RESEARCH PAPER

Beyond Compliance: The Impact of Hospital Accreditation on the Performance of the Healthcare Staff

S. Alexander[1*], Dr. A. Shameem[2]
[1]Research Scholar, AMET Business School, AMET University, Chennai, India
Email: shareblood.athmabb@gmail.com
ORCID: https://orcid.org/0009-0009-6667-0342
[2]Professor, AMET Business School, AMET University, Chennai, India
Email: drshameem@ametuiv.ac.in
ORCID: https://orcid.org/0000-0002-2869-2702
***Corresponding Author:** S. Alexander, Research Scholar, AMET Business School, AMET University, Chennai, India
Email: shareblood.athmabb@gmail.com

ABSTRACT

While hospital accreditation can be seen as an external process for ensuring healthcare quality, in practice, the extent to which formal standards are integrated into workers' day-to-day practice is important. This is an empirical study on the immediate impact of hospital accreditation practice on the performance of healthcare employees with the healthcare institutions that are accredited in Chennai. Leadership commitment, standards implementation, employee training and competency, and patient-safety and quality-improvement practices are measured as indicators of accreditation practices. There are two types of employee performance, namely task performance and contextual performance, and quality-oriented work behaviour, which are assessed.

The study uses survey responses from 156 healthcare workers and tests for a Pearson correlation and multiple regression analysis to identify practices associated with the best improvement to workforce performance. All three regression models were statistically significant, explaining 14.2% of the variance in task performance, 16.5% in contextual performance and 11.8% in quality-oriented work behaviour, respectively. In regard to individual predictors, employee training was a statistically significant predictor of task performance, patient-safety and quality-improvement practices were statistically significant predictors of contextual performance, and accreditation standards implementation was a statistically significant predictor of quality-oriented work behaviour. None of the other dimensions of performance showed significant association with leadership commitment when this was regressed on the other accreditation practices. The results suggest that there are specific pathways to workforce performance that are associated with accreditation, and that predictor-level significance is dependent on sample size and common variance between accreditation practices.

Keywords: Hospital accreditation, healthcare employees, task performance, contextual performance, quality-oriented work behaviour, patient safety

Introduction

The purpose of hospital accreditation is to move the general expectations of safe, effective and accountable care into the realm of actual measurable standards of an organisation. In the healthcare sector, accreditation bodies make healthcare facilities show how well they are led, how their clinical work is done, the capabilities of their staff, how well they record information, how well they control risks and manage performance. The National Accreditation Board for Hospitals and Healthcare Providers (NABH) has been gradually moving from documentation to measurable governance, patient safety and clinical outcomes in India (NABH, 2025). Internationally, accreditation also supports the work of the World Health Organization (WHO) on reducing avoidable harm and strengthening the implementation of safety policies in point of care, through institutional systems (World Health Organization, 2021).

Achievement of a certificate does not guarantee good performance, however. Whether or not the benefits are realised depends on employee understanding of the standards, the quality information they are receiving, appropriate training, adherence to SOP and reporting of risks, learning from errors and using quality information in their day-to-day decisions. Positive linkages between accreditation and various aspects of healthcare quality have been reported in systematic reviews, including the dimensions of quality care, such as safety, efficiency, process reliability and patient-centredness; however, these reviews also highlight methodological inconsistencies and less robust evidence of associations between accreditation and mechanisms operating at the system and/or the individual-worker level (Araujo et al., 2020;

***Corresponding Author:**
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Hussein et al., 2021; Alhawajreh et al., 2023). This uncertainty is significant because it is the employees who make the accreditation requirements happen as clinical, administrative and support practices.

Performance of healthcare workers has a multi-dimensional nature. Task performance relates to the ability to complete primary tasks effectively, accurately and timely. Contextual performance is defined by behaviours that are considered discretionary and that help to maintain the organisation and social environment such as co-operating, being initiating and helpful to colleagues. Quality oriented work behaviour involves employees' compliance with the patient safety standards, error prevention, responsibility for service quality and responsiveness to change associated with the accreditation process. These outcomes can be considered in isolation as an accreditation practice that enhances procedural task performance does not necessarily promote OBC and QB.

The present study seeks to answer this question by examining the direct influence of four accreditation practices – leadership commitment, implementation of accreditation standards, employee training and competency development and implementation of patient-safety and quality-improvement practices – on three dimensions of healthcare employee performance. The study, using data from 156 healthcare workers in Chennai, finds that accreditation practices that do not have a statistical association with the other practices in the study remain statistically significantly associated with performance.

