Hospitals' Readiness for Clinical Governance Implementation in Educational Hospitals of Yazd, Iran

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Abstract
Background: Clinical governance is a systematic approach to maintaining and improving the quality of patient care. This study aimed to assess some Iranian educational hospitals' readiness for clinical governance implementation through the organizational climate.
Methods: It was a cross-sectional study that used the Clinical Governance Climate Questionnaire (CGCQ) in three educational hospitals in Yazd, a city in central Iran, in 2012. A total of 186 personnel contributed to the study. Data were analyzed using SPSS version 16. Descriptive statistics and the Kruskal-Wallis test were used for data analyses.
Results: The mean scores of the clinical governance climate in Shahid Sadoughi, Shahid Rahnemoon and Afshar hospitals were 2.63±0.29, 2.58±0.32, and 2.68±0.29. The mean scores of quality improvement planning and change, quality improvement integration and motivation, clinical risk management and climate of blame and punishment, organizational learning, and training and development (T&D) opportunities for learning in the studied hospitals were 2.21±0.49, 2.80±0.40, 2.76±0.40, 2.91±0.54 and 3.06±0.72, respectively.
Conclusion: The results of this study showed that the educational hospitals' climate should be more supportive for successful implementation of clinical governance.

Keywords: clinical governance, organizational climate, hospital

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1. Introduction

Quality is a known essential ingredient of all service industries such as healthcare organizations (1). Therefore, innovative methods to improve the quality and efficiency of health services throughout the world have long been searched for (2). Clinical governance (CG) represents the latest in these efforts to assure and improve the quality of services in national health systems at the global level (3). The term CG has been built on an idea previously put forward by the World Health Organization (1983) where quality is described as the following four elements: a) professional management/performance (technical quality), b) resource allocation/use (efficiency), c) risk management, and d) patient satisfaction (3, 4). Nevertheless, the first popular definition of the term was introduced by the National Health Service, in response to some highly published medical failures (5, 6) and concerns about safety in health care (2), as "a framework through which NHS organizations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which

excellence in clinical care will flourish" (7-11). Although CG is no longer a new concept (7), there have been many definitions presented by different organizations with their own perspectives (5). In brief, clinical governance can be viewed as a systematic approach, a process, or a framework for the creation of structural and cultural changes within an organization which raises its capability to provide high quality, patient-centered care. Therefore, CG aims to raise patient safety and to reduce errors, mishaps, and harms (4, 9, 12-14) so it can lead to improved clinical outcomes, professionals' job satisfaction, and patients' appraisal of their care (3).

Despite the fact that the concept of CG has undergone a transformation since its inception (8) and a universally accepted definition of CG has been difficult to achieve, it is widely accepted that CG is designed to integrate, consolidate, and codify the fragmented approaches to quality improvement. Its ultimate purpose is the systematic joining up of initiatives to improve quality (5). The emphasis is not only about achieving a high quality of patient care, but also on continuously improving the quality of care (8). Although CG has emerged as a popular public discourse topic (5) in the last few years, the implementation of the CG approach presents a fundamental challenge for healthcare organizations (10). This is due to healthcare organizations having previously lacked explicit objectives to improve care or any notion of corporate responsibility in delivering a high quality of care (11). Also, studies in this field have not defined the ideal framework for introducing and successfully implementing CG initiatives. Thus, health care providers confront difficulties in operationalizing CG and developing systems, structures, and tools to manage and monitor this quality approach (3). Authors argue that the policy of CG will only result in improved care if robust infrastructures are created to support it (11). One of these important infrastructures is the readiness of the organizational culture or climate for CG implementation. The architects of CG have long emphasized that creating the right culture and corresponding supportive climate are the most critical elements for establishing and implementing an effective CG program (2, 3). Also, some authors argued that the ultimate goal of CG is to change the culture of health care provision so that quality improvement becomes routine in medical practice and health services management (15). Therefore, CG development within health care organizations is doomed to fail if they do not succeed in changing organizational culture. This issue becomes much more complicated, particularly in a hospital setting, when someone takes into consideration the presence of different subcultures that may exist and interact within the organization. In short, organizational climate (a term reflecting the culture or its manifestation) is defined as the attitudes, feelings, and behaviors that characterize life in an organization. In other words, the organizational climate, which means the atmosphere and/or what it is like to work in the organization, is superficial and a way to express culture (3).

