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Proposition of a substantive theory for the hospital accreditation process: the "commitment to care" model

ANDREIA MARIA BERTO [1]
ROLF HERMANN ERDMANN [2]
VIVIAN OSMARI UHLMANN [3]

[1] UNIVERSIDADE FEDERAL DE SANTA CATARINA (UFSC) / DEPARTAMENTO DE CIÊNCIAS DA ADMINISTRAÇÃO, FLORIANÓPOLIS – SC, BRAZIL
[2] UNIVERSIDADE FEDERAL DE SANTA CATARINA (UFSC) / PROGRAMA DE PÓS-GRADUAÇÃO EM ADMINISTRAÇÃO, FLORIANÓPOLIS – SC, BRAZIL
[3] UNIVERSIDADE FEDERAL DE SANTA CATARINA (UFSC), FLORIANÓPOLIS – SC, BRAZIL

Abstract

This study presents a substantive theory that aims to explain the factors that interact and influence the elements involved in the implantation, maintenance, and evolution of hospital accreditation. The study was carried out between 2015 and 2017, through the case of the Transamazonica Regional Public Hospital (HRPT), located in Altamira (state of Pará), in the northern region of Brazil. Interviews, documentary analysis, and participant observation were conducted longitudinally over a period of 24 months, a period that comprised the maintenance of level 2 of hospital accreditation in HRPT, and the evolution at level 3 and its maintenance at this level. Under a constructivist and qualitative bias, data collection was divided into five rounds, according to the guidelines of Charmaz grounded theory, and involved 56 participants. The proposed model, called "Commitment to Care," was an integrative and systemic alternative to understanding how hospital accreditation occurs in the organization studied. Its structure consists of three central categories: "The way we work," "Accreditation as an instrument of action," and 'Love to the cause'; a category of support: 'Development of health professionals'; and two outcome categories: "Excellence in Outcomes" and "Patient-Centered Care." These findings were in dialogue with complex thinking and the study of institutions.

Keywords: Hospital Accreditation. Substantive theory. Public hospital.

Proposição de uma teoria substantiva para o processo de acreditação hospitalar: o modelo "comprometimento com o cuidado"

Resumo

Este estudo apresenta uma teoria substantiva que se propõe a explicar como interagem e que fatores influenciam os elementos envolvidos no processo de implantação, manutenção e evolução da acreditação hospitalar. A pesquisa foi realizada entre os anos de 2015 e 2017, por meio do *case* do Hospital Regional Público da Transamazônica (HRPT), localizado em Altamira (PA), região Norte do Brasil. Entrevistas, análise documental e observação participante ocorreram de forma longitudinal num período de 24 meses, espaço de tempo que compreendeu a manutenção do nível 2 da acreditação hospitalar no HRPT, bem como a evolução ao nível 3 e sua manutenção. Sob um viés construtivista e qualitativo, o levantamento de dados foi dividido em 5 rodadas, conforme as diretrizes da *grounded theory* na vertente de Charmaz, e envolveu 56 participantes. O modelo proposto, denominado "comprometimento com o cuidado", se mostrou uma alternativa integradora e sistêmica à compreensão de como ocorre a acreditação hospitalar na organização estudada. Sua estrutura é constituída por 3 categorias centrais – "a forma como trabalhamos", "acreditação como instrumento de ação" e "amor à causa" –, 1 categoria de suporte – "desenvolvimento dos profissionais de saúde" – e 2 categorias de resultado – "excelência nos resultados" e "cuidado centrado no paciente". Esses achados dialogaram com o pensamento complexo e o estudo das instituições.

Palavras-chave: Acreditação hospitalar. Teoria substantiva. Hospital público.

Propuesta de una teoría sustantiva para el proceso de acreditación de hospitales: el modelo "compromiso con el cuidado

Resumen

Este estudio presenta una teoría sustantiva que tiene como objetivo explicar los factores que interactúan e influyen en los elementos involucrados en el proceso de implantación, mantenimiento y evolución de la acreditación hospitalaria. La investigación se llevó a cabo entre 2015 y 2017, a través del caso del Hospital Regional Público da Transamazônica (HRPT), ubicado en Altamira (estado do Pará), norte de Brasil. Las entrevistas, el análisis de documentos y la observación participante se llevaron a cabo longitudinalmente durante un período de 24 meses. Este período de tiempo abarcó el mantenimiento del nivel 2 de la acreditación hospitalaria en el HRPT, así como la evolución al nivel 3 y su mantenimiento en ese nivel. Bajo un sesgo constructivista y cualitativo, el levantamiento de datos se dividió en cinco rondas, según las directrices de la teoría fundamentada de Charmaz, e involucró a 56 participantes. El modelo propuesto, llamado Compromiso con el Cuidado, demostró ser una alternativa integradora y sistémica a la comprensión de cómo se da la acreditación hospitalaria en la organización estudiada. Su estructura consta de tres categorías centrales: 'La forma en que trabajamos', 'La acreditación como instrumento de acción' y 'Amor a la causa'; una categoría de apoyo: 'Desarrollo de profesionales de la salud'; y dos categorías de resultados: 'Excelencia en los resultados' y 'Atención centrada en el paciente'. Estos resultados dialogan con el pensamiento complejo y el estudio de las instituciones.

