The Changing Face of Healthcare Accreditation in Australia

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Abstract

Objective: To review the background of accreditation in healthcare. We examine the National Safety Quality Health Service (NSQHS) standards development and the perceptions of some of the NSQHS accredited accreditation providers in Australia.

Design: An exploratory qualitative study in which the researchers use interviews and content comparison analysis to examine the Australian NSQHS standards (the Standards), the approving accrediting agencies and the perceived impact of the changes on the healthcare system.

Setting: The researchers focus on providers’ accreditation products and services, and how the Standards will impact on the Australian Healthcare system. Australia is not alone in undergoing reforms in accreditation and performance in healthcare. Other countries and international organisations have recently revised and renewed their interest in how healthcare systems perform.

Outcome: This has led to the development of revised standards; quality and safety review frameworks; performance indicators for monitoring, assessing and managing healthcare systems to achieve effectiveness, equity, efficiency and quality.

Measures: Analysis of qualitative data using the constant comparison method.

Findings: Five major themes are found from in-depth interviews with accreditation program providers: the multiple levels of accreditation that are offered; the importance of assessor recruitment and training; the aspiration of service excellence; improved processes; and the importance of value versus price to those who are accredited by the participants of this study.

Conclusions: The findings focus on optimisation of the regulatory environment to drive performance and quality in health facilities and the importance of the assessors, in what is expected to continue to be, a value-driven accreditation market.

Abbreviations: ACSQHC – Australian Commission on Safety and Quality in Health Care; NSQHS – National Safety Quality Health Service.

Key words: accreditation; approved accrediting agencies; NSQHS; assessors; qualitative.
Introduction
A feature of good governance of health systems is the demonstration of its effectiveness, efficiency and quality to users, the community and funders. There are different approaches to ensuring quality and improving standards in healthcare services internationally. In some countries, quality assurance in healthcare has been left to professional organisations and provider associations with little specific regulation, where participation in quality assurance programs is largely voluntary or driven by funder requirements. In other countries, particularly where the State is the main funder and provider of healthcare, rigid controls are imposed over the health sector, leaving little scope for professional autonomy and consumer engagement. Unfortunately, the latter approach is frequently accompanied by acceptance of minimum standards and little openness in disclosing relative performance. [1] In this study we seek to explore how recent changes in Australia, from an accreditation model to one of regulation through the introduction of 10 National Safety Quality Health Service (NSQHS) standards, will impact healthcare services and those who have been selected to accredit them. We seek to answer the research question: What is the perceived impact of the introduction of the NSQHS standards in Australia on the accredited providers and those they accredit?

Accreditation
Background
Healthcare accreditation is reported from the early part of the twentieth century in the United States as a mechanism to ensure an appropriate environment in which clinicians could practise effectively. It was adopted in Canada and Australia, where it conformed to the early design of standards to control hospital environments. [2,3] Australia was therefore an early adopter in respect to accreditation and the associated use of standards within the healthcare system. This supported professional engagement, ownership and inclusion; inter-professional working; specialist knowledge and research application; as well as opportunities for uniformity and consistency. Sustained development has occurred since the 1970s with movement across the regulatory spectrum (voluntary, consequential engagement due to compliance to third party agreements, legislative requirements etc.). Standards utilised in Australian accreditation programs have been for general application (eg, governance) or for specific performance requirements (eg, ionising radiation). Recent developments and changes in accreditation and standards development are consistent with this history and development of the regulatory continuum. In the past decade, these accreditation systems have been forced to change in response to the ability to support a wider spectrum of healthcare delivery environments and services along with the demands of governments and the public for greater surety and information about quality of healthcare. Accreditation, originally perceived as a vehicle to enable organisational development, is increasingly an agent of government regulation. [3]

Recent research
To date research has focused more on evidence of the impact on health services than on accreditation providers; little has been published on the determinants of the growth or decline of accreditation organisations and programs. [4] This research is significant as it explores the introduction of the Standards into the accreditation programs of accreditation providers in Australia. Accreditation programs are traditionally a form of external peer review of organisational processes and structures. At the heart of an accreditation system are standards, which describe agreed good practice for a health service organisation such as a hospital. The focus for accreditation standards in the past has been on organisational policies and procedures rather than the organisation of clinical activity and has, over the last decade, developed more importance on outcomes.

