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staff experiences and perceptions

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Hospital accreditation: staff experiences and perceptions

Introduction

Accreditation is an external review process designed to assess how staff perform in relation to established standards (Shaw, 2004). An external, specially trained group performs an announced survey to assess compliance with predefined standards. Accreditation's primary objective is to ensure and stimulate high quality and safe care (Braithwaite *et al.*, 2010). Hospital accreditation systems operate in many countries (Greenfield and Braithwaite, 2008). Accreditation is a quality management mainstay, yet accreditation effects on service quality are debated; i.e., providers argue that accreditation is compelling, improves quality and helps staff to organise and strengthen patient safety (The Joint Commission, 2016; Nicklin, 2015; Institut for Kvalitet og Akkreditering i, 2009). Opponents argue that accreditation is resource intensive, bureaucratic and takes time from clinical work (Triantafyllou, 2014). In Denmark, this debate culminated in the national accreditation programme's dramatic termination in 2015 (Sundheds-Ældreministeriet, 2015).

Accreditation effects have been investigated in several studies with mixed results (Greenfield and Braithwaite, 2008; Brubakk *et al.*, 2015; Alkhenizan and Shaw, 2011). Nevertheless, accreditation is used in over 70 countries (Greenfield and Braithwaite, 2008), including Denmark; i.e., the Danish Healthcare Quality Programme (*Den Danske Kvalitetsmodel* [DDKM]). Unlike most accreditation programmes, DDKM was compulsory in all Danish public hospitals (Institut for Kvalitet og Akkreditering i Sundhedsvæsenet, 2009).

The DDKM aims were to: (i) create a framework for continuous quality improvement (QI); (ii) document and make healthcare quality transparent; and (iii) prevent harm. The DDKM versions 1 and 2 included 104 and 82 accreditation standards, respectively, which addressed organisation, patient pathways and disease-specific issues. The DDKM was conceptualised as a virtual quality circle, analogous to the Plan-Do-Study-Act (PDSA) cycle (Taylor *et al.*, 2014). Step one (plan) focused on creating guidelines describing how standards would be met; step two (do) focused on implementing these guidelines; step three (study) was the hospital survey and step four (act) required hospitals to take action when quality was inadequate. The first DDKM version was launched in August 2009 and the second in April 2012. After an intense public debate about DDKM's bureaucracy and the weak evidence for its effects, the Ministry of Health and regional authority managers terminated the hospital accreditation programme before the third version came into effect. From January 1, 2016, Danish public hospital staff no longer needed to participate in accreditation; instead, staff should focus more on quality and less on bureaucracy. It was argued that the potential for further improvements through DDKM was exhausted (Sundheds-Ældreministeriet, 2015).

Based on data from national clinical quality registries, analysts evaluated DDKM effects, finding that compliance with DDKM was associated with lower mortality rates (Falstie-Jensen *et al.*, 2015a), shorter hospital stays (Falstie-Jensen *et al.*, 2015b) and improved performance measures during preparatory work before external accreditation surveys (Bogh *et al.*, 2016). Results indicated that accreditation compels staff to re-priorities their focus and resources when preparing for external survey (Bogh *et al.*, 2016). Findings describe many effects, but we still wonder why some associations

manifest themselves, what processes remain unmonitored and whether accreditation has secondary effects. To address these issues, we interviewed hospital staff about their hospital accreditation experiences and perceptions generally and performance particularly.

Method

Context

The Danish public healthcare system covers all Denmark's citizens, who have access to free hospital and general practitioner care. The system is organised into five regions that are accountable for secondary healthcare. The regional acute hospital in our study has 320 hospital beds, 58,000 admissions and 499,000 ambulatory visits annually. The hospital was accredited under DDKM version one (2011) and two (2014).

Recruitment and data collection

Our study supplements prior research (Bogh *et al.*, 2016; Bogh *et al.*, 2017) by adding a qualitative perspective. We designed a semi-structured interview guide based on knowledge gathered from several informal site visits, observations made during an external survey and our prior research. The interview guide (Appendix 1) was discussed with colleagues in our research group and piloted at a different hospital, which did not lead to any changes. Three major themes were covered in the guide: (i) quality management; (ii) compliance with DDKM; and (iii) DDKM effects. To complement past quantitative work, questions focused on staff experience with DDKM and how accreditation had affected their work. To capture broad experiences, we recruited medical doctors, nurses and quality coordinators from three specialties, and one quality department employee (n = 8). A secretary from the hospital's central quality department established contact with the neurology, cardiology and endocrinology departments. We selected these departments to fit the populations from our earlier accreditation studies (Bogh *et al.*, 2016). The cardiology and endocrinology quality coordinators did not participate for personal reasons.

