JHIT
JOURNAL OF HEALTH INSTITUTES OF TÜRKİYE
TÜRKİYE SAĞLIK ENSTİTÜLERİ BAŞKANLIĞI DERGİSİ

Research Article

TÜSEB 2024;7(1):20-29 • **DOI:** 10.5578/tusebdergisi.20240120

A Qualitative Study on Quality Practices in Hospitals During the COVID-19 Pandemic

Özden Güdük[1], Özlem Özaydın[2], Şehriban Serbest[3]

[1] Department of Healthcare Management, Yüksek İhtisas University Faculty of Health Sciences, Ankara, Türkiye
[2] Department of Healthcare Management, İstinye University Faculty of Economics and Administrative Sciences, İstanbul, Türkiye
[3] Department of Nursing, Acıbadem University Facuty of Health Sciences, İstanbul, Türkiye

Cite this article as: Güdük Ö, Özaydın Ö, Serbest Ş. A qualitative study on quality practices in hospitals during the COVID-19 pandemic. TÜSEB 2024;7(1):20-29.

*This study was presented as an oral presentation at the National Nursing Management Congress held online between May 27th and 29th, 2021.

ABSTRACT

This study aimed to investigate the impact of the COVID-19 pandemic on mandated quality control and voluntary accreditation assessments in hospitals. Additionally, it also examined how the measures taken during the pandemic affected quality-related practices in hospitals. This is a qualitative study in which interviews were conducted with 12 individuals working in the quality control units of different hospitals between April 24th and May 4th, 2021. Interviews were conducted through online applications or by phone. A semi-structured questionnaire comprising six questions, created by the researchers and content analysis was used. Content analysis was used. Self-assessments were generally conducted in the last quarter of 2020, and many hospitals only addressed the sections mandated by the Ministry. The pandemic necessitated additional documents and revisions, leading to the preparation of new approval forms. Some meetings, trainings, and drills were not completed or were moved to online platforms. Increased workload and staff shortages culminated in negative attitudes towards quality processes. In some hospitals, quality unit employees were sometimes reassigned to new departments. The results of the study show that the COVID-19 pandemic negatively impacted hospitals' quality practices. Changes implemented to adapt to the new situation were not fully adequate. In order to better handle similar crises in the future, hospitals are recommended to implement technology-supported quality studies. This includes strengthening the integration of different hospital systems, as well as incorporating technology applications such as the Internet of Things to monitor patient indicators. Additionally, healthcare professionals, including quality employees, should receive training to increase their knowledge of digitalization in health. Finally, regulations and emergency solutions for possible quality crises should be included in quality practices.

Keywords: Hospital, quality, assessment, COVID-19, pandemic

ÖZ

COVID-19 Küresel Salgınında Hastanelerde Kalite Uygulamaları Üzerine Nitel Bir Çalışma

Çalışmanın amacı COVID-19 salgınının hastanelerin zorunlu kalite ve gönüllü akreditasyon değerlendirme süreçlerine etkisinin araştırılmasıdır. Ayrıca çalışma, pandemi sırasında alınan önlemlerin hastanelerdeki kaliteyle ilgili uygulamaları nasıl etkilediğini incelemektedir. Nitel araştırmalardan biri olan görüşme yöntemi kullanılmıştır. Farklı hastanelerde kalite biriminde çalışan toplam 12 kişi ile 24 Nisan-4 Mayıs 2021 tarihleri arasında çevrim içi internet uygulamaları veya telefon aracılığıyla görüşme yapılmıştır. Araştırmacılar tarafından oluşturulan yarı yapılandırılmış bir soru formu kullanılmıştır ve İçerik analizi yapılmıştır. Hastanelerin çoğunda, öz değerlendirmeler 2020 yılının son çeyreğinde yapılmıştır. Çoğu hastanede öz değerlendirmede yalnızca Bakanlığın zorunlu tuttuğu bölümler ele alınmıştır. Salgın nedeniyle ilave doküman ve revizyon ihtiyacı ortaya çıkmış, yeni onam formları hazırlanmıştır. Bazı toplantılar, eğitimler ve tatbikatlar tamamlanamamış ya da çevrim içi ortama taşınmıştır. Çalışanlar, iş yükü ve personel eksikliği gibi sebeplerden dolayı kalite süreçlerine karşı negatif tutum göstermiştir. Bazı hastanelerde kalite biriminde çalışanlar zaman zaman farklı birimlerde görevlendirilmiştir.

