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Selected determinants of the quality of hospital care. III. Scope of duties, authorization and responsibility among members of a therapeutic team

The effectiveness of teamwork depends on an explicit distribution of occupational competence. Competence is defined as a 'scope of authorization, duties and responsibility of an employee (manager) which is ascribed to his/her organizational position' (4). In a therapeutic team similar tasks may overlap. In order to avoid misunderstandings, the scope of duties, authorization and responsibilities should be documented and unequivocal (5). A group which has clearly defined rights and duties and has an influence on the tasks performed, in most cases develops in its members the sense of responsibility and community of goals, integrates them and trains them to act jointly (1, 3, 7, 8). The importance of improving teamwork in hospitals was accentuated in Objective 29 formulated by the WHO: 'hospitals in all member countries should provide an efficient care ... and actively act on behalf of the improvement of the state of health to the satisfaction of patients'. This goal will be achieved if the provision of services is based on 'cooperation between professional health care staff' (2).

In medical literature it is emphasized that one of the features of a therapeutic team is the 'commonly established scope of tasks and individual duties and rights associated with them ...' (9). The Accreditation Programme for Polish hospitals which strive to obtain the Quality Certificate contains specific criteria: 'all hospitals should define the scope of duties and responsibility at individual workplaces...' (6). Therefore, the following problem issues were posed: 1. Is there an explicit distribution of duties, authorization and responsibility among the members of therapeutic teams in hospital wards? 2. Does a documented distribution of duties, authorization and responsibility exert an influence on the performance of tasks in the ward?

MATERIAL AND METHODS

The study was conducted in 1999 in 85 wards of 21 hospitals: 4 hospitals (level II of reference) with 29 wards which possessed the Quality Certificate – Group A, as well as health units without accreditation – Group B. The study covered 17 hospitals with 56 wards of the same profile. Physicians and nurses in Group B were employed in hospitals with various reference levels (III, II, and I). In general, 560 physicians and nurses participated in the study. The research method was a diagnostic survey and the technique – a questionnaire form. The material obtained was subject to statistical analysis. A detailed description of the study material and methods has been published in Part I of the series of three articles published by the "Annales UMCS"*.

RESULTS

The results of the survey confirmed that compared to Group B, the staff of hospitals with accreditation statistically more often admitted that there was an explicit share of occupational tasks within the team (70.3% and 92.7% respectively) – $u = 6.2$ (***) $p<0.001$ (Tab.1). Physicians and nurses in Group B had significant difficulties in defining whether there was a clear distribution of duties, authorization and responsibility in a therapeutic team, compared to Group A – 17.3% and 3.9% respectively $\chi^2 = 21.5$ (***) $p<0.001$.

Tab.1. Evaluation of the distribution of duties, authorization and responsibility in a therapeutic team according to respondents' opinions (Groups A and B)

No.	Explicit distribution of duties, authorization, responsibility	Group A No. = 206		Group B No. = 354		TOTAL No. = 560	
		No.	%	No.	%	No.	%
1	Yes	191	92.7	249	70.3	440	78.6
2	No	7	3.4	44	12.4	51	9.1
3	Difficult to define	8	3.9	61	17.3	69	12.3
In general		206	100.0	354	100.0	560	100.0
Yes: u = 6.2 (***) p<0.001 Difficult to define: = 21.5 (***) p<0.001							

* L. Sierpińska, A. Ksykiewicz-Dorota: Selected determinants of the quality of hospital care. I. Accreditation and effectiveness of managing a therapeutic team. Ann. UMCS, sectio D, vol. 57, N 1, 2002.

The replies by the staff members in Group B, who had problems with defining the distribution of competence, were analysed according to the type of hospital in which they were employed. The results of the analysis showed that a corresponding group of employees from hospitals with levels I and II of reference did not define the share of duties, authorization and responsibility (34.4% each). A similar percentage of respondents from hospitals with level III of reference (31.2%) had doubts while providing an answer to this question. No significant statistical differences were noted with respect to the reference level of hospitals $\chi^2 = 0.15$ (-) $p>0.05$.

