MEDICAL PRACTICE

Journey of a Hong Kong public teaching hospital in preparation of hospital accreditation

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Hospital accreditation is a new concept for Hong Kong Hospital Authority hospitals. Queen Mary Hospital has been engaged as one of the hospitals in a territory-wide Pilot Scheme of Hospital Accreditation. In preparation for accreditation, Queen Mary Hospital has undergone the process of self-assessment, staff engagement, and service improvements which all require well-planned strategies to achieve successful outcomes. In this article, we highlight the journey of preparation and the staff engagement exercise we conducted to attain full accreditation. We also highlight the obstacles, conundrums, and pitfalls we encountered, along with successful overcoming strategies and countermeasures we adopted, and quandaries to be avoided. Throughout the preparation, the hospital's senior executives insisted that achieving hospital accreditation was not the main focus, but rather an emphasis on how the Pilot Scheme would bring about organisational transformations in our culture, and thus foster quality, safety, effectiveness, and reliability of services. We hope our experience can provide a reference and be of value to other hospitals that will go through the journey in the future.

Introduction

In March 2008, the Food and Health Bureau of the Hong Kong SAR Government and Hospital Authority launched a Pilot Scheme of Hospital Accreditation (pilot scheme) in partnership with Australian Council of Healthcare Standards (ACHS). The latter is an independent, not-for-profit organisation established since 1974, dedicated to improving quality in health care. A total of five public and three private hospitals in Hong Kong participated in the pilot scheme. Another three non-pilot private hospitals also joined the accreditation exercise (Table 1).

Accreditation is a process in which a hospital strives to deliver high-quality health care, based on external peer-reviewed standards.[1] Hospital accreditation is gaining popularity worldwide, but is a relatively new concept to the public health care system in Hong Kong.[2] In particular, the journey of preparation has never been described. Many health care workers are ignorant to the concept of accreditation or means of preparation. To develop everything from scratch could be daunting to hospital executives and frontline staff alike, especially if there is no sound and robust quality management scheme in the organisation to begin with.

Established in 1937, Queen Mary Hospital (QMH) is a public teaching hospital affiliated with the University of Hong Kong. It has more than 4800 staff, 19 clinical specialties, 1500 beds and an annual budget of more than HK$3.0 billion. It is also a tertiary referral centre for liver, kidney, heart, lung and bone marrow transplantation, paediatric and cardiothoracic surgery, and oncology in Hong Kong. Having such a formidable configuration, it is hardly surprising that launching a pilot accreditation scheme for QMH is no simple undertaking.

Key words
Accreditation; Efficiency, organizational; Organizational innovation; Quality assurance, health care

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The hospital accreditation journey

Structure

Twenty-four months prior the formal QMH accreditation process, a Core Team was formed to oversee preparation of the process. With the Hospital Chief Executive as its patron, the composition and organisation of the Core Team is shown in Figure 1. This team was accountable to top management via regular reporting to the Hospital Governing and Management Committee. Based on their expertise, experience and passion — rather than status and rank — Core Team members were recruited from different disciplines, including: clinical specialties, nursing, allied health, pharmacy, laboratory, administration,

香港一所公立教學醫院籌備醫院認證先導計劃的歷程

醫院認證計劃對於香港醫院管理局轄下的醫院來說是一個新概念，而瑪麗醫院是參與醫院認證先導計劃的其中一間醫院。要計劃成功運作，有賴於精心策劃。為籌備此項計劃，瑪麗醫院展開一連串工作，包括推動自我評核、確保員工積極參與，並致力改善服務質素。本文重點報告瑪麗醫院籌備認證計劃的歷程，以及確保員工積極參與所作的措施，並會分享有關籌備過程中遇到的障礙、難題和陷阱，以及提出解決方案和曾採取的對策。籌備過程中，醫院管理層強調達致認證計劃並非重點，反而應透過此計劃而推動醫院組織文化的變革，從而加強醫療的服務質素、安全性、有效性和可靠性。希望透過我們的經驗分享，可以為其他醫院推行類似計劃時作為參考。

