Contribution to systematic education of quality management in Slovak health care

Rusnakova V, Bacharova L

Abstract

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The aim **of the study was to contribute to quality improvement initiatives in Slovak health services through systematic approach to the education and training in quality management (QM). Consequently, the main objectives were to analyse the content of the education in QM abroad, to conduct an audit of perceived training needs in Slovakia, and to propose the design of QM training programme to be applied within CME scheme based on the study results. Triangular method in the design of the study was implemented. Review of relevant information, data from the questionnaire and semi-structured interview in the sample of 67 Slovak trainees from Health Management School and School of Public Health — were adopted in complementary fashion.**
Between findings **highlighted in the survey are positive attitudes to training in quality management documented by the median score higher than 6 in all tested areas, on scale 0—10. No significant differences in profession groups as physicians, nurses, HC managers or among training institutions involved were displayed. However, potential obstacles were identified in deeper study using interviews. The absence of knowledge and skills in management in general and in quality management approaches especially are observed. Typically, the role of strategic planning is undermined. The large scale of quality management approaches is converted to problems of accreditation. Barriers to participative culture, innovation, devolution of accountability, resistance to change and to team based management are authentic findings as well.**
Conclus*ions* drawn from the study were related to: fostering managers — "transformational leaders" for locally driven decision making in health care policy and practice; need of training activities for the continuing education in quality with respect to specific target groups interests and their level of knowledge in management; content of training oriented to-

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Abstrakt

Rusnáková V., Bachárová L.:
Príspevok k systematickému vzdelávaniu v manažmente kvality v slovenskom zdravotníctve
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Zámerom štúdie bolo prispieť k iniciatívam v zlepšovaní kvality v slovenskom zdravotníctve prostredníctvom systematického prístupu k vzdelávaniu a tréningu v manažmente kvality (MK). Z toho vyplynuli ciele — analyzovať obsah vzdelávania v MK v zahraničí, vykonať hodnotenie potrieb tréningu vnímaných na Slovensku a na základe výsledkov štúdie navrhnúť vzdelávací program v MK pre kontinuálne medicínske vzdelávanie. Pri *návrhu štúdie* bola uplatnená triangulárna metóda. Spracované a navzájom porovnávané boli dostupné predchádzajúce informácie, ďalej údaje z dotazníka, ako aj semištruktúrovaného interview vo výbere 67 účastníkov vzdelávania v manažmente v Škole zdravotníckych manažérov a v Škole verejného zdravotníctva. Medzi *zistenia,* na ktoré poukázala štúdia, patrí celkovo pozitívny postoj k tréningu v manažmente kvality, dokumentovaný mediánnym skóre vyšším ako 6 vo všetkých sledovaných oblastiach pri škále 0—10. Medzi zahrnutými profesijnými skupinami — lekármi, zdravotnými sestrami, zdravotníckymi manažérmi, ako aj medzi vzdelávacími inštitúciami sa nepreukázali signifikantné rozdiely. Možné problémy boli identifikované pri hlbšom sledovaní v rámci interview. Pozorovali sa chýbajúce znalosti a zručnosti v manažmente všeobecne, ktoré sa ešte zvýraznili pri otázkach zameraných na manažment kvality. Typickým javom bolo podceňovanie, nedôvera k úlohe strategického plánovania. Široká škála prístupov manažmentu kvality je redukovaná len na oblasť akreditácie. K autentickým nálezom patria bariéry v postojoch k participatívnej kultúre, inovácii, preberaniu zodpovednosti, rezistencia k zmenám a k tímovému manažmentu.
Závery vyplývajúce zo štúdie hovoria o: podpore manažérov — "transformačných vedúcich", ktorí sú schopní adekvátne rozhodovať o zdravotníckej politike a praxi rešpektujúc lokálne špecifiká; potrebe tréningových aktivít pre kontinuálne vzdelávanie v oblasti kvality, ktoré zodpovedajú záujmom jendotlivých cieľových skupín a úrovni znalostí v manažmente; obsahu vzdelávania orientovaného na kombináciu racionálneho využívania in-

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wards combination of rational utilization of information, critical analytical skills and planning for quality with human resource development-interpersonal skills, team building (soft skills), not just reduction of quality management tools to hard techniques (statistics, ISO norms); methods of education, where the usage of experiential learning methods, participative training inclusive action learning is highlighted; team training complemented with individual professional development support inclusive a coaching and mentoring scheme.
As implications **four types of CME training: Basic Module QM, Training for QM teams, Training Trainers Scheme and Guiding through Accreditation and Quality Award were proposed.** ***(Tab. 9, Ref. 38.)***
Key words: quality management, education, training, needs, Slovakia.