Palabras clave: Acreditación hospitalaria. Teoría sustantiva. Hospital público.

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INTRODUCTION

Since its introduction in the 1970s, accreditation has spread across the world and has become an established part of health systems in more than 70 countries (Greenfield & Braithwaite, 2008). Thus, it is considered an example of diffusion of innovation, in which an idea is adopted by some, transferred to others and then becomes normal practice (Rogers, 2003).

Hospital accreditation, however, cannot be just a quality tool available to hospitals, as each national health system, with its financing arrangements, means of payment and instruments for coordinating the service network, will appropriate its accreditation procedures. Thus, it is the internal relations of accreditation with health systems that give it meaning, as a political amalgamation of qualification of health services that, when shaped to meet the needs and limitations of each country, changes its essence and ceases to be a standard model (Fortes, Mattos & Baptista, 2011).

It is necessary to understand that, in the format presented in Brazil, accreditation is a voluntary, educational method (Monteiro, 2014; Seiffer, 2013; Thimmig, 2007), and, at the same time, a quality assessment and certification system, with pre-established standards that measure compliance with a quality model in health care (Ribeiro, 2006; Seiffer, 2013), able to promote institutional changes (Casimiro, 2005) as an incentive mechanism (Jorge, Carvalho & Medeiros, 2013) that favors good practices and leads to a culture of quality (Seabra, 2007).

Brazilian hospitals adopt 3 certifications: the Joint Commission International (JCI), with 39 accredited hospitals (Brazilian Accreditation Consortium [CBA], 2020); the QMentum International, with 85 accredited hospitals (Qualisa Institute of Management [IQG], 2020); and hospital accreditation by the National Accreditation Organization (ONA), with 350 certified hospitals (ONA, 2020).

ONA is formally recognized by the Ministry of Health as an organization responsible for the system of evaluation of hospital quality in the country, with greater coverage thanks to the adaptation of its standards to the Brazilian reality, with respect to national legislation (Viana, Sette, Botelho, Rezende & Poles, 2011), which makes the ONA instrument fundamental for this study. The certification has 3 conceptual levels, which guide the process of quality evolution: one linked to security, another linked to the integrated management of organizational processes and a third one focused on management excellence (ONA, 2018).

In this scenario, another point to be emphasized is that, in a country with 6,161 hospitals (Datasus, 2020), only 474 (CBA, ONA & IQG, 2020) have a certification focused on the quality of care. In other words, only 7.8% of Brazilian hospitals seek to voluntarily link themselves to a process of continuous improvement of their main activity: assistance provided to the patient. Nevertheless, the databases indicate exponential growth as of 2014.

Health accreditation programs are accepted because they are considered an important driver for improving quality and safety in hospital organizations (Baker & Dunn, 2006), but little has been published about the transparent examination of the different aspects of accreditation and, even less, about the results over time (Greenfield & Braithwaite, 2009). There is a lack of empirical evidence to examine the development, implementation and evolution of accreditation, which can be timely conducted by longitudinal and qualitative research (Greenfield, Pawsey, Hinchcliff, Moldovan & Braithwaite, 2012).

Thus, in the face of this peculiar environment, namely the hospital, the motivation to carry out the present research emerged, for which three observation lenses emerged: hospital accreditation, complex thinking and institutions. These lenses led to the formulation of the following research problem: how do they interact and what factors influence the elements involved in the process of implementation, maintenance and evolution of hospital accreditation?

Based on this question, the objective of the study was derived, which is to identify the structuring elements that contribute to the implementation, the maintenance and evolution of hospital accreditation, as well as the relationships between them, according to the perception of the social actors involved in the process, and jointly build a substantive theory capable of explaining the phenomenon involved in the hospital accreditation process.

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METHODOLOGICAL PROCEDURES

The option that best supported and conducted this study, in the search for understanding a specific context, was the interpretive paradigm in its constructivist approach.

When developing a substantive theory that explains how hospital accreditation occurs in practice, using grounded theory, the substantive area was defined as the accredited hospitals and a practical case was brought to the study. In addition, the method was used in all its phases - initial coding, focused coding and theoretical coding –, following the constructivist strand by Charmaz (2000, 2007).

