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Critical Success Factors for Quality Assurance in Healthcare Organizations

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1. Introduction

In recent years in the health services the need has been stressed to use management tools which highlight the central role of professionals and which support the implementation of a clinical leadership based on greater autonomy and decision-making in management. The purpose is to allow alignment with the ultimate goals of health systems, which are to strive for a service with a high degree of effectiveness, to respond to the needs and expectations of citizens, and to have medium and long term sustainability.

There are many conceptual approaches in the field of clinical management: its realization in defined organizational spaces (Clinical Units); synergy with other management tools such as the process or clinical pathway approach and the definition of competences; the use of clinical guidelines or the use of scientific evidence as guarantees of clinical effectiveness; the new relationship between professionals and patients where more proactive models promote the use of patient decision aids that encourage participation in shared decision-making, where core dimensions of healthcare quality such as continuity and safety are reasonably assured.

Clinical management could be defined as the ability of health professionals to manage the resources they use in their clinical practice efficiently and effectively (Torres-Olivera & Reyes-Alcázar, 2011). It establishes the effective involvement of professionals in achieving the objectives of the healthcare organization and is associated with greater decision-making capacity and autonomy. It also establishes greater commitment to the citizen (taking into account their needs and expectations) and to the healthcare organization by promoting sustainability in the short, medium and long term. There are many initiatives aimed at boosting clinical management in the public health sector as a strategy to ensure greater effectiveness and sustainability of the health services. This chapter seeks to analyze possible critical success factors to be considered when starting this type of project.

2. Critical Success Factors

A Critical Success Factor (CSF) is a particular feature of the organization's internal or external environment that is important for it to achieve its objective. A factor is critical if its

fulfilment is absolutely necessary to achieve these objectives, thus requiring action from the sectors involved. Critical success factors that can determine the proper development of clinical management can be summarized as follows:

2.1 Patient-centred care

From a public service perspective, the focus of healthcare is the citizen, so any approach to intervention should be based on their needs and expectations. To achieve this, these needs and expectations must be explored and understood. Their fulfilment must be seen as a fundamental dimension in the quality of service provided. In the last 40 years a large body of literature "*has been advocating a patient-centred approach in healthcare*" (Mead and Bower, 2000, 1087). Since then, different definitions of the concept have emerged. Byrne and Long (1976) proposed a definition that emphasized a style of medical consultation that uses the patient's knowledge and experience to guide the interaction between themselves and the healthcare professional. From a clinical management point of view rather than healthcare, Laine and Davidoff (1996) understood patient-centred care as more "*congruent with, and responsive to patients' wants, needs and preferences*." This entails: the inclusion of a biopsychosocial perspective in the treatment of disease; the patient being conceived as "*a personal experience rather than an object*" suffering from an illness (Mead & Bower, 2000: 1089); sharing decisions and responsibilities in a more cooperative manner; assuming an inter-subjective character in the doctor-patient relationship, strengthening its human dimension. This way of approaching healthcare attempted to oppose the conventional "*biomedical model*" (Friedson, 1970) of doctor-patient relationship. In that conventional model the relationship is reduced to identifying the clinical signs and symptoms of a disease and the subsequent prescription of a standardized treatment.

At present the clinical setting is much more open. The traditional reliance of service organizations on changes in their environment was not applicable to health services imbued with technical self-importance, the guarding of information and one-sided communication processes with patients. The paradigm shift aimed at making the citizen the real objective of clinical practice, has opened a new scenario in which the units must build a new relationship with the patient in which new skills and abilities should form part of the action plans of professional teams.

From the clinical management standpoint, the model of patient-centred care carries certain elements of responsibility for the patient. In this sense, it is assumed that the information must be accurate and shared, rights respected and participation guaranteed. These elements define perfectly the changes of direction that a clinical unit or department must take in order to develop a clinical management plan, and which basically involve:

- Knowing the users and potential users of the health services. Knowing who they are and how many they may be, but above all, knowing their needs and expectations. A clinical unit or department must build its services on that foundation.
- Knowing the level of satisfaction among patients who have used a clinical unit or department and using this information to detect new areas for improvement and development.
- Providing adequate and accurate information, promoting opportunities for participation and shared decision-making, properly handling procedures for informed

consent and patient decision aids. To achieve this goal it is essential to improve the communication skills of the professionals in the clinical unit.

- Transparency, to bring the results of the clinical unit or department to the attention of society, opening channels of communication that support the transmission of information and knowledge, and encouraging participation through social networks, patient forums, etc.

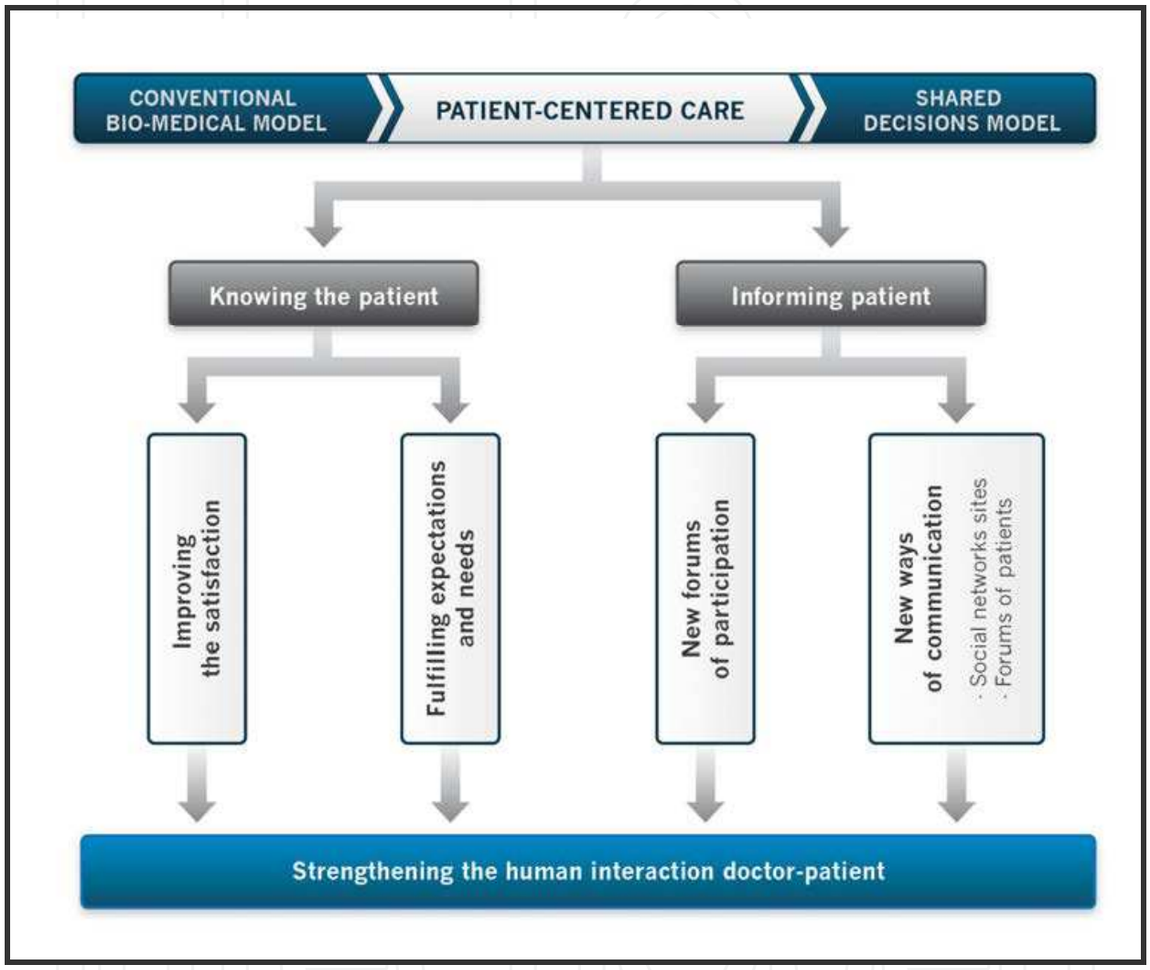

Fig. 1. Patient-centered care

2.2 Leadership

Clinical leadership is central to the strategy of clinical management. Studies, such as those of Cunningham and Kitson (2000) and West et al. (2004), have demonstrated the importance of clinical leadership in improving the quality of care and how the use of evidence-based medicine has resulted in a more patient-centred practice. The importance of the role played by the clinical leadership is acknowledged by the government agencies responsible for ensuring the quality of care, such as the National Health Service of Scotland being given responsibility for "*driving service improvement and the effective management of teams to provide excellence in patient/client care*" (NHS Scotland 2004: 4). Also, other organizations such as the

Joint Commission speak of "*effective leadership*" that determines the strength and consistency of performance in areas such as planning, management, coordination, provision and improvement of health services (Joint Commission Resources, 2009).

However, this leadership is not an isolated factor and requires other support. As stated by West et al. (2004), other support mechanisms and staff must be deployed and promoted for clinical leadership to be successful in achieving greater quality of care. Among these mechanisms, those associated with the empowerment paradigm (Abdelrazek et al., 2010) are highlighted. There is broad academic consensus on the importance of empowerment in work environments. On the one hand, there is a macro perspective on the contextual agents and socio-structural conditions that facilitate empowerment. On the other, the micro perspective focuses on the feelings of employees about their role within the organization, and has been called "*psychological empowerment*" (Knol & van Linge 2009). Both aspects of empowerment, structural and psychological, provide clinical leadership with performance tools that improve both individual work and the work context in which they are located.