formácií, kritické analytické zručnosti a plánovanie aktivít pre zabezpečovanie kvality, kde sa počíta s rozvojom ľudských zdrojov (interpersonálnych zručností, podporou tímovej spolupráce — mäkké zručnosti); nejde len o redukciu nástrojov manažmentu kvality na tvrdé techniky (štatistika, ISO normy); metódach učenia, s dôrazom na využívanie učenia sa "zo skúseností" a participatívneho tréningu vrátane akčného učenia; príprave v tímoch doplňanej podporou individuálneho profesionálneho rozvoja vrátane schém "coachingu" a "mentoringu".
Na uplatnenie v praxi v kontinuálnom vzdelávaní boli potom navrhnuté štyri typy aktivít: Základný modul MK, Tréning tímov kvality, schéma pre Tréning trénerov a Sprievodca procesom akreditácie a oceňovania kvality. *(Tab. 9, lit. 38.)*
Kľúčové slová: manažment kvality, vzdelávanie, potreby tréningu, Slovensko.

The notion of the quality management — quality control, assessment, and improvement — is being developed for more than twenty years in variety of forms in countries of Western Europe, USA, and Japan. The introduction of quality management principles was declared as a strategic goal for Slovak Health Care, which undergoes fundamental reform (Hlavačka, 2000). However, its real implementation posses a form of a declaration, where a rhetoric of quality is used.

Described issues require systematic and continuous attention to quality improvement, building capacities inclusive people capabilities, not only anecdotal declaration and attention to output. Recently propagated models of quality and total business excellence (Oakland, 1999; EFQM, 1999) accentuate such an approach. The role of enabling factors as planning for quality, adequate leadership, and investment in people are similarly important as business results, as satisfaction of customers and employee, and as acceptation of business by society. Described comprehensive concept of quality directed to total organisational excellence requires systematic, continuous approach to the work with people, support for transformational leadership as emphasised by Bass (1998), and adequate training as brought up by Jeffries et al. (1993).

Thus, an attention has to be payed to reorienting human resources, strengthening management and learning experiences to achieve better quality in HC. One can find large space for activities like an assessment of needs, definition of competencies, and utilisation of tools for easier introduction of quality requirements to practice inclusive cultivation of proper leadership for quality.

Having stated the context of the situation in quality management in the Slovak health service, an intervention based on adequate education and training design should be plausible contribution. Consequently, the main objectives were in systematic approach to learning process:

- *to summarise information regarding recommended training in quality management;*
- *to identify perceptions and expectations towards the quality improvement in Slovakia the same as potential obstacles for implementation QM in a current situation of Slovak health care;*
- *based on the conducted study results to revise recent curricula and training methods and to propose the content of new education programme to be applied.*

Sponsoring organisations of the created project were the Health Management School (HMS) and School of Public Health (SPH SPAM), institutions providing managers (Rusnaková et al., 1995; Hovorková, 2000) and Master of Public Health training (Badalik et al., 1994). Many of the experiences gained in both institutions serve as an entry point and have been utilised in the development of the proposed project as background information.

Approaches to quality management education in HC

The quality has been a central issue in health care organisations and among health care providers. The works of Donabedian (1980, 1985), Maxwell (1984), Berwick (1990), Graham (1990) but also organisations as Joint Commission on Accreditation of Health Care Organisations and World Health Organisation have major contribution to the definition, measurement, understanding and improvement of the quality in health care.

There are several definitions of quality in use. WHO (1999) defined the quality as follows:

- *the highest attainable level of professionalism;*
- *an efficient utilisation of resources;*
- *minimum risk for the patient;*
- *high level of patient satisfaction;*
- *the resulting effect on health.*

A useful model to be adopted in evaluating health service is that developed by Maxwell (1984). The model concentrates on six dimensions of quality: access, equity, relevant to need, social acceptability, efficiency and effectiveness.

The quality of care based on JCAHO (1990) criteria includes a feature of "excellence" going beyond an expectation of client. The definition of quality is formulated as "anticipating, meeting and exceeding customer expectations". So principles of Total Quality Management (TQM) and Continuous Quality Improvement (CQI) are recommended to apply in HC.