Literature Review

Accreditation is a rigorous, systematic external process of evaluation by a healthcare organisation against a set of standards. It's more of an organisational intervention than a single inspection event, as it requires preparing, using standards, redesigning routines, staff involvement, gathering evidence, external review and follow-up. Accreditation research covers the topics of organisational change, professional development, quality measures and attitudes of different stakeholders, as noted by Greenfield and Braithwaite (2008), and complex intervention effects are hard to detect in a simple comparison of accredited versus non-accredited by Brubakk et al. (2015).

There is mixed empirical evidence. The authors of the other studies found evidence of consistently improved care processes by accreditation (Alkhenizan & Shaw 2011) or benefits in efficiency, safety, effectiveness, timeliness and patient-centredness (Araujo et al. 2020), but cautioned against the interpretation of the evidence due to methodological limitations. Hussein et al. (2021) also reported positive trends in safety culture, process performance and efficiency, with less or mixed impacts on employee and patient satisfaction. The recently published Alhawajreh et al. (2023) review found that accreditation remains accepted as a quality-assurance tool and that the outcomes are greatly influenced by implementation efforts, staff engagement and context.

Leadership commitment provides direction, resources and legitimacy for accreditation activities. Leaders drive the emphasis on accreditation as a recurring evidence-gathering process or as an ongoing focus for operations. When the quality indicators are clearly visible and resources are allocated, and the expectations communicated and participation in improvement activities, there is less ambiguity and it becomes clear that compliance is an organisational responsibility. But, leadership effects can be either indirect or co-occurring with more proximal practices. When standards, training and safety procedures are part of the same predictive model, a general perception of a leader's commitment may only add a small amount of unique variance as it is already captured by the operational systems.

Standards implementation is the process of converting the accreditation criteria into a standard operating procedure, documentation requirements, role expectations and monitoring arrangements. The adoption of consistent standards can help minimize unwanted variability, define the desired work process, and also offer a point of reference for accountability. Studies over the years have indicated that repeat accreditation cycles can help increase the reliability of quality compliance, but this is not consistent for all indicators or over time (Devkaran & O'Farrell, 2014, 2019). The greatest impact of the workforce should be felt when standards are clear, feasible and part of normal work processes, rather than being kept more for external review.

Employees would carry out accreditation requirements correctly by if the organisation provide training to them so that they understand what it means. The issues of competency development are particularly relevant in healthcare as staff are required to integrate technical skills and documentation, infection control, communication and reporting risks, and patient-centred practice. Training can be used to directly enhance role knowledge and accuracy in task performance, and be used to support quality-oriented behaviour by enhancing confidence when the procedure or regulatory situation changes. Deficient staff training, resistance to change, and lack of knowledge about it have been constantly raised as problems in implementing accreditation (Alkhenizan & Shaw, 2012; Alhawajreh et al., 2023).

Practices related to patient safety and quality improvement involve risk prevention, reporting of incidents, and monitoring of outcomes and departmental improvement activity. These

practices are more proximal to employees' day-to-day work, and so may have a more direct impact than more remote accreditation signs. Patient safety is defined by the World Health Organization (2021) as "a system of organised activities, behaviours and environments aimed at preventing 'unnecessary' harm. Accredited settings suggest that staff experience and reporting and professional status can impact perceptions of safety performance (Kwan et al., 2021). When the safety practices are actively practiced employees are provided with more behavioural cues to be careful in task performance, problem solving and cooperative action.

This involves behaviour as well as output for individual work performance. Task performance is a measure of one's ability to perform formally required tasks, whereas contextual performance is a measure of behaviours required to maintain social and psychological conditions within the context in which technical work is performed (Borman & Motowidlo, 1993; Koopmans et al., 2014). Quality-focused work behaviour is also significant in healthcare due to adherence to patient safety protocols, error reduction and accountability for service quality, which all impact assurance in the organization. It is important to recognise that these performance dimensions may be affected differently by accreditation: standards and training may be particularly relevant to the way tasks are carried out; aspects of safety may encourage initiative and contribution to the context; and formal implementation, plus training may be more effective at supporting ongoing behaviour related to quality.

