“THE EFFECT OF HEALTH CARE ACCREDITATION STANDARDS ON THE LEADERSHIP AND QUALITY PRACTICES IN PRIMARY HEALTH CARE CENTERS IN JEDDAH”

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ABSTRACT

Increasing demand health care centers in front of great challenges toward continuity and maintain the level leadership and high-quality practices in primary health centers. Therefore, the problem of this study focuses on the application of acceptable leadership and quality practices in primary health care centers in Jeddah. The aim of the current paper seeks toward a better understanding of the effect health care accreditation standards on the leadership and Quality Practices in Primary Health Care Centers in Jeddah to deliver efficient and effective medical services and to achieve patient satisfaction. The study applied the comparative quantitative approach between 68 primary health care centers include accredited and non-accredited institutions to analyze the data and test the study questions. Where the researcher used a questionnaire to collect data from administrative and health leaders in primary health centers in the city of Jeddah. According to the findings, accreditation was seen as having a beneficial impact on a number of different aspects of quality and leadership. In addition, a number of components of the accreditation had a good association with the quality of the outcomes. This featured a scale that was connected with growing participation, as well as a scale that was associated with leadership.

الملخص:

زيادة الطلب على مراكز الرعاية الصحية أمام تحديات كبيرة نحو الاستمرارية والحفاظ على مستوى الريادة والممارسات عالية الجودة في المراكز الصحية الأولية. لذلك تركزت مشكلة هذه الدراسة على تطبيق ممارسات القيادة والجودة المقبولة في مراكز الرعاية الصحية الأولية بجدة. يسعى الهدف الرئيسي للورقة الحالية إلى فهم أفضل لتأثير معايير اعتماد الرعاية الصحية على ممارسات القيادة والجودة في مراكز الرعاية الصحية الأولية في جدة لتقديم خدمات طبية تتسم بالكفاءة والفعالية وتحقيق رضا المرضى. وقد طبقت الدراسة المنهج الكمي المقارن بين 68 مركزاً للرعاية الصحية الأولية تشمل مؤسسات معتمدة وغير معتمدة لتحليل البيانات واختبار أسئلة الدراسة. حيث استخدمت الباحثة استبانة لجمع البيانات من القيادات الإدارية والصحية في المراكز الصحية الأولية في مدينة جدة. وفقًا للنتائج، كان يُنظر إلى الاعتماد على أنه له تأثير مفيد على عدد من الجوانب المختلفة للجودة والقيادة. بالإضافة إلى ذلك، كان لعدد من مكونات الاعتماد ارتباط جيد بجودة النتائج. تميز هذا بمقياس كان مرتبطًا بمشاركة متزايدة، بالإضافة إلى مقياس مرتبط بالقيادة.

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Chapter One: Introduction

1.1. Preface:

Economic, social, political, cultural, and technological changes in the last decades of the 20th century highlighted the importance of the human dimension in organizational processes. Modern administrative thought focused on achieving the productive efficiency of administrative organizations through the development of human forces, focusing on organizational culture, supporting senior leadership, and working to create an organizational climate. Hospitals and healthcare institutions have adopted administrative techniques that boost performance and productivity. These include quality improvement and healthcare leadership.

Since the early 1990s, developing and developed countries have privatized healthcare. Changes in organizational self-sufficiency and outsourcing led to these gains. Mills et al., (2002) said, "One effect has been a rapid development in External Quality Assessment (EQA)". Governments and non-profits began using objective quality evaluation methodologies, they said. Combining these strategies with others to reduce service costs, give access, information, and compliance incentives improved primary healthcare in Jeddah. The WHO chose the term 'External Quality Assessment' to include all organizational review forms with documented standards method.

1.2. Problem Statement

Increasing demand health care centers in front of great challenges toward continuity and maintain the level leadership and high-quality practices in primary health centers. Therefore, the problem of this study focuses on the application of acceptable leadership and quality practices in primary health care centers in Jeddah. Moreover, the problem has comprised a lack of evidence in the literature review about an affective accreditation standards value. Based on study problem, major question is as fellow:

- What is the effect of health care accreditation standards on the leadership and quality practices in health care centers in Jeddah?

1.3. Research Aim and Objectives

The aim of the current paper seeks toward a better understanding of the effect health care accreditation standards on the leadership and Quality Practices in Primary Health Care Centers in Jeddah to deliver efficient and effective medical services and to achieve patient satisfaction. The goal of the study can be achieved through the following objectives:

- To identify if there are effective leadership practices that conducted in primary health care centers in Jeddah.
- To identify effectiveness of quality practices that carried in primary health care centers in Jeddah.

1.4. Significance of the Study

This study investigates the effect of health care accreditation standards on the leadership and Quality Practices in Primary Health Care Centers in Jeddah. Outcomes provide much changes in leadership and quality standards in health care centers in Jeddah. The overall benefits that the study afford a valuable insight enrich with information on the accessible, thus helping a smooth preparation process and contributing ultimately to positive changes at the level of the community health and safety.

1.5. Study Hypothesis

This study leads to following to hypotheses:

Null hypothesis:

- There is no significant effect of health care accreditation standards on the leadership and Quality Practices in Primary Health Care Centers in Jeddah.

Alternative hypothesis:

- There is a significant effect of health care accreditation standards on the leadership and Quality Practices in Primary Health Care Centers in Jeddah.
- Effective leadership practices in primary health care centers in Jeddah makes staff performance higher.
- Increasing quality improvement practices in primary health care centers in Jeddah makes the increase patient safety.

1.6. Methodology and Data Collection

The study applied the comparative quantitative approach to analyze the data and test the study questions. Where the researcher used a questionnaire to collect data from administrative and health leaders in primary health centers in the city of Jeddah.

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1.7. Organization (structure) of the Research

The study has involved six chapters, including background of study, purpose, questions, structure of the research, and significance. The second chapter comprises a review of literature, third chapter addresses important components of the research methodology utilized for the study, fourth chapter addresses the results and the analysis of data gathered in the study, fifth chapter outlines an interpretation of the results of the study, and the sixth chapter is the final which includes the conclusion and recommendations.

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Chapter Two: Literature Review

2.1. Preface

Primary health care centers are among the organizations that have taken the initiative to achieve long-term success. Therefore, it is noted that improving leadership and quality improvement practices in primary health care centers in Jeddah. This study focuses on shedding light on the role of leadership and quality improvement in primary health care centers in Jeddah, Saudi Arabia.

2.2. Literature Review

2.2.1. Healthcare in the Kingdom of Saudi Arabia

2.2.1.1. The healthcare system and position of PHC in Saudi Arabia

The Saudi healthcare system, consisting of a network of public and commercial health facilities (Figure 1), was established in 1926 when the first health directorate constructed two hospitals, one in Jeddah and the other in Mecca. In 1951, the Ministry of Health (MoH) was founded, and 11 hospitals were constructed. The origins of the current Saudi healthcare system date back to 1971, when the Saudi government enacted its first five-year plan (Alkhamis, 2012).

Saudi Arabia's healthcare approach includes PHCCs. Preventive, curative, and rehabilitative health care is the focus. It's important to provide comprehensive health care for all regions. All health facilities must be near together to give these services (Alharbi, 2018). PHCCs, pharmaceutical dispensaries, and maternity and child centers must be consolidated into a central health unit. Preventative healthcare has superseded curative in the last 20 years (Almalki, FitzGerald & Clark 2011).