TABLE 1. Hospitals in Hong Kong that participated in Australian Council of Healthcare Standards Hospital Accreditation (as of December 2010)

Public hospitals	Private hospitals
Caritas Medical Centre	Hong Kong Adventist Hospital
Pamela Youde Nethersole Eastern Hospital	Hong Kong Baptist Hospital
Queen Elizabeth Hospital	Hong Kong Sanatorium & Hospital
Queen Mary Hospital	Matilda International Hospital
Tuen Mun Hospital	Tsuen Wan Adventist Hospital
	Union Hospital

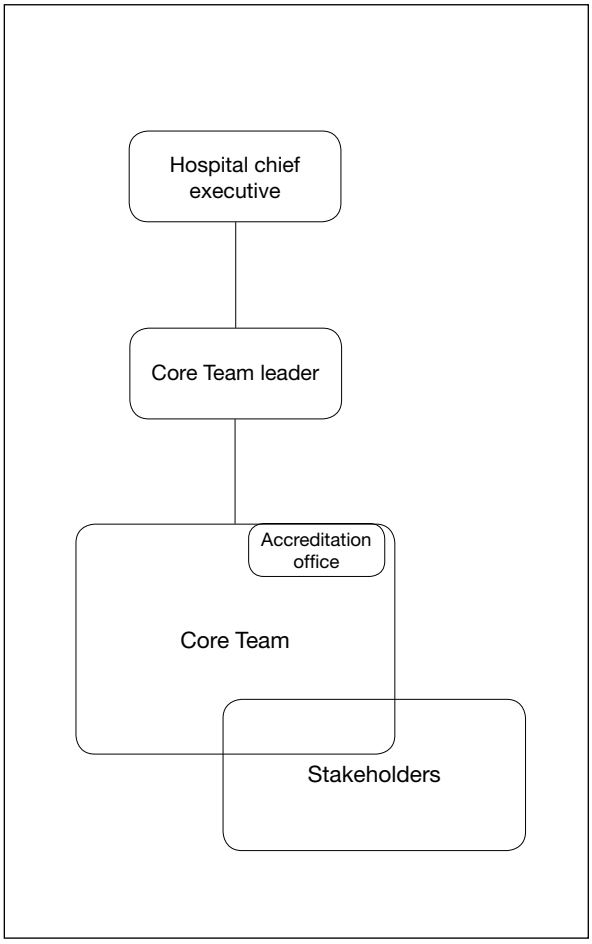

FIG 1. Queen Mary Hospital accreditation team structure

community partners, central audit, infection control, and quality and risk management. The collective wisdom from such diversified membership helped identify and analyse issues from different perspectives and ensure rational decision-making after due consultation and consideration.

Since all Core Team members have other commitments and could contribute only on a part-time basis, it was essential to appoint dedicated executives working full time to help steer and crystallise ideas and decisions, and put them into action. Accordingly, the Accreditation Office was set up with three full-time staff responsible for coordinating meetings, formulating plans, monitoring progress, engaging staff, conducting research, and communicating with the ACHS and Hospital Authority Head Office.

Self-assessment

The term "nuts and bolts" (NAB) according to Webster's New World's Thesaurus is defined as "detailed practical information about how something works or how something can be accomplished". Our Core Team meeting was termed a NAB meeting and defined its objective literally. The NAB meeting was a gap analysis exercise to eliminate blind spots and identify shortcomings, focusing on various clinical, support and corporate criteria using the prescribed ACHS standards as reference.[3] Under the ACHS framework, there were 13 standards that were expanded into 45 criteria. Each criterion had five levels of rating, from Level 1 (Little Achievement) to Level 5 (Outstanding Achievement). Our gap analysis rigorously scrutinised the first three levels of rating, namely, system awareness, implementation and evaluation, the attainment of which represented the meeting of minimum accreditation requirement.

