

## Comments on ACSQH Discussion Paper on Accreditation

### ***What is the purpose of accreditation?***

Many important issues are raised in the paper but it is difficult to discuss them constructively without agreement (or even assertions) about the purpose and objectives of accreditation. It would be valuable to have a clear vision of what an ideal accreditation system would look like to the Commission as a starting point.

The paper concentrates appropriate attention on problems with, and shortcomings of, current accreditation processes, many of which are widely accepted but difficult to resolve. To the extent that it takes for granted or ignores the strengths of current processes, it risks throwing the baby out with the bathwater.

The necessary first step in trying to improve or replace accreditation is to decide on some matters of philosophy and decide whether the objective is to:

- Detect poor performance to hold organisations or individuals accountable
- Detect poor performance in order to learn from failures and prevent recurrence
- Promote best practice and continuous quality improvement
- Require compliance with minimal standards
- Achieve effective risk management.

These objectives are not necessarily incompatible with one another but if, for example, the objective is to identify poor performance and hold people accountable, agencies will regard accreditation as threatening and inspectorial and their preparation will be inclined to be more defensive or evasive than if the objective is continuous quality improvement.

The best evidence we have indicates that individual or systems failures in hospitals contribute to roughly 6,000 preventable deaths each year. This is no less unacceptable because the same disasters happen in other, comparable health care systems or because we are altruistic or because our work is underpinned by science or because we have become accustomed to it. Accreditation is fiddling at the edges of this problem and the principal and explicit objective of accreditation must be to reduce clinical risks and improve patient safety. What other objective could be more important?

Detecting poor performance is an appropriate objective of the accreditation process but there is a big difference between holding people and organizations accountable and learning from mistakes in order to prevent repetition of them. The international patient safety movement encourages a culture of "open disclosure" so that failures of systems can be studied and the systems improved.

How does the accreditation process achieve balanced attention to structures, processes and outcomes? This is important, not only because outcomes are often hard to measure but also because attention only to outcomes provides a retrospective analysis. It would be far more valuable to have accreditation systems which are effective in preventing problems than to have systems which are effective at detecting them after the damage is done.

The ACHS EQulP 4 standards focus attention on clinical risks identified for priority action by the former Australian Council on Safety and Quality in Health Care, i.e. medication errors, infection control, pressure area care, falls, use of blood products and ensuring that procedures are performed on the correct patient, site and side. The standards could do more to encourage improved management of deteriorating

patients, appropriate “escalation”, safe handover and transfer and improved supervision.

### ***How is accreditation organised?***

The paper raises some important questions:

- Should standards be set by the same body that assesses compliance?
- Should the accreditation process be controlled by the services being accredited?
- Do we want a single form of accreditation or is the task to coordinate several forms of accreditation?
- To what extent will any revamped process in setting standards and assessing compliance draw on current processes, experience and expertise and to what extent will it replace them?

Answers to these questions will be shaped by the objectives of accreditation and they need to be resolved before some of the more specific questions in the discussion paper can be constructively debated.

### ***Who does the surveys?***

A weakness of the current ACHS process is that it depends too much on the good will of part-time, unremunerated and under-trained surveyors, most of whom are busy with senior and demanding jobs in the health care system. Many do not participate in surveys sufficiently frequently to maintain their skill in a demanding and important role. Inter-rater reliability is poor; the credibility of the process suffers and there is the temptation, rather than to draw attention to problems and deal with any consequent debate, for surveyors to gloss over them.

There will be a necessary and substantial expense in improving the education, evaluation and supervision of surveyors.

### ***Unannounced surveys***

In principle, unannounced surveys should be supported. However a lot of work is done by agencies to compile the evidence required to support their assertions and their self-assessment in ACHS surveys. Unannounced surveys would have to be of a form that did not require the retrieval of large amounts of evidence without notice.

### ***Tracer Methodology***

If the tracer methodology can be shown to be valid and reliable, it could be a very useful part of accreditation. It is presumably focused on finding actual failures in systems and it should not be regarded as a substitute for other methods for reviewing the design and operation of structures, systems and processes.

It would be preferable to learn from the JCAHO experience before adopting tracer methodology here.

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