The implementation of clinical governance in Iranian hospitals was initiated a few years ago under the authority of the Ministry of Health and Medical Education. Although clinical governance now has a structure in our hospitals (the Bureau for Clinical Governance and Quality Improvement), its actual application in terms of service delivery has not been achieved. Based on the above discussion, this study was aimed to assess the organizational climate's readiness for CG implementation in some Iranian educational hospitals.

2. Material and Methods

This descriptive study was done through the cross-sectional method in three educational hospitals in Yazd, Iran (Shahid Sadoughi, Shahid Rahnemoon and Afshar hospitals) in 2012. Sample size was calculated by Cochran's formula and a total of 189 employees contributed to the study. We used the stratified-random sampling method because we aimed to contribute samples from different units of the studied hospitals in the research. It is notable that all samples' contribution to the study was voluntarily and they were informed of study objectives. Also, their personal data were kept confidentially. Required data was gathered using the Greece version of Freedman's Clinical Governance Climate Questionnaire (CGCQ), which was developed by Karassavidou et al (2011). The Greece version of CGCQ was translated to Persian by the authors prior to study and used for data collection. In this instrument, the five dimensions that encapsulate the CG climate are labeled as follows: 1) quality improvement planning and change (18 items), 2) quality improvement integration and motivation (10 items), 3) clinical risk management and climate of blame and punishment (7 items), 4) organizational learning (7 items), and 5) training and development opportunities (7 items) (3).

In this study, the respondents were questioned to indicate their agreement or disagreement with the questionnaire statements about their hospital in the 5-points Likert scale (strongly agree to strongly disagree), which obtained the scores of 1 to 5. The lower score in each item indicates a more supportive hospital climate for clinical governance implementation. In this study, the scores below 2.5 were considered a weak situation of hospital climate for clinical governance implementation. Prior to the study, the reliability of the translated questionnaire was obtained by the

calculation of Cronbach's alpha (0.76) in a pilot study. Data analysis was done through SPSS software version 17. We used descriptive statistics (mean and standard deviation) and the Kruskal-Wallis test.

3. Results

Of all contributing employees in this study, 37% were males and 63% were females. Also, the majority (40%) of samples were in the age group of 31-40. In terms of profession, nursing and midwifery staffs formed 65% of our samples. Also, 10% and 25% of samples were physicians and other health professionals, respectively. Indeed, 76, 14, 8, and 2 percent of contributing employees had a B.Sc., an associate degree, a Ph.D., and a general physician degree. The mean scores for 5 dimensions of CGCQ are reported in table 1. As shown in table 1, clinical governance climate scores in studied hospitals were in the weak range. Shahid Rahnemoon and Afshar hospitals had the lowest and highest scores, respectively.

Table1. The mean scores of clinical governance climate dimensions in studied hospitals, 2012

Dimensions	Shahid Sadoughi Hospital	Shahid Rahnemoon Hospital	Afshar Hospital	Total	P_{value}
Quality improvement (QI) planning and change	2.19±0.46	2.18±0.49	2.29±0.56	2.21±0.49	0.50
Quality improvement (QI) integration and motivation	2.77±0.42	2.73±0.38	2.93±0.33	2.80±0.40	0.03*
Clinical risk management and climate of blame and punishment	2.79±0.40	2.71±0.40	2.75±0.39	2.76±0.40	0.51
Organizational learning	2.94±0.56	2.79±0.49	2.95±0.56	2.91±0.54	0.26
Training and development (T&D) opportunities for learning	3.08±0.58	3.09±1.05	2.97±0.56	3.06±0.72	0.69
Clinical governance climate	2.63±0.29	2.58±0.32	2.68±0.29	2.63±0.30	0.33

*Significant at P≤0.05

Table2. The dimensional mean scores of clinical governance climate in different units of Shahid Sadoughi hospital

Dimension	Inpatient units	Operating room	Radiology	Laboratory	Emergency Department	P_{value}
Quality improvement (QI) planning and change	2.13	2.14	2.27	2.23	2.60	0.05*
Quality improvement (QI) integration and motivation	2.72	2.71	3.01	2.84	2.85	0.48
Clinical risk management and climate of blame and punishment	2.82	2.78	2.75	2.96	2.64	0.28
Organizational learning	3.02	2.89	2.90	3.08	2.59	0.20
Training and development (T&D) opportunities for learning	3.17	3.19	3.05	2.81	2.59	0.04*
Clinical governance climate	2.62	2.61	2.69	2.66	2.65	0.95