Summarizing, the purpose of quality management in health care is to establish a system that measures and manages patient care in the way that provides the best care for all patients. It identifies opportunities for improvement as well as problems that require a resolution. On the other hand, it fulfils a societal commitment of health professions to the public. However, problems undoubtedly appear in

Tab. 1. Overview of explored curricula in quality management.

TOPICS	ACEHSA	LUBS	NUFFIELD	BIRMINGHAM	PSU	HQCB
I. Management and leadership						
strategic	+	+	+	+	+	+
operational	+	+	+	+	+	+
financial	+		+			+
II. Information Management						
design and data						
collection	+	+	+	+		+
analysis	+	+	+	+		+
interpretation	+	+	+	+		+
III. Education, Training						
and Communication						
education and training		+				+
communication	+	+	+			+
IV. Performance Measurement						
& Improvement+						
planning	+	+	+	+	+	+
implementation	+	+	+	+	+	+
evaluation	+	+	+	+	+	+
integration	+	+	+	+	+	+

case of immature management. All quality approaches require systematic planned managerial work, an attention to a process, mastering new knowledge and skills for innovative types of improvement, work with people and time, as was emphasised by Longo (1994), Oakland (1999). Respect to "soft" part of quality models as culture, communication, commitment are inevitable. Thus, the education and training for quality should be addressed ultimately.

Education for quality

According to industry standards, health care uses some of the most educated and the most specifically trained employees. By a tradition, the education and training in this sector is an ongoing pursuit, responding to frequent changes in technology, techniques, drugs, tests, etc. The same situation is to be found in the area of quality of care. But the education and training in this field has to be "just in time", fine-tuned to become a real instrument of improvement, not only a fashion (Ramsay, 1996).

Teaching of up-to-date topics as quality or evidence based approaches, have to respect local specifics and gaps. Managers planning to implement new approaches should consider broader behavioural and cultural background. Thus, teaching quality management is sensitive issue which need systematic approach, permanent re evaluation of own experience with information from external resources and literature and respect to local context.

Curricula in QM

Analysis of curricula content could be the first step in above declared systematic and critical approach. Materials from several sources were studied and main features are displayed in Panel 1.

Panel 1

a) Accrediting Commission on Education for Health Service Administration — *ACEHSA (1994). Curricula Content area VIII is devoted to Assessment of Organisational Performance and Quality of Services. Next to core quality improvement topics the evaluation and financial analysis are recommended areas for accredited Health Administration Programs,*

b) Business Excellence Program provided by Leeds University Business School — *LUBS (Oakland, 1999).*
Executive Development and Postgraduate Qualifications Programme in Business Excellence, also the module in the frame of the MBA course, devoted to Total Organisation Excellence and EFQM (1999) concept propagation;

c) Nuffield Institute for Health, MA Program *(Hurst, 1998).*
For the staff health and social service an MA program in quality assurance is proposed. The program's content is interesting for declared purposes not only in its orientation on health environment but also for emphasizing the evaluation part and research techniques. Attractive approach was used for the description of students achievement. Aspects of the development were divided into 4 areas: subject, discipline, intellect (evaluation and critical ability) and person related, including the communication and team work;

d) Birmingham University Quality Training Program *(Hill et al., 1994) program directly oriented to Health Service Practice, in the form of a workshop (short term training);*

e) Training in Providers Support Unit for Health and Social Care, Belfast *(PSU) examples of strictly practice oriented training workshops are those, offered by management training institution next to Hospital Trust in Belfast.*

f) Certifications Program for Healthcare Quality Professionals — *HQCB (Maronde, 1999) defines list of proved requirements of Certification for Healthcare Quality Professionals.*
The results of the comparison of quality management curricula content are presented in the Table 1.

Based on above presented materials, one can recognise common core content for the education and training in quality management (Tab. 2).

In addition, the review of typical curricula content has been annexed by an information regarding feasibility of methods of education and training, as depicted in the Table 3.

Methods, listed in the table, should achieve not only information transfer but also a support for social influence, reinforcing of a need for change essential for quality management introduction.

Design of survey

A combination of approaches suggested by Robson (1993) — the review of accessible information from the past, data from the questionnaire and in depth interview in the sample of potential trainees — was adopted as a basis for the design and development of new training program in quality management. Participants in the survey were involved in the training in two educational institutions — the Health Management School (HMS) and the School of Public Health (SPH), both representing providers of training in Health Care management.