Therefore, professional leadership must be encouraged in all its aspects, making the stakeholders of the clinicians the objectives of the organization, striving for commitment to them and providing effective leadership tools from the management structures.

This process necessarily involves the need to define the map of the competencies, attitudinal and/or knowledge and abilities, that healthcare professionals have to incorporate. In other words, it is a matter of cataloguing best practices to guide professionals to achieve their own development goals. It establishes a set of competencies that helps determine the gap between the actual competencies that a particular professional may have and those required by their competencies map. An appropriate training programmes can then be established to reduce any gap. Different international organizations, such as the International Union for Health Promotion and Education (IUHPE), have encouraged and agreed standards for career development within the healthcare sphere, helping to establish a common international professional development framework (Shilton, 2009).

In this regard, the launch of an ambitious professional development project by the Andalusian Agency for Healthcare Quality (Spain) is highlighted. A tool for the Management of Individual Development Plans has been designed and implemented which allows the competence gaps to be identified among the professionals of the clinical units. This is achieved through a process of self-assessment based on identifying levels of achievement in relation to a catalogue of best practices for the job. Training or professional development programmes are established according to the identified gap.
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It is also important to clearly define the figure of the manager or director of the clinical unit, establishing their competency map and their assigned functions. Interaction with the managers of other healthcare centres and political structures of the healthcare system is stressed as one of the core attributes that define clinical leadership, according to Christian and Norman (1998). They also play the role of manager of all the resources (human, financial, equipment and materials) that make up the Clinical Unit.

On this topic, it should be noted that the Observatory for Quality of Health Training-Spain, using the tool for the Management of Individual Development Plans, has defined the competency map of the managers or directors of the Clinical Units of the Andalusian Public

Health System. This map consists of 26 specific practices and 106 requirements with different levels of achievement (from the essential to the strategic) in 12 key competencies: [1] Attitude of continuous learning and improvement [2], Scientific and technical capacity, [3] Capacity for decision-making, [4] Communication [5] Management and Planning, [6] Promotion of professional development, [7] Management of the quality of clinical safety, [8] Efficient management of resources, [9] Innovation and Leadership, [10] Promotion of research and teaching, [11] Guidance to citizens [12] Results-orientation.
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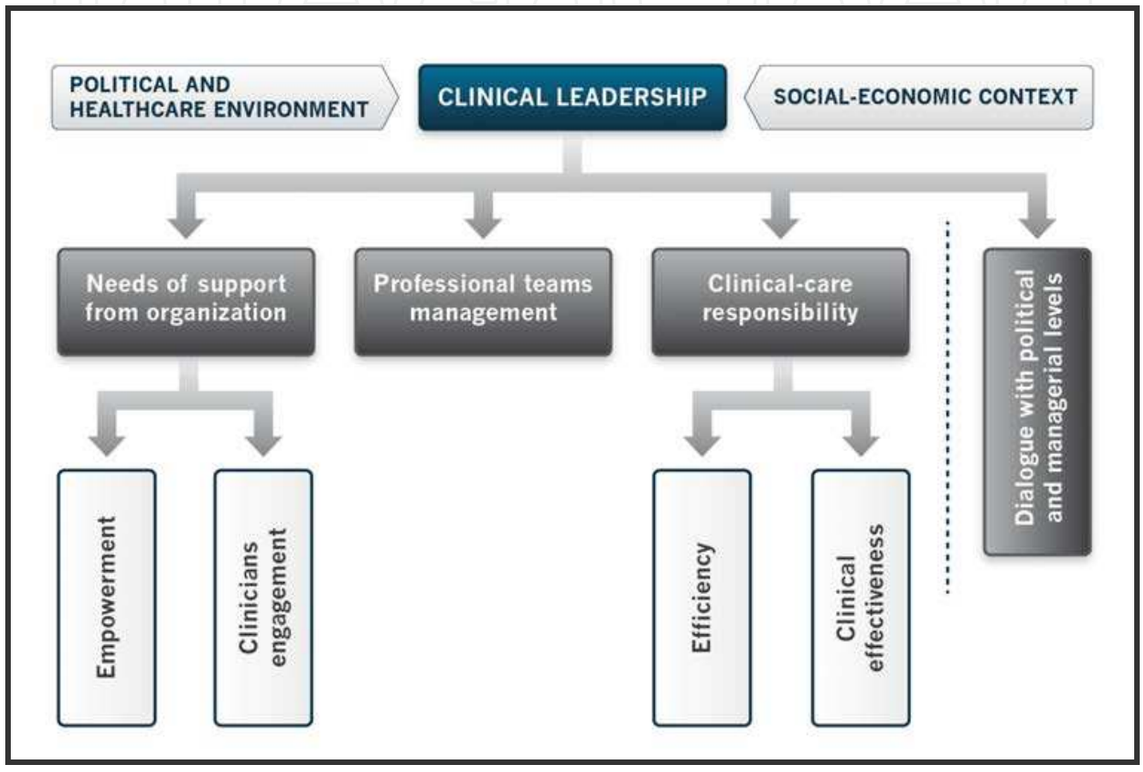

Fig. 2. Leadership

2.3 Teamwork

A patient-centred approach to healthcare involves a multidisciplinary care process built around a team with common goals and developed in an integrated organizational model. The importance and effectiveness of teamwork in healthcare processes have been widely studied in recent decades. In fact, some studies have empirically validated their effectiveness through the study of their structures and dynamics (Mickan, 2005). Mickan (2005) indicates two large blocks of benefits of effective teamwork: collective and individual benefits. Among the collective benefits may be found those affecting the organization, such as reducing the time and costs of hospitalization and greater accessibility for patients, and those affecting the team such as a more efficient use of healthcare services or improved communications. The individual benefits affect the patients by improving satisfaction, greater acceptance of treatment and improved health outcomes, and the professionals, who experience improved satisfaction and well-being at work.

In the view of this chapter's authors, teamwork will play an important role in the effectiveness of the results obtained in clinical practice. In other words, the capacity of health professionals in a particular clinical unit to integrate will be directly related to their clinical effectiveness and their decision-making ability. This will therefore determine the final results of the unit. For example, the Strategic Plan 2010-2013 of the Hospital Clinic of Barcelona is based on teamwork as an essential element in the organization of healthcare units (Castells, 2011).

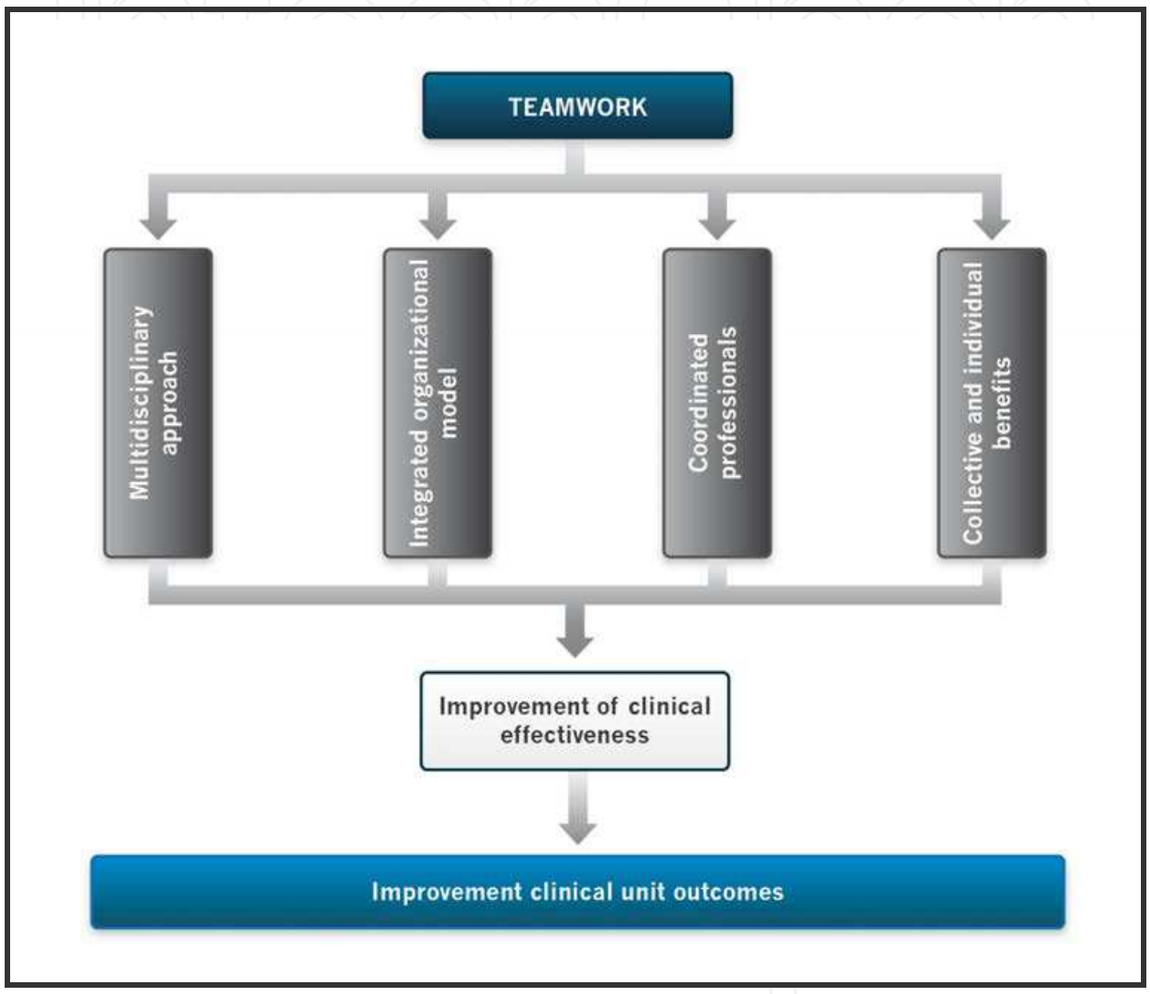

Fig. 3. Teamwork

Teamwork encourages a sense of belonging and differentiation as a motivating element. The team must know what the objectives of the unit are, and what their individual contribution to them is, regardless of the professional group and level to which they belong. Similarly, they should know what their results are, both individually and collectively, and actively participate in the improvement processes that are instigated. The working model must transcend the limits of the clinical unit, with continuity of care being a dimension that the healthcare unit must take into account in order to improve clinical outcomes through consensus building between different levels of professionals involved in patient care.