*Significant at P≤0.05

The dimensional mean scores of the clinical governance climate in different units of the studied hospitals are shown in table 2-4. Based on the information provided in the tables 2-4, a statistical difference was seen between the scores of different hospital units in one dimension of CG (training and development opportunities for learning) in Shahid Sadoughi Hospital. Nevertheless, the same difference was not found in other dimensions of CG. Table 3 shows that there are no statistical differences between the scores of clinical governance and its dimensions in Shahid Rahnemoon Hospital. Also, in this hospital all units had the highest score in training and development opportunities for learning. Based on the above table, a statistical difference was seen between the scores of different hospital units in one dimension of CG (quality improvement integration and motivation) in Afshar Hospital. Nevertheless, the same difference was not found in the other three dimensions of CG.

Table3. The dimensional mean scores of clinical governance climate in different units of Shahid Rahnemoon hospital

Dimension	Inpatient units	Operating room	Radiology	Laboratory	Emergency Department	P_{value}
Quality improvement (QI) planning and change	2.17	1.93	2.80	2.46	2.12	0.16
Quality improvement (QI) integration and motivation	2.66	2.89	2.63	2.67	2.87	0.56
Clinical risk management and climate of blame and punishment	2.81	2.68	2.81	2.47	2.45	0.31
Organizational learning	2.67	3.05	2.66	3.14	2.86	0.17
Training and development (T&D) opportunities for learning	2.83	3.82	3.28	3.14	2.86	0.17
Clinical governance climate	2.71	2.66	2.82	2.70	2.54	0.58

*Significant at P≤0.05

Table4. The dimensional mean scores of clinical governance climate in different units of Afshar hospital

Dimension	Inpatient units	Operating room	Radiology	Laboratory	Emergency Department	P_{value}
Quality improvement (QI) planning and change	2.33	2.08	2.72	2.42	1.75	0.29
Quality improvement (QI) integration and motivation	2.95	2.64	33.33	3.00	3.20	0.01*
Clinical risk management and climate of blame and punishment	2.72	2.61	2.86	3.21	3.07	0.45
Organizational learning	2.95	2.79	3.43	2.64	3.14	0.29
Training and development (T&D) opportunities for learning	3.01	2.77	2.71	3.14	3.50	0.02*
Clinical governance climate	2.70	2.47	2.96	2.78	2.68	0.10

*Significant at P≤0.05

4. Discussion

The architects of CG have long argued that achieving the right culture is the most important element in implementing the CG program (2, 3). Also, some authors argued that the ultimate goal of CG is to change the culture of health care provision so that quality improvement becomes routine in medical practice and health services management (15). Building up an appropriate CG climate is the route that ensures that aims and values, aligned with a successful CG system, are internalized by all key players. This will empower and motivate all participants in the CG change effort to accept the initiated new system and the output from it and transform their behaviors and practices (3). In this study, we assessed the readiness of some Iranian educational hospitals' climate for implementing the CG improvements. The mean scores of the clinical governance climate in the three studied hospitals were 2.63±0.30, 2.59±0.81, and 2.68±0.86. These scores show that our hospitals' climates are not supportive enough for CG implementation. Also, the analysis of mean scores of the CG climate factors indicates that the studied hospitals do not have a suitable situation in these factors as follows:

- **Quality improvement (QI) planning and change:**

In this factor, all hospitals were assessed in the strength situation. Although these hospitals had mean scores below 2.5, their scores lean to the weakness side. Quality improvement planning and change contains 18 items that are related to planning for initiating change, aiming at improving the quality of health services. Specifically, the items of this factor capture mainly the issues of long-term planning (reactive rather than proactive approach) related to quality improvement, implementation problems associated with support to deliver change, immediate pressures to solve problems, insufficient training, orientation of the appraisal systems, and poor communication between staff members in and across departments (3). Therefore, according to obtained scores of the studied hospitals in this factor, our hospitals should develop a long-term plan for CG implementation with a clear vision, mission, goals, and strategies. Also, the sufficient resources should be allocated to specific trainings in relation to clinical governance. Indeed, we should design and implement a responsible appraisal system.

- **Quality improvement (QI) integration and motivation:**

In this factor, all studied hospitals were assessed in the weakness side. This factor contains ten items concerned with the aspects of effective integration and motivation for implementing a planned quality improvement program in the hospital (3). The low scores of the examined hospitals in this factor indicated that we do not have a good motivational mechanism in the hospitals for supporting CG. Based on our experience, the educational hospitals, due to some resource scarcity, have serious barriers for motivating their personnel to act as highly-motivated employees. This will harm the power of hospitals to successfully implement of CG.