The analysis was built on interviews and observations that occurred in a longitudinal manner over a period of 24 months, time span that comprised the maintenance of level 2 of hospital accreditation in HRPT, as well as the evolution to level 3 and its maintenance.[1] In addition, the previous phase, reported by those involved or retrieved from documentary evidence – as ONA visit reports –, completed the previous 8 years. This hospital was built at the tertiary level of health care – the most complex –, in a region that did not have such assistance installed and demanded, until then, the sending of the population that needed health care, at a medium and high complexity level, to Belém, whose land journey takes many hours, by unpaved roads - not passable in rainy seasons – and / or on 1.5 hour flights, for extreme cases.

Documentary analysis, participant observation, reports in interviews and cumbuca conversations contributed to the construction, together with those involved, of a systemic scenario, with the factors that influence it, in a qualitative bias. The data collection was divided into 5 rounds and involved 56 participants. Among those involved in the research are hospital staff and patients, representatives of the Social Health Organization (OSS)[2] and consultants or ONA evaluators.

The interview script consisted of a single question in the first interviews and integrated others arising from the established contacts, as a way to validate the codes. The first interviews were conducted with subjects selected for occupying strategic functions.

There were 2 types of interviews. First, between researchers and interviewee; afterwards, after realizing that those involved were working on some issues with brainstorming, which led to the promotion of group reflections called "*cumbuca* conversation". Different actors participated in the *cumbuca* conversations, among which directors, mid-level managers and technical professionals stand out. In these moments, the social actors were encouraged to reflect on points that resulted from previous interviews and/or to build associations between the resulting categories.

There was also the elaboration of an observation guide, which served as a guide for attention and the choice of episodes to be observed, as well as the possibility of inserting as many facts as possible that could be seen and contributed to the understanding of the action of those involved in the context. Participant observation (Charmaz, 2009) occurred on representative occasions on the path to excellence and the maintenance of ONA hospital accreditation, as well as in everyday moments, in which the action could be verified in the normality.

This study resulted in the construction of a substantive theory, which, after its elaboration, presented interfaces with the previous theoretical-empirical knowledge, providing points of complementarity and new lenses on the theme "hospital accreditation".

[1] The hospital was accredited at level 1 in June 2010. The process up to level 3 took 5 and a half years.

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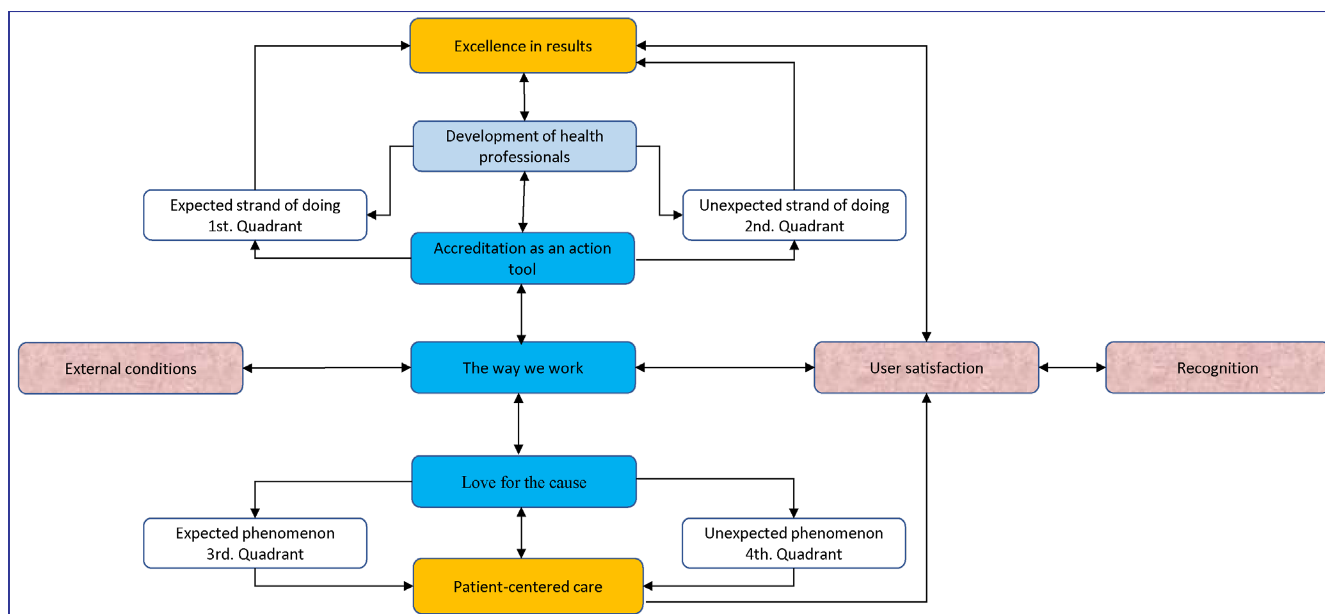
PRESENTATION OF THE MODEL "COMMITMENT TO CARE" AND REFLECTIONS IN THE LIGHT OF ADJACENT THEORIES: COMPLEX THINKING AND INSTITUTIONS

