear to be present initially when the process is introduced and when handled and addressed early can be overcome.

Training and staff development

Respondents considered training as an important aspect of accreditation. They felt that developing staff capacity allows them to appreciate the process and outcomes. Health workers observed that they had undergone a lot of training and support supervision as part of the accreditation process, which they felt had enabled them to learn new things and be more aware. The respondents noted that the trainings had given them new skills they did not have before like developing SOPs, organizational policies and customer care relations. They also felt that training was something long term that they would carry beyond RUNH.

"Yes we did establish and one thing that even my staff and us as management realized and we all agreed that motivation mostly people are thinking about monetary but the staff were saying that the trainings and the development the capacity development that we have been undertaking is more important to them than even the aspect of monetary because a training is something that is there to stay forever and certification it is something that is there to stay for long. Money you cannot for instance go to an institution two years down the line and show while I was here I was given 10,000 but I can parade a certificate I have undergone this kind of training. So that one has really…really helped a lot so we have been…we have diversified our training we have a training center but besides the training center we have been able to engage even with other institutions outside like this week there were staff who went for trainings but at the same time appeal for more partnership in terms of training". (R2)

This means that training is a pillar of accreditation and an investment that sometimes a priceless both for the organization and staff.

This finding confirms the Donabedian theory that indicates the structure, which includes human resource and specifically, the employees training and employee compensation has an impact on how the human resource act, and ultimately this has an impact on quality of health care services.

Management support

Management support was considered an important factor by respondents. They saw it as the primary determinant of success. Staff said they received more support from management during the accreditation process than was the case before. This made them own the process. They trusted that management would embrace and support them. SafeCare is successful when management support staff and involve other staff and therefore the process stop appearing like it's a management tool.

"So if they need anything they can only invite me that 'kindly come in and assist us but the committees they own the committees the CEO and myself again can only come in as members not as management no…no it is their management. So that helps them to understand and to own up the process" (R2)

"Like before when we started this journey we didn't have some committees in place like infection prevention, quality improvement, committees we didn't have those committees and without them initially we made mistakes of course we could involve even some of the management members into these committees and you find issues are not coming out clearly until we realized let us give this to the people completely the mandate to the rest of the staff and none of us the management will be there apart from receiving the feedback. So when we left those committees to be run by the staff themselves they kind of owned it and now they are able to penetrate they are able to interact with the rest of the colleagues because they interact at a colleague level not at a management and …and employee and employer level. So they are now able to give us only feedback then we act and we support them where they need. So that has really helped involving the staff and making them own the whole process and showing them it is not for the good of the management that you are doing this it is for your own good".(R6) Accreditation is driven by management desire to excel in quality and also to benchmark the organization to international standards, support and buy in key to drive acceptance and success.

Shortage of staff

Respondents stated that shortage of staff affected the ultimate goal of SafeCare accreditation that is provision of quality services to both internal and external customers. Healthcare workers stated that shortage of staff is a hindrance to attaining and maintaining accreditation. This is brought by

high staff turnover without proper replacement plans in place and also hiring of new staff with little or no experience which lenders their presence not be felt, the experienced staff therefore has to cover both for self and new staff until when competency is build. Shortage of staff means that continuity of quality is broken or slowed by training new staff and also bringing in new staff also appear to impair the culture that had been established.

Those in management also stated that financial capabilities to hire more staff may lead to shortage if resources are minimal to allow hiring.

"when a staff leave this hospital he/she leaves a gap that could affect the quality since the staff covering has to also carry their own duties you also need to train new staff to be at par and this takes time and you will find that the quality results are not so good during that time"(SD1) Where staff are stained by shortage accreditation may be affected since the optimal deliverance of staff is weighed down and also may exacerbate staff burn and therefore affect staff morale to perform as expected. Meaning of accreditation may also be lost if staff continue experiencing shortage and may interpret it as a management support failure.

Poor infrastructure

Healthcare workers alluded to the fact that poor infrastructure leads to poor accreditation progress. Respondents agreed that for the full potential of accreditation to be realized a few changes were necessary and some may be costly for the facility even though the cost was a one time off investment on the budget. Those who had worked here for a long time agreed they had seen the hospital undergo various infrastructural changes all related to making processes easy. According to Donabedian theory development and improvement of infrastructure is inevitable since its part of process enhancement and ultimately improve the outcome.