Research Gap

Research on accreditation tends to focus on an organisation's accreditation, clinical results or patient satisfaction, as well as on general quality measures. There are few studies that break down accreditation into specific practices and examine the simultaneous role these practices play in various aspects of employee performance. This is especially lacking in India where the size of the healthcare institutions varied and there has been rapid growth in accreditation by NABH and significant variation in the type of healthcare institutions, their professional composition and accreditation status. A workforce analysis can be used to determine which accreditation practices are correlated with performance and which have unique predictive value above and beyond other practices.

Objectives and Hypotheses

The study aims to investigate the relationship between hospital accreditation practices and the performance of healthcare employees, to quantify the total variance explained by the hospital accreditation practices for the three measures of employee performance (task performance, contextual performance and quality-oriented work behaviour) and to identify which accreditation practices contribute the most to each of the three measures.

H_1	*Leadership commitment for accreditation is associated with higher performance of healthcare workers.*
H_2	*The implementation of accreditation standards positively predicts the performance of healthcare employees.*
H_3	*employee training and competency development is a significant and positive predictor of the performance of healthcare employees.*
H_4	*Positive relationships between patient-safety and quality-improvement practices and healthcare employee performance.*

The study was based on quantitate approach, cross sectional and explanatory survey study. The setting consisted of government healthcare centres, private hospitals, multispeciality hospitals, speciality hospitals and diagnostic centres in Chennai all of which are accredited healthcare institutions. The unit of analysis was healthcare centre employees (HCE).

Sample

A final sample of 156 employees, from all clinical, allied, administrative, technical and support roles were used. This diverse profile allowed this analysis to speak to the implementation of accreditation across a range of professions. The sample included 58.3% women, 62.2% were in the age range of 25-45 years. Most of the professional groups were nurses (34.6%) followed by allied healthcare professionals (17.3%) and doctors (15.4%).

Table 1- Profile of the Respondents

Variable	Category	Frequency	Percent
Gender	Male	65	41.7
	Female	91	58.3
Age	Below 25 years	20	12.8
	25-35 years	53	34.0
	35-45 years	44	28.2
	45-55 years	26	16.7
	Above 55 years	13	8.3
Education	Diploma	27	17.3
	Undergraduate	44	28.2
	Postgraduate	57	36.5
	Doctoral degree	20	12.8
	Professional qualification	8	5.1

Professional category	Doctor	24	15.4
	Nurse	54	34.6
	Allied healthcare professional	27	17.3
	Administrative staff	21	13.5
	Technical staff	17	10.9
	Support staff	13	8.3
Healthcare centre	Government healthcare centre	31	19.9
	Private hospital	49	31.4
	Multispeciality hospital	44	28.2
	Speciality hospital	19	12.2
	Diagnostic centre	13	8.3
Accreditation status	NABH	83	53.2
	JCI	19	12.2
	NABH and JCI	27	17.3
	Other accreditations	27	17.3

Measures

Four dimensions were used to assess accreditation practices: leadership commitment towards accreditation (LCA), accreditation standards implementation (ASI), employee training and competency development (ETCD), and patient-safety and quality-improvement practices (PSQI). Task performance (TP), contextual performance (CP) and quality-oriented work behaviour (QOWB) were the three dimensions of employee performance represented. Responses were noted on a five-point Likert scale (1 = strongly disagree to 5 = strongly agree). The confirmatory factor loadings for the items of the retained constructs ranged from .836 to .872, which are very high. Task and contextual performance were understood in the same way as the multidimensional individual work performance literature (Koopmans et al., 2014).

Table 2 - Study Constructs and Operational Focus

Code	Domain	Operational Focus	Items
LCA	Accreditation practice	Leadership support, communication, resources, review and employee participation	5
ASI	Accreditation practice	Work procedures, role expectations, documentation, SOP compliance and guideline adherence	5
ETCD	Accreditation practice	Training adequacy, knowledge, guidance, adaptation and competency evaluation	5
PSQI	Accreditation practice	Patient safety, reporting, monitoring, error prevention and improvement activity	5
TP	Employee performance	Effectiveness, accuracy, timeliness, procedural adherence and professional competence	5
CP	Employee performance	Collegial support, participation, extra-role commitment, workplace contribution and initiative	5
QOWB	Employee performance	Safety adherence, error reduction, quality responsibility, adaptation and continuous improvement	5

Data Analysis

Descriptive statistics, Pearson product-moment correlations and multiple linear regression were used for the analysis. Two sets of regression models were obtained, one for task performance and another for contextual performance and quality-oriented work behaviour. For all models, LCA, ASI, ETCD and PSQI were entered concurrently. The relative contribution of the predictors was compared using standardised beta coefficients. A 5% level of statistical significance was used. The degrees of freedom for the regression model were (4, 151) and for correlation tests were 154. Variance inflation factors for the accreditation predictors were in the range of about 1.23 to 1.44, thus, there was no significant multicollinearity problem. The design is of a cross-sectional type, and relies on the perceptions of employees, so that coefficients are presented as prediction associations, not causal effects.