Responsible Author

Özden Güdük

Department of Healthcare Management,
Yüksek İhtisas University
Faculty of Health Sciences,
Ankara-Türkiye
e-mail: ozdenguduk@gmail.com

Received: 16.11.2023
Accepted: 02.01.2024
Available Online Date: 30.04.2024

Çalışmanın sonuçları COVID-19 salgınının, hastanelerin kalite uygulamalarına olumsuz etki ettiğini göstermektedir. Yeni duruma uyum sağlamak amacıyla bazı değişiklikler hayata geçirilmiş olmasına rağmen tam anlamıyla yeterli olmamıştır. Gelecekte benzer krizlerle daha iyi başa çıkabilmek için hastanelerin teknoloji destekli kalite çalışmalarını hayata geçirmeleri önerilmektedir. Bu, farklı hastane sistemlerinin entegrasyonunun güçlendirilmesinin yanı sıra hasta göstergelerini izlemek için "Nesnelerin İnterneti" gibi teknoloji uygulamalarının sisteme dâhil edilmesini de içerir. Ayrıca, kalite çalışanları da dâhil olmak üzere sağlık çalışanlarının sağlıkta dijitalleşme konusundaki bilgilerini arttırmak için eğitim almaları gerekmektedir. Son olarak, olası kalite krizlerine yönelik düzenlemeler ve acil durum çözümleri kalite uygulamalarına dâhil edilmelidir.

Anahtar kelimeler: Hastane, kalite, değerlendirme, COVID-19, pandemi

INTRODUCTION

COVID-19 (SARS-CoV-2 infection) originated in the city of Wuhan, China in December 2019 and rapidly spread worldwide (1). The first case in Türkiye was reported on March 11, 2020, and thousands of people quickly succumbed to the disease (2). As the number of cases increased in Türkiye, national measures were taken, including occasional partial and full lockdowns (2,3).

Among all commercial sectors, the greatest impact of COVID-19 was on the healthcare sector (4,5). Increasing numbers of patients in hospitals and worsening working conditions for healthcare workers (including grave risks to personal safety) overtaxed the healthcare system, damaging its efficient functioning; for example, demand for intensive care beds increased as approximately 5% of individuals with COVID-19 requiring intensive care, overwhelming availability (6-8). Outpatient services, elective surgeries, and non-urgent procedures were postponed to re-direct facilities and manpower towards pandemic control (9,10). Administrative and financial processes of hospitals were also disrupted by this global pandemic. Quality management practices were one of the processes affected; in hospitals, in-service training for staff and meetings were canceled, and audits were postponed (9).

Efforts to improve the quality of healthcare services in Türkiye have gained momentum since the announcement of the Healthcare Transformation Program in 2003. Starting with ISO 9001 quality management certification, quality and accreditation practices carried out by the relevant departments of the Ministry of Health have evolved into a standardized structure since 2007 (11,12). Regardless of ownership (public, foundation, or private), all hospitals are required to provide services in compliance with the Healthcare Quality Standards (HQS). Hospitals are evaluated annually by certified external assessors trained for this purpose and appointed by the Ministry of Health (13). Self-assessment, defined as “the evaluation activity carried out within the institution based on the Healthcare Quality Standards under the responsibility of the hospital quality director,” is required twice a year (14).

According to the Healthcare Quality Standards (HQS), hospitals are required to establish committees and commissions on specific topics, convene at designated intervals, document processes, and track defined indicators. They must conduct training activities, some directed at specific groups of employees, others requiring the full staff participation. These training activities may be single occurrences or periodically repeated (14).

Apart from the quality assessments mandated by the Ministry, hospitals have the option to voluntarily request evaluations for compliance from independent accreditation organizations (national or international) if they wish (15). On March 13, 2020, in response to the COVID-19 pandemic, The Ministry of Health of Türkiye, through the Directorate General of Healthcare Quality, Accreditation, and Employee Rights, canceled nationwide the “On-Site Assessments for Healthcare Quality Assessments” mandatory for all hospitals (16). No further external assessments were conducted until August 2, 2021 when the effects of the pandemic began to ease (17).

This study aimed to investigate the impact of the COVID-19 pandemic on mandated quality control and voluntary accreditation assessments in hospitals. Additionally, it also examined how the measures taken during the pandemic affected quality-related practices in hospitals.

MATERIALS AND METHOD

This study adopted a qualitative research methodology, using the “individual in-depth interview” as data collection technique. A convenience sampling method was used. Interviews were terminated when data saturation was reached. Twelve participants working in the quality units of different hospitals were interviewed online or by telephone between April 24th and May 4th, 2021, by two researchers. The duration of each interview was around 15 minutes. A semi-structured interview form comprising six questions created by the researchers was used. The following are some example questions in the semi-structured format: Did your hospital undergo any external evaluations during the COVID-19 pandemic? If so, were there any differences compared to

before the pandemic? Has your hospital conducted any internal evaluations during the COVID-19 pandemic? If so, were there any differences compared to the period before the pandemic? How do you assess the impact of the COVID-19 pandemic on quality practices in the hospital in terms of document management? The traditional content analysis method was employed for data analysis (18).

Immediately after each interview, the content recorded in audio form was transcribed verbatim. Transcripts were read line by line, and meaningful expressions were coded. The identified expressions were named based on the similarities or differences of the codes and grouped into themes and subthemes (19).

Ethics committee approval for the study was obtained from Acıbadem University Medical Research Evaluation Board. Additionally, approval was obtained from the Ministry of Health COVID-19 Scientific Research Evaluation Committee.

Prior to the interviews, participants were informed about the study. All consented verbally to participate in the study.

RESULTS

Seven of the interviewees work in public hospitals and five work in private hospitals and have an average of 7.5 years of experience in the quality unit. The characteristics of the participants are shown in Table 1.