Procedures and analysis

During April and May 2016, the principal researcher (SBB) conducted all interviews (which lasted 30 to 60 minutes) in individual rooms at the hospital. Interviews were audio recorded and imported into NVivo 11 for coding and analysis. We applied framework analysis (Ritchie and Spencer, 1994; Ritchie *et al.*, 2013) to the interview data, by following five stages: (i) familiarisation; (ii) identifying thematic framework; (iii) indexing; (iv) charting and mapping; and (v) interpretation. A co-author (AB) listened and analysed one interview and then compared notes with SBB (Figure 1). The main author and a co-author (CvP) translated quotations from the interviews from Danish to English. In the quotations, we use 'D' for doctor and 'N' for nurse and numbers 1 to 3 to distinguish the three clinical departments.

Figure 1 here

Findings

Implementation and compliance through the accreditation cycle

Interviewees perceived DDKM's implementation to be chaotic, characterised by uncertainty. However, as standards implementation progressed, most interviewees reported that DDKM made more sense than at the beginning. Nevertheless, interviewees perceived DDKM's meaningfulness differently even if they worked in the same department:

That was, in fact, DDKM's big problem, it was hard to see a meaning with it because it was simply so confusing. (D1)

Honestly, nobody would say that ... DDKM was a bad idea. Our way of working ... is actually very healthy. (N1)

These quotations illustrate the challenge that leaders (or other key personnel responsible for implementation) faced in explaining and justifying accreditation interventions. The interviewees did not play pivotal roles in promoting and implementing DDKM in their respective departments; however, they emphasised that it was hard to 'sell' accreditation to their colleagues when they neither fully understood implications, nor felt procedural 'ownership'. Nonetheless, interviewees perceived DDKM implementation to be successful and reported that hospital staff complied with the standards throughout the entire accreditation cycle. When the second version was released, staff began to focus on new requirements, but the positive changes introduced in Version 1 were maintained. The interviewees perceived Version 2 to extend Version 1 and reported that Version 2 was more straightforward, albeit challenging and even daunting. The disease-specific accreditation standards required documenting QI in processes that failed to comply with stipulated target values. However, these standards received limited attention in the implementation process, and raised no concerns about compliance in internal or external surveys.

Priorities

Interviewees reported that DDKM required doctors and nurses to allocate more time to administrative tasks at the patients' expense. Developing guidelines was the most time-consuming task. They indicated that greater workplace responsibility led to more work when preparing for accreditation. Other improvement initiatives, which they perceived more relevant to patient care, were paused during preparations:

Anything else had to be put aside, I would say, if one asks management, there was simply no focus on anything else. We couldn't talk about anything else, couldn't commit us to anything else, many things that were impossible because of accreditation. (N2)

Interviewees reported that accreditation ensured focus on often neglected areas and processes, such as updating obligatory fire/emergency drills or discarding/reassessing outdated instructions. However, they considered some DDKM requirements to be trivial, and perceived workflows to be tedious and time-consuming, which caused frustration.

Structures

Most interviewees reported positive changes in organisational structures after accreditation. They reported that during the preparatory work for Version 1, a new and more comprehensive QI system was created. At the new structure's core were clearer roles and responsibilities, new responsibilities for key personal and more explicit information flows. They expected these new organisational structures to become a foundation for further efforts to improve quality:

DDKM has made a mark that does not disappear, that's for sure ... It has been fantastically rewarding to take part in peeping into the engine room ... it has been tremendous and rewarding. (D3)

Participants felt that after accreditation, hospital staff were in a better position to implement new initiatives owing to experience, creating a new structure and a shared language. The DDKM standards' foundation in the PDSA cycle contributed to a shared QI language. Interviewees stated that they had used PDSA before DDKM, but that it had now become a daily routine; e.g., was applied in morning conferences and staff meetings.

An online library was established to manage policy updating requirements, guidelines and instructions, as described in the DDKM Standard for Documentation and Data Management (7). The system sends a reminder to a responsible person at least every other year, a service to which interviewees attached significance. Nurses particularly emphasised the online library's importance as vital for maintaining care levels, despite staff turnover. Nurses stated that they used the system several times per week to seek information about care. Even a skeptical interviewee recognised that DDKM compelled staff to focus on relevant topics as diverse fire doors and defect device procedures. Before implementing DDKM, workplace safety routines or technical defects had often been given low priority compared with clinical work.

