Hospital quality management: a historical foundation

By

Sahar MOUKHAFI

PHD student, Laboratory of Research in Management of Organizations (LARSGO), FSJESK, ENCG-Kénitra, Université Ibn Tofail.

saharmoukhafi@gmailcom

&

Abdelhay BENABDELHADI

Professor, Laboratory of Research in Management of Organizations (LARSGO), FSJESK, ENCG-Kénitra, Université Ibn Tofail.

ABSTRACT

The hospital world is characterized by a great complexity, indeed the hospital, whose main mission is the production of care, is a field of interaction between medical knowledge, caregivers and administrative management.

In order to assimilate the evolution of hospital quality, a perspective of its history is required.

The history of hospital quality is marked by two main phases, according to E. Minvielle (Minvielle, 1999) these two phases are called: the professional administrative phase and the organizational phase.

Before going into more detail on quality history, we present definitions of hospital quality.

Keywords: hospital world, care production, hospital quality.

RÉSUMÉ

Le monde hospitalier se caractérise par une grande complexité, en effet l'hôpital, qui a pour mission principale la production de soins, est un terrain d'interaction entre les savoirs médicaux, soignants et la gestion administrative.

Afin d'assimiler l'évolution de la qualité hospitalière, une mise en perspective de son historique est requise.

L'historique de la qualité hospitalière se marque par deux phases principales, selon E. Minvielle (Minvielle, 1999), ces deux phases sont appelées : la phase administrative professionnelle et la phase organisationnelle.

Avant de détailler davantage l'historique de la qualité, nous présentons des définitions de la qualité hospitalière.

Mots-clés : monde hospitalier, production de soin, qualité hospitalière.

Introduction

based on the definition of the World Health Organization (WHO) of the term quality, which is "To provide each patient with the range of diagnostic and therapeutic procedures that will ensure the best health outcome, according to the current state of medical science, At the best cost for the same result, with the least iatrogenic risk and for the greatest satisfaction in terms of procedures, results and human contacts within the care system." We can conclude that medical and care activities are at the center of any reflection on hospital quality.

However, this definition broadens the concept of quality to include all functions of the hospital organization, including cost control, risk management and user satisfaction in the broadest sense.

According to the WHO definition, quality is defined in the context of a global and multi-professional approach. Thus, some dimensions of quality of care cannot be based solely on the commitment of health care professionals. According to this approach, the perception of quality is systemic and total in relation to the hospital organization. This approach to quality is the result of a long historical evolution, which began in the industrial world before spreading to the healthcare sector.

The development of quality approaches in hospitals is directly linked to the quality movement that has taken off in industry. This movement, although targeted towards a common objective, includes several currents that it is important to identify. Today, quality approaches have only been transferred to the hospital sector in a fragmented and localized way. The difficulty of these transfers lies in adapting the concepts, methodologies and tools to the specific context of health care institutions, particularly in terms of culture and terminology.

This reflection leads us to ask some pertinent questions, namely

What are the stages in the evolution of hospital quality?

What are the principles and bases that characterize each of these stages?

What are the different points of view of hospital quality?

- **Definitions of hospital quality:**

Several definitions of hospital quality have emerged, the most recognized worldwide are: "Quality means guaranteeing each patient the range of diagnostic and therapeutic acts that will ensure the best result in terms of health, in accordance with the current state of science, at the best cost for the same result, with the least iatrogenic risk and for his or her greatest satisfaction in terms of procedures and human contacts within the care system." WHO

"High quality care is care aimed at maximizing the well-being of patients after considering the benefit/risk ratio at each stage of the care process." Avedis Donabedian. (Donabedian, 1988).

"High quality care contributes strongly to increasing or maintaining quality of life and/or length of life." American Medical Association, 1984