"You see with safe care comes with a bit of implementation and some changes that are necessary might require finances so you may find that finance now becomes a little bit a challenge"(R1)

"With accreditation we have to build a new sluice in theatre which is a cost, buy quality test kits and for privacy at the pharmacy put up a dispensing booth all this require funds but the benefits outweigh the expenses."(R2)

"because of accreditation now we are provided with cleaning items more frequently and also personal protective equipment, including fire extinguishers are now in every place all this require financial resources"(ND5)

This challenge of poor infrastructure is in line with the street level bureaucracy model that indicates one of the challenges that front-line workers face that prevents them from giving quality services is shortage of resources. The health workers at RUNH indicate clearly that poor infrastructure may lead to poor quality. They also noted that for them to achieve higher level accreditation, then they required more resources in specific areas such a pharmacy and theatre.

Motivation and staff recognition

Respondents stated that for the accreditation process to be seamless even with increased workload, it was important to recognize the effort of frontline staff implementing the process and helping the hospital realize accreditation. Healthcare workers felt that accreditation more often targeted service improvement to the clients and ignored their plight, more so management used accreditation to market the facility but failed to recognize the implementers. Findings show that at RUNH management had not implemented a system of rewarding and recognizing the healthcare worker who are the implementers. Staff also stated that accreditation process should come with some financial incentive to match the achievements.

"So in terms of recognition, we can say that one has not been implemented, the other thing is that those joining the hospital are given salaries the same as us who have been working for this accreditation" (D2)

"Now that the hospital is improving, and I think the income-the revenue is going up, still they should consider the employees because when am happy, when I am motivated well, I will treat this people well when am very happy. And I think that one will result to good image of the hospital". (SD3)

"They have never called me or we to say you have done well, you are only called when you have done something like a mistake" (R4) this show that staff place great importance to recognition that may look little to the management or less important to management, reward and recognition is also seen as a stimulator of positive competition.

Perception on quality of care

The purpose of accreditation is to improve quality of care. Healthcare workers stated that they felt quality of care had improved due to better coordination and sustained quality improvement brought about by SafeCare. They also stated that clinical guidelines were now adhered and the scope of services also increased to enhance patient satisfaction.

Enhanced patient satisfaction

Healthcare workers stated that they had received positive feedback from majority of clients and patients who said things had improved and the care was good. Long queues were also reported to have become order of the day since most client come seeking services because they perceived good quality of care.

"The biggest benefit which I could basically attribute is the aspect of quality and the aspect of safety in patient and the staff so those two issues are very important"(R2)

"Yeah it has really decreased because now ah one of the things safe care has also been able to try to help us establish was to have a kind of a feedback mechanism which we have really had patients even responding to us giving the feedback both positive and negative. Like yesterday we even had one who, three days later still comes back to say 'I just want to say thank you for what you do'(R2)

"As I am telling you one challenge we have always had I think it shouts most is our long queues because I think we have quite a number of patients I think this is a low season for some reason but we have been having quite a number of patients so this can be attributed to good services otherwise why would patient flock this place?"(R5)

Some healthcare workers stated that they were not aware if patient complains and quality of care had gone down because client satisfaction index was not shared with them, they thought management only involves them when something wrong or bad happened between then and clients but not when good things like quality of care or where the patient appreciated they services.

"The complains, unless they get something that touches on you, that's when they will call you. Come, tell us, what happened? This and this happened. Tell us? Of which it should be negative.

Something positive, I have never heard someone calling you because you did something good. But something negative they call you and even you can be suspended" (SD1)

"I think they are in a position to answer that (management) because what we normally tell the patients, who normally complain to us we tell them this are administrative issues, why can't you get this on the suggestion box or maybe you write in some letter and then you put it in the mail box. So it is them who normally open the box, now I think it is them to tell us."(SD1) accreditation is a drive of patient satisfaction.

Adherence to clinical guidelines and standards

Respondents stated that there was increased adherence to clinical practice guidelines. Safecare team had also facilitated them with tools to carry out clinical audits; these that had never been available before the accreditation process.

