Arab American University
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Nursing Perception towards the Influence of the Joint Commission International Accreditation on the Quality of Health Care in Palestine: Istishari Arab Hospital and An-Najah National University Hospital

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Thesis Approval

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Declaration

I certify that I have completed and written this master's thesis, and unless referenced otherwise the work of this thesis is the own work of the researcher and has not been submitted to another degree or qualification in another country.

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Abstract

A health care agency's accreditation shows that it meets the highest international health and health standards. The purpose of this study is to assess nurses' perceptions of the influence of the Joint Commission International Accreditation (JCIA) and the quality of health care at Istishari Arab Hospital (IAH) and An-Najah National University Hospital (NNUH).

In this study, the quantitative method was used, and then primary data were collected by distributing online questionnaires to 220 nurses at both hospitals. The developed questionnaire is divided into two parts. The first seeks demographic information about nurses in IAH and NNUH. The second section is about quality practices and the JCIA, and is divided into six sections representing quality output, quality management, leadership, strategy quality planning, human resource utilization, and the joint commission international accreditation. Descriptive statistics, as well as inferential statistics are used to analyze data. The Statistical Package for the Social Sciences (SPSS) and Amos version 25 are utilized in the data analysis.

According to the findings, the majority of nurses at IAH and NNUH have a neutral perception toward improving the quality of care after accreditation. Furthermore, some have a neutral perception of organizational factors such as strategic quality planning, human resource utilization, and JCIA, while others have a negative perception of organizational factors such as quality management and leadership commitment. The study also found that the previously mentioned organizational factors were positively related to the quality of care outcomes. On the other hand, these findings indicated that there was no significant relationship between some demographic factors and nurses' perceptions of quality of care improvement.

Nursing leaders must know the workload in their units to make sure nurses have sufficient time to plan for improvements in quality. Their departments and hospital administration must build an efficient mechanism to enhance quality improvement proposals. Also, nurses and other staff need a motivational system based on their performance evaluations, to provide the JCIA a sense of pleasure and acknowledgment about their efforts and involvement in quality improvements. New metrics to closely monitor personnel and supervisors' quality performance should be developed. In addition, a health committee specialized in quality from various medical specialists is recommended to be formed to monitor Palestinian hospitals that have received a quality certificate and impose penalties for violations of medical laws.

Keyword: JCI, quality of health care, hospital, nursing

List of Abbreviations

IAH	Istishari Arab Hospital.
NNUH	An-Najah National University Hospital.
JCIA	Joint Commission International Accreditation.
JCI	Joint Commission International.
JC	Joint Commission.
JCR	Joint Commission on Resources
JCHC	Joint Commission for Hospital Certification.
NABH	National Hospitals accredited by the Accreditation Board
KASH	Hospital accredited by Kerala Accreditation standards (KASH).
UAEs.	United Arab Emirates
GFI	The Goodness of Fit Index.
CFI.	Comparative Fit Index.
AGFI	The adjusted goodness of fit index.
RMR	Root Mean Square Residual.
SRMR	Standardized Root Mean Square Residual.
RMSEA	Root Mean Square Error of Approximation
IFI	Incremental Fit Index.
NFI	Normed Fit Index.
NNF	Non-normed Fit Index.
PNFI.	Parsimony normed fit index
PGFI	Parsimony goodness of fit index.
KMO.	Kaiser-Meyer-Olkin
CFA	Confirmatory Factor Analysis.
SEM	Structural Equation Modeling

CR Composite Reliability

Chapter One: Introduction

1.1 General Background

A health care agency's accreditation shows that it meets the highest international health standards. The organization's high level of patient care has received international recognition and approval (Joint Commission International, 2021). The Joint Commission (JC) is divided into two parts: the Joint Commission on Resources (JCR) and the Joint Commission International (JCI) (Joint International Committee, 2021). JCI's aim is to advise, support and continually improve international health organizations, health ministries and public health agencies in order to reach the highest standards in terms of patient safety and quality.

The JC is the biggest accrediting body in the United States, and the accreditation of JCI between the American Hospital Association and the American Medical Association is usually required by other countries through its international arm; JCI. The JCI is a non-governmental, non-profit organization. The most well-known certified healthcare provider in the United States. Accreditation of the JCI is an international assessment method used in quality and efficiency assessment and improvement. Healthcare institutions always seek to be efficient and effective. Patient safety and quality of care are prioritized by focusing on standards based on evidence, mainly patient safety, healthcare quality and building safety facilities, patient rights and administrative competence (The Joint Committee, 2017).

Accreditation of hospitals is critical. The majority of hospitals in most nations are selected to receive the JCIA. JCI is aimed to assist hospitals in consistently providing best quality health care and displays a culture of excellence in which they are constantly

enhanced and hospitals can also standardize care processes, reduce variations and risks, and provide consistent, safety and quality of care in the end.

The acquisition of an international quality accreditation certificate is an assessment mechanism and a way of enhancing the quality, performance and quality of services in hospitals and health centers. In the Palestinian context, in 2020, two hospitals, namely, Istishari Arab Hospital (IAH) and An-Najah National University Hospital (NNUH) have successfully received the International Quality Accreditation Certificate from the Joint Committee for Accreditation of Quality and Public Protection in Hospitals and Health Centers, and are thus the first two hospitals to obtain this certificate in Palestine. This great success stems from the hospital administration's belief in Palestinian patients' right to receive the best possible healthcare and that all hospital workers have worked together to achieve this aim.

Both IAH and NNUH contain many different departments, such as intensive cardiac care, surgery, a neonatal intensive care unit and other departments where medical care is provided for patients coming from all over Palestinian areas. Both hospitals work to achieve lofty goals, with regard to offering high-quality health services that guarantee patient safety and patient satisfaction. In addition, the quality of services given by the hospitals reduces the need for patients to be sent to other countries for treatment, which would positively affect or reduce the waste of public money and would give patients the ability to access all the services they need and, whether diagnostic or therapeutic, at home and in the hands of a highly-skilled and qualified national community, in a healthy environment that respects all of the needs of patients, their companions, and visitors.

1.2 Problem Statement

Due to the provision of humanitarian services in general and medical services in particular, the health sector is regarded as one of the most fundamental pillars of Palestinian society. Hospital accreditation denotes compliance with the highest international standards and requirements for health care service. JCI standard sets out performance requirements, functions and organizational structures required for JCI accreditation in hospitals. According to the JCI, a recognized medical organization should meet the highest international standards and health requirements (JCI, 2021).

This study did not include the Gaza sector because the hospitals in Gaza do not have the JCIA. So the researcher was unable to approach the hospitals in Jerusalem, the research range was limited to at IAH and NNUH.

Despite the significant resources required for accreditation and the conflicting findings regarding its effectiveness, healthcare institutions are seeking approval to enhance patient care quality and safety. Quality of care is a top priority for policymakers and hospital administrators in many East Mediterranean countries (El-Jardali, et al., 2008). Accreditation is expected to have positive influence on improving the quality of health care services offered to patients as well as the performance of medical staff, physicians and nursing who offer these services. Two hospitals in Palestine, namely, IAH and NNUH have recently received the JCI accreditation. Investigating the perceptions of medical staff, particularly the nursing staff towards the influence of this accreditation is the main focus of this study. More specifically, the study aims to investigate whether or not the application of JCI accreditation standards improves the perceived quality of health care by nurses working in IAH and NNUH.

1.3 Significance of the Study

Nurses are the heart of the health care service; they are the primary defense line in any medical facility and the backbone of medical attention. Patients have the greatest contact with nurses and are responsible for identifying, responding and representing patients' needs and interests (Al-Qahtani, et al. 2013).

According to the literature, hospital accreditation is a significant indicator of the quality of healthcare delivered. A significant number of quality reports from quality officers and supervisors on quality care services and the effective role of nurses in the operation of hospital accreditation at Palestinian hospitals has prompted researchers to evaluate and categorize the quality problem. Furthermore, the JCI will continue to monitor Palestinian hospitals in order for them to continuously comply with the latest JCI hospital standards.

On the other hand, understanding nurses' perceptions improves compliance with the latest quality standards and helps the nursing administration to know the strengths and weaknesses of nurses in order to work on developing and improving their skills, as well as creating systems and plans that help in developing the work of nurses and directing them to develop proactive plans to improve the quality of service provided in Palestinian hospitals.

This topic was chosen because the implementation of the JCIA is very important around the world, and the researcher has worked in the health sector and would like to incorporate this concept into his own field of work.

It takes 2-3 years for any hospital to obtain the JCI certificate and during this period, all medical staff is trained, developed and improved according to the JCI standards. The

nurses who work at IAH and NNUH have a good knowledge of the JCI standards. Also, the study that the researcher will undertake needs five months or more to be studied and applied, and by then, these hospitals would have had the JCI Certificate for more than a year, and this increases the knowledge of the standards of the JCI among nurses.

1.6 Research Aim and Objectives

The study aims to determine the nurses' perceptions towards the influence of the accreditation of the JCI on the quality of the health care service provided at IAH and NNUH. The following are the main objectives of the study:

- To assess nurses' perceptions towards the influence of JCI accreditation in IAH and NNUH.
- To examine nurses' perception of the quality of health care (QHC) after accreditation in IAH and NNUH.
- To determine the relationship between nurses' perceptions of the influence of accreditation on the quality of care and selected demographic and organizational factors in IAH and NNUH.

1.7 Research Questions

The study seeks to answer the following key question: What are nurses' perceptions of the influence of JCIA on the quality of health care at IAH and NNUH?

Below are the details of questions emanating from the main question:

1. What are nurses' perceptions on the influence of the JCIA in IAH and NNUH?

2. What do nurses think about the quality of health care after JCI accreditation in IAH and NNUH?

3. What is the relationship between nurses' perceptions of the influence of accreditation on the quality of care and selected demographic and organizational factors in IAH and NNUH?

1.8 Research Hypotheses

Accordingly, the following hypotheses are formulated:

H1- Nurses have positive perceptions about JCI accreditation and the quality of health care provided at IAH and NNUH.

H2- There is no significant difference in nurses' perceptions of the influence of JCI accreditation on the quality of care based on demographic factors (gender, age, and years of experience, level of education and position, training, hospital).

H3- The organizational elements (leadership commitment, quality strategic planning, the use of human resources, quality management) are not significantly affected by the perceptions of nurses as to the influence of JCI accreditation on health care quality.

1.9 Conceptual Definitions

The following basic terminologies used in the thesis are defined below:

1. **Nursing Perceptions**: - is a collection of methods used by nurses to understand and analyze their environment information. (Business Dictionary, 2015).
2. **Organizational Factors** are defined as "structure and philosophy, team resources and administrative support, as well as communication and coordination mechanisms" (San Martin et al., 2005).

3. **Quality of Care: -** This refers to how the probability of intended outcomes of health is increased in line with current professional knowledge or the extent to which health services raise the probability of desired outcome of health for individuals and populations (WHO,2021).

1.10 Conceptual Framework

Based on the literature review, the framework established contains aspects linked to demographic factors, organizational factors, and how these factors may effect nurses' perceptions of quality of care improvement at NNUH and IAH.

Figure 1: The demographic and organization factors influences the perception of nurses towards improvement in quality of care.

1.10 Thesis Structure

The chapters of the study are arranged as the following:

1.10.1. Chapter 1: Introduction

This chapter is composed of a general information to the thesis topic. And also the study problem and significant of the study, study objectives, questions, hypotheses, terminology of the Study.

1.10.2. Chapter 2: Literature Review

This chapter contains the related studies that the researcher has studied. It also contains the data necessary for the reader to have clear and understandable images of basic concepts in JCIA. Emphasis was placed on understanding nursing perception towards the influence of JCIA on quality of healthcare.

1.10.3. Chapter 3: Study Methodology

The study design and procedure are presented in-depth in this chapter. The methods utilized in the analysis, information and data gathering concerns are also described in this chapter.

1.10.4. Chapter 4: Data Analysis and Interpretation and Discussion

In chapter four, the findings are presented and debated. The findings are presented and discussed after they have been analyzed.

1.10.5. Chapter 5: Conclusion and Recommendations

Recommendations and conclusions were made in this chapter.

References

Appendices

Chapter Tow: Literature Review

2.1 Overview

Although the researcher looked at studies on the subject of the JCI and its effect on the quality of care, he discovered only a few studies which spoke about the perception and involvement of nurses in hospital accreditation.

Similar research in other Arab countries such as Jordan, Qatar, Lebanon, Saudi Arabia, Palestine, and others are worth noting. There are no previous studies in the West Bank on the subject, to the best of our knowledge.

2.1 Overview of the Joint Commission International (JCI)

The JCI is the international section of the Joint Commission, a non-governmental non-profit organization and the most important accreditor for medicine in the United States (The LWF, 2020). Since 1917, via the American College of Surgeons' efforts to enhance health care through the implementation of standards, the joint commission's history in the United States emerged. With support from the international committee of physicians, nurses, health authorities and public policy experts, the JCI has produced a set of international health norms and standards of practice for health facilities and practitioners.

The JCI is one of the world's most important non-profit organizations in the field of patient safety (World Hospital, 2021). JCI sees a world that offers every patient the greatest possible treatment. The most obvious approach of achieving this objective is their certification program. In this connection, JCI releases a number of needed standards which regularly represent the newest ideas on patient safety and quality improvement. To gain certification, JCI must carry out a complete and rigorous on-site survey of Health Organizations which conform to these standards. Once the organizations are accredited, they must continue meeting our requirements and are

regularly evaluated by re-surveys. JCI is entirely different from the accredited organizations (World Hospital, 2021).

In addition to meeting their requirements for certification, JCI works to enhance the quality of care in all hospitals. Their international professionals consistently support the achievement of quality goals and patient care outcomes in hospitals, city governments and health departments (World Hospital, 2021).

The JCI, formed by the Joint Commission in 1994, collaborates with health organisations, representing over one hundred countries. JCI now has an internationally qualified consultants and survey team on five continents (World Hospital, 2021).

Every hospital and healthcare group that requests JCI accreditation must plan for about two years. During this phase, the entire organization cooperates to create and implement the latest high quality, patient-safe policies, processes and procedures necessary to fulfil our requirements.

2.2 Context of the Study

Two hospitals in West Bank has been contributing remarkably to the quality of health care services offered to patients in Palestine; these are the IAH and NNUH. They work towards the high aims of providing quality health services that guarantee the safety and contentment of patients with the services given. Furthermore, the quality of the hospital's tertiary services will reduce the need to transfer patients for treatment outside the country, which will positively affect or reduce the waste of public money, and will give patients the ability to access all of the services they require, whether diagnostic or therapeutic services, at home and in the hands of a highly skilled and qualified national staff.

The first stage of the operation of the IAH in 2016 was the operational capacity of 100 beds, followed by a steady operation of an increase in beds, bringing the total number

of functioning hospital beds to 330. This has been achieved within two years, at least half of which are quality beds (IAH,2021). The IAH is situated on a 13,000 m^2 lot, on which a 25,000 m^2 building has been constructed spreading out across 14 stories (IAH,2021). The specialty departments that account for the majority of work at the IAH (IAH,2021) are:

- Nutrition Department
- Ear, Nose and Throat Department
- Emergency Department
- Orthopedic and Joint Surgery Department.
- Anesthesiology and Resuscitation Department.
- Urology Department.
- Cardiology Department.
- Cardiothoracic Surgery Department.
- Tissue Examination and Clinical Laboratories Department.
- Diagnostic Radiology Department.
- Interventional Radiology Department.
- Molecular Genetics Laboratory.

NNUH is neither private nor for profit, and it is Palestine's only teaching hospital, providing education and health care, and a space for medical research and training, as well as the best scientific environment and the most modern infrastructure for students to learn and grow (NNUH,2021).

The hospital was constructed on an area of 17,000 square meters and contains a fully equipped intensive care unit, an emergency room, a dialysis department, and a department for x-rays, ultrasound and tomography, as well as 120 beds (NNUH,2021). Construction began in 2008 in the city of Nablus. The hospital provides services for

extremely complex cases requiring cardiac care, as well as for eye surgeries, including corneal transplantation and artificial cornea and the hospital provides the ability to perform advanced liver surgeries, general surgery and orthopedics. In addition to the hospital's provision of health care services for children, these include advanced surgeries in the spine, cancer and blood diseases in children, as well as the provision of many advanced and modern services among others. NNUH is, at present, the only provider of medical services related to advanced electrophysiology, complex open heart surgeries, and bone marrow transplants for both adults and children for the treatment of leukemia, which makes the hospital one of the most advanced and modern health and medical service providers in Palestine. Welcoming patients from all over the West Bank and the Gaza Strip (NNUH,2021).

