Hospital Accreditation: A solution for developing countries challenges or a challenge for the hospitals?

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Abstract

Background Inasmuch as accreditation is of great significance for hospitals, this study aimed to explain the accreditation challenges of Iranian hospitals through a content analysis approach. Methods A qualitative study was run through the content analysis method in 2018. 19 semi-structured interviews were conducted with experts and data were saturated in this level. To increase the accuracy and precision of the study, Guba and Lincoln's four criteria including credibility, dependability, conformability and transferability were used. MAX QDA10 was used for data analysis via 5-step framework analysis approach. Results The findings of the interview analysis led to the identification of 5 main themes and 29 subthemes. The main themes included macro problems and policy making, evaluators' problems, structural and process problems, executive problems, and problems with the accreditation measures. Conclusion The results shed light on the fact that Iranian hospitals need to experience major changes in applying accreditation as a quality assurance mechanism. In other words, it seems necessary for policy makers affiliated with Ministry of Health and Medical education to revise accreditation measures according to hospital needs and try to clarify the structure and executive process of the accreditation. Moreover, improving and standardizing the evaluators` skills is recommended.

Introduction

Hospitals and health care services are vital components of every human society, to which many financial and social resources are undoubtedly devoted(1). In addition, the quality of health services and hospitals is also very important for many stakeholders, including governments, nongovernmental organizations providing health care and social welfare, and patient-centered organizations(2). Therefore, countries are using different approaches to ensure the quality and improvement of health care standards, and accreditation is one of the most effective mechanisms used to evaluate the performance and to improve the safety and quality of health services(3), to the extent that within the past 50 years, hospital accreditation has been one of the most widely used strategies to improve the quality and functioning of health care systems in more than 70 countries(4).

Accreditation is a systematic assessment by an independent external organization to confirm the existence of pre-defined standards in the structure, process and outcomes with the aim of stimulating the culture of continuous improvement in the quality of medical and hospital care and protecting people's health(5). Accreditation is an effective program for improving the quality of care, patient safety, service provider satisfaction, and improving financial performance and professional development(6–9). Furthermore, based on the best interests of their health systems, countries can benefit from accreditation standards in order to maintain the primary principles of universal health care, justice, quality, efficiency and sustainability(10). The history of using standards for the external evaluation of healthcare organizations dates back to 1917 by the American College of Surgeons. The use of these standards led to the establishment of the Joint Commission for Hospital Accreditation in the United States in 1951. During the 1980s and 1990s, the Accreditation Program was expanded worldwide, and today most health and medical organizations are using accreditation standards, especially in developed countries(11). In

Iran, there have been plans for assessing healthcare centers for many years, but a structured form, called hospital accreditation program, was compulsorily announced by the Ministry of Health and Medical Education in the universities for Medical Sciences in January 2012(12). Despite the international popularity and effectiveness of the Accreditation Program, some weak points are evident in the implementation of the program. In this regard, some evidence and previous studies show that in most cases, the implementation of the accreditation program has several problems, including increased staff workload and employees' resistance to accreditation(13), excessive dependence of the accreditation program on assessment judgments and high costs(14), the high number of measures and the time-consuming nature of accreditation process(15), the same weight of the measures and lack of clarity in the measures(16), and the lack of staff motivation and group work(17). Hence, given the importance of accreditation for hospitals, this study aimed to explain the accreditation challenges of Iranian hospitals through a content analysis approach.

Methods

The present study is a qualitative research conducted through the content analysis method in 2018. Content analysis is a general term for analytical methods in which the content quality of the data is interpreted and explained through an in-depth or internal manner(18). In the present study, semi-structured interviews aimed at determining the initial framework and explaining the accreditation challenges of Iranian hospitals were carried out with six managers and authorities in charge of accreditation at universities, 8 managers and authorities of hospitals, and 5 experts in quality improvement departments of hospitals. The interviewees were selected through purposeful sampling. Purposeful sampling is one of the most common sampling methods in qualitative studies in which the participant groups are selected based on pre-specified criteria related to research questions(19). In this study, the sampling continued until saturation was finally achieved through 19 semi-structured interviews. The selection criteria encompassed having at least a bachelor's degree, a minimal five-year experience and executive activities in the field of accreditation, having at least two years of management experience, being able to speak well, and having willingness to participate and cooperate in the interviews. Taking into account the participants' opinions and making the necessary prearrangements, at this stage we interviewed them preferably in their workplaces. At the beginning of the interviews, some general explanations were orally given about the study and its objectives, as well as the measures taken to keep their information confidential. Most of the interviews lasted at least 50 minutes, and all the interviews were conducted by a single interviewer. The interviews were recorded with the permission of the participants and were then transcribed word by word shortly after their completion.The instruction for the semi-structured interviews was prepared using some studies and the perspectives of a number of faculty members. The final reviewed version of the instruction included five main open-ended questions and a number of sub-questions. The face validity of the interview instruction was approved through four initial interviews with the university accreditation managers and authorities, and a portion of the analyzed data was used in the final stage.