"We now have this clinical guideline in our places of work that we follow like how to examine antenatal mothers" (ND1)

"am happy we did some antibiotic resistance test on our antibiotic stock in the pharmacy and that now guarantees that we are now stocking superior antibiotics for our clients before accreditation we dint know ant thing like that"(R1) This means that healthcare start to attach importance to adhering to standards when they realize accreditation audit show positive improvement or negative results may be so because of now adherence, medical field is also driven by evidence based practice and health workers tend to appreciate when this is demonstrated and shown like during clinical audits.

Increased number of services

Majority of respondents agreed that as a result of accreditation the hospital had started offering additional services to enhance both client satisfaction and quality. The hospital was looking at community needs in general and was committed one stop health facility that provided comprehensive services to the clients.

"Me I would just say with those additional clinics, it is something good Yes because actually we've seen, there before we used to lose many patients because the moment someone comes

maybe I want ENT you tell that patient no ENT, goes away but nowadays you see the number even has increased, because of those clinics and clients tell us that they are happy to have this services here because they can be checked by a variety of doctors who are experience in those different areas without going to big hospital like Kenyatta."(ND5)

Accreditation process tends to maximize on efficiency and this could be the reason why HCO realize of other unexploited avenues, leads to expansion and adding value to services provided.

Sustained quality

The health workers noted that the Safe Care quality requirements were sustainable, and it was unlikely that the quality of services will deteriorate after the accreditation was acquired. They noted that the accreditation was well embraced by everyone and they had accomplished a lot in terms of Quality of services. However, some respondents were concerned about new inexperienced staff that were ignorant of the SafeCare process and were less committed to providing quality care.

"I feel the new staffs coming in; you see they are very young girls and boys, very young staff. It's not like us. We have grown old here, and we know what we want. The young girls and boys come in; you want to tell them this is what you are supposed to do. It's like you are wasting their time. They are on their phones most of the time and not with the patients and just waiting to be employed by the county and they compromise the quality in this hospital some are also don't care and they tell you on the face am just her for experience" (ND1) This means that accreditation ought to become part of the organization culture, any one coming in just adopts and the process is cultivated to new employees during induction and orientation and after evaluated or assigned specific role that are assessed during the staff appraisal period. Accreditation deliverable should be collective for each and every staff.

4.4 Summary of Chapter

In this chapter, the researcher analyzed data that was collected from a multi- disciplinary professionals working at RUNH for diverse views and opining as shown above. The study findings show that healthcare workers had different views on the perceptions of the role that they played to facilitated accreditation. Coordination of the process was a key role for management staff while frontline staffs were involved in implementing the QIP and reinforcing quality

standards. Healthcare workers experience increased workload and also their efforts in this treacherous journey were not adequately recognized and rewarded. Quality of care was perceived to have improved and increase in client numbers was thought to support this. Further discussion, conclusions and recommendations are outlined in the chapter that follows.

CHAPTER FIVE: SUMMARY, DISCUSSION, CONCLUSON AND RECOMMENDATIONS

5.1 Introduction

This chapter presents a discussion of the key findings in chapter four above. The discussion is organized in three sections according to the study objectives, 1) role and experience's, 2) factors that influence accreditation and finally 3) perceived quality of care.

5.2 Experiences during the process of pursuing SafeCare accreditation

The majority of staffs were involved in the accreditation process. Introduction was through staff trainings and sensitization meetings between the hospital and the SafeCare accreditation organization. The role of management in accreditation was to ensure that staff complied to accreditation standards while that of other frontline staff was to ensure that the quality aspect of accreditation was implemented. Interviews with staff indicated that staff had a role in infection prevention which had improved since accreditation. The frontline staffs were also involved in developing and implementing standard operating procedures and policies that enhanced quality of care to patient. Majority of those interviewed understood their role in the accreditation process. A few of those interviewed could not differentiate between SafeCare level five accreditation (certification) and the Kenyan health system organization of health facilities by level of care (based on scope of service and infrastructure). Most of the respondents acknowledged that their collective roles in the process helped the hospital achieve accreditation and this boosted their morale. The findings also show that staff felt their role was recognized and appreciated by stakeholders and patients i.e. clients and outsides while management had not appreciated their role either through a word of mouth or in writing this concurs with findings by (Attal, 2009), who concluded that the practices of "training and education", "incentive compensation" and "employee development" produced the greatest influences on total quality management implementation. While accreditation had introduced the facility to performance appraisal for staff majority felt it was a management routine program that was not linked to any benefits.