A small group of physicians and nurses from hospitals without accreditation reported that in the wards where they were employed there was no explicit distribution of duties, authorization and responsibility. Doctors and nurses from clinical hospitals in Group B (level III of reference) constituted the greatest percentage of respondents who mentioned that the staff in the ward had no distribution of duties, authorization and responsibility (47.7%), followed by the respondents employed in hospitals with level I of reference (31.8%), and the staff of hospitals with level II of reference (20.5%). No statistically significant differences in the answers provided by respondents were observed according to the level of reference of hospitals $\chi^2 = 4.9$ (-) $p>0.05$.

Apart from an explicit distribution of duties, authorization and responsibility, their documentation is of great importance. The analysis showed that the majority of respondents had it in a written form, especially in hospitals with accreditation (Fig.1). No statistically significant differences were observed between Groups A and B in possessing a scope of duties, authorization and responsibility in written form – 97.1% and 87.3% respectively $\chi^2 = 15.1$ (***) $p<0.001$.

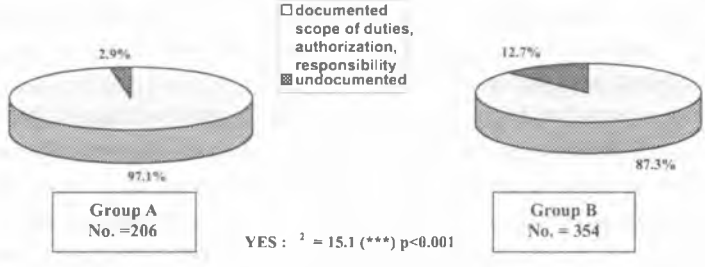


Fig. 1. Documented scope of duties, authorization and responsibility among hospital staff (Groups A and B)

A detailed analysis of data concerning Group B showed that ward head nurses exclusively possessed their scope of duties, authorization and responsibility in a written form – 100% (Tab. 2). This was statistically significant, compared to the remaining occupational groups – $u = 3.9$ (***) $p<0.001$. Ward heads/managers of clinics constituted the most numerous group of staff who reported that they did not receive the scope of tasks in a written form (17.6%). Some of them mentioned that only charge nurses had a docu-

Table 2. Documented scope of duties, authorization and responsibility by the type of position held (Group B)

No.	Answers	Group B No.= 354								TOTAL	
		ward heads/ managers of clinics		ward head nurses		assistant doctors		charge nurses			
		No.	%	No.	%	No.	%	No.	%	No.	%
1	Yes	28	82.4	47	100.0	51	83.6	183	86.3	309	87.3
2	No	6	17.6	-	-	10	16.4	29	13.7	45	12.7
In general		34	100.0	47	100.0	61	100.0	212	100.0	354	100.0

Yes : ⟶ Ward head nurses vs. remaining occupational groups : u = 3.9 (***) p<0.001

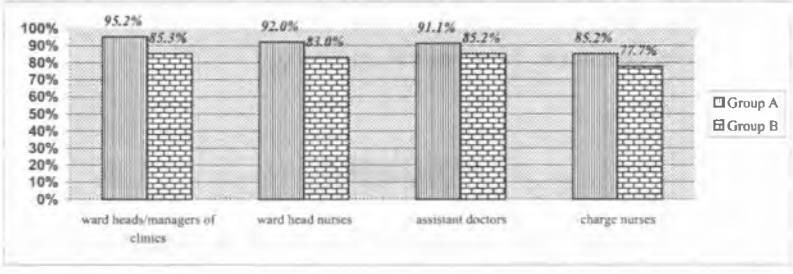
No : ⟶ Ward heads/managers of clinics vs. ward head nurses: = 8.9 (**) p<0.01
Assistant doctors vs. ward head nurses: = 8.5 (**) p<0.01
Charge nurses vs. ward head nurses: = 7.2 (**) p<0.01

