

## Impact of Hospital Accreditation on Quality of Care as perceived by Nursing Staff in King Khaled Hospital in Najran at Kingdom of Saudi Arabia

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**Abstract: Background:** Accreditation has attracted great interest in recent years as a comprehensive approach for improving and maintaining healthcare quality .The accreditation movement is gaining prominence due to globalization and especially the global expansion of trade in health services. **Aim:** To assess the perceived impact of hospital accreditation on quality of care through the health care professionals, specifically nurses. **Design:** descriptive exploratory design was utilized. This research study followed a cross-sectional survey design. **Methods:** The study was conducted in king khaled hospital (KKH) in Najran at Saudi Arabia that successfully passed the accreditation requirements. (both national and international surveys).A purposive sample (120 nurses) that was limited to only nurses who have been working in the hospital for at least 3 years (i.e. had passed through both accreditation surveys were constitute the study sample. Data was collected through utilizing quality implementation scale. It composed of two parts; the first part is related to demographic data of the respondents. The second part is consisted of nine scales and subscales subdivided into 54 items to evaluate quality implementation and outcomes in health care organizations particularly in the context of accreditation. **Results:** Hospital accreditation is a good tool for improving quality of care as the high score of ‘quality results’ variable indicates that nurses perceived an improvement in quality during and after the accreditation process. The most important predictors of better quality results were leadership, commitment and support, use of data, education and training, rewards and recognition and benefits of accreditation. **Recommendations:** In order to ensure that accreditation brings effective quality improvement practices, there is a need to assess quality based on patient outcome indicators, This can be done by strengthening the current accreditation program to be more outcomes oriented. Senior management of the hospitals undergoing accreditation program should be highly committed to accreditation process and should support hospital staff. Staff involvement at all stages of accreditation program is crucial to achieve the ultimate goals and benefits of accreditation.

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### 1. Introduction

There is an increased interest around the world in evaluation of healthcare, coming not only from governments but also from healthcare providers and consumers. In the majority of countries, the quality of patient's care provided through the healthcare delivery system has become the focus. Since quality is a crucial factor in health care, initiatives to address quality of health care have become a world-wide phenomenon (Al Awa *et al.*, 2010). The necessity for quality and safety improvement initiatives permeates health care (National Health Care Quality Report, 2008).

In developing countries, accreditation is increasingly being used as a tool for government regulation to guarantee quality of care. The accreditation process is an integral part of health care systems in over 70 countries and the International Society for Quality in Health Care is the largest associated international body. In some regions, the accreditation of health care organizations remains voluntary, while in others it has become government-

mandated (El Jardali *et al.*,2008, Greenfield & Braithwaite, 2009 and Pomey,*et al.*,2010).

Its rapid growth over the last 40 years is partially attributable to media reporting of serious inadequacies in the quality and safety of health care services and an escalating focus on patient. International accreditation such as that from the Joint Commission International (JCI), a nonprofit organization that is part of The Joint Commission on Accreditation of Health care Organizations is founded in the late 1990s to survey hospitals outside of the United States, creates a mark on the world map and increases business through medical tourism (Shaw ,2004).

Accreditation is an internationally recognized evaluation process used to assess and improve the quality, efficiency, and effectiveness of health care organizations. Simply put, accreditation is based on the premise that adherence to evidence-based standards will produce higher quality health care services in an increasingly safe environment. It is also a way to publically recognize that a health care organization has met national quality standards .These standards are

usually regarded as optimal and achievable and are designed to encourage continuous improvement efforts within accredited organizations (**Pomey, et al., 2005 and 2010**).

The key difference between accreditation and other forms of quality regulation is that by focusing on optimal or desirable rather than minimum standards of patient's care, accreditation has a strong performance improvement orientation, stimulating healthcare organizations to pursue increasingly higher levels of quality beyond the minimum needed for licensing. Another difference is that accreditation has traditionally been a voluntary process in which organizations choose to participate, rather than one required by government regulations. More recently however, some countries have made participation by hospitals legally compulsory (**Shaw, 2004**).

Accreditation is a learning and continuous quality improvement process. Besides its basic purpose of assessing hospitals compliance with standards, a hospital accreditation program may play an educative, consultative and informative role and provides a platform for continued dialogue among various stakeholders (**Nandraj et al., 2001**). Hospital accreditation by a recognized quality certifier is an increasingly important way for hospitals to demonstrate their clinical expertise and commitment to quality of care (**Dror, 2011**). Quality of care is now prominent on health policy agendas of governments of several countries in the East Mediterranean Region. Quality health care can be defined as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (**El Jardali et al., 2008**). Although there are many different definitions for quality, in this study, quality refers to two simple domains, the technical and interpersonal. This focus does not include continuity of care.

