Pitfalls in the uptake of the idea of accreditation

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Experiences from 5 years with DDKM

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After 5 years, DDKM is now a well established fact in Danish healthcare

- DDKM has made a positive difference
- But there are challenges that if not addressed properly may lead to DDKM becoming another dinosaur

Example 1 – Signing off test results

"Test results should be signed off by the physician who has assessed the result"

Does this mean

- That surveyors will scrutinize a large number of test results, looking for the signature?
- That the hospital must make sure that any unsigned test results are signed off before survey, in order to assure accreditation?

Or does it mean

- That there is a procedure to assess and act on test result and pass on the information that this result has been handled?

Example 2 – Screening for malnutrition

- There is good evidence that screening for malnutrition is helpful to identify patients in nutritional risk
- Does this mean that every single patient entering a hospital should be screened?

Example 3 – Overwhelming number of procedures and guidelines

- In an anaesthesia department in a medium sized general hospital, more than 900 guidelines were in effect, including
  - Guidelines on how to load and unload the dishwasher in the coffee room
  - Guideline on how to insert an i.v. cannula

Example 4 – claims that the burden of documentation is overwhelming and steals time from patients

- In reality very little documentation is required by the accreditation standards only
- But some requirements may not have been recognized
- And some hospitals require actions that are seen as meaningless, but nevertheless must be carried out – and documented

- Less than optimally functioning IT systems are common place

So where can things go wrong?

- Reading the standards as rules, rather than as a guidance, an opportunity for reflection – and an assessment tool
- Implementing standards in a fragmented way, measurable element by measurable element – missing the holistic perspective
- Turning accreditation into a bureaucratic exercise, where an accreditation manager is assigned to assure that the hospital at survey will present the evidence needed to demonstrate formal compliance with the accreditation standard – and is told that a spotless accreditation award is his/her success criterion

Behind this we can identify some more fundamental misconceptions

- Mistaking an assessment based on transparent judgment and objective facts for an objective measurement
  - A useful assessment of system performance cannot be based solely on an establishment of the presence or not of certain objectively observable items
- Overlooking the fact that healthcare is a complex system, not just a complicated one
  - (we will elaborate on this later)

A suggested framework to understand, communicate, and manage these problems

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Did anything happen before we began to manage healthcare? The situation 60 years ago

- Ancestor of present day CEO: Hospital administrator / inspector.
  - Caretaker – makes sure buildings and infrastructure works
  - Accountant – makes sure wages are paid and expenses accounted for
- Professionals (physicians) decide upon activities and are able to ensure adequate funding
- National Board of Health regulates – almost exclusively by regulating individual physicians (and other professionals)

Enter hospital management!

- Need to contain cost
- Need to be able to meet external expectations (waiting time as an example)
- Driven by increasing complexity

- Eventually, but much later, need to address quality and safety of healthcare

The Four P's of Degani and Wiener

- Philosophy
- Policies
- Procedures
- Practice

- Technique!

Degani A, Wiener EL. On the Design of Flight-Deck Procedures. NASA Contractor Report 177642, 1994.

Procedures can have different characteristics

- Guidelines – to support decisions
- (Proper) procedures – to support execution

- Anyhow, procedures should be seen as tools, not as prescriptions or orders

Now we add quality surveillance and improvement

- P-D-S-A cycle – powerful metaphor

  that may lead astray

The perverted quality circle

- Describe in detail how everything should be done
- Have everyone document every action in details
- Check if documented actions corresponds to prescribed actions
- Sanction if this should not be the case

What makes an organisation deliver good quality?

- Clearly articulated and communicated goals, propagating down through the organisation – from overall organizational goals to treatment plans for individual patients
- A problem-sensing attitude (vs a comfort-seeking)
- Mixture of quantitative and qualitative information
- Avoiding
  - Fragmentation
  - Diffusion of responsibility
  - Multiple, competitive, ambiguous, and conflicting goals

Dixon-Woods M et al: Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study. BMJ Qual Saf 2014;23:106-15

Complexity is a fundamental condition for healthcare organizations

- Complexity is a feature of the system, not of the components
- Knowledge is limited and local
- Complexity renders the system the ability to develop and learn – improve – but also to drift into failure
- A complex system probably cannot achieve high reliability – but it should strive for resilience
- A complex system has no ”natural” boundaries – boundaries are chosen for a purpose
  - Accreditation of organisation vs accreditation of patient pathways/population care

Sidney Dekker. Drift into failure. Ashgate, 2011.

A good team culture is vitally important -

- Brings diversity into an organization

Bringing together the picture

What should accreditation address? – What could standards be like?

- Standards can express the ”quality philosophy” of the total healthcare system, but should leave much of the operationalization to the organization
- Standards may, however, provide guidance for development of policies and procedures
- Standards can require a goal-setting-process for the organization
- Standards can require a quality assessment/improvement process for the organization, including both the national/accountability part and the local/improvement oriented part
- Standards can require a systematic approach to professional development

What more would we like to address?

- Can standards require ”something that promotes good team culture”?
- Can standards require ”something that promotes resilience of a complex organization”?

- If not directly, can standards somehow promote the emergence of such properties??

What should accreditation assess?

- Accreditation can assess the process by which policies and procedures are developed, and also the actual content of policies and procedures – but to what extent is that useful?
- Accreditation can assess practices – the ”tracer methodology” as applied in IKAS and in different variations in many other accreditation organizations – intends to do this in a way that complements quantitative assessment
- Accreditation can assess the goal-setting process
- Accreditation can assess the QI process – and in principle, outcomes too
- Accreditation can assess the approach to professional development

What more would we like to assess?

- How could we assess the presence or absence of ”good team culture”?
- How could we assess, if the organization has the properties of a resilient organization?