Introduction of new Standards
In 2010 the Australian Commission on Safety and Quality in Healthcare (ACSQHC) announced the introduction of the Standards effective January 1 2013, which are mandatory for the majority of healthcare services in the country. Focused on improving safety and quality the Standards aim to ‘…provide a nationally consistent and uniform set of measures…they propose evidence-based improvements strategies to deal with gaps between current and best practice outcomes that affect a large number of patients’. [5] In addition to confirming that minimum standards are in place a quality improvement mechanism should ‘…allow health services to realise aspirational or developmental goals’. [5] However there appears to be limited structural motivation to achieve best practice, instead compliance with the 10 standards is reflected in the ratings of ‘not met’, ‘met’ or ‘met with merit’. The new Standards replace ones that recognised achievement beyond the minimum standard to achieve accreditation despite Braithwaite’s warning against a ‘cookbook’ regulatory strategy and stressed the importance of continuous improvement as measures of success. [6] Emerging research, which explores the implementation of the national strategy, is focused on different contexts and concerns such as difficult standards.
Implementing the new Standards

Poole reported the findings of a survey of 415 participants from public hospitals, private hospitals, day procedure services and community-based services. [7] She found respondents reported having the most difficulty in implementing actions related to the involvement of consumers and carers. This finding informed additional tools and materials which can be developed and tailored for the varying requirements of different types of health service organisations to assist in the implementation of this standard. Designed to reduce the administrative burden of accreditation, Jessing, Brookes and Rubin reported on the development of auditing systems. Comparison across wards and departments is achieved by creating a measurement of process indicator audits, which are completed by staff and allow for benchmarking, calculate the compliance rate and generating graphical data. [8] In addition, a monthly review and action planning process is incorporated in the system. The program reports to increase local ownership, improve timeliness of reporting and importantly reduces time away from clinical duties.

The importance of orientation in the implementation of the Standards was explored by Boyd and Sheen who conducted a review of 42 articles to explore the role of workplace orientation as a core requirement of the new Standards and found orientation provided an opportunity to meet several of the core standards detailing overlap and outlining potential curriculum design for practitioners to implement. [9] Greenfield et al conducted an extensive and comprehensive research program based on observations and 34 interviews with 197 diverse stakeholders. [10] This study identified the expected benefits strategy was enhanced levels of patient centred care at each level of the health system, promoting engagement of clinicians in patient quality improvement, identifying and responding to patient safety problems and the implementation of standardisation, integration and transparency through the National framework. The evidence-based clinically focused Standards were considered to be important in increasing engagement in safety and quality improvement and direct practice. Implementation challenges identified included expectation management regarding the reform, confusion concerning aspects of the strategy, the reliability of assessing compliance and an insufficient focus on continuous improvement. In addition the inconsistency between accrediting agencies ie, low inter-rater reliability, was of concern to participants. Strategies to facilitate implementation were identified as ongoing and broad consultation, educational activities and materials, strategies to promote reliability and accountability and outcomes are being used to inform the strategy and operations for ongoing quality improvement. This summary of the emerging research presents the issues and concerns from the providers’ perspective. What is less understood are the perceptions of accreditors about the introduction of the new Standards, which is our contribution to the growing body of literature on the implementation of the NSQHS.