Accredited hospitals offer higher quality of care to their patients. Accreditation also provides a competitive advantage in the health care industry and strengthens community confidence in the quality and safety of care, treatment, and services. Overall it improves risk management and risk reduction and helps organize and strengthen patient safety efforts and creates a culture of patient safety (**Pomey et al., 2004**). Not only does it enhance recruitment and staff education and development, it also assesses all aspects of management and provides education on good practices to improve business operations. The common understanding of hospital accreditation is that it is a means to improve and ensure quality. In a wider sense it can contribute to reforming the health sector. Hospitals are an integral part of health systems; by harmonizing standards in hospitals in line with other institutions and levels of care, continuity of care is

improved and the health care network strengthened (**WHO, 2003**).

Although many health-care organizations in developing countries are undergoing or considering accreditation, there is little research on its impact and consequently no conclusive evidence that it improves quality of care. Evidence shows that nurses are key factors in quality of care and are interested in providing good patient outcomes. In fact, nurses spend up to 90% of their time caring for patients and are therefore most likely to feel the impact of accreditation on quality (**Aiken, & Patrician, 2000 and Pallas et al., 2003**).

#### **Aim of the study:**

To assess the perceived impact of hospital accreditation on quality of care through the health care professionals, specifically nurses.

#### **Context:**

The accreditation process (both national and international surveys) was conducted in King Khaled Hospital (KKH) as one hospital affiliated with the Ministry of Health. King Khaled Hospital is one of the larger sized hospitals in Najran at Saudi Arabia with a total of 400 beds capacity with a unique multicultural and multi-language. It has a total of 600 registered nurses with different cultural backgrounds: Indian, Filipino and Saudi nationals. The accreditation process was conducted during 2009 to 2012. The national survey was implemented between May 2009 and June 2010. The International American Survey: Joint Commission on Accreditation of Health Care Organizations (JCAHO) was started in January 2011. Throughout the process, the hospital was exposed to challenging self-assessment of present standards, and meeting the required standards. The hospital had met the accreditation requirements successfully in 2012.

#### **2-Methodology:**

##### **Design:**

Descriptive exploratory design was utilized. This research study followed a cross-sectional survey design.

##### **Study objectives:**

- 1-To assess the perceived impact of hospital accreditation on quality of care
- 2-To investigate the perceived contributing factors that can explain change in quality of care.

##### **Setting:**

The study was conducted in different departments affiliated with King Khaled Hospital (KKH) that newly and successfully passed the accreditation requirements (both national and international surveys). These departments include: medical, surgical, intensive care

units, and others specialties (burn unit, kidney dialysis unit, outpatient clinics, and emergency unit).

**Study sample:**

A purposive sample that was limited to only nurses who have been working in the hospital for at least 3 years (i.e. had passed through both accreditation surveys (national and international) were constitute the study sample. Different categories of nurses were also selected. The total sample size was (120 nurses: 13 head nurses and 107 staff nurses).

**Study tools:**

Data for the present study was collected through utilizing the Quality Implementation Scale developed by **Shortell et al., (1995) and Pomey and, Francois (2004)**, to evaluate quality implementation and outcomes in health care organizations particularly in the context of accreditation. It composed of two parts, the first part is related to demographic data of the respondents which include such items (age, unit, educational qualifications, occupational category and years of experiences). The second part is the survey tool consisted of nine scales and subscales subdivided into 54 items that were rated on a five-point Likert scale (ranging from one for strongly disagree to five for strongly agree. The dependent variable was quality results (5 items), whereas the independent variables were leadership, commitment and support; (9 items), strategic quality planning (7 items); quality management (6 items); human resource utilization (6 items); which is subdivided into two subscales: (education and training subscale (3 items) and rewards and recognition subscale (3 items)), Use of Data (7 items); and Accreditation (14 items); which is subdivided into two subscales: (staff involvement subscale (5 items) and benefits of accreditation subscale (9 items). The overall Cronbach's coefficient alpha estimate for internal consistency was .87. The tool items were assessed for validity; coverage and relevancy by a jury of professors from nursing administration department, at two different universities. Based on their recommendations minor modifications were made.

