

## **National Safety and Quality Accreditation Standards**

As a past Chairman of the Board of Directors of the Australian Council on Healthcare Standards (ACHS) and a WHO consultant in health care quality to a number of countries, I have a reasonable knowledge of accreditation and other quality programs, both in Australia and internationally, and am pleased to provide a submission to the above Discussion Paper.

The Paper is comprehensive, thoughtful and very readable. However it does not address any principles for standards development, does not acknowledge the cost implications of possible changes or extensions of accreditation and pays limited attention to existing databases (at least in acute care). My overall impression is that in seeking uniformity of accreditation programs insufficient attention is given to differences in the various facilities and services, which provide health care, and a reader might equate an accreditation award or certificate with licencing, rather than something requiring more than simply complying with the basic requirements for practice i.e. being “licenced”.

My specific comments on various sections of the Paper are:

### **6.1 Effectiveness in identifying poor performance**

Identification of patient outcomes is possible currently in the ACHS program, through its Clinical Indicator program. As the purpose of a hospital is to treat compromised people it is surely part of an accreditation process to ensure that the hospital is effective in this regard.

Early on after joining the Board of the ACHS, in the 1980s, I became aware of the possibility of a hospital receiving full accreditation and yet having poor clinical outcomes. This occurred with a Victorian suburban hospital, of which, as a surgeon, I had knowledge of major issues with the standards of care of the surgeon who did the bulk of the surgery in that facility.

In 1985 the ACHS began to seek the assistance of the Medical Colleges in introducing a clinical component to accreditation through the development of clinical performance measures, which we called Clinical Indicators (CIs). In 1989 Commonwealth funding enabled the ACHS to establish an R&D unit for this task and in 1993 the first set of indicators (a generic one) was introduced into the accreditation process. Over a decade all of the Medical Colleges worked with the ACHS to develop discipline specific sets of CIs, which were subsequently introduced into the accreditation program. Hospitals reported their data six monthly and received back aggregate and peer comparative information yearly. A national database was established and the aggregated data from this are made available in an annual publication. Data are received regularly from over 650 facilities, the maximum number submitting data on a particular set being over 400. It is most likely still the most comprehensive and diverse national clinical database in any country, but it remains underutilized.

In the US the Joint Commission began the same process in 1987, but established its own working parties instead of joining with the Colleges and their progress in obtaining uniform national data was slower, this not being achieved until after 2000.

The ability of the database to identify poor performance can be illustrated using a CI in the ACHS/RACS set, reflecting the rate of removal of an histologically normal appendix in children undergoing appendicectomy. Figure I. shows a significant trend down (red line) from 1999 to 2003 and then a rise. With the 20<sup>th</sup> centile (green line)

however the fall continues, indicating possible outlier influence. The outlier hospitals can be identified, as shown in Figure II, with three, of 42 health care organizations (HCOs) reporting paediatric data, well above their peer levels.

Figure I

## Appendicectomy with normal histology (%)

Rate of removal of a “normal” appendix in children (red line) fell then peaked again  
The 20<sup>th</sup> centile rate (green line), however, fell from 18.4% in 1999 to 10.1% in 2005 suggesting an influence of outliers on the mean rate

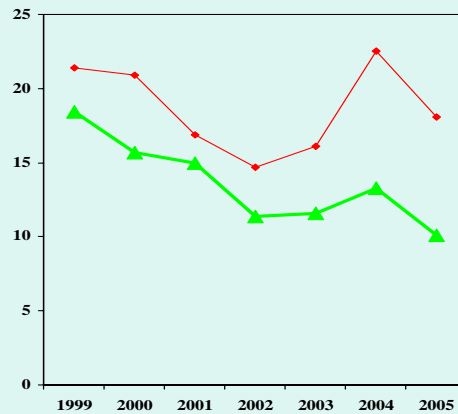
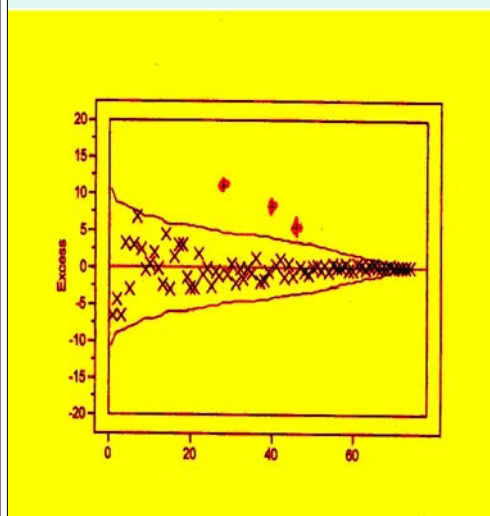