Results

The average scores on items for all of the accreditation and performance dimensions were above the scale midpoints. The accreditation dimensions that had the highest mean item ratings were leadership commitment and patient-safety practices (both approximately M = 3.52), followed by employee training (M = 3.45) and standards implementation (M = 3.17). Task performance (M = 3.51) was highest followed by contextual performance (M = 3.36) and quality-oriented work behaviour (M = 3.27) for employee performance. The findings reveal a generally satisfactory but not uniformly positive attitude towards accreditation practices and results.

Table 3 - Mean Item Scores for the Study Constructs

Construct	Mean item score
Leadership commitment towards accreditation	3.52
Accreditation standards implementation	3.17
Employee training and competency development	3.45
Patient-safety and quality-improvement practices	3.52
Task performance	3.51
Contextual performance	3.36
Quality-oriented work behaviour	3.27

Note. Construct-level mean item scores were calculated from the reported means of the five items in each construct.

Correlation Analysis

Eleven of the 12 correlations among the different dimensions of accreditation and employee performance were positive and statistically significant at 5% level, with the relationship between leadership commitment and quality-oriented work behaviour being positive but not significant (r = .127, p = .114). Correlations were between .127 and .364. Task performance had its strongest correlation with PSQI (r = .305, p < .001), followed by ETCD (r = .294, p < .001). Contextual performance was most strongly related to PSQI (r = .364, p < .001) and ASI (r = .277, p < .001). QOWB was most strongly related to ASI (r = .310, p < .001). Most proposed relationships are supported by the pattern and the pattern suggests small-to-moderate bivariate associations.

Table 4 - Correlations between Accreditation Practices and Employee Performance

Accreditation practice	TP	CP	QOWB
Leadership commitment	.190*	.229**	.127
Standards implementation	.243**	.277**	.310**
Training and competency development	.294**	.237**	.223**
Patient safety and quality improvement	.305**	.364**	.160*

Note. TP = task performance; CP = contextual performance; QOWB = quality-oriented work behaviour. * p < .05. ** p < .01.

Multiple Regression Results

Four accreditation practices were combined to create statistically significant models for the three dimensions of employee performance. They accounted for 14.2% of the variance in task performance, 16.5% in contextual performance and 11.8% in quality-oriented work behaviour. The adjusted explanatory power ranged from 9.5% to 14.3% showing that accreditation is related to employee performance but it works in conjunction with influences on the employee's performance that are not captured by the models.

Table 5 - Regression Model Summary

Outcome	R	R^2	Adjusted R^2	F	P
Task performance	0.376	0.142	0.119	6.248	< 0.001
Contextual performance	0.407	0.165	0.143	7.460	< 0.001
Quality-oriented work behaviour	0.344	0.118	0.095	5.050	< 0.001

Note. For each model, F degrees of freedom = (4, 151). All overall regression models were significant at p < .001.

For task performance, the overall model was significant, F(4, 151) = 6.248, p < .001. ETCD was the only significant unique predictor (beta = .181, t = 2.140, p = .034). LCA (beta = .050, p = .551), ASI (beta = .120, p = .155) and PSQI (beta = .163, p = .074) did not reach the 5% significance level after the other predictors were controlled.

Based on the result, it can be concluded that in this sample, competency development is the most clearly independent related to employees' core job execution. The overall model was significant in the contextual performance F (4, 151) = 7.460, p < .001. PSQI was the only significant unique predictor (beta = .254, t = 2.846, p = .005). LCA (beta = .071, p = .391), ASI (beta = .141, p = .091) and ETCD (beta = .074, p = .376) were not significant after simultaneous entry. Thus, it seems that employees are more likely to demonstrate initiative, cooperation and extra role contribution when patient-safety and improvement routines are implemented.

The overall model was significant, F(4, 151) = 5.050, p < .001, for quality-oriented work behaviour. ASI was the only significant unique predictor (beta = .273, t = 3.208, p = .002). ETCD showed a positive but nonsignificant tendency (beta = .157, p = .069), while LCA (beta = .002, p = .981) and PSQI (beta = -.009, p = .922) were not significant. The negative PSQI coefficient measure was small and statistically non-significant, and is not interpreted as an adverse relationship.