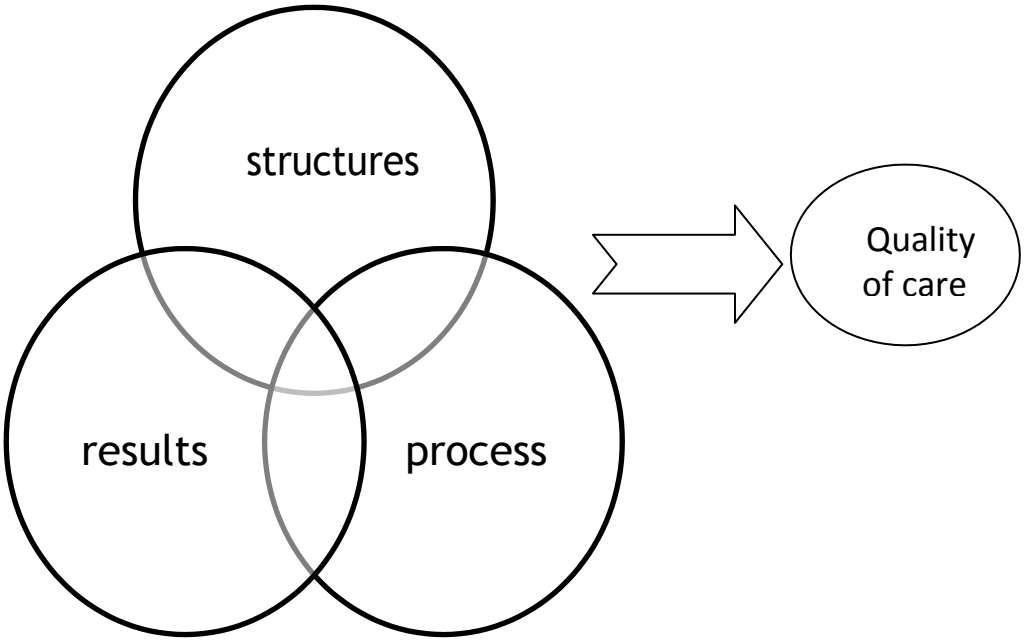
"The ability of health services for individuals and populations to increase the likelihood of achieving desired health outcomes, consistent with current professional knowledge." Institute of Medicine, 1990

The term "quality" has a multidimensional character, and depends on the vision of each health care actor, generally speaking its definition has evolved from a professional definition centered on the technical quality of the finished product or service, to a definition that includes the degree of patient satisfaction as a main element.

Avedis Donabedian, one of the pillars of quality of care, distinguishes three dimensions of quality of care: (Donabedian, 1988)

- Structures: all the resources used in the care process, such as equipment, devices and premises ....
- Processes: refers to the care delivered to patients, and how well it conforms to pre-established rules and standards.
- Outcomes of care are generally influenced by the patient's health status, survival, quality of life, progression of health status, satisfaction is also considered in this category.

Figure 1: Avedis Donabedian's diagram of the three perspectives of quality (Donabedian, 1988)



According to Donabedian, quality of care has several dimensions: effectiveness, which is reflected in the results of care in terms of health status after the course of care, but also the patient's point of view; efficiency, which links the results of care to the resources used; accessibility, which is summarized by the degree of conformity to the patient's preferences and values; legitimacy, which encompasses the values of society; and finally, equity. (Donabedian, 1988)

One of the most relevant ways to measure quality of care is from the patient's perspective and satisfaction. Quality assessment is done through the measurement of the user's opinion, as the user's perception of the quality of care is an essential aspect along with the measurement of outcomes.

While the Institute of Medicine (Crossing the Quality Chasm) states that quality of care includes the elements of: safety, effectiveness, efficiency, timeliness, equity, and patient-centeredness.

The Pickler/Commonwealth Program for Patient-Centered Care is a patient-centered quality of care program developed in 1988, it emphasized 8 characteristics of quality most important to the patient, they are:

- respect for the values, preferences, and needs expressed by the patient
- integrated and coordinated care
- clear and high quality education and information for the patient and his family
- physical comfort, including pain management
- emotional support and alleviation of fear and anxiety
- appropriate involvement of family members and friends
- continuity;
- accessibility.

- **Quality of care from different perspectives:**

Improving the quality of hospital care has been a priority since the 1960s in the Anglo-Saxon countries, and a great deal of work has been done in this area, affirming that the quality of care can be expressed from several points of view of the different actors in care: the patient/consumer, the professional, the health care institution, the social welfare system and the government.

Each type of point of view must have different criteria for standardization and a different perception of quality of care.

From the patient's point of view, quality depends on his or her needs and expectations in terms of care and services. According to him, quality is clinical efficiency in terms of diagnostic accuracy to the effectiveness of the treatment and care provided.

For health care facilities/institutions, quality is the production of the most effective care possible, at the lowest cost (cost, efficiency), with a condition that the patient returns to the facility when needed.

From the point of view of the social welfare system, quality is the cost-effectiveness, management and use of resources to achieve the desired health outcomes.

And finally for society, quality is the optimization of resources in favor of the communities and the citizen in general.

The concept of satisfaction is one of the tools for measuring the quality of care, from the patient's point of view, it is essential for its evaluation.