Method

The research is a qualitative study where data were obtained by means of open-ended, semi-structured interviews [11-13] and the examination of relevant documents. Although the research is positioned across several organisations its purpose is not to focus on differences between organisations but on major themes that are common to each of the providers interviewed. Given the exploratory nature of the research, together with a focus on contemporary events, it has been undertaken as a qualitative case study. [14] The study took place at the work locations of the providers of healthcare accreditation Australia wide. Three of the twelve approved providers of healthcare accreditation were interviewed. This study reports analysis of in-depth interviews ranging from 80-120 minutes in length. The organisations involved are long established; operate nationally and/or internationally; have developed specialisation in sectors of healthcare accreditation; and are accredited themselves (eg, JAS-ANZ). Interviews were conducted by arrangement with the interviewees and were audio recorded. Immediately following each interview the researcher reflected on the interview then compiled a memo to record an account of the interview (eg, non-verbal communication, observations etc.). Interviews were analysed using the constant comparison approach advocated by Strauss and Corbin [15,16] to identify phenomena and build these into concepts. Each interview was analysed on a line-by-line basis throughout, in an attempt to ensure that no concepts escaped the process of analysis. Initially concepts were identified from phenomena in interview transcripts in an open coding process. [15,16] At the end of the third interview the constant comparison process had generated 37 concepts, some of which were single concepts, while others were composite concepts (ie, they contained more than one instance of a concept). Composite concepts were...
constructed using an axial coding process [15,16] where concepts with similar meaning were combined. At the conclusion of analysis of the first three interviews 48 single-spaced pages of interview data had been analysed. As open and axial coding were taking place the researchers had been attempting to think of the data at a theoretical level in order ultimately to reorganise it back into a meaningful whole following the coding schema proposed by Strauss and Corbin [15,16] and Schreiber. [17] At this point in the study the researchers reflected on the data analysis carried out so far. Data had been collected from different sources; interviews and observations across the organisations, as Corbin has suggested, with multiple data sources being an important condition that influenced the research process positively. [18] Credibility and trustworthiness of data collected had been achieved by the constant comparison of data both within and between interviews, thus ensuring that themes were robust. In the early stages of analysis categories had developed quickly, slowing as data analysis progressed. [18] Understanding concepts arising from the open coding process had been accomplished by utilising an ongoing process of querying the data in the manner suggested by Corbin, [18] Glaser, [19] Strauss [20] and Strauss and Corbin 15,16] (eg, What is going on here? What does this mean? Why is the respondent saying that?). Concepts had been built from data as described above and it is proposed to continue interviews and analysis until saturation (ie, no new concepts emerging) occurs in order to ensure that concepts are robust and dense. [21] At several points during data analysis an independent researcher conducted analysis of interview data in order to ensure credibility of the overall analysis.

During open and axial coding the researchers had also commenced the third level of coding, often referred to as selective coding. [22,23] As third level coding continued, the researchers attempted to make linkages between concepts by moving them from lower to higher levels of abstraction in order to provide a conceptual ordering of the data. [18] From making linkages between categories the issues discussed by interviewees, as constructed by interviewees themselves, could be grouped into five main domains or themes. An independent researcher also analysed the construction of each theme as a means of ensuring credibility based on inter judge reliability.

Results
The five themes that emerged from analysis were: 1) multiple levels of accreditation offered; 2) assessor recruitment and training; 3) service excellence; 4) improved processes; and 5) value versus price. These are now discussed.

Theme 1: Multiple levels and types of accreditation offered
All interviewees discussed the presence of an available and emerging range of accreditation models or programs now available highlighting the multiple levels and types. One commented that the introduction of national Standards in 2013 has ‘…seriously opened up the market to competition’. The interviewees discussed three types of accreditation that have been developed over the years: 1) the ACHS model; 2) ISO certification with some clinical standards since 2007; and 3) the National Standards since 2013. Some organisations offer National Standards as a standalone accreditation, ISO certification and ISO incorporating the National Standards. Accreditation providers have also now incorporated the Standards in a type of hybrid of their previous model. The ongoing issue of multiple accreditations being required for services also emerged.

Theme 2: Assessor recruitment and training
The need for competent and well-trained assessors was highlighted by all interviewees. One stated that a clinical background is a requirement with ‘…fairly high level experience in the healthcare sector’ along with the ability ‘…to understand the risks across the hospital. Assessors are subject to annual performance reviews in which client satisfaction is part of the review process. Periodic observation of assessors in the field is also carried out’…just to make sure that they are still performing well. Twice-yearly auditor training workshops are also held as special training sessions. In special circumstances (eg, the need for a mental health specialist) the organisation co-opts technical experts to ‘…audit with one of the auditors, so you audit as a team’.

Another interviewee reinforced the need for assessors to have ‘…some association with either health or community services’, and of ‘…a number of assessors who are still current practitioners in the health environment’. This organisation does not actively recruit assessors, stating that ‘…they come to us’.

Organisations of the three assessors interviewed have developed programs of assessor or surveyor training and ongoing professional development. The use of competency based learning models was demonstrated including training delivered externally and internally to the accreditation organisation.