The substantive theory about hospital accreditation at HRPT was built based on findings, reflections and sharing of views that elapsed from the interactions between the various people involved in the research over 24 months. The result was a consensus of "ours" on how hospital accreditation proved possible for implementation, maintenance and evolution in a public health establishment, based in a context of recurring weaknesses and located in the middle of the Brazilian Trans-Amazon region, which in itself already represents a barrier to the process that has been unveiled. The research data led to the gradual construction of a "model" that was conventionally called "commitment to care".

In the foundation of the constituted model, 3 central categories are referenced – "the way we work, "accreditation as an instrument of action" and "love to the cause" –, 1 support category – "development of health professionals" –, 2 result categories – "excellence in results" and "patient-centered care" –, all impacted by the conditions and reflexes of recognition, both external. These categories impact subcategories and interact with each other, forming a general framework permeated by the interrelations created and strengthened by the installed social activity, according to Figure 1.

Figure 1
Model "commitment to care"



Source: Elaborated based on research data (2018).

The category "external conditions" has a greater explanatory relationship with the economic aspect of institutional studies (Cavalcante, 2014; North, 1990; Rocha, 2004; Williamson, 1985, 1996), with inference from the sociological aspect (Daniel, Pereira & Macadar, 2014; Dimaggio & Powell, 1983, 1991; Scott, 1995, 2008), while the central category "the way we work" finds support in complex thinking (Agostinho, 2003; Morin, 2002, 2003, 2013; Stacey & Griffin, 2006) and in institutional work studies (Bruning, Amorim & Gobri, 2015; Lawrence & Suddaby, 2006; Lawrence, Suddaby & Leca, 2011). In complex thinking, by understanding the social actor and organizations in the environment in which they interact; in institutional work, for the doing of individuals, for their actions, acts and ways of understanding this context.

External conditions – location, State, OSS, health system, epidemiological profile, Belo Monte,[2] public and social policies, culture and local values – represent the entry of the model's social action and determine, modify and contingency the installed process and the way it takes place, through institutions that constitute it. Thus, the central category is impacted at all times

[2] Hydroelectric plant built on the Xingu River, which ranks among the largest in the world and caused a drastic change in the service profile.

by external conditions, which, in their relations with the scenario, determine, in a paradigmatic way, as “the way we work” will position itself as an answer to the challenges, creating its own format to develop in this health establishment. “The way we work”, as a category, demonstrated the practice understood in its essence and the deep knowledge of the organization’s managers, who understand its processes, are aware of their bottlenecks and recognize the best way to minimize the harm, risk and dissatisfaction of the welcomed patient, together with other hospital professionals. Therefore, these external conditions serve as a possibility for improvement.

Accreditation itself is the strongest institution at HRPT, perhaps the one that is most culturally interwoven throughout the hospital process. Institution is understood here as a mental habit (Veblen, 1988), for acting as the social fabric, maintained and modified by subjects’ actions and decisions over time. But, at the same time, as habits of thought accepted as guidelines for conduct (Mitchell, 1910), without neglecting the bias that accreditation involves the process by which social actions and obligations come to have a status as a rule in social thought and action (Meyer & Rowan, 1983).

The “accreditation as an instrument of action” served HRPT as a manual to structure the hospital based on quality of care and principles linked to safety, patient focus, systemic vision, method orientation and continuous improvement. The research itself started with the assumption that accreditation was the tool used to determine the path of that hospital. Another common understanding was that this was the perspective that led to the expected strand of doing, peculiar to the organizations that operate motivated by quality certifications, despite the nuances of the scenario found. However, in the doing we found something that was not expected and that defines the difference in the vision of those who do and those who receive assistance, that is, we show that the professionals who work at HRPT are concerned with recognizing their achievements, especially those who are not positive to the process. For making sense throughout the research, together, this element was called the unexpected action of doing.

Social action, which illustrates the first quadrant of the model “commitment to care” and represents “accreditation as an instrument of action” in its expected aspect, is composed of the categories “instrumentalization of doing”, “internal construction”, “involved in the process”, “focus on processes”, “resource maximization” and “quality and safety culture”.

The internal construction takes place through 2 pillars, the first represented by the category “involved in the process” and the second, by the category “instrumentalization of doing”, which, together, form what has been called the triangle of making, an addendum in which the 3 pillars of isomorphic influences are observed (Scott, 2008): the regulator, the cultural-cognitive and the normative. The first is linked to laws, rules or sanctions that regulate health organizations and their professionals; the second supports the shared logic, which is common and has spread in the way it is done at HRPT; and the third instrumentalizes and tells how things should be done, integrating accreditation and pointing out what is expected of the social actors involved (Scott, 2008).