Since 1995, other government entities have maintained 20% of the country's hospital beds using MOF monies transferred through affiliated ministries. These organizations provide higher-quality services than the Ministry of Health. Individuals can obtain services from many independent organizations. Overpopulation makes such systems slow for those who require assistance.

2.2.2. Accreditation

Accreditation in healthcare is an internationally recognized method used to review and enhance the quality of healthcare services given as well as increase the efficiency, and effectiveness of resource usage in health care organizations for better health outcomes. It is also a mechanism to publicly declare that a health care organization has met national quality norms and requirements (Nicklin, 2015).

Organizations who frequently participate in accreditation programmes view it as a dependable and essential instrument for enhancing the quality of the services they offer. Accreditation is founded on the assumption that adherence to evidence-based standards will enhance the quality of health care services offered in an increasingly (Hussein, 2021). secure and sustainable environment

2.2.2.1. Brief Overview of Accreditation in the Healthcare Sector

Accreditation is seen as a tool designed to enhance the quality, efficiency, and efficacy of a healthcare organization by refining its structures, processes, and results. Accreditation arose initially in reaction to disparities in the quality of education between institutions, and subsequently it moved to the healthcare industry (Desveaux et al., 2017). The objective was to achieve self-guidance for organizations by outlining excellence criteria and guiding principles that would consistently result in higher quality than when firms do not employ them.

Accreditation has become a recognized component of healthcare systems in more than seventy countries since its introduction in the 1970s. Greenfield et al., (2012) discovered there are now over 22 national healthcare accreditation bodies, and healthcare accreditation is practiced in over seventy countries worldwide. Several factors, including a strong emphasis on patient safety, extensive efforts to minimize avoidable harm to patients, the expansion of health services, and advancements in the healthcare professions, contributed to the development and expansion of healthcare regulation.

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2.2.2.2. Accreditation in Primary Health Care

In Saudi Arabia, there are three tiers of health care services: primary, secondary, and tertiary. In actuality, there are four levels of care, as depicted in Figure 1.

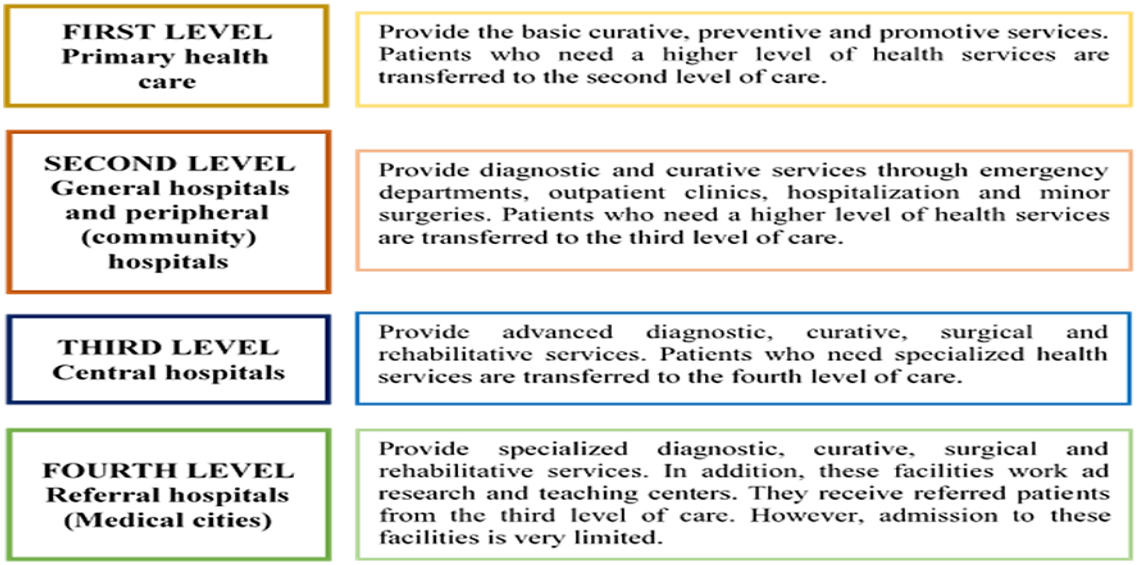

Figure 1: Care levels in Saudi Arabia's health-care system

Primary care is the first health level. Ministry of Health delivers it through primary care facilities. Primary health care services encounter barriers in illness patterns, personnel, information systems, financial assistance, and accessibility (Almalki, FitzGerald and Clark, 2011).

Accreditation was created to enhance acute care quality. With the rise of primary care and the emphasis on this sector of the healthcare business, accrediting bodies are focusing more on quality and improving primary care services. In Canada, efforts were concentrated on adopting primary care-specific accrediting criteria that do not apply in a hospital context.

Accredited PHCs have a better image than non-accredited centers due to increasing accreditation requirements. Accreditation of PHC aims to enhance health services, worker conditions, and patient happiness (Ekawati e al., 2017). The healthcare system that focuses on enhancing PHC quality increases PHC's function and emphasizes care management, boosting system efficiency, risk management, patient safety, and employee satisfaction.

Primary care empowers doctors and staff. Primary care practitioners become the bridge between the community and advanced healthcare by emphasizing their importance, allowing patients to make better educated health decisions. Studies (Devkaran and O'Farrell, 2015; Al-Damen, 2017) suggest that accredited PHC providers and administrators are more happy. They have clear policies and processes in a well-structured environment. Accreditation in PHCs improves communication, teamwork, and employee satisfaction. Comprehensive documenting and applying theory in practice contribute to directors' and workers' happiness.

In 1992, the WHO established that primary health care comprises of four fundamental elements: health promotion, illness prevention, curative medicine, and rehabilitation. As there are no easily identified primary care tasks and no uniform structure for this part of the health system, accrediting bodies try to build standards based on community hospitals and family physician practices.

Using the European Practice Assessment programme to give feedback and outreach visits to primary care practices to enhance quality improvement, a research was conducted in Europe on the efficacy of quality-improvement in boosting primary care practice management. The European Practice Assessment accreditation programme analyzed and improved primary care management based on quality criteria. Tabrizi and Gharibi (2019) found that primary care practices that used organizational concepts enhanced their practice management.

2.2.2.3. The Life Cycle of Accreditation

The life cycle of accreditation describes the intricate stages and dynamics of accreditation as a quality intervention. Joint Commission International (JCI) has issued an accreditation preparation approach indicating that the majority of hospitals would undergo several steps during the certification process (Joint Commission International, 2010).

2.2.2.3.1. The initiation phases

This involves implementing JCI quality criteria. Adoption and revival are sub phases. Adoption sub phase involves implementing new standards. JCI recommends forming teams and leaders to coordinate accreditation preparatory efforts. Team leaders coordinate preparations. As JCI requires policies and processes, relevant papers are examined. Gap analysis prompts additional compliance upgrades in the revitalization sub phase (Devkaran et al., 2019). JCI recommends a Baseline Assessment/Gap analysis to assess existing procedures and standards compliance. This shows how to bridge the performance gap between an organization's present performance and accreditation requirements. Also, baseline quality data is collected and compared to quality monitoring criteria. The process comprises reviewing JCI compliance, devising an action plan to remedy shortcomings, adopting new procedures and data gathering targeting compliance, performing an organization-wide training programme, and assigning appropriate resources.