To increase the accuracy and precision of the study, Guba and Lincoln's four criteria including credibility, dependability, conformability and transferability, which were among the criteria for reliability confirmation in qualitative studies, were used in data coding(20), and the results indicated that the interview questions were reliable. To achieve data credibility in this study, we used continuous data comparison, data summarization and categorization without data damage, sampling for interviewing with maximum diversity, and time integration, such as doing in-depth interviews at the times and locations suggested by the participants and the possibility of giving feedback to the data, full and continuous involvement of the researcher in the data, and comparative and continuous analyses. For conformability of the present study, the contents of some of the interviews and extracted codes were handed in to a number of faculty members who were familiar with the method of analyzing qualitative research and did not participate in the study. They were asked to verify the accuracy of the data encoding process.In the present study, data dependability was assessed by the research team members and qualified people who examined the accuracy of the coding process. To create the data transferability power, a complete description of the issue as well as the participants' characteristics, the data collection and data analysis methods, and some examples of the participants' statements were provided so that it would be possible for others to track the research route. To analyze the data, a five-stage framework analysis method was used so that in the first stage, the audio files from the sessions were listened to by the researcher several times and the scripts were repeatedly read in order to be familiarized with the data. To identify a thematic framework, the repetitive ideas in the familiarization process were formed into groups of similar ideas or themes in the second stage. The third stage was indexing, in which the units or clusters of the data related to a particular theme were identified. Following the indexing stage, the data were summarized in a table of themes based on the thematic framework. Finally, in the fifth stage, the data were ultimately combined, and maps and interpretations were used to define the concepts, show the relationship between the concepts, characterize the nature of the phenomenon, and provide explanations and suggestions(21).Furthermore, in order to ensure dependability, two members of the research team analyzed the contents individually and discussed the issues to reach an agreement. The data analysis was also done using the MAX QDA 10 software. To this end, at the end of this stage, the accreditation challenges of the hospitals in the country were identified.

Results

Among the 19 interviewees, there were 13 (68.42%) female and 6 (31.58%) male ones, and their mean age was 53.25 ± 6.3 years. The findings of the interview analysis led to the identification of 5 main themes and 29 subthemes as described in Table 1. The main themes included macro problems and policy making, evaluators' problems, structural and process problems, executive problems, and problems with the measures.

Accreditation macro problems and policy making incorporated 5 subthemes as follows: non-alignment of educational and medical accreditation policies, waste of resources and spending additional expenses, lack of a healthy and independent third organization, ignoring the process owners and accreditation stakeholders, and disparate and contradictory regulations and supervisions by different deputies.In this

regard, the interviewees believed that educational accreditation policies were not in line with the policies of medical accreditation. One of the participants stated:

"Unfortunately, our medical and educational deputies aren't consistent and don't have the same policies, so, when they pay attention to education, treatment is abandoned, when they consider treatment, education is ignored"[P_{17}].

Another participant said:

"Regarding hospital accreditation, we should do something to highlight the grading of educational accreditation in medical accreditation"[P_{16}].

The interviewees believed that there were waste of resources and extra expenses were spent in accreditation. In this regard, one interviewee stated that:

"Accreditation doesn't consider the fact that in some towns where there aren't lots of patients and there's no need to have a hospital at all, they shouldn't build a new hospital; or in some hospitals, unnecessary sections are launched, and they buy CT scan, MRI, and so on"[P_2].

The interviewees believed that currently, there was not a healthy and independent third company to carry out the accreditation process. One participant stated that:

"We need an institution or organization to act independently, develop evaluators autonomously, train independently, and even dispatch evaluators on its own"[P_{10}].