Management is committed to the following main business concepts in order to improve the quality of services in NNUH:

1- The quality management system is continuously improved and updated.

2- Concentrating on the happiness of patients.

3- Increasing the involvement of employees as they produce quality.

4-Providing a safe, healthy, and convenient work environment for all patients and staff.

5- Decisions are based on facts based on employee participation in these hospitals at the strategic and the operational levels.

6- Continuous improvements to achieve continuous improvements of all hospital operations and services through a defined approach for quality targets & indicators developing and implementing them in every associated department.

2.3 Hospital Accreditation

Accreditation is a self-evaluation and external peer assessment process used to examine health organizations accurately and continuously in accordance with specified standards. Accreditation shows an organization's dedication to improving quality, patient safety and satisfaction, increasing efficiency and proving accountability. Accreditation is a way to achieve public acknowledgment by achieving default national operational standards of a healthcare organization (Pomey et al.,2005).

The Joint Commission for Hospital Certification (JCHA) was created in 1913 in the United States and included Canada until 1959, when it established its own accreditation system. A group of volunteers from the American College of Surgeons, the American Hospital Association, and other professional organizations came together to form JCHA. Performs peer reviews of hospitals around the United States on a voluntary basis (American College of Surgeons, 2021). Since 1918 the committee set minimum requirements for the protection of public safety, patient rights, care standards, and effective service regulation and has since continued developing comprehensive recommendations based on physics, organization, and professional standards. External auditor of installations, organizations, persons and related tasks like qualifications of employees, ongoing training, medical records and quality assurance are included (American College of Surgeons, 2021).

Accreditation is a process where a health care facility assesses the hospital compliance of specified national and international standards with a view to increasing health care protection and efficiency through an objective evaluation system (Miller, 2009). Hospital accreditation is an external assessment by the independent professional accreditation organization of hospital structures, processes and results using optimal and pre-determined standards. According to the Joint Commission (2017), accreditation

in hospitals is aimed at providing patients and their caregivers with a happy atmosphere, improving quality, increasing results and satisfying the patient, and lowering costs through standardized care.

Today, accreditation of hospitals is utilized as a method to provide health organizations with quality of care. It is widely considered to provide a systemic and legal method for assessing whether health facilities achieve or not preset quality requirements based on evidence and best practices (El-Jardali et al, 2008).

The study by Araujo et al, (2020) aimed to assess the impact of hospital certification on measures of medical quality. The study has carried out a systematic evaluation and general findings showing that accreditation can increase efficiency, safety, efficiency, promptness and patient focus. On the other hand, only one study investigates access effects and no study has yet looked at equitable impacts.

The study by Izadpanah et al, (2020) was to learn about medication management criteria for national hospital standards for FDANP accreditation. The study used the questionnaire for data collection, one of the study's more essential results was that the following were proven to be effective: standards for secure drug and medical equipment storage, as well as a realistic system for detecting and monitoring medication errors. They had an effect on the following factors: the most influenced factors/standards were continuous monitoring of medication and medical equipment use, not separate factors/standards.

According to the Joint Commission (2017), the following points are critical for hospital pathways to JCI accreditation:

- Learn about JCI's accreditation standards, policies and procedures, then go over the survey process guide and share your knowledge with the team.

Because of their roles in overseeing care, nurses must share more information than other health professionals.

- Conduct a baseline evaluation of the hospital's performance in relation to the JCI standards.
- Update hospital policies and procedures in accordance with best practices.
- Determine where changes are required by evaluating the problems and beginning with the international patient safety goals (IPSGs), then assessing the hospital's risk of adverse outcomes and addressing the issues as soon as possible.
- Work with staff to overcome obstacles through maintaining a safety culture and empower them by training and continuous education in new policies and procedures.
- Assess your readiness at the midpoint by preparing the staff for the mock survey and involve them in the areas that need improvement.
- Continue training for long-term change by keeping employees informed and motivated about new procedures. Then finish the mock survey planning.
- Process evaluation and improvement. Encourage staff to make corrections and promote a sense of togetherness.
- Use this sample survey to evaluate your hospital ready to conduct an actual JCI inspection and plan revisions and enhance your spot according to the audit findings.
- Prepare the survey final and make required changes in the light of the recommendations of the JCI survey.

Any hospital may apply for JCI (2017) accreditation if it meets all the following criteria:

- The hospital is not in the United States or any of its lands.
- The hospital is currently in existence as a national healthcare provider in the country, is certified to provide care and treatment as a hospital (if necessary), and does the following at a least:

1- Provides a full spectrum of clinical services for acute care – diagnostic, curative and rehabilitative.

2- Provides a set of designated services, such as pediatric, eye, dental and psychiatric care for a hospital specialty.

3- Services are available 365 days an annum for all types of hospital; ensures all services for patients are operational 24 hours a day, 7 days a week; and provides assistance and support, as necessary, for emergency, emergency and/or emergency needs 24 hours a day, 7 days a week for patients (such as diagnostic testing, laboratory, and operating theatre, as appropriate to the type of acute care hospital).The hospital provides services addressed by the current JCI accreditation standards for hospitals.

- The hospital is responsible for increasing the quality of its care and services or is ready to take over.
- The hospital is open and in full operation, receiving and releasing patients with a volume that will allow for a comprehensive review and continued conformity to all current JCI hospital accreditation standards.
- The hospital fulfills the parameters indicated in the current requirements for accreditation participation (APRs).

2.4 Dimensions of Study

1- Quality Output: is to the degree to which a number of inherent qualities comply (CROS, 2021). Quality results are crucial factors in every hospital for the achievement

of the targets, and the higher the outcomes, the higher the level of hospital health care is offered.

2- Leadership/Commitment: Leadership is the capacity to affect behavior, commitment is a commitment to a specific organization, cause or belief, as well as a commitment to participation (CTB, 2021). It evaluates the extent to which senior hospital managers have guided, established and supported a quality improvement environment.

3-Strategic Quality Planning: systematically approaching a company with an association strategy's quality assurance and improvement plans at the highest level. Strategic quality planning has historically been considered separate and distinct from strategic business planning since quality planning is generally done at the smallest organization levels (Strategic Quality Planning, 2000). It assesses efforts to set strategic objectives and action plans and assesses the level of empowerment and involvement of the nurses in the development of quality of the hospitals.

Quality should be part of strategic planning of quality. Strategic planning defines the route between its position and the desired level. It concentrates on results. It offers a systemic method of defining itself, evaluating and checking its services and products. It is a long time approach and can be adapted to various organizational needs (Zeren et al., 2009).

4- **Human Resources Utilization:** is the extent of the successful deployment of available human resources for attainment of individual, collective, organizational or national aims and objectives (Irmgard, 1997.p 7-8). This evaluation should assess to what degree the nurses were properly educated and trained in support of quality improvement and how well their efforts and participation in quality have been recognized and rewarded.

5- **Quality Operation Management**: Operations management is the process of converting various inputs of a business into output; it includes all activities involved in producing a good or service from raw materials. However, the quality of operational management relates under commercial circumstances to a state of management that is remarkable for its functioning. Based on numerous aspects, the operational management is operating excellence, in other words, is a concept which evolves through time and which constitutes a basis of continual progress. It's about delivering consumer delights and strategic competitiveness, rather than being just a concept for building operations. The operational management is vital to any business, the production of goods and services is accountable for fulfilling the expectations of our consumers and the market, which is the most significant act of all organizations. (Lyngso, 2017).

2.5 JCIA the Gold Standard of the World

Accreditation is a lengthy process that necessitates commitment. There is a lot of preparation work that goes into a survey and subsequent performance and enhancement work is undertaken to ensure the preservation of these accreditation requirements. Organizations receiving and retaining JCI accreditation are committed to offering the highest possible quality of treatment for their patients (World Hospital.2021).

As one of the most important instruments for positive change, JCI standards and evaluation criteria stand alone in the world. Its criteria and methods of assessment according (Joint Commission Resources, 2017) are:

- Built to stimulate and encourage sustained improvement in quality.
- Created for Risk Management.
- Based on building a patient safety culture.

- Created and validated in every area of the world by health care practitioners from around the world.
- Built exclusively for the health care industry by health professionals.
- Applicable to medical institutes and global health systems.

2.6 Benefits of Joint Commission Accreditation

The eight categories of medical programs approved by the JCI on World Health include hospitals, academic medical centers, ambulatory facilities, clinical laboratories, home care facilities, long-term care facilities, medical transport organizations and primary care centers (World Hospital.2021).

Literature and recent research show that JCI accreditation offers numerous benefits for healthcare organizations, patients, health care providers and the community. These benefits are summarized in the following points:

- It helps organize and enhance patient safety efforts (Al-Awa et al., 2011).
- It enhances the trust in the quality and safety of care, treatment and services in the community (Devekaran and Farrell, 2014).
- It provides a competitive advantage in the market (Joint Commission Resource, 2017).
- It may reduce the costs of liability insurance (Devekaran and Farrell, 2014).
- It provides education to improve business operations (Al-Qahtani et al., 2013).
- It provides professional advice and consultations, and promotes employee education (Al-Qahtaniet al., 2013).
- It provides an extensive customized review (Joint Commission, 2017).
- It promotes employee recruitment and development (Joint Commission, 2017).
- The authority gives consideration to the Medicare certificate (Wagner et al., 2012).

- It gives a structure and management framework for the organization (Hyder et al., 2010).
- It offers practical methods for improving or sustaining performance excellence (Almoajel, 2012).

Yildiz and Kaya (2014) showed that the benefit of accreditation was typically substantial for nurses. The dependent variable (quality results) and the independent variables were statistically importantly positive in conjunction with the (accreditation benefits and employee participation).

2.7 Quality in Healthcare

In the healthcare field, quality of care is more than an idea. It has become essential to patients' health and financial well-being, since the last decades, quality has become one of the basic pillars in life and because of its importance and urgency in our lives, it has different definitions that many scholars know, including W. Edward Deming, who led the Japanese and American quality revolutions, said, “A product or service possesses quality if it helps somebody and enjoys a good and sustainable market” (Deming, 1994). It is important to note that it does not actually determine quality; rather, it means value in terms of customer support and marketability of a product or service.

Donabedian, a founder in the theory and management of healthcare quality, has previously stated that “several formulations are both possible and legitimate, depending on where we are located in the system of care and on what the nature and extent of our responsibilities are” (Donabedian, 1988).

The Institute of Medicine (IOM) developed the most durable and widely-cited definition of healthcare quality in 1990. The IOM defines quality as the "degree to which health services for individuals and populations increase the likelihood of desired

health outcomes and are consistent with current professional knowledge"(Lohr et al., 1990).

Quality shall be defined as the degree to which the provision of health services to individuals and communities increases the probability of desired health outcomes (quality principles), is compatible with existing professional skills (competent professionals) and fulfills health user standards (marketplace) (Letts, 2005).

Why a focus on quality now?

Over many decades, the world has gained a wealth of knowledge and experience in increasing the quality of health care. The problem often facing national policy makers, both high- and low-middle-income countries, in spite of their wealth of experience, is to know which quality strategies, supplemented and integrated with existing policy initiatives, would have the most impact on the results of their health systems. This guidance supports focus on health system quality and allows policymakers and planners to take educated strategic choices to increase quality (Letts, 2005).

There are two primary reasons for emphasizing quality in healthcare institutions at this time. These are:

- There is a strong sign that quality continues to be a critical issue even in advanced and resourced health systems, with unprecedented results and significant disparities in health care requirements inside and across health care systems (Letts, 2005).
- In those areas where health systems need to maximize resources and extend population protection, particularly in developing countries, the development and scaling process needs to rely on strong local quality initiatives to ensure new investments achieve optimum results (Letts, 2005).

2.8 Quality of Care and JCIA

Quality of care is not a fresh idea for health organizations. Health quality is a wide notion covering many elements of patient care. Quality health care is characterized as safe, efficient, patient-focused, prompt, effective and fair treatment (Committee on Quality of Health Care, 2001). Quality is a complex concept that signifies various things for different people according to (Institute of Medicine 1990). It is really quite straightforward and is described as "the degree of quality in healthcare."

The Institute of Medicine published a report on health care quality in the United States called Crossing the Quality Chasm: A New Health System for the Twenty-First Century on March 1, 2001. (Institute of Medicine, 1990). Crossing the Quality Chasm is a follow-up to Err Is Human, the IOM's 1999 patient safety studies, which urge for a major overhaul of the U.S. healthcare system. The project was conceived in 1959.

Crossing the Quality Chasm Agenda: A Road Map for Improving Care Quality (Cohn et al., 2008) are:

- It is a shared agenda of six objectives aimed at improving the quality of the care to unprecedented levels that all healthcare sectors, including policy-makers, buyers, regulators, professionals of health, health trustees, and managers, and consumers, commit to a national declaration of purpose for the entire healthcare system.
- To establish a new set of guiding principles for redesigning care procedures for the physicians and patients and health organizations supporting care provocation.

- To select a list of priorities for first efforts, resources to drive innovation and to launch change processes by the Ministry of Health and Human Services.
- That medical organizations actually implement more effective organizational assistance methods to make possible changes in the provision of care.
- That buyers, regulators, healthcare professionals, education agencies and the Health and Human Services Department create an environment that promotes and rewards improved infrastructure by (1) developing evidence-based praxis, (2) promoting information technology uses, (3) aligning payment incentives and (4) preparing employees to serve better patients within walking distance.

The committee proposed six components that define healthcare quality. High-quality healthcare should include the following (Cohn et al., 2008):

1. Safe: Preventing patients from being injured as a result of the treatment provided to them.
2. Effective: To provide scientific-based services to people who may benefit without offering services to others who are unlikely to gain (avoiding underuse and overuse, respectively).
3. Patient-centric care: means that patient wants, needs, beliefs and values are respected and fulfilled and that the patient's values are the foremost priority in all healthcare choices.
4. Timely: reduces waiting times and potentially harmful delays for both the patients who receive and provide treatment in some circumstances.

5. Efficient: not wasting anything, including supplies, equipment, ideas and resources.
6. Equitable care: shall not differ according to the qualities based on the characteristics of the individual, including gender, race, geography or socioeconomic conditions.

The quality of health care and patient safety is now good, and is at the top of the national health agenda, according to Jaber (2014). The health policy agendas of governments in several nations in the East Mediterranean area now focus on the quality of care (El-Jardali et al., 2008).

The principle of continuous quality improvement, according to (National Healthcare Quality, 2019), includes, but is not limited to:

- Staff participation in the organization's process of improving quality.
- Taking care of all internal quality processes and seeing the quality of every process.
- Concentrated on customer external and internal demands.
- Everyone should be liable for improvements in quality in the organization.
- Focus on the efficient utilization of physical and human minimum waste.
- Strong leadership is required to promote advances in production systems' quality.
- Develops strong indicators and an analysis technique to evaluate quality improvement conformance.

2.9 The Role of Nursing in Hospital Accreditation

There are many sublime professions whose presence in this life is no less important than in other professions and if some see the opposite, then there is no profession that

reduces the value of its owner or reduces the efforts that they undertake, in order to help others, for example a profession of a cleaning worker is a very important occupation (Siman et al., 2014). Some people who think with a mentality that does not contain any type of culture see that this profession has no value, or they treat the owner of this profession with mockery. If that profession did not exist, pollution would have completely prevailed in the place and society. On the other hand, we find many great professions, the doctor has his/her role, the worker has his/her role, and the engineer has his/her role. We cannot dispense with any of them in exchange for the other (Siman et al., 2014).

Nursing is considered among the great noble professions that help the individual rise from the health conditions that s/he is going through to the better, for it is a help for the patient after God shares his/her pain and tries to relieve him of his pain, and s/he is aware of everything and enjoys a high degree of culture that may not exist from others. Nursing includes women and men, and the nursing staff is called the angel of mercy, because it really is so, only the nurse who supervises your case will follow you up (Joint Commission, 2021)

Both the medical and nursing professions are complementary, and no one is more relevant than the other, regardless of what some think. So the doctor diagnoses the case and then prescribes the appropriate medication; after that, the nurse takes on the rest of the job of monitoring the patient's condition and staying up late with him/her to administer medication and painkillers through which it helps to relieve his/her pain, by giving him/her motivation and support, and to share his/her life for several days.