2.2.2.3.2. The pre-survey phases

The pre-survey phase takes place three to six months prior to the accreditation survey. Following a mock survey, as recommended by JCI, the team conducts an assessment of existing gaps and works to close them within a limited time frame. Due to the staff's awareness of the impending survey and the organization's investment in preparation, it is anticipated that compliance will significantly increase (ramp up) during the pre-survey phase (Nugroho and Sjaaf, 2019). In addition, JCI accreditation involves the submission of a four-month compliance record prior to the accreditation assessment, providing an additional incentive for improvement. The peak degree of compliance performance is therefore expected to occur during this time.

2.2.2.3.3. The post accreditation slump

Upon earning accreditation, the quality performance of the majority of hospitals tends to revert to pre-accreditation levels. There is less pressure on the personnel to perform at a high level, allowing them to concentrate on tasks that had previously been put on the back burner. Lack of leadership, a lack of incentives to develop, competing demands, organizational changes, or lack of regular performance tracking can prolong this phase. An employee's absence from the company's management team could have a significant impact on the quality of the product or service. It is possible that standards will not be incorporated into practice if the purpose is to just comply with the survey.

2.2.2.3.4. The stagnation/maturation phase

This period happens a few months after the accreditation survey and follows the post-accreditation slump. Since the hospital is in compliance with JCI standards, as confirmed by the survey, there are no fresh measures to push additional improvements, which is anticipated to result in a plateau in compliance performance. If there is no ongoing performance management system, there may be a decrease that lasts until the following phase of initiation in preparation for reaccreditation (Devkaran and O'Farrell, 2014). Typically, the certification process comprises a periodic (snapshot) examination, as opposed to a continuous assessment, which leads to a more reactive rather than forward-looking emphasis and can be a cause in persistent quality shortcomings.

2.2.2.4. Key principles of Accreditation

2.2.2.4.1. Health-care outcomes

Accreditation provides a framework to assist in the development and implementation of policies and procedures that enhance operational efficiency and promote positive health outcomes. Accreditation is crucial for enabling systems and processes within a health care institution to enhance the quality of care and, consequently, health care outcomes (Yousefinezhadi et al., 2017).

2.2.2.4.2. Patient satisfaction

At least in hospitals, accreditation has been found to affect patient satisfaction. The patient safety and quality of health outcomes of accredited organizations are superior. Accreditation may also result in equitable health outcomes among all population groups; better distribution of high-quality services and cost-effective utilization of resources have been demonstrated to have increased, which may provide the most disadvantaged with equitable access to high-quality treatment.

2.2.2.4.3. Costs/Resources

Accreditation also has a favorable effect on the organization's financial results. It reduces liability costs, promotes effective investment and utilization of health care services resources, and identifies regions in need of funding as opposed to randomly dispersing budgets (Kipyegon, K. and Nyarombe, 2015). Accreditation can facilitate participation in reimbursement programmes by health care institutions. Accreditation, on the other hand, necessitates a substantial budget and long-term funding; as was the case in Zambia, where an assessment revealed that accreditation costs are typically not covered by government resources alone and require the assistance of foreign donors. There is effort to be done in articulating the long-term value of certification to healthcare organizations, as institutions with limited financial resources prefer to use their funds to operate their services rather than spend money on accreditation.

2.2.2.4.4. Continual performance Enhancement

Accreditation displays an institution's accountability and credibility regarding the quality of healthcare and increases the sustainability of a healthcare quality improvement strategy by promoting the efficient and effective use of resources and continual self-evaluation against standards (Terra and Berssaneti, 2019). As such, it is a process of continuous quality improvement in which healthcare organizations must continually address new difficulties in order to satisfy worldwide standards. It is argued that certification by itself is not always a change agent, but that the accreditation process is an effective instrument for continual learning, planning, and improvement to obtain better results.

2.2.3. Quality of health care service

The quality of healthcare is one of the most frequently stated topics in health policy principles and is currently a top priority for national, European, and international policymakers. At the national level, addressing the issue of healthcare quality can be brought up for a variety of reasons, including the general commitment to offer high-quality healthcare since health is a public good (Chassin and Loeb, 2013).

The American Joint Commission on Accreditation of Health Organizations defined it as "the degree of adherence to generally recognized contemporary standards of good practice and expected outcomes for a specific service, diagnosis, or medical problem."

According to Blumenthal, (1996) finds that the quality of health care refers to:

- To match the standard standards of health services provided to the community with the required service levels and when needed.
- To ensure that the simple effective activities are carried out at the required level.
- To improve the quality of health services to improve the health of the community.
- A continuous search for various possibilities to improve the health service, while setting clear goals to raise the health level.
- The process of continuous monitoring of performance levels through selected indicators that depend on the components of health care.

The perspective of patients on the quality of health treatment is essential for multiple reasons. First, the high quality of services provided by healthcare facilities is associated with factors such as patient satisfaction and readiness to re-use services in the future (Abbasi-Moghaddam et al., 2019). Second, patient comments and views are a crucial requirement for many quality evaluation systems in the health care industry. Thirdly, the perceived high degree of service quality influences the financial performance and efficiency of health care facilities.

2.2.3.1. Effect of quality improvement and patient safety

Quality management, patient care, and patient safety are receiving more attention from hospital administration and other hospital stakeholders around the world. As part of the healthcare transition, the contemporary healthcare system and its executives are aiming to achieve high-quality services in all parts of hospital administration (Chassin, 2013). All of the accomplishments accomplished over the period through arduous effort must be maintained by ongoing quality improvement. The leaders' decades-long work enabled the system to improve the offered services and their quality through the implementation of improved staffing patterns, infrastructure, and clinical environments. This should be accomplished by continual quality improvement, regular internal review, and then an external audit by reputable national or worldwide accreditation authorities.

In recent years, interest in the implementation of continuous quality management enhancements has increased. The majority of healthcare providers have implemented quality improvement strategies that build on traditional quality assurance approaches by focusing on the process rather than the people (Siva et al., 2016). When measuring quality improvement in accreditation programmes, compliance with the program's requirements and criteria is evaluated. Compliance with accrediting criteria, quality improvement, positive organizational changes, and organizational learning are correlated positively, according to research (Willis et al., 2016). Araújo et al., (2019) claimed that the most effective method for working on accreditation is for organizations to view the process as a tool for quality improvement and to integrate that into their organizational culture. Despite the reluctance anticipated from medical professionals, such an approach would aid organizations in achieving better outcomes.

2.2.4. The concept of Total Quality Management (TQM)

TQM can be defined as the continual pursuit of excellence through the development of the skills and attitudes necessary to prevent defects and satisfy customers/users completely at all times. TQM is an organization-wide activity that must involve every member of an organization (Kwakye, 2018).