Similarly, another participant said:

"The structure of the third organization, their type of expertise, not having stakeholders, and in fact, not having political factions, are of overriding importance. That's why we couldn't establish a healthy third company"[P_4].

In their opinion, process owners and stakeholders were not taken notice of in accreditation. One of the participants stated that:

"We write down a lot of accreditation measures but they are infeasible and should be ignored; this shows that in the formulation of accreditation measures, the people who must be involved aren't included, while those whose presence is somewhat unnecessary are involved, and this brings about duality"[P_{18}].

Three of the interviewees believed that disparate and contradictory instructions and regulations were imposed on hospitals by different deputies. One participant stated that

"At times, this kind of disparate supervision misleads the hospitals; for example, each of them apply a different taste to the hospital"[P_7].

Besides, a participant asserted:

“The appearance of various groups is one of our problems. There are sometimes contradictions between these measures, accreditation comments and evaluations and case evaluations”[P6].

Evaluators’ problems included seven subthemes as follows: shortage of evaluators to be assigned to different provinces, costs of travel and residence of evaluators in various provinces, evaluators’ lack of motivation due to inappropriate payments, irrelevancy of evaluators’ expertise with the areas of evaluation, involvement of a large number of people and the impact of their personal tastes on evaluations, effect of the mood and position of evaluators and evaluatees on judgment and evaluation quality, and irregular and tight schedules of evaluations. Some interviewees believed that there was a shortage of evaluators to be allocated to different provinces. A participant stated that:

“They had predicted a specific number of evaluators to register at the ministry, but there weren’t that many applicants in that field. Anyway, one of the country’s challenges is that some provinces don’t have evaluators at all”[P_4].

Two of the interviewees thought that the travel and residence of the evaluators in different provinces were costly. One affirmed that:

“Now that we’re facing economic problems and should reduce expenses, their costly travel and residence is a real challenge”[P_{10}].

However, one of the interviewees believed, inappropriate payments to evaluators would cause them to lose motivation and reduce in number. In this regard, it was said that:

“Since there is no specific motive for evaluators, it makes a big challenges and can make them lose motivation and diminish their number over time”[P_{10}].

Three of the interviewees believed that allocation of the evaluators was irrelevant to the areas under evaluation. One participant declared:

“One specialist sees the hospital and everything else from a doctor’s point of view, while a nursing expert sees everything from the standpoint of a nurse”[P_{11}].

Similarly, another participant stated that:

“The first and second generations were more precise, because, for example, one who evaluated the units was doing it related to his/her own expertise, but it wasn’t the same in the third generation”[P_7].

Most of the interviewees believed that evaluators’ personal taste influenced their evaluations. A participant stated that:

“Hospitals toil, spend lots of energy, instruct and implement very much, then an evaluator comes and thinks everything should be done in the same way as it is in her/his own city, but that’s not right, because the nature of the measure must be considered”[P_{14}].

As the interviewees said, evaluators’ mood and conditions were effective in judging and evaluating quality. One interviewee emphasized that:

“A tired evaluator may not evaluate well; or the evaluation by one who goes to a hospital environment where, let’s say, something bad has just happened, for example somebody has died and his/her relatives are making lots of noise, shriek and fight, will be affected by the situation”[P_{2}].

Two of the interviewees believed that the schedules for evaluations were irregular and tight. A participant said:

8].

Structural and process problems included the five following subthemes: ignoring the infrastructures of space, finance, equipment and human force in accreditation; unstandardized and old hospital buildings; failure to create healthy competition between hospitals; inconsistency of the strategic plan of hospitals with the accreditation program; and instrumental use of accreditation to raise hospital rank and increase tariffs. Most of the interviewees believed that the infrastructures of space, finance, equipment and human force were not taken into account in accreditation. One of the participants stated that:

“We don’t have the standards of our infrastructures, such as human force, space structure, and equipment in accreditation at all”[P_{16}].

In addition, another participant said:

“Our nurses are exhausted, our system is worn out, we’re all disappointed, all without motivation, there are some things wrong, one of which I think is a shortage of human forces”[P_{15}].

Four of the interviewees thought that hospital buildings were old and not standard. A participant stated:

“It’s really good to plan for having a social isolation room and a psychological isolation one in each section of the new hospitals which will be built, but it’s very hard for old hospitals which don’t even have vacant rooms”[P_{14}].