The focus on processes refers to the way in which the management of the processes is established and to how much the organization is more or less strong than those who work in it, because organizational maturity emerges when processes resist people, although it is recognized that professionals are fundamental parts in the construction of doing. This contributed to two movements represented by the subcategories “maximizing resources” and “culture of quality and safety”. The first is related to the sustainability of the hospital and the second is related to how the service provided presents consubstantiated results to the service user: the patient. After reaching level 3, we observed a greater care with improvement and the resource, which goes beyond cost, evolving to the awareness of maximizing resources, as something that is no longer local to be systemic. In this way, organizational action can occur involuntarily to objective conditions, rational or of efficiency, since the organizations surpassed the forces of an institutional sector are impelled to share socially legitimate practices, increasing their expectation of survival through isomorphic uses (Dimaggio & Powell, 1991).

Regarding the culture of quality and safety, it is worth mentioning how those involved understood that it took place. For this purpose, history matters to this hospital and its professionals. Its trajectory tells how HRPT is and acts, enabling past problems to fortify it over the years, giving stability to the evolution of doing and the results presented. Thus, the path was consolidated, initially, with the awareness of patient safety and evolved through the learning of all involved and the constitution of a collective mental model. Hospital accreditation has driven this process concomitantly, first with safe processes and then with the evolution of process and risk management, followed by improvement cycles and express, finally, as quality, with the

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interrelation of the indicators, demonstrating organizational maturity and systemic results linked to the effectiveness of the action. Those involved perceive organizational maturity, while observing a new path to follow, which demonstrates the logic of continuous improvement installed – seen in different ways, depending on the hierarchical degree of the involved.

The second quadrant of the commitment to care model, also supported by the central category “accreditation as an instrument of action” in its unexpected aspect, is made up of the categories “recognition of weaknesses”, “do the right thing”, “fix errors”, “mitigate risks”, “circumvent the limitations” and “strategy in practice as everyday action”.

The unexpected aspect of doing was qualified as the operation in addition to the technical part. Here, the context is fundamental for understanding, since the journey begins at the heart of the hospital’s location and the external determinants that make HRPT a unique case. Thus, the exit category corresponds to the recognition of the weaknesses that are put to HRPT and that go from resources to culture. These weaknesses are strengthened by what is called the motor circle, which are the ways out of the recognition of weaknesses, where there is the purpose of doing it right. For this purpose, it is vital to correct errors, which will be the support to mitigate risks and, in such a way, circumvent the limitations.

In addition to being concerned with the assistance side, which is not the focus of this study, these weaknesses are linked to the transaction costs and the degree they require from specific assets, that is, specialized assets that cannot be reemployed without sacrificing their productive value if contracts end or are affected prematurely (Williamson, 1985). However, what proved to be considerable in the research is that those involved recognize that the weaknesses exist, at the same time that they understand that they can be transposed, even with the need for strategies to overcome obstacles.

The next category in this quadrant, “strategy in practice as a daily action”, is contrary to that common in organizations, which is thought out, created and put into practice. It relates to the everyday doing, as if the weaknesses and external determinants had generated a mechanism that allows this practice to be commonplace, everyday.

This reality aligns with unstable and complex environments, such as the hospital case, in which the differentiation between formulation and implementation of strategies, in most cases, is eliminated (Meyer, Pascuci & Murphy, 2012). This reality aligns with unstable and complex environments, such as the hospital case, in which the differentiation between formulation and implementation of strategies, in most cases is eliminated.

The support category “development of health professionals” has foundations in the categories “as an organizational strategy driven by accreditation” and “by local need”. The significant turnover and professional unpreparedness led HRPT to understand that learning lacked translation in safe and permanent processes, beyond people, and that was the strategy adopted from the beginning and that remains today, as a permanent process of education for the maintenance and evolution of results. The training action was, by local necessity, substantiated by the location of the hospital, due to the insufficiency of training schools in the health area and because there are few professionals in the region, whose training was insufficient for a hospital planned to serve medium and high complexity at high levels of quality. Although local need is an implicit point in most organizations, at HRPT it occurs in an exacerbated way and brought a positive impact that supports the recognition of weaknesses and turns the motor circle, solidifying doing in a strategy in practice as daily action. As a form of compensation, another aspect of support for permanent education was introduced at HRPT, translated into the category “as an organizational strategy driven by accreditation”, acting as an instrument to support the process instituted during the initialization, maintenance and evolution of certification levels.