**Pilot Study:**

A pilot study was carried out on a sample of 10% before starting the actual data collection to ascertain the clarity, and applicability of the study tools. It also helped to estimate the time needed to fill in the questionnaire. Based on the results of the pilot study, modifications, clarifications, omissions, and rearrangement of some questions were done.

**Ethical consideration:**

Prior to implementation of the study, Ethical approval was obtained from the KKH administrators together with written consents from participating

nurses before proceeding with the study. The respondents were assured of complete confidentiality.

**Procedure:**

The researcher explained the study purpose to the selected sample who was assigned to the previous selected units at King Khaled Hospital. They were further informed that the participation was voluntary. The instrument was distributed to the study sample on their workplaces, with explanation of how to answer it. It took about 10-15 minutes from each respondent to answer it. The collection of data for the study was completed for duration of three weeks (Feb. 2012).

**Statistical Design:**

The collected data were organized, tabulated and statistically analyzed using SPSS software statistical computer package version 15. Frequency; percentage, mean, standard deviation, and Chi-square were calculated. For comparison between more than two means, the F value of analysis of variance (ANOVA) was calculated; Correlation between variables was evaluated using Pearson's correlation coefficient. Regression analysis was calculated to understand how the typical value of the dependent variable changes when any one of the independent variables is varied, while the other independent variables are held fixed. Most commonly, regression analysis estimates the conditional expectation of the dependent variable given the independent variables. Significance was adopted at  $p < 0.05$  for interpretation of results of tests of significance (**Crawley, 2007 and Field, (2009)**).

**3. Results :**

Regarding to demographic data of the study sample (Table 1), results of the present study revealed that 40% of sampled nurses age below 30 years old, while 22.5% of them were in age between 46-55 years. Regarding to years of experiences, data in table (1) show that 37.5% of the study sample had years of experiences ranged between 3-to less than 5 years while only 11.7% had more than 11 years of experiences. As regard to educational background, it is clear from the same table that 55% of sampled nurses held a bachelors' of science in nursing. The highest percentage (89.2%) of sampled nurses held staff nurse positions in their hospitals. It is clear also from table (1) that there were statistical significant differences between nurses demographic data according to different work places. As it is clear that more than half of the sample (53.3%) who their age ranged between 30-45 years were working in ICU, ( $\chi^2 46.057, P = .000$ ), as for years of experiences, statistical significant differences were found according to different work place ( $\chi^2 97.063, p = .000$ ). Data in table (1) also clarifies that 45.5% of baccalaureate nurses were working in surgical units, while only 7.6% of them were working in medical units ( $\chi^2 26.017, p =$

.000). As for occupational category , statistical significant differences were found according to different work place as 37,4% of staff nurses were working in ICU , while 17.8% of them were in medical units ( $x^2 = 11.493, p = .009$ )

Regarding to mean scores of quality results variable as an outcome of accreditation process, data in table (2) and figure (1) shows that nurses had high mean scores regarding their perception of quality results in all subscales. As it is clear that there was high mean scores regarding improvement in: the quality of customer satisfaction ( $4.216 \pm 0.650$ ), the quality of services provides by the administration ( $4.266 \pm 0.644$ ), the quality of care provided to patients ( $4.291 \pm 0.57$ ), the quality of services provided by the clinical support department ( $4.208 \pm 0.516$ ), as well as the hospital maintained high quality health services ( $4.116 \pm 0.7$ ). This indicates that nurses perceived an improvement in quality during and after the accreditation process.

Data in table (3) shows comparison between nurses' demographic characteristics and their perception of quality results as an outcome of accreditation process. It is clear that there was a statistical significant differences between (age, years of experiences, and units) and quality results ( $F = 10.260, p = .0000$ ), ( $F = 8.424, p = .000$ ), ( $F = 5.854, p = .001$ ). While data in the same table clarified that there was no statistical significant differences between nurses educational preparation, and occupational category and their perception of quality results ( $F = .147, p = .702$ ,  $F = .223, p = .638$ ).

When comparing between quality of care implementation total mean scores as perceived by nurses according to their work place , data in table (4) shows a statistical significant differences between mean scores of all subscales of quality implementation as perceived by nurses according to their work places except for benefits of accreditation subscale as no statistical significance differences was found ( $F = 1.900, p = .134$ ). Moreover ,data in the same table show that the highest mean scores for the majority of quality of implementation subscales were seen in medical units compared to other units .

