Short-Notice Accreditation Assessment Pilot

THE AUSTRALIAN COUNCIL ON HEALTHCARE STANDARDS
ACHS

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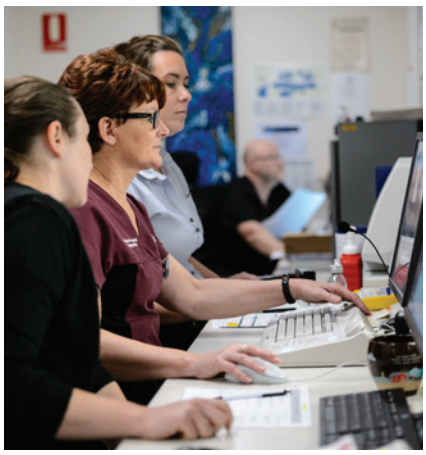
Wide Bay
Hospital and
Health Service

Queensland
Government





Introduction

In November 2014, the Wide Bay Hospital and Health Service (WBHHS) embarked on their first full accreditation survey against the newly established National Safety and Quality Healthcare Standards (NSQHS) and the additional five EQuIP National Standards (offered by the Australian Council of Healthcare Standards (ACHS)). Our experience was not too dissimilar to other health services.

In the 12-months prior to the survey, preparatory work commenced. A restructuring of the committees to ensure everything in the Standards was covered off as a priority. Each committee undertook their gap analysis, compiled their evidence lists and worked to ensure that deficits were rectified before the surveyors came on-site.

Six-months prior to the big week, the organisation engaged a consultancy visit comprising of three surveyors for three days. The aim (and expense) associated with the additional visit was to ensure that we were 'on track' to be accredited. We needed to know if we had missed anything and what our vulnerabilities were. We found some vulnerabilities; resources were tasked to rectify the risk and project officers were placed in supernumerary positions to assist with the progression of the work required.

Three months out and the tension was starting to rise, as was the workload. An extensive self-assessment needed to be written and submitted. If we needed further support, we had to get it now or we were not going to pass. Regular reports were submitted to the executive and Board to ensure they were aware of the risk areas; there could be no surprises. The Accreditation Committee was now meeting more frequently with the urgency rising.

Two months out and the commencement of a month-long negotiation on surveyor timetabling began. The right surveyor needed to be in the right area at the right time to meet with the right people. Balancing surveyor requirements (individual surveyors allocated to individual standards) and organisational requirements (three regional, eight rural, one outpatient, one corrections, mental health, oral health, and community services to be visited within a one-week period) become an exhausting process; and we still didn't get it right.

Meetings with key stakeholders were scheduled. The final month was about ensuring that each person identified to meet with a surveyor was supplied with the right information. We needed to ensure that each person knew how to answer the potential questions.

The opening and closing presentations needed to be confirmed. Sorting through options to showcase the best of what we had achieved while addressing the some of the previous recommendations was a priority. The executive/surveyor briefing needed to be crafted to ensure the surveyors were aware of changes and risks, without damaging our reputation. Logistics needed to be finalised: catering coordinated across multiple sites, teleconference and videoconference details coordinated, rooms booked, visitor access cards and computer access organised and approved. Finally, the evidence bundles needed to be compiled.

The survey week arrived. All efforts were focused on the accreditation assessment, meeting with surveyors and providing them with the information they required but were not previously supplied. Tension and workloads reached a peak. For many key staff, there was no standard work completed that week beyond the requirements of the accreditation. Their diaries were completely rescheduled.

By Friday evening, the survey team left and the organisation could breathe. Claims that the cycle of work build-up would never again occur, could be heard. Plans were discussed in debriefing conversations to ensure that we would 'always be ready' next time.

This experience would resonate with many staff working in quality and clinical governance spheres.

Background

Accreditation grew in popularity for Australian healthcare organisations in the 1980s. By the 1990s the accreditation industry was firmly established. While voluntary at that point, healthcare industry self-regulation frameworks had resulted in an almost 100 per cent enrolment in healthcare accreditation programs. By 2012, the Australian Commission on Safety and Quality in Health Care (ACSQHC) had released the National Safety and Quality Healthcare Standards leading to the legislated requirements of all healthcare organisations to be accredited.

The introduction of accreditation and external regulation frameworks demonstrated that quality of service delivery and standards had improved, however many organisations felt the increasing burden associated with accreditation requirements and expectations. Instead of accreditation being embedded into daily practice, an industry had been built — of quality managers, educational programs and associated tools — to ensure organisations could 'do' quality or accreditation.