2.4 Autonomy and responsibility

The ability to make decisions on resources in clinical practice is the core concept of clinical management. That capacity has to be based on the commitments established with the organization through procedural agreements that define the playing field between healthcare units (departments) and Corporate Management. This is probably one of the most difficult success factors to develop in practice because it incorporates a different culture, which clashes with the values, or rather with the roles traditionally assigned to the different actors in the system. There is widespread academic agreement on the need to maintain a certain degree of autonomy for healthcare professionals in order to improve not only their ability to cope with everyday challenges, but also as a fundamental aspect of their personal performance and motivation (Harrison and Dowswell, 2002). The demands of autonomy and responsibility for the clinical units stem from those benefits that have been empirically demonstrated in the professional field (Schulz et al. 1991, Akre et al. 1997, Kapur et al. 1999). The main focus of these analyses has been on the ability of professionals and clinical units to determine or establish their own clinical strategies and the assessment of their own performance. However, demands for autonomy and "*decentralization*" of decision-making in clinical practice have not been without developmental difficulties. As in any other field of work, autonomy in clinical practice has faced problems that derive from the ongoing "*bureaucratization*" of the processes and "*mechanization*" of the tasks of professionals, with their decisions subject to ever increasing controls. (McKinlay & Arches, 1985).

There is little tradition of managers delegating tasks and responsibilities to healthcare professionals, even though it is the clinical decisions that have a more direct impact on resource consumption. Furthermore, healthcare professionals are not inclined to take responsibilities which they believe are outside their healthcare role. To this can be added a traditional distrust between the two camps. The nature of this distrust is rooted in the culture clash between the medical corpus and those that Alford (1975) termed "*corporate rationalists*", these are managers and healthcare policy-makers that need not be medically qualified (Camprubí, 2011). For Alford, the corporate rationalists are confronted by structures that represent the interests of the "*professional monopolists*", i.e., the healthcare professionals, and they stress rational planning and efficiency over the decisions of healthcare experts (Alford, 1975, Lewis, 2006). Along the same line, Lewis states "*…the power of the medical profession in the health policy arena, by analysing which actors are perceived as influential, and how influence is structured in health policy*" (Lewis (2006). Despite the claims of other studies, Lewis empirically demonstrates the increasing capacity of healthcare professionals to influence health policy, and therefore they have greater responsibility in decision-making.

It is therefore essential to incorporate new management styles where the prime role of managers is to facilitate healthcare processes and to support the operation of clinical units. On the other hand, professionals must be introduced to, and trained in, the various competencies that encourage their participation and involvement in decision-making on the use of resources. Finally, all this must be articulated through management or grant agreements that clearly establish the commitments made by both sides, linking the achievement of individual objectives, and those of the clinical unit, to an incentives model. Although there is broad consensus on this, when it comes to it being put into practice,

healthcare organizations face difficulties caused largely by the, not always peaceful, coexistence of strong, pre-existing corporate interests or divisional structures that detract from the patient-centred vision and which make decision-making difficult at the clinical unit level. At other times, it is the managers of the healthcare organizations themselves who are reluctant to redirect their own role to allow real decentralization of management processes, incorporating and engaging clinical decision makers. It is probably necessary to introduce different rules which enable some professional and management roles to be redefined, or to create less hierarchical structures that more obey effectiveness and efficiency criteria, that allow effective integration of resources to give a more cohesive response to the needs and expectations of the citizens.

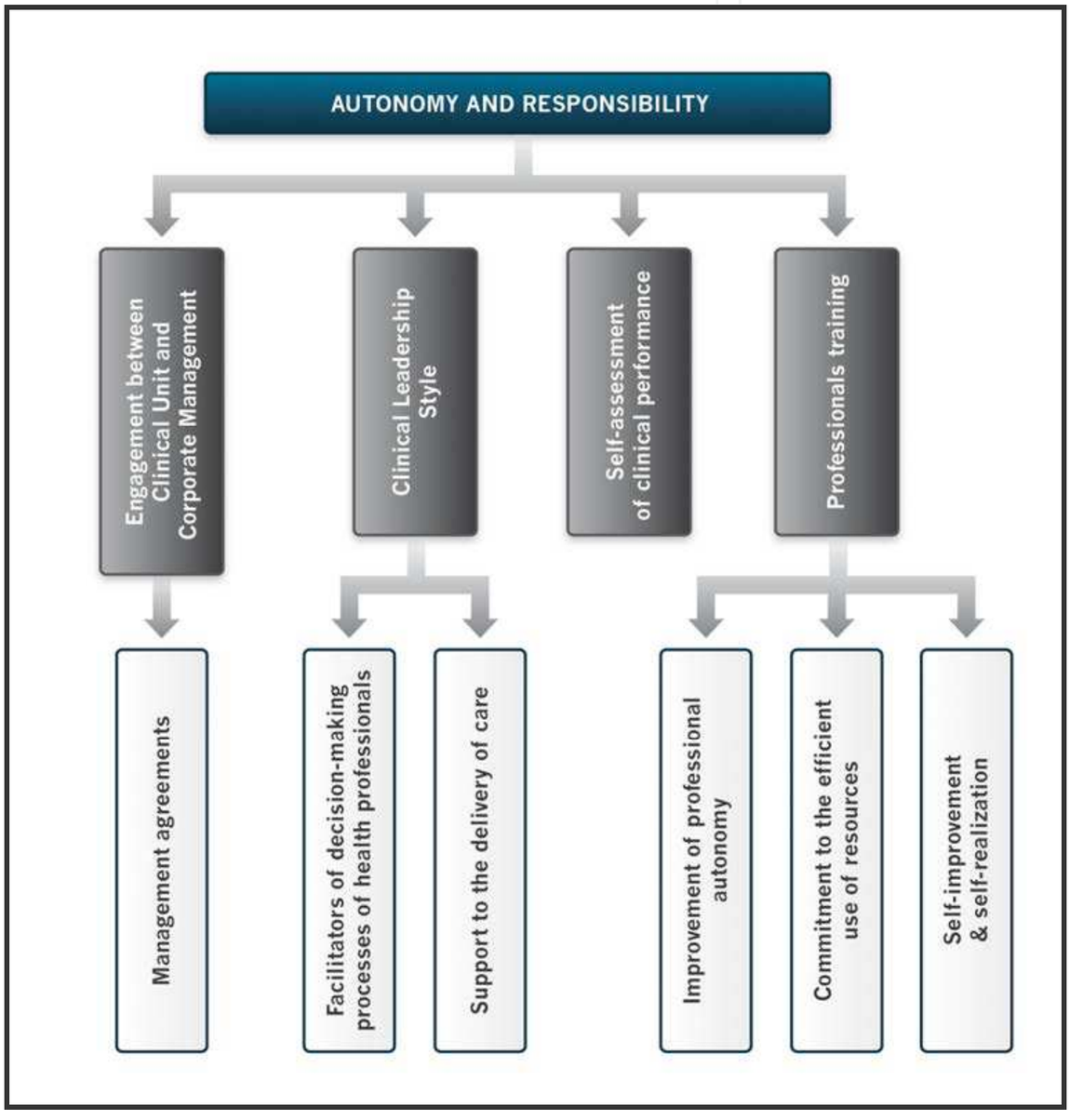

Fig. 4. Autonomy and responsibility

2.5 Care organized from an integrated view of processes

In today's information society the citizen plays a major role, in such a way that their expectations have a direct impact on the modes of action of any service delivery organization. Factors such as user-perceived quality have become essential elements that bring legitimacy to any organization providing services, and thus become an important value to be analyzed by any healthcare organization (Torres Olivera, 2003).

This scenario requires an analysis of what healthcare organizations are doing, how they are doing it and what level of response is given to the needs and expectations of the user of healthcare services. However, this may not be sufficient unless it is done from a comprehensive view of healthcare processes. For instance, it is difficult to refer to concepts such as total quality, or a comprehensive view of quality, if some issues on continuity of care and appropriateness of healthcare processes have not been previously resolved.

The possibility of receiving comprehensive and continuous healthcare currently faces a number of difficulties, largely caused by how the health services are organized. Departmental segmentation is possibly due more to the interests of managers and professionals than the needs of users. Organizations can be unnecessarily complex, and often "*super-specialization*" does not properly address the diversity or multisystemic nature of the problems that health services face. If inadequate mechanisms for coordination between different levels of care and a poor patient-centred tradition are added, the idea of comprehensiveness that encompasses the concept of total quality may seem a little beyond reach (Torres Olivera, 2003 2004).

On the other hand, if the expectations of citizens regarding what they demand from healthcare organizations, especially if they are public, are explored in depth, it is seen that they express a desire for higher quality healthcare in terms of accessibility, effectiveness , safety and information. Satisfaction must be measured, but it is increasingly conditioned by elements of comprehensiveness. In fact, poor coordination between levels of care has a negative effect on accessibility to services, and the effectiveness and safety of clinical performance.