The study results also demonstrate that staff had both positive and negative connotation based on their experiences during the process of accreditation. The professionals do not uniformly

visualize the experience of the Accreditation process; some employees could understand the process in a positive way, while others only approached it with a negative view. However, there were those who could reflect on the Accreditation, extracting the negative aspects and the success points of the process. The findings showed that staff attributed their experience in been accredited to offering quality services to both their internal and external customers. Working in an accredited institution was seen as increasing staff satisfaction because of the good name in the public domain. Management attributed accreditation as attracting new and more stakeholders though increased networking, this included insurance companies and partners who brought more business to the organization. Even though many studies had attributed accreditation to increased cost both direct and indirect (Alkhenizan & Shaw, 2012) findings from this study disagree with his and show that managers perceived the benefit of accreditation outweighed costs and also cost was viewed as a onetime expenditure rather than recurrent, this study findings also contradict findings by (Shaw, 2000) who had made a conclusion that, despite the fact that we are living in an increasingly evidence-based world, there has been very little hard evidence presented as to what impact individual accreditation Programmes have on the healthcare system, or on benefits to healthcare providers and other stakeholders (Holtmann, 2018). Communication within the organization had improved and relationship between staff and management. Findings also show that documentation, time management, human resource management as improved. The study subjects mentioned that the employee working in an accredited institution feels better prepared to meet the requests of the clients, while maintaining the level of quality through the standardization of routines and greater organization.

5.3 Perceptions on factors that influence progress towards attainment of accreditation

The findings of the factors that influence attainment of accreditation were highlighted equally among all the groups of various cadres of health workers interviewed. Among the factors that positively influenced attainment of accreditation were viewed as staff trainings and capacity building which made staff have better understanding of their role, acquired new knowledge and also changed their attitude and behavior this concurs with a study by (Hayes, 2002) who stated that organizational change is typically associated with some degree of individual change, which is often the outcome of training and development Programmes. Respondent also agreed that accreditation standards enable the organization to hire qualified people who could then deliver and help maintain the accreditation status.

Among the negative (barriers) attributes that staff highlighted included Staff resistance which was considered to pose particular challenge, although all the staff who participated in the study agreed that this can be overcome through training and sensitization to the process of accreditation it was clear it had some impact to the process. Shortage of staff and staff turnover was another key challenge this concurs with a study by (El-Jardali et al., 2014) who concluded that staff shortage, financial constrain and staff resistance as barriers that affect accreditation process. In particular, there was view that staff were trained, and then moved on or were pouched by other organization who felt that working in a hospital that is accredited made them better. Those that were left then had to start training and orientating new employees and this staff felt could fluctuate quality levels. Staff also explained this as a barrier because they felt that hired staffs were more likely to be newly qualified inexperienced staffs that are trained and once experienced move on to other organization. This constant turnover meant that new staffs constantly had to be trained to take on accreditation activities. Staff also felt there was increase in workload since accreditation activities were added on top no of their routine work and this coupled with staff shortage can be major barrier towards attainment or maintaining accreditation status.

5.4 Perceptions on quality of care

Quality of care and improvement is the epitome of why HCO seek accreditation. Findings reveal that healthcare workers had confidence that care had improved since accreditation this concurs with a study by (Ng et al., 2013) who found that accreditation drives quality of care in many health organization either public or private.. This was attributed to the increase in numbers seen and the staff also felt that the standard operating procedures and clinical guidelines were been followed and implemented. Positive feedback an compliments were also common after accreditation while also complains received had gone down however they were concerns that many complains received occurred over the weekend when staff perceived management was absent. Social bloggers and use of social media was also blamed on false new and propaganda that were baseless and could not be ascertained, this negatively sometimes affected patient perceptions. Staff also felt that patient satisfaction index and data should be shared across since some were clueless about perceived quality of care from patient feedback as this data was analyzed and used by management and the only time concern on quality was raised is when a staff had done a mistake or a complaint lodged against them. Staff were confident that quality of

care was sustainable but with management support in terms of capacity building them, motivation and improving staff to patient ratios.

This chapter presents the conclusions drawn from the findings highlighted in chapter four and five and the recommendations made therein

5.5 Conclusion

The results from this study indicate that understanding the perceptions of health workers who are the front line implementers of the accreditation process is important because hospitals are searching for new care models and other forms of management, aiming to achieve results that optimize resources, increase quality of care, and guarantee the improvement of the service offered. In this context, the Hospital Accreditation program appears as a possibility to promote changes among staff and influence their behavior toward owning the process and guarantee achieving high level standard of care to their clientele. This can be facilitated though training and sensitization of workers with the right information pre-accreditation, during the phase of accreditation and post accreditation.