Issues with accreditation

While the initial intent was good, the structure under which accreditation processes within Australia facilitated a focus on 'meeting accreditation' rather than delivering quality care on a daily basis. Event management for the survey week, development of evidence folders, temporary project officers and even the establishment 'quality managers' positions were all symptoms of an accreditation system which focused organisations on gaining the certificate rather than embedding quality practices.

Reflected in the experience of many healthcare organisations, short-term project officers were employed to ensure that work was completed. The focus of accreditation to improve quality care had shifted to a task-based project to ensure the right paperwork and processes were in place. Beyond creating a hidden and sunk cost, the practice of employing project officers to complete work disempowered front-line staff from creating workable quality solutions to the issues relevant to their work area.

Further, project officer employment disconnected the accountability and ownership of the accreditation process from all the staff and shifted it to a select few.

The system then creates the results seen throughout many health services; waste of resources, little meaningful improvement, and change implemented to meet the requirements of accreditation rather than patient care.

Traditional approaches to accreditation had led to an event management response by health services. There was little time for surveyors to assess the organisations in real terms. Surveyors were unknown to the health services, had limited knowledge of the journey thus far, nor the organisation's aspirational direction. Consequently, the lead-up to the survey week focussed on 'polishing' the organisation and staff to ensure they provided the best impression. The orchestrated accreditation week moved traditional quality managers into the role of event managers, ensuring surveyors and staff were carefully choreographed every minute of the day. The goal of the event was to ensure the Standards were 'ticked off' and reputation risk was carefully managed.

The survey week culminated in the final summation. Feedback provided advises staff that all is well at the time. However, as the exhaustive process ends, there is wide-spread feeling of despondency. Questions are asked about what was really achieved; was the effort worth the outcomes and, what does this really mean for our patients? Having 'passed the test' staff moved quickly back to their 'real' work. Accreditation and quality is moved to the back of thought processes and disassociated with daily work practices until the next time the surveyors are on site.

Further, the survey week lends itself to be point-in-time assessment which can easily be 'gamed' to ensure the organisation paints itself in the best light. Knowing the dates in advance enables strategic decisions in relation to leave approvals (or non-approvals) and which temporary facades can be implemented to bury potential issues that the organisation just has not had 'time' to fix. Staff can be 'scripted' so that any potential questions are answered according to what meets the requirements of the Standards.

The surveyor time spent with patients and on wards is comparatively minor compared time surveyors are kept in meetings, reading 'evidence' and certifying that previous recommendations have been appropriately completed. The surveyors do not have sufficient opportunity to see quality care in action but they do have a lot of time to see 'quality care in folders'.

Moving forward

WBHHS is an organisation which has undertaken considerable transformation since being established in July 2012. A focus on delivering high quality care at the right time in the right place has driven performance to higher levels. Across all national and state key performance indicators, the organisation features as being of excellent standard, with the delivery of the lowest waiting times, excellent emergency performance and good financial management. The concept of excellence is embedded within the organisation and all are engaged in a continual drive to improve.

The accreditation process did not have the same impact, staff across the organisation saw the process as a paper based exercise, something that management did, it was not changing the quality of care.

The WBHHS saw a future in which accreditation certification was built into a Business As Usual (BAU) model. Ownership for quality frameworks needed to move from a traditional centrally managed project and be devolved to being 'everyone's business'.

Greater aspiration

Emerging research demonstrated that care delivery practices alter in accordance to the accreditation cycles (Barnett, Olenski & Jena 2017; Mumford et al. 2015). This research, which supports anecdotal evidence, is showing that the best quality of care is delivered during the accreditation visit. The WBHHS desired to focus organisational efforts on delivering quality care everyday, rather than event managing a process separate from the staff-consumer interface.

The WBHHS had a goal to ensure that the best quality care is delivered every day. By rethinking the way accreditation models are traditionally structured, the process could be reconfigured as a driver rather than end-goal of quality care.

Developing a new model

While WBHHS were considering options to move forward with a short-notice accreditation model, Logan Hospital (who are a part of Metro South Hospital and Health Service (MSHHS)) were considering similar concepts to truly embed quality care outcomes. Independently, both health services approached ACHS. ACHS welcomed the opportunity to explore alternative approaches and began concept negotiations which resulted in a partnership to trail a new accreditation model.

Many meetings and workshops were held with ACHS in Sydney to work through the concept. Using Lean methodologies and process mapping, we were collectively able to identify steps in the accreditation process which created waste. An agreed model which incorporated the desired outcome (quality care is measured by what staff do every day, not what they prepare for in advance) and the logistical requirements of the accrediting body were reached.