When quality results ( dependent variable) as an outcome of accreditation process was correlated with other independent variables ,data in table (5) clarifies that there were statistical significant positive correlation between quality results and leadership, commitment and support ( $r = .581, p = .000*$ ), strategic quality planning ( $r = .454, p = .000*$ ), education and training ( $r = .349, p = .000*$ ), reward and recognition ( $r = .234, p = .010*$ ), quality management ( $r = .590, .000*$ ), use of data ( $r = .607, p = .000*$ ), staff involvement in accreditation ( $r = .557, p = .000*$ ), and in benefits of accreditation ( $r = .404, p = .000*$ ).

Regression model testing (table 6) show the most important predictors of better quality results .As seen in the table, the most important predictors were: leadership, commitment and support ( $\beta = .728, p = .0000$ ), education and training ( $\beta = .249, p = .015$ ), reward and recognition ( $\beta = .245, p = .002$ ), uses of data ( $\beta = .448, p = .022$ ) and benefits of accreditation ( $\beta = -.716, p = .000$ ).with the adjusted  $R^2 = .477$

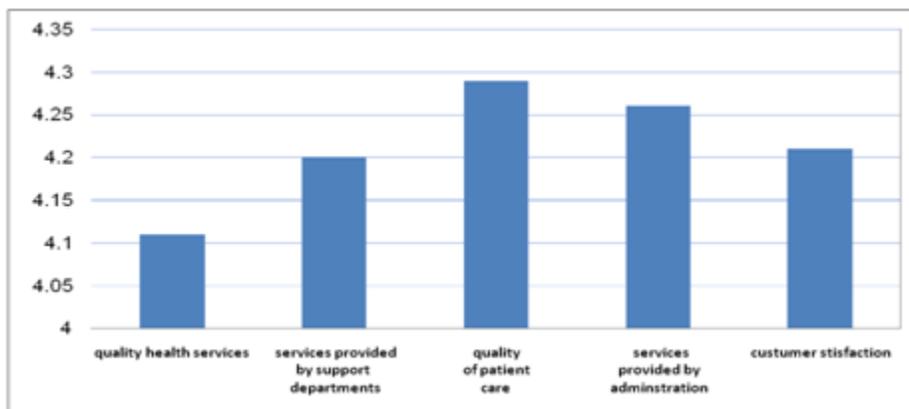
**Table (1): Demographic Data of the Studied Sample in different Work Places (Total No 120)**

Demographic data	Medical (no =25)		Surgical (no =35)		ICU (no =40)		Other places (no =20)		(Total No 120)		$X^2$ $p$
	No	%	No	%	No	%	No	%	No	%	
●Age:											
Below 30 years	18	37.5%	20	41.7%	3	6.3%	7	14.6%	48	40%	46.05 .000*
30-45 years	7	15.6%	3	6.7%	24	53.3%	11	24.4	45	37.5%	
46-55 years	0	0	12	44.4%	13	48.1%	2	7.4	27	22.5%	
●years of experiences											
3- less than 5 years	0	0	24	53.3%	13	28.9%	8	17.8%	45	37.5%	97.06 .000*
5- less than 8 years	5	13.9%	10	27.8%	12	33.3	9	25%	36	30%	
8- less than 11 years	20	80%	1	4%	2	8%	2	8%	25	20.8%	
Over 11 years	0	0	0	0	13	92.9%	1	7.1%	14	11.7%	
Nursing educational preparation :											
Bachelors of science	5	7.6%	30	45.5%	21	31.8%	10	15.2%	66	55%	26.01 .000*
Diploma	20	37%	5	9.3%	19	35.2%	10	18.5%	54	45%	
●occupational categories :											
Head nurse	6	46.2%	6	46.2%	0	0	1	7.7%	13	10.8%	11.49 .009
Staff nurse	19	17.8%	2	27.1%	40	37.4%	19	17.8%	107	89.2%	

\*Significant ( $P < 0.05$ )

**Table (2) Mean Scores of Nurse's Perception Regarding Quality Results Subscale Items as an Outcome of Accreditation Process**