Evolving from "*how much*" is it done to "*how*" is it done, is undoubtedly an important qualitative step in healthcare organizations, and is related to a different vision of healthcare that assumes a commitment to quality and which requires a comprehensive view of the processes taking place in their services. The integrated approach to these care processes should pursue the following objectives: [1] Ensure continuity of care through a continuous and shared vision of healthcare [2] Adapt the functional structure of the services to the needs and demands of citizens, [3] Link professional effort to the final objective, the patient outcome, sharing responsibilities, [4] Put the resources (costs) in the right place (greater benefit).

Process management is organized through a number of key elements such as: [1] user-centred approach, [2] greater involvement of healthcare professionals, [3] support from the best scientific evidence available, and [4] use of integrated information systems.

Process management attempts to ensure continuity of care at all times, and is therefore intended to seek a unique and coordinated provision of services, avoiding fragmentation of care at multiple levels (Consejería de Salud - Regional Ministry of Health, 2001). Therefore, process management is understood as the set of elements that are linked sequentially to

meet the health needs of citizens. It provides a vision that goes beyond inter-level coordination and attempts to delve into the meaning of "*Care Continuity*" (Torres Olivera, 2001). This approach requires healthcare organizations to order the actions that are performed in different areas, by different professionals at different times. The processes are thus approached horizontally, involving all levels of care and all the professionals involved in them.

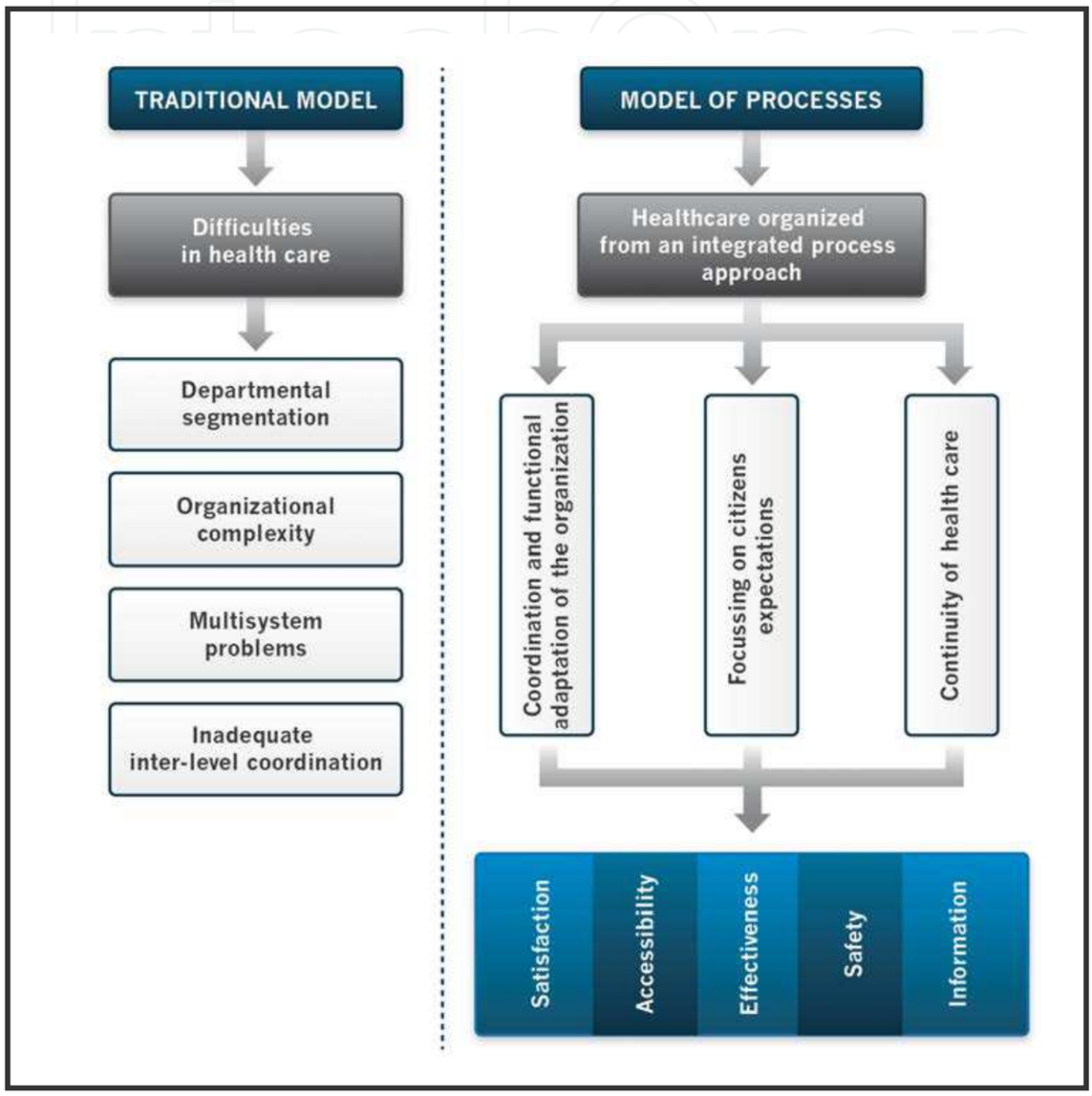

Fig. 5. Care organized from an integrated view of processes

Integrated process management is an approach to patient healthcare that seeks to coordinate resources across the health system (Fernández, 2003). This means an integrated approach to preventive actions and health promotion, the use of clinical practice guidelines, appropriate criteria in the management of resource and support to diagnosis, the appropriate use of drugs and the evaluation of results.

This means trying to analyze working methods in the light of the best available evidence, proposing elements for improvement so that added value is given to recipients of the healthcare process, i.e. the citizens and patients. Process mapping a clinical unit or department will determine its portfolio of services and its quality characteristics, as well as establish roadmaps for patients in the healthcare setting and establish the competencies that professionals have to develop (Mora Martínez, 2002). The approach to healthcare with a focus on processes and the definition of roadmaps for patients allows the identification of critical elements related to information or communication with the patient, or the introduction of important aspects related to healthcare quality such as patient safety.

2.6 Professional competencies

The term *Competence* in its current sense is due to David McClelland, a psychologist at Harvard University, an expert in motivation theory, who published an article in 1973 which caused a radical shift at the time. The article suggested going beyond the traditional evaluation methods in human resources management to focus on directly searching for those behaviours that were shared by those who were excellent at their job within a specific culture, and which differentiated them from the rest (McClelland, 1973).

From this perspective, the determination of professional competences, and the generation of tools that manage them, becomes a key to continuing professional development (Reyes-Alcázar et al., 2011). Competence management not only encourages professional development but also innovation in learning models and processes of exchange and dissemination of knowledge. It also directs an organization towards professional excellence, cooperative work and the development of models of professional recognition and incentives.

The map of competencies of healthcare professionals should be set as a Gold Standard that contains the knowledge, skills and attitudes desirable for developing excellent clinical practice.

A typical competency map consists of a set of key competencies for a specific job and the best practices that a professional should develop for optimum performance in that job. The map should be related to the desired results and the individual and organizational objectives. Consequently, competence refers to a person's ability to efficiently undertake a specific job. Thus, competence has to meet certain criteria: [1] Consider the context, i.e., the real world scenarios where these competencies have to be developed. [2] Identify the desired results in terms of level of development, achievement or mastery of tasks or functions. [3] Associate the level of development of each task or function with the performance, requirement or evidence criteria. [4] Involve the areas of responsibility of the professional.

By comparison with the competence map, the healthcare unit professionals can carry out a process of self-assessment to establish the competence gaps, and produce individual professional development plans that will determine the training and learning processes that are needed for their development.

One of the most important projects currently under development in the field of competence management is that undertaken in Andalusia (Spain) by the Andalusian Agency for

Healthcare Quality for the Public Health Service since 2006. This accreditation model is intended to recognize excellence of professionals through a self-assessment system that identifies the competences that a particular professional should have, the good practices that should be present in each job and the evidence that must be provided to demonstrate those competences.