The first level in the ACHS accreditation framework was "system awareness". System awareness implied the organisation's consciousness to assure quality, accountability, and proper management. As obvious as it may sound, system awareness should not be taken for granted and we discovered well-established practices within the hospital that lacked proper governance. The next level in the framework was to analyse and assess whether there was appropriate implementation of policies or guidelines. In a large organisation,

in certain areas it would not be surprising to encounter implementation inconsistencies resulting in policies that were distorted, misinterpreted, or even disregarded. In the course of our gap analysis, one major gap we identified at QMH was the widely variable practices in patient fall prevention, despite the existence of well-promulgated organisational guidelines. The third level in the framework was to analyse and determine whether appropriate system evaluation has been undertaken. One well-accepted form of evaluation is by way of clinical audit.[4] Although the QMH has a long history of conducting clinical audits, our gap analysis revealed that there still existed wide variability with respect to the complexity, depth, and significance of whatever evaluations were conducted.

The NAB meetings helped the Core Team to identify major gaps within the hospital, which were then presented to top management. To close these gaps, significant input of resources, alteration in systems, and changes in mindset were needed. A summary of major gaps identified and our efforts to close them are listed in Table 2.

TABLE 2. Major gaps and improvement measures in Queen Mary Hospital*

Gaps	Improvement
Outdated disinfection and sterilisation model	• Hospital-wide audit conducted • Disinfection and sterilisation policy revised • HK$8M in resources and infrastructure allocated • Issue on outdated disinfection and sterilisation model escalated to HAHO for corporate-wide consideration
Inappropriate management of ventilated patients in general wards	• Magnitude of problem evaluated • Senior clinician commissioned to submit proposal • New ventilator ward set-up • Update training and education for staff conducted
Lack of document control system for policies and guidelines	• Task force established • Document control policy formulated • Policy implemented by phases • Pilot online document library constructed
Outdated care delivery model in clinical wards and operation theatre	• Task force established to research and design a generic nursing care plan for use in QMH • Pilot implementation in 12 wards • Review and refinement of nursing care plan • Updated / revised nursing care plan and discharge plan in clinical wards and operation theatres implemented
Fragmented medical records	• Explanation to all department heads the benefit of integration of clinician, nursing and allied health documentation into a single record • Use of integrated records implemented in three small specialties • Extension of use of integrated records into all clinical specialties
Repeated utilisation of SUD	• Stock take conducted to identify all SUD used within the hospital • Master plan to phase out the use of SUD developed • New policies to regulate the reuse of SUD implemented
No credentialing/ delineation of clinical roles	• Credentialing committee to define scope of practice for clinicians involved in high-risk high-volume procedures and new technologies established • Delineation of role of supporting staff working in clinical area completed • Compliances audited
Lapse in medication safety	• Common medication safety risks identified through quality rounds • Pharmacy conducting medication safety checks at ward levels implemented • Additional resources to enhance medication delivery and reduce ward stock provided
Inadequate monitoring for procedural sedation	• Taskforce to risk stratify sedation procedures set up • New system to regulate paediatric procedural sedation implemented • Additional staff to enforce HKMA sedation guideline recruited • Education and training of frontline staff on safe use of sedation drugs conducted
Insufficient coordination in quality and risk management	• Publication of HKWC Quality of Care Report • Composition and terms of reference of Cluster Quality and Risk Management Committee revamped to include both clinical and non-clinical risks • Risk Register introduced
Incidents under-reporting	• Education and training for staff on use of AIRS conducted • Role of Patient Relationship Office promulgated to patients and public

* AIRS denotes Advanced Incident Reporting System, HAHO Hospital Authority Head Office, HKMA Hong Kong Medical Association, HKWC Hong Kong West Cluster, QMH Queen Mary Hospital, and SUD single-use devices