Quality Results Items	Mean	SD
Over the past 3 years, the hospital has shown		
1- Steady, measurable improvements in the quality of customer satisfaction	4.216	.650
2- Steady, measurable improvements in the quality of services provided by the administration (finance, human resources, etc.)	4.266	.644
3- Steady, measurable improvements in the quality of care provided to patients (e.g. medical, surgical, ICU, etc )	4.291	.570
4- Steady, measurable improvements in the quality of services provided by clinical support departments such as laboratory, pharmacy, and radiology, etc).	4.208	.516
5- Over the past few years, the hospital has maintained a high quality health services despite financial constraints	4.116	.700
Total	21.000	2.667

**Figure (1) Mean Scores of Nurse's Perception Regarding Quality Results Subscale Items as an Outcome of Accreditation Process****Table (3): Comparison between Nurses' Demographic Characteristics and their Perception of Quality Results subscale**

Demographic Data	Quality Results	
	F	P value
1-Age	10.260	.000*
2- Years of experiences	8.424	.000*
3-Units	5.854	.001*
4- Educational preparation	.147	.702
5- Occupational category	.223	.638

\*Significant ( $P < 0.05$ )**Table (4) Comparison between Quality of Care Implementation total Mean Scores as Perceived by Nurses according to their Work Place (Total No 120)**

Quality Implementation Subscales	Medical (n=25)	Surgical (n=35)	ICU (n=40)	Others (n=20)	F-test	P
	Range Mean±SD	Range Mean±SD	Range Mean±SD	Range Mean±SD		
-Quality results	22.76±2.14	20.91±3.77	20.10±.496	21.35±2.62	5.85	.001*
-Leadership , commitment and support	40.36±5.03	34.88±3.94	36.15±1.23	37.40±4.17	11.86	.000*
-Strategic quality planning	29.12±5.28	27.02±2.52	28.10±1.82	30.30±3.06	4.99	.003*
-Education & training	13.04±1.30	11.74±.85	12.07±.729	13.100±1.37	12.36	.000*
-Reward & recognition	7.24±.43	8.22±3.11	6.52±1.85	8.60±2.18	5.699	.001*
-Quality management	27.48±2.55	23.05±2.61	24.02±.47	24.85±2.03	24.80	.000*
-Use of data	30.72±5.23	26.11±4.17	28.02±.800	29.500±3.54	8.817	.000*
-Staff involvement in accreditation	22.12±3.66	18.71±2.83	20.07±.34	20.55±1.27	10.56	.000*
- Benefits of accreditation	38.24±8.31	35.05±6.07	36.42±1.58	36.000±1.58	1.900	.134

\*Significant ( $P < 0.05$ )

**Table (5): Correlation between Quality Results as an Outcome of Accreditation Process and other Study Independent Variables**

Independent Study Variables	Quality Results	
	R	P value
-Leadership ,commitment ,and support	.581**	0.000
Strategic quality planning	0.454**	0.000
-Human resource utilization :		
1- Education and training subscale	0.349**	0.000
2-Reward and recognition subscale	0.234**	0.010
-Quality management	0.590**	0.000
-Use of data	0.607**	0.000
-Accreditation:		
1- Staff involvement in accreditation subscale	.557**	.000
2-Benifites of accreditation subscale	.404**	.000

\*Significant (P &lt;0.05)

r=Correlation Coefficient

**Table (6): Regression Model Testing for Predictors of Better Quality Results**

Predictors	Unstandardized coefficient		Standardized Coefficient	T	P
	B	± SE	beta		
Leadership ,commitment ,and support,	0.474	0.130	0.728	3.646	.000*
Education and training subscale	0.571	0.232	0.249	2.416	0.015*
Reward and recognition	0.282	0.088	0.245	3.188	0.002*
Use of data	0.302	0.130	0.448	2.332	0.022*
Benefits of accreditation	-0.368	0.085	0-.716	-4.332	0.000*
Adjusted R <sup>2</sup> = .477					

#### 4. Discussion:

Accreditation can be the single most important approach for improving the quality of health care structures. It will eventually become a tool for international categorization and recognition of hospitals. When implemented appropriately, accreditation can strengthen the fundamental leadership and steering role of national health authorities (WHO, 2003).

Results of the present study revealed that there were statistical significant differences between demographic data of the study sample (age, experiences) and their perception of quality results as an outcome of accreditation. This result is contradicted with **leggat et al., (2010)** who stated that, age and nurses years of experiences have non-significant correlation with perception of quality care results. Results also revealed that there was a statistical significant differences between units and nurses perception of quality results ,more over the highest mean scores for the majority of quality of implementation subscales were seen in medical units compared to other units .In this respect, **Sekhar (2007)** reported in his study that the general care units participants rated the perception of quality results very high as compared against the mean of scores obtained by intensive care units participants.