mented scope of tasks. Others admitted that the such a situation was more convenient for the hospital management. Assistant doctors occupied the second position with respect to the lack of the scope of duties in a written form (16.4%). Part of assistant doctors explained the lack of documented duties by poor organization of work in the ward. Some charge nurses (13.7%) reported that they did not possess the scope of duties in a written form. The lack of a documented scope of duties, authorization and responsibility among ward heads, assistant doctors and charge nurses was statistically significant (p.<0.01), compared to ward head nurses (Tab. 2).

The answers provided by respondents in Group B who mentioned that they did not receive a documented scope of duties, authorization and responsibility were analysed from the point of view of the level of reference of the hospital in which they were employed. The analysis of the results showed that the greatest number of respondents in Group B did not receive the scope of duties in a written form in clinical hospitals (64.5%), which was statistically significant, compared to the remaining hospitals $\chi^2 = 20.1$ (***) $p<0.001$. Respondents from hospitals with the level II of reference were placed in the second position (22.2%), whereas the last position was occupied by those from hospitals with level I of reference (13.3%).

While analysing the research material it was important to know the answer to the question whether the fact of possessing the scope of duties in a written form had any effect on the content and scope of tasks performed by the staff in the ward. In hospitals with accreditation, a higher percentage of respondents in all occupational groups performed tasks according to their scope of duties, compared to Group B. Figure 2 presents

the results. A detailed analysis of the results confirmed that the activities performed in hospitals with accreditation (Group A) were to a greater degree compatible with the scope of duties, compared to Group B. The results of the statistical analysis with respect to the compatibility between the realization of tasks and the scope of duties, authorization, and responsibility varied according to the position held. A significant difference concerned exclusively charge nurses in Group B $\chi^2 = 7.6$ (**) $p<0.01$ who most frequently performed activities exceeding their scope of duties, compared to charge nurses from hospitals with accreditation. In the remaining occupational groups no statistically significant differences were observed between Groups A and B ($p>0.05$) – Fig. 2.



ward heads/managers of clinics : ^{2} = 1.32 (-) p>0.05 *ward head nurses : ^{2} = 1.1 (-) p>0.05*

assistant doctors : ^{2} = 0.82 (-) p>0.05 *charge nurses : ^{2} = 7.6 (**) p<0.01*

Fig. 2. Compatibility between the tasks performed and the scope of duties, authorization and responsibility (Groups A and B)

Among physicians and nurses in Group B who reported that they possessed their scope of duties in a written form, despite which the activities they performed in the ward exceeded this scope, the level of reference of the hospital in which they were employed, was analysed. Once again, the result obtained indicated that the greatest number of discrepancies between the activities performed by the staff of hospitals without accreditation and their scope of duties was noted among doctors and nurses in clinical hospitals (48.6%), followed by physicians and nurses from hospitals with level II of reference (33.3%), and respondents in Group B from hospitals with level I of reference (18.1%). A statistically significant difference concerned all hospitals with levels III, II and I of reference $\chi^2 = 10.1$ (**) $p<0.01$.

DISCUSSION

Common actions biased towards quality improvement, which prepare a hospital for accreditation, exert an influence on many elements of teamwork (2, 6). One of these actions is the development of explicit duties, authorization and responsibility for the team

members. A comparative analysis of the results obtained showed that among physicians and nurses from hospitals with accreditation an unequivocal distribution of occupational tasks is significantly more often noted, compared to the respondents from hospitals without the Quality Certificate. In the group of doctors and nurses from hospitals without accreditation a significantly greater number of the staff did not receive documented scopes of duties in clinical hospitals, compared to the hospitals with levels II and I of reference.

The results of the study confirmed that in hospitals with the Quality Certificate, in all occupational groups, a greater percentage of the staff performed tasks according to their scopes of duties, compared to group B. The greatest discrepancies between the activities performed by respondents from hospitals without accreditation and their scopes of duties occurred in doctors and nurses from clinical hospitals.