- **Genesis of hospital quality:**

Quality as seen from the perspective of a professional bureaucracy

H. Mintzberg describes the hospital organization as a professional bureaucracy, this model of structures is based primarily on the skills and knowledge of the operational center

(professionals), in the case of the hospital, the service delivered, which is the production of care must be controlled by the operators who perform it(Mintzberg, 1982).

This type of organization also relies on the development of standards and norms that have the role of coordinating work and determining what must be done beforehand

Quality in the hospital is therefore based on the control of professional practices on the one hand, and on compliance with rules and standards established in advance by management or legal texts on the other.

- **First phase: evaluation of hospital quality:**

In 1980, two different orientations emerged, in the United States and then in Europe, namely the evaluation of the quality of professional practices and the evaluation of the quality of care provided within the hospital institution.

The quality of professional practices:

This approach sums up quality in terms of professional expertise, or the mastery of knowledge in each hospital specialty. In fact, quality is defined as the technical mastery of care acts.

In 1970, several American studies noted differences in the performance of medical and surgical procedures, which were not directly related to the patient's condition or even to the technical conditions of the hospital environment. This led experts in the field to create a movement whose objective was to develop recommendations for good clinical practice, considered to be a standardized description of the best medical attitude for a given pathological case.

The evaluation of the quality of professional practices has affected several specialties, we cite: indicators of prescription of specific acts such as chest X-rays, nosocomial infections (Wennberg J., Guttenshon A., 1973).

Quality for nurses can be summarized as the control of technical acts or gestures such as intravenous injections, the insertion of a catheter, etc., and the control of preventive acts; this control is based on medical knowledge.

- **The quality of hospital services:**

The evaluation of hospital services has a bureaucratic character of quality, it is defined through the respect of rules pre-established by the management of the hospital in coordination with health professionals or legal rules.

Avedis Donabedian provides a framework for the analysis of quality of care assessment (QCA) based on 3 levels of assessment: (Donabedian, 1988) (see previous pages)

The objective is to define references (explicit quality standards) for all these care actions, then to develop indicators for each level of assessment, and finally to make them quantifiable.

This approach is based on two major points:

- To focus on the standardization of rules and norms, the evaluation of quality is done through a comparison with these standards and the quality of care is defined as the conformity to them.

- To give all care actions a quantifiable character, and subsequently define standards.

These characteristics provide the health care institution with a management technique based on evaluation tools that measure the degree of conformity of each care act, which makes it possible to compare the different care units.

Through these two approaches, we deduce that the evaluation of the quality of care is concerned with both the professional and administrative aspects.

- **Phase Two: Quality Assurance:**

In 1980, the quality movement was no longer satisfied with evaluation, but set itself the objective of correcting the undesirable points detected in the evaluation phase through a system of actions.

This movement is concretized in the hospital through two fundamental points (Walker, A. H. and Restuccia, J D, 1984):

- Master in place monitoring slides that are valid on a daily basis.

- Designing a work execution scheme based on pre-established standards or norms, based on the principle of quality assurance which is compliance

The application of the quality assurance principle in the hospital involves two phases: monitoring and evaluation, and implementation of corrective actions.

The first phase is based on the detection of undesirable events, such as nosocomial infections, falls of the elderly, patient complaints, etc., which will then be monitored.

The result of the first phase is the development of written procedures in order to avoid the organizational risks associated with the oral transmission of information.

The second step is to carry out corrective actions in order to minimize the discrepancies between what has been done and what should be done, based on pre-established guidelines,

which include laws, recommendations, rules and pre-established standards. Sometimes corrective actions can be stated in a baseline.

Hospital quality under the impact of the bureaucratic-professional approach:

The production of quality in the hospital is done through two successive phases: the evaluation phase and the phase of development of corrective actions, it is the administrative and professional staff who have the common role of ensuring them, so this production begins with the evaluation stage.

To ensure its application, professionals and administrators are both involved in the quality process, so we distinguish two categories:

- The autonomous co-productions of the quality: they are the steps made by the professionals or the administrators, it engages only one of the two.
- Crossed co-productions: there are certain tasks that require the cooperation of both professionals and administrators, for their accomplishment and to ensure their quality, as for example: the placement of patients admitted to the emergency room in downstream beds, this task requires coordination between the two for the co-production of quality(Minvielle, 1999).

In both cases, to ensure quality of care, professionals and administrators must set themselves the goal of quality while respecting pre-established rules and standards from a professional bureaucratic perspective.