According to the interviews, from the date of the first COVID-19 case in Türkiye until the interviews with the participants, no external evaluations were conducted in any hospitals in terms of Healthcare Quality Standards except for one hospital (which occurred on March 13, 2020). However, during this time frame, one private hospital underwent an accreditation inspection conducted by the Joint Commission International (JCI).

In the interviews, participants expressed that quality controls within the hospital were affected during the COVID-19 pandemic. This study analyzes the quality practices implemented in hospitals during the COVID-19 pandemic. It evaluates the impact of the pandemic on various aspects of quality practices, including external evaluation, self-assessment, document management and indicator tracking, mandatory meetings, training, staff participation in quality activities, support from senior management, and the workforce in the quality unit. The study also presents a separate section on the remote Joint Commission International (JCI) accreditation evaluation experienced by one hospital. The themes and sub-themes of the study are shown in Figure 1.

External Evaluation

When evaluated in terms of quality efforts in healthcare services, only one public hospital underwent an HQS assessment, and one private hospital experienced an accreditation evaluation by JCI during this period.

The HQS assessment for the single hospital that underwent evaluation took place just two days after the announcement of the first case on March 13, 2020. Since this evaluation occurred very early in the pandemic, there were concerns and uncertainties regarding issues such as contact and distancing.

Table 1. Characteristics of participants

Participant code	Title	Years of working in the unit	Sex	Organization
K1	Quality director	4	Female	Public
K2	Quality director	2	Female	Public
K3	Quality director	7.5	Female	Public
K4	Quality director	3	Female	Public
K5	Quality director	3	Female	Public
K6	Quality director	4	Female	Public
K7	Quality director	8	Female	Public
K8	Clinical quality manager	9	Female	Private
K9	Clinical quality manager	3	Male	Private
K10	Quality improvement and performance manager	14	Female	Private
K11	Clinical quality manager	11	Female	Private
K12	Quality director	23	Female	Private

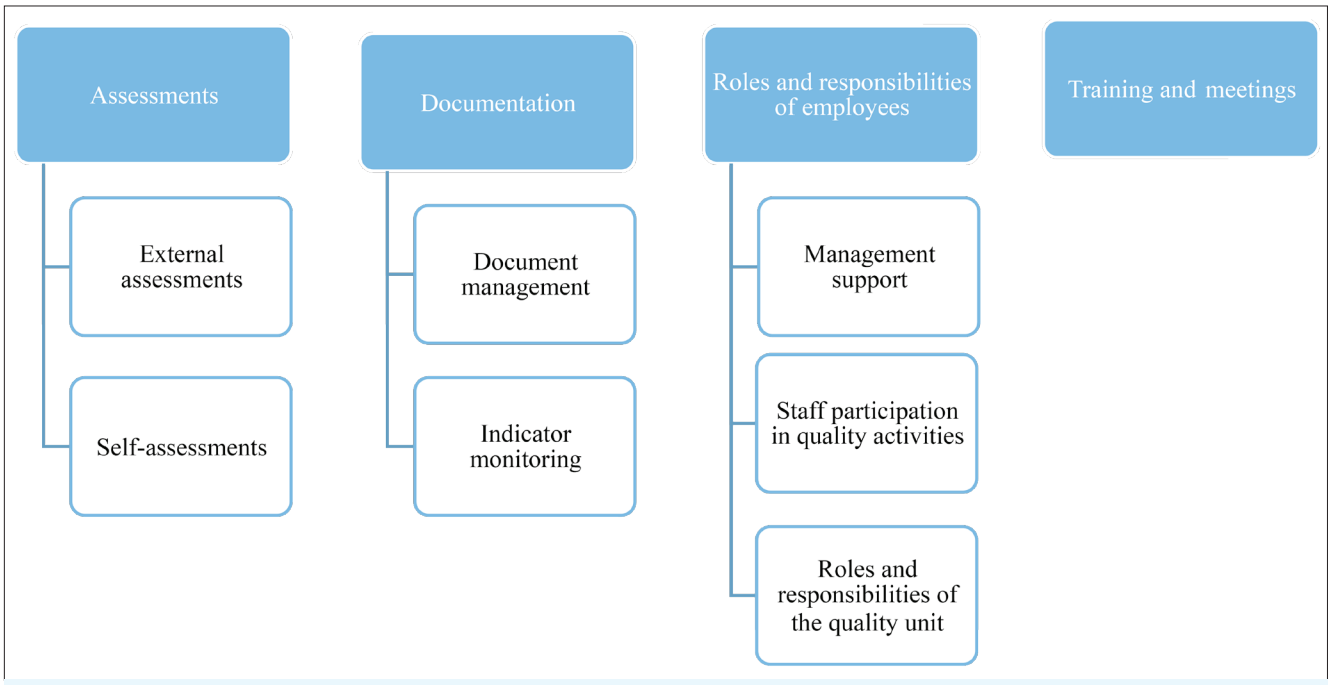

Figure 1. Themes and subthemes.

"The evaluation date had been pre-determined, so it was not canceled. However, both the assessors and hospital staff had a lot of uncertainties about many aspects. We took some measures to reduce contact, but there were still some question marks, such as whether the evaluation would proceed as usual, for example, whether patient clinics would be visited (K10)."