Improvement

In the course of preparing QMH for external evaluation, we have identified a number of success factors. The *sine qua non* to success is that it was made explicit to all that changes were intended for the greater good of patients and staff, and not for the purpose of attaining certain awards or status. It would be a losing battle, if people felt that the reason to improve was for the latter goals. Another critical success factor is that ownership of all programme improvements must rest with staff, which is the only way to fully engage them. If not, they are liable to feel isolated or manipulated by the issues. Empowerment and selection of the right stakeholders are essential in enhancing ownership. The third key to success is the setting of mutually agreeable objectives for improvement programmes. Since staff feel perplexed if they do not understand the rationale behind them, setting laudable and clear objectives are therefore necessary. At QMH, we impressed only three simple objectives upon our staff. These were: ensuring safety, augmenting efficacy, and enhancing the patient/staff experience. Such unequivocal objectives helped to keep improvement measures focused. The final critical success factor was that the approach taken had to be "humanised", as overwhelming and rigid directives/ measures only lead to dissent and resentment. Since many improvement programmes needed implementation at the same time, good coordination was crucial. The Department of Quality and Safety took on the onerous responsibility to prioritise and orchestrate all hospital-based improvement

programmes and to obviate overlap, excessive oversight, or overkill.

There are different methods for introducing improvement or changes. Within the public health system, it is usually not feasible to use material rewards as a means of positive reinforcement. Occasionally, imposing negative reinforcement to enforce changes through regulation may seem necessary. Nevertheless, this method is only applicable when there is a very stronger calling, professionalism, and an innate drive to pursue continuous self and patient improvements. Examples of using education and learning to effect changes include the promulgation of hand hygiene practice and online incident reporting. The last and most reliable method to manage change is to implement system changes, for which due consultation, explanations and trials must be carried out. The introduction of a compulsory 2D barcode for authenticating blood transfusions is one such example.

In preparing the QMH for accreditation, we found that documenting improvements and changes is a useful means of sustaining the momentum of our quality agenda. Progress of various improvement measures was collated into a report which was uploaded onto our hospital intranet for staff perusal and scrutiny. Each issue had a designated stakeholder to lead the changes, and there was also a description of the extent of the problems, actions or remedial plans implemented (with time frame), the resources needed, and deliverables targeted. This report was a "living" document and updated monthly. The report proved to be a successful tool to drive changes, as it emphasised timeliness and enhanced accountability. More importantly, it demonstrated that the hospital's commitments to improve could be judged by deeds, and not just words. By the time of the ACHS Organization Wide Survey, the report also served as a good source of evidence for surveyors to appraise in order to demonstrate the hospital's continuous efforts over time.

Staff engagement

There are two reasons for extensive staff engagement — to convey information and to achieve staff buy-in.

There are different channels to convey information to staff. Monthly Accreditation Newsletters were published and distributed through the internal electronic mail system ever since the preparation for accreditation began. These publications served as a platform for the accreditation team to keep staff abreast of latest progress. The messages conveyed were kept interesting, short and succinct as long winding text and high-sounding words would not appeal to frontline workers. Although newsletters could achieve wide coverage, they constitute unidirectional means of communication that many colleagues simply ignore them.

Direct communication is challenging but has the advantage of more staff interaction and participation. We organised several forums that were well attended by more than 200 participants at a time. The impact of such forums, however, should not be overestimated as number of participants in each was invariably less than 5% of the our total work force. An even better approach is to confer face to face with staff. At the governance level, we participated in meetings of the Hospital Management Committee, Cluster Medical Committee and Central Nursing Department. At the operational level, we visited all administrative, clinical, and allied health departments to explain what accreditation was. At the frontline level, we visited staff at their workplace. Frequently asked questions and answers were used to facilitate understanding and alleviate concerns about hospital accreditation. In particular, we allayed the fear and skepticism of many through reiterating the key message, namely that it would not be the performance of individuals that could cause the hospital accreditation process to fail.

The second and more important reason for engagement is to achieve staff buy-in and modify the mindset of our health care workers.[5] To accomplish this, it was essential to help staff visualise the potential benefit of accreditation as a tool to continually improve service quality and standards. Unless they could see the benefit, it would be futile trying to convince or coerce them into supporting any accreditation scheme or campaign.

In our accreditation journey, we found that recognition is another powerful tool for staff engagement. Staff feel disengaged if their efforts are not recognised. Accordingly, we selected a collection of commendable and representative quality improvement projects undertaken by staff and compiled them into a Quality of Care Report, which was distributed throughout the hospital and within the community. The report was welcomed by colleagues as they felt their hard work was appreciated. It was also an excellent demonstration to ACHS surveyors on the merits and strengths of the hospital.