Self-completion questionnaire was used in the first step. The structure of the questionnaire form was intentionally kept as simple as possible to achieve an adequate response rate. A pre-coded classification of responses on score scale and an optional free text comment for every question was applied. Main topics of the questionnaire (see below in Findings) include expected areas for the training, based on education materials published by the Join Commission on Accreditation of Health Care Organizations (1996) " Using Performance Tools".

The evaluated sample consisted from 67 participants, (80 forms distributed):

- *33 physicians;*
- *8 nurses;*
- *24 representatives of PAM (Profession Allied to Medicine) — 13 with economic education, 11 others.*

Both training provided institutions were equally represented in the sample — there were 34 respondents (51 %) from HMS and 33 (49 %) from SPH Response rate was 84 %.

In depth interviews were held with ten respondents on senior managerial position (head of department with managerial span not less then 10 persons) as the second stage. The interview was semi-structured with a mix of opened and closed questions. Areas mapped in the interview are depicted in the Table 4.

Data analysis

The questioners were analysed using the EPI INFO package. Non parametric statistics were used for those data in form of a score. The majority of variables were frequencies, thus chi square for contingency tables, eventually non parametric version of ANOVA — Kruskal Wallis H test, was involved in further assessment. However, the important part of the research was qualitative data.

Limitations of the survey

From research point of view, the survey was a subject to several constrains. Mainly qualitative study based on a relatively small sample of respondents was conducted. Personal data regarding sex and age were intentionally omitted — to keep the questionnaire design simple.

Later on, the survey which involved participants of the basic training in the management only (see above), is not representative sample of all managers in health care. Also professional groups were not represented equally. The main gap was within the profession of nurses, because of a limited participation in the pool of trainees.

While it could be recognized that used sample may not be representative, it does not diminish the value of the findings based on intense scrutiny of participants approaches to quality management. Valuable information was collected from questionnaire comments and in depth interview, especially regarding "soft" elements and culture for quality.

Main findings

Material collected during the study enables authors to address series of questions indicated at the beginning. Self rated

Tab. 2. Essentials of quality management curricula.

– planning
– leadership
– customer supplier chain
– people work -teams, commitment, communication
– QM tools and techniques
– evaluation, critical analytical skills

Tab. 3. Methods of education.

Groups, teams oriented
– experiential learning sessions taught using lecturers, case studies, interactive discussions, role plays, practical exercises and appropriate use of IT, distance learning, work based learning, support of practical skills and techniques development assessed work related assignments and project
– action learning
Spectrum of Paired Support Relationship, Conway (1998)
– guiding
– coaching
– mentoring

Tab. 4. The structure of the interview.

Main areas covered by the interview:
– self perceived need for knowledge and training based on personal experiences in QM – comments to questionnaire questions (when needed brief explanation of each of seven areas covered in the questionnaire was prepared for better information);
– literature resources orientation – basic sources;
– area of implementation with the highest priority, creating priority list of topics for training;
– time available for training for a respondent and the staff supervised;
– main barriers for quality improvement initiatives;
– culture in organisation based on ideal model Harris and Hartman (1992);
– ideas on other form of assistance next to typical courses

Tab. 5. Distribution of scores.

Question/score distribution	0	1	2	3	4	5	6	7	8	9	10
1. Deeper insight into the concept of quality management inclusive TQM	2	2	1	4	1	3	9	8	6	5	15
2. Information on a process of certification and accreditation in health service	2		2	4	1	3	6	6	9	7	27
3. Tools and techniques for planning	2	1	1	4	3	7	5	10	11	6	15
4. Tools for team building	2			3	2	7	5	11	15	6	14
5. Tools for data collection	2	1	2	7	6	13	8	5	4	6	12
6. Skills in Data Analysis	1	2	3	3	7	11	4	8	9	5	13
7. Tools for Understanding the Root Causes of Performance	1	2	2	1	1	5	4	12	10	6	17
Sum of scores	12	5	7	29	20	64	47	67	72	50	123

Tab. 6. Descriptive statistics.

Questions/Total Sample Score	Median Score	Q1-Q3 Range*	Mode Score
1. Deeper insight into the concept of quality management inclusive TQM	7	5-9	10
2. Information on a process of certification and accreditation in health service	9	6-10	10
3. Tools and techniques for planning	7	5-9	10
4. Tools for team building	8	6-9	8
5. Tools for data collection	6	4-9	5
6. Skills in Data Analysis	7	5-9	10
7. Tools for Understanding the Root Causes of Performance	8	6-10	10

Total number of respondents 67 from 80; Response rate 84 %

* inter quartile range

scoring forms, with scores related to perceived training needs (score from 0 — "not required", to 10 — "urgently required") were summarised in Table 5.