The concept of total quality management is one of the modern administrative concepts that aim to improve services quality by responding to the requirements of the client continuously. It has captured the attention of

researchers, academics, and administrators who are particularly concerned with developing and improving production and service performance in various humanitarian organizations. Which increased the interest in quality management and improvement in the eighties, after business organizations achieved many gains and a good reputation as a result of their application of total quality management (Robbins and Counter, 2005). Robbins and Counter (2005) define TQM as a management philosophy centered on continual improvement, responsiveness to needs, and meeting or exceeding the needs and expectations of customers.

2.2.4.1. The Fundamental aspects of TQM

2.2.4.1.1. Customer-Centered

The client is the quality evaluator. From a TQ standpoint, all strategic decisions made by a healthcare institution are "customer-driven." Customer-centric businesses measure the aspects that influence customer satisfaction. Numerous aspects of a customer's purchase, ownership, and services contribute to their impression of value and level of satisfaction (Mosadeghrad, 2015). Also, decreasing sources of dissatisfaction and reducing faults and errors contribute greatly to the company's perceptions of quality. In addition, consumer surveys and focus group tactics can assist in comprehending the client's needs and values. Customer attention extends beyond internal interactions; yet, society is a significant customer for businesses. Business ethics, patient health and safety, the environment, and the sharing of quality standards are required actions in healthcare systems and communities.

2.2.4.1.2. Strategic planning and Leadership

Strategic planning must foresee numerous changes, including customer expectations, new prospects, the development of advanced diagnostic technologies, the evolution of the patient care system, and social expectations (Ginter, Duncan and Swayne, 2018). Achieving quality and healthcare service leadership demands a strong focus on the future and a commitment to develop long-term relationships with key consumers, employees, physicians, nurses, suppliers, and members of the public and private community. Through their personal participation in planning, monitoring healthcare quality performance, and staffing for quality achievement, senior executives serve as a model for reinforcing the organization's values and fostering leadership.

2.2.4.1.3. Constant progress and learning

Continuous improvement is an integral component of the management of any system and procedure. A well-defined and well-executed approach to continuous development and learning is necessary for achieving the maximum level of performance (Jimoh et al., 2019). Learning is the process of adjusting to change, which results in the formation of new objectives or strategies. Improvements and learning must be integrated into an organization's operations. Continuous improvement requires recurring cycles of planning, implementation, and change.

2.2.4.1.4. Participation and Teamwork

The success of a healthcare institution depends increasingly on the knowledge, abilities, and motivation of its workforce. In healthcare administration, individuals and departments work independently. Individuals in TQ collaborate within team structures such as quality circles, steering committees, and self-directed work teams. Department collaborates to optimize the system through cross-functional teamwork

2.2.4.1.5. The management of processes

Ross (2017) noted that while the majority of quality issues are related to procedures, just a few are caused by workers. It entails planning and administering the actions required to attain a high level of performance in a process, as well as finding opportunities for enhancing quality and customer satisfaction.

2.2.4.1.6. Quality control and assurance

Quality assurance is the planned or systematic efforts required to provide appropriate assurance that a patient's services or safety will meet a specific quality criterion. This department is responsible for quality planning, control, improvement, internal auditing, and dependability (Kiran, 2016). In addition, it comprises quality guidance and expertise, personnel training in quality, analysis of customer diagnosis, treatment records, medical claims details, and liability cases involving patients. Management is accountable for defining, documenting, and defending the quality policy, quality manual, performance, safety, and reliability.

2.2.4.2. The Importance of TQM in Healthcare systems

TQM phrase represents the mentality, culture, and organization of any group or corporation; that seeks to supply consumers with services and goods which suit their demands. This culture requires a specific level of quality throughout all phases of operation. In conjunction with techniques for eliminating operational flaws, processes are executed correctly on the first attempt. This methodology has been well acknowledged by managers and quality practitioners as a change management quality method that plays a significant role in management growth. Diverse researchers (Keinan and Karugu, 2018; Othman et al., 2020) have affirmed TQM as a strategy to increase the

flexibility, productivity, effectiveness, and competitiveness of a business in order to satisfy customers' demands as the source of sustainable competitive advantage for business organizations as a means of achieving excellence, developing a right-first-time mentality, acquiring efficient and dynamic business solutions, pleasing customers and suppliers, and above all as a technique for enhancing organizational performance.

TQM is both a management philosophy and a crucial management issue, as it is crucial for achieving efficiency and competitiveness. The term Total Quality Management (TQM) would be used to describe a comprehensive and integrated managerial system committed to creating a working environment in hospitals that achieves continuous improvement for the abilities and skills of every employee and working system. This enhancement aims for a continuous improvement of all hospital-specific TQM applications and hospital-specific TQM elements that lead to improved health services (Balasubramanian, 2016).

The quality of health services encompasses a vast array of crucial facets. In the case of medical services, the seller consists of physicians, hospitals, nursing homes, clinics, etc., as they offer health services for sale at predetermined pricing. The purchaser is the customer or patient who pays the specified prices for these health services. It may also encompass the quality of performance that is immediately and intimately tied to healthcare, such as food, housing, safety, security, employee attitude, and other aspects that occur in hospitals and nursing homes. Therefore, the time required to schedule an appointment, delay time, service time, and timing for medical treatment and surgery.

2.2.4.3. Advantages of Total Quality Management

Successful implementation of Total Quality Management in the hospital provides the following advantages:

2.2.4.3.1. Holistic quality

If hospitals successfully apply Total Quality Management, they would be able to attain holistic quality. This means that not only will the quality of products and services increase, but also the quality of R&D, management, planning, and decisions. The ultimate objective of TQM is quality improvement. Other benefits listed in this section are the consequence of comprehensive quality enhancements (Garza-Reyes, Rocha-Lona and Kumar, 2015).

2.2.4.3.2. Expense reductions

According to Aburayya et al. (2020), cost savings are an advantage of implementing TQM in hospitals. Implementing Total Quality Management in hospitals can reduce failure-related expenses. In addition, TQM generates considerable returns on investment, improves hospital finances in general, and has a favorable effect on employment. The cost savings have no detrimental effect on the quality of care; rather, the quality of care and management of patients tend to improve. According to Muralidharan (2015), quality enhancement is followed by cost reductions due to fewer errors, less delays, and better utilization of time or resources. The cost decrease boosts production, so allowing the hospital to become more competitive. The competitiveness increases the likelihood of survival and the number of available jobs.

2.2.4.3.3. Prevention of errors

D'Andreamatteo et al. (2015) cite an additional significant advantage of implementing Total Quality Management in healthcare organizations. TQM not only reduces administrative expenses, but also prevents costly and perhaps catastrophic errors. Thus, lives can be spared, and expensive litigation can be avoided.

2.2.4.3.4. Employee contentment

Prajogo and Cooper, (2017) indicate that TQM has favorable effects on employee satisfaction. Arunachalam and Palanichamy, (2017) suggests that there is a high correlation between cooperation as a dominating TQM practice and job satisfaction. In addition, they assert that customer attention, a component of Total Quality Management, has a favorable effect on employee job satisfaction. Participation in the TQM program has a very good effect on employees, according to Arunachalam and Palanichamy (2017) job satisfaction increased, employees had more favorable evaluations of the firm's climate, and employees had positive opinions of the study organization.

2.2.4.3.5. Customer contentment

TQM is frequently employed to increase customer satisfaction through better service quality. Therefore, customer satisfaction is a significant benefit of TQM. Nguyen and Nagase (2019) have investigated the application of TQM in various industries. Their findings about client satisfaction in the pharmaceutical industry are extremely positive. In 76% of instances, the impact on client satisfaction was extremely favorable.