Conundrums and pitfalls

In the course of this pilot scheme, we were able to identify a number of obstacles and pitfalls. Some staff were reluctant to admit there were service gaps. Reasons for such attitudes include: cynicism about the exercise; bureaucratic lethargy to shoulder additional responsibilities; internalisation of service gaps as personal failures; or simply complacency.

Such problems were not unique to any organisation, and persistence and perseverance with education and explanations was the only way to address them.[6] We also found that listening was another powerful tool to overcome staff reluctance; it was always important to understand before being understood.

Vested interest is another major obstacle we identified. Every stakeholder, party or working unit has their own interests to protect, which is a fact of life. Some stakeholders might fear the accreditation exercise as an intrusion into their jurisdiction, while others might regard it as an administrative evil depriving them of clinical autonomy. This is a delicate matter which, if not handled well, results in non-cooperation by staff, or worse still, opposition. To overcome vested interests, sincerity is critical and its importance cannot be over-emphasised. Transparency is the key to demonstrating sincerity. Showing empathy and not leaving colleagues to solve problems on their own are also effective measures.

Inertia is a major obstacle; according to Newton's First Law of motion is "the tendency for an object to remain in its original state, unless acted upon by a force". The definition literally describes the resistance to change observed in many organisations. Inertia exists at all levels and the inertia of clinicians is most difficult to overcome.[7] Having clinicians address clinicians can frequently create leverage for change with the desired impact resulting from mutual understanding and peer acceptance. Another useful tactic is to present valid facts and data that are difficult to dispute with any rational arguments. In the change process, the most difficult hurdle is to convince the first batch of targeted individuals to change; implanting changes become progressively easier once a single group of clinical champions support the accreditation scheme and are perceived to be on board.

Another pitfall is the use of technical and business terms, which do not appeal to clinical staff. In our communication with staff, we have therefore emphasised "quality" in plain English. We deliberately refrained from jargon (words like mandates, reflections, or recovery strategy). The Improvement Record Sheet we introduced was simple and was used only to identify problems, how to deal with them, and what results to anticipate. When terms like service gaps and key improvement were introduced, explicit explanations and illustrative examples were given. Whenever possible, we used language familiar to health care staff. As an example, we compared diabetes mellitus management with fire safety, which was used as an analogy to gain recognition by clinicians and establish rapport (Fig 2).

Poorly managed meetings can create havoc. During NAB meetings, there was a conscious effort to avoid discussion entailing minute details. Members were also reminded that suggestions made must stay within context and within "therapeutic doses". Despite due diligence, occasionally discussions could still end up in circular arguments, with much waste of time and energy and a great deal of unnecessary documentation. The accreditation team embraced this lesson and regarded it as a learning experience.