The emergence of a new reflection on the organization of quality work:

At the end of the 1980s, a new trend emerged in the United States, and later in Europe, in which traditional methods and approaches to quality assessment and assurance were questioned, despite their successes, especially in the logistical and technical sectors of the hospital. The aim of this questioning was to broaden the field of investigation of quality.

The questioning of traditional approaches:

There are several criticisms of traditional approaches to quality, which can be divided into two main points: the first is the lack of consideration of the organizational dimensions of the hospital in the traditional approach to quality, and the second is the prescriptive aspect of the methods for improving quality.

- **Professional practices in the organization:**

The vision of quality oriented towards professional practices is narrow, neglecting other aspects of quality of care, such as the involvement of users and other care actors in the care process (Berwick, 1989.) (D. Berwick and D.N. Schumacher were the first to emphasize the

reductive nature of this approach, which is centered on the analysis of professional practices and on medical expertise only.

This questioning is based on classical approaches from the industrial world, mainly the work of W.E. Deming, which states that only 15% of deficiencies are related to the technical expertise of professionals, and 85% are the result of organizational factors, which shows that malfunctions are not always the responsibility of health professionals, but due to errors in the management of the hospital organization to the various care services (Deming, 1991).

Continuous improvement and compliance with standards:

According to traditional approaches, quality is compliance with norms and standards, such an approach limits the level that could be reached in the quality of health care services, the risk is to develop norms and standards that affect only a minimal level of quality and far from excellence.

- **Total quality management:**

Following these findings criticizing the traditional approaches, a new movement is emerging, called total quality management, following the example of the industrial world, the hospital is committed to making the transition from the detection of defects to a quality management system (Husser, 2006).

This movement is based on several principles:

- The search for continuous improvement of excellence in work, so quality improvement is an ongoing process.

- Quality is no longer compliance with standards and norms, but rather the ability of the health care institution to provide services that are as close as possible to the requirements of the patients.

- The organizational aspect is essential, the care entity must master the organizational modes as well as possible, a break with functional management is then required, all the care actors must be involved in the quality process.

The management of quality sets several objectives related to the quality of care and the organization of the entity, its success is based on a process approach, each activity is presented in the form of a process and not described as a function only, this allows the detection of malfunctions using methods and tools: control diagrams, which allow to map and evaluate the processes as well as the intensity of the malfunctions; "fishbone" diagrams, which allow to visualize the causes of the malfunctions and to locate the responsibilities.

Following the implementation of quality management, quality departments were set up in hospitals, and accreditation institutions were created, while giving major importance to the patient.

- **Accreditation of health care institutions and quality improvement:**

The purpose of accreditation is to evaluate the quality of a health care institution and to ensure its continuous improvement through changes in medical, paramedical and managerial practices. The accreditation procedure provides a general and independent assessment of quality in the health care organization, using indicators, criteria and reference systems, covering procedures, good clinical practice and the results of the various services and activities in the organization. The accreditation process must be external and independent of the health care organization, and its evaluation affects all of its activities and practices. It verifies that the conditions for the safety and quality of care and patient management are taken into account by the health care organization.

In 1918, the first accreditation program saw the light of day in the United States, with the help of an association of surgeons, then adopted by four other associations of health professionals, who created an organization, called today: joint commission, this organization is responsible for the certification of all American hospitals today. (Halgand Nathalie, 2003)

In Canada, health professionals joined the Joint Commission in 1950, and in 1956 created their own accreditation body called Accreditation Canada.

The Australian certification program developed in 1974, based on the Canadian experience.

Most other countries applied the principle of accreditation later, as did France, which created the ANAES "National Agency for Health Accreditation and Evaluation"
in 1996, based on the Anglo-Saxon model.

Morocco has recently embarked on a project to establish a hospital accreditation program with the cooperation of the WHO, in a process aimed at developing a national hospital accreditation system that would provide institutions with a frame of reference for better functional organization and technical capacity and, consequently, higher quality care.

Accreditation and total quality:

Accreditation is a systemic approach based on six main objectives, inspired by both American and European procedures. It represents an opportunity for hospital managers to evaluate the

quality of health care services and organizational practices, in order to optimize resources and improve quality by making decisions about organizational changes.

Accreditation is a strategic process, the aim of which is to ensure continuous quality improvement by measuring the hospital's ability to engage in a quality process that aims at excellence at all levels and that has a strong focus on the patient, who is at the heart of the health care system.