2.2.5. Previous Studies

According to a study carried by Jaafaripooyan et al., (2011), which aimed to identify and propose measures to evaluate the performance of health care and to use some measures as a means to support a decision taken by the authorities and decision-makers to evaluate their programs during a specified period and to contribute to the

knowledge of measuring performance and improving accreditation in the field of health care. The results of the study indicate that accreditation programs and measures can be used to evaluate general performance in health care, and these measures depend on the features and content of how performance and accreditation are conducted. Ng et al., (2013) concluded that there is no convincing evidence that presents the effectiveness of accreditation programs. However, Ng et al., (2013) believe that the study findings "may include increased staff engagement and communication, multidisciplinary team building, positive changes in organizational culture, and enhanced leadership and staff awareness about the Continuous Quality Improvement CQI" The conclusions reached by this study can help various stakeholders especially while boarding the accreditation process and its procedures (Ng et al., 2013).

According to Algarni et al., (2018), the aim of this study is to identify the aspects that relate to performance level; including enablers and inhibitors that influence leadership performance in the healthcare sector of the Kingdom of Saudi Arabia (KSA). The overall findings show the role of culture in shaping performance level. In addition, the domination of factors related to the national culture and Islamic values has appeared the greatest factor affecting leaders' decisions; it also forms their relations with subordinates as well as their commitment to the organization. Therefore, researchers are encouraged to test the proposed propositions further. The paper discusses the implications of the study findings for healthcare sector managers in different levels. This paper fulfils an identified need to study how culture can influence workforce practices in healthcare organizations and to what extent can that affect the quality of services delivered to the patients

Despite the lack of clear proof on the proven role and value in improving patient and organizational outcomes, there is a dire need to investigate what aspects of accreditation serve a useful purpose. Meanwhile, the health care service can be improved as long as its quality is to be measured. With the tremendous improvement across Saudi Arabia's implementation of quality measurement in the interim, there is also work that needs to be done to gain a better understanding of the effect of health care accreditation standards on the primary health care services and employee's performance in primary health care centers. As for the primary health care services in Jeddah, it can help to pursue an improvement of the quality of care provided to the citizens of Jeddah.

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Chapter Three: Research Methodology

3.1. Preface

The study aimed to identify the effect of health care accreditation standards on the leadership and quality improvement practices in primary health care centers in Jeddah, and to achieve this, the researcher used the descriptive analytical approach through the use of various statistical methods. The chapter included the study method, the study population and its sample, a description of the demographic variables of the study sample members, the study tools, the sources of obtaining information and the statistical treatment used, in addition to the validity of the study.

3.2. Research Approach

This study was conducted in 2022; several months after the centers conducted the accreditation survey. The study targeted 68 of Primary Health Care centers (include accredited and non-accredited) in Jeddah that utilized method of a comparative quantitative component.

3.3. Research Design

This study applied comparative quantitative component using self-administered questionnaire adapted from previous study tool was used to collect data from primary health care centers (include accredited and non-accredited) and interpret them in order to reach conclusions that contribute to providing directions for improving and developing reality and revealing the relationship between these variables (Creswell, 2016).The literature related to the subject of the study was also consulted from books, articles and previous studies to prepare the theoretical side of the research.

3.4. Data Collection

Data collection and evaluation assist answer research questions, test hypotheses, and assess outcomes (Gliner et al., 2016). Data collecting is popular in physical and social sciences, humanities, industry, etc. Methods vary by discipline, but the goal is always accurate selection. Data collection is to gather quality information that may be analyzed for rich insights and trustworthy answers to problems. Study integrity depends on accurate data gathering. Errors are reduced by using appropriate data gathering tools and following explicit instructions (Kabir, 2016). Data collection took two months.

3.4.1. Data Collection tools

Ethical approval for the study was provided by directors of selected health care institutions in Jeddah and the IRB number is A01279. As for data collection and statistical analysis, a special questionnaire was designed for this purpose. This tool has been previously used in Saudi Arabia to assess the perceived effect of health care accreditation standards on the leadership and quality improvement practices on healthcare professionals. The questionnaire was designed according to Likert scale, with the answers (strongly disagree, disagree, don't know, agree, strongly agree,), given the weights (1, 2, 3, 4, 5). The higher the mean, indicates to higher degree of consent on the clause.

3.4.2. Data collection methods

Questionnaires are systematic surveys or pre-defined sets of questions given to respondents to collect quantitative data (Dewaele, 2018).

The questionnaire is one of the best techniques to collect data for analyzing huge populations since it can collect massive quantities of data from individuals. The situation applies to this study since it requires as much information from the research sample as feasible to appropriately depict the community. Using a questionnaire, the study collects the viewpoints of a large number of community members.

The survey measured leadership and quality improvement.

3.5. Sampling

3.5.1. Sample size and selection of sample

All 68 (include accredited and non-accredited) centers that conducted the leadership and quality improvement practices survey participated in this study.

The administrative and health leaders in primary health centers were chosen to represent the sample because they are the appropriate category to illustrate the effect of health care accreditation standards on leadership and quality practices in primary health care centers in Jeddah.

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3.5.2. Sampling technique

A total of 68 (include accredited and non-accredited) centers participated in component of the study. The centers were distributed across all the five directions of Jeddah. The indicated sample involve adapted and non- adapted group. The study sample involve administrative and health leaders of western, southern, north, western and central Jeddah primary health care centers.

3.6. The model of the study

The proposed model for this study is illustrated in figure 3 identifies some specified primary health care accreditation standards include leadership and quality improvement.

Figure 2: The Proposed Model

3.7. Data Analysis

Data collected from the questionnaires was coded, entered, and analyzed using SPSS 20.0 at a significance level of 0.05. The analysis was conducted to explore demographic characteristics of respondents. Cronbach's Alpha was used to measure the internal consistency and reliability of the scales.

3.8. Ethical Considerations

Directors of primary health care centers (accredited and non-accredited) approved the study. All participants gave written consent before data collection. Before requesting participation, primary care center administrators were notified. After clearance, PHC personnel received the questionnaires. Staff were informed that their participation was voluntary, that it wouldn't effect their jobs, and that directors wouldn't see their comments. Participants were asked to complete the survey in their leisure time and in any environment, then return it in a sealed envelope within a week.

3.9. Data Security

A questionnaire was electronically distributed to the participants after securing the consent of the questionnaire. The questionnaire was conducted in Arabic and translated immediately thereafter. The questions were then translated to English to facilitate data analysis.

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Chapter four: Results

4.1.Preface:

The results of the study, in addition to an interpretation of those results, are presented in this chapter. It is abundantly clear that there is a connection between the findings and the research questions and objectives that were established for the study. In order to gain a better understanding of the effect of health care accreditation standards on the leadership and quality practices in primary health care centers in Jeddah, an analysis of the data was carried out for each of the specific objectives.