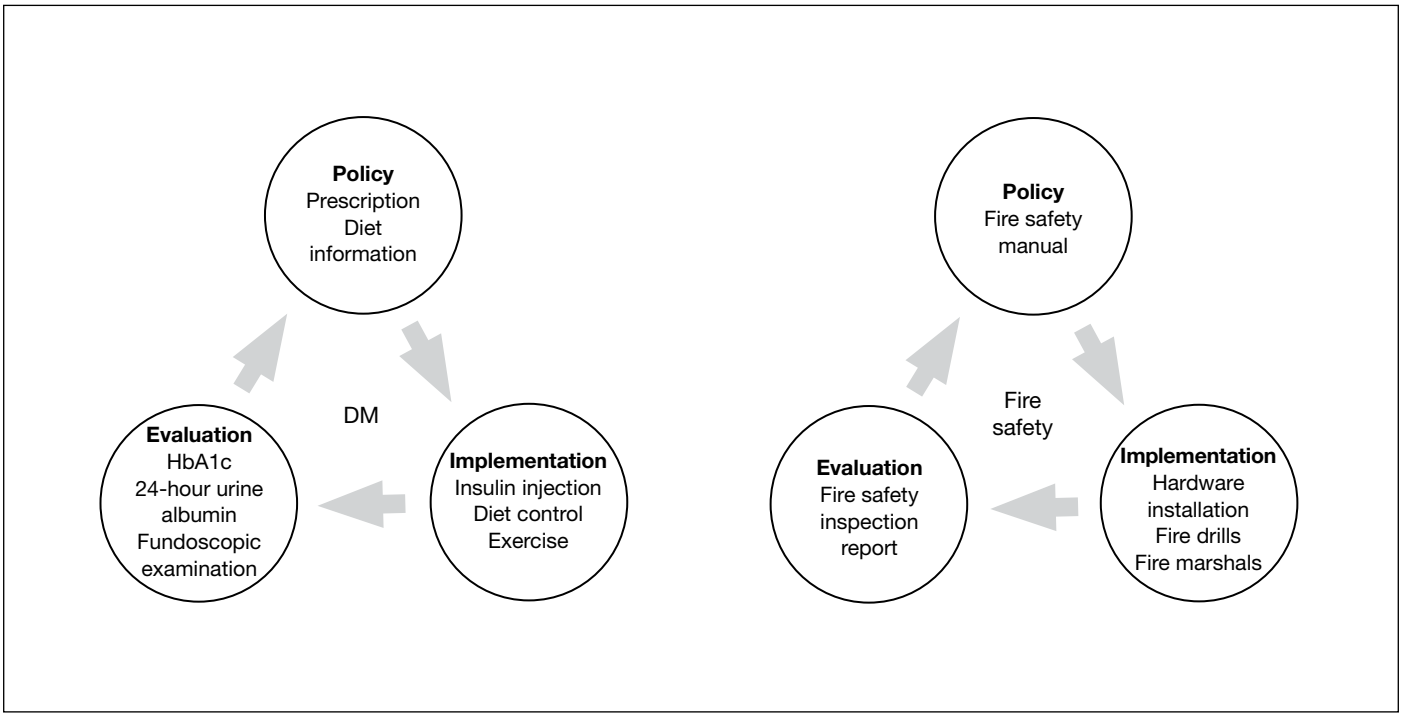

FIG 2. Analogy comparing management of diabetes mellitus (DM) and fire safety

Lack of alignment of all Core Team members and other key stakeholders on the same ideology and understanding of accreditation is another major pitfall. Formal orientation and training is needed to align their thinking. All Core Team members went through induction training provided by ACHS and some had also undergone training as surveyors, both locally and abroad.

The last pitfall is thinking that one can complete preparation for accreditation by cloistering behind a desktop. Good documentation and record keeping is essential but accreditation is an exercise that requires team members to be out of the office, in so doing they must explore and interact with people as a means of achieving fruitful outcomes.

Achievement

The QMH underwent the Organization Wide Survey in late autumn 2010, and was recommended for full accreditation status for 4 years by ACHS. The results were considered very satisfactory. More importantly, the organisational transformation seen in our systems, the enhanced quality culture and improved staff morale, far exceeded what we had expected to accomplish in the course of this accreditation exercise.

Limitation

Despite all that has been described, evidence to demonstrate the success of hospital accreditation in terms of service improvement or culture change is not available. Understandably, part of the reason was that it would take a relatively long period before any beneficial effect would manifest, and that culture change by itself is not an entity that could be measured with ease. To address this limitation, QMH has commissioned the School of Public Health, Li Ka Shing Faculty of Medicine, The University of Hong Kong to conduct an independent longitudinal research to study into the long-term impact of hospital accreditation on clinical governance, staff attitudes towards quality care, change in organisational culture, and patient satisfaction.[8,9]

Conclusion

There is no reason to ignore, fear, or feel annoyed by hospital accreditation. This is part of our quality journey and accreditation is only the means, by which the ultimate target is to make a change in the culture of the health care system in Hong Kong. Success or failure hinges on whether our health care community can be convinced that this is a golden opportunity to make our practice safer, more effective and reliable, for the ultimate benefit of the patients we serve.

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