To obtain accreditation, it is necessary to teach how this occurs, and, in a longitudinal way, there is the evolution of training according to the levels experienced. During level 1, the focus was on safety training; at level 2, in process interaction training; at level 3, in critical analysis and interrelation of indicators. Currently, training refers to the systemic process of results. Under these lenses, the dissemination of the quality process is perceived as a driver of the strategy that drives it.

With that, we observe the reinforcement of the normative pillar by Scott (2008), which points out what is expected of the social actors involved, their attitudes and performances in accordance with prescriptions of action and behavior imputed by hospital accreditation. At the same time, the change reflected in the evolution of institutional levels remains important, but what is relevant in this category is the speed with which individuals process this change. Thus, the greater the capacity of individuals to absorb positive mental models for development, the greater the potential for development (Cavalcante, 2014).

Such development categories indicate that the category "excellence in results" is supported by the knowledge acquired by health professionals, who, in addition to being more qualified, observe assistance through quality and safety lenses.

Thus, the result category "excellence in results" demonstrates the evolution of the quality of care, in a process that started with the decision to enable hospital accreditation as a guide for conducting the process at HRPT. Excellence in results runs through the numbers presented, which lead to an improvement in the quality of care and, henceforth, has a background of perception that goes beyond numbers and needs experience in the area where it occurs to assess a plausible explanation.

In the case analyzed, the data were polished slowly and, over time, they were better, more consistent and consistent with the level of excellence. The excellence in the results was obscure, not visible to the eyes, but it was set. The scraps of the fabric on which it had been installed had to be darned; there was a hint of complexity that was not fully clarified in the eyes of those who led, built and moved that process. However, the results in 2017 were different, doing became enlightened and professionals understood that excellence in results was an effectively systemic process, that was acquired through the experiences lived/learned and (now) managed by each one and together, within a historical process, that became apparent when they reached the understanding that the whole is the sum of each integrated part.

Thus, when the results provided evolution of performance with favorable trends, those involved in the process realized the difference in the way of doing, in which accreditation as an instrument of action, added to the development of health professionals in its expected and unexpected aspects, can be effectively translated into excellence in results, as long as they add a dose of love.

The central category "love for the cause" brings the good side of the social actor and, with it, support for the lower quadrants of commitment to care. The findings of this study led to a point that is not common in organizational examinations, but which has shown to influence, holistically, in all components of commitment to care, overlapping the technique, duty with the profession, organizational responsibility and social nature. Thus, love for the cause was instituted as a central category that supports action.

This category is composed, on the one hand, by the quadrant designated by technical knowledge that finds love, which is considered a phenomenon expected of the hospital for its mission, and, on the other, by the quadrant with emotional appeal and that demonstrates the personal donation of those involved in hospital care, termed as an unexpected phenomenon. The sum of these quadrants gives rise to what those involved in the research consider the project of their lives. It is a feeling that refers to the complexity of the dialogical thinking presented by Morin (2002, 2010), that unites both technique and feeling, doing and feeling, the phenomenon to a cause, which those involved in the study consider personal in their lives.

The third quadrant of commitment to care, linked to the love of the cause in its expected phenomenon, is circumscribed by the categories "guaranteeing care security", "being with the patient", "proximity to the community and the health system" and "serving as a solution to the health network".

The category "guaranteeing care security", one of the most representative of the process, would certainly be present because it represents principles imbricated in the fundamentals of health management proposed by ONA, name good care practices and, in recent years, be linked to the international safety goals that the World Health Organization (WHO) promulgates as vital to safe care.

However, in order to guarantee care security and be with the patient, it is essential to express the empathy aroused by the circumstance in which they find themselves looking for a health service. Being close to the patient encompasses the action beyond what is plausible, in which the professionals go through all the interim to offer care, innovating in the way of doing, in the solutions, and guaranteeing solidarity.

The proximity to the community and the health system makes the hospital one of the main references in Altamira, which has been developing social, educational and project actions external to the hospital. In addition, it is one of the largest or the largest local employer, as well as contributing considerably to the local economy. Being together with the patient, allied to the proximity to the community and the health system, is reinforced when HRPT develops activities focused on the community, in order to ensure continuity of care for patients who were hospitalized, citizen prevention and the role of the hospital in the context of the health network. Thus, institutional work takes place in an intentional effort to affect an institution or a set of institutions, in which institutional workers act in a conscious way of what is intended (Bruning, Amorim & Gobri, 2015).

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As if derived from the proximity to the community and the health system, voluntarily or involuntarily, the category “serving as a solution to the health network” appears”, contributing to the social and assistance role of HRPT, surpassing what is stipulated as performance within the Brazilian health system: offering medium and high complexity assistance to referral patients.