- **Clinical risk management and climate of blame and punishment:**

In this factor, all hospitals had high scores. This factor contains seven items related to blame and punishment culture and to proactive risk management items, which are considered barriers and/or shortcomings to continuous learning and change (3). The high scores of the studied hospitals in this factor means that they do not have a clinical risk management system. Also, the existence of a culture of blame and punishment can be viewed as a main barrier to CG initiatives. Some other previous studies about patient safety culture in Iranian hospitals (16, 17) have showen that the culture of "name, shame, and blame" is dominant in our hospitals. These cultural characteristics are detrimental to healthcare quality and directly oppose the concept of patient safety, which is the goal of CG. In order to solve this problem, the studied hospitals need to change the existing culture in which errors are viewed as a result of individual failures to one in which errors are viewed as a source of continuous learning, which is called a system approach to errors.

- **Organizational learning:**

In this factor, all hospitals had high scores (above 2.5), which means that they are in the weakness situation. This factor concerns whether clinical risks are addressed in a way that promotes and facilitates organizational learning. In more detail, the seven items that are incorporated in this factor are concerned with the dissemination of good practices in the hospital and the systematic examination, collection, storage, and dissemination of information related to clinical risks (3). Some other reported studies (16, 17) corroborate our results in this dimension. In the last few years, hospital information systems have started to be used in Iranian hospitals, yet we still have problems in information management. In this area, we should develop a road map of health information and allocate enough resources for information management infrastructures.

- **Training and development (T&D) opportunities for learning:**

In this factor, all examined hospitals were assessed in the weakness situation. This factor is more related to items referring to working with colleagues and to training and development in a way that facilitates learning opportunities (3). We think that the individualism culture of our hospitals' personnel relates to this weakness. Therefore, in this area we should strengthen the teamwork competency of healthcare providers.

Briefly our study indicated that the educational hospitals' climate is not supportive for CG improvements. Also, we identified the main barriers to successful implementation of CG. The comparison of our results with some studies about CG in Iran (18) and other countries (3) shows that other hospitals have the same barriers for successful CG implementation, but any progress in healthcare quality improvement through CG initiatives requires overcoming these issues. It is notable that existing literature explains that CG is an approach that has seven pillars as follows:

- Patient and public involvement: this refers to the involvement of patients in decisions about their care as well as their input in developing services
- Clinical effectiveness: this refers to the use of evidence-based guidelines in clinical practice
- Clinical audits
- Risk management
- Staffing and staff management
- Training, education, and continuous professional education
- Use of information to improve patient care (8, 19)

Also, some authors have explained that the implementation of CG as a quality agenda requires changes at three levels, including individuals, teams, and organizations. They argued that individuals need to embrace behavioral change and build a modern approach to reflective practice, which places patients at the center of their thinking. Teams need to become truly multidisciplinary, with understanding about other team members' roles, sharing of information and knowledge, and a way of working that constantly revisits assumptions about the quality and safety

of the care being provided. Finally, organizations need to put systems and local arrangements in place to support individuals and teams and assure the quality of care provided, as well as creating a dynamic for regular quality improvement (13). Indeed, the elements of CG cannot be implemented or monitored without strong clinical and administrative or managerial leadership (19). We have to invest in all aforementioned aspects if we want to introduce CG into our hospitals successfully. It is notable that the results presented in this study are cross-sectional. Therefore, they fail to capture the effects of ongoing efforts. Also, the generalization of the findings should be done with caution due to the limitations of cross-sectional studies.

5. Conclusion

In brief, our findings showed that the studied hospitals have serious problems in all dimensions of the clinical governance approach, with the exception of quality improvement planning and change in Shahid Sadoughi and Shahid Rahnemoon hospitals. These findings mean that educational hospitals have failed in the application of CG from the viewpoint of the CG climate. In other words, the examined hospitals' climates are not supportive for CG implementation, which can lead to poor patient care. Therefore, hospital managers and policy makers should address the structural and cultural changes that provide the capability of continuous quality improvement. The findings of this study can be helpful in formulating suitable strategies for this purpose. Also, some investment in the hospitals' infrastructure can be suggested.

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There is no conflict of interest to be declared.

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All of authors contributed to this project and article equally. All authors read and approved the final manuscript.

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