In the private hospital where the JCI accreditation evaluation was conducted, the evaluation process was carried out online and remotely. Detailed information about this evaluation is given separately at the end of the results section.

Apart from quality activities, it was stated that some external evaluations were conducted during the COVID-19 pandemic for both public and private hospitals. In public hospitals, small-scale visits and assessments were carried out by teams appointed by the Provincial Health Directorate's Public Hospitals Directorate. Similarly, some external evaluations were conducted in private hospitals. However, it was reported that these evaluations mainly focused on entries into the Public Health Management System (PHMS), billing, COVID-19 patient statistics, and healthcare service delivery processes. It was also noted that in private hospitals, these evaluations were monitored by different units within the hospitals and were not conducted by the quality unit.

Self-Assessment

According to the statements made by the quality unit employees interviewed, self-assessments were postponed in the early months of the pandemic. Self-assessments began again in the last quarter of 2020 when the number of patients decreased. In these self-assessments, it was noted that most hospitals only evaluated the sections required by the Ministry. However, some hospitals were reported to have conducted work that covered all sections for compliance with the HQS Hospital Set V6.

"In December 2020, we conducted a self-assessment. We conducted narrower and more limited evaluations, focusing only on the topics mandated by the Ministry. For example, a full building tour was not conducted (K4)."

"We started our self-assessment in October-November 2020, and we completed the self-assessment based on the entire new guide. While we were conducting the assessment, the Ministry only made statements about self-assessment in some topics. However, since we had already started, we completed our work based on the entire guide. It took time for the field to adapt due to the addition of new indicators, etc., so it took longer than usual (K3)."

According to the information obtained from the participants, some hospitals made changes to the self-assessment process. For example, instead of completing the assessment process all at once as had been done in the past, the assessment was distributed over the year. Additionally, to minimize viral transmission and effectively use human resources, self-assessment teams were formed with fewer people. Many hospitals in fact reported that only the quality

unit employees were involved in self-assessment and creating the reports.

"We made a self-assessment plan, but we couldn't stick to the plan. Even though we couldn't follow the plan in terms of time, we conducted the self-assessment after October. Some members of the assessment team had COVID-19, or senior management employees who were part of the team had to attend meetings outside the institution due to COVID-19. Because of these reasons, the teams couldn't work effectively, and the quality unit was primarily responsible for managing the process (K5)."

In self-assessment, it was mentioned that in some cases, verbal feedback obtained from unit managers was used instead of field visits and file reviews. Due to the awareness of the workload of hospital staff, it was reported that efforts were made to be as flexible as possible during quality activities.

"We tried not to irritate the employees in the field because we knew their workload. We didn't delve too deep into the standards; we gave verbal warnings for some things; we didn't put them in writing (K3)."

"We did not conduct self-assessment; we only carried out integration studies on some issues regarding compliance with the Health Quality Standards-6 (K6)."

Document Management and Indicator Tracking

During the COVID-19 pandemic, additional documents and consent forms were prepared and revised, adding to workload. Release of quality standards revisions, HQS V6, coincided with the pandemic, leading to occasional integration issues with the system due to the emergence of additional indicators and documents.

"There was a need for document revisions, and some specific aspects related to COVID-19 were added. The new version of HQS Hospital Set had been released, and some changes were necessary for it (K1)."

"Changes were made to patient care instructions. New procedures were developed for surgery or delivery services for patients with COVID-19 (K11)."

The pandemic presented work overload, staff shortages, and job changes that challenged unit manager and employee participation in various processes.

"Unit managers already had a heavy workload, and there was some resistance in document and indicator work. Especially in making adjustments according to the new guide and in the stages of data extraction, there was a passive response (K5)."

Instead of unit managers and employees coming together, quality unit managers individually made field visits to units to conduct their work one-on-one. Document management processes were primarily carried out by quality units.

"There were fewer opportunities for collaboration with unit managers in terms of adapting to new indicators or standards compared to pre-COVID-19 times. In the compliance efforts with the new guide, we invited unit managers from areas like palliative care and intensive care to our office, provided information without overwhelming them, and tried to handle the work without putting too much pressure on them (K3)."

"When we conduct observations in the field or review patient files, there are sometimes negative reactions like 'Are we going to deal with quality matters in the midst of all this work?' During this process, I mainly handled the work on my own that we usually do with unit managers. For the past two days, I've been going to the intensive care unit to create the indicators myself and extract the data. Because in units like the intensive care unit, I can't just tell someone to give me this data or do that (K4)."

Most hospitals had not fully completed the transition process in document management and indicator tracking. In some hospitals, the process was disrupted due to quality unit employees being assigned to other units.

"The need for document revisions arose, but due to employees in the unit being assigned to other places within the hospital, our own work remained unfinished. There are still documents that we haven't revised (K2)."

Mandatory Meetings and Training Under Quality Scope

In the early stages of the pandemic, mandatory meetings concerning quality practices were not held and were only re-started in the second half of the year. Adjustments to the way these meetings were conducted included face-to-face meetings with fewer participants and shorter durations.