The model consisted of:

- 48-hour notification of when surveyors were arriving on site
  - Names of surveyors
  - Which sites were being surveyed (WBHHS)
  - Which standards were being assessed
- Removal of opening presentations
- Facility and safety orientation provided
- Meetings kept to minimum with an emphasis on seeing quality care in action rather than in the board room
- Higher percentage of surveyor time spent in the patient care areas
- A lead surveyor identified for each organisation to ensure an ongoing relationship was built. Subsequent visits could be effectively coordinated through the lead surveyor
- Separate evidence bundles were not to be generated
  - Each organisation was to use their standard business documentation to demonstrate functioning against the Standards
  - If information was genuinely not physically available on the day of on-site visitation, the organisation had a grace period in which to supply the supporting evidence
- Advanced Completion 90-days (AC90) processes remained in place
  - If breaches or deviations from the Standards were noted and the Standard was not being assessed at the given on-site visit, the surveyor could still issue an AC90 in that standard
- Senior leaders, committee chairs and staff who traditionally were heavily involved in quality and accreditation processes needed to ensure that their knowledge and work practices were spread to their staff
  - Short-notice models prevented the ability to schedule (or prevent) staff leave
  - All staff needed the knowledge
- A simple itinerary template which minimised meetings and maximised surveyor time in patient care areas

This model ensured that organisational knowledge and quality standards needed to be built into the business functioning of all staff, not remaining in the hands of a few.

Signing off

After two years of planning and negotiating, the agreed model and associated logistics were presented to the ACSQHC, as the accreditation scheme owner. The proposed model did not fit within the current approved scheme resulting in agreed changes for the trial to be implemented. Further, agreement from Queensland Health (as the accreditation scheme regulator) was needed.

All parties reached successful agreement on the model. To demonstrate efficacy and outcomes, a formal trial and associated research project was progressed. Jointly funded by ACSQHC and Queensland Health, the research project is conducted independently of the two health services and the ACHS. A governing structure for the project has been established to ensure the intent of the trial and research objectives are maintained.

Selling the concept

Understanding the concerns of staff was essential to meeting their needs. Overall, the 'business as usual' concept was seen as a logical and beneficial step forward in the evolution of accreditation practices, however, concerns about reputation risk, fear of failure, accountability and readiness needed to be addressed.

Organisational notification of the agreement to proceed with the model was released by the Chief Executive. Individual support and readiness steps were provided through the Clinical Governance Support Unit and senior managers. Utilising the WBHHS Head of Department forum as a platform, communication, updates and engagement with senior managers ensured that a consistent and constant message was provided on the concept and progress of the Short-Notice Accreditation trial.

For those staff working within both health services, particularly in ward and patient care areas, the concept of a short-notice, business as usual model was logical and a desired option for accreditation models. The accreditation cycle with its associated workload impacts had created a negative perception of the process and detracted from the accreditation intent. However, there was trepidation due to the significant shift from a centrally managed event to a process that would shift the ownership of quality to each individual person. No longer could staff hide behind polished organisational presentations, elaborate evidence folders and scripted answers.

Integrated quality improvement registers, audits and inclusive governing standards committees supported the transition from a separate process to a practical demonstration of how quality care was being delivered. Day to day work (including risks, education modules, governing documents, audits, quality improvements, patient screenings, etc) were continually mapped back to the Standards to ensure there was a connection. Committee structures, minutes and meetings were established into a central repository for all staff to access at any point. Demonstration of adherence to the Standards were stored with the relevant committee.

Senior managers and board members expressed the same level of concern. The heightened concern related to reputational risk. Moving to the short-notice model with the focus on improved patient care outcomes and embedding quality standards in everyday practice, rather than the cyclic attainment of a certificate reinforced the validity of the concept as a way forward. This cohort of staff were responsible for leading the organisation and governing committees through the short-notice process. Despite the initial trepidation, the actual and potential benefits to patient care outcomes out-weighed any concerns.

To support the transition to the new model of embedding accreditation and quality, a number of value-added processes were implemented. The safety and quality committees were reconfigured to ensure that they provided the governance of specific Standards for the organisation. The committees were responsible for reporting on their compliance against the Standards, escalating potential risks and developing organisational frameworks for day to day delivery of the Standards. Further, they reviewed the organisation through the lens of the Standard, identifying trends that may not have been perceptible through the established divisional reporting frameworks.

The establishment of Ward To Board reporting ensuring that single data sets were used at each level of the organisation (ward, unit, division, organisational and broader Board reporting) linking performance reports with quality reports. This reporting structure resulted in consistency of information filtered through all levels of the organisation and allowed quality standards to be a part of everyday business. In addition, a central quality improvement register/database enabled organisational staff to identify improvements and recommendations (regardless of source) which were being implemented throughout the organisation. The reporting system was able to pull information and collate the data by

accountable person, ward, division, or by allocated standard. This enabled a comprehensive view of what activities were occurring to improve quality outcomes for patients, and the ability to identify and link activities across units or through to the governing Standards committees should similar projects be undertaken by different areas.