The patient may have been subjected to a dangerous operation and the doctor performs the necessary and goes to help and follow the case of others, but here s/he leaves the nurse or the nurse who continues to follow the case, and it may be a reason to save your

life in the event that it deteriorates in a moment, and no one is with you, and no one can help you. In cases where serious cases occur and a large number of cases are transferred at the reception, the nurse is the one who helps you upon your arrival, and those assistances that s/he provides for you are the reason for saving your life from death, until the doctor examines you in light of a number of cases.

- **Profession of Nursing**

Nursing is the independent and collaborative care of persons, families, groups and communities of all ages, in all environments, sick or well. It involves health promotion, prevention of diseases and treatment of those who are unwell, disabled and dead. The WHO has classified the nursing profession as medical treatment for the patient or as recovery profession and sometimes as the uncontaminated heroes in hospitals and emergency departments. theory (WHO, 2021). It provides assistance to the person in all cases, whatever his/her condition s/he is going through, whether his/her condition is deteriorating, s/he tries to save him/her or does not feel the pain as much as possible.

Or the individual is going through final cases in his/her life, whether s/he is dying, or the medical team is in despair from the patient's condition or s/he has no time left and leaves. After that life, here a nurse is someone who leaves him/her for the rest of the time without despair, and tries to make him not suffer at his/her last time in life, a nurse is not only a medical profession, but a person who must be psychologically qualified to deal with cases of all kinds.

Nurses carry the amount of suffering that the person may have in his/her condition, and they are able to help and assist you in different ways at a time when your closest friends and family may not be able to bear you and do not understand the extent of your suffering. Because of the pain and the constant complaints, you make when you believe

s/he isn't helping you, s/he has provided you with everything that s/he can help you, whether psychologically or medically (WHO, 2021).

As a result, the researcher in this study has choosen nurses as the population's targets to determine their perceptions of JCI accreditation and its effect on the quality of care delivered in IAH and NNUH, because nurses play a critical and essential role in saving patients and providing high-quality services to people of all ages without being exhausted or bored. In every health-care organization, nurses play a critical role in ensuring quality. Through their expanding roles as caregivers, educators, executives, administrators, advocates, counselors, supervisors, consultants, decision makers, team builders, and so on, they have various responsibilities in shaping quality. They are at the heart of patient care and, as a result, are critical drivers of quality improvement (Liewellyn, 2014). As key drivers of quality improvement, they must cultivate the following quality competencies:

- Educating patients about the concept of patient-centered treatment and encouraging them to participate fully in their health-care plans.
- Increasing their knowledge of data processing in order to make more effective use of data in order to monitor the results of health-care and quality-improvement processes.
- Strong communication skills, as well as an appreciation of the value of teamwork and teambuilding.
- Having a high level of risk awareness and the ability to implement effective risk management techniques to reduce the risk of harm to patients and providers.

- Understanding evidence-based treatment and the potential to incorporate new evidence into patient care and clinical practice.
- Using technology to facilitate decision-making and quality improvement in an efficient and successful manner.

The top management of each healthcare organization should recognize the important role of the nurses in interacting with patients and their families and communicating in person and even through body language, with all the departments in the hospital, using various means of communication such as verbal, written, telephonic, intranet. JCI stressed the need to improve the communication capabilities caregivers, clinical and non-clinical departments, departments and workers (Joint Commission, 2017).

The nurse has a significant role in and distinct skills as a member of the team, according to Manzo et al., (2012). S/he helps the health service organization to carry out the accreditation procedure and monitor it. The nursing staff are capable of interacting with all support fields in the organizational structure, being autonomous, responsible, leaders, managers and clinical auditors. They have an impact on the accrediting processes, their efforts and their support. As a result, they should be recognized and rewarded for their efforts to increase quality in order to encourage them to go on improving quality. Supportive leadership is essential for achieving JCIA.

2.10 Palestine's Health Situation

Several bodies provide health services in the Palestinian territories, namely the Ministry of Health, military medical services, NGOs from civil society organizations, the United Nations Relief and Works Agency for Palestine Refugees (UNRWA), in addition to the private sector. Although the Palestinian Authority allocates a large part of its resources to the health sector from the gross domestic product, the health sector has not improved

as required as was expected after the establishment of the Palestinian National Authority in 1994. Palestine ranks 113th according to the international classification of the Human Development Report issued by the United Nations, it is considered among the medium-developed countries (UNDP,2015).

Causes and factors of weakness in the Palestinian health sector:

1- Israeli Obstacles: Perhaps the practices of the Israeli occupation and the permanent violations of Palestinian health rights are considered the most important reason behind the weakness and inability to truly awaken the Palestinian health sector.

2- Double the available capabilities:

On the other hand, there is a clear weakness in the performance of the medical staff, a weakness in the available capabilities, and a weakness in the maintenance and continuity of the work of medical equipment, which led to the inability to fully provide health services to citizens. This weakness has been exacerbated by a state of distrust by the Palestinian citizen of Palestinian doctors, and therefore reliance is placed on external referrals for treatment, whether in Israel, Jordan or Egypt, especially in cases of cancer, heart and nerve diseases.

In addition, the weakness of the financial resources allocated to the health sector in general, hinders the possibility of developing the health sector.

3- External referrals for treatment: As was mentioned previously, and due to the weakness of medical capabilities and equipment, in addition to the weakness of the medical staff in dealing with difficult cases, the Department of Treatment Abroad was established in the Ministry of Health. Thus, difficult pathological cases such as malignant tumors, blood diseases, some micro-neurosurgeries, cardiovascular surgeries, pediatrics, orthopedics, and eye diseases are referred abroad.

Some positive indicators in the sea of negatives in the Palestinian health sector

Given the magnitude of the challenges facing the Palestinian government, and despite the modernity of the Palestinian health infrastructure, there are some achievements and successes that have been achieved on the ground in the health sector in Palestine, especially when taking into account that the Ministry of Health was able to control many diseases. The report issued by the Preventive Medicine in the Ministry of Health for the year 2020 confirmed that no cases of polio, cholera, tetanus, rabies, diphtheria, whooping cough, rubella and leprosy were recorded, despite the presence of these types of diseases in the neighboring countries of Palestine (UNRWA,2020).

There are also many indicators of a clear rise in health awareness and culture in the Palestinian community. Health care during pregnancy and periodic visits to qualified medical staff, in addition to childbirth in health facilities, have become axioms for the Palestinian community. Moreover, attention to hygiene, movement, sports and avoidance of obesity and exercise has become a general culture practiced by both sexes in Palestinian society.

Among the positive indicators that have a positive impact in the future is the general orientation of many Palestinian medical staff towards specializing in various medical fields, and not being satisfied with general medicine, including specializations in heart and neurosurgery, and orthopedics, in addition to specializing in various tumors and strokes. Success has been written for many rare operations, whether in Ramallah, Nablus or the European Hospital in Gaza.

2.11Previous Studies

The researcher reviews a lot of previous researches about this topic and one of them was conducted by Despotou et al., (2020). This study suggests an overall positive attitude towards accreditation has been established, and it established a correlation

between experience and attitude towards certification and perceived positive safety effect. Participants accepted that the IPSG (International Patient Safety Goals) had been adopted.

Al-Shawan (2021) conducted a study to evaluate the methods and efficiency of quality improvement at King Fahd Hospital in Khobar, Saudi Arabia. This study used a convergent parallel mixed method. The variations in a total of 12 qualitative results before and after quantitative analysis accreditation are evaluated with an interrupted time series. Thematic analysis has been used to collect and interpret qualitative data from hospital staff and healthcare professionals. The quantitative results have shown that follow-up accreditation has had a favorable impact on nine of the 12 results. Improved outcomes included the following: average duration of stay, compliance with the hygiene level for hands, hospital infection rate, radiological report, outlier's percentage, pressure ulcer rate, percent of correct identification of patients, and percentage of critical cases. Not improved results were the rate of patients being released without being seen from the emergency room, the rate of cancelations in the operation room, and the rate of patients falling. The qualitative study revealed that the participants regarded the accrediting procedure favorably. Some inconveniences of this procedure were also identified, however, probable biases in observational KPIs, concentration on improving the process without strengthening the hospital organization and increased workload.

Another study by Katoue et al., (2021) was to examine the attitudes of healthcare professionals (HCP), the problems perceived in adopting accreditation, and how these challenges may be solved. It is a qualitative phenomenological context. The results of this study showed that the perception of healthcare professionals stated that certification had enhanced a culture of patient safety in their organizations, by employee

commitment in excellent practices. Administrative support, accreditation training for staff and extension of electronic systems were provided for facilitators to carry out accreditation arising from the interviews. Participants reported many challenges for the implementation of accreditation, including challenges relating to personnel (e.g. high workload, accreditation requirements), problems with the systems and organizational resources (e.g. poor teamwork between health care workers' perceptions, insufficient infrastructure in certain facilities) and challenges in relation to patients (misunderstanding accreditation). However, most participants showed good accreditation attitudes and valued the impact of the program on quality of healthcare. Participants offered ways of supporting accreditation, including expanding employee numbers to minimize burden, strengthening employee motivation and accreditation training, fostering proactive leadership and teamwork for employees and enhancing patient sensitivity.

The study by Emel et al., (2020) was to produce an instrument for assessing nurses' perceptions of the quality control methods implemented in hospitals. In addition, the nurses' impression of the impact on the quality of patient care and work satisfaction of these implementations were studied. A descriptive, comparative, cross-sectional online survey was used for this investigation. The results of this study showed that a measured perception of implementing quality management programs by participants is valid and dependable. In the organization where they worked, nurses' views on quality control were quite negative, and they had negative opinions towards their application. However, it had little impact on patient views as to the Quality of Care while implementing quality management programmers. Participant satisfaction was lower

than normal and quality management systems were implemented in hospitals and had a negative effect on work satisfaction.

The study of Mosadeghrad et al., (2020) was to compare Iranian certification techniques with the world's main international hospital accreditation agencies. A comparative research was used in this study. The findings revealed, while government-mandated accreditation for Iranian hospitals has been found, private, non-profit and voluntary are three major international accrediting programs. Although Iran's system of hospital accreditation comprises an auto-assessment and on-site survey, the other nations utilize auto-assessment, on-site surveys and unnoticed surveys, periodic reviews, review of important indicators of performance and measure patient happiness. The international accreditation award levels are "Fully accredited," "Provisionally accredited," and "Not accredited," and the accreditation certification is valid for three to four years. The accreditation certificate issued by Iran is valid for two years and is divided into seven levels ranging from "Excellent" to "Not accredited."

The study of Joseph, (2020) aimed to to assess the quality of delivery of public health care to non-accredited hospitals in certified hospitals. It also compared the impact on public health in Kerala of national and state accreditation schemes. The investigation was transversal in scope. The study revealed that in accredited and not accredited facilities, patient satisfaction is comparable. Patient satisfaction in national hospitals accredited by the Accreditation Board (NABH) is lower than in the hospital accredited by Kerala Accreditation standards (KASH). KASH accredited hospitals have a higher mean score on six quality healthcare delivery constructs than NABH accredited hospitals.

Another study by Al-Mohammed, (2020) was to evaluate perceptions of good management of hospital quality in the United Arab Emirates (UAEs). The study used qualitative design. The results of the study revealed four topics: (1) governance of corporate (hospital) services, (2) accreditation, (3) satisfaction of staff and (4) quality and performance management. The role of governance was underlined by interviewing health-care workers, which confirmed that they have a well-structured governing body. In the field of accreditation and improvements in patients' quality, the role of hospital leadership was also critic. The staff supported the introduction and development of hospital standard and expressed a need for continued motivation and acknowledgment. Nugroho et al., (2019) conducted a systematic review of the literature on hospital accreditation and healthcare quality. The purpose of this study was to examine the effects of certification on the quality and results of the hospital service. According to eight papers, the quality of healthcare was enhanced by hospital certification. These articles provide valid proof for the commencement, pre-survey, post accreditation, and stagnation phases at the four stages of the accreditation cycle. From the start to the completion of the trial, the quality of hospital health services improved dramatically.

The study of Agustine, (2019) aimed at evaluating the attitude of healthcare professionals as to the consequences of accreditation in hospitals and implementing changes for quality patient care in Asian countries. The study used systematic reviews in the Asian region and a systemically screened five electronic databases from 14-21 May 2018. According to the results of the included research, positive judgments by medical professionals about the quality of medical services have an effect on hospital accreditation.

One more study by Avia et al., (2019) was to explore and evaluate the effect on quality of care of the hospital accreditation. The study used the semi-structured interviews

between June and December 2017 with 15 staff from four public acute care hospitals authorized to the UAE's Ministry of Health and Prevention. The results indicated enhanced quality of management (81,81%), staff participation (27,27%), and quality of outcomes (27,27%) in the hospital accreditation system (54.54 percent). The study examined nurses and other health workers on the basis of their work experience, their education and their age.

Also, Al Mansour, A. (2018) identified the impact of accreditation on the quality of health services. The study employed a systematic examination of papers comparing the effect of accreditation in accredited and non-accredited hospitals globally. The study shows that the accreditation of hospitals is a great instrument for improving quality of care, because the high score of the 'quality results' component suggests that the quality of nurses increased throughout and after the accreditation process. Leadership, engagement, encouragement, use of information, education, training, incentives, recognition and credential advantages were the most important elements for improved quality results.

Yildiz et al., (2014) analyzed the perspectives of Turkish nurses about the effect of accreditation on quality of care and the impact of certification on quality results. The study was conducted as a cross-sectional questionnaire survey of 258 nurses who began employment in the hospital before and after accreditation and were therefore familiar with the pre-accreditation and post-accreditation periods at the hospital. The study demonstrates that the advantages of accreditation articles are often substantial for nurses. The dependent variable (quality results) and the independent variables had a statistically significant positive correlation (accreditation benefits and employee participation).

Also, Wocher et al., (2014) examined the Japanese nurses' assessment of JCI's effects on patients' quality and to assess their level of awareness of the aims of JCI accreditation. The study employed the descriptive approach and the questionnaire tool as a key tool for data collection. The study found that the health care professionals thought and discovered that JCI Accreditation's good influence is an important means of improving the quality of care. Yang et al., (2014) conducted a study to identify present conditions in nursing perspectives, nursing performance, work stress and burnout in connection to JCI accreditation, and to establish links between these factors. This cross-sectional study was conducted by use of questionnaires. The research has shown that the relationship between healthcare and perception is substantial. Burnout was also negatively associated with cognition and nursing and had a good impact on the stress of work.

Manzo et al., (2012) investigated the role of healthcare providers and their impact on hospital accreditation. It is a study of qualitative. The findings reveal that the supply of therapeutic, administrative, education and research concerns in the course of accreditation have an essential influence. On the other hand, the research demonstrated favorable and negative accreditation impressions of the staff. Pride in their job in nursing, professional maturity and advancement were related with the positive aspects. The negative opinions were related to their seniors' lack of acknowledgment, including their managers' financial benefits, working-load and pressure to carry out accreditations without sensitizing professionals.

In the Arab context, a study by Al-Ishaq, (2009) aimed of the study was to assess the impressions of healthcare personnel of the safety culture in medical hospitals Hamad. The study employed the descriptive approach and the questionnaire tool to obtain the necessary information. The results showed that a culture of safety was an important

step in proactive changes to the safety of patients and staff in which errors and accidents can be masked for fear of harmful impacts.

2.11 Comments on Previous Studies

Hospitals have been very interested in the issue of JCI accreditation and its proper implementation that ensures that the objectives are met efficiently and effectively. As a result, the researchers sought to identify the degree to which it was carried out in hospitals, and to determine its impact upon hospitals and on the quality of the services provided by hospitals. This study highlighted so many previous studies carried out at regional and international level on a JCIA for the identification of the intersections and conflicts. At the international level, studies have addressed the JCIA from several perspectives, including the implementation of the JCIA and the effect on healthcare quality, as well as determining factors that influence nurses' perceptions, health providers' perspectives on certification and its influence on healthcare quality.

All previous studies have unanimously agreed on the importance of joint commission international accreditation for hospitals and how its proper implementation aids in the achievement of the hospital's goals and quality plan, as well as the desired results.

The current study differs from previous studies in that it was conducted on the first two hospitals that obtained the accreditation of the JCI in the West Bank, in Palestine. The current study is also distinguished as the first study that addresses the perception of nursing towards the influence of JCIA on quality of health care in IAH and NNUH.

The current study is similar to the majority of previous studies in that it dealt with the issue of the perception of nursing towards the influence of JCI accreditation on quality of health care. It is similar to some previous studies in its selection of the study sample and its methodology, namely, (Yildiz et al., 2014) and (Al-Ishaq, 2009).