4.2.Result:

4.2.1. Characteristics of the study group

It is clear from the table related to the Accredited bodies that there is an equality between the study sample in gender by 50%, while it is clear with regard to nationality that most of the study sample are Saudis with a percentage of 97.1%, followed by non-Saudis with a percentage of 2.9%, as it turned out that the most expensive sample of the study was over 40 years old 50%, followed by 30 to less than 40 years with 38.2%, and finally less than 30 years with 11.8%. As for the educational level, most of them had a diploma with a percentage of 50%, followed by a bachelor's degree by 23.5%, a doctorate by 14.7%, a high school by 8.8%, and finally a master's degree by 2.9%. As for the main specialization of the study sample, most of them were Nurse with a percentage of 41.2%, followed by Administrative with 35.3%, Physician by 14.7% and Technician by 8.8%, and we find that the percentage is equal with regard to working in administrative or other positions.

Also It is clear from the table related to non-accredited bodies, we find that most of the study sample are males with a percentage of 52.9%, followed by females with a percentage of 47.1%, while it is clear with regard to nationality that most of the study sample are Saudis with a percentage of 91.2%, followed by non-Saudis with a percentage of 8.8%, as it turned out that the most expensive sample of the study Their age was greater than 40 years at 53%, followed by those from 30 to less than 40 years with 38.2%, and finally less than 30 years with 8.8%. As for the educational level, most of them had a diploma with a percentage of 64.7%, followed by a bachelor's degree by 20.6%, a doctorate by 8.8%, and finally a master's degree by 5.6%. As for the main specialization of the study sample, most of them were Administrative with a percentage of 35.3%, followed by Nurse by 29.4%, Physician by 23.5% and Technician by 11.8%, and we find that most of the study sample works in administrative work by 61.8%.

4.2.2. The effectiveness of quality practices that carried in primary health care centers in Jeddah:

Table 1The effectiveness of quality practices that carried in primary health care centers in Jeddah

Accredited			Unaccredited		
Items	Mean	SD	Items	Mean	SD
Q1: Accreditation stimulates the continuous quality improvement in the primary health care centre.	4.18	.834	Q9: Accreditation makes safe and secure environment in the primary health care centre.	4.47	.507
Q5: Accreditation improves work condition as workflow became more organized and systematic.	4.03	1.058	Q5: Accreditation improves work condition as workflow became more organized and systematic.	4.44	.561
Q9: Accreditation makes safe and secure environment in the primary health care centre.	3.97	1.087	Q8: Accreditation has given insight to implement safety plan and policies in the primary health care centre.	4.41	.500
Q8: Accreditation has given insight to implement safety plan and policies in the primary health care centre.	3.91	.965	Q11: The primary health care centre's participation in accreditation enables it to be more responsive when changes are to be implemented.	4.38	.493
Q3: Accreditation ensures adequate and qualified staff to meet the services of the primary health care centre.	3.91	1.026	Q10: Accreditation ensures proper program for the maintenance of equipment and infrastructure.	4.32	.535

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Q12: Accreditation enables the primary health care centre to better use its internal resources (e.g., finances, people, time, and equipment).	3.91	.965	Q1: Accreditation stimulates the continuous quality improvement in the primary health care centre.	4.29	.524
Q10: Accreditation ensures proper program for the maintenance of equipment and infrastructure.	3.88	1.094	Q12: Accreditation enables the primary health care centre to better use its internal resources (e.g., finances, people, time, and equipment).	4.26	.751
Q11: The primary health care centre's participation in accreditation enables it to be more responsive when changes are to be implemented.	3.85	1.048	Q3: Accreditation ensures adequate and qualified staff to meet the services of the primary health care centre.	4.21	.592

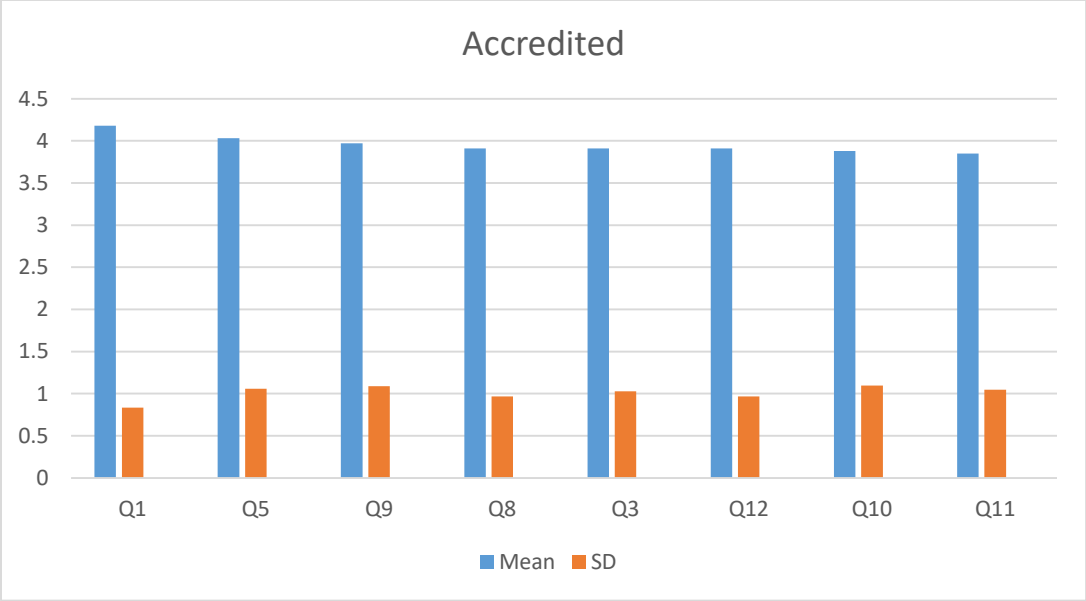

Figure 1quality practices of Accredited

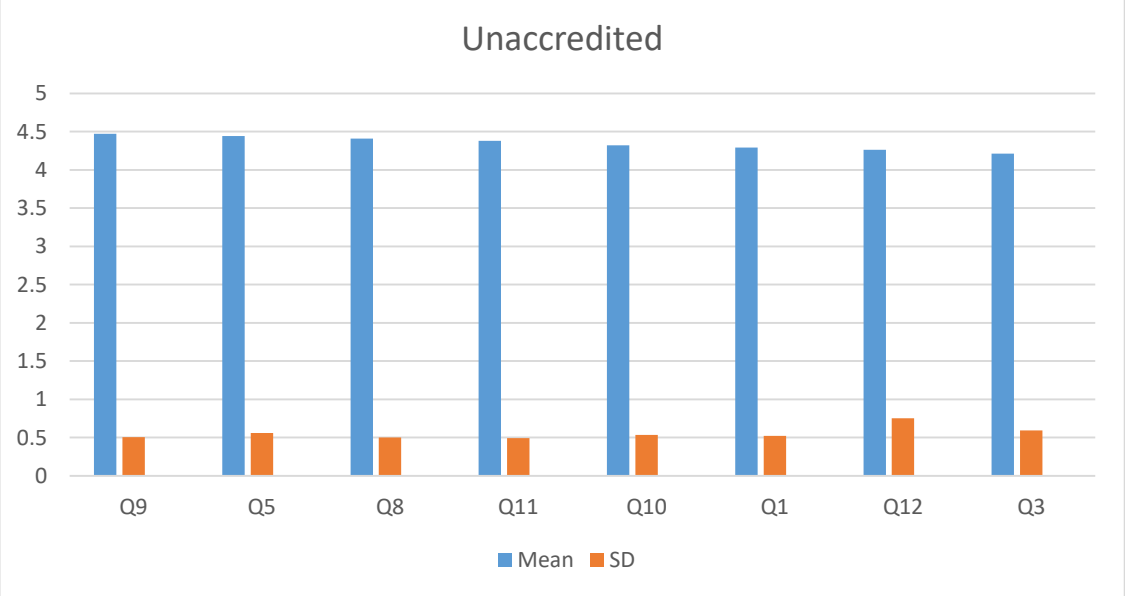

Figure 2quality practices of unaccredited

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4.2.3. the effective leadership practices that conducted in primary health care centers in Jeddah.:

Table 22. the effective leadership practices that conducted in primary health care centers in Jeddah

Accredited			Unaccredited		
Items	Mean	SD	Items	Mean	SD
Q6: Accreditation enhanced the role of management and leadership.	4.09	.900	Q6: Accreditation enhanced the role of management and leadership.	4.41	.500
Q2: Accreditation promotes uses of novel strategies to improve managerial processes in the primary health care centre.	4.06	.886	Q13: Accreditation ensures mechanism of appropriate recognition and rewards for good performances.	4.38	.604
Q16: Accreditation improves integration of information among all the employees.	3.94	.983	Q16: Accreditation improves integration of information among all the employees.	4.35	.597
Q7: Accreditation emphasize ethical management in the primary health care centre.	3.94	.983	Q14: Accreditation ensures mechanism for addressing the health needs of the employees.	4.32	.638
Q13: Accreditation ensures mechanism of appropriate recognition and rewards for good performances.	3.88	.977	Q2: Accreditation promotes uses of novel strategies to improve managerial processes in the primary health care centre.	4.29	.524
Q15: Accreditation enable employees to perform their work with considerable freedom.	3.82	.999	Q15: Accreditation enable employees to perform their work with considerable freedom.	4.26	.618
Q14: Accreditation ensures mechanism for addressing the health needs of the employees.	3.79	.978	Q7: Accreditation emphasize ethical management in the primary health care centre.	4.24	.781
Q4: Accreditation ensures the proper distribution of responsibilities to the management.	3.74	1.109	Q4: Accreditation ensures the proper distribution of responsibilities to the management.	4.18	.716

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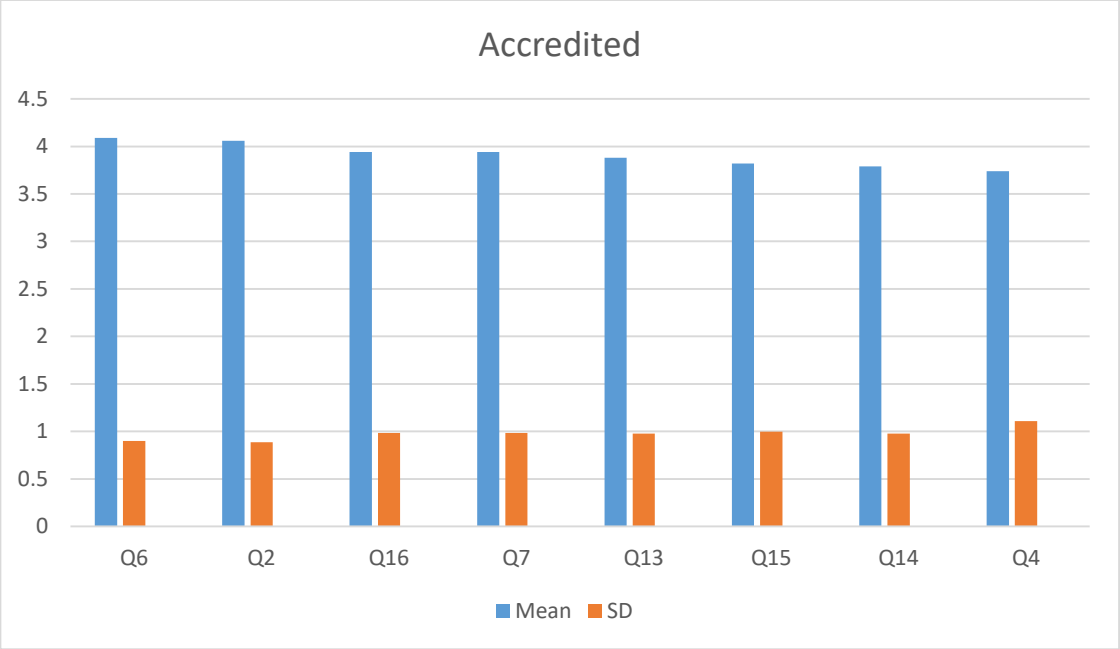

Figure 3 leadership practices of Accredited

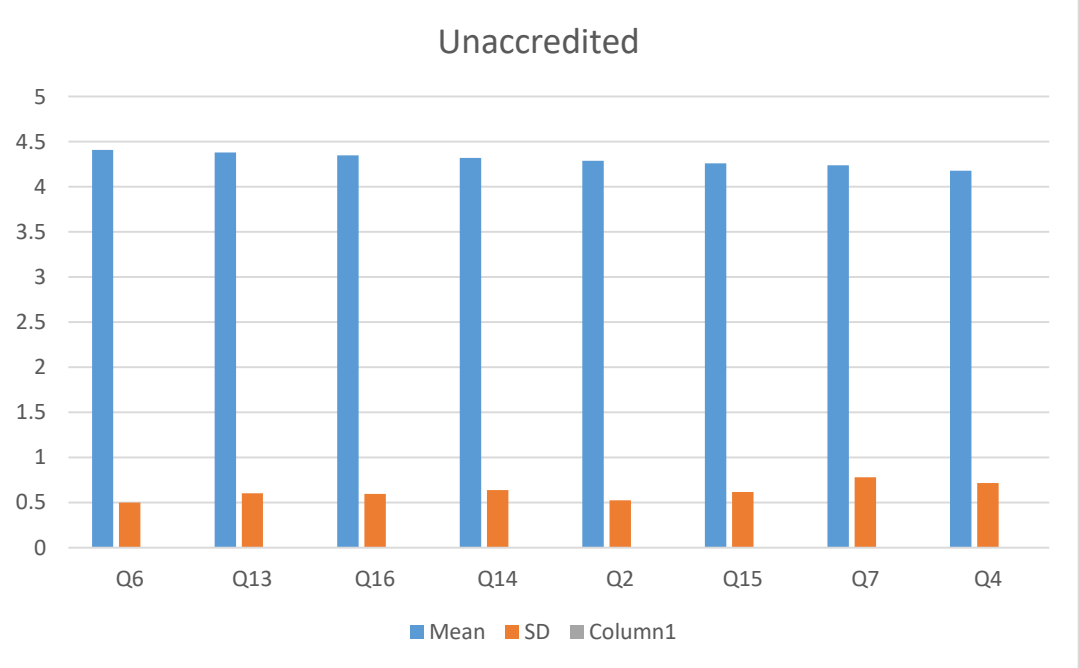

Figure 4 leadership practices of unaccredited

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4.2.4. There is a significant effect of health care accreditation standards on the leadership and Quality Practices in Primary Health Care Centers in Jeddah.

