Preparing the Organization for Hospital Accreditation

HOSPITAL AUTHORITY HONG KONG

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OBJECTIVES

- Benefits of Hospital Accreditation
- Preparing for Hospital Accreditation – General (theoretical) approach
- Preparing for Hospital Accreditation – Personal experiences, lessons learned!
  - Case Study 1: Accreditation of KFNGH Government Hospital
  - Case Study 2: Accreditation of Mater Private Hospital

Focus on how hospital accreditation drives and facilitates quality improvement in healthcare
EXPERIENCES WITH ACCREDITATION

- 15 years experience in healthcare quality, 4 countries
- Roles – Healthcare Regulator, Surveyor, Quality Manager, Hospital Management Team, Quality Champion, Healthcare Consultant
- Many lessons learned!!
- Accreditation: ACHS (Australian Council on Healthcare Standards)
  JCI (Joint Commission International)
  CAP (College of American Pathologists)
- Consultancy Projects: CCHSA (Canadian Council – Accreditation Canada)
  CHKS (Healthcare Accreditation and Quality Unit)
  Gooch and Associates
  HCPro
- Managed tender process to select DHCC Hospital Accrerditor
- Developed standards, survey process for OP Clinics, Day Surgery Centers
- ISQua Accreditation of Quality Standards (according to ISQua Principles)
- Selected DHCC Laboratory Accreditors
- ISO Certified Internal Auditor, Certified Professional Healthcare Quality (CPHQC)
KEY CONCEPTS RELATED TO ACCREDITATION

- “Engage the greatest resistors” ….Physician Engagement
- Pareto Principle – 80/20 Rule
- “Biggest bang for your buck” – i.e. put your resources into the areas that will have the greatest impact
- Focus on systems and processes rather than departmental approach
- Carrot versus Stick approach
- Quality Improvement (non-punitive) versus Regulatory (punitive)
- Continual survey readiness
- Continuous process improvement (QI versus QA)
- “Manage what you measure”
WHY ACCREDITATION?

- A process where healthcare organizations compare their performance with recognized healthcare standards
- Standards are patient-centered – aim to improve quality and safety of healthcare provided
- Over time, organizations are required to demonstrate continuous improvement of structures, processes and outcomes

BENEFITS

- Improved quality of care
- Increased public / consumer confidence
- Increased efficiency, cost reduction, credibility with insurers
- Improved management systems
- Support of staff education
- External, objective evaluation

Research findings from accredited hospitals report significant improvements in: Leadership, Medical Records, Infection Control, Medication Errors, Staff Training, Credentialing, Quality Monitoring
Theoretically, continual survey readiness is the ideal state. An organization does not prepare to be ready by ‘survey day’, lapse after survey, then prepare again before next survey. The organization meets survey requirements continually, and are ready to meet standards at all times, regardless of survey date.

Realistically, continual survey readiness is more often seen in organizations familiar with accreditation, that have been surveyed according to standards for many decades.

Over time, surveys and standard requirements become part of organizational culture.

Where do I start if this is the first time my organization has been through accreditation?

No one approach ensures successful accreditation, but there are many techniques that hospitals consistently use to achieve standards.
COMMON ACCREDITATION STRATEGIES, SUGGESTIONS

The following components may be used as part of your accreditation strategy. Some steps can be simultaneous, and some may need to be repeated at different stages of the accreditation strategy. The list is not all inclusive. Do what works for you!

1. Realistic Timeframe for Preparation (Project Plan) – (e.g. 12 – 24 months)

2. Strong Leadership Commitment – Board, CEO, Clinical Leaders

3. In-Depth Knowledge of Standards – (survey process guides, training)

4. Organization-Wide Communication / Education Strategy

5. Baseline Assessments / Periodic Assessments, Monitoring (Action Plan)

6. Mock Survey - Gap Analysis (external consultant)

7. Self-Assessment - Departmental Reviews, Tracers (internal assessment)
STRATEGIES THAT HAVE WORKED

- Importance of **physician commitment** to the accreditation process
  - Must see accreditation standards as a framework by which organizational processes will be improved
  - Care will ultimately be of higher quality and safer for their patients
  - Reassure physicians that accreditation is **not** intended to tell them how to practice medicine!