Another participant also contended:

“Some standards aren’t applied because our hospital is old. For example, our hoteling standards aren’t perfect; so, we can’t make some departments in there”[P_{19}].

Two of the interviewees believed that there was not healthy competition between hospitals. One of them claimed:

"Well, if you encourage competitions over numbers and indices, one of the paths that will open is data-making path, and many hospitals may be heading towards providing wrong data to universities in order to show their own statistics better than what they really are"[P_1].

Some interviewees thought that the strategic plans of hospitals were not consistent with accreditation. In this regard, a participant stated:

"This very strategic plan is real when it's done at the university; it's real when it's done in the ministry" [P_{17}].

A number of the interviewees believed that accreditation was used as a tool to raise the rank of hospitals and increase the tariffs. It was said:

"A hospital is now in trouble; it doesn't have money; we do it and ask them to consider its accreditation so high that we can increase the tariffs and allocate more money to the hospital." [P_2].

The executive problems included the following subthemes: increased workload and dissatisfaction of hospital staff, increased attention of the staff to documentation, and lack of attention to main tasks, staff resistance against accreditation due to being compulsory; physicians' lack of involvement in accreditation due to the lack of financial gains and time-consuming nature of accreditation process. Some of the interviewees believed that increased workload was causing dissatisfaction among hospital staff. One of the participants expressed:

"We have too much expectation of our personnel though they are insufficient in number; they're usually working double shift; we ask them for excellent accreditation; they're also questioned regularly; these altogether have made them lose motivation. We're all under pressure"[P_{15}].

A majority of the interviewees believed that the issue of accreditation and the increased attention of the staff to documentation had caused the main tasks not to be properly taken into consideration. One participant stated that:

"Although accreditation was very good and they wanted it to exist, it had made the nurses away from bedside. They were going toward filing and documenting which made them further from bedside. They spent more time on writing than on dealing with the patients[P_{14}].

Similarly, another participant maintained:

"We give each nurse 8 patients and 2 to 3 intubates; so we'll beover-expectant to ask them do everythingstandardly, take care of the patients, have good relationships with all the patients, and provide us with excellent documentation and write down everything in detail"[P_{15}].

Two of the interviewees believed that the compulsory accreditation program would cause the staff to resist it. A participant stated that:

“In an organization where accreditation came from a macro level, i.e. the ministry, and was considered compulsory, there would be usually resistance against it[P_2].

According to most of the interviewees, doctors were not mainly involved in accreditation nor did they cooperate in its implementation. As one of the participants stated:

“Unfortunately many doctors did not get involved in accreditation perhaps because they did not receive any gains (financial gains or promotion)[P_6].

A number of interviewees believed that the accreditation program was a time-consuming process. Accordingly, a participant said:

“In fact, it was a very lengthy process, and, for example, it took three complete working days and we were involved three working days in the hospital”[P_4].

The problems of accreditation measures included seven subthemes as follows: interference and parallel work within the areas of responsibility of some measures, ambiguity and unclearness of some measures, using the same measures in evaluating different hospitals, weakness of the measures in some areas, the same weight of the measures; inappropriate structure in scoring the measures, and failure to review the measures in line with the changes in the social, economic and political conditions of the society. Some interviewees believed that there was interference and parallel work in the responsibility areas of some measures. In this regard, a participant pointed out that there was another issue, called parallel work. According to him:

“They sometimes had task interference which greatly caused tension in the organization: tension between human resources and nursing offices, between environmental health and infection control, or between environmental health and occupational health "[P_1].

A number of the interviewees believed that some measures were ambiguous and unclear. One of the participants confirmed:

“You have to think a lot to know what the measure means. You need to read it several times although they all have recommendations and stars. When we read it to different people, they may have different impressions. It’s not so clear and explicit”[P_{41}].

In addition, another participant stated that:

“The accreditation manual itself needed explanations. They had provided it for some measures to a great deal and supplied some explanations, but some measures were still vague and unclear [P_2].

According to a majority of the interviewees, a number of similar and general measures and checklists were used to evaluate different hospitals. As one participant underlined,

“Hospitals differ from one another and they cannot be assessed with the same measures. Single specialty and general hospitals vary a lot. Even an educational hospital was different from a medical hospital [P_6].

Another participant contended:

“As they use the same checklist and the same instruction to evaluate hospitals, they can’t easily distinguish between the hospitals that are inherently different, like general and private hospitals, or non-educational and educational ones”[P_2].