Summarizing the evaluation of scores (Tab. 6), it is possible to conclude that a median score higher than 5 was observed in all tested questions, the highest score for the question 2 (median 9) and minimum was achieved in the question 5 (median 6). However, as illustrated by crude comparisons of inter quartile range, there are no significant differences among the scores for individual questions.

Next to basic description of the sample, possible differences between professions and training institutions were tested. No evidence of significant differences was showed among professions involved in the study as the Table 7 documents it.

*However, it is possible to recognize a tendency to use higher scores in the group of nurses. Further, the score data were tested for possible influence of the participation in training institution on evaluation results. Significant differences were not shown in majority of the areas. Only in the question 1 (an insight into the concept of quality management inclusive TQM) significantly higher score appeared in the SPH group of respondents, where median score was 8 compared to 6 in the HMS group (*p<0.05 Kruskal Wallis).*

Written comments to areas introduced in scoring part of the questionnaire were studied carefully, too. In general, good cooperation from respondents in the scoring part was not followed completely in the explanatory part of questionnaires. In 18 from 67 forms the comments were missing totally. Frequent absence of comments was for question 7, than in question 5. Some of comments indicated a doubt on the relevance of the use of self-rated scores only. Analysis of comments also indicates scepticism, limited orientation in the area of quality management, as well as needs for further information, as being verbalised in panel 2. Finally, strong criticism was addressed to recent trends in the accreditation. Comments for rest of the questions are summarised in the Table 8.

Panel 2

Question 3:
score: 0

Tab. 7. Statistics of professions.

Question/vs median for profession groups sample	median total	median nurse	median physician	median economist	median others
1. Deeper insight into the concept of quality management inclusive TQM TQM	7	8	7	7	6
2. Information on a process of certification and accreditation in health service	9	10	9	8	7
3. Tools and techniques for planning	7	9	7	8	7
4. Tools for team building	8	10	8	7	7
5. Tools for data collection	6	8	5.5	6	5
6. Skills in Data Analysis	7	7	7	8	5
7. Tools for Understanding the Root Causes of Performance	8	9	8	8	8
Sum	52	61	51.5	52	45

comment: irrelevancy of the planning in our system of "mismanagement", but the training is important
score: 0
comments: planning tools are possible to use in stable economy. In recent situation the planning for longer period than one month is an utopia
Other comments to question 1 and 2:
the philosophy of management and TQM will be actual after basics problem were solved, problems of existence of HC organisations and all system;
in recent situation it is difficult to express needs for QM, only after stabilisation, after cumulated problems were sold, and the similar is valid for the accreditation.

Tab. 8. Comments to queries.

Synopsis of comments to questions
Ad 3 Tools and techniques for planning
– planning tools are feasible in stable economies. In recent situation the planning for longer period than one month is an utopia
– without any vision the direction can not be indicated
– important for goal oriented activities
Ad 4 Tools for team building
– team work could support a progress
– are important part of a success
– teamwork is unavoidable in HC
– there are non sufficient skills in team building
– there is an absence of team cooperation on different levels of structures
– motivation of staff and improvement of responsibility for success in teams member
Ad 5 Tools for data collection
– data collection without technology is impossible – scepticism
– are interesting but not inevitable for current clinical practice
– important practical skills and training
– important for control of own results, feedback
– only basic information needed
Ad 6 Skills in Data Analysis
– interesting but not inevitable for current clinical practice
– important to understand indicators related to economy and health care
– only basic information needed
– only basic information is needed in team cooperation
– too much data is not utilised
Ad 7 Tools for Understanding the Root Causes of Performance
– important are questionnaires, cooperation with psychologists, sociologists
– important because of increasing responsibility of staff, adequate financial compensation performance and quality are dependent issues
– it is important in some cases to improve performance efficiency of all company activities at all levels is not followed
– important for planning changes, interventions for performance improvement
– it is priority to elaborate performance evaluation criteria are useful but not frequent discussed topics
– new topic for me insufficient criteria for rewarding, absence of competencies grids, adequate normatives

Interview results

We followed the structure indicated in the methodology section in face to face interview. List of problems and barriers was pointed out as:

— *dilemma between managerial an professional position;*
— *absence of deeper knowledge of management concept, even an absence of understandings of basic managerial terminology, inclusive quality;*
— *problems with time management;*
— *problem in division of competencies, delegating.*

Among the covered topics the accreditation and performance assessment were indicated as those with the highest priority. All participants confirmed their interest in education and training, however time constrain was emphasized for several times. The ideal training will be not longer than 2—3 days. The main problem could be with the staff in first line.