"We only held face-to-face meetings for mandatory committees; no online meetings were conducted. Some members did not want to attend committee meetings (K2)."

"We conducted our committee meetings. By sharing the meeting agenda in advance, we ensured that the topics were discussed quickly, so our meeting durations were not long (K3)."

When committee members tested positive for COVID-19 or were contact with positive cases, there were not enough participants and annual meeting quotas were not met.

"Meetings were held face-to-face, but sometimes full attendance could not be achieved due to those on leave or other reasons related to illness. When members could not fully attend meetings due to being the only staff in their units, or due to administrative staff falling ill, we postponed the meetings. Out of the required minimum of four meetings per year, two or three were able to be held. Some meetings were conducted consecutively during periods with low case numbers (K5)."

Additionally, some drills properly conducted in the field were carried out at the desk, and drill plans were created.

Most of the in-service trainings under the HQS scope were transferred to an online format before the pandemic but trainings that remained face-to-face were not conducted except for orientation trainings. Some groups of employees (such as cleaning staff, etc.) faced barriers to participating in online training.

"In-service trainings were already being conducted online by the Provincial Health Directorate, and they continued in the same way. However, we couldn't conduct the clinical-based trainings required in HQS-6 (K3)."

"We didn't conduct training. We only provided orientation training for interns starting at the hospital, and we did it in small groups with numerous repeated sessions (K4)."

"We conducted orientation training, but we had to keep it very short (K7)."

"Participation in online training was low due to reasons like some employees, such as the cleaning staff, not having a computer or internet access (K6)."

"We provided face-to-face training for occupational health and safety as well as infection control to our cleaning staff who were unable to receive online training. We minimized contact by creating smaller groups with fewer participants (K10)."

Some hospitals successfully transitioned their meetings and training sessions to online platforms while others lacked sufficient infrastructure in this regard.

"We didn't conduct face-to-face training, but we have plans to conduct training sessions via Zoom in the future (K4)."

"Online field trainings were conducted, but we faced some obstacles at the beginning. There were postponements and meetings could not be held on time due to infrastructure requirements. However, with time we gradually got accustomed to these remote meeting or training platforms and started using them effectively (K12)."

The participation of Hospital Employees in Quality Practices

Due to the additional workload and staff shortages brought about by the COVID-19 pandemic, many employees exhibited a negative attitude towards quality processes. Many healthcare workers especially those working in intensive care units or palliative care units, prioritized patient care and perceived quality checks as an extra burden.

"Hospital employees had a low perception of and support for quality, which made it challenging during the COVID-19 process. From my perspective, it was very exhausting and stressful. Even tasks that should have been the responsibility of doctors, such as clinical quality, were expected from us. Units didn't want to take on quality tasks, but due to the assignments of our unit's employees, we couldn't even manage our own work (K2)."

"Employees are very resentful, especially those working in intensive care and palliative care units, as they are facing excessive workloads. The number of staff in these units is insufficient, and they are working overtime. Therefore, they have a very negative reaction to quality practices. They don't want to do documentation and record-keeping tasks, except for the most basic and mandatory documents (K2)."

"Quality took a backseat in the eyes of employees in terms of priority (K5)."

In contrast, unit managers and those with experience in quality controls display a more positive attitude. Note that physicians had lower participation in quality monitoring activities than other healthcare workers.

"We didn't receive too many negative reactions from unit managers, and we worked in mutual harmony because we were understanding and somewhat flexible with them (K3)."

During the pandemic, decreases in indicator rates may have arisen from a more uniform patient population, suspension of elective cases, lack of reporting or delayed completion of medical records.

"The motivation in the field is very low. Their participation in quality activities has decreased during this period. For example, the number of fall reports has decreased. Normally, due to the characteristics of our patients, falls are a common occurrence, but during this period, the reports have decreased (K5)."

Support from Senior Management

Two participants did not experience sufficient support from senior management in continuing quality improvement

efforts during the pandemic. Two participants noted no change compared to the pre-pandemic period. One participant did not provide a comment. The remaining participants perceived strong support from senior management. The following are statements made by some participants about their senior management support.

"The senior management supported the continuation of quality initiatives, and even though many hospitals did not conduct self-assessments, our hospital performed a self-assessment upon the directive of the chief physician (K1)."

"The senior management's perspective is that when there is an audit, the activities of the quality unit are important and come to the forefront; otherwise, the quality unit remains inactive. This is why constant reassignments from the quality unit to other departments occur. During this process, the absence of assessments created a perception that the quality unit was unnecessary (K2)."

"The senior management highly values quality. I was able to present my meetings, indicator sharing, and self-assessment results to the senior management. Additionally, we handle efficiency matters. I did not encounter any issues in terms of communication and information sharing with the senior management (K3)."

"There was no decrease in the senior management's view of quality. However, due to their frequent involvement in external activities like the provincial health directorate, their attendance at meetings has naturally decreased (K5)."

"We had a daily meeting with the hospital's senior management at 5.30 PM to discuss various topics including department targets, indicators, and leadership. I felt well-supported by the senior management (K9)."