As most of the interviewees pointed out, accreditation measures have weaknesses in some areas. One of the participants declared:

“In general, the measures of the IT syllabus definitely need to be revised. They’re outdated! The ones related to maintenance and repair, especially those related to supply, are of poor quality, too. The maintenance area has become a bit better, but it’s still far from the standards”[P_1].

Furthermore, a participant stated:

“Accreditation is still financially weak and defective; that is, a hospital might have worked even well, but maybe it goes bankrupt! Lots of our public hospitals have a negative balance of course”[P_2].

Some of the interviewees thought that the weight and importance of the measures ought not to be the same. A participant affirmed:

“Some measures are much more important for hospitals, i.e., they’re more important in specific types of hospitals. Therefore, this measure should be scored higher. Its score shouldn’t be the same as the one which was obtained in, for example, another hospital with a different specialty”[P_6].

Additionally, a participant stated:

“If they want to change the weight of the measures, they should do it proportionate to the hospital. For example, if we have a financial measure in a private hospital, the weight of the financial measures will certainly increase much more than that of a public hospital.”[P_2].

Some interviewees believed that the scoring method was unsuitable. In this regard, a participant pronounced:

“At present, the scores given to the measures are currently zero and one, and this inevitably will bring about scoring problems "[P_{11}].

According to two interviewees, the measures needed to be revised in accordance with the changing social, economic and political conditions of the community. One of the participants stated:

“It’s necessary to review the measures every few years because social conditions, types of community diseases, and economic policies of the country are all changing over time”[P_6].

Discussion

The results showed that the accreditation challenges of Iranian hospitals included the problems related to macro level and policy making, those of evaluators, structural and process drawbacks, executive problems, and the complications pertinent to the measures. One of the problems of accreditation in Iran is the waste of resources and spending additional expenses in that the accreditation program uses up a considerable amount of resources and it is costly. However, it seems that accreditation can reduce its total cost by continuous quality improvement. The cost of accreditation for other hospitals is also a key constraint and consumes the resources that can be used for medical services (22). The challenges of accreditation implementation in Australia are also divided into four levels including the system, program, organizational and individual levels. The system level deals with legal and financial support for accreditation programs which are in line with policy making problems in the present study (23). In Iran, the Ministry of Health and Medical Education is responsible for hospital accreditation. Hence, reduced rank and credibility of hospitals will reduce the tariffs and, as a result, decrease the income of hospitals in the country, and will impose a huge financial burden on the government. Thus, the role of the Ministry of Health as the owner of public hospitals and the organization that evaluates and validates hospitals will create a conflict of interest. This will in turn reduce the quality of hospital accreditation programs. In this regard, the existence of a third, healthy and independent organization seems essential. In Kenya and Tanzania, the National Hospital Insurance Fund (NHIF) runs the hospital accreditation program, and one of the problems in Uganda is the implementation of the accreditation program by its Ministry of Health (24).

Inasmuch as the standards are documentation-oriented and the evaluators are not professional in terms of evaluation techniques, and the irrelevance of evaluators’ specialties to the areas under evaluation, evaluators have sought to review the documents for giving higher scores and have paid less attention to observing work processes and evaluating the outcomes in hospitals. Due to the shortage of evaluators and their lack of motivation and their deficiency of relevant and sufficient knowledge, and in view of their evaluation skills which was not at a professional level, some conflicts between evaluators and evaluates may occur. The results of Shaw studies in European countries showed that accreditation evaluators had to be selected on the basis of their merits and qualifications. Moreover, they needed to have both management and clinical experiences and be fully familiar with accreditation standards and processes (25, 26). Furthermore, many accreditation agencies believed that evaluators needed to have appropriate, relevant, and long-term experience of accreditation (27). Therefore, the members of an evaluation team should be graduates of Medicine, Nursing, and Healthcare Management so that clinical and managerial experiences of the accreditation team would be balanced. The results of a study by Jaafaripooyan et al. on the performance of accreditation evaluators in Tehran also indicated educational weakness of the evaluators in terms of accreditation, work experiences irrelevant to evaluation, the lack of incentive