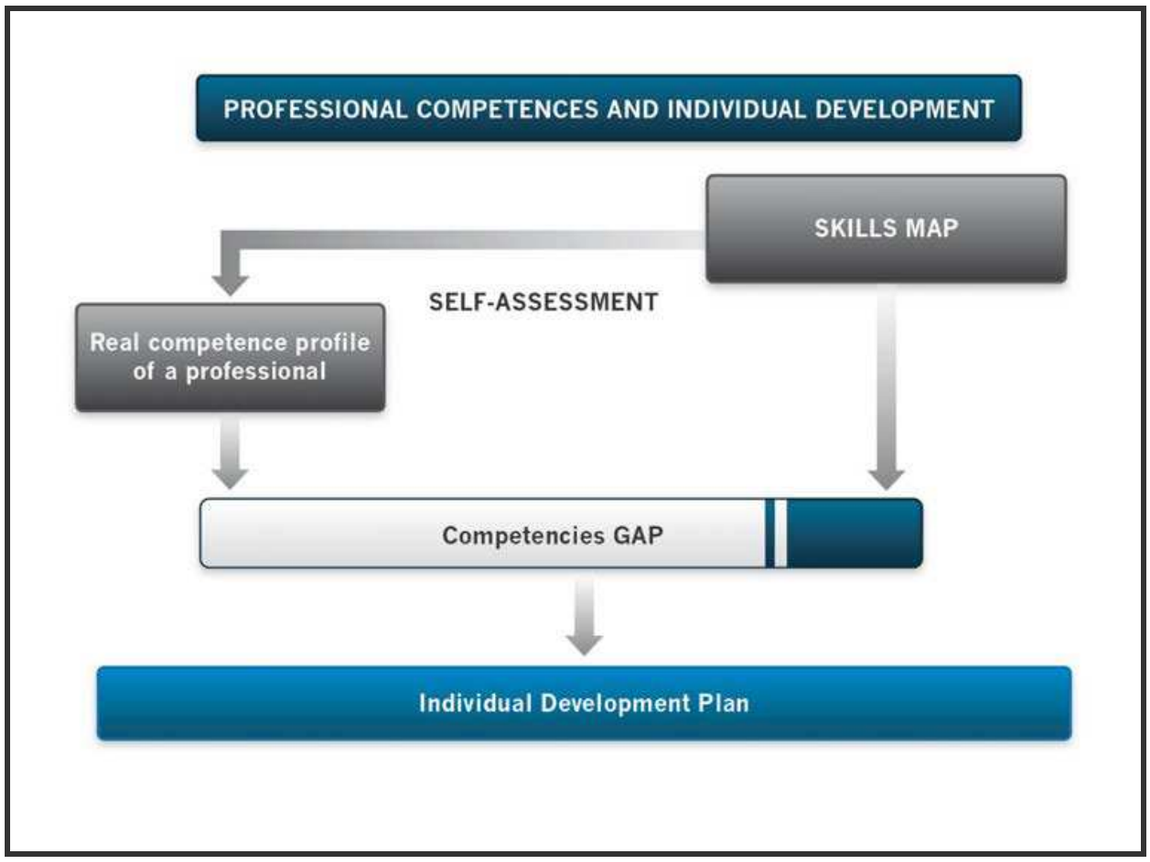

Fig. 6. Professional competencies

In the Competence Management Model of the Andalusian Public Health System, the *Accreditation* is defined as a recognition, explicit and public, of meeting the necessary requirements for the provision of quality care, as well as the beginning of a line of continuous improvement by a professional. (Almuedo-Paz et al, 2011).

The Competence Management Model of the Andalusian Public Health System has defined a total of 70 Competence Manuals, aimed at all professional healthcare groups. Specifically, 50 Competence Manuals have been published for the medical specialties, 9 for nursing specialties, 3 for the pharmacy disciplines and another 8 for healthcare specialties.

These Competence Manuals are structured into 5 blocks and 10 criteria, each of which contains a set of Competencies. In turn, each Competence is expressed through a set of observable and measurable behaviours called "*Best Practices*". The fulfilment of Best Practice is demonstrated through the contribution of Evidence by each professional, from their actual practice. This Evidence is an objective tool for assessing their competence.

Also in Spain, the Catalan Institute of Health (ICS) began Project COM-VA© in 2005, a healthcare and management competence assessment for hospital nursing professionals. (Juve-Udine, 2007). In this model, the competencies encompassed the individual qualities indicative of effective performance. These attributes include knowledge, abilities and attitudes that enable the professional to make the right decisions in each case. Moreover, the term competence also means the sphere of responsibility or professional area in which the law gives the professional the right to make autonomous decisions. The healthcare competencies of the COM-VA© model define 6 domains: 1) caring for the patient; 2) assessing, diagnosing and addressing changing clinical situations; 3) helping the patient to keep to their treatment; 4) helping to ensure safety and the healthcare process; 5) facilitating the process of adaptation and coping, 6) teamwork and adapting to a changing environment (Juve-Udine, 2009).

2.7 Results-orientation

Results-oriented concerns in clinical management are such that some authors have stated that "*healthcare management is inconceivable without a measurement of results*" (Marín-León, 2011: 90). Healthcare units have to establish mechanisms to measure their results, as much in terms of healthcare outcomes as in management and user satisfaction. An evaluation programme is defined as "*the systematic collection of data related to a programmes activities and outcomes that results in decisions to improve efficiency, effectiveness, or adequacy*" (Keller et al., 2002; Washington County Department of Health and Environment, 1999; Patton, 1997; Berkowitz, 1995). The evaluation process must be accompanied by a prior planning process that delineates the compliance objectives, both those that are strategic to the unit and those operational and care objectives of the processes. This will allow the objectives in the Procedural Agreements made with the Corporate Management to be assessed.

In this sense, healthcare units must have a Balanced Scorecard to collect information in summary form, identifying areas for improvement and allowing the unit to establish benchmarking processes. The information systems of the centre (hospital, primary care, etc.) must support the collection of information necessary to enable the unit to analyze its results and propose actions for improvement.

According to Keller et al. (2002), an integrated evaluation programme and results-oriented planning consists of two fundamental elements in its design. First, it involves the selection of aims, which will clarify the objectives to be achieved. Generally, the objectives are difficult to measure and should be broken down into measurable indicators, according to criteria of continuity in time and external comparison. Second, it involves designing a specific strategy to enable the achievement of those aims and objectives identified. From the standpoint of healthcare units, the selection of an appropriate strategy will help improve quality in terms of efficiency and effectiveness, while the identification of aims will improve quality in terms of adaptation.

Indeed, the development of a Balanced Scorecard helps to translate the strategy of an organization into measurable objectives. In a sense, the healthcare unit is put to the test to see if it is capable of monitoring what it does. The Balanced Scorecard developed by Kaplan and Norton in 1992 has gained enormous popularity in recent times. It was the result of a year-long study that arose out of a general notion that as knowledge became a basis for

competition, conventional financial measures were becoming obsolete (Kaplan and Norton, 1992 en Keller et al., 2010). The term balanced reflects the balanced consideration given to long- and short-term objectives, financial and nonfinancial measures, leading and lagging indicators, and external and internal performance perspectives (Keller et al., 2010). The BSC is a system of causal relationships among composite indicators (Key performance areas), that integrate large amounts of information (Key performance Indicators) into an easily understood single metric (Lovaglio, 2011). This basic outline of corporate and business management has also been exported to the healthcare setting. The work conducted by Baker and Pink (1995) is highlighted among the first in this field. In that study, the authors proposed a balanced scorecard model for hospitals with which they hoped to obtain a balanced view between the areas for improvement identified by the organization and those identified by patients. As Lovaglio (2011) confirms, the basic principles of a balanced scorecard model for the health sector have been adequately agreed in the scientific literature (Chow et al. 1998, Zelman et al. 1999), and have also been widely applied in public healthcare systems and organizations (Inamdar, Kaplan and Bower, 2002; Northcott and France, 2005). This reinforces the certainty of its feasibility and applicability for any healthcare unit. The indicators of a clinical unit must include those of an operational nature that assess processes and tasks from the standpoint of efficiency, and those of a comprehensive nature that allow the monitoring of fulfilment of the strategic goals previously agreed by the organization. Recently, studies have proliferated which investigate the factors affecting the variability of healthcare. Variability attributed to medical practice itself is, from the standpoint of clinical management, an inefficient use of resources because resources are allocated to services of dubious effectiveness (Bernal-Delgado, 2008; Peiró et al., 2009). In other words, setting strategic goals also means avoiding variability in clinical practice and moves the model closer to evidence-based practice.

The existence of both strategic and operational level indicators in clinical units facilitates designing a more accurate results orientation, and thus management structures can align the Mission, Vision and Values of the unit with the desired results. In general, it can be theorized that a Mission of a clinical unit or department would be to efficiently and effectively manage the resources used in its normal clinical practice. Its Vision would be to achieve a continuity of care model to meet the expectations of patients and professionals. Finally, the Values that underpin the daily work would be, at least, transparency, integrity, cooperation, and scientific rigor.

In short, promoting results orientation within healthcare units provides four basic results focused on quality improvement: 1) A set of healthcare indicators that can be subjected to longitudinal comparison over time; 2) Another set of indicators of the satisfaction with the care given to users/patients; 3) A map of areas that need improvement; 4) The possibility of establishing standardized processes of comparison with the best units, or in other words, monitoring performance using the benchmarking criteria.

2.8 Capacity of self-assessment and external assessment

The concept of Continuous Quality Improvement (CQI) should permeate the entire development of clinical management. Initially designed for the business sphere, the concept of CQI has been gradually incorporated into healthcare models (Chovil, 2010; Hyrkäs & Lehti, 2003; LeBrasseur, Whissell, & Ojha, 2002; Shortell, Bennett, & Byck, 1998). Its adoption

by a healthcare unit "*enables it to be proactive rather than reactive by relying on a continuous evaluation of processes and outcomes*" (Chovil, 2010: 22).

