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Over Implementation of Quality Standards: A Threat to Patient Safety and Work Conditions - The Danish Experience

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Components / Steps in Accreditation

- **Standards**
  - Terms of reference
  - Inspiration for Quality Improvement
- **External evaluation process /survey** - rooted in a recognised organisation
  - Peer based
  - ISQua accredited
- **Formal status of accreditation** – Council decision

**DHQP constitutes both a tool and an incentive for management**
After 5 years - DHQP is now ‘a well established fact in Danish Healthcare’

- DHQP has made a positive difference

- But there are challenges – that if not addressed properly - may lead to DHQP becoming yet another dinosaur
Example 1  Standard 2.8.6
Early follow-up on test results and results of examinations are performed

‘Element 4: Acknowledge the receipt of test results and results of examinations’

Does this mean that:

- Test results should be *signed off* by the physician, who assessed the result and acted appropriately?
- There is a procedure for assessing and acting on test results, and pass on the information, that this result has been dealt with?
- The hospital must make sure that any unsigned test results - are being signed off before survey, in order to assure accreditation?
- Surveyors will scrutinize a large number of test result sheets, checking for doctors’ signatures?
<table>
<thead>
<tr>
<th>Title</th>
<th>2.8.6 Early reaction to test results and results of examination (3/3) #</th>
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<tr>
<td>Sector</td>
<td>Hospitals</td>
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<td>General patient pathway standards</td>
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<td>Theme</td>
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<tr>
<td>Standard</td>
<td>Early follow-up on test results and results of examinations are performed.</td>
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<tr>
<td>Purpose</td>
<td>To ensure prompt and effective treatment so no patients come to harm or are caused unnecessary inconvenience due to absent early reaction to results of examination</td>
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<td>Content</td>
<td>This is a critical patient safety standard, for further information see paragraph &quot;Criteria for awarding of accreditation status&quot; in the introduction. In this standard, tests and examinations are not to be narrowly understood as results from laboratories and diagnostic imaging departments but as all types of results from diagnostic examinations performed by one department for patients who are treated in another department. The standard addresses diagnostic departments providing test results; departments providing care and receiving test results and departments which are both diagnostic and provide care, e.g. a gastromedical department which performs and provides results on gastroscopic examinations and receives lab results. The guidelines for giving and receiving test results must be adjusted to the individual department. As a minimum, the guidelines in element 1 of the standard describe the following: a) Content of test results and examinations b) Time requirements for response times and documentation of these c) The way responses are documented d) The way it is secured that responses are forwarded to a recipient who is responsible for reacting on the outcome e) The diagnostic department's procedure in cases where a result is deviating to such a degree that it requires an acute effort As a minimum, the guidelines in element 2 of the standard describe the following: a) Routines securing that test results are early seen by recipient who is responsible for reacting on the outcome b) The way there is signed for reception of responses c) The way it is secured that patients receive responses d) The receiving department's procedure in cases where a result is deviating to such a degree that it requires an acute effort e) How to ensure overview in the individual patient pathway regarding required tests and examinations where there are no results yet.</td>
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**Element 1 of the standard.**

**Step 2  Element 4**  Acknowledge the receipt of test results and results of examinations.

**Step 2  Element 5**  On reception of test results and results of examination, which require acute efforts, the reaction is early.

**Step 2  Element 6**  For each patient it has been registered which tests and examinations have been requested and which results have been received.

**Step 3  Element 7**  The hospital has targets for the quality of early reaction to test results. The hospital collects quantitative data which reflect the level of rating achievement of the targets. The quality monitoring includes deadlines for responses. Data are analysed and assessed.

**Step 4  Element 8**  The hospital has implemented initiatives to improve the quality of early reaction to test results. The effect of the initiatives has been assessed and it has either been concluded that they had the desired effect or new corrective initiatives have been implemented.

This element is not relevant if the hospital meets the stipulated quality goals.