While significant work was undertaken to rethink and redesign how Standards and quality processes were embedded into a business as usual concept, additional behind the scenes work needed to be undertaken. What the health services and ACHS were proposing was not without some risk. The two health services were in the same state and there were implications from a statewide perspective to ensure that full support of the implementation of a short-notice accreditation model was gained. Presentations were given to the state's Chief Executives in relation to the concept.

Acknowledgement of the Deputy Director General (Clinical Excellence Division) Dr John Wakefield's support needs to be made. Dr Wakefield understood the concept and supported the vision as being the way forward for accreditation processes in Australia. Through his support, the Director-General and decision makers in Queensland Health were encouraged to provide their backing to this Australian-first trial. Through Dr Wakefield, the research arm of the project was financed in conjunction with negotiations with ACSQHC. This research is underpinning the project and demonstrating effectiveness of the trial.

From the beginning, substantial communications, research and briefing notes were delivered to address potential concerns. Cautious enthusiasm was built and remained until the first accreditation notification phone call was received.

The story so far

The WBHHS has now experienced three short-notice survey visits. Each successive visit has demonstrated the validity of the trial. While there was apprehension and still a degree of 'event management' for the first visit, the third visit was conducted independently of senior leadership or clinical governance involvement; our staff and the care they delivered could shine without facades.

Preliminary findings have demonstrated that after the first two visits, 96 per cent of staff felt that the short-notice model of accreditation to be better (30 per cent) or a lot better (66 per cent) than traditional accreditation models. Over 80 per cent of staff felt that the Short-Notice Accreditation model more clearly identified how safety and quality is delivered on a day-to-day basis and that the model more accurately reflected organisational delivery of quality care when compared to traditional accreditation models.

In relation to efficiency, the preliminary results have demonstrated a more even distribution of work associated with quality activities throughout the year, as opposed to the cyclic peaks and troughs experienced in traditional models of accreditation. This strong finding affirms the cultural changing impact of truly embedding quality practices into daily work.

Staff who were involved in the process have expressed a desire to remain in this model of accreditation. The process itself was calm, meaningful, and enabled care to be delivered with minimal disruption. Further, knowledge was more likely to be devolved enabling all staff to be empowered with the quality standards in practical and meaningful way, relevant to their work environments.

From policing to partnerships

The organisational findings have mirrored surveyors' findings. Of the surveyors engaged with the process at both health services, **all** (100 per cent) agreed or strongly agreed that the short-notice survey concept was more effective than traditional accreditation models.

Surveyors have felt that the preparatory work for accreditation is diminished. While there was a slight increase in their workload prior to coming on site, surveyors reported a significant decrease in the intensity of that workload. Surveyors were able to see quality and safety within the organisation as it occurs daily, rather than a staged event. As such, surveyors have felt that the recommendations they provided were meaningful and provided the ability to make real change for the betterment of patient outcomes and service delivery.

The amount of time surveyors spent out of the boardrooms and in the service delivery areas meant they could see first-hand how care was delivered. Ward areas were 'caught' in acts of excellence where surveyors could provide positive reinforcement to the teams at the time. Staff felt they could be more open and transparent than they were traditionally able to be. Staff were not scripted; staff were encouraged to engage with surveyors as if they were a part of the team.

The consistency of lead surveyors has had an unintended (and positive) consequence of shifting the survey team from police mode to partnership mode. On subsequent visits, the consistent survey team were able to witness the change and improvement in organisational functioning. The surveyor team could spend time collaborating with the teams and provide suggestions, talk through potential problems and work on possible solutions which would further benefit organisational delivery of service. Quality and accreditation is now seen as a journey, recognising where the organisation has come from to where it is going, rather than a point-in-time snapshot with minimal understanding of context. This paradigm shift may have considerable influence on accreditation processes into the future.

Conclusion

It is still early days. The results and experiences are based on three short-notice visits, however, the findings seem compelling.

The traditional models of accreditation served its purpose in setting standards for quality care. The unintended consequence was an establishment of an industry which met the needs to the survey team, minimised organisational reputation risk and created cyclic work burden to demonstrate (superficially) that standards had been met.

The short-notice survey model encourages a complete rethink of how accreditation and safety and quality standards/teams are placed within organisations. The preliminary results are clear. Staff and surveyors believe this model more clearly represents delivery of quality and safety, the work burden is decreased, and positive partnerships are built.

References

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