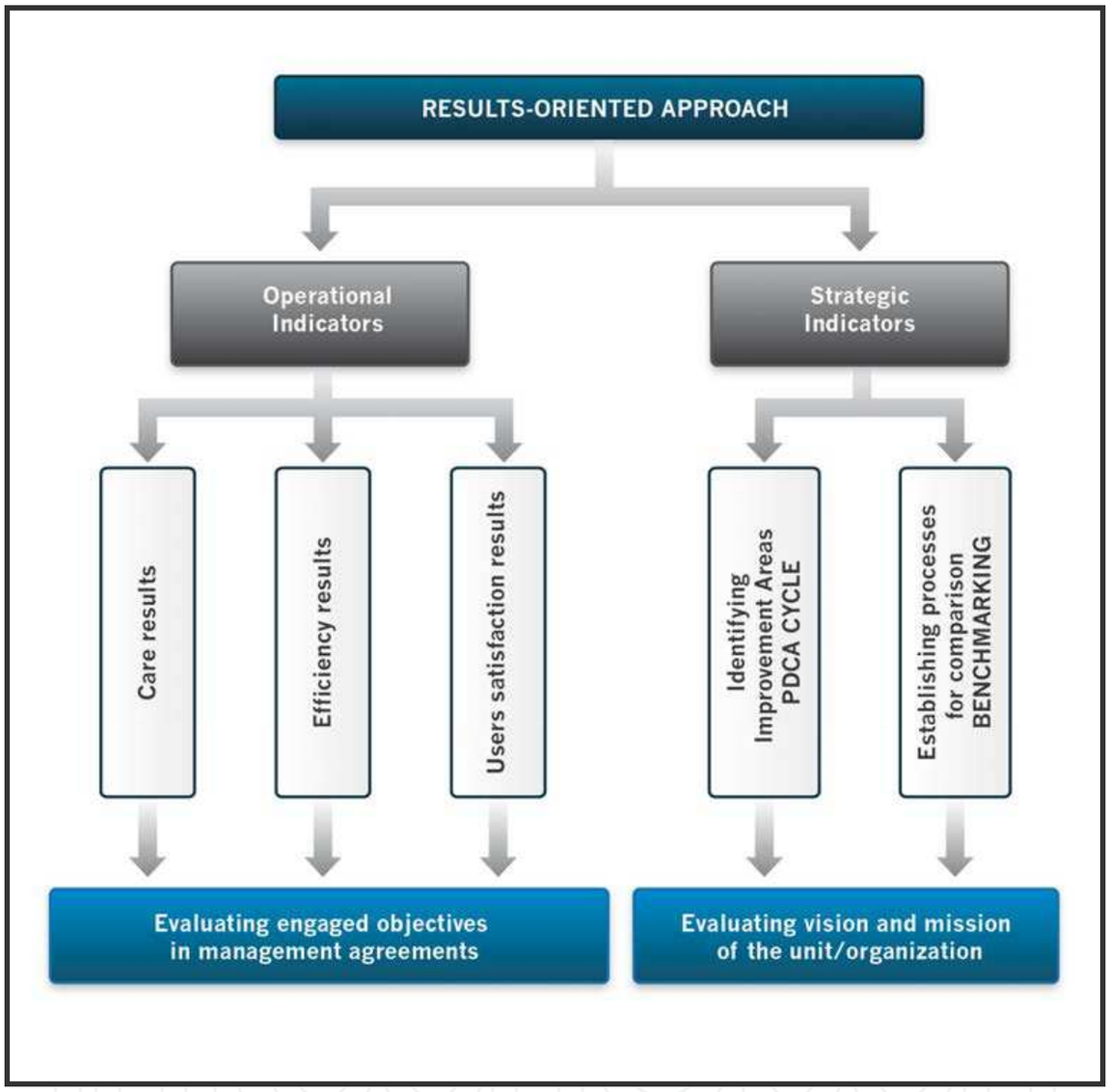

Fig. 7. Results-orientation

One of the most widely used methods to achieve this has been the process of self-assessment by professionals and healthcare units. Studies such as that of Hyrkäs & Lehti (2003) have demonstrated the favourable impact of self-assessments in healthcare units on the satisfaction perceived by patients. However, self-assessment cannot be the only means of monitoring the performance of healthcare units. This self-assessment process must be endorsed on a regular basis through a process of external assessment to objectively establish achievements and examine the quality of healthcare provided by the healthcare unit.

As noted above, the external assessment of performance of a healthcare unit can be given by indicators of satisfaction of the users/patients. In fact this is a process of external assessment

of results focused on the evaluation by end users. However, external assessments do not address all aspects that must be evaluated to identify the greatest possible number of weaknesses, areas for improvement and subsequent corrective actions. All these dimensions, much more specific regarding the efficiency of processes and reflections on the potential of healthcare units, must be determined by agents specialized in the field of healthcare assessment. In recent years, the commitment to healthcare quality has encouraged the emergence of agencies, organizations and international agreements responsible for the assessment and accreditation of healthcare professionals, centres and units.

Some of the most important international, national and regional organizations and agencies dedicated to the accreditation of healthcare units and centres are the following.

Firstly, The International Society for Quality in Health Care (ISQua) which is a not-for-profit organization that emerged in 1986. The International Journal for Quality in Health Care is published on behalf of ISQua. Also, ISQua organizes an international conference which provides a forum and meeting place for agencies specialized in accreditation and external assessment, organizations dedicated to healthcare and all types of stakeholders.

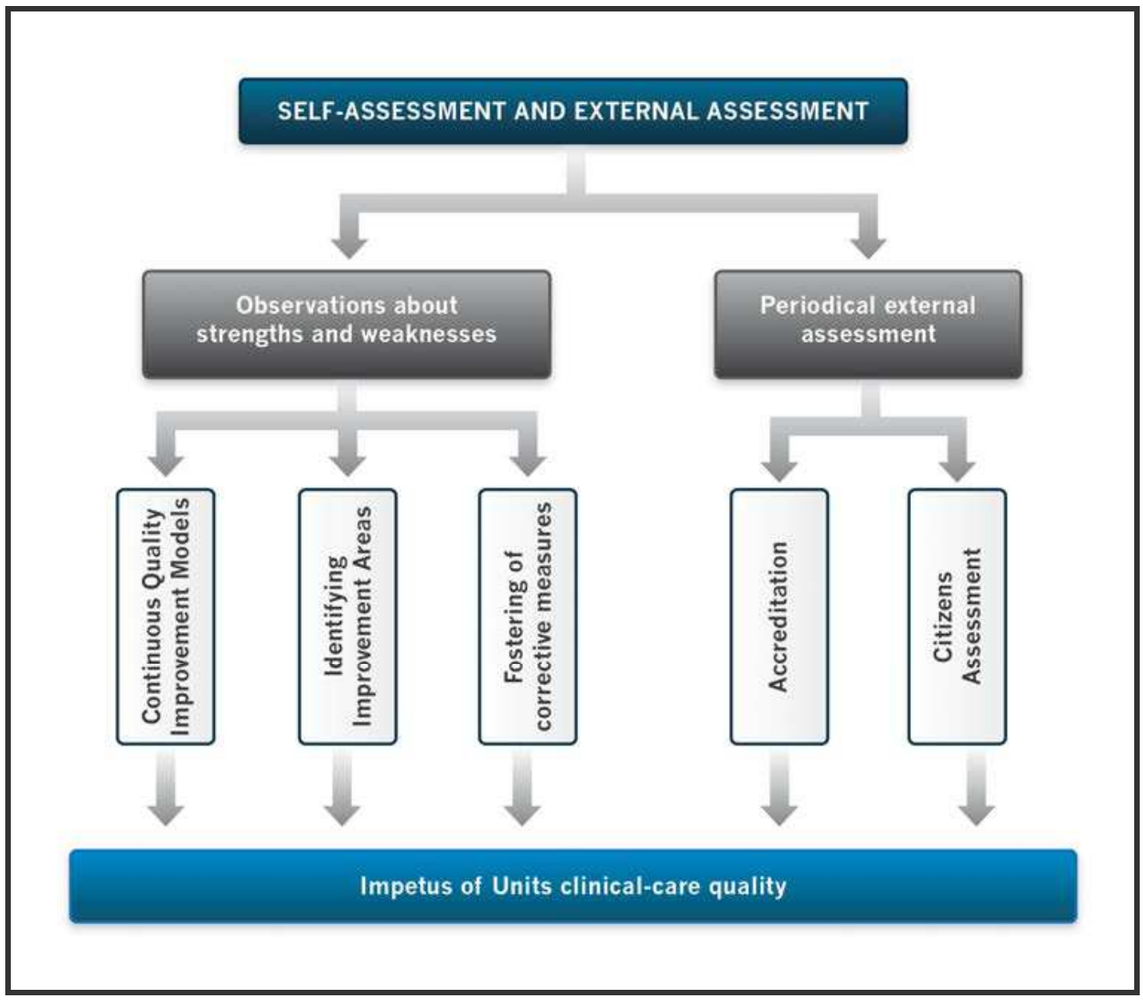

Fig. 8. Capacity of self assessment and external assessment.

The Joint Commission of the USA is highlighted among the accreditation and external assessment organizations in the Anglo-Saxon sphere. This independent not-for-profit organization was originally founded in 1917 and re-founded in 1951 with the purpose of hospital accreditation. The stated mission of the organization is "*To continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value*" (Joint Commission, 2011).

The following are also highlighted in the Anglo-Saxon sphere: the Australian Council on Healthcare Standards (ACHS), Australian General Practice Accreditation Limited (AGPAL), Australian Quality Improvement Council (QIC), Accreditation Canada, Agency for Healthcare Research and Quality (AHRQ) of the USA, Institute for Healthcare Improvement (IHI) of the USA, National Committee for Quality Assurance (NCQA) of the USA and Quality Health New Zealand.

Among the accreditation and external assessment organizations in the European sphere are highlighted: the French National Authority for Health (HAS), Netherlands Institute for Accreditation in Healthcare (NIAZ), Health Information and Quality Authority (HIQA) of Ireland, Healthcare Accreditation and Quality Unit (CHKS-HAQU) of the United Kingdom, and the Andalusian Agency for Health Care Quality (ACSA) in Spain, among others.

In Latin America are highlighted: the Technical Institute for the Accreditation of Health Care Establishments (ITAES) of Argentina, Consortium for Brazilian Accreditation (CBA), Superintendence of Health of Chile, and the Colombian Institute for Technical Standards and Accreditation (ICONTEC).

Finally, in Asia and Africa are highlighted: Malaysian Society for Quality in Health (MSQH), Health Service Accreditation of Southern Africa (COHSASA) and the Taiwan Joint Commission on Hospital Accreditation (TJCHA).