**References**

1. Vejledning nr. 9207 af 31. maj 2011 om håndtering af parakliniske undersøgelser
Quality Cycle – PDSA Cycle

- Step 1 – Plan
- Step 2 – Do
- Step 3 – Study
- Step 4 – Act

Litterature
The Perverted Quality Cycle

• Describe in details how everything should be done
• Have everyone to document every action in details
• Check if documented actions - corresponds to prescribed actions
• Sanction if this should not be the case
Example 2 – Standard 2.14.1

The patients' nutritional risk is assessed, and they get an adjusted nutrition

• Does this mean that every single patient entering a hospital should be screened?

Element 1: There are guidelines for nutritional screening with a view to identify patients with special nutritional risk

Purpose 1 of the standard: To identify patients with a nutritional risk

There is good evidence that screening for nutritional status is helpful to identify patients at nutritional risk
Example 3
– Overwhelming number of procedures and guidelines

In an anaesthesia department in a medium sized general hospital, more than 900 guidelines were in effect, including

- Guidelines on how to load and unload the dishwasher in the coffee room
- Guideline on how to insert an i.v. cannula
- ...

Danish Institute for Quality and Accreditation in Healthcare
Example 4
Staff claims that the burden of registration is overwhelming and steals time from patients

• In reality very few registrations are required by the DHQP standards in themselves
• But some DHQP requirements may not even have been recognized correctly – meaning registration not asked for
• And some hospitals / - require actions that are seen as meaningless, but nevertheless must be carried out – and documented
• Much registration is required by local administrative registries and national ones
• Less than optimally functioning IT systems are commonplace
Sygeplejersker drukner i dagligt skrivearbejde

PATIENTSIKKERHED:
Jeg udfulder stakkevis af dokumenter på en arbejdsdag. Jeg er ikke i tvivl om, at det kunne gøre mere effektivt.

AF Charlotte Struense Hansen, sygeplejerske, Kiropraktisk tjeneste i Vendsyssel
Selvfølgelig er kvalitetskontrol og dokumentation væsentlige for at sikre, at vi oplever det bedste på arbejdet.

Morten Staberg: Der sniger sig stadig nye krav ind løbende

NYHEDER
På torsdag er det præcis to år siden, at speciallæge i pædiatri, Morten Staberg, skrev en kronik i Politiken, der for alvor satte dokumentationsmængden på hospitalerne på dagordenen. I dag har han netop forlattet ansættelse i et offentligt forhold for konsulentarbejde og forskning. Vi har bedt ham komme med et reality check.

Dato 7. Okt 2013
Forfattere Bente Bundgaard, bbu@dadl.dk

Hvad synes du om den nye IKAS-rapport?
»Det er ikke de enkelte krav fra IKAS, der er problemet, men den samlede mængde. Der er krav fra IKAS, lovmæssige krav, krav fra de enkelte sygehus, afdelinger, NIP, kirurgiske tjeklisten og sikkert meget mere. Heldigvis har IKAS været opmærksomme på, og hvor meget de øger dokumentationsbyrden. Men i rapporten er der desværre også den vanlige tendens til at sætte lighedstegn mellem dokumentation og kvalitet. Øget dokumentation giver i sig selv ikke højere kvalitet.«

REGISTRERING Et sundhedsvæsen ramt af registreringspsykose?

Dagens Medicin, Sektion 1, Side 22
14. februar 2014, 1680 ord, id: 64421586
Knut Borch-Johnsen Formand for Dansk Selskab for Kvalitet i Sundhedsvæsenet, vicedirektør, Holbæk Sygehus Hanne Sveistrup Demant Bastyrskabsmedlem af Dansk Selskab for Kvalitet i Sundhedsvæsenet, vicedirektør, Psykiatrien, Region Sjælland

IKAS

KRONIK Der er gode argumenter for hver enkelt registrering i sundhedsvæsenet. Problemet er blot, at summen af registreringer er blevet en belastning i det daglige. Derfor er tiden inde til en kritisk revision af vores registreringspraksis.