Findings indicate that healthcare workers are receptive to changes and easily adopt if management is supportive and this becomes a win win situation where the organization management can bask in the glory of accreditation and the health workers can work in a better improved environment while the clients receive quality services.

The study finding also underscore the notion that accreditation process increases the overhead costs but rather healthcare organizations mangers should look at the broader benefits associated with accreditation and exploit them to achieve economic gains. Healthcare workers (internal customer) should be appreciated, recognized and rewarded for their efforts to achieve accreditation status but not only associating accreditation to improved patient outcomes (external customer).

The results of this study also show that the process of accreditation should be all inclusive and should not be left to the management or the quality improvement team this enhances accountability among staff and to make the process sustainable.

5.6 Recommendation

This study strongly indicate that accreditation is beneficial to HCO and from healthcare workers perspective it is important to involve everyone in the process of accreditation through organizing in-house trainings which can be beneficial to enhance the understanding of accreditation among the employees. Most importantly before arranging a training session for staff, understand what is required to ensure that the resources invested are targeted at areas where training and development will yield positive return on the investment, this can be done through staff training needs assessment.

In order to address the issues of staff shortage and high turnover which was highlighted in this study, the management of HCO is strongly advised to consider a system of incentives for employees to encourage them to stay and contribute to future rounds of accreditation, thus ensuring continuity of knowledge, skills and expertise. Having human resources process to replace those who exit in a timely and efficient way is recommended. Management needs to recognize and reward healthcare workers not necessarily by financial means but though individuals, teams, departments, section acknowledgement of exemplary performance example awarding certificates, display of employee or department of the month.

To address fluctuations in quality of care and sustainability of accreditation when new and inexperienced employees are employed the HCO should have orientation program that include accreditation and quality of care.

The accreditation body should enhance support and ensure that facilities that are undergoing accreditation are fully supported with information about accreditation; processes involved and make everyone understand the meaning of SafeCare accreditation/certification this will enhance cooperation, owning up of the process and will create awareness of the process. The accreditation body should also enhance bottom up approach of creating awareness and accountability to avoid the process looking like a management driven process after gaining management buy-in first. Accreditation organization should also have standard benchmark protocols to enhance learning of key lessons by other organizations struggling in the accreditation process or looking to start the process in their own HCO. Caucus of facilities in level five should be formed to facilitate organizations sharing and drawing strength and lessons from each other's by exchange of information.

Information about accreditation should also be enhanced to the general public to create awareness this will create demand for accreditation and enhance quality of care to clients.

5.7 Recommendations for improvement of the SafeCare accreditation model

The key recommendation from the study on SafeCare certification model improvements is as follows:

1. Accreditation bodies should attempt to involve the entire HCO. Everyone in the organization should feel accountable for the outcome of the survey and ultimately quality of care. Management buy- in should be followed by bottom up approach to enhance awareness and accountability among all staff. This should be done during pre-assessment phase, assessment phase and post assessment phase during quality improvement phase.
2. Accredited organizations should also support training and development of the organizations internal quality improvement team. Access to tool for quality improvement and preparation for the next level should be enhanced.
3. Internal self-assessment should be encouraged and tools to carry out this should be enhanced.
4. Accreditation is meant to lead to confidence in the quality of care provided by an organization healthcare should have tools that they can record date to demonstrate this.
5. Benchmarking of accredited organizations by the accrediting body and submission of quality measures to a data library to review the improvement between surveys and draw lessons and action points should be implemented; access to assessment materials and case studies should be enhanced.

5.8 Limitations of the study

Every research study is limited by the constraints placed upon the researcher (Yin, 2003). As a result, the following limitations of this research included.

The researcher was a former surveyor of SafeCare and had worked with RUNH during the process of accreditation 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 minor observation. Thus, the potential for bias was reduced. Time was also limited and the number of case study was only one a limitation arising from this is that the generalization of the findings of the study is limited to the selected case.