In short, the external assessment of healthcare units through accreditation means the certification of compliance with predetermined quality standards by an external organization. This accreditation ensures the commitment of the healthcare unit to the continuous quality improvement developed in its process of self-assessment.

As discussed above, there are a significant number of quality accrediting or certifying agencies or organizations in different countries, some public but most of them private entities. Their approaches are different even though their terms of reference (standards) are very similar. The differences lie primarily in the field of accreditation, [a] in how the self-assessment processes are managed, [b] in whether the assessment processes are systemic or fragmented [c] in the possibilities of exploiting the information that results from the certification process. In this sense a model focused on continuous improvement in the context of a clinical unit is a model best suited to promote cultural change in healthcare organizations. This is because they take a different approach to clinical practice compared with models oriented to the global accreditation of health centres -which may improve some aspects of management and organization of the centre but have little impact on actual clinical practice- (Cutler, 2000). The continual use of external assessment results to promote the identification of areas for improvement in ongoing self-assessment processes is an important way of promoting real changes in the way of doing things at the level of clinical units and departments (Schrijvers 2003).

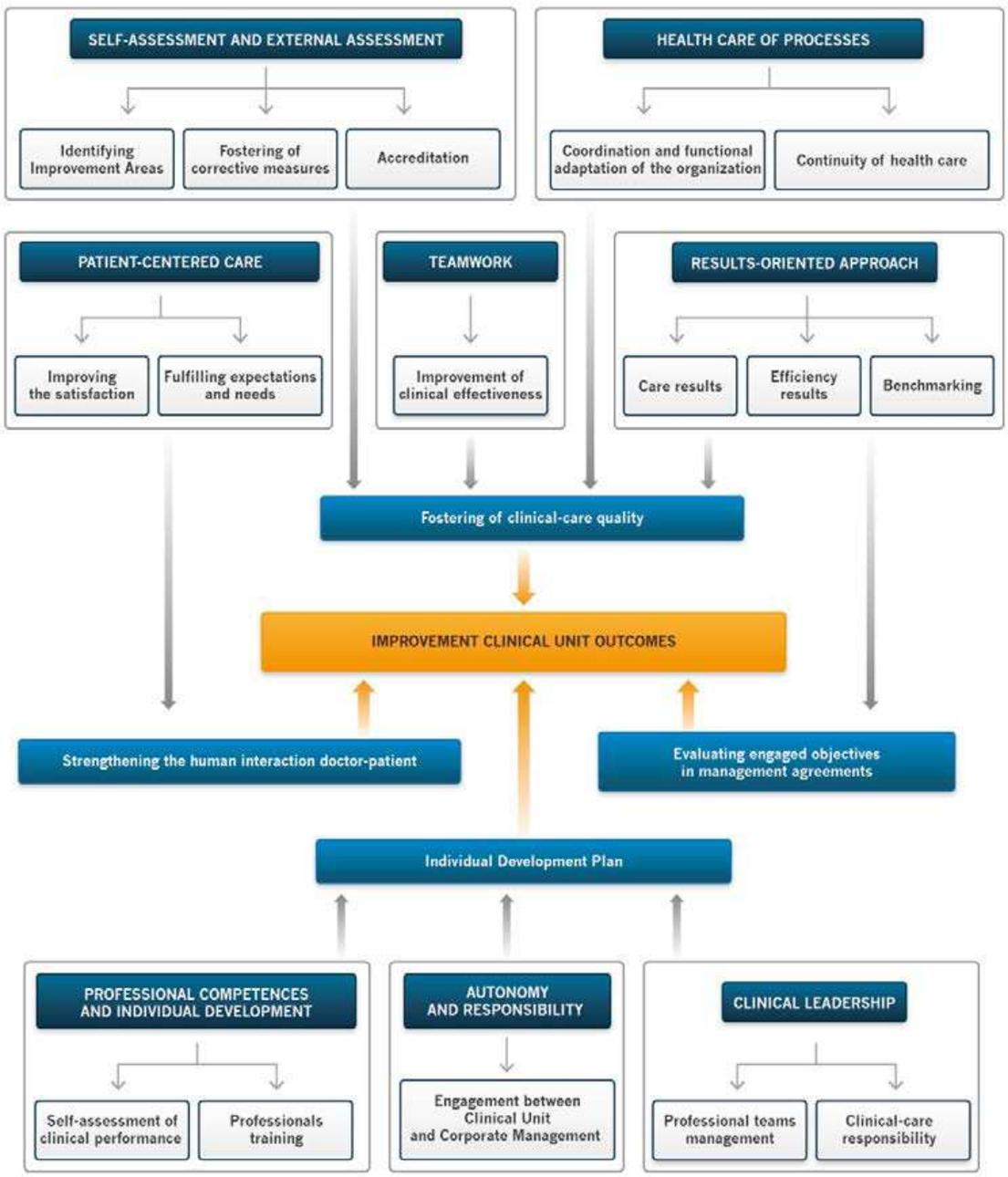

Fig. 9. Critical Success Factors for quality assurance in healthcare organizations.

3. Conclusion

Clinical management encourages the capacity of self-organization and professional autonomy, it stimulates accountability in the management of the resources used in clinical practice, and it instils the culture of continuous improvement and results orientation. It thereby facilitates an organizational design which is more adaptable to the needs of professionals and citizens.

Critical success factors that can determine the proper development of clinical management can be summarized in the following key ideas:

1. Orient health services to citizens and patients, exploring their needs and expectations, promoting their participation by providing accurate and quality information. To ensure the achievement of this critical success factor it is essential to measure patient satisfaction and use this information to improve healthcare.
2. Form multidisciplinary teams which provide integrated responses and share common goals.
3. Establish procedural agreements with corporate management which clearly set out the commitments of both parties, agreements that signify a greater capacity for decision-making and greater accountability on the part of the clinical units and departments.
4. Define the set of healthcare processes of clinical units and departments that address their quality characteristics and critical safety points.
5. Determine professional competence maps for members of healthcare units, departments and organizations, which allow individual development plans and specific training plans to be established.
6. Set indicators so that healthcare outcomes, satisfaction, efficient resource management and benchmarking can be measured.
7. Promote self-assessment and submit to periodic accreditation processes and/or external quality assessment.

By taking into account the critical success factors outlined above, a management plan for a clinical department or unit can be approached with a guarantee of success. Essentially it involves: Optimizing the existing knowledge in the organization and putting it at the service of citizens. Increasing the quality in healthcare processes through further development of competence of the professionals involved in them. And finally, using a different vision of the organization to orientate it to processes, by decentralizing decision-making and encouraging greater involvement of professionals in corporate objectives.

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5. References

Abdelrazek F., Skytt B., Aly M., El-sabour M.A., Ibrahim N. & Engstro¨ M. M.(2010). Leadership and management skills of first-line managers of elderly care and their work environment. *Journal of Nursing Management,* vol.18, pp.736–745

Akre, V., Falkum, E., Hoftvedt, B.O. and Aasland, O.G. (1997). The communication atmosphere between physician colleagues: competitive perfectionism or supportive dialogue? A Norwegian study. *Social Science and Medicine*, vol.44, no.4, pp.519–26

Alford, R.R. (1975). *Health Care Politics*, University of Chicago Press, Chicago

Almuedo-Paz A, Brea-Rivero P, Buiza-Camacho B, Rojas-De-Mora Figueroa A, Torres-Olivera A. (2011). Skills Accreditation as an impetus for continuous professional development. *Revista de Calidad Asistencial*, Vol.26, no.4, (forthcoming)

Bernal-Delgado, E. (2008). How can we improve effectiveness (quality) by reducing the gap between research and action? 2008 SES-PAS Report. *Gaceta Sanitaria*. vol.22, no.1, (April 2008) pp.19-26

Byrne, P. & Long, B. (1976). *Doctors Talking to Patients*, HMSO, London:

Camprubí, J. (2011). Una nueva forma de trabajar que mejora las decisions: Gestión Clínica de la Efectividad, *Una nueva forma de trabajar… mirando al futuro III Congreso de Gestión Clínica*, pp. 79-85, ISBN 978-84-694-2735-4, Madrid, Spain, Oct 18-19, 2010.

Chovil, N. (2009). One Small Step at a Time: Implementing Continuous Quality Improvement in Child and Youth Mental Health Services. *Child and Youth Services,* vol.31, no.1, pp.21-34.

Chow, C.W., Ganulin, D., Teknika, O., Haddad, K., Williamson, J. (1998). The balanced scorecard: a potent tool for energizing and focusing healthcare organization management. *Journal of Healthcare Management.* Vol.43, no.3, pp.263 – 280

Christian, S.L., Norman, I.J. (1998). Clinical leadership in nursing development units. *Journal of advanced nursing*, vol.27, no.1, pp.108-116

Cunningham, G. & Kitson, A. (2000). An evaluation of the RCN Clinical Leadership Development Programme: Part 2. *Nursing Standard*, vol. 15, no. 13-15, pp. 34-40.

Cutler, D. McClellan, M. Newhouse, J. (2000). How does managed care do it? *Rand Journal Economist* vol.31, pp.526-48

Castells, A. (2011). Gestión Hospitales basada en resultados: Hospital Clinic de Barcelona, *Una nueva forma de trabajar… mirando al futuro* III Congreso de Gestión Clínica, pp. 105-109, ISBN 978-84-694-2735-4, Madrid, Spain, Oct 18-19, 2010

Deem, J.W., Barnes, B., Segal, S. & Preziosi, R. (2010). The Relationship of Organizational Culture to Balanced Scorecard Effectiveness. *S.A.M.Advanced Management Journal,* vol. 75, no. 4, pp. 31-39

Fernández Fernández, I., Fernández de la Mota, E., Sanz Amores, R. (2003). Gestión por procesos asistenciales: aplicación a un sistema sanitario público. *Cuadernos de Gestión* vol.9 pp.19-37

Friedson, E. (1960). Client control and medical practice. *American Journal of Sociology*, vol.65, pp.374-382.