Workforce in Quality Unit

Quality unit personnel in three public hospitals mentioned that they were sometimes assigned to other units, especially during periods when the number of patients increased.

"Not constantly, but especially during periods when the number of patients increased, we were assigned to inpatient units, vaccination clinics, and such. We performed data entry into the PHMS (K1)."

"There are three of us in the unit, and none of us were assigned to other units, so we were able to focus more on our own tasks (K3)."

"Out of the three active members in the quality unit, two of us were occasionally assigned to patient units and the vaccination clinic. We are responsible for PHMS data entries (K2)."

"I was not assigned to another unit (K9, K10, K11, K12)."

Many factors delayed monitoring of the quality unit's processes. These included quality unit employees being exposed to or infected with COVID-19; being on administrative leave due to chronic illness; and supervisor shift count increases.

"There are two people working in the quality unit. The other colleague had a chronic illness, so I worked alone for a long time, which is why I wasn't assigned to another department (K4)."

"There are two people in the unit. There hasn't been any assignment to another department, but my other colleague's supervisor shift count increased, so most of the time, we had to work alone. For a period, my colleague was temporarily assigned to another hospital for a few months. Even when administrative units were working flexibly, we worked full-time (K5)."

Notes regarding the remote JCI accreditation experience

Prior to a JCI accreditation evaluation at a private hospital December 14-18, 2020, JCI offered evaluation options to the hospital. In response, the hospital's senior management requested evaluation online.

"JCI offered various options for conducting accreditation evaluations: either extending our accreditation period until the pandemic was over, the second option was a hybrid evaluation, which involved a local team leader physically present while the other three evaluators joined via video conference, and the third option was for all evaluators to conduct the evaluation entirely online. Our hospital's senior management decided to proceed with the online evaluation (K9)."

Before undergoing evaluation, the hospital reported preparations carried out as in the past with some additions. For instance, efforts were made to improve team reactions, empower employees to express themselves effectively online, and use body language effectively. For example, training was provided to hospital employees on how to position themselves during the evaluation process.

"During the preparation phase for the evaluation, we conducted all our preparations just like a regular audit. However, there was a need to improve the reactions of the teams. Employees had to express themselves very effectively online and use body language well. It was crucial not to lose the online connection at any point, so we worked on that aspect (K9)."

Technical improvements ensured there were no disruptions in online connection. The hospital's information systems unit collaborated with the quality unit, and technical devices were tested in the field. For use in the assessment, "trolleys" were equipped with wheels and a computer apparatus, a remote control, and a 360-degree camera. These mobile computers are powered by a 4.5 GB line in case of internet disconnection. Teams conducted daily field assessments using this technical equipment for the two months leading up to the assessment to identify and address functional problems in advance.

"Information technologies and information systems, and in our partnership, the institution designed its own devices, and we tested these devices in the field. This way, we developed the habits of employees in terms of how they will position themselves during assessment (K9)."

"We did it just like an assessment. I opened my computer, and we created computers called trolleys, which are wheeled with a computer apparatus, a remote control, and a 360-degree camera, powered by a 4.5 GB line in case of a Wi-Fi disconnection, by the information systems. In the last two months, every afternoon, we prepared the teams by conducting field assessments with this technical equipment (K9)."

The most significant difference in this online external assessment compared to previous evaluations is the sharing of documents through the online platform before the inspection. In addition, a test was held with the evaluating organization 20 days before the assessment.

During the evaluation process, each auditor was provided with a trolley to individually visit the areas. A phone was integrated into each computer to view medical records or to show vantage points that the trolley could not reach.

"Each auditor had a trolley, and we also integrated a phone into each computer. For medical records or points where the trolley couldn't reach, we were able to show them using the phone (K9)."

Because the accreditation organization set and communicated all the rules to the hospital prior to this remote online evaluation, nothing was left to uncertainty. The support of information systems was crucial to the evaluation. There were no technical issues due to the coordinated efforts of the units.

"It was a great experience for us that was absolutely no different from a regular evaluation. JCI had set all the rules for remote assessment (K9)."

DISCUSSION

In today's competitive environment, evaluating, monitoring, and improving quality service enhances productivity and increases business volume (20). The COVID-19 pandemic has significantly impacted the healthcare sector, not only in the delivery of healthcare services but also the administrative and managerial processes of hospitals. Quality improvement initiatives in hospitals and mandatory quality assessments were disrupted in the early stages of the pandemic. Some activities were canceled, others postponed.

Two days after the first COVID-19 case was identified in Türkiye, the Ministry canceled mandatory quality assessments (16), though quality assessments previously scheduled and coinciding with the day of the announcement were still conducted. Absent procedures for conducting assessments during the pandemic, there were many uncertainties for planning the quality assessment process. However, as a rapid response to the global pandemic developed, assessments were conducted online. The JCI accreditation that took place in December proceeded smoothly through established procedures and a clear and defined assessment process. The COVID-19 pandemic has shown the importance of being prepared for future unexpected situations that may arise and the need to develop assessment processes that can be adapted to different scenarios.