Theme 3: Service excellence
There is an interest and perceived value in the differentiation of compliance with improvement assessment with accreditation providers interested and capable of supporting both key agendas. One interviewee discussed moving beyond the three forms of accreditation discussed in Theme
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1 above. She spoke of creating a two-tiered system where tier one is the ‘…compliance tier’ and tier two is ‘…service excellence’. She said, ‘…so you go beyond compliance and take a journey to excellence’. Although according to this interviewee no organisation has yet commenced the journey to excellence she commented that ‘…it’s met positively…because I think people in healthcare want more than just compliance’. The interviewee explained the ways in which organisations can access the service excellence programme. The main ways are by applying for a service excellence award and following the processes associated with it, or by being assessed by the accrediting body against criteria developed by it. The interviewee explained that what service excellence involves ‘…is sustainable improvement’. She predicted that once the compliance cycle had been completed organisations would be keen to discuss service excellence. Continuous improvement beyond compliance is the key to service excellence. Continuing with the theme of excellence another interviewee stated ‘Our philosophy is to work and to help improve, quality improve or lead continuous improvement in the health and community sector.’ The organisation has a mission to ‘…help the sector’. The third interviewee provided a contrasting perspective of assisting organisations to achieve excellence. She spoke of encouraging auditors to ‘…identify best practice, so I guess we would do that in a qualitative way’. However, when prompted for examples of processes to identify best practice the interviewee stated ‘We have to be very careful doing that, because that’s overstepping the mark. We’re auditors. We’re not consultants. That’s the job of a consultant and that’s a huge tension in this business…’

Theme 4: Improved processes

One interviewee suggested that the new Standards meant that all hospitals would now be accredited to the same standards, instead of a mixture of ISO and other standards. A consistent approach under the new standards should result in even and improved processes, as organisations would have a common understanding of the intent of each standard. Evaluation ‘…to make sure we have the same understanding of the intent of each standard, or each criteria, and of each action, then it will definitely change process’. She believed that it is the intent of the new Standards to change processes, and then outcomes. However, changing processes through the adoption of common standards depends heavily on auditor competence, which is only as good as the auditors undertaking the audit.

Another interviewee believed that the new Standards would change processes, but mainly for large organisations. She stated ‘… my feel for the national Standards at the moment is they are big hospital standards’ describing some organisations as ‘…very small, simple things’. The interviewee gave an example of day surgery in relation to the requirement of element two of the standard that requires input from the consumer. She questioned how this could occur given limited contact between medical practitioners and clients. She queried how consumer involvement in a situation like the one just discussed could change practice. She did not think the standards would change. The third interviewee suggested that ‘…the information collecting arm is going to be very powerful, and I guess it will standardise practice in healthcare services.’ From standardisation would come the opportunity to improve processes. The threat of accreditation failure to healthcare institutions would be a very potent one that would encourage change.

Theme 5: Value versus price

The cost of delivering accreditation programs and processes, as with all quality activities, comes at a cost. Interviewees identified that healthcare organisations generally focus on value propositions rather than service cost. One interviewee explained ‘… decisions are not being made around the price, it’s around the value of the accreditation’. She cited examples of healthcare institutions that had received ‘… glowing reports’ in the past, which caused them to reflect that ‘…we’re not that good. We need somebody to tell us what we’re not good at, what we’re not doing well’. Their decision was driven by a need to identify weaknesses, leading to improvement, a focus on value not price of audit. She concluded that ‘…day surgeries are very price sensitive leading to improvement, a focus on value not price of audit. Interviewees explained ‘… decisions are not being made around the price, it’s around the value of the accreditation’. She cited examples of healthcare institutions that had received ‘… glowing reports’ in the past, which caused them to reflect that ‘…we’re not that good. We need somebody to tell us what we’re not good at, what we’re not doing well’. Their decision was driven by a need to identify weaknesses, leading to improvement, a focus on value not price of audit. She concluded that ‘…day surgeries are very price sensitive leading to improvement, a focus on value not price of audit. Interviewees explained ‘… decisions are not being made around the price, it’s around the value of the accreditation’. She cited examples of healthcare institutions that had received ‘… glowing reports’ in the past, which caused them to reflect that ‘…we’re not that good. We need somebody to tell us what we’re not good at, what we’re not doing well’. Their decision was driven by a need to identify weaknesses, leading to improvement, a focus on value not price of audit. She concluded that ‘…day surgeries are very price sensitive leading to improvement, a focus on value not price of audit. Interviewees explained ‘… decisions are not being made around the price, it’s around the value of the accreditation’. She cited examples of healthcare institutions that had received ‘… glowing reports’ in the past, which caused them to reflect that ‘…we’re not that good. We need somebody to tell us what we’re not good at, what we’re not doing well’. Their decision was driven by a need to identify weaknesses, leading to improvement, a focus on value not price of audit. She concluded that ‘…day surgeries are very price sensitive leading to improvement, a focus on value not price of audit. Interviewees explained ‘… decisions are not being made around the price, it’s around the value of the accreditation’. She cited examples of healthcare institutions that had received ‘… glowing reports’ in the past, which caused them to reflect that ‘…we’re not that good. We need somebody to tell us what we’re not good at, what we’re not doing well’. Their decision was driven by a need to identify weaknesses, leading to improvement, a focus on value not price of audit. She concluded that ‘…day surgeries are very price sensitive leading to improvement, a focus on value not price of audit.