5.9 Areas for further research

This study focused on SafeCare accredited facilities it would be prudent to explore perception of healthcare workers in other facilities using other models like JCI, ISO, TQM, Kaizen, Lean six sigma etc. this study looked at supply side, it would be prudent to also conduct a perception study from the perspective of demand side and validate the aforementioned increased in quality of care on the patient.

The study also used case study method with qualitative method of data collection further study is recommended incorporating other study design to enrich the findings.

The researcher recommends further research to study the phenomenon of perceptions of SafeCare accreditation from the perspective patients and clients to help incorporate their view that can help build and interlink with healthcare workers views to strengthen the process. Finally a study inclusive accreditation bodies, key stakeholders like insurance organizations such as NHIF would enrich knowledge of the whole accreditation process from all possible dimensions.

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APPENDICES

APPENDIX I: STRATHMORE UNIVERSITY STUDY APPROVAL

Strathmore UNIVERSITY

6th June 2019

Mr. Ndungu, Paul,
P.O. Box 1292,
Kikuyu,Nairobi.

REF Protocol ID: SU-IERC0386/19 **Student No.:** MBA-HCM 99628/17

Perception towards Safe care Accreditation and Quality of Care among Healthcare Workers: A Case Study of Ruaraka Uhai Neema Hospital

We acknowledge receipt of your application documents to the Strathmore University Institutional Ethics Review Committee (SU-IERC) which includes:

1. Study Protocol submitted 4th April 2019
2. Cover letter listing all submitted documents 4th April 2019
3. Proposal declaration Page signed by supervisors 4th April 2019

The committee has reviewed your application, and your study *"Perception towards Safecare Accreditation and Quality of Care among Healthcare Workers: A Case Study of Ruaraka Uhai Neema Hospital"* has been granted **approval.**

This approval is valid for one year beginning **6th June 2019** until **5th June 2020.**

In case the study extends beyond one year, you are required to seek an extension of the Ethics approval prior to its expiry. You are required to submit any proposed changes to this proposal to SU-IERC for review and approval prior to implementation of any change.

SU-IERC should be notified when your study is complete.

Thank you.

Sincerely,

STRATHMORE UNIVERSITY INSTITUTIONAL ETHICS REVIEW COMMITTEE (SU-IERC)
06 JUN 2019
TEL: +254 (0)703 034 000
P. O. Box 59857 - 00200
NAIROBI - KENYA

for: Prof Florence Oloo
Secretary
Strathmore University Institutional Ethics Review Committee

Ole Sangale Rd, Madaraka Estate. PO Box 59857-00200, Nairobi, Kenya. Tel +254 (0)703 034000
Email info@strathmore.edu www.strathmore.edu

APPENDIX II: NACOSTI STUDY APPROVAL LETTER & PERMIT

NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

Telephone:+254-20-2213471,
2241349,3310571,2219420
Fax:+254-20-318245,318249
Email: dg@nacosti.go.ke
Website : www.nacosti.go.ke
When replying please quote

NACOSTI, Upper Kabete
Off Waiyaki Way
P.O. Box 30623-00100
NAIROBI-KENYA

Ref: No. **NACOSTI/P/19/11643/30047**

Date: **4th June, 2019**

Paul Kamau Ndungu
Strathmore University
P.O. Box 59857-00200
NAIROBI.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"Perception towards safecare accreditation and quality of care among health workers: A case study of Ruaraka Uhai Neema Hospital"*** I am pleased to inform you that you have been authorized to undertake research in **Nairobi County** for the period ending **6th June, 2020.**

You are advised to report to **the County Commissioner and the County Director of Education, Nairobi County** before embarking on the research project.

Kindly note that, as an applicant who has been licensed under the Science, Technology and Innovation Act, 2013 to conduct research in Kenya, you shall deposit **a copy** of the final research report to the Commission within **one year** of completion. The soft copy of the same should be submitted through the Online Research Information System.

GODFREY P. KALERWA MSc., MBA, MKIM
FOR: DIRECTOR-GENERAL/CEO

Copy to:

The County Commissioner
Nairobi County.

The County Director of Education
Nairobi County.

APPENDIX III: PARTICIPANT INFORMATION SHEET AND CONSENT FORM

Title of Project: perception towards SafeCare accreditation and quality of care among health workers at Ruaraka Neema Uhai hospital, Kenya.