Accreditation is like any quality approach, it covers all the activities undertaken in the hospital, all the acts linked to care represent a chain which determines the overall quality level of the entity (from reception to medical and nursing acts, including the hotel business, internal transport, biomedical and medical-technical acts...).), its objective is to make all care professionals aware that they are involved in a quality approach that aims to organize the health establishment by adopting the methods and techniques of quality management. (LETEURTRE, 1998)

It is based on a global approach to the health care organization through: audit, quality management and evaluation.

The audit enables a comparison to be made between the practices undertaken in the hospital and the quality references and standards. This comparison helps to identify the hospital's strong points and its weak points, which are called situations of non-compliance with standards and therefore

of non-quality.

Non-quality can be: organizational (structure and management tools failing), medical and care (nosocomial infections, readmission ...), logistical (accommodation summary, lack of variety of meals served ...) or technical (delays in repairs ...), thereafter, action plans are made with indicators of results, which are subject to evaluation to calculate the differences between the quality objectives and achievements, these differences are analyzed in the context of an audit.

- **Quality of care from different points of view:**

Ensuring better quality during hospitalization is a priority for the health care system.

Much work on this subject has been done in Anglo-Saxon countries since the 1960s, and it has been argued that the quality of health care can be reflected through the points of view of the different parties involved: the patient/consumer, the professional, the health care institution, the social welfare system, the government (van Campen, 1995)

Each type of viewpoint has standard criteria and a perception of quality of care that varies according to its structure and objectives:

Quality, from the patients' perspective, is defined in terms of their needs and expectations for care and services.

Quality, from the practitioner's perspective, is defined in terms of clinical effectiveness, in addition to the accuracy of diagnosis, appropriateness and effectiveness of the treatment and care provided. (van Campen, 1995)

Quality, for health care facilities/institutions is the ability to produce the best delivery of care at the lowest cost (cost-effectiveness), with the objective that patients return when they need it

Quality, from the point of view of the Social Protection system, is about the cost-effectiveness, management and use of resources to achieve the desired health outcomes.

Finally, from a societal or health system perspective, quality is often expressed in terms of value for money and benefits to the community at large.

The concept of patient satisfaction is used to assess the quality of care from the patient's perspective. Feedback from patients (users) of the health care system is generally considered essential to assess and assure quality.

Conclusion:

In this article, we have analyzed the evolution of quality within hospital organizations. This allowed us to understand the evolution of the perception of quality, as well as the factors that influenced the transition of quality from a mere concern of control to a total approach to the organization.

Our analysis of the evolution of the hospital quality movement has led us to conclude that the hospital organization has strong specificities that affect the different parameters of the organization. Its bureaucratic-professional configuration and the complexity of the care production process in which knowledge from the medical, nursing and administrative world confronts each other have forced these organizations to adapt the different.

Bibliographie

Berwick, D. (1989.). *Continuous improvement as an ideal in health care.*NEJM.

Deming, W. (1991). *Hors de la crise* . Paris: Edition Economica.

Donabedian, A. (1988). *The quality of care. How can it be assessed?*(Vol. 260). JAMA.

Halgand Nathalie. (2003). L'accréditation hospitalière : contrôle externe ou levier de changement . *Revue française de gestion, 6*(147), pp. 219-231.

Husser, J. (2006). Le management stratégique de la qualité hospitalière par l'encadrement intermédiaire. *XVème conférence internationale de management stratégique*, (p. p07). Annecy/Genève.

LERAT-PYTLAK, J. (2002). *Le passage d'une certification ISO 9001 à un management par la qualité totale.* Toulouse: thèse de doctorat en sciences de gestion, université de Toulouse,.

LETEURTRE, H. (1998). *L'accréditation hospitalière : gestion des services de soins.* France: édition Berger-Levrault,.

Mintzberg, H. (1982). *structure et dynamique des organisations.* Paris: Les Edition des organisations.

Minvielle, E. (1999). Les politiques d'amélioration de la qualité des soins à l'hôpital. Quel fondement organisationnel ? *Politiques et management public, 17*(4), pp. 59-84.

van Campen, c. S. (1995). Quality of Care and Patient Satisfaction: A Review of Measuring Instruments. *Medical care Research and Review., 52*, pp. 109-133.

Walker, A. H. and Restuccia, J D. (1984). Obtaining Information on Patient Satisfaction with Hospital Care: Mail versus Telephone. *Health Services Research., 19*(3), pp. 291-306.

Wennberg J., Guttenshon A. (1973). variations in medical care among small areas. *Science, 182*, pp. 1102- 1108.