Processes

Interviewees felt that DDKM did not improve processes that were monitored by national clinical quality registries. Here, DDKM's disease-specific standards did not add new requirements and were thus considered irrelevant, because the national quality registries had already created a longstanding focus on these areas. Requirements for guideline design and adoption compelled staff to examine their routine practices. These reflections often highlighted the same task in diverse ways, which in turn led to better aligned work. In some cases, staff used guidelines to search the literature for best practices, or to align their work processes with other regional hospitals. However, the work required to meet the DDKM requirements was not without cost. Several interviewees noted that effort spent writing guidelines took time away from patient care, particularly during preparation for DDKM Version 1:

The first time we sought accreditation, I must say, well, there wasn't any focus on our core business. All these guidelines and instructions to make us clean the shelves once a month that had to be documented, really, there it got out of control, and that actually moved the attention away from our core business, we could really tell. It affected patient care; people wouldn't talk about anything else: What is it we will not get done on time? Who should get this done? When

should we find time for this task? Instead of having professional development in focus. (N3)

Terminating DDKM Version 3

Most interviewees expressed relief that the DDKM third version was cancelled. They generally had confidence in how QI now worked. The interviewees expected that organisational changes stimulated by DDKM would be sustained and that hospital staff would focus on continuous QI. Abolishing the external surveys was not a major concern.

It is not a problem that DDKM is abolished. It has been running so long, the good things are jammed in, and it has become part of the everyday work. And where it frustrated us, we skip it. (N2)

Discussion

We investigated hospital staff experiences and perceptions of how accreditation affects service quality. We found that DDKM served, in part, as a framework for continuous QI in hospitals and that previously neglected processes were addressed. Yet, staff did not perceive that clinical processes directly addressed by DDKM were improved, which corroborates previous studies demonstrating that DDKM generally did not improve care processes in the long term (Bogh *et al.*, 2016). An existing management focus on clinical areas covered by clinical registries explains why DDKM did not improve processes in these areas. This finding explains why an earlier study found no association between accreditation and care process improvements when voluntarily accredited and non-accredited Danish hospitals were compared (Bogh *et al.*, 2015). Moreover, our findings do not indicate that DDKM improved care processes beneath target values, as shown in earlier research (Bogh *et al.*, 2016).

In accordance with earlier studies describing accreditation as an effective enabler or catalyst for change (Pomey *et al.*, 2010; Greenfield and Braithwaite, 2008), we found that DDKM contributed to organisational improvements and a new foundation for future improvement. The preparation for accreditation provided opportunities for hospital staff to reflect on their work, and whether structured process improvements were needed. However, reduced time for patient care and downgrading other improvement initiatives in the preparation period were considered trade-offs. El-Jardali *et al.*, (2008) demonstrated that nurses perceived accreditation to be an improvement tool; however, we only found limited support for this assertion because improvements in one focus area appear to have been at another's expense.

Pomey *et al.*, (2010) found that after ten years with accreditation, Canadian hospitals no longer considered accreditation challenging, even if they were given recommendations to improve. Our study found that DDKM yield and meaningfulness increased over time. The DDKM Version 2 was easier to implement than Version 1 because staff had become familiar with methods and expectations. Additionally, changes in structures were considered permanent, and staff stated that DDKM had contributed to a culture in which QI played a significant role.

Limitations

Our findings enrich understanding from previous accreditation studies by explaining why Danish healthcare accreditation did not contribute to improved care. Although we believe that our results are relevant to other settings, our study's limitation is the relatively small sample. However, the interviews provided rich material with diverse responses from different professionals and after six interviews, no new information emerged indicating data saturation. Another limitation is that we conducted the interviews after the accreditation program was terminated, which likely introduced recall bias. However, informants seemed easily to recall and share their experiences, and their statements were congruent. Additionally, honest answers were more likely because the accreditation model was already terminated when we conducted the interviews. Findings from improvement initiatives are context dependent and thus not always transferrable (Ovretveit, 2011; Fulop and Robert, 2015). Conversely, DDKM comprises well-described and standardized interventions that are based on accreditation principles established by the International Society for Quality in Healthcare.

Conclusion and recommendations

Hospital staff should acknowledge that accreditation is a daunting task that involves the entire organisation. It critically reviews the whole hospital, including areas that are often neglected. While accreditation dominates hospital staff agendas, sometimes at patients' and other improvement initiative's expense, improvements cannot be expected in departments with mature QI. Yet, accreditation creates organisational foundations for future QI initiatives. Healthcare leaders and quality improvers should put effort into integrating accreditation programmes with other improvement initiatives in their organisations. Even more importantly, they should monitor their organisations for accreditation side effects.