programs for evaluators, and the limited access to professional evaluators all over the country, which is totally consistent with the results of the present study (28). While the results of various studies indicated that the main members of evaluation teams should be 3 to 5 (27, 29), and in Uganda, a team of 2 to 4 people evaluates the accreditation program (24), the involvement of a large number of individuals and the effect of their personal tastes on evaluation might cause a lot of problems in scoring the accreditation of Iranian hospitals. Evaluators' moods and conditions have a great impact on their judgment and evaluation quality. In fact, evaluators should ideally judge and evaluate hospitals based on predetermined experiences and standards (30). Nonetheless, the participants in this study believed that the evaluators' judgments and mood affected their evaluations in the hospital accreditation program in the country. Although Low held that evaluators should play the role of counselors and mentors in hospitals in order to provide high-quality care and acceptable standards to hospitals (29), the irregular and tight evaluation schedules in Iranian hospitals are not following this goal, and it seems that, as accreditation evaluators were mainly health deputy inspectors in universities during the past few years, they did their evaluations like inspections and did not appear as accreditation evaluators.

Prior to the implementation of the accreditation program, the standards and essential requirements such as buildings and physical and human infrastructure need to be investigated. In the United States, the Health Ministry and Medicaid and Medicare Centers have strict annual regulations for issuing licenses for the establishment of hospitals and healthcare centers, and hospitals will only be allowed to work with such licenses. Additionally, among the licensed hospitals, only those seeking reputation and gaining more market share endeavor to fulfil the advanced quality measures defined by a third-party non-governmental organization such as the Joint Accreditation Committee (15). But in Iran, hospitals do not have the required standards, and they must all enforce the accreditation program. In this regard, the accreditation program challenges in Australia also point out the importance of the characteristics and infrastructures of healthcare organizations and institutions for better implementation of the program (23). In the hospitals, hospital tariffs are determined based on the accreditation scores, and the hospital with higher scores and ranks is more liable to set higher tariffs. This has led many hospitals to see the accreditation program as a means of increasing their tariffs.

Increased workload and dissatisfaction of hospital staff were among the hospital accreditation problems. Generally, new programs are associated with increased workload, and providing documentation and evaluation activities are also time-consuming. Therefore, it is necessary to take heed of the factors that increase the staff's motivation and participation, in addition to managing fair division of their tasks. The Brazilian nurses' views on accreditation also showed that they did not have enough time to carry out accreditation activities and did not receive appropriate rewards for it (31). In the study by Ng et al., increased workload of the staff and their resistance to changes were among the weaknesses of the accreditation program (13). In addition, the results of the study by Pongpirul et al. revealed that documentation of the patients' healthcare records was the biggest obstacle to the implementation of accreditation programs in Thailand (32). According to the participants, the staff's resistance to accreditation due to its compulsory nature was one of the drawbacks of the accreditation program implementation. In fact, unlike the United States' accreditation program which was voluntary, the Iranian

Ministry of Health and Medical Education necessitated all public and private hospitals to implement the accreditation program. Given the lack of standardized spaces for different departments and the dearth of human resources to enforce the standards, hospitals could not easily adapt themselves to the accreditation program, and thus a kind of resistance to the program was created. However, it seems that if the goals of accreditation are properly explained to the staff by holding training classes before the implementation of the program, such problems will be largely averted. One of the influential factors in reducing staff resistance in Hong Kong was the awareness of the accreditation goals and of the opportunities for the staff and hospitals (13). In the study by Saadati et al., negative perceptions of the nurses about hospital accreditation incorporated poor motivation systems, over-documentation, and work stress (33). Similarly, in the study by Mahmoodian et al., the increased workload of the staff and the lack of teamwork and task division were outlined as the accreditation challenges that caused staff dissatisfaction (34). The lack of physicians' involvement in accreditation due to the lack of financial gains was also stated as a problems of hospital accreditation. The participants maintained that physicians did not get involved in accreditation, and unfortunately, there was not enough supervision of the issue. Furthermore, physicians' tasks were carried out by nurses, and this gave rise to increased dissatisfaction. In their study, Hakkak et al. addressed the lack of physicians' participation in accreditation, which was considered a hospital accreditation challenge in the country, and is consistent with the results of the present study (35). According to the participants, another problem of accreditation implementation was its time-consuming nature. It seems that the implementation of the accreditation program is initially time-consuming due to the provision of the necessary context, and this is one of the challenges of accreditation in Iran and the world. In their studies, Sack, Pomey, and Reznich also stated that accreditation was a time-consuming process, and pointed out that the process could be shortened (38–36).