Unfavourable results of the attempt to assess a culture for quality based on Harris and Harman's (1992) ideal model of are displayed in the Table 9.

Findings synopsis

Material collected in the survey helps to clarify the context for QM education, mainly for continuous medical education (CME). Needs audit results in general is promising expression of positive attitudes to quality initiatives and interest for education in studied area. The fact that no significant differences in an attitude to proposed training content was found among professions — nurses, physicians, economists and PAM, may represent a signal of existing awareness of quality management in Slovak health services in general, not only in specific groups of professionals.

Similarly no significant differences were observed in majority of items when comparing respondents from two training institutions — SPH and HMS — involved in the survey.

However, more comprehensive analysis based on comments and interviews revealed scepticism and cumulation of problems in health care, differences among professions, same as different statements to discussed topic and cultural acceptation of quality. Those are substantial facts to consider in training design.

Discussion

Specifics of profession's groups involved

Despite the fact, that no statistically significant differences in scoring among profession groups were documented, the tendency in the group of nurses to use higher scores occurred. At one hand it could be justified by higher openness of nurses to all types of training (parallel with training in information technology, better responsiveness in basic management training within HMS).

However, the analysis of free comments and deep interview confirmed lower level of orientation in quality management in general, compared to other groups under scrutiny. Limited knowledge of foreign languages and therefore limited access to relevant literature resources could be the plausible reason. Also the highest score of needs for issues of the accreditation and the team building was found in the group of nurses. The lowest score obtained was for data analysis. This last item probably will need an intervention, because significant increase of the role of nurses is

expected not only in data collection, but also in an assessment of nursing specific data in nursing processes in quality management. The problem is even more actual in the context of limited training in research and evaluation methods within this group. It has been repeatedly declared that insufficient experiences in any type of the research exist in this group. Nursing is the profession with high potential for future health care and large target group for education and training (Bamford,1997).

Differences among professional groups were more striking in the interview and may indicate potential culture problem. Competencies among professions are unclear and the dominance of physicians is visible, especially in the group of heads of medical departments. Physicians in general suffered from a dilemma between their professional and managerial responsibilities. In nursing profession, the professional identity is underdeveloped. All these issues may invoke future problems or barriers in a communication among professions. The impact could be visible especially in planning of interdisciplinary teamwork, so important for quality management.

Content of training

As being indicated by the scoring, the highest emphasis in survey has been put on the availability of information on the certification an accreditation. It seems worthwhile to reflect this fact in training proposal. Variety of approaches to the evaluation in the area of quality improvement and organisational excellence recently being put forward by experts in European Foundation for Quality Management (1998). Discussed are benefits of the accreditation and self-assessment for health service organisations, too (Stamatis 1996). Profit is also in identification of shortcomings of organisation and even in improving of performance — Pit (1999). Among reasons for high interest payed to this issue in Slovak cohort are the experiences from contra verse accreditation of hospitals in Slovakia. Pilot accreditation project, based on criteria copied from other countries, was implemented into inadequately prepared environment. Thus the implication is very clear: to involve this topic into the plan of our training activities.

The team building became the next topic of our interest, according to scoring, within relatively uniform allocation of scores. The significance of the team cooperation was frequently emphasized in respondents' comments. However, the interview revealed high level of individualism, low effectivity of work in a team and a gap in techniques of team building. Communication barriers in organisations, blocks between professions but also in implementation of transition steps in health care system were accentuated. Thus suggestions are directed not only to immediate training, but also to more difficult areas to be influenced — professionals identity (nurses) development and the culture and values cultivation within organisations. The program for TQM training in hospital, proposed by Stamatis (1996) could serve as an inspiration. Stamatis advice to avoid becoming a slave to orthodoxy of TQM and to respect what is functioning and what is not is valuable observation in our context. Requirements expressed by participants on previous HMS courses could be utilized in the preparation of training proposal. They preferred demonstrations of cases from practice rather then theoretical constructions and were opened to the idea of solving own problems in teams, trying to apply techniques of quality management in own working environment.

Tab. 9. Overview of responses related to "ideal culture".

