EQuIP accreditation: Feedback from a Sydney teaching hospital

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Abstract

The Australian Council on Healthcare Standards' new Evaluation and Quality Improvement Program (EQuIP) accreditation model reflects the worldwide trend towards incorporating continuous quality improvement and patient-focused care goals into hospital/health service accreditation. We conducted a post-EQuIP feedback survey among senior clinical and managerial staff at a Sydney teaching hospital and identified significant levels of negative feedback among respondents. Principal concerns were related to perceptions that the process was unnecessarily unwieldy and that it offered little value in terms of patient care delivery for the significant amount of human resources it consumed.

Background

Accreditation of health sector organisations involves the voluntary assessment of the quality of structures, processes and (more recently) outcomes using agreed standards. Compliance with these standards is assessed by surveyors who are experienced and qualified peers from both management and clinical strands, and who are external to the organisation under review. Accreditation survey findings are sanctioned by the accrediting body. In Australia, the United States and Canada this is a self-funding organisation controlled by a board which consists of representatives from health professional associations.

The American College of Surgeons initiated the first hospital accreditation program in the early twentieth century as a stimulus to hospitals to raise the quality of their work and facilities (Scrivens 1997). Early American programs were concerned with promoting better practice in hospital management and also with making clinicians responsible for hospital policy and its development (Scrivens 1995). By the 1950s, accreditation was widely supported in the United States health sector, with about 50% of hospitals volunteering to be surveyed. The Joint Commission on the Accreditation of Hospitals

was established and over time introduced the involvement of other non-medical professional associations. In the 1970s, professional standards review organisations were introduced to improve hospitals' quality assurance mechanisms. These became direct competitors of the Joint Commission, which responded by rewriting standards to reflect best rather than minimum acceptable practice (Scrivens 1995).

After some decades of interest impeded by inter-sectoral differences over professional representation and the role and function of the accrediting body, hospital accreditation was introduced in Australia in 1974 with the formation of the Australian Council on Healthcare Standards.

Since the 1970s, accreditation systems in Australia, the United States and Canada have been increasingly recognised as a means of promoting organisational quality, and program aims are identified as educational rather than inspectorial (Scrivens 1995; Australian Council on Healthcare Standards 1996; Scrivens 1997). More recently, accreditation programs have been restructured to reflect the adoption by the health care sector of industry's continuous quality improvement or total quality management model, and the emergence of patient-focused care as a key determinant of health service quality (Scrivens 1997).

The continuous quality improvement model promotes a continuous search for improved quality at all levels within the organisation, using process- and outcome-related measurement and data analysis as the yardstick of improvement. Continuous quality improvement has demanded the redefinition of hospital activity to reflect the process of patient care rather than just administrative structures (Scrivens 1997).

The patient-focused care movement has sought to re-focus organisational attention away from internal and hierarchical concerns, and towards the principal goal of providing patients with a seamless and rational service (from the patient's point of view) from pre-admission to post-discharge. This assumes that health outcome occupies a primary position as a quality determinant.

Reflecting this direction, the Australian Council on Healthcare Standards launched a new Australian accreditation model in 1996 – EQuIP. This new model differs from earlier approaches because standards reflect the imperative to provide seamless patient care services. The model also requires the organisation to self-assess against standards at departmental- and hospital-wide levels prior to survey.

The results of organisational self-assessment are forwarded to the Australian Council on Healthcare Standards for scrutiny prior to survey. The self-assessment process requires departments to document achievements and gaps/weaknesses against criteria in six domains:

- continuum of care
- improving performance
- leadership and management
- human resources management

- safe practice and environment, and
- information management.

Action plans are also required for all gaps identified. Self-assessment results are documented in EQuIP workbooks, and the EQuIP model promotes the use of the workbooks as ongoing departmental and organisational quality planners and as baseline documentation for future accreditation surveys. There are currently 173 criteria for self-assessment within the six domains (Australian Council on Healthcare Standards 1996).

The new self-assessment dimension requires organisations to make a significant commitment to workbook preparation prior to accreditation survey week.

St George Hospital, a 600-bed teaching hospital in south-eastern Sydney, recently underwent EQuIP accreditation. In order to gain organisational feedback about the new process, a survey was conducted among senior clinical and managerial staff. A literature search indicated a paucity of published commentary or evaluation of the new accreditation model.