'Tag faget tilbage'. Det er beskeden fra en nyligt stabelretet Face bookgruppe, hvor ansatte i sundhedssektoren udtrykker deres utilfredshed med udviklingen i sundhedsvæsenet på følgende måde: »Tiden er kommet til, at vi som sundhedsfaglig gruppe melder fra over for myndighedernes tiltagende kontrol og bureaucrati og kræver faget tilbage.

»Beskedet er også hørt af en del politikere, som under efterårets valgkamp udtalte, at en 'tilfældsdagorden' skal erstattes den eksisterende kontrolkultur. Ved årsmødet i Dansk Selskab for Kvalitet i Sundhedsvæsenet var temaet 'Kvalitet i bal', og fra alle niveauer i sundhedsvæsenet lød kravet om en kritisk revision af den måde, vi måler og kontrollerer på i det danske sundhedsvæsen.«

23. oktober 2014
So - where do things go wrong?

- Considering standards as rules / as ‘building regulations’
  - rather than as a guidance, an opportunity for reflection
  - an assessment tool, a tool of structuring practicising for quality

- Implementing standards in a fragmented way
  - measurable **element** by - measurable **element**
    - like checklists
      - missing the holistic perspective of the content of a standard
So - where do things go wrong?
Understanding standards?

- A recipe always telling what to do?
- A recipe telling always to do the same?
- A toolbox: For defined tasks – Having decided to act, here is the description of how to do it?
Statements on Overimplementation: Documentation has conquered the intention of improvement

- Check lists are not intended for being instruments for documentation - but support for execution
- Check lists as a robust instrument to support your memory if interrupted during processes
- No time for documenting that things are being done while following the check list
- Rather look at real work as done – and at the tracks it leaves behind
So - where do things go wrong?
Understanding Accreditation?

- Turning accreditation into a bureaucratic exercise

  - assigning special staff - accreditation managers – to assure that the hospital at survey will present documentation needed to demonstrate **formal compliance** with accreditation standards

  – and tell that a spotless accreditation award is their success criterion
Overimplementation

... ‘If the bureaucratic way of acting will be prominent, more energy will be spent on demonstrating formal compliance with standards; rather than real willingness to change and improve’.

Carlo Ramponi (2008 former CEO of the JCI)
Why not just standardize everything?

Healthcare is a complex adaptive system.

Which means that we cannot understand the system just by understanding all parts of it.

“Healthcare is not entirely deterministic, neither on the patient level nor on the system level.”

We cannot always predict the consequences of our actions – we cannot even expect that the same action will always lead to the same outcome.
Behind all this –
Can we identify some more fundamental misconceptions?

- Mistaking an assessment, based on transparent judgment and objective facts, for an objective measurement

- A useful assessment of system performance cannot be based solely on a finding of presence or not of certain objectively observable items

- Overlooking the fact that healthcare is a complex system, not just a complicated one
What makes an organisation – (any hospital) deliver good quality?

- Clearly articulated and communicated goals, propagating down through the organisation – from overall organizational goals to treatment plans for individual patients
- A problem-sensing attitude (vs a comfort-seeking)*
- Mixture of quantitative and qualitative information
- Avoiding
  - Fragmentation
  - Diffusion of responsibility
  - Multiple, competitive, ambiguous, and conflicting goals

Why does “Work As Imagined” differ from “Work As Done”?  

- Lack of knowledge of WAI  
- Lack of will to comply with WAI  

- BUT ALSO legitimate trade offs ("ETTO" i.e. Effectiveness Thoroughness Trade Off)  
  - Effectiveness vs safety  
  - Multiple competing tasks or goals
Accreditation survey can assess the alignment between WAI and WAD

- Formalized WAI, as described in manuals, procedures, guidelines etc.
- Cultural WAI – WAI as described by actors in the system
- WAD – as observed, documented, described in interviews with patients and other actors
Thank You

Any ????????? / Comments

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