The researcher benefited from reviewing previous studies related to the issue of perception of nursing towards the influence of JCIA on quality of health care, preparing literature reviews for study, determining the research variables that constitute the dimensions of health service quality and how each study addresses these dimensions, as well as selecting the study sample and designing its tools.

Chapter Three: Research Methodology

3.1 Overview

The methodology is discussed in this chapter. In particular, it identifies the approach of research, identifies the population and study sample, selects the method for data collection, and describes the research instrument. In addition, operating variables are assessed for validity and reliability, statistical analysis techniques are outlined and some ethical problems finally highlighted.

3.2 Research Approach

As stated previously, the aim of this study is to determine nurses' perceptions of the JCIA's influence on the quality of health care at IAH and NNUH. In general, researchers could perform qualitative, quantitative or mixed studies. When collected data is explorative in nature, the first approach is adopted. This type of research produces data from interviewees' answers or responses to open-ended questionnaires, observations or secondary sources. Quantitative research, on the other hand, is carried out by developing theories and formulating hypotheses regarding the phenomena of interest.

This kind of research uses structured questionnaires to collect data (Sekaran and Bougie, 2016). Mixed studies take qualitative as well as quantitative approaches.

This study is designed to produce a quantitative, descriptive electronic cross-sectional survey. Questionnaires were used to evaluate the perceptions of nursing staff on the influence of JCI accreditation on the quality of care at IAH and NNUH. This method is straightforward, easy and fast to perform and allows the researchers to simultaneously compare several different variables and test the study hypothesis.

3.3 Population of Study

Sekaran and Bougie (2016) indicated that a population is comprised of the entire range of individuals, events or matters in which the researcher is interested while the sample is a subset of the entire population. Since the purpose of the current study is to determine nurses' perceptions of the JCIA's influence on the quality of health care at IAH and NNUH, the population includes all nurses working in these two hospitals. According to the human resources departments in both hospitals, the population size is found to be 200 nurses in NNUH and 211 nurses in IAH.

3.4 Sample of Study

The population of the study is estimated to be 411 nurses at IAH and NNUH. The study sample is easily calculated for selection from the total population. In particular, the sample size required is determined using the Thompson Formula (2012).

$$n = \frac{N \times p(1-p)}{([N-1 \times (d^2 \div z^2)] + p(1-p))}$$

where:

n: Sample size.

N: Population size (411).

z: Confidence level at 95% (1.96).

d: Error proportion (5%).

p: Probability of picking a choice (50%).

As a result, by substituting in the preceding formula, it is found that simple a randomization of 199 nurses at both hospitals is required to be surveyed.

4.4 Research Instrument

A questionnaire for evaluating the effect of JCI accreditation on the quality of care was adopted in relation to validated instruments and questions used in earlier studies (Jaber, 2014) and (El-Jardali et al., 2008) and then amended by the research team in line with the expectations of nurses at both hospitals.

4.4.1. Questionnaire Design

The questionnaire consists of two sections:

4.4.1.1. First section: Demographic Data

This section contains the basic needed demographic data which are: gender, age, academic qualification, position, training related quality , hospitals , years of experience.

4.4.1.2 Second Section: Quality Principles and JCI

The part comprises 36 issues split into six groups, graded on a five-point Likert scale, and ranging from one to five very disagreeable issues. The dependent variables were quality outputs (5 questions), while independent variables were leadership commitment (6 questions), quality strategic planning (6 question); management of human resources

(4 questions); quality operations management (6 matters); the joint commission international accreditation : (9 questions).

Table 3.1: five-point Likert scale

Range	Descrpition of Range
1.00-1.81	Very Weak Degree
1.80-2.60	Weak Degree
2.60-3.40	Moderate Degree
3.40-4.20	Big Degree
4.21-5.00	Very Big Degree

4.4.2 Data Collection Method

Data concerning each variable in the hypotheses need to be collected after development of the study hypotheses. When collecting primary data, the most common data collection methods are observations, interviews, and questionnaires. There are three types of questionnaires: (1) self-administered questionnaires, (2) mail questionnaires, and (3) electronic questionnaires (Sekaran and Bougie, 2016).

The questionnaire instrument is used as a data collection method in this study because it is more efficient than the other methods. Specifically, questionnaires are personally-administered and electronically-distributed to nurses at IAH and NNUH. A total of 220 completed questionnaires were received within a period of approximately two month, from 25/04/2021until 25/06/2021. For further, descriptive and inferential statistical studies all these answers are valid.

Questionnaires are distributed electronically with personnel managed for five main reasons: (1) easy to manage, (2) reachable wherever possible, (3) not costly, (4) quick to deliver, and (5) Respondents are free to respond whenever they want.

4.4.3 Statistical Analysis Techniques

Of 250 distributed questionnaires, the data were examined from 220 completed questionnaires. The rate of response was 88%. Descriptive statistics as well as inferential statistics are employed to analyze the data. More specifically, descriptive statistics are used to describe organizational factors characteristics of respondents. Additionally, demographic part shows percentage of nurses who filled questionnaire based on gender, age, experience, hospital and position. These statistics are also used to assess reliability of factors.

The ANOVA and t test are used to test if there is difference between the means of demographic part elements. The Person Correlation Coefficient for organizational factors indicates that there is positive linear relationship between quality output and organizational factors.

In order to examine data, two statistical methods have been applied. In order to examine the initial data and analyze the descriptive thesis sample, such as means, standard deviations and frequencies, the Social Sciences Statistical Package (SPSS) version 25 was utilized. The testing of the structural equation model (SEM) using IBM-SPSS-Amos version 25 was done using confirmatory factor analysis (CFA). For inferential data analysis, structural equation modeling (SEM) was used.

SEM is defined as “a family of statistical models that attempt to explain the relationships between multiple variables” (Hair et al., 2006, p. 711). SEM has the following advantages: “(1) estimation of multiple and interrelated dependence relationships, and (2) the ability to represent unobserved concepts in these relationships and account for measurement error in the estimation process” (Hair et al., 1998, p. 584).

In other words, SEM has conducted several independent multiple regressions simultaneously which suggest the determination of direct and indirect effects. A series of separate multiple regression tests were required to be carried out based on “theory, prior experience, and the research objectives to distinguish which independent variables predict which dependent variable” (Hair et al., 1998, p. 584). SEM was chosen over multiple regression and ANOVA for a variety of reasons (Hair et al., 2006): To begin with, these multivariate statistical techniques only evaluate single relationships. Second, unlike these techniques, SEM takes into account measurement error. Finally, using model fit indices, SEM can determine the overall model fit. The maximum probability estimate method was employed when the sample is between 200 and 400 since it is regarded a "moderately robust" method of estimating the infringement of normality (Hair et al., 2006).

4.4.4 Validity of Questionnaire

The validity of the questionnaire entails ensuring that it will measure what it was designed to measure, that it includes all of the elements that must be included in the analysis, and that its paragraphs are clear enough for everyone who uses it.

I. Judging the Tool

The researcher confirmed the questionnaire's validity as follows:

The questionnaire was presented to agroup of arbitrators made up of seven faculty members from Arab American University, An-Najah National University, Al-Quds Open University, Hebron University, and Al-Quds University who are experts in quality, nursing, medicine, industrial engineering, and finance. Some changes were proposed, and the questionnaire in its final version was appended to the thesis appendix (A&B).

II. Structure Validity of the Questionnaire:

The questionnaire's validity constructor was checked using two measures, namely the convergent validity Assessment and the discriminant validity Assessment, and all of the questionnaire statements were connected and important, as indicated in Tables (4.18) and (4.19) in Chapter 4.

4.4.5 Reliability Analysis

The researcher did the stability test by applying Cronbach's alpha coefficient and Convergent Reliability to each area of the questionnaire.

Cronbach's Alpha and Convergent Reliability were both greater than 0.8 for each component, indicating that the complete questionnaire was very reliable, as shown in the table (4.22) and (4.23) in chapter 4.

3.10 Ethical Issues

Regarding this study, there are five ethical issues that deserve mention. First, the two hospitals' administrations were contacted, and it was agreed to distribute questionnaires to the nurses. The respondents were also informed of the study's aim on the questionnaire's cover page. In addition, the information submitted by the respondents is kept totally private. Furthermore, there is no willful misrepresentation of the data. Finally, there is no potential for a conflict of interest between this research and any other**.**

Chapter Four: Data Analysis and Discussion

4.1 Overview

The methodology used for this study was described in the previous chapter. The statistical analysis results, as well as their discussion are presented in this chapter. The following topics are covered in detail: sample characteristics, descriptive statistics for study variables, analysis of variance, validity and reliability tests, and hypotheses testing using SEM and Confirmatory Factor Analysis (CFA).

4.2 Demographic Characteristics

This section presents and discusses in a descriptive way, demographic characteristics in terms of their gender, age, experience, educational level, hospital, training and position.

Table 4.2: Demographic Characteristics

		Frequency	Percent
Gender	*Male*	96	43.6%
	Female	124	56.4%
Age	*Less than 20*	5	2.3%
	20-25 years	92	41.8%

	26-30 Years	92	41.8%
	31-35 Years	23	10.5%
	More than 35	8	3.6%
Experience	*Less than 5 years*	135	61.4%
	5 years – less than 10 years	64	29.1%
	More than 10 years	21	9.5%
Education	Diploma degree	32	14.5%
	BA (Sc.) degree	170	77.3%
	Postgraduate studies degree	18	8.2%
Hospital	NNUH	115	52.3%
	IAH	105	47.7%
Position	Practical nurse	51	23.2%
	staff nurse	129	58.6%
	Head nurse	17	7.7%
	others	23	10.5%
Training	*1= yes*	139	63.2%
	2 = no	79	36.8%

Table 4.3 shows descriptive statistics of demographic characteristics. The results indicate that 43.6% of respondents are males, while the remaining 56.4% of them are females. With respect to age groups, 2.3% of respondents are 20 years or less, 41.8% are between 20 and 25 years, 41.8% are between 26 and 30 years, 10.5% are between 31and 35 years, and 3.6 % are over 35 years. As for the experience, less than 5 years represents 61.4%, 5 years to less than ten years represents 29.1%, and more than 10 years represents 9.5%. In terms of educational level, 10.5% hold diploma degree, 77.3 % hold BA (Sc.) degree, 8.2% hold postgraduate studies degree. Regarding the hospital in which nurses' work, 52.3% work in NNUH and 47.7% work in IAH. As for status or job title, 23.2% are of practical nurses, 58.6% of staff nurses, 7.7% of head nurses

and 10.5% of others. As for the training of nurses, 63.2% were trained, representing No. 1, while 36.8% were not trained, representing No. **2.** The majority of participants (56.4%) were female, which may be based on the premise that 56% of nurses at both hospitals are female. The majority of participants (83.6%) were between the ages of 20 and 30, with 10.5 % older than 30. The majority of participants (61.5%) had less than 5 years of experience. This result could be explained as follows: First, both hospitals offer fresh graduates' prospects for recruitment. Second, health care workers with long years of hospital experience choose employment with morning shifts in public hospital clinics and medical centers that avoid shifts at night. Thirdly, experienced nurses have better job options abroad or in nursing and training.

The majority (77.3 %) received bachelor degrees and approximately (8.2 %) completed their postgraduate education. The study shows that (58,6%) of nurses are staff nurses, (23,2%) are practical nurses with diploma, (7,7%) are head nurses and (10,5%) are other nurses. Because both hospitals are highly-specialized hospitals that demand skilled and competent nurses to provide high-quality health care and services, this result is related to the hospital's strategy of employing nurses with at least a bachelor's degree. The majority of nurses at both hospitals, on the other hand, are graduates of local universities such as Bethlehem University, Al-Quds University, Hebron University, and Al-Najah University, where nursing programs are offered. Quality training was received by approximately 63.2 %of respondents, indicating that the both hospitals invested heavily in nursing education, training, and quality of care. According to Katoue et al (2021), staff training and education is a key indicator of effective human resource management and is connected with considerable increases in care quality. Agustine (2019) discovered that JCI accreditation had a positive impact on providing

nurses with training and continuing education, which is essential for developing their competencies and improving their quality performance.

4.3 Assessment of the Normality

To determine normality, scale data were evaluated after missing data were replaced with variable means (Coakes, 2006). Variables must be normally-distributed because factor analysis and structural equation modelling both assume this (Hair et al., 1995; Tabachnick and Fidell, 2001, Kline, 2005).

For the initial diagnosis of the distribution of variables boxes and whiskers as well as steam and leaf plots were utilized to examine outliers. Outliers are defined as "observations with a different set of features which separate them from the remaining observations" (Hair et al., 1995, p.57). These outliers could have very high or extremely low scores (extreme values) and lead to non-normal information and statistical distortion (Hair et al., 1995), (Tabachnick and Fidell, 2001). As extreme values represented less than 5 percent of the data, the changing scores method used by Tabachnick and Fidell were (2001). Extreme values were recoded (modified) to their nearest values in this circumstance (up or down).

A number of methods can be employed to check any genuine differences from normality. Skewness and kurtosis are one way. If the distribution observed is absolutely normal, skewness and kurtosis numbers should not be important when using this method. In large samples of 200 or more, even modest deviations from standard conditions may be meaningful but not substantial (Hair et al., 1995). "In a broad sample, the statistically significant variable of skewing and kurtosis is often not sufficiently different from normal in the analysis" (Tabachnick and Fidell .2001, p. 74). The

absolute skewness and kurtosis values must be examined; however, this method is more suitable for small samples. An example is that a value above 10.0 in the kurtosis index could suggest a problem, whereas a value more than 20.0 could indicate a more severe condition. (Switzerland, 2005). It is therefore advisable to limit absolute values of skewness and kurtosis to 3 and 10 each. With the help of SPSS, skewness and kurtosis were inspected (see Table 4.3), Univariate normality indicator. The final descriptive statistics for the items utilized in this thesis are also provided in Table.2.

While analyzing skewness and kurtosis values was useful, it is advised that for larger sample sizes, visually assessing normal probability plots be used (Hair et al., 1995). The values gathered around the straight line in these probability plots suggested that there was no substantial deviation from normalcy. Because the variables were normal, there was no need to modify the data (Tabachnick and Fidell, 2001). To ensure the data is scattered as normal distribution, normality testing should be performed (Coakes and Steed, 2007). Curran et al. (1996) stated that univariate normality will be achieved if the skewness coefficient is within ± 2.0 and kurtosis is within ± 7.0 range. Awang (2012, 2015) suggested that the skewness coefficient should be within the range of -1.0 to 1.0, to state that the tested data is normally distributed according Table 4.3.

Table 4.3: Measures of the Constructs and Descriptive Statistics

Statements	N	Minimum	Maximum	Mean	Std. Deviation	Skewness	Std. Error	Kurtosis	Std. Error
Quality_output1	220	1	5	2.17	0.945	0.960	0.164	0.762	0.327
Quality_output2	220	1	5	2.30	1.056	0.972	0.164	0.493	0.327
Quality_output3	220	1	5	2.34	1.054	0.923	0.164	0.389	0.327
Quality_output4	220	1	5	2.28	1.123	1.018	0.164	0.424	0.327
Quality_output5	220	1	5	2.39	1.102	0.818	0.164	0.047	0.327
Leadership_co1	220	1	5	2.16	1.021	1.201	0.164	1.232	0.327
Leadership_co2	220	1	5	2.39	1.107	0.944	0.164	0.148	0.327
Leadership_co3	220	1	5	2.53	1.108	0.722	0.164	-0.150	0.327
Leadership_co4	220	1	5	2.76	1.170	0.419	0.164	-0.755	0.327
Leadership_co5	220	1	5	2.44	1.060	0.818	0.164	-0.048	0.327

Leadership_co6	220	1	5	2.50	1.083	0.794	0.164	-0.047	0.327
Quality_Planning1	220	1	5	2.25	0.875	0.634	0.164	0.205	0.327
Quality_Planning2	220	1	5	2.35	1.008	0.945	0.164	0.607	0.327
Quality_Planning3	220	1	5	2.75	1.161	0.376	0.164	-0.807	0.327
Quality_Planning4	220	1	5	2.70	1.098	0.566	0.164	-0.560	0.327
Quality_Planning5	220	1	5	2.49	1.045	0.728	0.164	0.080	0.327
Quality_Planning6	220	1	5	2.51	1.079	0.735	0.164	-0.055	0.327
HR_Utilization1	220	1	5	2.30	1.039	1.012	0.164	0.541	0.327
HR_Utilization2	220	1	5	2.61	1.163	0.822	0.164	-0.213	0.327
HR_Utilization3	220	1	5	2.56	1.155	0.696	0.164	-0.345	0.327
HR_Utilization4	220	1	5	2.67	1.206	0.495	0.164	-0.703	0.327
Q_Management1	220	1	5	2.35	0.952	0.937	0.164	0.829	0.327
Q_Management2	220	1	5	2.45	1.069	0.867	0.164	0.139	0.327
Q_Management3	220	1	5	2.46	1.091	0.807	0.164	0.004	0.327
Q_Management4	220	1	5	2.44	1.016	0.741	0.164	0.120	0.327
Q_Management5	220	1	5	2.32	1.002	1.005	0.164	0.797	0.327
Q_Management6	220	1	5	2.50	1.062	0.889	0.164	0.212	0.327
JCI1	220	1	5	2.55	1.086	0.561	0.164	-0.343	0.327
JCI2	220	1	5	2.65	1.107	0.718	0.164	-0.286	0.327
JCI3	220	1	5	2.78	1.167	0.530	0.164	-0.705	0.327
JCI4	220	1	5	2.65	1.086	0.668	0.164	-0.271	0.327
JCI5	220	1	5	2.76	1.115	0.468	0.164	-0.487	0.327
JCI6	220	1	5	2.70	1.094	0.408	0.164	-0.482	0.327
JCI7	220	1	5	2.70	1.114	0.425	0.164	-0.708	0.327
JCI8	220	1	5	2.78	1.069	0.500	0.164	-0.479	0.327
JCI9	220	1	5	2.65	1.039	0.580	0.164	-0.404	0.327

4.4 Quality Results as Perceived by Nurses

The nursing perceptions of care quality were measured using descriptive statistics and frequency, mean, standard deviation and the average score percentage for each item in every domain were calculated, followed by the general score and a mean score percentage for each domain. The perceptions of nursing participants were sorted into three categories, positive, neutral and negative, on the basis of the percentage of answers. Positive, neutral, and negative perception are defined as follows:

1. Positive perception: According to the Healthcare Research and Quality Agency, a positive perception is the percentage of answers (Strongly agreed) to positive formulations and is deemed to be a strength where the percentage is larger than 70%.