Consejería de Salud (2001). *Guía de diseño y mejora continua de procesos asistenciales: calidad por sistema.* Available from: http://www.juntadeandalucia.es/salud ISBN 84-8486-024-8

Harrison, S. & Dowswell, G. (2002). "Autonomy and bureaucratic accountability in primary care: what English general practitioners say [Autonomie et responsabilité bureaucratique en soin primaire : ce que disent les praticiens généralistes Anglais]. *Sociology of health & illness*, vol. 24, no. 2, pp. 208-226

Hyrkas, K. & Lehti, K. (2003). Continuous quality improvement through team supervision supported by continuous self-monitoring of work and systematic patient feedback. *Journal of nursing management* vo.11, no.3, pp.177-88

Inamdar, N., Kaplan, R.S., Bower, M. (2002). Applying the balanced scorecard in healthcare provider organizations. *Journal of Healthcare Management*, vol.47, pp.179 – 195

Joint Commission Resources. (March 2009). *The New Standards: Section 3. Leadership*. 18.7.2011. available from http://www.jcrinc.com/The-New-Standards/The-New-Standards-Section-2-Improving-Organ/The-New-Standards-Section-3-Leadershi/

Joint Commission. Resources. (July 2011). *2011 Accreditation Process Guide for Hospitals*. 18.7.2011. available from http://www.jcrinc.com. ISBN: 978-1-59940-400-4

Juvé-Udina ,M.E., Farrero, S., Matud, C., Monterde, D., Fierro, G., Marsal, R. (2007). ¿Cómo definen los profesionales de enfermería hospitalarios sus competencias asistenciales? *Nursing* vol.25 no.7 pp.50-61

Juvé-Udina, M.E., Farrero Muñoz, S., Matud Calvo, C., Rius Ferrus, L., Monterde Prat, D., Cruz Llauna, R., Artigas Lage, M. (2009). Pesos competenciales asociados a las diferentes áreas de cuidados en el ámbito hospitalario. *Nursing* vol. 27, no.7, pp.54-58

Kaplan, R. S., & Norton, D. P. (1992). The Balanced Scorecard: Measures that drive performance. *The Harvard Business Review*, vol.70, no.1, pp. 71-80

Kapur, N., Appleton, K. & Neal, R.D. (1999). Sources of job satisfaction and psychological distress in GPs and medical house officers. *Family Practice*, vol. 16, no. 6, pp. 600–601

Knol, J. & van Linge, R. (2009). Innovative behaviour: the effect of structural and psychological empowerment on nurses. *Journal of Advanced Nursing,* vol. 65, no.2, pp.359–370

Laine, C. & Davidoff, F. (1996). Patient-centered medicine: a professional evolution. *Journal of the American Medical Association*, vol. 275, pp. 152-156.

LeBrasseur, R., Whissell, R. & Ojha, A. (2002). Organizational learning, transformational leadership and implementation of continuous quality improvement in Canadian hospitals. *Australian Journal of Management*, vol.27, no.2, pp.141–62

Lewis, J.M. (2006). Being Around and Knowing the Players: Networks of Influence in Health Policy. *Social science & medicine,* vol. 62, no. 9, pp. 2125-2136

Linda, O.K., Schaffer, M.A., Lia-Hoagberg, B. & Strohschein, S. (2002). Assessment, program planning, and evaluation in population-based public health practice. *Journal of Public Health Management and Practice,* vol. 8, no. 5, pp. 30-43

Lovaglio, P.G. (2011). Model building and estimation strategies for implementing the Balanced Scorecard in Health sector. *Quality and Quantity,* vol. 45, no. 1, pp. 199-212

Marín-León, I. (2011). Gestión de Hospitales basada en resultados, *Una nueva forma de trabajar… mirando al futuro* III Congreso de Gestión Clínica, pp. 89-94, ISBN 978-84-694-2735-4, Madrid, Spain, Oct 18-19, 2010.

McClelland, D. (1973). Testing for Competence Rather Than for Intelligence. *American Psychologist*, vol.28, no.1, pp.1-14

McKinlay, J.B. & Arches, J. (1985). Towards the Proletarianization of Physicians. *International Journal of Health Services,* vol. 15, no. 2, pp. 161-195

Mead, N. & Bower, P. (2000). Patient-Centredness: A Conceptual Framework and Review of the Empirical Literature. *Social Science and Medicine*, vol. 51, no. 7, pp. 1087-1110 ISSN: 0277-9536

Mickan, S.M. (2005). Evaluating the effectiveness of health care teams. *Australian Health Review*, vol. 29, no. 2, pp. 211-217

Mickan, S.S. & Rodger, S.S. (2000). Characteristics of effective teams: a literature review. *Australian Health Review,* vol. 23, no. 3, pp. 201-208

Millward, L.J. & Bryan, K. (2005). Clinical leadership in health care: a position statement. *International journal of health care quality assurance*, vol. 18, no. 2, pp. R13-R13-R25. ISSN: 09526862

Mora Martínez, J.R., Ferrer Arnedo, C., Ramos Quirós, E. (2002). Gestión clínica de procesos: mapa de procesos de enfermería en centros de salud. *Revista de Administración Sanitaria* vol. 6, pp.135-59

National Health Service Scotland (2004*) Leadership Development Framework for Discussion*. NHS, Scotland.

Northcott, D. & France, N. (2005). The balanced scorecard in New Zealand health sector performance management: dissemination to diffusion. *Australian Accounting Review*, vol.15, no.37, pp.34 – 46

Patton, M.Q. (1997) *Utilization-Focused Evaluation*. Thousand Oaks, Sage Publications, California, USA

Peiró, S., Meneu, R., & Bernal-Delgado, E. (2009). Effectiveness, variation and inequalities. Hysterectomies and prostatectomies due to neoplasm in Spain (2002-2004). *Revista Española de Salud Pública*, vol. 83, no. 1, pp. 109-121

Reyes-Alcázar, V., Salvador-Sanz, A., & Segura, C. (2011). Mapa de competencias y buenas prácticas de los profesionales de una UGC del corazón. In: *Gestión Clínica en Unidades del Corazón,* Torres-Olivera, A. and V. Reyes-Alcázar, (Ed.), 93-118, Sociedad Española de Calidad Asistencial, ISBN 978-84-615-0671-2, Madrid, Spain

Schrijvers, G., Oudendijk, N. & ,de Vries, P. (2003). In search of the quickest way to diseminate health care innovations. *International Journal of Integrated Care,* Vol. 3, pp.1-22, ISSN 1568-4156

Schulz, R.I., Girard, C., Harrison, S. & Sims, A.C.P. (1991). Perceived autonomy and work satisfaction amongst psychiatrists. *Journal of Management in Medicine*, Vol. 5, no. 2, pp. 54–65

Shilton, T. (2009). Health promotion competencies: providing a road map for health promotion to assume a prominent role in global health. *Global Health Promotion*, vol. 16, no. 2, pp. 42-46, 61, 75

Shortell, S. M., Bennett, C. L., & Byck, G. R. (1998). Assessing the impact of continuous quality improvement on clinical practice. *The Millbank Quarterly* vol. 76, 593–624

Torres Olivera, A., Fernández, E., Paneque, P., Carretero, R., & Garijo A. (2004). La Gestión de la calidad asistencial en Andalucía. *Revista de Calidad Asistencial*, vol.19, no.3, pp. 105-112

Torres Olivera, A., Lledó, R. (2001) La coordinación entre niveles asistenciales. *Revista de Calidad Asistencial* vol. 16, pp.232-234

Torres Olivera, A. (2003). Desarrollo de los Procesos Asistenciales Integrados en Andalucía. *Cuadernos de Gestión,* vol.9, pp.127-134

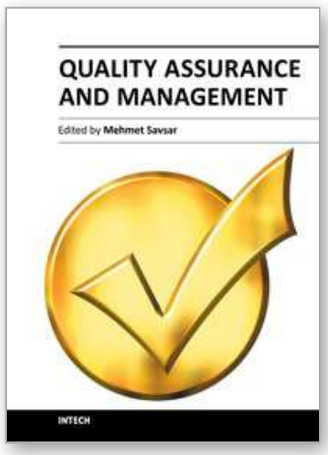
Torres Olivera, A. (2003). La gestión por Procesos Asistenciales Integrados: una estrategia necesaria. *Atención Primaria,* vol.31, pp.561-563

Torres Olivera, A., Reyes-Alcázar, V. (2011). *Gestión Clínica en Unidades del Corazón,* Sociedad Española de Calidad Asistencial, ISBN 978-84-615-0671-2, Madrid, Spain.

Washington County Department of Health and Environment. (1999). *Community Health Service Plan, 1992–1996 and 1996– 2000.* Department of Health and Environment. Stillwater, MN: Washington County, USA

West, B., Lyon, M.H., McBain, M. & Gass, J. (2004). Evaluation of a clinical leadership initiative. *Nursing Standard*, vol. 19, no. 5, pp. 33-41

Zelman, W.N., Blazer, D., Gower, J.M., Bumgarner, P.O., Cancilla, L.M. (1999). Issues for academic health centers to consider before implementing a balanced-scorecard effort. *Academic Medicine,* vol.74, no.12, pp.1269 – 1277



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