Method

A close- and open-ended response survey was designed by the authors and distributed to all members of the hospital executive, all department heads (clinical and non-clinical), all nursing unit managers and all senior clinical staff (medical, nursing and allied health). The survey sought feedback about preparation for the EQUIP survey, EQUIP survey week, and overall views about the process. A total of two hundred surveys were distributed.

Results

Eighty-eight surveys (44%) were returned and analysed. Results, by question, are shown in Tables 1 to 3. They summarise views on EQuIP preparation, EQuIP survey week and overall impressions of EQuIP.

Preparing for EQuIP survey week

The EQuIP workbooks

Responses (yes/no/unsure) to nine close-ended questions which sought feedback about preparing for EQuIP accreditation are summarised in Table 1. Respondents were asked to note down reasons for their response to each of the questions. These qualitative responses were content-analysed and results are also summarised in Table 1 (final column).

Responses to questions 1 to 9 suggest that many respondents encountered difficulty with the EQuIP preparation process, and that the EQuIP workbooks were widely held to be overly long, repetitive and difficult to use. Most respondents reported that the process

Table 1: Feedback – preparing for EQuIP

N = 88	Yes %	No %	Unsure %	Not stated %	*Reasons for negative responses (content analysis) – categories listed in order of prominence*
1. Did you find the EQuIP workbook format easy to use?	47	44	6	3	'No' responses: • Standards unclear/ambiguous/poorly worded • Unnecessary duplication/length
2. Did you find the compliance self-rating process satisfactory?	45	18	31	6	'No' and 'Unsure' responses: • Compliance rating guidelines were inadequate • Compliance rating was too subjective
3. Were the Australian Council on Healthcare Standards compliance rating guidelines helpful?	48	17	31	4	'No' and 'Unsure' responses: • Too broad/subjective • Australian Council on Healthcare Standards workshop conducted too early to be useful • No useful practical examples given
4. Did you find individual standards comprehensible?	67	18	10	5	'No' and 'Unsure' responses: • Too subjective/general/jargonised • Too repetitive
5. Were standards relevant to your department's core business?	63	17	16	4	'No' and 'Unsure' responses • Often irrelevant • Often repetitive
6. Did the workbook completion process tax your department's resources significantly?	77	19	1	3	'Yes' responses: • Generally time-consuming (at management and staff levels) • Patient care time lost • Overtime required to complete process
7. Did your department forego other activities in order to complete EQuIP preparation?	60	25	10	5	'Yes' responses: • Planned quality improvement and research activity foregone • Patient care time lost • Departmental planning activity foregone • Staff development/education activity foregone
8. Did the workbook completion process identify gaps which you weren't aware of?	48	45	6	1	
9. As you know, workbooks will serve as baselines for future EQuIP surveys. Do you think that this will significantly reduce future EQuIP-related workload?	69	5	22	4	'Yes', 'No' and 'Unsure' responses: • As long as workbook format remains stable • Ongoing updates will be necessary

was a significant burden to their department and that it had required the foregoing of a range of pertinent activities. Worryingly, some respondents (n = 10) reported that patient contact time had been foregone in order for preparations to be completed.

Cost – staff time

Question 10 asked respondents to estimate how many hours per week they spent on preparing for EQuIP during the final six months prior to survey week. EQuIP preparation actually commenced some 18 months prior to survey, but we considered it to be unrealistic to canvass an estimate over such a long period. Responses ranged from one hour per week to 30 hours per week. The mean estimate was 6.7 hours per week (sd 6.6). We used this mean to calculate an estimate of staff time costs incurred to complete EQuIP preparation, as follows:

6.7 (hrs/week)

x 29.30 (mean hourly $ rate)

x 26 (weeks)

x 200 (population of relevant managers/clinicians approached)

= $1 020 812.

The hourly rates were derived from respondents' indication of their position within the organisation. The estimate was calculated as follows:

- 20 respondents @ $25.00/hr
- 51 respondents @ $28.00/hr
- seven respondents @ $35.00/hr, and
- nine respondents @ $45.00/hr.

We recognise that this cost estimate is crude. However we believe it is likely to be conservative. It suggests that staff time equivalent to at least $1 million was utilised in preparing the organisation for EQuIP accreditation during the final six months.