2. Neutral perception: the percentage of neutral responses for all items or when the percentage is between 50% and 70%.

3. Negative perception: According to the Healthcare Research and Quality Agency, a positive perception is the percentage of answers (Strongly disagreed) to positive formulations and is deemed to be a strength where the percentage is lower than 50%.

Table 4.4: Quality outputs domain: The influence of accreditation on quality of care as perceived by nurses at IAH and NNUH, the statement represents the quality outputs 1 to 5 questions about the quality output domain.

Statement	Mean	PMS (Percentage of mean)	Standard deviation
Quality_output1	2.17	43.2%	0.945
Quality_output2	2.30	46%	1.056
Quality_output3	2.34	46.8%	1.054
Quality_output4	2.28	45.6%	1.123
Quality_output5	2.39	47.8%	1.102
Total score	11.48/5 =2.29	45.9 %	

The total value of the quality domain is, according to Table 4.4 (2.29) and the influence percentage is (45.9%). This shows that nurses have a negative attitude of JCI accreditation's influence on quality of care at IAH. Some of the respondents (46%) agreed, however, that in its medical, surgical, intensive care and cancer units, the IAH and NNUH continuously enhanced the quality of the care they gave to patients. About (45.6 %) of the participants agreed to enhance patient satisfaction via certification, while (46%) of respondents believed that accreditation enhanced other services,

including as lab, pharmacy and radiology, (43%) agreed that accreditation improved administration services. The substantial proportion of responders (47.8%) agreed that training in international quality standards was conducted by the team.

The results of these studies are in agreement with those of Emel et al (2020), who discovered that quality control systems like JCI accreditation had a negative impact on the quality of patient treatment. This could be interpreted as follows: First of all, there was an excellent quality system in place for investment in nursing education and development at both hospitals. Second, both hospitals have an educational department which monitors training courses, but either this department does not do its job properly, or its employees are negligent and do not deserve that job. Third, there is no fair system between the nurses and the officials, giving them the impression that their efforts are not appreciated.

4.5 Leadership Commitment Domain

In this respect, nurses were asked if there is a clear vision and leadership of the quality of treatment and service given in hospitals. As the motive force behind improving quality, caregivers were asked to estimate the top management of such operations and to evaluate the engagement of caregivers. The nurses were asked about change management actions based on suggestions and findings of accreditation.

Table 4.5: The nurses' perception of leadership commitment to quality at IAH and NNUH, the statement represents the leadership 1 to 6 questions about the leadership commitment domain.

Statement	Mean	PMS (Percentage of mean)	Standard deviation
Leadership_co1	2.16	43.2%	1.021
Leadership_co2	2.39	47.8%	1.107

Leadership_co3	2.53	50%	1.108
Leadership_co4	2.76	54%	1.170
Leadership_co5	2.44	48.8%	1.060
Leadership_co6	2.50	50%	1.083
Total score	14.78/6 =2.46	49.2 %	

The overall score of the negative responses is (2.46) and the percentage is according to Table 4.5 is (49.2%). This suggests that nurses are not aware of their commitment to leadership in hospital management to provide the appropriate working atmosphere and supportive environment that improves the quality of services and care at hospitals. The largest percentage (50 %) was linked to a clear vision by the hospital management for improving care and services quality in hospitals. The lowest percentage (43.2%) has been linked with the declaration on the management of human, physical or financial resources in hospitals in order to improve the quality of care which is regarded as a field in which hospital management needs improvements and corrections.

The findings show that nurses have a negative perception of the hospital administration leadership's commitment to providing an environment that improves the quality of health care provided to patients. This can be explained as follows: First, the hospital administration is more concerned with administrative issues than with other such as the quality health care. Second, not allocating sufficient funds to improve the quality of health care provided to patients. Third, there is no clear incentive system in place to reward employees for their participation and efforts in improving quality, giving them the impression that their efforts are not appreciated. Fourthly, the lack of senior management support for leadership, as specified by the Joint Commission (2017), highlighted that the process of accreditation was influenced by support for top management and considered leadership to be a crucial component of JCI accreditation.

4.6 Strategic Quality Planning Domain

In this area, nurses were questioned if they had sufficient time to plan for improvements in quality and how they worked to build plans to achieve these goals.

Table 4.6: The nurses' perception of the strategic quality planning for quality at IAH and NNUH, the statement represents the quality planning 1 to 6 questions about the strategic quality planning domain.

Statement	Mean	PMS (Percentage of mean)	Standard deviation
Quality_Planning1	2.25	45%	0.875
Quality_Planning2	2.35	47%	1.008
Quality_Planning3	2.75	55%	1.161
Quality_Planning4	2.70	54%	1.098
Quality_Planning5	2.49	50%	1.045
Quality_Planning6	2.51	50%	1.079
Total score	15/6= 2.5	50%	

According to Table 4.6, the overall score is (2.5), and the percentage is (50%). This suggests that nurses at both hospitals have a neutral perception toward strategic quality planning. The statements about nursing involvement in developing quality improvement plans and the hospital's quality improvement goals received the highest percentages (55%). The hospital has a clear strategy to improve the quality of medical services, according to the lowest percentage (45 %).

According to the findings, nurses in both hospitals have a neutral perception toward the quality planning strategy. This can be explained as follows: First, in both hospitals, there is a special department for quality assurance. Second, many nursing staff members lack experience and knowledge of quality standards. Third, there is no system in place

that allows nurses to participate in the development of quality improvement plans, giving them the impression that their efforts are not appreciated.

4.7 Human Resources Utilization Domain

In this area, nurses were asked whether they were continuously trained and trained to improve their abilities and performance.

Table 4.7: The nurses' perception of human resources utilizations for quality at IAH and NNUH, the statement represents HR_Utilization 1 to 4 questions about the human resources utilization domain.

Statement	Mean	PMS (Percentage of mean)	Standard deviation
HR_Utilization1	2.30	46%	1.039
HR_Utilization2	2.61	52%	1.163
HR_Utilization3	2.56	51.2%	1.155
HR_Utilization4	2.67	53.4%	1.206
Total score	10.14/4 = 2.53	50.7%	

Table 4.7 shows that the total value is (2.53) and that the percentage is (50.7%). This shows that nursing workers have a neutral perception of the use of human resources. The lower percentage (46%) in that nursing staff have the training and training needed to improve their quality skills, the greatest percentage (46%) of which is the effectiveness of the hospital system for nurses to submit management advice on improving quality.

The findings indicate that nurses in IAH and NNUH have a neutral attitude toward the use of human resources. This can be explained as follows: First, both hospitals have a high-quality system for investing in nurse education and development. Second, officials lack experience and knowledge of international quality standards. Third, there is no complaint and suggestions box to help improve quality. Fourth, there is insufficient

nursing staff to meet the needs of patients. Fifth, the non-disbursement of financial competencies for ideal nurses.

4.8 Quality Management Domain

In this area, nurses were questioned whether their hospital at IAH and NNUH saw quality as a continual search of techniques for improved and successful quality improvement policies and processes.

Table 4.8: The nurses' perception of quality management to quality at IAH and NNUH, the statement represents Q_Management 1 to 6 questions about the quality management domain.

Statement	Mean	PMS (Percentage of mean)	Standard deviation
Q_Management1	2.35	47%	0.937
Q_Management2	2.45	49%	0.867
Q_Management3	2.46	49.2%	0.807
Q_Management4	2.44	48.8%	0.741
Q_Management5	2.32	46.4%	1.005
Q_Management6	2.50	50%	0.889
Total score	14.52/6 =2.42	48.4%	

According to Table 4.8, most interviewees disagreed with the fact that the hospital considers quality as an ongoing quest for improvements and has effective policies and processes to support this progress in quality. In general, the percentage of adverse reaction results are (2.42), which indicate that nurses in the IAH and NNUH have a negative perception of quality management.

According to the findings, nurses at both hospitals have a negative attitude toward quality management. This can be explained as follows: First, both hospitals have a department for quality management and monitoring of quality issues. Second, officials lack experience and knowledge of international hospital quality standards. Third, there has been little progress in scientific research on quality and its application in hospitals.

Fourth, the procedures for gaining access to the administration by the nurse are difficult and time-consuming. Fifth, there is racial discrimination between the nurse and the official.

4.9 The Joint Commission International Accreditation (JCIA) Domain

Table 4.9: The nurses' perception of JCIA to quality at IAH and NNUH, the statement represents JCI 1 to 9 questions about The Joint Commission International Accreditation domain

Statement	Mean	PMS (Percentage of mean)	Standard deviation
JCI1	2.55	51%	1.086
JCI2	2.65	53%	1.107
JCI3	2.78	55.6%	1.167
JCI4	2.65	53%	1.086
JCI5	2.76	55.2%	1.115
JCI6	2.70	54%	1.094
JCI7	2.70	54%	1.114
JCI8	2.78	55.6%	1.069
JCI9	2.65	53%	1.039
Total score	24.2/9= 2.68	53.8%	

Table 4.9 showed that nurses had a neutral opinion of JCI accreditation at both hospitals this is shown in the total score of (2.68). (53.8%). The majority of the nurses (55.6 %), because the last survey (JCI examination) and certify allow the hospital to respond better to the population's requirements, have agreed to act on recommendations made to your hospital. Although (55.2 %) of neutral nurses believed that the accreditation will assist improve teamwork, collaboration and efficient internal resource management, the lower percentage (51%) prepared for JCI accreditation, a major change was implemented in the hospital.

The results show that the nurses at both hospitals have a neutral view of their participation in the preparation and implementation of JCI accredited treatment, as recommended by the JCI survey, and that a number of changes have been carried out at the hospital. These findings are consistent with the conclusion of Manzo et al. (2012), who claimed that the nurse plays an essential role and has unique capabilities as a member of a team, which assists the health organization with the process of accreditation implementation and monitoring. Nursing measures, commitment and support therefore have an impact on the accreditation procedure.

4.10 Influence of Demographic Variables on Perception of Nurses

The ANOVA test was employed to examine whether the perception of JCI accreditation on the quality of care depends on demographic parameters such as gender, age and years of expertise, education level, the hospital and training in nurses differed significantly.

Table 4.10: One-Way ANOVA comparing the nurses' perception towards the influence of JCI accreditation on the quality of care according to age

Experience		Sum of Squares	df	Mean Square	F	Sig.
Quality output	Between Groups	29.275	4	7.319	0.425	0.791
	Within Groups	3705.561	215	17.235		
	Total	3734.836	219			

Table 4.10 shows that there is the significance value is 0.791, which is greater than 0.05 and therefore, we conclude that there is not a statistically significant difference between means of age. Hence, the null hypothesis cannot be rejected.

Table 4.11: One-Way ANOVA comparing the nurses' perception towards the influence of JCI accreditation on the quality of care according to experience .

Experience		Sum of Squares	df	Mean Square	F	Sig.
Quality output	Between Groups	9.466	2	4.733	0.276	0.759
	Within Groups	3725.370	217	17.168		
	Total	3734.836	219			

Table 4.11 shows that there is the significance value is 0.759, which is greater than 0.05 and therefore, we conclude that there is not a statistically significant difference between means of experience. Hence, the null hypothesis cannot be rejected.

Table 4.12: One-Way ANOVA comparing the nurses' perception towards the influence of JCI accreditation on the quality of care according to education

Education		Sum of Squares	df	Mean Square	F	Sig.
Quality output	Between Groups	7.517	2	3.759	0.219	0.804
	Within Groups	3727.319	217	17.177		
	Total	3734.836	219			

Table 4.12 shows that there is the significance value is 0.804, which is greater than 0.05 and therefore, we conclude that there is not a statistically significant difference between means of education. Hence, the null hypothesis cannot be rejected.

Table 4.13: One-Way ANOVA comparing the nurses' perception towards the influence of JCI accreditation on the quality of care according to position**.**

Position	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	32.726	3	10.909	0.636	0.592
Within Groups	3702.110	216	17.139		
Total	3734.836	219			

Table 4.13 shows that there is the significance value is 0.592, which is greater than 0.05 and therefore, we conclude that there is not a statistically significant difference between means of education. Hence, the null hypothesis cannot be rejected.

Table 4.14: One-Way ANOVA comparing the nurses' perception towards the influence of JCI accreditation on the quality of care according to age on Gender, Hospital and Training .

Variable	t	df	Sig. (2-tailed)
Gender	-0.210	218	0.834
Hospital	-2.732	218	0.007
Training	-4.759	216	0.000

It can be observed from Table 4.14 that for gender's variable, P-value is 0.834 greater than 0.05 and therefore there is no a statistically difference between means of gender. Additionally, for the hospital variable, P-value is 0.007 less than 0.05 so there is a statistically difference between means of hospital. Finally, the variable training has a P-value of 0.000 which is less than 0.05 and it can be concluded that there is a statistically significant between means of training.

According to the finding, the relationship between demographic variables (gender, age, years of experience, educational level and position) and nursing perceptions of the influence of the JCI accreditation on health quality at both hospitals was not statistically significant. The results show that the hospital created an education system and raised knowledge of the JCI and quality programmer, which all nurses, regardless of their

background, were targeted. These findings are consistent with Jaber (2014), whose demographic data showed no significant link between the nurses at Saudi Arabia-accredited hospitals.

It is also consistent with Al-Qahtani's (2012) findings, which indicated no significant association between gender, degree of education, and position. However, they contradict Al- Qahtani's findings, which were related to age and years of experience and proven to have an impact on nurses' judgments of quality.

The findings show a statistically significant relationship between demographic variables (training, hospital) and nurses' perceptions of the influence of JCI accreditation on care quality at both hospitals. The following is how the results can be interpreted: First, both hospitals have an excellent educational system in place where nurses are trained on a regular basis and quality-related courses are held. Second, the nature of work in the hospital for the nurse is safe, which boosts the nurse's confidence in himself to innovate and develop in his field of work.

4.11 Influence of Organizational Variables on Nursing Perceptions

The strength of the association between two variables is assessed using correlation coefficients. The coefficient of Pearson is the most popular sort of coefficient of correlation. The correlation of Pearson (sometimes known as the R of Pearson) is a correlation coefficient commonly used in linear regression. A Pearson correlation study investigated the connection between independent and dependent variables.

Table 4.15: Relationship between Quality output and organizational factors

Pearson Correlation	r
Leadership Commitment	.464**
Strategic Quality Planning	.431**
Human Resources Utilization	.274**
Quality Management	.405**
JCI	.316**

**. Correlation is significant at the 0.01 level (2-tailed).

The positive relationship between care quality and the organizational factors showed up as shown in Table 4.15: leadership, commitment (r = 0.464), strategic quality planning (r = 0.431), quality management (r = 0.405), human resources (r = 0.274), JCI (r = 0.361), as seen by both hospitals 'nurses.