Figure II

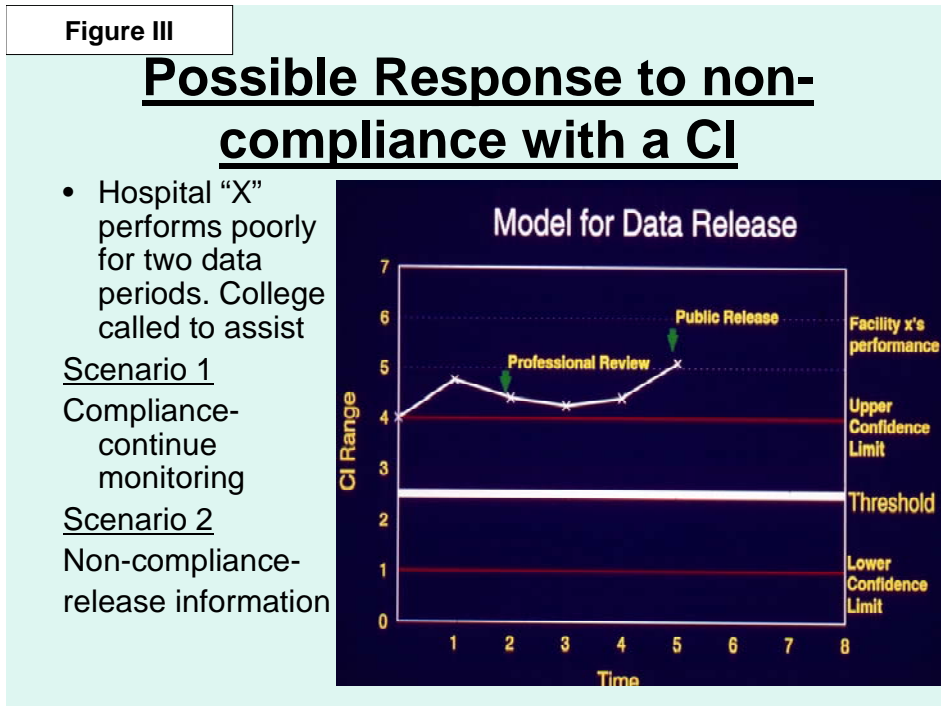
## Paediatric appendicectomy with normal histology (%)

Three of 42 HCOs providing data had numbers well above those of their peers.



Hopefully the outlier facilities would take action to correct a problem such as disclosed above and monitoring would continue. However if there was no

improvement with successive reporting, then an appropriate response would be to advise the hospital to invite the relevant professional group (eg a Medical College) in to assist it. If the problem was still not corrected then the accrediting body would need to consider sanctions, such as withholding accreditation or, public release of the information. Such a scenario is illustrated in Figure III



### 6.2 Transparency

It is appropriate that the standards used by an accrediting body are publicly available and also that the accreditation decision is available. Evidence, mainly from the US experience, indicates that many health care providers welcome and utilize publicly released specific health outcome data, but the broader community is less attracted to it and more generic information is favoured<sup>1</sup>. Thus release of the accreditation decision alone may well suffice, unless, as in the scenario outlined above, an HCO is unable or unwilling to make appropriate changes to achieve improvement.

### 6.4 Duplication and overlap

Integration has existed for some time in a limited way, for example with accreditation of pathology services in acute hospitals by NATA/RACP being accepted by the ACHS. This "deemed status" could be extended to the extent that where an "approved" accrediting body has been satisfied with a facility's (or a part of it) performance, then that decision, for a given period, should be accepted by other accrediting bodies. For example if a hospital sought and achieved ISO accreditation for its governing body and management functions, then the hospital might have "deemed status" for those functions and another accrediting body, such as the ACHS, might confine its assessment to the other service and clinical areas.