The fourth quadrant of commitment to care, linked to love for the cause in its unexpected phenomenon, groups the categories “hospital has significance for people”, “possibility of doing good”, “involvement of professionals”, “principle of belonging”, “resilience of care groups”, “affective relationship” and “feeling of accomplishment”.

In this category, there is the sum of the meaning attached to the place with the activity developed in the hospital, which is taking care of people, which allows the view of the good side of the human being. The possibility of doing good has a fraternal appeal, in which patients and professionals support each other in the pursuit of better doing, more humane care. The profession itself has this bias, however, in the view of the interviewees, over time, the automation of care makes the result more operational and mechanical than humanized and patient-centered; empathy disappears in the prescription of the method, the protocol. Therefore, the possibility of doing good comes to illuminate the opposite path. Thus, there is a similarity with Veblen’s idea of evolutionary process, moved by the instinct called parental bent, that is, one who would incline the subject to seek the improvement of the well-being of the family and society (Cavalcante, 2014; Rutherford, 1984), where care is installed and reinforces the human side of professionals.

The assistance provided is constantly judged to check if what is done is the best for those involved, beyond the external view of regulatory bodies or ONA’s assessment. Accreditation is seen as an instrument, but it is not what builds the categories focused on the love of the cause, which are fueled by the commitment to care. The accreditation rendered the hospital a lot of technique and knowledge, but what has been established is the result of the experience of a local group, experienced over the years, which instituted other ways of providing assistance, especially by implementing guidelines linked to feeling/to union/to love.

It is clear, therefore, that usual actions foster this social activity and are entangled between what is formal and what is informal, what is expected and what is unexpected, as a way of stating that reality has precedents based on feelings, that can favor their development or not, in a solid line between the opposites. In addition, points like these favor the work, translated by those involved in allegories such as the work team and embracing the cause, that define the union of these professionals. Therefore, the performance presented goes according to the cohesion agreement of these teams, and the principle of belonging is fundamental.

The possibility of doing good, coupled with the involvement of health professionals and the principle of belonging, strengthens the emergence of a sense of accomplishment, made explicit during the research at the moments when they express the various points of weakness to, next, vibrate with the victories achieved. The feeling of accomplishment finds strength in the possibility of growth that the hospital provided/provides for many of its employees. Furthermore, the professional is fulfilled when they see themselves progressing, which motivates them to continuous improvement – own and the organization –, gives enthusiasm to performance, raises team morale, ultimately contributing to patient-centered care.

The result category “patient-centered care” highlights the humanization side of doing as an effect of the care process. This category showed a strong link with the emotional side of the quadrants related to the phenomena linked to the love of the cause, which denotes alignment with complex thinking. Thus, it enabled an answer to the questioning that Morin asks in the famous Method 5– “Will it be possible to transform hominization into humanization”? (Morin, 2007) –, because the results found demonstrated the appeal that the place instigates in those involved, offering these professionals the possibility of self-realization through doing, and, as such, turn what they do more humane, offer the other a care centered on their needs. A possible explanation of what makes this category of results so expressive is the understanding of those involved in their role in that context. When observing themselves apart geographically, with few local health resources and difficulty in traveling and assistance, they realize that the hospital, if placed at risk of life, it is what is best for themselves and their loved ones, which leads them to maintain and improve their processes.

People understand themselves as belonging to the place where they live and the hospital where they work, as well as accepting the ONA accreditation certification as a tool that showed them how to be better, as a guide that allowed them to go beyond, do better for others and for themselves, promoting patient-centered care. Therefore, while it looks like a miracle solution

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that elevates the desire to work for a better world (Fortin, 2005), emphasizing the feeling of belonging of the group to the hospital and to Altamira, it brings the regulatory dimension of isomorphism (Scott, 1995, 2008), associated with prescriptions and standards imposed by the conception of the desirable, along with building standards that demonstrate how things should be done, with the assumption that they are "legitimate means to pursue valid ends" (Scott, 1995).

The categories that end the commitment to care are "user satisfaction" and "recognition" – professionals, the hospital and the process –, providing the inclusion of the stakeholders' view of quality and care security.

About the main user, who represents the patient effectively treated at the hospital and their family, there is satisfaction, measured internally by the Customer Service (CS), that, in addition to verifying the quality established by the service from the patient's perspective, acts as a mediator when there are problems or weaknesses observed during care, or as a supporter in solving needs raised by the patient. This contact reduces the weaknesses that impact the assistance, as well as the risks associated with non-conformities found, corroborating with high levels of satisfaction.

The hospital's recognition occurs when it is considered benchmarking by its peers who work in the Brazilian health market and perceive it as a possibility beyond what they already undertake in their hospital organizations. This type of recognition, known as success, is seen as a mimetic influence in the organizational field, since, in view of the uncertainties regarding the standardization of assistance through accreditation, this positive experience in the national environment emerged (Daniel et al., 2014).