4.12.1 Measurement Model Assessment

This section describes the procedures used to assess the validity and reliability of the constructs as well as the model fit indices. To account for construct validity, an exploratory factor analysis (EFA) was first performed on SPSS 24.0, followed by a CFA. In terms of reliability, Cronbach's alpha and composite reliability were calculated to assess the internal consistency of the measures used in the study.

4.12.1.1 Validity Assessment

In order to determine the building validity there was an EFA test carried out on all items of the questionnaire. Construction validity relates to the degree to be shown by the item actions of a particular building (Cavana et al., 2001).

For a validity assessment of a construction, convergent validity or discriminatory validity may be used. On the one hand, convergent validity indicates a high relationship between the scale elements employed to measure a certain building. On the other hand,

discriminatory validity means that the articles used for measuring distinct buildings do not have a link (Cooper and Schindler, 2003).

Validity is the degree to which the variable proposed is measured by the designed instrument. To put it another way, validity refers to whether the study tool measures the correct notion (Sekaran and Bougie, 2016). According to Sekaran and Bougie (2016), the three types of validity to test the goodness of the measuring instrument are content, criterion, and construct validity. The first one is the biggest of all.

The intent validity of a measuring instrument ensures that it contains enough and representative dimensions and items to capture the variable. In this context, the higher the content validity, the more dimensions and items that tap the variable to be measured. A panel of expert judges can confirm the measuring instrument's content validity.

Seven professional judges assessed the research instrument in terms of content, wording, form, and sequence of questions in order to ascertain the validity of the instrument. Based on their feedback, the appropriate modifications were implemented.

4.12.1.1.1 Convergent Validity Assessment

Factor analyses are statistical methods used to examine the convergent validity of a study structure. The Kaiser–Meyer–Olkin sample adequacy measurement (KMO) was used to determine the suits of the sample size before factor analysis was performed (Kaiser, 1974). KMO test scores vary between 0 and 1.

The bigger the sample size, the closer is the outcome. This will lead to more consistent outcomes from the factor analysis. As Kaiser (1974) notes, if the KMO value is greater than 0, sample size should be accepted. Hutcheson (1999) recommends that the value from 0.5 to 0.7 is fine while the value from the mid-range is good, while the value from the center of the range is great and from the top range almost ideal.

Also consideration must be given to Bartlett's Sphericity test. This test determines if the study population's correlation matrix is significantly different from an identity matrix with zero covariance and coffee coefficients (Bartlett, 1954).

When the test is significant, this suggests that the study matrix differs considerably from the study matrix, which is beneficial because the variables of the study intended to evaluate a common phenomenon should be correlated to certain extent. The importance of the Bartlett test shows that an investigation of the running factor is appropriate. The KMO test is used to assess the sample adequacy of the data to be utilized to analyze the factor. Furthermore, we may use the KMO test to check that the data we have can be used for a factor analysis. In Table 4.16, the data set will be suitable for factor analysis, as the value of the test = 0.915.

Table 4.16: KMO and Bartlett's Test

KMO and Bartlett's Test		
Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		0.915
Bartlett's Test of Sphericity	Approx. Chi-Square	4550.044
	df	630
	Sig.	0.000

Table 4.16 the P-value of the Sphericity test by Bartlett is less than 0.05, which suggests the correlation matrix as a matrix of identity that is significantly differing in its form.

Table 4.17: Total Variance Explained

	Initial Eigenvalues		
Component	Total	% of Variance	Cumulative %
Quality Output	11.983	33.286	33.286
Leadership Commitment	3.155	8.764	42.050
Quality Planning	2.470	6.860	48.910
Human Resources Utilization	2.343	6.509	55.419
Quality Management	1.654	4.594	60.013
JCI	1.343	3.730	63.743

Table 4.17 displays the unique values of the six components derived from the factor analysis and the total variance explained. These 6 components account for approximately 63.743% of the variance.

The factors are rotated, which is important for interpreting the outcomes of the analysis and making them easier to interpret. Rotation causes it to be distinct items as explained or predicted by different underlying factors, and each component explains more than one item. The analysis has sorted the numerous questions into distinct groups of things, and the items are sorted based on the items with the highest factor loading. In general, the item contains loading from all factors, however we asked that the analysis of factor loadings less than 0.50 be omitted from the report. The researchers should investigate and designate the contents of grouped items that include high factor loads from each component. Table 4.18 presents the factor loadings.

Table 4.18: Factor loadings and uniqueness

Items	Factor loadings	Uniqueness
Quality_output1	0.705	0.366
Quality_output2	0.762	0.289
Quality_output3	0.776	0.367
Quality_output4	0.718	0.399

Quality_output5				0.631		0.420
Leadership_co1			0.641			0.447
Leadership_co2			0.779			0.304
Leadership_co3			0.758			0.320
Leadership_co4			0.612			0.453
Leadership_co5			0.751			0.320
Leadership_co6			0.703			0.452
Quality_Planning1		0.715				0.397
Quality_Planning2		0.746				0.359
Quality_Planning3		0.719				0.372
Quality_Planning4		0.779				0.346
Quality_Planning5		0.718				0.353
Quality_Planning6		0.717				0.397
HR_Utilization1					0.757	0.274
HR_Utilization2					0.663	0.367
HR_Utilization3					0.607	0.453
HR_Utilization4					0.628	0.365
Q_Management1		0.696				0.414
Q_Management2		0.756				0.317
Q_Management3		0.688				0.455
Q_Management4		0.768				0.275
Q_Management5		0.720				0.354
Q_Management6		0.668				0.444
JCI1	0.584					0.395
JCI2	0.759					0.360
JCI3	0.725					0.345
JCI4	0.758					0.326
JCI5	0.733					0.324
JCI6	0.742					0.338
JCI7	0.787					0.278
JCI8	0.788					0.298
JCI9	0.770					0.309

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.
a. Rotation converged in 6 iterations.
Uniqueness = (1-communalities)

All of the factor loadings are very significant and above the 0.5 criterion suggested by Jöreskog and Sörbom (1996). Table 4.18 shows the following:

1 - The first factor is divided into nine phrases that ranged between (0.584- 0.788), and accordingly this factor can be called by the name of the Joint Commission International.

2 - The second factor is divided into six expressions that ranged between (0.668-0.768), and accordingly this factor can be called the Quality Operations management.

3 - The third factor is divided into six expressions that ranged between (0.715- 0 .779), and accordingly this factor can be called quality planning.

4 - The fourth factor is divided into six expressions that ranged between (0.612- 0.779) and accordingly this factor can be called the name of leadership.

5 - The fifth factor is divided into five expressions that ranged between (0.631-0.776) and accordingly this factor can be called the name of quality output.

6 - The sixth factor is divided into four expressions that ranged between (0.607: -0.757) and therefore this factor can be called the name of human utilization.

4.12.1.1.2 Discriminant Validity Assessment

Discriminant validity can be identified in two ways: either by looking at correlation among building structures, or by comparing "the percentages of variance extracted for any two constructs to the correlation estimates square between them" (Hair et al., 2006, p. 778).

Table 4.19: Discriminant validity

#		1	2	3	4	5	6
1	**JCI**	**0.779**					
2	**Quality Planning**	0.549***	**0.739**				

3	**Quality Management**	0.543***	0.394***	**0.718**			
4	**Leadership Commitment**	0.444***	0.397***	0.431***	**0.718**		
5	**Quality Output**	0.351***	0.493***	0.478***	0.547***	**0.72**	
6	**HR Utilization**	0.667***	0.493***	0.464***	0.575***	0.347***	**0.742**

Discriminant validity of constructs, Note: †= p < 0.100; *= p < 0.050; **= p < 0.010; ***= p < 0.001

When the correlation coefficients are lower than 0.7, the distinction is proposed. In order to sustain discrimination, the latent construction is better than other latent constructs when Average Variance Extracted (AVE) values are above the highest square correlation (Fornell and Larcker, 1981). The results presented in Table 4.19 inform that the six factors had square roots of AVE: 0.779, 0.739,0.718,0.718,0.72, and 0.742. The square roots of AVE of the six factors were greater than the inter-construct correlation. Hence, we conclude that the six factors had fulfilled the criteria of discriminant validity.

Table 4.20: Discriminant validity (HTMT Approach)

#	**Factor**	**1**	**2**	**3**	**4**	**5**	**6**
1	**JCI**						
2	**Quality Planning**	0.55					
3	**Quality Management**	0.541	0.403				
4	**Leadership Commitment**	0.451	0.41	0.429			
5	**Quality Output**	0.355	0.501	0.477	0.542		
6	**HR Utilization**	0.673	0.49	0.477	0.591	0.334	

In Table 4.20 discriminant validity based on variance were listed, the mean correlation between JCI and Quality planning is 0.55, the mean correlation between quality management and JCI is 0.541 but the mean correlation value between quality

management and JCI is 0.403. The mean correlation value between leadership commitment and JCI is 0.451, while it is 0.41 between leadership commitment and quality planning but equal 0.429 between leadership and quality management. The mean correlation value between quality output and JCI is 0.355, and it is 0.501 between quality output and quality planning, 0.477 between quality output and quality management but it is 0.542 between quality output and leadership commitment. The mean correlation between HR Utilization and (JCI, quality planning, quality management, leadership commitment and quality output) are (0.673, 0.49, 0.477, 0.591 and 0.334) respectively. The recommended value for mean correlation is 0.85 as Kline (2011).

4.12.1.2 Reliability Assessment

The reliability of a measuring tool reflects how free of biases it is, and thus ensures that the tool is coherent over time and across various instruments (Sekaran and Bougie, 2016). To assess the reliability of the research variables, the Cronbach Alpha coefficient is used. The Cronbach Alpha coefficients are usually below 0.60 and less than 0.70 and are generally bad, acceptable and good. . In short, higher Cronbach Alpha coefficients demonstrate more internal consistency and so improve the instrument (Sekaran and Bougie, 2016). The reliability of a study is measured by the degree to which consistent results are achieved throughout time without substantial fluctuations in the phenomenon using the same scale. The reliability of each scale was assessed with Cronbach's alpha and composite reliability. In other words, the Cronbach alpha is an indicator of the internal consistency of a scale It indicates how tightly items on a scale are linked as a group. Interior consistency means that consistent results are obtained by using the same size on various samples to simultaneously analyze the under investigation phenomenon.

Table 4.21: Convergent Reliability

#	Factor	**CR**	**AVE**	**MSV**	**MaxR(H)**
1	**Leadership Commitment**	0.864	0.516	0.331	0.87
2	**Quality Output**	0.842	0.518	0.3	0.853
3	**Quality Planning**	0.878	0.546	0.301	0.879
4	**Quality Management**	0.864	0.516	0.295	0.874
5	**HR Utilization**	0.83	0.551	0.445	0.836
6	**JCI**	0.933	0.606	0.445	0.934

It can be observed from Table 4.21 of convergent reliability that all the values of Composite Reliability (CR) are greater than 0.8 which is the value recommended by Hair et al., (2006). Therefore, that indicates that the measurement model is reliable.

As well as, the values of Average Variance Extracted (AVE) are greater than 0.5 which indicates the reliability of a measurement model

Table 4.22: Cronbach's alpha

Factor	**Number of items**	**Alpha**
JCI	9	0.932
Quality Planning	6	0.876
Quality Management	6	0.862
Leadership Commitment	6	0.862
Human Resources Utilization	4	0.827
Quality Output	5	0.84

Cronbach's alpha is a measure of reliability or internal consistency. The values of Alpha indicate that the reliability is good because all Cronbach's alpha values are greater than 0.8. However, according to Table 4.22, the first factor JCI has an excellent Cronbach's alpha value because it is greater than 0.9.

4.12.1.3 Overall Model Assessment (Fit Indices)

When evaluating the whole model, the fit indices should be evaluated. Model fit indices are divided into three types: absolute, progressive and indices for parsimony fit.

Model Chi-Square ($\chi 2$), Root Mean Square Error (RMSEA) and GFI incorporate absolute fit indices. These include: Chi-Square ($\chi 2$) model, Root Medium Square Error (RMSEA), Root Mean Square Residual (RMR) and Standardizing Root Medium Square (RMR) model (SRMR). Three incremental fit indexes include standard fit index (NFI), non-standard fit index (NNFI) and compared fit Index (CFI). The Parsimony Fit Index (PGFI) and Parsimonious Normed Fit Index (PNFI) are included in the Parsimony Goodness-of-Fit index (PNFI). A brief description of each of the indices and their recommended cut-off values is provided in Table 4.23 below.

Table 4.23: Model of Fit Indices: Descriptions and Cut-off Values

Type	Fit Index	Description	Recommended Cut-off Value
Absolute Fit Indices	Chi-Square (X^2)	Evaluates the overall fit of the model by comparing the differences between the sample covariance matrix and the fitted covariance matrix	$p > 0.05$
	Normed-Chi-Square (X^2/df)	Evaluates the model fit after reducing the impact of large sample sizes on the model Chi-Square (X^2)	$1 < X^2/df < 3$
	RMSEA	Evaluates the degree to which the study model fits the covariance matrix of the population	< 0.08
	GFI	Evaluates the degree to which the model can replicate the covariance matrix	> 0.90
	AGFI	Similar to GFI with adjustments made based on the degrees of freedom (*df*)	> 0.90
	RMR	The square root of the difference between the residuals of the sample covariance matrix and the hypothesised covariance model	< 0.08
	SRMR	Similar to RMR but easier to interpret when the study questionnaire comprises different types of scales (e.g. scales that range from 1 to 5 and others that range from 1 to 7)	< 0.08
Incremental Fit Indices	NFI	Assesses the model by comparing X^2 of the study model to that of a null model	> 0.90
	NNFI	Similar to NNFI but provides better interpretations for models that are simple	> 0.90
	CFI	A revised version of NFI that works better when sample sizes are small	> 0.90
Parsimony Fit Indices	PGFI	An index that is based on GFI while accounting for loss of degrees of freedom. It does not work well when the model is complex.	> 0.50
	PNFI	An index that is based on NFI while accounting for loss of degrees of freedom. It does not work well when the model is complex	> 0.50

Source: **Based on Hooper, et al. (2008)**

The following values represent the final model's fit indices: $\chi 2$ = 830.026 , df = 579, $\chi 2$/df = 1.433 , p = 0.00, GFI = 0.800, AGFI = 0.826, CFI= 0.939 , NFI = 0.827, SRMR = 0.050, RMSEA = 0.044. Most models meet their cut-off criteria.. The recommended value was 0.90 lower than that of GFI and AGFI. All other fit indicators indicate that the study model matches the sample data

4.13 Confirmatory Factor Analysis (CFA)

In this study, the Confirmatory Factor Analysis (CFA) is used to validate the study constructs or measurement model, as well as to assess how well the generated items represent the underlying construct. The study therefore clarifies the problems of building validity and reliability in the CFA (Awang, 2015). In the field study, the instrument validation can be determined using the CFA method. A CFA is a method by which significant indicator variables against latent variables are found or determined

and then the dominant indicators are evaluated when the variables are studied. The study framework is presented in Figure 1. The model consists of six constructors which are JCI, Quality Planning, Quality Management, Quality Output, Leadership, and Human Resources