- Ask the accreditation organization for assistance and clarification with standards interpretation – don’t waste time going down the wrong path

- Adjust your project plan when required to be more realistic – change often takes longer than one expects

- Learn from what others have done well and adapt the experience to the needs of your organization (information sharing)

- Staff end up feeling that accreditation is extra work for which they are not rewarded or recognized – RECOGNISE THE STAFF

- Focus on motivating staff and celebrating milestone achievements!
ACHIEVING ACCREDITATION!

- Celebrate the success!
- Let your patients know what you have achieved
- Publically communicate achievement (press releases, marketing)
- Maintain the momentum from the survey – establish an ongoing system of standards compliance and survey readiness
PHYSICIAN ENGAGEMENT – Quality Gala Dinner (Nov 2008)
OBSERVATIONS AS AN ACCREDITOR

- Healthcare Providers don’t like to be surveyed
- Healthcare Providers are very nervous to be surveyed
- The 1st survey is the worst (no previous experience with survey) but facilities are much more relaxed, after they’ve been surveyed a few times (familiarity with process, increased trust)
- Some staff are very happy when we find problem areas, areas of non-compliance, because the facility leadership are more likely to act as a result of the survey report
- The facilities that have the most problem areas, areas of non-compliance are the facilities that need our help the most!!! DO NOT PUNISH THESE FACILITIES! Work with them!
1. CHALLENGES RELATED TO HEALTH, SAFETY AND ENVIRONMENT

Actions / Resolutions:

- Education sessions on chemical waste management (COSHH) conducted
- Chemical / medical waste management policies and guidelines developed
- Requirements for Materials Safety Data Sheets (MSDS) clarified
- Fire safety education sessions introduced
- Fire warden training schedules distributed to all Healthcare Operators
- Fire drills conducted for Ibn Sina Building, blocks A, B, C and D
- Facilities provided with fire evacuation plans
- Recruitment of fire safety specialist to address fire safety needs
2. CHALLENGES RELATED TO MEDICAL RECORDS

Actions / Resolutions:
- Education sessions on medical records management conducted
- DHCC Medical Records Policy developed and distributed to Healthcare Operators

3. CHALLENGES RELATED TO INFECTION CONTROL AND STERILIZATION

Actions / Resolutions:
- Developed process and resources for communicable diseases reporting
- Launched communicable diseases reporting
- Commenced collection of communicable diseases data and reporting to DOHMS
- Procured additional DOHMS reporting booklets to facilitate reporting
- Education sessions on infection control and sterilization conducted
- Sterilization policy developed and distributed
4. CHALLENGES RELATED TO BLS CERTIFICATION

Actions / Resolutions:
- Determined that all clinical staff need current BLS certification
- Provided facilities with dates of BLS courses conducted by HMSDC

5. CHALLENGES RELATED TO APPROPRIATE FIT-OUT OF FACILITIES

Actions / Resolutions:
- List of suppliers generated to provide appropriate sharps bins
- Sharps management policies and guidelines developed, education sessions conducted
- Biomedical policies and ‘Biomedical Engineering Equipment Management Plan’ developed and distributed. Contents address specific challenges such as requirements for refrigerators including temperature control, and radiation safety
- Biomedical requirements incorporated into Quality Improvement Department education sessions
6. CHALLENGES RELATED TO JOB DESCRIPTIONS

Actions / Resolutions:

- Specialized job description and performance appraisal templates sourced
- Templates provided to Healthcare Operators as required

7. CHALLENGES RELATED TO THE USE OF MEDICAL ERRORS DATA

Actions / Resolutions:

- Education sessions on medical errors, sentinel events and incident reporting conducted
- Sample incident reporting policies and incident reporting forms distributed
- Sentinel event policy and reporting form developed and distributed
8. CHALLENGES RELATED TO USE OF PATIENT SATISFACTION SURVEY RESULTS

**Actions / Resolutions:**

- Decision reached for all surveyors to score standard 8.5 as ‘not applicable’ until facility has reached 18 months of operation. This ensures that the facility can implement patient satisfaction surveys for a sufficient period to allow trending and implementing of improvements.