Participants reported that additional documents were prepared due to the COVID-19 pandemic, and revisions have been made to these documents. Furthermore, the demand for new documents following the release of new quality standards occasioned disruptions in the system. It should be noted that beyond document preparation and revision, there may also be issues with the use of new documents. Employees may need some time to adapt to changed documents. Such situations dictate providing necessary information and removing outdated documents from the field, and it should be clearly defined how and who will execute out these processes. Additionally, to conserve paper, hospitals should convert their quality efforts to digital platforms as much as possible.

The guidelines published by the Ministry of Health instructed that collective activities such as meetings and training sessions aimed at preventing the spread of COVID-19 among employees should be conducted remotely, such as through distance learning and teleconferencing (21). Some study participants mentioned that inadequate technical infrastructure of their hospitals prevented immediate transition of such activities online and in some

hospitals, even when they were moved online, there were barriers to access. Strengthening hospitals' information systems and technical infrastructure are essential to address these challenges.

The viewpoint of healthcare professionals regarding quality studies was negative even before COVID-19. Quality studies were believed to increase workload and not contribute to career development and evaluation systems (22). Negativity became even more pronounced when combined with the increased workload and stress of the pandemic. Most participants in this study indicated that frontline healthcare personnel reacted negatively to quality improvement efforts. However, unit supervisors and personnel who had previously been involved in quality initiatives had a more positive approach. A study has shown that as years of experience in the profession increase, healthcare workers' knowledge and perception of quality improvement also improve (23). Involving hospital employees in quality processes without increasing their workload is recommended.

The understanding and attitude of senior management regarding quality have significant impact, positive or negative, on quality initiatives within the hospital (15). Though most study participants stated that senior management supported them, some reported lack of support. According to study participants, quality unit employees are less likely to be reassigned to different departments or have fewer reassignments in hospitals where senior management support is high.

It should be noted that the study has certain limitations. Firstly, the data were obtained solely from quality department employees working in 12 hospitals. Therefore, it is recommended to conduct studies with greater participation in the future to ensure more comprehensive results. Secondly, the study only took into account the opinions of the workers of quality departments, whereas the opinions of hospital managers and field workers may provide a more multifaceted perspective.

CONCLUSION

The COVID-19 pandemic negatively impacted hospitals' quality practices in various ways. Changes implemented to adapt to the new situation were not initially fully adequate. The pandemic showed us that hospitals need to harness the benefits of advancing technology, especially digitization, more extensively in their quality practices. In order to better handle similar crises in the future, hospitals are recommended to implement technology-supported quality studies. This includes strengthening the integration of different hospital systems, as well as incorporating technology applications such as the Internet of Things to monitor patient indicators. Additionally, healthcare professionals, including quality employees, should receive training to increase their knowledge of digitalization in health. Finally, regulations and emergency solutions for possible quality crises should be included in quality practices.

Ethics Committe Approval: This study was approved by the Acıbadem University Medical Research Evaluation Board (Decision no: ATADEK-2021/08, Date: 21.04.2021). Additionally, approval was obtained from the Ministry of Health COVID-19 Scientific Research Evaluation Committee.

Informed Consent: Patient consent was obtained.

Peer-review: Externally peer-reviewed.

Author Contributions: Concept and Design- All of authors; Analysis/ Interpretation- ÖG, ŞS; Data Collection or Processing- ÖG, ŞS; Data Collection and/or Processing- All of authors; Writing- ÖG, ŞS; Review and Correction - All of authors; Final Approval.

Conflict of Interest: Authors declare that they have no conflicts of interest or funding to disclose.

Financial Disclosure: Authors declared that this study has received no financial support.

REFERENCES

1. Alrawashdeh HM, Al-Tammemi AB, Alzawahreh MK, Al-Tamimi A, Elkholy M, Al Sarireh F, et al. Occupational burnout and job satisfaction among physicians in times of Covid-19 crisis: A convergent parallel mixed-method study. BMC Public Health 2021;28;21(1):811. https://doi.org/10.1186/s12889-021-10897-4
2. Türkoğlu MC, Yılmaz FK. Sağlık politikası analizi: Türkiye'de COVID-19 pandemi döneminde uygulanan sağlık politikaları. Toplumsal Politika Derg 2021;2(1):11-29.
3. Varol G, Tokuç B. Halk sağlığı boyutuyla Türkiye'de Covid-19 pandemisinin değerlendirmesi. Namık Kemal Tıp Derg 2020;8(3):579-94. https://doi.org/10.37696/nkmj.776032
4. Roy S. Economic impact of COVID-19 pandemic. A preprint 2020;1:29.
5. Oral İ O, Sevinç DE. COVID-19 eksenli sağlık krizinin ekonomi üzerindeki etkileri üzerine bir inceleme. J Manag Theory Pract Res 2020;1(1):58-70.
6. Baş K, Sur H. COVID-19 sağlık krizinin ülkelerin sağlık sistemleri üzerine etkisi; küresel sağlık sistemleri boyutuyla bir değerlendirme. ESTÜDAM Halk Sağlığı Derg 2023;8(1):105-13. https://doi.org/10.35232/estudamhsd.1135965
7. Yüncü V, Yılan Y. COVID-19 Pandemisinin sağlık çalışanlarına etkilerinin incelenmesi: Bir durum analizi. Iğdır Üniversitesi Sosyal Bilimler Derg 2020;(Ek Sayı):373-402.
8. Türkmen E. COVID-19 salgınında yoğun bakım ünitelerinin organizasyonu. Yoğun Bakım Hemşireliği Derg 2020;24(Ek-1):39-45.