Results of the present study revealed non statistical significant differences between nurses' demographic data and educational background as well as, occupational category. This result is contradicted with, **Schreuder et al., ( 2010)** who reported that there was a positive correlation between percentage of nurses with bachelor of nursing science degree and perception of quality of care as well as he reported that , nurse's educational background and work roles and responsibilities may influence their perception of quality outcomes and results .While **leggat et al.(2010)**found a non-significant differences between level of education and perception of quality results. Moreover, **Sekhar (2007)** revealed that nurses at supervisory level have scored very higher in their quality perception than nurses at staff level.

Results of the present study revealed that nurses perceived an improvement in quality during and after the accreditation process. As they rated high score of the variable 'quality results'. In this respect **El Jardali et al., (2008)**, reported that accreditation seems to have improved perceived quality of care in sampled hospitals and nurses perceived improvement in quality as a result of accreditation.

When quality results as a dependent variable was correlated with all other independent variables, results of the present study revealed statistical significant positive correlation between the quality results and

leadership, commitment and support; strategic quality planning; quality management; education and training, reward and recognition; uses of data, staff development and benefits of accreditation. This result is consistent with previous researches done by **Pomey, et al. (2005)** and **pomey et al., (2010)** who reported that the dependent variable (quality results) was found to be positively correlated with leadership, commitment and support; staff development, uses of data variables. Moreover they added that leadership, commitment and support was significantly associated with quality results which indicate that senior management was highly committed to the accreditation in their hospitals.

In the same issue, **D'Andrea (2006)** and **Seren and Baykal (2007)** reported that staff involvement was significantly associated with better quality results. Evidence shows that involvement of staff is crucial when implementing changes or new initiatives in an organization particularly when it comes to reducing resistance to change. Since an organization's decision to reach accreditation requires high short-term investment which can yield long-term benefits that are not always guaranteed, staff involvement at all stages including recognition can be beneficial to achieving the ultimate goals of the organization. To achieve this, the management and support given by the administration can play an important role.

Previous researches done by **Seren and Baykal (2007)** support our study results that use of data was found to be significantly associated with improved quality at accredited hospitals. This demonstrates the importance of using data in driving quality improvement activities. While no literature was found to document the association between the use of data and accreditation, it is important to note that the use of data in the accreditation process can help hospitals track improvement activities, measure performance and provide evidence for compliance to accreditation standards.

Results of the present study revealed positive correlation between quality results and reward and recognition. This result is contradicted with **Montagu (2003)** who reported that rewards and recognition was not found to be a predictor of quality results in hospitals but evidence shows it influence staff satisfaction, performance and retention.

Results revealed that most important predictors of better quality results were leadership, commitment and support, use of data, education and training, rewards and recognition and benefits of accreditation. In this respect **El Jardali et al., (2008)** found that the predictors of better quality results were leadership, commitment and support; use of data; quality management and staff involvement.

#### Conclusion:

The findings of the present study revealed the following:

- Statistical significant differences between demographic data of the study sample (age, experiences, and work place) and their perception of quality results as an outcome of accreditation.
- Hospital accreditation is a good tool for improving quality of care. The high score of the variable 'quality results' indicates that nurses perceived an improvement in quality during and after the accreditation process.
- Statistical significant positive correlation between the quality results as a dependent variable and all other independent variables (leadership, commitment and support; strategic quality planning; quality management; education and training, reward and; staff development and benefits of accreditation).
- The most important predictors of better quality results were leadership, commitment and support, use of data, education and training, rewards and recognition and benefits of accreditation.

#### -Recommendations:

- In order to ensure that accreditation process brings effective quality improvement practices, there is a need to assess quality based on patient outcome indicators. This can be done by strengthening the current accreditation program to be more outcomes oriented.
- Senior management of the hospitals undergoing accreditation program should be highly committed to accreditation process and should support hospital staff.
- Staff involvement at all stages of accreditation program is crucial to achieve the ultimate goals and benefits of accreditation.
- Decision makers in ministry of health should support hospitals under accreditation through increased annual budget.
- Quality of services should be considered during preparation of accreditation.
- Replication of the present study in different hospital sizes to show if there is any differences in accreditation outcome when compared with different hospital sizes.

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