Table 6 - Standardised Regression Coefficients for Employee Performance

Outcome	Predictor	B	t	P	Decision
Task performance	LCA	0.050	0.597	0.551	Not significant
	ASI	0.120	10.429	0.155	Not significant
	ETCD	0.181	20.140	0.034	Significant
	PSQI	0.163	10.801	0.074	Not significant
Contextual performance	LCA	0.071	0.860	0.391	Not significant
	ASI	0.141	10.703	0.091	Not significant
	ETCD	0.074	0.887	0.376	Not significant
	PSQI	0.254	20.846	0.005	Significant
Quality-oriented work behaviour	LCA	0.002	0.024	0.981	Not significant
	ASI	0.273	30.208	0.002	Significant
	ETCD	0.157	10.831	0.069	Not significant
	PSQI	-0.009	-0.098	0.922	Not significant

Note. LCA = leadership commitment; ASI = accreditation standards implementation; ETCD = employee training and competency development; PSQI = patient-safety and quality-improvement practices.

Hypothesis Decisions

Table 7 - Summary of Hypothesis Testing

Hypothesis	Statement	Decision	Empirical basis
H1	Leadership commitment positively predicts employee performance	Not supported	No significant unique effect on TP, CP or QOWB
H2	Standards implementation positively predicts employee performance	Partially supported	Significant for QOWB; not significant for TP or CP
H3	Training and competency development positively predicts employee performance	Partially supported	Significant for TP; not significant for CP or QOWB
H4	Patient safety and quality improvement positively predict employee performance	Partially supported	Significant for CP; not significant for TP or QOWB

Statistical Test Results and Inferences

Table 8 - Consolidated Statistical Tests and Inferences

Test	Outcome or relationship	Statistic	P	Inference
Pearson correlation	LCA with QOWB	r = 0.127	0.114	Positive relationship, but not statistically significant
Pearson correlation	Strongest task-performance association	PSQI: r = 0.305	< 0.001	Higher safety and improvement practice scores are associated with higher task performance
Pearson correlation	Strongest contextual-performance association	PSQI: r = .364	< 0.001	Safety and improvement practices show the strongest bivariate relationship with contextual performance
Pearson correlation	Strongest QOWB association	ASI: r = 0.310	< 0.001	Standards implementation has the strongest bivariate relationship with quality-oriented work behaviour
Multiple regression	Task performance model	F (4, 151) = 6.248; Adj. R2 = 0.119	< 0.001	The predictor set significantly explains 11.9% of adjusted variance; ETCD is the only significant unique predictor
Multiple regression	Contextual performance model	F(4, 151) = 7.460; Adj. R2 = -0.143	< 0.001	The predictor set significantly explains 14.3% of adjusted variance; PSQI is the only significant unique predictor
Multiple regression	QOWB model	F(4, 151) = 5.050; Adj. R2 = 0.095	< 0.001	The predictor set significantly explains 9.5% of adjusted variance; ASI is the only

				significant unique predictor
Coefficient test	Leadership commitment across outcomes	|t| <= .860	>= 0.391	Leadership commitment has no significant direct unique effect after controls

Note. Statistical significance was evaluated at alpha = .05. R2 values are unadjusted unless identified as adjusted R2. QOWB = quality-oriented work behaviour.

Overall inference

The three regression models are statistically significant, but the outcomes of the predictor level (at the level of the predictor) are different. Task execution is explained by training, contextual contribution is explained by practices for safety, improvement of quality and standards implementation is explained by work behaviour oriented to quality. The absence of a significant leadership coefficient suggests that the role of leadership commitment may be to play a role in the above operational accreditation mechanisms, but not as an independent predictor.

Discussion

The study shows that the practice of accreditation is linked significantly to the performance of healthcare workers, however, in different ways and to different levels. The overall argument that accreditation can have an impact on organisational performance was confirmed by all three regression models. Comparing the adjusted R-squared values, the results for accreditation are 0.119, 0.143 and 0.095 for task, contextual and quality-oriented work behaviour, respectively, indicating that only part of the variance in these behaviours is explained by accreditation. Other factors such as professional expertise, workload, staffing, technology, supervisory relationships and motivation of individuals will probably be significant as well.