EQuIP survey week

Responses (yes/no/unsure) to five close-ended questions which sought feedback about EQuIP survey week are summarised in Table 2. Respondents were asked to note down reasons for their response to three of the questions. These qualitative responses were content-analysed and results are also summarised in Table 2 (final column).

Responses to questions 11 to 15 suggest that many respondents were dissatisfied with aspects of the survey process. Face-to-face meetings with surveyors were widely perceived to be 'chatty' and 'big picture' in nature, and respondents expressed disappointment that their workbooks were not subjected to some form of scrutiny during survey week. The feedback session at the conclusion of survey week was again a source of disappointment for a substantial number of respondents, who felt that their department's performance was unrecognised or 'lost' in the overall rating process.

Table 2: Feedback – EQuIP survey week

N = 88	Yes %	No %	Unsure %	Not stated %	*Reasons for negative responses (content analysis) – categories listed in order of prominence*
11. Were you involved in a face-to-face meeting with accreditors?	82	18	–	–	
12. If yes, were you satisfied with the meeting process? (n = 72)	51	36	6	7	'No' and 'Unsure' responses: • Surveyors wanted to discuss the 'big picture' rather than the 'evidence' as set out in workbooks • Superficial/'just a chat' • Workbooks not discussed at all
13. Did you attend the surveyors' Friday afternoon feedback session (at conclusion of survey)?	72	28	–	–	
14. If yes, were you satisfied with the session? (n = 63)	60	17	13	10	'No' and 'Unsure' responses: • Too global – department's efforts buried and unrecognised • 'Standard-by-standard' feedback was slow and difficult to follow
15. Do you think that the ratings (as reported by surveyors) reflect your department's performance?	58	8	25	9	'No' and 'Unsure' responses: • By collapsing performance in many areas to one hospital compliance rating, meaning for departments and divisions is lost

Table 3: Feedback – overall views on EQuIP accreditation

N = 88	Yes %	No %	Unsure %	Not stated %	*Reasons for negative responses (content analysis) – categories listed in order of prominence*
16. Were you happy with this hospital's facilitation of the EQuIP process?	86	9	2	3	'No' responses: • Concerns about 'lengthiness' and 'time'
17. Did you find the 'hospital-wide team' model a useful means of facilitating EQuIP accreditation?	70	9	17	4	'No' responses: • View that 'department-by-department' approach would yield a better result
18. Can you suggest any improvements re hospital facilitation for next time? If yes please state (n = 27)	31	–	–	–	'Yes' responses: • Allocate resources for data collection etc • More emphasis on planning for next survey • Involve clinicians more thoroughly • More cross-divisional liaison/comparison of workbooks
19. Now that you have 'been through' the Australian Council on Healthcare Standards EQuIP accreditation process, do you consider it to be worthwhile?	45	22	23	10	'No' and 'Unsure' responses: • Concerns about 'value' – no evidence that process has/is likely to impact on patient care • Concerns about 'magnitude' of process (in 'time' and 'paper' terms) and its negative/potentially negative impacts on patient care: – some respondents (n = 10) reported clinical care time loss – one respondent reported detrimental average length of stay impacts • Concerns about general usefulness and time wastage: – 'why waste time in preparing if we're already doing it and the assessors don't test the evidence presented?' – 'assessors should be experts in similar fields and come in cold'
20. Can you suggest any improvements to the Australian Council on Healthcare Standards regarding EQuIP? If yes, please state (n = 39)	44	–	–	–	'Yes' responses: • Reduce repetition in and length of the standards • Develop workbooks which are specific to type of organisation – instead of trying to 'fit' the organisation to the standard • Involve clinical and 'floor' staff in the survey process – 'visit the wards and units' • Improve education and support • Develop a more standardised survey process • Views regarding the concept generally – the merits of moving from an inspectorial to a continuous improvement model.

Overall views on EQuIP accreditation

Responses (yes/no/unsure) to five close-ended questions which sought feedback about EQuIP survey week are summarised in Table 3. Respondents were asked to note down reasons for their response to each of the questions – these qualitative responses were content-analysed and results are also summarised in Table 3 (final column).

About half of the respondents considered the EQuIP process to be worthwhile. One quarter held equivocal views of its value and a further quarter expressed negative views. Principal concerns revolved around a perception that the process lacked value. It was lengthy, repetitive and labour intensive, but there was little evidence of an impact on clinical service delivery.