- Retrospective review and scoring conducted of previous assessments to ensure consistency of scoring.
9. CHALLENGES RELATED TO AVAILABILITY OF DRUGS AND RESUSCITATION EQUIPMENT

**Actions / Resolutions:**

- Education sessions on drug distribution including inspection, narcotics / controlled medications
- List of required emergency drugs developed
- Addressed lack of back-up oxygen supply and problems with transporting and refilling cylinders by arranging for Life Pharmacy to provide required services
- Crash cart requirements defined according to class of anesthesia, scope of service or patient type
10. CHALLENGES RELATED TO AVAILABILITY OF EMERGENCY / HOSPITAL SERVICES PLAN

Actions / Resolutions:

- Obtained Quality Council resolution, after consultation with Planning Council, that majority of Outpatient Facilities need a written agreement with a hospital but clarified that it is sufficient for smaller low-risk facilities to have a documented plan using existing U.A.E dialing 999
Organization Accredited by
Joint Commission International
ACCREDITATION APPROACH

- **Selected Accreditor** – Joint Commission International

- **Hospital-Wide Communication Strategy** – 3 day workshop, posters etc.

- **Mock-Survey (gap analysis)** from External Consultant – Gooch and Associates

- **Accreditation Taskforces** (based on chapters of standards, issues)

- **Self-Assessments (by department)** – conducted by multidisciplinary staff
RESPONSE TO ACCREDITATION / STANDARDS

Response to Accreditation Process: RESISTANCE!

“*We are already a high performing organisation*”

“*We are too busy*”

Nobody likes someone else to come in to assess their performance – feeling of going through an exam – defensive

Response to Standards: FIERCE RESISTANCE!!

“*Why are we using American standards?*”

“*This is not America, this is the Middle East, so these standards don’t apply*”

RECOMMENDATIONS

- Work hard to obtain physician engagement, and persist with education
- Stress that the standards are “International” (comply with ISQua principles)
RESPONSE TO GAP ANALYSIS REPORT

- Response to Mock Survey (Gap Analysis): LEADERSHIP IN SHOCK!!
  - We knew we would have areas to improve, but overall, we thought we were performing quite well
  - The mock survey report exposed far bigger issues than we realised, and it was actually quite embarrassing

RECOMMENDATIONS

- Be receptive to constructive criticism
- Try to resist the urge to become defensive. Focus on being pro-active, and developing strategies for improvement
- Remember: The mock survey report is a chance to address challenging areas BEFORE the actual survey
- The mock survey (gap analysis) report provides an excellent road map for improvement
GAP ANALYSIS – Stand-Out Issues

1. **Delinquent Medical Records**

   “Even for a hospital of this size, you have a spectacular number of delinquent medical records”.

2. **Outdated Policies / Procedures / Plans**

   “Policies, procedures and plans are out of date. Some policies have not been updated since they were first drafted. Policies need to reflect current evidence based clinical practice”.
   “Your policies need to reflect your actual practice”.

3. **Quality Assurance, not Quality Improvement**

   “The hospital focus on quality assurance is an outdated approach. Hospital initiatives need to demonstrate quality improvement”.
List of 7th January 2003 identified 79 doctors with delinquent charts

Total number of delinquent medical records attributed to the 79 doctors = 4,742 charts

31 of the 79 doctors had in excess of 50 delinquencies. 10 of these doctors had over 100 delinquencies.