CONCLUSIONS

1. It was confirmed that among members of therapeutic teams in hospitals with the Quality Certificate the distribution of occupational competence was observed significantly more often, compared to respondents from hospitals without accreditation.
2. The majority of respondents in hospitals with accreditation possessed their scopes of duties, authorization and responsibility in a written form, and more frequently performed occupational tasks according to this scope, compared to the staff of hospitals without the Quality Certificate.
3. The most frequent lack of the scope of duties in a written form and the greatest discrepancy concerning the performance of occupational tasks was observed among members of therapeutic teams in clinical hospitals without accreditation.

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SUMMARY

An important precondition for an effectively working team is the distribution of competence among the members of the team. The accreditation criteria for Polish hospitals lay down a requirement concerning the formulation in a written form of the scope of duties, authorization and responsibility at individual workplaces. This conditions a high level of services provided by the members of a therapeutic team. Therefore, the study was undertaken in order to discover whether there was an explicit share of competence and if it exerted an influence on the level of performance of the scope of duties, authorization and responsibility among members of therapeutic teams in hospital wards.

The study covered 55 ward heads/managers of clinics, 72 ward head nurses, 106 assistant doctors and 327 charge nurses from 21 hospitals, who were employed in 4 hospitals which possessed the Quality Certificate, and in 17 hospitals without accreditation. The study was conducted by the method of a diagnostic survey, the technique being a questionnaire form.

The results of comparative analysis showed that among members of therapeutic teams in hospitals with the Quality Certificate the distribution of occupational competence was significantly more often observed. The greatest number of respondents in this group possessed the scope of duties, authorization and responsibility in a written form, compared to physicians and nurses from hospitals without accreditation. Moreover, it was confirmed that the most frequent lack of the scope of duties in a written form as well as

the greatest discrepancies concerning the performance of occupational tasks were noted among the members of therapeutic teams in clinical hospitals without accreditation.

Wybrane determinanty jakości opieki w szpitalu. III. Zakres obowiązków, uprawnień i odpowiedzialności wśród członków zespołu terapeutycznego

Istotnym warunkiem efektywnie pracującego zespołu jest podział kompetencji wśród członków grupy. Kryteria akredytacyjne dla polskich szpitali stawiają wymóg sformułowania pisemnego zakresu obowiązków, uprawnień i odpowiedzialności na poszczególnych stanowiskach pracy. Warunkuje to wysoki poziom usług świadczonych przez członków zespołu terapeutycznego. Postanowiono sprawdzić, czy istnieje jednoznaczny podział kompetencji i czy ma on wpływ na poziom realizacji zakresu obowiązków, uprawnień i odpowiedzialności wśród członków zespołu terapeutycznego w oddziałach szpitalnych. Badaniami objęto 55 ordynatorów i kierowników klinik, 72 pielęgniarki oddziałowe, 106 lekarzy asystentów i 327 pielęgniarek odcinkowych z 21 szpitali. Pracowali oni w 4 szpitalach z certyfikatem jakości i w 17 szpitalach bez akredytacji. Badania przeprowadzono metodą sondażu diagnostycznego, techniką był specjalnie skonstruowany kwestionariusz ankiety.

Wyniki analizy porównawczej wykazały, że wśród członków zespołu terapeutycznego w szpitalach z certyfikatem jakości występuje istotnie częściej podział kompetencji zawodowych. Większość tej grupy badanych posiada zakresy obowiązków, uprawnień i odpowiedzialności na piśmie w porównaniu z lekarzami i pielęgniarkami ze szpitali bez akredytacji. Stwierdzono również, że najczęstszy brak zakresu obowiązków na piśmie oraz największa rozbieżność w realizacji zadań zawodowych występowała wśród członków zespołu terapeutycznego w szpitalach klinicznych bez akredytacji.