Recognition of the process occurs when its activities are likely to be a reference for other organizations, when referenced in scientific works as successful cases and/or when their indicators appear as benchmarks of excellence, serving as a reference for other organizations. The same goes for the recognition of professionals who maintain, improve and innovate the techniques undertaken in the activity, accumulating learning and knowledge about the hospital activity, becoming distinct in the job market – and elevating their "pass" –, acting as references within the professional categories of activity. In this same line of perception, Agostinho (2003) argues that the relationships of the actors reside in reciprocity between individuals who, when looking for self-interest, rely on cooperation. Therefore, the recognition itself strengthens and is strengthened by professionals through others – for example, patients and the community served.

CONCLUSION

The first stage of the objective of this research was to identify the structural elements that contribute to the implementation, maintenance and evolution of hospital accreditation. Its service started with the construction of nine categories, grouped by those involved in the research based on the relationship they established between the codes previously obtained from the data collections. Then, as the study progressed, it was revealed that hospital accreditation was structured by the impact of external determinants, by the way those involved carried out their activities, by the use of accreditation as an instrument of action, for the development of health professionals, for excellence in results, for the love of the cause and for patient-centered care.

The second part of the objective is to recognize the relationships between the structuring elements according to the perception of those involved in the hospital accreditation process (social actors). Thus, those involved in the process pointed out the relationships between the categories by means of interwoven threads of complexity, and, due to the external constraints, especially the location and the power of the State, the way we work is determined, which is impacted, on the one hand, by the accreditation technique as an action instrument with its expected and unexpected aspects of doing that guarantee excellence in results and, on the other hand, for the love of the cause, which in its phenomena, expected and unexpected, provides patient-centered care, reflects user satisfaction and results in recognition of the process, professionals and the hospital.

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In the third and last part of the objective, it was proposed to build, together with those involved in the process, a substantive theory capable of explaining the phenomenon intertwined in the hospital accreditation process. Thus, a systemic model called "commitment to care", which is made up of a central axis, through which there are the inputs from the external scenario, the practice of organizational doing and the result of this process inside and outside the hospital context. To support the model, there are 3 central categories – "the way we work", "accreditation as an instrument of action" and "love to the cause" –, 1 support category – "development of health professionals" – and 2 result categories – "excellence in results" and "patient-centered care" –, that are driven by the constraints and reflections of external recognition. These categories have an impact on the subcategories and with each other, basing the aforementioned scheme, which is permeated by the interrelations created and strengthened by the daily routine installed.

New categories of analysis were established in this study, which contribute to the understanding of hospital accreditation. These results allowed for a look beyond the mainstream and made it possible to respond to points that were not covered in previous studies on high-performance hospital organizations. Thus, we came to the conclusion that these issues are among the main factors that made HRPT stand out as a case in which accreditation found ground for implementation, maintenance, modification and evolution. Such categories include external determinants, in particular the state, culture and location, in addition to the way those involved act, strategy as a daily practice, proximity to the network and, consequently, to the health system, and the link created between practices favored by love for the cause and the significance attributed to the place and the organization.

The knowledge derived from the constructed substantive theory refers specifically to the phenomenon studied in the unit of the substantive area: the HRPT. Although not generalist, the commitment to care serves for a more robust reading of the complexity of the system and allows technicians possible adaptations. Therefore, part of the theory or specific categories can be adapted for use by most hospital organizations, accredited or not. In the continuation of this study and in the sense of generating an extension of the function proposed by ONA – and, consequently, generate improvements to the Brazilian health system –, studies connected to the strengthened links in the chain of assistance of the health network are suggested, provided by the accreditation. Studies on these aspects would find support in complex thinking and institutional work.

In addition, studies focusing on transaction costs could be approached in the same environment for in-depth reflections, since this research was partially observed. However, we realize that there is room for new contributions, especially with regard to the uncertainty of the environment caused by the location and its determinants.

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Andreia Maria Berto
ORCID: https://orcid.org/0000-0002-8792-7751
Ph.D. in Administration from the Universidade Federal de Santa Catarina (UFSC); Professor-tutor at Fundação Getulio Vargas (FGV).
E-mail: andreiamberto@hotmail.com

Rolf Hermann Erdmann
ORCID: https://orcid.org/0000-0002-4094-2268
Ph.D. in Production Engineering from the Universidade Federal de Santa Catarina (UFSC); Full professor at the Department of Administration Sciences at Universidade Federal de Santa Catarina (UFSC). E-mail: rolf.erdmann@ufsc.br

AnVivian Osmari Uhlmann
ORCID: https://orcid.org/0000-0003-2743-5293
Ph.D. in Administration from the Universidade Federal de Santa Catarina (UFSC). E-mail: vouhlmann@gmail.com

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