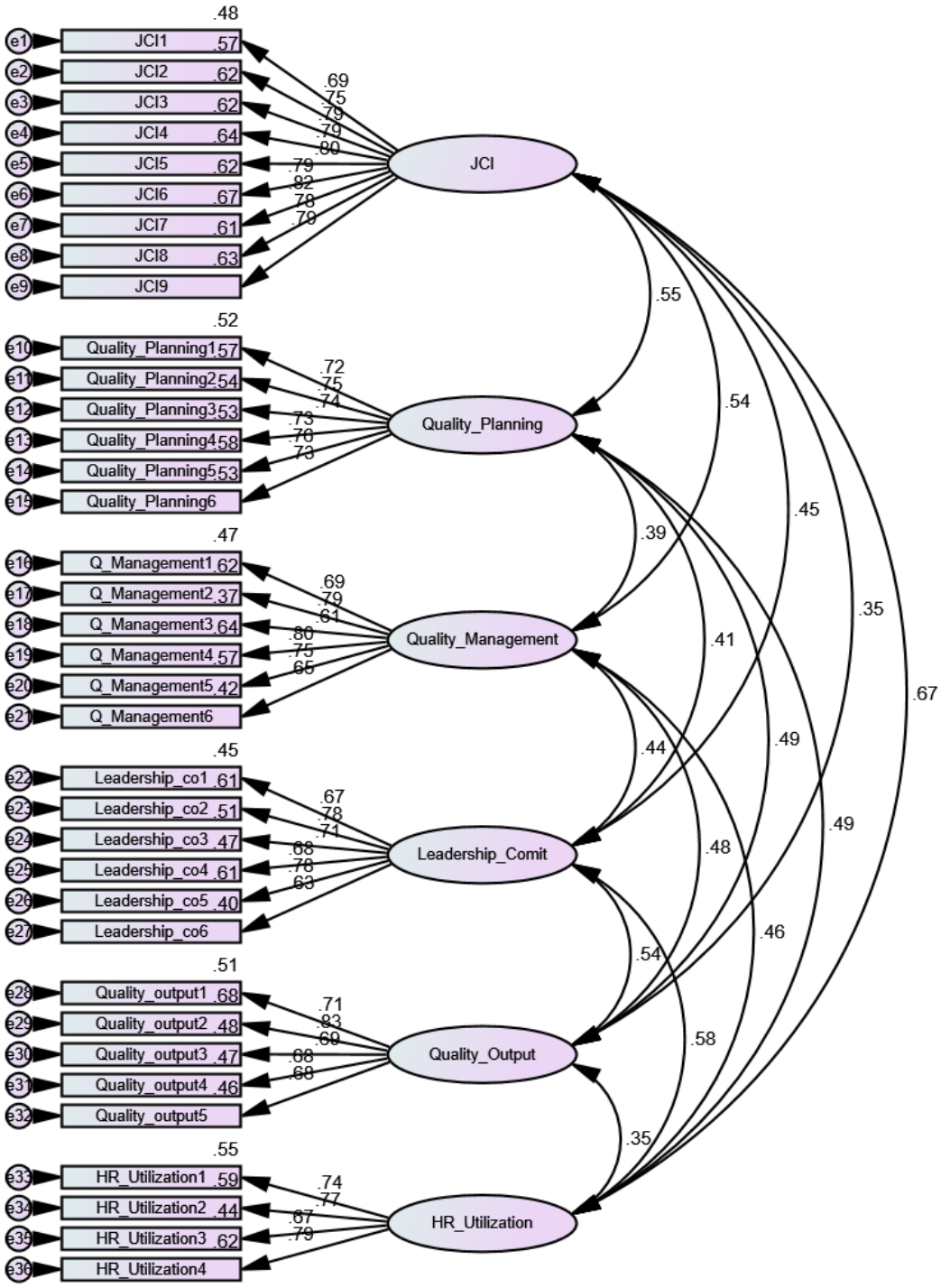

Figure 2: Research Framework illustrated in IBM-SPSS-AMOS Graphic

4.14 Structural Model Assessment and Hypotheses Testing

Structural equation modeling (SEM) is defined as "a family of statistical models that attempt to explain the relationships between multiple variables" (Hair, et al., 2006, p. 711).

The revised structural model shows satisfactory fit indices according to Table 4.24: $\chi 2 = 830.026$, df = 579, $\chi 2/df = 1.433$, p = 0.00, GFI = 0.800, AGFI = 0.826, CFI= ,939 , NFI = 0.827, SRMR = 0.050, RMSEA = 0.044 .Some of the fit indices, including GFI and AGFI, are below the acceptable values, while all of the other indices meet their cut off criteria. The structural model has therefore been accepted.

Table 4.24: Model's Fit Indices

Index	Cut off values	References	Model fit
$\chi 2$	-	-	830.026
df	-	-	579
$\chi 2/df$	-	-	1.433
p	> 0.5*	(Forza & Filippini, 1998; Awang, 2012)	0.000
GFI	> 0.8	(Baumgartner and Homburg, 1996; Doll, Xia and Torkzadeh, 1994; Forza & Filippini, 1998; Greenspoon & Saklofske, 1998)	0.800
AGFI			0.826
CFI	> 0.9	(Hair et al., 2010; Awang, 2012)	0.939
NFI	>0.8	(Forza & Filippini, 1998)	0.827
SRMR	< 0.08	(Hair et al., 2010; Awang, 2012)	0.050
RMSEA	< 0.05		0.044

* = the p value is sensitive to sample size where it is rare to find a higher p value with a high sample, therefore, it is considered satisfactory.

Figure 2 depicts the model of the structure equation for the model in terms of standardized regression weight.

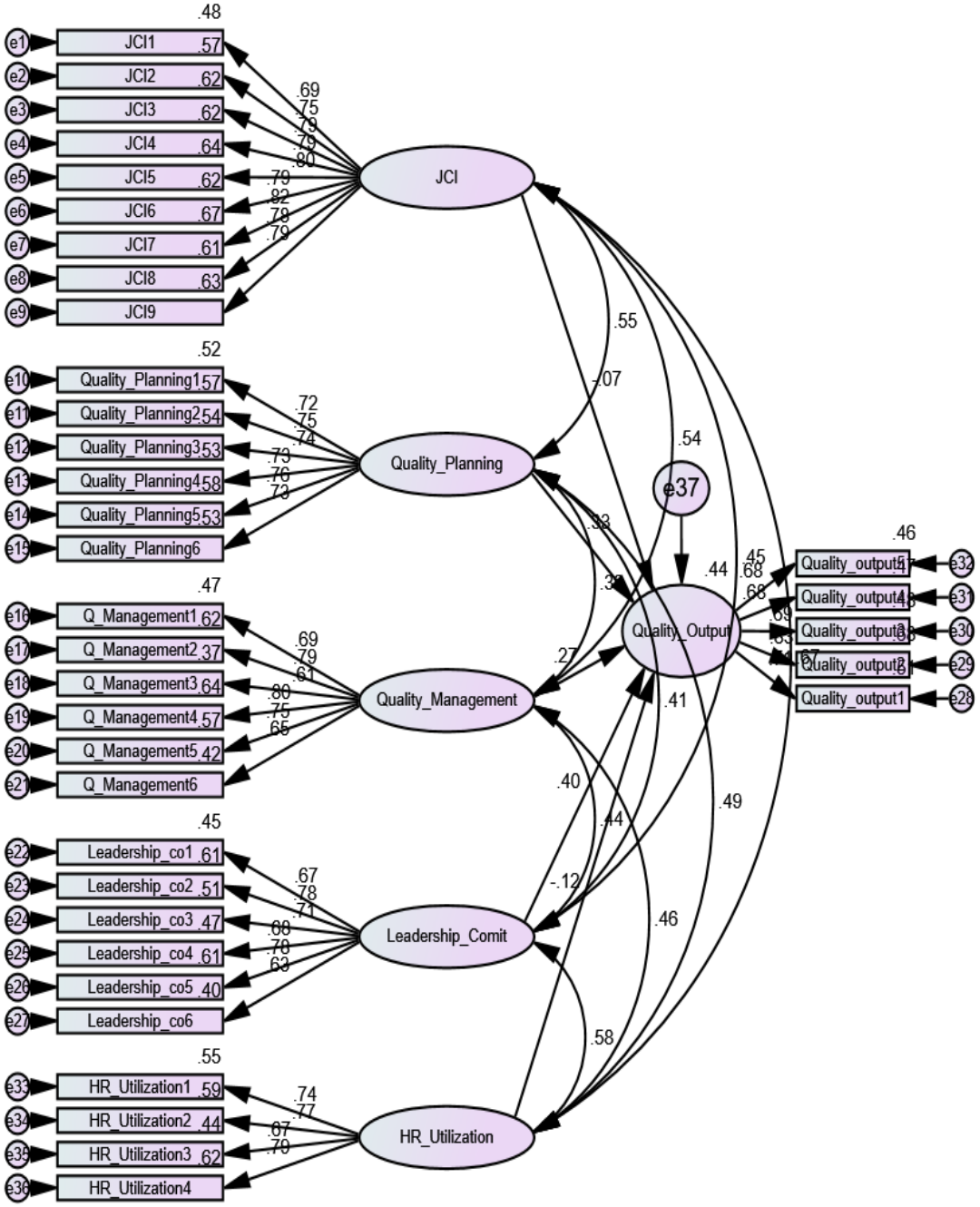

Figure 3: The model of the structure equation for the model in terms of standardized regression weight.

Table 4.25 outlines the results of sub-hypothesis testing of the third hypothesis in the study. A discussion of these results follows.

Table 4.25: Sub-hypothesis testing of the third hypothesis in the study.

Sub Hypothesis			Estimate	S.E.	C.R.	P	Decision
Quality_Output	<---	JCI	-0.065	0.091	-0.713	0.476	Unsupported
Quality_Output	<---	Quality_Planning	0.346	0.094	3.693	0.000	Supported
Quality_Output	<---	Quality_Management	0.281	0.090	3.130	0.002	Supported
Quality_Output	<---	Leadership_Comit	0.388	0.095	4.081	0.000	Supported
Quality_Output	<---	HR_Utilization	-0.108	0.097	-1.108	0.268	Unsupported

* Significant at $p < 0.05$

From above table, we conclude that the direction between JCI and Quality output should be changed to (JCI ←---- Quality output). Also the path between (HR Utilizations and Quality output) should be changed to (HR_Utilization ←--- Quality output), all the other directions are supported and on the same direction

- ✓ **Hypothesis A:**

Quality_Output <--- JCI

This hypothesis is unsupported, showing that there is no significant relationship between quality output and JCI because the P-value is greater than.05 (p= 0.476). It can be interpreted as follows: First, many nurses do not apply JCI standards in hospitals. Second, many nurses do not have sufficient knowledge of JCI standards. This finding contradicted the findings of Katoue et al (2021) and Al Shawan, (2021), who found that accreditation improves the quality of health care delivered to patients.

Hypothesis B:

Quality_Output <--- Quality_Planning

This hypothesis is supported indicating a highly significant positive relation between quality output and quality planning. (p = 0.000). This finding has supported Manzo et al (2012)'s findings, which revealed that the nurses have participated in quality improvement planning but not given sufficient time for this improvement.

- ✓ **Hypothesis C:**

Quality_Output <--- Quality_Management

This hypothesis is supported indicating a highly significant positive relation between quality output and quality management, (p = 0.002). The following can be explained: First, the hospital has a department of quality that monitors the quality system of the hospital. Secondly, in defining policies and methods for standardizing health care in the hospital, the quality committee is essential. Thirdly, there are Quality Officials and quality committees in a multidisciplinary team who monitor the adherence of the hospital to different quality measures.

Hypothesis D:

Quality_Output <--- Leadership

This hypothesis is supported indicating a highly significant positive relation between quality output and leadership. (p = 0.000). These findings are consistent with the findings of Jaber (2014), Al-Qahtani et al (2012) and El-Jardali et al (2008), who have concluded that the quality of care has a good correlation with the leadership

commitment to support of the top management and regard this variable as the best predictor of the quality of care without this commitment from the top management.

- ✓ **Hypothesis F:**

Quality_Output <--- HR-Utilizations

This hypothesis is not supported, indicating that there is no significant relation between quality output and JCI because P value above .05 (p= 0.268). This can be explained as follows: First, IAH and NNUH have a high-quality system for investing in nurse education and development. Second, officials lack experience and knowledge of international quality standards. Third, there is no complaint box to help improve quality. Fourth, there is insufficient nursing staff to meet the needs of patients. Fifth, the non-disbursement of financial competencies for ideal nurses.

Chapter Five: Conclusions and Recommendations

5.1 Overview

This chapter presents the main findings of the study, provides key suggestions, gives some guidance for future researchers and discusses the limitations of the study.

5.2 Conclusions

Worldwide health organizations are introducing JCI accreditation as a tool for improving and strengthening the quality of the health services they offer to patients and their communities. The heart of the JCI accrediting system is quality of care. This study evaluated the perception of nurses regarding the influence of JCI on the quality of care at IAH and NNUH. The study used a quantitative descriptive electronic design and studied the data of 250 nurses working in various departments, whether closed or open, or in outpatient clinics at IAH and NNUH. According to the findings of this study, the majority of nurses at both hospitals have a neutral perception toward enhancing the quality of treatment after both hospitals were accredited by the JCI. Furthermore, some have a neutral perception of organizational factors such as strategic quality planning, human resource utilization, and JCI accreditation, while others have a negative perception of organizational factors such as quality management and leadership commitment. The study also found that the previously-indicated organizational characteristics were favorably-related to the quality of care outcomes. However, there was no statistically-significant association between various demographic characteristics, such as gender, age, occupation, years of experience, education level, and nurses' opinions of enhancing quality of care, according to these findings. There is a considerable association between several demographic factors, such as quality

training, and the hospital in which it works, as well as nurses' perceptions of how to improve quality of care.

5.3 Recommendations

Improvement of healthcare quality should be a key strategic objective for all health workers, health managers, management, executives and policymakers. The highest level of quality enhancements commitments in the healthcare system should also be achieved and reflected in policies, protocols and procedures to support quality enhancement programs.

The following recommendations are worth mentioning on the basis of the preceding conclusions:

1. Nursing leaders must be aware of the workload in their units in order to ensure that nurses have enough time to plan for quality improvement in their departments. Adequate nursing staffing is a critical component in improving care quality.
2. Creating a safety culture within the hospital requires strong leadership, careful planning, and monitoring. To boost nurses' and other staff's confidence and commitment to what needs to be done, hospital management must develop an effective system for enhancing suggestions for quality improvement and involving them in the decision-making process.
3. Development of a motivational system for nurses and other personnel, based on their performance assessments to enable JCIA standards to be implemented, thereby giving the feeling of satisfaction and recognition for their efforts and participation in quality enhancements. To make nurses feel recognized and appreciated for their talents and participation in the quality improvement process, the establishment of an effective reward system is quite important.

4. Creating new indicators to closely monitor the quality performance of employees and managers in relation to quality improvement activities such as leadership commitment, strategic quality planning, human resource utilization, and quality management.
5. It is crucial that the JCIA standards are continuously adopted and committed as a key quality program, which improves the process of continuous improvement in hospital quality.
6. Start the implementation in the Palestinian health organizations of worldwide quality program, in order to improve the overall quality of healthcare, eliminate medical mistakes and the injury of patients.
7. The professional standards of the treatment of patients, based on international norms and on evidence of best practice, must be adopted by all Palestinian hospitals.
8. Creating a health committee of various medical specialties, preferably young people, to monitor the work of hospitals that obtain international quality standards certificates, such as the JCI certificate, and that this committee works on developing programs to assist other hospitals in obtaining such certificates, as well as the authority to impose penalties. Any hospital that received one of the quality certificates but did not work to put the quality standards into action.

5.4 Directions for Future Research

1. Comparative studies must be done on the perception of nurses of the effect of the Joint Commission on International Accreditation (JCIA) on the quality of healthcare in the Palestinian hospitals, especially West Bank, before and after receiving a JCI certificate.
2. Comparative studies must be done on the perception of nurses of the effect of the Joint Commission on International Accreditation (JCIA) on the quality of

healthcare in West Bank hospitals and Al-Quds hospitals are obtaining a JCI certificate.

3. To ensure successful quality improvement a thorough evaluation of the interaction between JCI accreditation and the quality indicators is required.
4. Conducting evaluation studies in order to identify the determinants for successful implementation in healthcare workers of the JCIA standards.

5.5 Limitations of Study

- This study would performed in a few hospitals because not all hospitals in the West Bank have a JCI certificate.
- The majority of hospitals in the West Bank do not have a JCI certificate.
- Many nurses lack knowledge of the JCI standards.
- The researcher did not know the perspective of the nurses about the quality of care at IAH and NNUH Hospital before the JCI initiative.

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Appendixes

Appendix (A): Questionnaire, Arabic version

كلية الدراسات العليا
الجامعة العربية الامريكية
برنامج إدارة الجودة

اخي الفاضل / اختي الفاضلة

تحية واحترام.....

يقوم الباحث بإعداد دراسة كمتطلب تكميلي لنيل درجة الماجستير في إدارة الجودة بعنوان **" تصور الممرضين تجاه تأثير اعتماد اللجنة الدولية المشتركة على جودة الرعاية الصحية في المستشفى الاستشاري ومستشفى النجاح التخصصي"**

تمثل الاستبانة أحد الجوانب الهامة في البحث , ويهدف إلى تقييم تصورات الممرضين تجاه تأثير اعتماد اللجنة المشتركة الدولية على جودة الرعاية الصحية المقدمة , أرجو التكرم والإجابة على الأسئلة المطروحة وتزويد الباحث بآرائكم القيمة من خلال وضع إشارة (X) على الإجابة التي ترونها ملائمة . كما يأمل الباحث أن تغني إجاباتكم وترفع من مستوى البحث العلمي.