## **6.6 Surveyors**

The practice of having surveyors, who are in current health care employment, is extremely valuable in terms of peer acceptance and two-way learning. However time constraints are an issue for the individual and the employing facility.

The use of some full-time surveyors is necessary and may improve efficiency in the pre-survey phase and in the completion of the post-survey report. It is essential, however, that such full-time surveyors (if retired from practice) both remain abreast of healthcare practices and do not survey too far outside their own health care area of expertise.

I witnessed an embarrassing example of this problem, when on a Joint Commission survey of an American mid-west hospital some years ago (as an observer). I was accompanying the medical surveyor, who was a retired physician (internist) from Boston, and we donned theatre garb and went into an OR, whilst an operation was in progress. Having moved about the room for some minutes he stopped at the anaesthetist (anaesthesiologist in the US), kicked one of the metal legs on the anaesthetic machine and asked him “Do you know how this works?” The anaesthetist replied succinctly “I ought to as I built the ----- thing”.

It would be of value, in recruiting surveyors, to raise the prestige value of surveying. Appropriate recognition can be made in ways other than pecuniary.

## **6.7 Information to support accreditation**

As indicated above in comments for **6.1**, on the clinical side a large national database already exists in the ACHS program, with the denominators (patients at risk) for some of the CIs being in the millions, and the data are available nationally. Whilst it is noted in the Discussion Paper that the ability of health services to “opt out” of performance reporting is a limitation, its voluntary nature should be weighed against the likelihood of “gaming” of data in a compulsory system and the risk which that poses to the educational value and culture of the program.

## **7.3 Process of developing standards**

Consideration should be given, at the commencement of the development process, to establishing a set of principles for the standards. The Discussion Paper indicates that ISQua and ISO have developed guidelines for the development of standards but does not enlarge on these. However discussion of the principles involved will be essential to ensuring that future standards are of relevance and value. For example a standard should meet the following principles:

- Be set at an optimal level
- Reflect best practice
- Be consistent with the aims of the organization and meet legal requirements
- Support competencies in practice and encourage improvement
- Address an issue of importance to the consumer/community
- Be achievable
- Be sustainable

## **7.4 Appropriateness of standards**

Adherence to the above principles should ensure their appropriateness

### **8.1.1. Register of accredited bodies**

d. Whilst a nationally agreed set of accreditation data might be desirable the cost implications are considerable. It also would need to be determined if one of the existing programs might be modified for this task or whether a new authority would be established

### **8.1.2. Standardise accreditation language and definitions**

This should be one of the more easily achieved recommendations as to a considerable extent the language is already international. I believe it is important to maintain the concept that achieving accreditation is moving to a higher level than simply certification and this can be conveyed in the language used.

### **8.1.4 Better use of data for evaluation of health service performance**

This is an appropriate proposal. However it is essential that there has been uniformity of definitions used in the various programs before the data are aggregated. This was a major problem in the US when the Joint Commission started collecting clinical information. Again significant costs may ensue in data collection, collation, refinement and distribution.

### **8.1.5 System wide accreditation against safety and quality standards**

The question posed at the end of this section does not seem to be related to the benefits a-d, listed above it in the text. The text addresses accreditation processes/programs and the question addresses health services.

### **8.1.6 Introduction of unannounced surveys**

Whilst this is a reasonable concept it remains doubtful that its introduction would achieve cost savings, for if extra costs are required in “ramping up” for a survey then those extras might be continually maintained in a state of readiness. Another issue is the possible change in culture from one of an accrediting body providing, as it does, professional advice (in a two way learning process as indicated above) to an inspectorial culture provoking antipathy. It might also be counter to the suggestion above of increasing the prestige of surveying.

### **8.1.7 Introduction of Tracer Methodology in external accreditation reviews**

Whilst this variation in surveying looks promising, to extend it beyond one facility or health care setting, as suggested in point f., could prove to be costly.

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### **Reference**

1. Collopy BT. **Target and tailor the data.** Healthc Pap. 2005; 6(2): 40-5