Record number of delinquent medical records for one physician = 478 charts

10 of the 14 Medical Services departments had doctors with delinquent medical records

47 doctors on the January 2003 list were residents

32 doctors on the January 2003 list were non-residents
Doctors receive a first notification letter
Doctors receive a second notification letter
Doctors receive a third warning letter from Medical Records Department
If charts are not completed during the one month period, Medical Records notifies Medical Services (records now six weeks delinquent)
Medical Services notifies Finance Department to suspend salary payment of each doctor until charts are completed. Medical Services notifies each doctor of this action
The salary is paid in its entirety upon completion of all delinquent medical records.
Some doctors view suspension of the salary payment as a ‘compulsory savings plan’. This action did not act as a deterrent!
*Suggestion: Link incident of delinquency to performance evaluation*

**SOLUTION**

Medical records clearance form prior to approval of annual leave!!!
Standards from all accreditation organizations require healthcare organisations to have comprehensive disaster / emergency plans.

Sometimes staff don’t take this requirement seriously because they don’t think it will ever happen.

In the event of a disaster, hospitals are the front line, and absolutely need to be ready! The difference in implementation will have a dramatic impact on the outcome of patients.

E.g. 1 – Hurricane Katrina – New Orleans
E.g. 2 – Fire at Royal Marsden Cancer Hospital – London (Jan 2008)
Evacuated 160 patients, 800 staff safely, no panic, no injuries
KFNGH (Riyadh) has the 9th largest ER department in the world (the 1st 8 are in North America)

KFNGH developed a comprehensive disaster plan (partly due to accreditation requirement, partly because we might need it!)

At the time, the greatest concern was potentially being hit by scud missiles from Iraq

All staff were very well trained on how to deal with a range of emergencies, and due to the political situation, people paid attention to the emergency plans and drills, and took them seriously

Scuds were never launched at Riyadh. What was unanticipated was a series of bombings that hit residential compounds, and ensured that we implemented our disaster plan.

We implemented the disaster plan brilliantly!!!
IMPLEMENTATION OF EMERGENCY PLAN – Lessons Learned

- All the staff that were on the emergency contact list were able to be contacted, and demonstrated a very fast response time.

- News of the disaster spread quickly, and everyone wanted to help, so everyone who wasn’t part of the emergency plan also showed up. It was a bit chaotic to organize all the extra healthcare workers.

- Teamwork was superb!

- We initially overestimated how many patients were from the disaster, as all the regular emergency cases (car accidents, other) were still coming in at the same time.

- All the ORs were mobilized quickly, and were ready to see patients immediately.
IMPLEMENTATION OF EMERGENCY PLAN – Lessons Learned

- The challenge was prioritizing the cases for the OR because we didn’t know the extent of the crisis, how many patients were still coming in, and if we should hold some of the ORs for more serious cases, or treat the patients we already had.

- At the crisis call center (me) we didn’t know how much / what we could communicate to media, embassies.

- We held a de-briefing meeting 2 days after the crisis to analyze what worked, what didn’t, and what we could do to improve next time. Everyone did a great job, and the de-briefing meeting in itself was very valuable exercise.

RECOMMENDATION

- Put a disaster plan in place not only because it is an accreditation requirement, but because it is very useful to have. Hopefully you won’t need it!
QUALITY IMPROVEMENT INITIATIVE – Bed Utilization, Hemodialysis Unit

- Waiting list for available appointments for outpatient hemodialysis patients was in excess of 6 months

- Doctors were admitting outpatient hemodialysis patients as inpatients, to allow immediate access to hemodialysis treatment

- These patients were occupying acute care beds: check in, receive a day pass out, then just show up for the appointment

- During August 2004, 34 outpatients occupied acute care beds (3 of these patients had been in hospital greater than 1 month) - monthly trend

SOLUTIONS

- Bed utilisation taskforce recommendations were implemented

- Outpatient hemodialysis slots were increased (6am – 12pm), staff rotated through split shifts