9. Cansever İH. COVID-19 Sürecinde Türkiye'de sağlık politikaları. Başkent Üniversitesi Sağlık Bilimleri Fakültesi Derg-BÜSBİD 2021;6(Özel Sayı):86-104.
10. Çırpan H, Güner Ş. Kaotik durumlarda hastane yönetimi ve liderlik: KOVİD-19 salgını üzerine nitel bir araştırma. Süleyman Demirel Üniversitesi Vizyoner Derg 2021;12(30):449-65. https://doi.org/10.21076/vizyoner.820495
11. Çobanoğlu FS. Tıp fakültesi ve SBF ebelik ve hemşirelik bölümü öğrencilerinin hastane kalite standartları hakkında bilgi düzeylerinin araştırılması. (tez). Sivas Cumhuriyet Üniversitesi Sosyal Bilimler Enstitüsü Sağlık Kuruluşları Yöneticiliği Anabilim Dalı. Yüksek Lisans Tezi. 2022.
12. Güdük Ö, Kılıç CH. Sağlık hizmetleri akreditasyonu ve Türkiye'de gelişimi. Düzce Üniversitesi Sağlık Bilimleri Enstitüsü Derg 2017;7(2):102-7.
13. T.C. Sağlık Bakanlığı Sağlık Hizmetleri Genel Müdürlüğü. Sağlıkta kalite sistemi. Available from: https://shgmkalitedb.saglik.gov.tr/TR-8785/turkiye-saglikta-kalite-sistemi.html (Accessed date: 26.08.2023).
14. T.C. Sağlık Bakanlığı, Sağlık Hizmetleri Genel Müdürlüğü, Sağlıkta Kalite, Akreditasyon ve Çalışan Hakları Dairesi Başkanlığı. SKS Hastane (Sürüm 6.0). Sağlık Bakanlığı Yayın No: 1156, Ankara. Available from: https://shgmkalitedb.saglik.gov.tr/TR,12679/saglikta-kalite-standartlari-sks.html (Accessed date: 26.08.2023).
15. Karaca L. Sağlıkta akreditasyon denetçilerinin sağlık hizmetleri akreditasyonuna bakış açılarının incelenmesi. (tez). Karamanoğlu Mehmetbey Üniversitesi Sağlık Bilimleri Enstitüsü, Karaman. 2022.
16. T.C. Sağlık Bakanlığı, Sağlık Hizmetleri Genel Müdürlüğü. Sağlıkta kalite değerlendirme programlarının iptali hakkında. Available from: https://shgmkalitedb.saglik.gov.tr/TR-64418/saglikta-kalite-degerlendirme-programlarinin-iptali-hakkinda.html (Accessed date: 26.08.2023).
17. T.C. Sağlık Bakanlığı, Sağlık Hizmetleri Genel Müdürlüğü. 2021 yılı sağlıkta kalite değerlendirmeleri hakkında. Available from: https://shgmkalitedb.saglik.gov.tr/TR-84374/2021-yili-saglikta-kalite-degerlendirmeleri-hakkinda.html (Accessed date: 26.08.2023).
18. Hsieh HF, Shannon SE. Three approaches to qualitative content analysis. Qualitative Health Res 2005;15(9):1277-88. https://doi.org/10.1177/1049732305276687
19. Kumbetoglu B. Sosyolojide ve antropolojide niteliksel yöntem ve araştırma. 6. Baskı. Ankara: Bağlam Yayıncılık. 2019.
20. Khambhati R, Patel H, Kumar S. A performance evaluation and comparison model for Urban Public Healthcare Service Quality (UrbPubHCServQual) by Fuzzy TOPSIS Method. J Nonprofit Public Sector Marketing 2022;34:291-310. https://doi.org/10.1080/10495142.2020.1865232
21. T.C. Sağlık Bakanlığı. COVID-19 pandemisinde sağlık kurumlarında çalışma rehberi ve enfeksiyon kontrol önlemleri bilimsel danışma kurulu çalışması. Available from: https://dosyahastane.saglik.gov.tr/Eklenti/186465/0/covid-19saglikkurumlarindacalismarehberiveenfeksiyonkontrolonlemleripdf pdf.pdf?_tag1=1C2B3509FD3142EC6CCB7DAB33E956C22CD923A1 (Accessed date: 28.08.2023).
22. Bayer N, Zeybek Yılmaz E, Baykal, Ü. Sağlık çalışanlarının kalite belgelendirme sürecine ilişkin görüşleri. Sağlık Bilimleri Yaşam Derg 2091;4(1):0-0.
23. Doğan D. Kalite ve indikatör yönetiminde çalışanların bildirim düzeylerinin saptanması ve geliştirilmesi. (tez). Beykent Üniversitesi, İstanbul. 2016.