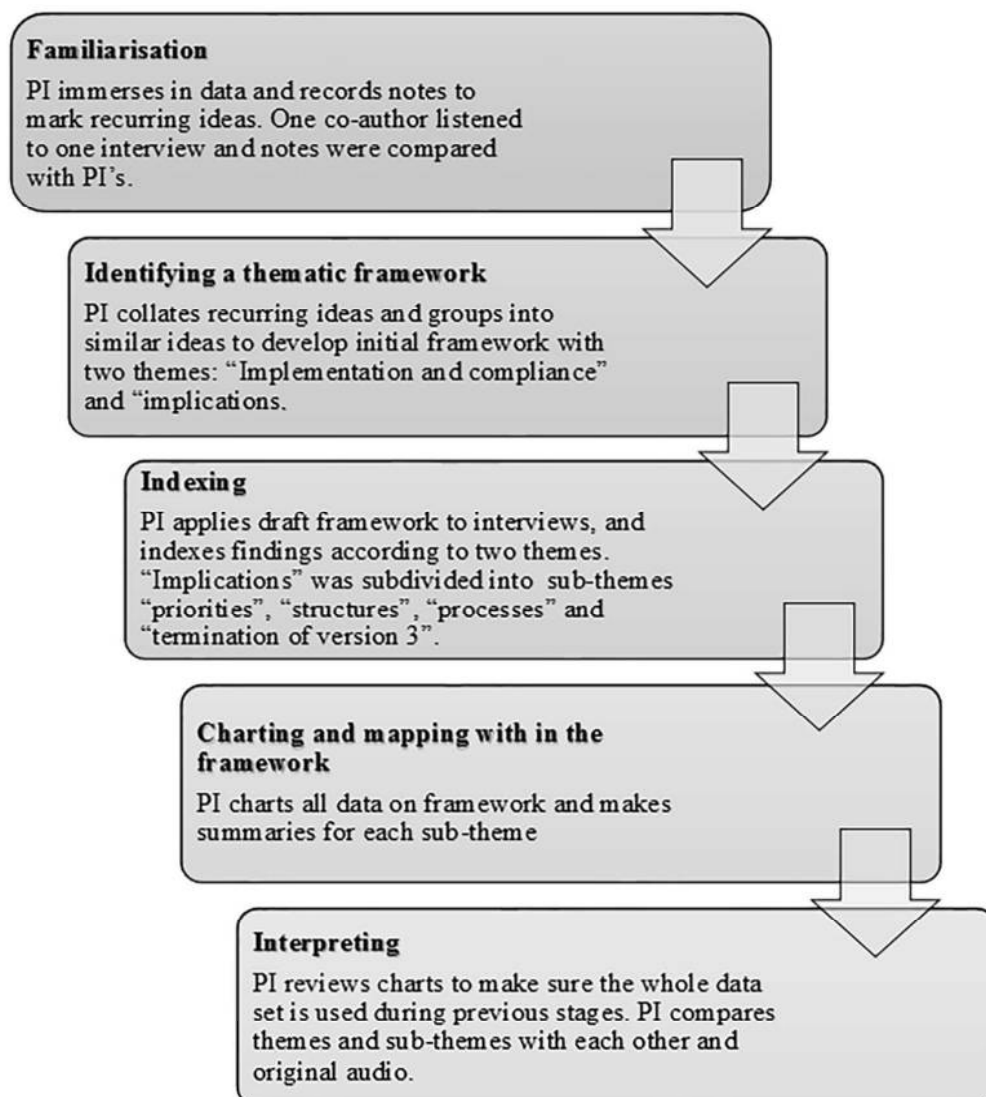
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Figure 1: Framework analysis.



Appendix 1: Interview guide

- Briefly, tell me a little about yourself and the work you do here at the hospital.

- Describe your daily functions relating to stroke/heart failure/diabetes.
- Can you tell me about how you and your colleagues work with quality improvement in this department?
- Tell me about how you and your colleagues worked with DDKM in relation to patients with stroke/heart failure/diabetes.
- How was DDKM introduced in your department and by whom?
- In which situations in your daily work was DDKM discussed.
- How much time did DDKM occupy during a normal day?
 - Was the time used on DDKM stable or did it peak at certain times during the accreditation cycle?
 - If yes, then were there any secondary effects of increased time spent on DDKM
- Fulfilling clinical guidelines is measured through quality registries.
 - Do you use these data?
 - How?
- Has DDKM influenced service quality as measured in the registries for stroke/heart failure/diabetes?
- Has DDKM contributed to new initiatives to improve clinical processes?
- Has DDKM had an effect in general?
 - On clinical process quality?
 - Has DDKM had an effect on clinical processes that are below the target values (unsatisfactory quality).
- Has DDKM contributed to more system based or a more person-based quality improvement work?
- How has DDKM's termination affected your work?
 - Has termination affected clinical processes?