It is clear from the table that there is a statistically significant effect between the accredited health care centers and the practice of leadership and quality in the center, where the significance ratio was less than 0.1, which indicates a strong influence of accreditation standards in increasing the effectiveness of quality and leadership in health centers.

Table 3Correlations accredited

Correlations accredited			
		Leadership	Quality
Leadership	Pearson Correlation	1	.936**
	Sig. (2-tailed)		.000
	N	34	34
Quality	Pearson Correlation	.936**	1
	Sig. (2-tailed)	.000	
	N	34	34
**. Correlation is significant at the 0.01 level (2-tailed).			

Table 4Correlations Unaccredited

Correlations Unaccredited			
		Leadership	Quality
leadership	Pearson Correlation	1	.826**
	Sig. (2-tailed)		.000
	N	34	34
quality	Pearson Correlation	.826**	1
	Sig. (2-tailed)	.000	
	N	34	34
**. Correlation is significant at the 0.01 level (2-tailed).			

Table 5One-Sample Statistics

One-Sample Statistics				
	N	Mean	Std. Deviation	Std. Error Mean
leadership	34	4.3051	.52422	.08990
quality	34	4.3493	.48440	.08307

Table 6One-Sample Test

One-Sample Test						
	Test Value = 0					
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Leadership	47.887	33	.000	4.30515	4.1222	4.4881
quality	52.355	33	.000	4.34926	4.1803	4.5183

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Chapter five: Discussions

5.1. Discussion

It was believed that accreditation would improve the quality of the services that were provided, in particular by standardizing the delivery of those services, enhancing the culture of healthcare in the community, and fostering improved teamwork and collaboration among the PHCCs.

The purpose of this research was to investigate the effect that health care accreditation standards have on the leadership and quality practices of primary health care centers in the city of Jeddah. According to the findings, accreditation was seen as having a beneficial impact on a number of different aspects of quality and leadership. In addition, a number of components of the accreditation had a good association with the quality of the outcomes. This featured a scale that was connected with growing participation, as well as a scale that was associated with leadership.

Accreditation improves working conditions by making workflow more organized and systematic, which demonstrates that quality practice in accredited health care centers in Jeddah is effective. This is demonstrated through the fact that accreditation stimulates continuous quality improvement in primary health care centers and that accreditation improves working conditions. Accreditation enhances working conditions by creating a more ordered and systematic workflow, whereas the efficacy of quality in non-accredited health care facilities is proved by the fact that accreditation creates a safe and secure atmosphere in primary health care centers.

In accredited health care centers, effective leadership practices have also evolved as a result of accreditation's enhancement of the role of management and leadership, as well as accreditation's promotion of the adoption of novel ways to improve managerial processes in primary health care centers. Accreditation improved the role of management and leadership, and it ensured a framework of appropriate recognition and rewards for good performances, while successful leadership techniques surfaced in non-accredited health care centers through accreditation.

The extent of compatibility between accredited and non-accredited primary health care centers in determining the effectiveness of leadership in health care centers is evident through the fact that leadership encourages the use of new strategies that help improve administrative processes. This aspect of leadership is what makes it possible to determine the effectiveness of leadership in health care centers.

It has been shown that there is a statistically significant effect between the accredited health care centers and the practice of leadership and quality in the center. This is in line with what healthcare professionals have said about how they perceive accreditation to have a positive effect on management and leadership in the centers.

Theoretically speaking, a cornerstone for successfully implementing accrediting standards and increasing the overall quality of services provided by PHCCs is having strong leadership and support from management.

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Chapter six: Conclusion and Recommendations

6.1. Introduction:

This chapter addresses the positives and negatives of the study, as well as the consequences of the approach that was taken and the data that were obtained. In particular, we will improve our understanding of how accredited primary care might be implemented. In conclusion, this chapter provides some of Research contribution, Strengths, limitations of the study, recommendations for future study and policy and Closing remarks.

6.2. Principle findings:

Employee engagement and participation in the accreditation programme helped break down professional barriers, established a sense of cooperation, and raised trust in the process and what accreditation was seeking to achieve. These benefits were all achieved through the program. In the systematic review, several strategies that promoted staff engagement in the accreditation process were identified. These strategies included assigning credible leaders who champion continuous quality improvement, selecting key facilitators or champions, and explaining the ethos that lies behind the accreditation process. This last activity is also connected to the requirement that workers should have a greater awareness of the objectives of accreditation.

It can be advantageous to organize in-house trainings using local knowledge in order to strengthen the employees' awareness of accreditation through the usage of this training. This tells a lot about how much you want to grow yourself, and it's also an important step toward getting to where you want to be. However, prior to scheduling a training course for employees, it is essential to gain an understanding of the prerequisites that must be met to guarantee that the resources invested in will be directed toward domains in which training and development are required and that a satisfactory return on the investment will be ensured. The individuals involved in the accreditation process need to have a sense of support and there has to be assistance for centers that are in the accreditation phase.

6.3. Research contribution:

This study added to the body of knowledge regarding how professionals interpret the true outcomes of accreditation; however, there was no opportunity to investigate patients' points of view. The perspectives of patients on accreditation continue to be a poorly investigated topic, and a research programme would again be advantageous to the long-term implementation of accrediting programmes.

6.4. Strengths and limitations of the study:

Strengths of the study:

We conducted interviews with a variety of healthcare professionals based in various geographic places. This gave us the opportunity to compare the perspectives of healthcare professionals who have worked in environments that are analogous to the one in which we were interested. In addition, the questionnaire was distributed through the electronic connection in order to expedite the process of data collection from leaders and healthcare professionals in order to determine the significance of accreditation. This was done so that the importance of accreditation could be determined.

limitations of the study

Accreditation's effect on professionals' perceptions rather than patients' was chosen because this was a new initiative and staff members were directly involved in its implementation. Patients were unable to express their views on accreditation because of this. This could, however, represent an opportunity for future research.

6.5. Implications and Recommendations:

Reflexive monitoring can either encourage or hinder cognitive participation, depending on the findings of an evaluation of the effects of accreditation. If professionals are able to understand the advantages of taking part in such a program, they will most likely be more motivated to sign up for it and get involved. Alternately, if they are unable to identify any benefits associated with, this will discourage them from taking part in the activity. In spite of this, reflexive monitoring paves the way for a better understanding of accreditation, and this is true regardless of whether the effects of accreditation are positive or remain the same.

6.6. Direction for further research:

The individuals involved in the accreditation process need to have a sense of support and there has to be assistance for clinics that are in the accreditation phase. One more thing that can be learned from this study is that it is quite useful to include the appropriate individuals in the programme. If this isn't done in order to obtain helpful

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recommendations, then it should be done in order to educate various segments of the community about the programme.

6.7. Closing remarks:

Providing the Q&A Directorate with the ability to operate on its own is something that ought to be taken into serious consideration. This will grant the management more leeway in terms of decision making and the distribution of resources, and this increased sense of individual accountability and responsibility may contribute to the achievement of superior outcomes.

In terms of resources, several areas require improvement, including the transition to an electronic, web-based system; the improvement of the vital statistics system, particularly in respect to the reporting of fatalities; and the improvement of the reporting of morbidity data

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