Discussing

The principal findings reinforce the changing nature of accreditation in Australia including an acknowledgement of the multiple levels and types of accreditation that are offered; the importance of assessor recruitment and training, the aspiration of service excellence; improved processes; and the importance of value versus price to those who are accredited by the participants of this study. The study identifies the multiple layers of accreditation still apparent within the sector with the NSQHs Standards in some ways adding to that. Interviewees appear hopeful that the new standardised model will ultimately replace some layers. Also of interest is an expectation that the accreditation program marketplace will become more open and competitive in the future.
The findings also stress the critical importance of assessors; their skills, contributions and inter-rater reliability to accreditation providers and the accreditation process. The importance of the need to attract, train, retain, and value assessors/surveyors as an important part of the standards compliance process is critical to providers. Comprehensive and thorough selection, induction and ongoing certification of assessors again highlight the significant role that they play in accreditation. The findings also suggest that providers are still experiencing a push to achieve more than compliance and to reach a standard of service excellence beyond the NSQHS Standards from their clients. While some healthcare providers only meet the basic standard there is a willingness to extend beyond the use towards service excellence, supporting and recognising best practice and innovation. There is a perception that improved processes will result through the shared language of the 10 NSQHS, potentially leading to greater consistency amongst healthcare providers.

Participants suggest a value-driven accreditation market will continue despite some concern of a market-driven system leading to discounted audit prices. While some sectors will be price sensitive they will also be those who face challenges in meeting compliance with all of the standards, for example day surgery patients.

The strength of this study includes examination of the new Standards from the perspective of the accredited accreditation providers. A potential weakness is lack of participation from all accreditation providers in Australia, possibly reflecting concerns of the new marketplace or the necessity for them to alter their products to align with the national Standards. A limitation of this exploratory study is that not all providers participated and therefore the findings are strictly not generalisable. It is important that future studies include all providers wherever possible. The issues identified in this study provide information for health service providers and healthcare system policy development on the development of accreditation from minimum requirements and compliance. It also identifies the need for improvement processes and agendas as well as standardised system performance assessment. Future research may include a potential longitudinal study of continued changes and outcomes in the landscape of Australian accreditation, which is moving along a regulation continuum and attempt to study the other accredited providers in Australia.

Conclusion

The healthcare system in Australia is currently implementing a stronger regulatory framework that has many key and important features. These include common standards, legislated participation and sector wide involvement and the provision of common platforms for performance review and reporting. An important agenda is the identification and opportunities to enable a robust continuum of compliance to improvement in these formal quality processes. The provision of accreditation services to monitor against the national Standards as well as against standards focused on specialised service provision and linkage to individual health provides quality strategic agendas and plans should be supported. A key driver associated with both the interpretation of quality and performance and the consistency of ratings of organisations in a complex system is the availability, training and engagement of assessors and surveyors with in-depth understanding of health service delivery and healthcare organisations.

Competing interests

The authors declare that they have no competing interests.

References

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Announcing a forthcoming Special Edition

Arising from conference proceedings at Hong Kong and Huahin (Thailand) in 2014 and 2015 a series of papers has been arranged under the special edition title ‘Financing and protecting the health of Asia’s elderly populations’.

The Editor for this special edition will be Professor Geoffrey Lieu, Founder and Chairman Emeritus of The Institute for Health Policy and Systems Research in Hong Kong, who chaired the aforementioned conferences.

Commentary from the Australian perspective will be provided by Dr Jo. M. Martins, a former World Bank public health specialist and special invited guest contributor to the special edition.

This special issue will be published in late 2015.

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