	Yes	No
Behaviour is supportive to achieve organisational goals	1	9
Decisions were made at the appropriate level by people who had live with them	1	9
The organisation was supportive of the needs of its employees	2	8
Superiors and subordinates had high levels of trust and confidence in each other	2	8
Cooperation and team work existed at all levels	0	10
Messages moved upward, downward or across depending on information needs	1	9
Downward communication was accepted with an open mind by subordinate	1	8
Individuals spoke with pride about themselves and their employer	3	6

The item on performance assessment was evaluated with the same rating as the team building. Performance management was described as underdeveloped area in our management, also not covered in training (SPH respondents). Several complaints were addressing the neglected objective evidence for quality of a work, the absence of monitoring as well as of performance indicators in health care practice. Minimum attention is devoted to the work process itself. Traditionally, the quality of a technology is solely preferred. Significantly more attention is needed to be oriented to provide explanations on tools designed to facilitate an understanding of the process and understanding the factors, contributing to excellent or poor performance. So, the task of propagating the monitoring of health care processes in their complexity is actual, too. Through indicators of condition, technical quality, relational quality, information, and product control will enable health service professionals to provide objective evidence on their work not only to peers but also to non professionals, and to society as being referred by van der Bij and Vissers (1999).

Planning techniques were among the most contradictory issues in needs assessment. There was visible penetration of negative influences and experiences from "planned economy" from the past. Also scepticism concerning financial situation and financial planning in health care in our country and absence of the vision and the strategy in majority of health care organisations and system et all were frequent comments. Such observation is congruent with limited utilisation of strategic behaviour in Slovak hospitals as showed by Hlavačka at all (2001). However, the interest in training devoted to planning and goal setting techniques prevailed still. So, despite the described conditions, the strategic planning is an indisputable tool of treating organisations and systems in their complexity. One could expect a benefit even in highly unstable environment from the cascade approach with bottom up initiatives in searching for core processes and critical success factors, Oakland (1999). Thus, parallel cultivation of planning and the leadership for a quality is the role for learning, too.

Finally, two linked areas — data collection and data analysis, were marked with relatively low scores (median 6 and 7). Data analysis was characterised as an interesting, but not inevitable for current clinical practice. Such types of statements are in a contradiction to recent requirements of quality and the Evidence Ba-

sed Medicine and Health Care approach. Results from interviews in our survey revealed that the term of EBM is attractive, however only few respondents declared serious interest for training or their own contribution to this activity. Similar findings where found in detailed audit (Bacharova et al., 2000).

Also tools for data collection were in all groups of professions rated with the lowest score. Scoring was explained through dissatisfaction with routinely collected data in comments. It may also reflect a tendency to delegate this responsibility to information technology only or to co-workers of lower rank. Neither data collection for a purpose of quality projects, nor even meta analysis was commented. The interview emphasised insufficient skills in indicators development and usage. This fact should be taken in to account when adjusting planned curricula.

Barriers for training

Based on survey results especially of interview part is possible to indicate also potential barriers for planned training in quality. They could be summarised as follows:

- *a resistance to a change in general;*
- *unsupportive culture for a change resulting from cumulated problems in HC;*
- *frequent incidence of communication blocks;*
- *low quality of interpersonal relations, loyalty of employees and clients, too;*
- *the absence of an accountability;*
- *high level of general aggressiveness;*
- *high level of individualism;*
- *the absence of corporate identity.*

Indicated comments are symptoms of pronounced problems in our health care system. One can anticipate problems in affirming change socially. Those facts may influence the will to cooperate and to achieve better situation. Especially alarming is the resistance to any change. Number of symptoms of "must culture" and no "want culture" expected in quality improvement activities was observed (Table 9). One must assume a lot of "people work" at highly professional level to achieve a progress.

Despite certain pessimism based on depicting cultural problems, interventions proposal of several authors are available. Series of statements have been addressed by Jackson and Hinchliffe (1999) and Casson and Cliveg (1995) on improving culture of an organisation through training programmes. They refer to Torrington at al. (1989) quoting that a culture within an organisation could be changed once managers fully understood it. Holway (1991) then takes this concept further on by declaring that "the only things of real importance that leaders do is to create and manage culture". With other word — the adequate leadership for quality is vital. Nevertheless, this does not mean that culture can be controlled, rather a generally accepted set of beliefs and assumptions can be established to improve or secure organisational effectiveness. Further on, the team role is emphasised by Oakland and Porter (1998) in solving above mentioned culture problem, but not panacea.