In accordance with the results of this study, another problem of hospital accreditation was that some measures were ambiguous and unclear. That is to say, some accreditation measures had been written vaguely and required literary editing, and some others were too general and only referred to the implementation of a single code or circular. The use of the same measures in evaluating different hospitals was deemed to be one of the problems of the accreditation program. In other words, some measures were not feasible in some hospitals of the country, and the structure, ownership and diversity of hospitals needed to be taken into account in the formulation of the measures. For example, in Pakistan, accreditation measures could not be applied to all hospitals, because some hospitals were basically much weaker than others (39). Concerning the problems with the weakness of the measures in some areas, the study by Ahmadi et al. reflected the fact that the accreditation model of Iranian hospitals did not cover 45.4% of the measures provided by the Joint Accreditation Committee, and the Ministry of Health did not pay enough attention to some important issues related to the patient care process when setting up hospital standards (40). The results showed that the interviewees considered the same weight of the measures as one of the problems of the accreditation measures. To put it differently, the same weight has been considered for accreditation measures in the current hospital accreditation system in the country, while the measures do not have the same importance and their implementation requires different

workloads. Some measures are in the form of mere notifications, but some others entail several months of work in hospitals. Hence, giving different weights to the measures can help hospitals spend their time and resources on more important ones. A study by Mosaddeqhrad et al. also indicated that hospital managers had moderate satisfaction with the content of hospital accreditation standards and the most frequent dissatisfaction was with the lack of transparency of the standards and measures, the same weight of accreditation measures, and the large number of standards and measures (41).

Conclusion

According to the results it seems that Iranian hospitals need to experience major changes in applying accreditation as a quality assurance mechanism. In other words, it seems necessary for policy makers who are affiliated with Ministry of Health and Medical education to revise accreditation measures according to hospital needs and to try to clarify the structure and executive process of the accreditation. Improving and standardizing the evaluators' skills is also recommended.

Declarations

- Ethics approval and consent to participate

The article's proposal is approved by ethics committee affiliated with Shiraz University of Medical Sciences with the ID of IR.SUMS.REC.1396.S1016.

- Consent to publish

Not applicable

- Availability of data and materials

While identifying/confidential patient data should not be published within the manuscript, the datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

- Competing interests

All authors declare that they have no conflict of interest regarding this study.

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- Authors' Contributions

NB, FGM, KP, SKN have contributed in data collection, data analysis and preparing the initial draft of the article, RR and ZK have edited and finalized the article and PB has designed the study and supervised the

whole project.

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Tables

Table1. Accreditation Challenges of Hospitals in the Country

Main Theme	Subtheme
Macro problems and policy making	Non-alignment of educational and medical accreditation policies
	Waste of resources and spending additional expenses
	Lack of a healthy and independent third organization
	Ignoring the process owners and accreditation stakeholders
	Disparate and contradictory regulations and supervisions by different deputies
Evaluators' problems	Shortage of evaluators to assign to different provinces
	Costs of travel and residence of evaluators in different provinces
	Evaluators’ lack of motivation due to inappropriate payments
	Irrelevancy of evaluators' expertise with the areas of evaluation
	Involvement of a large number of people and the impact of their personal tastes on evaluations
	Impact of the mood and position of evaluators and evaluatees on judgment and evaluation quality
	Irregular and tight schedules of evaluations
Structural and process problems	Ignoring the infrastructures of space, finance, equipment and human force in accreditation
	Unstandardized and old hospital buildings
	Failure to create healthy competition between hospitals
	Inconsistency of the strategic plan of hospitals with the accreditation program
	Instrumental use of accreditation to raise hospital rank and increase tariffs
Executive problems	Increased workload and dissatisfaction of hospital staff
	Increased attention of the staff to documentation, and lack of attention to main tasks
	Staff resistance against accreditation due to its compulsory nature
	physicians’ lack of involvement in accreditation due to the lack of financial gains
	Time-consuming nature of accreditation process
Problems with the measures	Interference and parallel work among the areas of responsibility of some measures
	Ambiguity and unclearness of some measures
	Using the same measures in evaluating different hospitals
	Weakness of the measures in some areas
	The same weight of the measures
	Inappropriate structure of scoring the measures
	Failure to review the measures in line with the changes in the social, economic and political conditions of society