Dear Ruaraka Neema Uhai Hospital staff,

This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part. Voluntary Nature of the Study: This is purely voluntary and you are not obliged to take part. Be assured that your privacy will be protected. The data collected will be anonymous, that is, it contains absolutely zero identifiers and makes it impossible to determine who participated and who did not. Compensation for your participation is not provided as part of this academic study. Your responses are anonymous, secure, and without risk to you. No personal identifying information is required or gathered during your participation and the privacy of your responses is assured.

You can also choose to discontinue from taking part at any time if you do not wish to continue taking part. Risks and Benefits of Being in the Study:

Being in this study does not pose any risk to your safety or wellbeing; employer related promotion or potential employment opportunities. The benefits derived by participation in this study will assist in understanding the perception of SafeCare accreditation, challenges and enablers among SafeCare level five accredited facilities in Kenya.

If you need further information or clarification, please contact me Paul Ndungu (principle investigator) at paul.ndungu@strathmore.edu or telephone (+254 737 023147).

If you have questions about your rights as participants, please contact the Institutional Review

Board (IRB) team at Strathmore University

In order to protect your privacy, signatures will not being collected; your participation in the survey would indicate your consent, if you choose to participate. You can choose to print or keep a copy of the consent.

APPENDIX IV: INTERVIEW SCHEDULE TOOL

[Shake hands]My name is Paul Ndungu. Currently, I'm an MBA-HCM candidate at Strathmore University. I'm very glad to make this interview with you, your participation will be Confidential and coded .....I would like to ask you some questions about your personal opinion, your perception, experiences and role you have had, and some of Challenges you faced throughout the accreditation process. In order to learn more about hospital staff role, experiences and perception towards accreditation. Your participation is highly appreciated and I hope this interview will going smoothly. You have the right to stop me at any time and asking me any question come into your mind and you have the right to withdraw from the study at any time during the interview. The interview consists of 13 questions and might take about 30 - 40 minutes. Are you ready to start the interview right now?

Section A -Experiences of healthcare workers

1. What does accreditation mean to you?
    - Assess quality
    - Improve quality
    - Standardize primary health care
    - Improve patient/staff satisfaction
2. What is your role in the accreditation process?
    - Ensuring that the quality aspect of the accreditation is implemented and
    - highlighted
    - Ensuring that all accreditation criteria are met
    - Training on accreditation standards and doing local surveys
    - Ensuring that staff comply with accreditation standards
    - Ensuring that patients are satisfied with changes brought about by accreditation
3. Is this process newly introduced to you or you have been exposed to it before?
    - Yes, it is new
    - No, it isn‘t new, I have been exposed to it previously, through…
4. How did you engage your staff into the process?
    - Engaging staff through:
    - Meetings, briefing sessions, town meetings, staff meetings, weekly

- accreditation briefs, assigning staff accreditation focal persons, involving staff
- in accreditation training and surveys, explaining the benefits of accreditation

B- Was it easy or not to engage the staff? What were some of the challenges?

- Staff resistance
- Accreditation was a new and vague concept
- Difficulty in communicating the importance of accreditation
- Resistance more prevalent among older employees
- Staff shortages
- Heavy workload
- Not able to ensure enough physicians and specialists
- High turnover rate of staff
- Physicians have limited time to assess medical history and complete medical record

5. What are the resources or funding did the higher authority (board, management) provide to facilitate the process of accreditation and its implementation.
    - Resources- Information, guidebooks, training, guidance, support, books, websites, brochures…
    - Funding for: Training, accreditation process, costs to recruit additional staff, costs of necessary infrastructural work (redesigning the center to meet criteria), accreditation costs

Section B -Staff perceptions on factors that influence accreditation

6. In your opinion, has the accreditation process improved the quality of care delivered by RUNH? If Yes..... (How)??
    - Documentation
    - Recording minutes of meetings
    - Thoroughly completing medical records
    - Documenting rules and regulations
    - Translation of theories of quality into actions

- Introduction and reinforcement of quality standards
- Infection control
- Occupational safety
- Waste management
- Fire management
- Incident and accident reporting
- Enhanced employee awareness and involvement
- Giving guidance to employees
- Empowering employees and engaging them in decision making
- Developing a job description for employees and clarifying their tasks
- Better evaluation of employees
- Better relationship between the centers and the communities they serve
- Health awareness lectures and campaigns
- Community needs assessment
- Home visits
- Improved work conditions
- Work flow became more organized and systematic
- Enhanced role of management and leadership
- Forming interdisciplinary quality team
- Strategic plans
- Action plans
- Better relationship between the centers and patients
- Follow-up on patients
- Taking client suggestions, complaints and compliments into consideration
- Enhanced patient confidentiality
- Better relationship between the centers and local authorities
- Strengthened relationship with the Ministry of Health
- Strengthened relationship with county government other local authorities?

b) To what extent do you think this improvement is sustainable?