The unique effect of standards implementation was only maintained for quality-oriented work behaviour in the analysis of the three performance outcomes, with all three showing a positive correlation with standards implementation. This discovery indicates that for workers, attention to the aspects of safety, adaptation and service quality, the three elements of standardisation, procedural clarity and documentation are particularly relevant. The nonsignificant unique effects of this factor on task and contextual performance do not rule out the possibility of association, but rather indicate that it shared variance with training, leadership and safety practices, which is what accounts for the nonsignificant unique effects in the simultaneous models. This is consistent with the longitudinal data that found that if accreditation requirements are maintained throughout the accreditation cycle, then accreditation can lead to increased compliance and process reliability (Devkaran & O'Farrell, 2014, 2019).

Task performance was only significantly predicted by unique variables – training and competency development – and quality-oriented work behaviour was positively near significantly associated with training and competency development. New words, processes for paperwork, new requirements for audits, and new safety procedures are often implemented when the accreditation process takes place. Training enables employees to translate these needs into competencies in their jobs and minimises uncertainty in the face of change. That there was no significant impact on contextual performance is theoretically plausible: training could reinforce formally demanded behaviour but not necessarily other behaviours that might be considered discretionary cooperation or initiative.

Patient-safety and quality-improvement practices were the only significant unique predictor and each of the three outcomes was positively correlated with patient-safety and quality-improvement practices Staff need to communicate, take initiative and support colleagues outside of the confines of narrowly defined tasks in order to take safety reports and ensure that errors are prevented and that outcomes are monitored. This could account for why there is a strong association with contextual performance. This finding is consistent with the findings of the study which found that patients' perceptions of patient-safety systems were correlated with the experience of accreditation among employees, and the effects of professional position and implementation experience (Kwan et al., 2021).

However, there was a positive correlation between leadership commitment and task performance and contextual performance, which was less than significant in all of the multivariable models, and nonsignificant for quality-oriented work behaviour. Don't take this to mean that leadership isn't important. Leadership adds value via Standards, Training, Resource Allocation, and Safety Systems, are possible explanations. When these operational mechanisms are added, then there is not much of an immediate effect of a general leadership measure. These therefore need to be translated into 'real' accreditation practice to give rise to 'visible' outcomes in the workplaces.

The findings also shed light on the variation in accreditation effects found in the literature, systematic reviews. Accreditation doesn't occur in a uniform way. Hospitals can have the same accreditation status, but have different levels of implementation of the standards and of staff training and patient safety practices. The binary trait of the organisation (accredited or not) might therefore mask the practices in which the accreditation is implemented, and which can lead to positive outcomes for the workforce (Brubakk et al., 2015; Hussein et al., 2021; Alhawajreh et al., 2023).

Practical Implications

Accreditation should be treated as a process or an on-going project, not a project that happens once in a while at a hospital. The first step towards this is to make accreditation criteria specific to the job role and break them down into clear and concise procedures that can be followed as part of a staff member's regular duties. Second, training should be

more than an awareness session; it should be demonstrated, simulated, practiced and competency checked. Third, patient-safety systems should facilitate easy reporting, and report without punishment or visibly tied to corrective action. Fourth, leaders need to monitor progress on evidence throughout the accreditation cycle and ensure departments have the support they need to address gaps identified.

The results are useful for human-resource and quality management in implementing differentiated interventions to performance. Task performance training is especially relevant, safety and improvement practices are especially relevant for the contextual contribution and consistent standards implementation are relevant for quality-oriented work behaviour. It is possible to incorporate employee competency in procedures, adherence to safety rules, initiative, and teamwork and participation in improvement in employee appraisal systems, rather than just output or attendance. Assessment can also be enhanced by looking at the behaviour of standards being integrated, rather than just the existence of manuals, committees and records, by accreditation bodies.

Conclusion

The accreditation of hospitals has an impact on the performance of healthcare employees, but it is not a strong impact in all cases. The total effect of the accreditation practices was significant in the total variance for task performance, contextual performance and quality-oriented work behaviour in the sample size of 156 employees. Although trained and competent, the independent contributions of either training or competency development predicted task performance, patient-safety and quality-improvement practices predicted contextual performance, and accreditation standards implementation predicted quality-oriented work behaviour. No direct unique effect was found for Leadership commitment after accounting for effects of operational practices. The "central managerial implication" is that accreditation becomes more than just complying, when leadership commitments are transformed into something useful like standards, reinforced competencies and active safety-improvement routines.

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