- The waiting list for outpatient slots was reduced, and the acute care inpatient beds were available for acute care patients
DEPARTMENTAL REVIEW REPORT – ANAESTHESIA DEPARTMENT

1. Organizational Structure and Function
2. Department and Division Leadership
3. Manpower, Physical Facilities, Equipment
4. Residency, Fellowship, Training Programs
5. Academic Activities including Research
6. Departmental Policies and Procedures
7. Quality Management, Clinical Service Performance
8. Intradepartmental Interaction
9. Interdepartmental Relationships, Support Services
10. Summary of Recommendations

RESULT: 51 recommendations just for Anaesthesia Department!
DEPARTMENTAL REVIEWS – Approach

- Guidelines established by Department Review Taskforce

- Interviewed key individuals within Anaesthesia department
  (Chairman, Deputy Chairman, Division Chiefs, Consultants, Staff Physicians, Residents, Technicians, Nurses)

- Interviews with key individuals from departments other than Anaesthesia department
  (OR Director, OR Supervisor, Reps from Pediatrics, Surgery, Cardiac, Hepatobiliary, ICU, O&G and Dentistry)

- Site visit of the operating rooms, recovery rooms and offices

- Review of Anaesthesia department’s annual report, self-assessment report, statistics, policies, procedures, clinical indicators

- Review of supporting documentation provided by divisions of Anaesthesia

- Review of confidential reports provided by departments that have close working relationship with Anaesthesia
The tracer methodology is used to evaluate priority processes during the on-site survey.

The process follows patients through healthcare organizations, making sure that they receive the safest and most effective care, treatment, and services.

Much more interactive and unscripted than the interview-based process.

Tracer methodology allows for flexibility and follow-up on identified issues.

Surveyors trace the path of a clinical or an administrative process to gather evidence about an organization’s quality and safety of care and services.

Surveyors look for staff to demonstrate good communication and safe delivery of care, treatment, and services. They look how well your healthcare team works together to ensure safe, high-quality patient care.
INTRODUCTION TO ACCREDITATION – Sydney, Australia
MATER PRIVATE HOSPITAL – Sydney
EXPERIENCE AS A “QUALITY CHAMPION” – Accreditation Preparation

- I was a junior employee, and was nominated as the radiology “Quality Champion”

- Did I understand the big picture of accreditation, or what I was doing? – Not really

- Preparing for accreditation - What did I do?
  - Read the ACHS standards cover to cover, and memorized them
  - Created records for everything! (daily ph logs for chemicals, records and trending of repeat films, checks of sensitivity, grey scales of x-ray film for resolution, densitometer readings, machine calibration records)
  - Completely updated policies and procedures, put them all in organized folders
  - Ensured all staff had current training (e.g mammography) and all certificates were in education and training records

- Great sense of accountability and responsibility – didn’t want to be the person / department that messed up and failed the accreditation for the hospital = Pressure / Stress
EXPERIENCE AS A “QUALITY CHAMPION” – Survey Day

- All my records were organized on the bench
- All the staff were wearing uniforms, name badges, looked good, sense of nervous anticipation (like feeling before an exam), and a bit of an adrenalin rush
- Everyone knew the mission / vision statements, fire exits, policies
- The accreditors walked through the department, looked at the department briefly, exchanged a few words with the head of radiology, and that was it!
- Feeling – Disappointed that they didn’t look at my records – bit of an anticlimax!

RECOMMENDATION

- Celebrate your staff’s achievements. They have worked really hard to ensure accreditation success!
TAKE HOME MESSAGES FOR ACCREDITATION PREPARATION

1. Accreditation takes commitment

2. Accreditation is a lot of work!

3. No single strategy ensures success for each organisation

4. There are many lessons to be learned from the experience of others

Finally…..

5. Improved healthcare quality and safety, makes all the hard work worth it!!

WISHING YOU GREAT SUCCESS WITH YOUR ACCREDITATION JOURNEY!