- Very sustainable
- Somehow sustainable
- Not sustainable
- Sustainable depending on:
- MOH strategic decision
- Availability of funding
- Sufficient/necessary provision of training
- Staff compliance (nurses, doctors, allied health practitioners…)
- Follow up from MOH
- Patient satisfaction results
- Staff satisfaction results

7. Did the accreditation enhance your satisfaction as a health care professional? If Yes..... (How) accreditation has affected your satisfaction?
    - Staff training, education and development
    - Staff perceived accreditation as an opportunity to develop themselves
    - Staff perceived accreditation as an opportunity to help the society
    - Accreditation made staff more aware about their rights
    - Enhanced communication between staff and the management
    - Engaging staff from the beginning of the process
    - Allowing staff to voice their opinions and concerns regarding accreditation
    - Enhanced communication among staff
    - The importance of teamwork was emphasized
8. What aspects of your work have been affected by accreditation?
    - Documentation
    - Recording minutes of meetings
    - Thoroughly completing medical records
    - Documenting rules and regulations
    - communication and relationship with other colleagues
    - learning new concepts
    - better organize your tasks

- time management
- affect your way treating your patients which in turn positively affect patient satisfaction

9. List the top three barriers/challenges that you have faced throughout the accreditation process and mention some of the approaches to overcome those challenges
    - Financial barriers
    - Staff resistance
    - Accreditation was a new and vague concept
    - Difficulty in communicating the importance of accreditation
    - Resistance more prevalent among older employees
    - Staff shortages
    - Heavy workload
    - Not able to ensure enough physicians and specialists
    - High turnover rate of staff
    - Physicians have limited time to assess medical history and complete medical record
    - Not all the standards are applicable to the context of Kenyan health system
    - Referral system to hospitals is lacking
10. What are, in your opinion, some strategies to better implement accreditation in the future?
    - Financial support From Ministry of Health and international agencies
    - Follow-up meetings and communication and collaboration with the MOH, the
    - accreditation team, and among other centers, and hospitals
    - Local experts are recommended to perform assessment
    - Practical training sessions and continuing education
    - Engaging municipalities or local authorities to gain their support

Section C -quality improvement and quality of care

11. From your perspective, of accreditation process do you think quality on health services was enhanced?
12. Do you think accreditation on healthcare services is now more efficient? If yes how?
    - By increasing quality through process improvement.
    - By decreasing costs and increasing efficiency on the long run.
13. Did accreditation enhance patient satisfaction? What aspects of patient satisfaction?

To what extent do you think the accreditation process has affected patient satisfaction in the hospital?

- Highly affected patient satisfaction
- moderately
- mildly

Modified interview schedule adopted from Alaradi, Limya Khalil (2017) and El-Jadari

APPENDIX V: RESEARCH TIME FRAME 2018-2019

Month	**May-August 2018**	**September-2018 to march 2019**	**April 2019**	**May 2019**
activities				
Developing concept notes				
Presenting concept notes				
Developing proposal and defending				
Data collection and analysis				
Writing report and presentation				

APPENDIX VI: RESEARCH PROPOSAL BUDGET/ EXPENDITURE ESTIMATES

Item	**Activity**	**Quantity**	**Unit price** **Ksh**	**Total amount** **Ksh**
proposal	Printing	60 pages	30	1800
	Photocopying	5 copies	180	900
	Binding	5 copies	200	1000
	Travelling cost	500		500
	Miscellaneous	2000		2000
project	Travelling cost	20000		20000
	Co-assistance stipend	10000		10000
	Audio recorder	2000		2000
	Data collection	20000		20000
	Data analysis	20000		20000
Final document	Printing	100 pages	30	3000
	Photocopying	7 copies	300	2100
	Binding	7 copies	300	2100
			Sub total	**85400**
			10% contingency	8540
			Grand total	**93940**