Discussion

The EQuIP process reflects current trends in approaching health care service delivery in Australia. Standards place the patient at the centre of the care and treatment process, and the pre-survey self-assessment process mandates ongoing documentation of gaps or weaknesses and corresponding action plans. These are essential components of continuous quality improvement across the organisation.

Why then were there high levels of negative feedback about EQuIP accreditation among this sample of hospital-based clinical and non-clinical decision-makers? Negative feedback may in part be explained by the fact that the ongoing nature of the EQuIP process was to some extent hidden by the baseline-generating nature of the organisation's first EQuIP survey, and hence the perceived usefulness of the workbooks as continuous quality improvement tools was lost.

Clearly the number, wordiness and repetitiveness of standard criteria resulted in perceptions of a cumbersome and unnecessarily time-consuming process. Concerns about the value of the process (time spent in relation to benefits at patient care level) are worrying. They may indicate that the process yielded few insights into gaps and weaknesses, while consuming precious time and energy. They may also result from incomplete understandings of how key EQuIP survey results are used at the top of the organisation. For example, support from the Australian Council on Healthcare Standards regarding the need for increased staffing/resources in identified 'gap' areas is likely to be invaluable to senior hospital managers in arguing for resource enhancement at area health service and departmental levels.

The survey findings should present a red flag to health sector accreditors. The findings suggest that key benefits of the EQuIP process (for example, its long-term usefulness as an organisational continuous quality improvement tool) have not been well ingested by hospital managers and clinicians. The current unwieldiness of the self-assessment process places high demands on increasingly value-conscious health service decision-makers, and this has negatively impacted on EQuIP's perceived credibility. The lack of

observable surveyor scrutiny of departmental workbooks may result in morale-lowering and anti-climactic feelings among staff upon conclusion of the EQuIP survey.

The survey results suggest that there is a need for the Australian Council on Healthcare Standards to:

- pay more attention to educating organisations regarding the strategic goals of EQuIP
- refine the standard criteria to eliminate repetition and jargon, and
- incorporate organisational and departmental achievements into the summation conference at the end of survey week, as a means of closure for staff.

Accreditation is a costly process in the short term. Fees payable to the accrediting body and staff time lost are significant. In addition, patient care time was reported as lost to the demands of the EQuIP preparation process by a small number of respondents. One respondent questioned the 'morality' of EQuIP-related expenditure in the face of today's financial pressures on patient care delivery.

Despite this, if accreditation identifies poor, risky or defunct practices then it is likely to be cost-saving in the longer term (Hurst 1997). It must be asked whether the move to organisational self-assessment (to serve continuous quality improvement goals) limits the ability of the external review process to accurately locate poor, risky or defunct practices. Self-assessment masks the effects of internal organisational politics and imperatives on the gap-identifying process, which is the very *raison d'être* of accreditation in the first place.

We question the Australian Council on Healthcare Standards' identification of EQuIP as an accreditation process (in the external peer review sense). Rather, it represents the external application of a continuous quality improvement framework at the hospital/health service level.

We contend that little would be lost in reducing Australian hospital accreditation's current process load to the external review of efforts to develop, refine, report and gap-analyse outcome indicators. Why not harness the significant organisational energy currently consumed by EQuIP preparation and re-direct it to nuts and bolts work on departmental and hospital-wide outcome measurement? External review could be specialty-specific – perhaps more likely to create a collegial environment where gap/issue identification and analysis could proceed positively. Whilst specialty-specific peer reviewing is currently unfashionable, it seems eminently sensible in the face of the current, very costly EQuIP 'paper chase'.

References

Australian Council on Healthcare Standards 1996, *The EQuIP Guide: Standards and Guidelines for the ACHS Evaluation and Quality Improvement Program,* Australian Council on Healthcare Standards, Sydney.

Hurst K 1997, 'The nature and value of small and community hospital accreditation', *International J Health Care Quality Assurance,* vol 10, no 3, pp 94–106.

Scrivens E 1995, 'International trends in accreditation', *Int J Health Planning and Management,* vol 10, pp 165–81.

Scrivens E 1997, 'Putting continuous quality improvement into accreditation: Improving approaches to quality improvement', *Quality in Health Care,* vol 6, no 4, pp 212–8.