يرجى العلم أن جميع الأسئلة المطروحة ضمن هذه الاستبانة لأغراض البحث العلمي وأن إجاباتكم ستكون محاطة بالسرية الكاملة والعناية العلمية الفائقة, مع العلم أن الإجابة قد تستغرق 15 دقيقة .

شكرا لتعاونكم وحسن استجابتكم....

الباحث
جبريل سليمان الهرينات

القسم الاول : البيانات الديموغرافية
يرجى الإجابة على الأسئلة التي تتضمن البيانات الشخصية بوضع إشارة (X)

1- الجنس :

□ ذكر , □ أنثى

2- العمر .....

3- سنوات الخبرة :

□ أقل من 5 سنوات □ 5- أقل من 10 سنوات □ 10 سنوات فأكثر

4- المؤهل العلمي:

□ دبلوم
□ بكالوريوس
□ *دراسات عليا*

5- المستشفى الذي تعمل به :

□ *مستشفى النجاح التخصصي* □ مستشفى الاستشاري

6- طبيعة العمل :

□ *ممرض/ة مؤهل/ة* □ *رئيس/ة قسم*
□ *ممرض/ة قانوني/ة* □ *المشرف /ة*
□ *اخرى , يرجى تحديد .....*

7- هل تلقيت تدريبًا متعلقًا بجودة رعاية المرضى؟

□ نعم □ لا

القسم الثاني :

فيما يلي مجموعة من العبارات خاصة بمبادئ الجودة واللجنة المشتركة الدولية بحيث (1 =معارض بشدة ، 5 =موافق بشدة) , يرجى التكرم باختيار الإجابة المناسبة بوضع إشارة (X) بعد قراءة العبارات الآتية , *وان تختار الإجابة واحدة فقط .*

المحور الأول: نتائج الجودة .						
الرقم		**موافق بشدة**	**موافق**	**محايد**	**معارض**	**معارض بشدة**
1	أظهر المستشفى تحسينات ثابتة قابلة للقياس في جودة الخدمات التي تقدمها الإدارة (المالية ، الموارد البشرية ،الخ) خلال العامين الماضيين .					
2	أظهر المستشفى تحسينات ثابتة قابلة للقياس في جودة الرعاية المقدمة للمرضى (الطبية والجراحية والاورام وامراض الكلى و العناية المكثفة وغيرها) خلال العامين الماضيين.					
3	أظهر المستشفى تحسينات ثابتة قابلة للقياس في جودة الخدمات التي تقدمها أقسام الدعم السريري مثل المختبر والصيدلة والأشعة خلال العامين الماضيين.					
4	نافس المستشفى باقي المستشفيات في الضفة الغربية في جودة الخدمات التي قدمها للمرضى خلال العامين الماضيين.					
5	خضع الفريق الى تدريب مرتبط بمعايير الجودة العالمية.					

المحور الثاني : التزام القيادة .						
الرقم		**موافق بشدة**	**موافق**	**محايد**	**معارض**	**معارض بشدة**
6	توفر الإدارة المستشفى بيئة عمل تعزز سلامة المرضى كأولوية قصوى.					
7	هناك سياسة واضحة من قبل إدارة المستشفى في الحفاظ على بيئة تدعم تحسين الجودة.					
8	الإدارة العليا هي القوة الدافعة الأساسية وراء جهود تحسين الجودة.					
9	تسعى إدارة المستشفى الى مكافأة الممرضين وتقديرهم (على سبيل المثال ، ماليًا أو غير ذلك) لتحسين الجودة					

10	لدى الإدارة المستشفى قدرة على إدارة التغييرات (مثل التكنولوجية) اللازمة لتحسين جودة الرعاية والخدمات.					
11	لدى الإدارة المستشفى فهم شامل لكيفية تحسين جودة الرعاية والخدمات.					

المحور الثالث: استراتيجية التخطيط الجودة .

الرقم		موافق بشدة	موافق	محايد	معارض	معارض بشدة
12	لدى المستشفى استراتيجية واضحة اتجاه تحسين الجودة في الخدمات الطبية					
13	لدى كل قسم في المستشفى أهداف محددة من أجل تحسين الجودة .					
14	لدى جميع الممرضين في المستشفى معرفة بالخطة المتبعة لتحسين الجودة الخدمات .					
15	تسمح إدارة المستشفى للممرضين في المشاركة في وضع الخطط للتحسين الجودة .					
16	يلعب المدراء (مشرفو التمريض ومسؤولو التمريض) دورًا رئيسيًا في تحديد الأولويات لتحسين الجودة.					
17	تلعب توقعات المرضى بشأن الجودة دورًا رئيسيًا في تحديد الأولويات لتحسين الجودة					

المحور الرابع: استخدام الموارد البشرية

الرقم		موافق بشدة	موافق	محايد	معارض	معارض بشدة
18	يتم تزويد الممرضين بالتعليم والتدريب اللازمين (من خلال برامج تعليم التمريض) لتحسين الجودة و المهارات الوظيفية والاداء .					

19	يوجد تعاون بين الإدارات لتحسين جودة الخدمات.					
20	يوجد لدى المستشفى صندوق شكاوي لتحسنن الجودة الخدمة المقدمة .					
21	يوجد بالمستشفى نظام فعال للممرضين لتقديم اقتراحات للإدارة حول كيفية تحسين الجودة.					

المحور الخامس: إدارة عمليات الجودة						
الرقم		موافق بشدة	موافق	محايد	معارض	معارض بشدة
22	يتم توفير التعليم والتدريب للممرضين حول كيفية تحديد والعمل على فرص تحسين الجودة.					
23	يفحص المستشفى بانتظام المعدات والإمدادات للتأكد من أنها تلبي متطلبات الجودة.					
24	لدى المستشفى سياسات وإجراءات فعالة لدعم تحسين جودة الرعاية والخدمات.					
25	يتم اختبار جودة الخدمات التي يقدمها المستشفى بدقة قبل تنفيذها.					
26	يرى المستشفى أن تحسين الجودة هو عملية تحسين مستمرة .					
27	يشجع المستشفى الممرضين على الاحتفاظ بسجلات الجودة .					

المحور السادس: اعتماد اللجنة المشتركة الدولية .

الرقم		موافق بشدة	موافق	محايد	معارض	معارض بشدة
28	أثناء التحضير لاعتماد اللجنة المشتركة الدولية ، تم تنفيذ تغييرات مهمة في المستشفى.					
29	عملت بالتوصيات المقدمة إلى المستشفى الخاص بك منذ المسح الأخير (فحص اللجنة المشتركة الدولية) .					
30	لقد شاركت في التغييرات التي نتجت عن توصيات الاعتماد .					
31	يعزز الاعتماد على تحسين رعاية المرضى.					
32	يتيح الاعتماد تحفيز الموظفين ويشجع العمل الجماعي والتعاون.					
33	يتيح الاعتماد تطوير القيم المشتركة بين جميع المهنيين في المستشفى.					
34	يُمكِّن الاعتماد المستشفى من استخدام موارده الداخلية بشكل أفضل (مثل الموارد المالية والأفراد والوقت والمعدات).					
35	يُمكِّن الاعتماد المستشفى من الاستجابة بشكل أفضل لاحتياجات السكان.					
36	يُمكِّن الاعتماد المستشفى من أن تكون أكثر استجابة عند تنفيذ التغييرات .					

هل لديك ملاحظات أخرى تود ذكرها ؟

.....

.....

.....

.....

شكرا لتعاونكم

Appendix (B): Questionnaire, English version

College of Postgraduate Studies

Arab American University

Quality Management Program

Dearest brother/sister

Regards and greetings :

The researcher is working on a study titled "Nurses' perceptions of the influence of Joint International Committee accreditation on the quality of health care in Istishari Hospital and An-Najah Specialized Hospital" as a supplementary requirement for obtaining a master's degree in quality management.

One of the most important aspects of the study is the questionnaire, which aims to assess nurses' perceptions of the impact of JCI accreditation on the quality of health care provided. The researcher also hopes that your responses will enrich and elevate scientific research.

Please keep in mind that all questions on this questionnaire are for scientific research purposes only, and that your answers will be treated with complete confidentiality and great scientific care, with the understanding that the answer may take up to 15 minutes.

Thank you for your time and consideration.

Researcher ,

Jebril Suliman AL-Hrenat

Section One: Demographic Data

Please answer the questions that include personal data by ticking (X).

1- Gender:

□ male, □ female

2- Age……

3- Years of Experience:

□ Less than 5 years □ 5- Less than 10 years □ over than 10 years

4- Academic Qualification:

□ Diploma

□ Bachelor

□ Postgraduate

5- The hospital you work in:

□ An-Najah Specialized Hospital □ Istishari Hospital

6- Nature of work:

□ Practical Nurse □ Head Nurse

□ Staff Nurse □ Supervisor

□ Other, please specify .....

7- Have you received training related to quality of patient care?

□ yes □ no

Section tow:

The following are a series of statements related to quality principles and the Joint Commission International, so please select the appropriate answer by ticking (X) after reading the following statements, and please select only one answer.

Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Quality outputs					
1 - Over the last two years, the hospital has shown consistent, measurable improvements in the quality of services provided by management (finance, human resources, etc.).					
2- Over the last two years, the hospital has demonstrated consistent, measurable improvements in the quality of care provided to patients (medical, surgical, oncology, nephrology, intensive care, and so on).					
3- Over the last two years, the hospital has demonstrated consistent, measurable improvements in the quality of services provided by clinical support departments such as laboratory, pharmacy, and radiology.					
4 - During the previous two years, the hospital competed with other West Bank hospitals in terms of the quality of services it provided to patients.					
5 - The team received training in accordance with international quality standards.					
Leadership commitment					
6- the hospital administration creates a work environment that prioritizes patient safety.					
7 -The hospital administration has a clear policy in place to maintain an environment that encourages quality improvement.					
8- the Senior management is the primary driving force behind quality improvement efforts.					
9 - the hospital administration seeks to reward and recognize nurses (financially or otherwise) for improving quality.					
10 - the hospital administration t has the ability to manage changes (e.g., technological) required to improve the quality of care and services.					

11- the hospital administration has a thorough understanding of how to improve the quality of care and services.					
Statement	**Strongly Agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
Strategic Quality Planning					
12 -The hospital has a clear strategy for improving medical service quality.					
13- Each hospital department has specific quality improvement goals.					
14 -All nurses in the hospital are aware of the plan used to improve service quality.					
15- the hospital administration allows nurses to participate in the development of quality improvement plans.					
16 -Managers (nursing supervisors and nursing administrators) play an important role in establishing quality improvement priorities.					
17 -Patients' quality expectations play a significant role in setting.					
Human Resources Utilization					
18 - Nurses are given the education and training they need (via nursing education programs) to improve their quality, job skills, and performance.					
19 - There is cross-departmental cooperation to improve service quality.					
20 - To improve the quality of the service provided, the hospital has a complaint box.					
21 - The hospital has an effective system in place for nurses to provide management with suggestions on how to improve quality.					
Statement	**Strongly Agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
Quality Operations Management					
22- Nurses are educated and trained on how to identify and act on quality improvement opportunities.					
23- The hospital inspects equipment and supplies on a regular basis to ensure they meet quality standards.					
24 -The hospital has effective policies and procedures in place to support the improvement of care and services.					

25 -Before they are implemented, the hospital's services are thoroughly tested for quality.					
26 -The hospital views quality improvement as an ongoing process.					
27- The hospital promotes the keeping of quality records by nurses.					
The Joint Commission International Accreditation					
28 - During the hospital's preparation for JCI accreditation, significant changes were implemented.					
29 - You learned about the hospital recommendations made since the last survey (JCI inspection)					
30 - You were a part of the changes brought about by accreditation recommendations.					
31- Encourages reliance on improving patient care.					
32 - Accreditation promotes employee motivation and teamwork and cooperation.					
33 - Accreditation allows for the development of values that are shared by all hospital professionals.					
34 - Accreditation allows the hospital to better utilize its internal resources (e.g. financial resources, people, time and equipment).					
35 - Accreditation allows the hospital to better respond to the needs of the community.					
36 - Accreditation allows the hospital to be more responsive when implementing changes.					

Are you interested in mentioning other notes?

……

……

……

Thank you for your assistance

Appendix (C): Experts and arbitrators who reviewed the survey.

No.	Name	Details
1.	Dr,Mohammad Abusharbeh	Assistant Professor in Finance, Arab American University-Palestine
2.	Dr. Yahya Saleh	Associate Professor in Industrial Engineering. Expert in Quality Management, An-Najah National University.
3.	Dr.Muhmmod Abuhaded	Vice Dean of Al-Quds University's Faculty of Medicine. PhD in Immunology .
4.	Prof-Fathallah A Ghanem	Assistant Manager HRM Full professor in Al-Quds University
5.	Dr. Ahmad Al-Batran	PhD The nursing .
6.	Dr.Kamal All-Najjar	Dean of the College of Education at Hebron University PhD in Education
7-	Dr. AbdulMuhsen Abu-Fannouneh	PhD in Public Health Assistant Professor in Al-Quds University

الملخص

يظهر اعتماد وكالة الرعاية الصحية أنها تلبي أعلى معايير الصحة والصحة الدولية. تهدف هذه الدراسة الى تقييم تصورات الممرضين عن تأثير اعتماد اللجنة الدولية المشتركة (JCIA) وجودة الرعاية الصحية في المستشفى الاستشاري العربي (IAH) ومستشفى النجاح الوطني(NNUH) .

تم استخدام النهج الكمي في هذه الدراسة وبعد ذلك تم جمع البيانات الأولية من خلال توزيع الاستبيانات عبر الإنترنت على 220 ممرض في كلا المستشفيين. الاستبيان مقسم إلى جزأين ، الأول يسعى للحصول على معلومات ديموغرافية حول الممرضين في كلا المستشفيين والقسم الثاني حول ممارسات الجودة و اعتماد اللجنة الدولية المشتركة ، و تنقسم الاستبانة إلى ستة أقسام تتمثل في مخرجات الجودة ، وإدارة الجودة ، والقيادة ، وتخطيط جودة الاستراتيجية ، واستخدام الموارد البشرية ، والاعتماد الدولي للجنة المشتركة . تم استخدام الإحصاء الوصفي و برنامج الحزمة الإحصائية للعلوم الاجتماعية (SPSS) و برنامج اموس اصدار ٢٥ في تحليل البيانات.

وفقًا للنتائج ، فإن غالبية الممرضين في كلا المستشفيين لديهم تصور محايد اتجاه تحسين جودة الرعاية بعد الاعتماد. علاوة على ذلك ، لدى البعض الممرضين تصور محايد للعوامل التنظيمية مثل التخطيط الاستراتيجي للجودة ، واستخدام الموارد البشرية ، و اعتماد اللجنة الدولية المشتركة ، بينما لدى البعض الآخر تصور سلبي للعوامل التنظيمية مثل إدارة الجودة والالتزام القيادي. ووجدت الدراسة أيضًا أن العوامل التنظيمية المذكورة سابقًا كانت مرتبطة بشكل إيجابي بجودة نتائج الرعاية. من ناحية أخرى ، أشارت هذه النتائج إلى عدم وجود علاقة ذات دلالة إحصائية بين بعض العوامل الديموغرافية وتصورات الممرضين حول تحسين جودة الرعاية.

يجب أن يعرف قادة التمريض حجم العمل في اقسامهم للتأكد من أن الممرضين لديهم الوقت الكافي للتخطيط لتحسين الجودة. يجب على إداراتهم وإدارة المستشفى بناء آلية فعالة لتعزيز مقترحات تحسين الجودة. يحتاج الممرضون والموظفون الآخرون إلى نظام تحفيزي يعتمد على تقييمات الأداء الخاصة بهم ايضا ، لإعطاء اعتماد اللجنة الدولية المشتركة إحساسًا بالمتعة والاعتراف بجهودهم ومشاركتهم في تحسينات الجودة. يجب

تطوير مقاييس جديدة لمراقبة جودة أداء الموظفين والمشرفين عن كثب. بالإضافة إلى ذلك ، يوصي الباحث بتشكيل لجنة صحية متخصصة في الجودة من مختلف الأخصائيين الطبيين لمراقبة المستشفيات الفلسطينية الحاصلة على شهادة الجودة وفرض العقوبات على مخالفة القوانين الطبية.

الكلمات المفتاحية: اللجنة الدولية المشتركة ، جودة الرعاية الصحية ، مستشفى ، تمريض .