Benefits for a culture in an organisation could be expected also from an adoption of principles of self assessment and business excellence techniques, Jackson (1999). Once some benefits had been recognised an acceptance within experimented team is growing. An observation that success is contagious, is an interesting experience. Positive role is possibly assumed from competent trainers or consultants- facilitators involved in quality initiatives see Jeffries at al (1993). Competencies of trainers and/or facilitators should involve not only an awareness of the quality improvement techniques, but to be prepared to react to

- *changes of organisational structure;*
- *usage of methods of monitoring activities;*
- *skills which people use, everyday behaviour of both staff and managers to meet customer's needs in a company he/ she works for, Jeffries (1993). Preparation to above mentioned role is an aim of discussed type of training.*

Learning methods

The selection of adequate training methods plays an important role in quality management. The continuum of formal, informal and new-non-traditional methods is at disposal, as referred by Rothwell and Kazanas (1993) and applicable in the case discussed. An emphasis on experiential learning, case studies, projects, group role-playing and teamwork is indisputable. Special methods, such as out-door learning are being considered as well. The aim is not only to increase the attractiveness of the training but to support teams and new culture in trainees' organisations, too. The method of a choice is the action learning used to treat unsolved problems in groups of colleagues.

Attractive approach could be and further development in Slovak condition needs on job management coaching. The idea addressed by Tichy and Cohen (1997) that "successful leaders must develop other leaders through teachable points" is appealing. Similarly as other Tichy's ideas of building the teaching organisation, with full scale of development tools for individual contributors within an organisation. Mentoring concept broadly discussed by Conway (1998) provides another area for systematic concentration. An impact on learning capacities inclusive critical skills fostering is possible to expect.

However, important for new training products must be the implementation in concrete place. The adjustment to organisational goals, locating training into corporate context, integration with existing cultures and practices are inevitable. Then, teams learning capacities fostering same as individually oriented managerial development support could bring an effect in the success of the organisation.

Conclusions and implications

It is possible to summarise, that previous experiences in education for quality management with careful analysis of the audit of perceived needs in Slovakia, were linked together and discussed in details. Consequently, recommendation for content of the curricula and methods for further training in quality improvement mainly for CME could be formulated.

The framework of typical components of courses in quality management was presented in the findings section. Then, content of training should be in Slovak situation oriented towards a combination of rational utilisation of information, critical analytical skills, with human resource development- leadership, interpersonal skills, communication (soft skills), not just reduction of quality management tools to hard techniques as statistics and ISO norms.

To secure the success of education programs adequate training approaches should be addressed as well. Fostering managers — "transformational leaders" for locally driven decision making in health care policy and practice is inevitable. So, the need of training activities for the continuing education in quality with respect to specific target groups interests and their level of knowledge in management are important aspect, too. Methods of education, where:

- *the usage of experiential learning methods,*
- *participative training inclusive action learning*
- *team training complemented with individual professional development support inclusive a mentoring scheme*

should be highlighted, together with above-mentioned content and converted into four type of training activities displayed in Panel 3.

Panel 3

Basic Module in Quality

The first type of training activity needed is a part of general training in the management. The aim is to increase awareness of quality management, to develop critical analytical skills and propagate use of basic quality management tools

Training for Interdisciplinary Quality Teams

Training in quality for teams could be the second step for those, who are aware of essentials of management, inclusive principles of quality management. To provide participants with practical guide to the quality approach inclusive CQI and TOE suitable for their real working conditions, for solving their problems is the principal aim of this type of the training Special care in the context of teams preparation is required by the group of nurses.

Guiding through Accreditation and Quality Award

While, limited impact of quality movement in the society as well as in health services is observed in Slovakia until now, the stimulation and propagation of success fostering initiatives could be beneficial. People and organisations, which are interested — potential applicants, will be guided or informed on requirements of the accreditation and the quality mark awards. The effect of a synergy on culture of organisations through self-assessment could be expected.

Training trainers

Based on broader assessment of training needs, not only new knowledge and skills transfer is expected, but also the leadership development, enforcement of new cultures and values implementation in organisations is a matter of general interest. This dimension requires adequate preparation from side of the trainers able to react to changes and to meet customer's needs in a company he/she works for. Cultivation of individual personal development through breeding of coaching and mentoring scheme is additional dimension.To summarize, the implication of study seems to be threefold. First, careful reflection of the reality in the development of quality management could be recognised as a contribution to further development in the area. Secondly, the recommendation for CME training with respect of training needs and the tailor fitted content was prepared. Finally for sponsoring institutions to develop the philosophy and techniques of quality management with implementation to systematic approach to education was attractive, as well.

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