

255: A SCORING SYSTEM FOR STANDARDS COULD HELP DECISION MAKING IN THE FRENCH ACCREDITATION PROCESS

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Objective:

The 1999 French accreditation process is based on a self-assessment by professionals of health care organisations (HCOs) followed by an on-site survey. All the 86 standards are the subject of written comments and a scoring using a four-grade scale by both the professionals of HCOs and the surveyors. Scores can range from A to D, or be not applicable. To use this scale, HCOs professionals and surveyors were given general rules based on the existing level of quality of care and the actual ability to ensure C.Q.I. and risk management. The final decisions of the process (on a four-level classification scale, from no recommendation to major reservations) are made by an Accreditation College on the basis of the written comments and proposals made by the surveyors. During the time course of the study, scores determined during the self-assessment or during the survey were not communicated to the College.

The aim of this study was to analyse how this scoring system was used, and to assess the relationship between the decisions made by the College and the scores determined by surveyors.

Methods:

The study included 80 accreditation procedures consecutively completed between December 2001 and May 2002. We compared the scores given by HCOs professionals during the self-assessment, those given by the surveyors and the final decisions by the Accreditation College for all the 86 standards. Results were analysed using the Statview™ Statistical software (comparisons using Chi-square test, significance level $p < 0.05$).

Results:

This sample of 80 HCOs was representative of the 3 100 French HCOs as to the number of beds, the type of clinical activities and the public or private status.

Final decisions by the Accreditation College were: no recommendation, $n = 18$, recommendations, $n = 40$ and reservations, $n = 22$. There were no cases of major reservations.

Surveyors assessments were as follows: out of 6 880 cases (80 HCOs and 86 standards):

- scores non available : 95 (1.4 %) ;
- scoring not applicable : 70 (1.0 %), e.g. operating rooms requirements in HCOs without surgical activities ;
- overall compliance to standards : scores of A in 18.1 % of cases ; B in 53.3 % ; C in 22.6 % and D in 2.3 % ;
- 89 out of the 160 " D " scores were observed in the last standards of each accreditation chapter. These "evaluation" standards asked for documentation of ongoing C.Q.I. program.

Scores given by surveyors and decisions made by the College were closely related. For example, concerning patients records, recommendations or reservations were noted in 2 % of A scores, 16.8 % of B scores but 39.4 % of C and D scores. However, the relationship did not hold for the " evaluation " standards.

Scores determined during self-assessment were raised by visitors in 14 % of the cases and lowered in 18 %. Frequent and more substantial decreases were noted for standards relating to operating rooms and medications.

Conclusions:

The scoring system for standards has proved easy to use by professionals of HCOs and surveyors. Specific scoring guidelines per standard are mandatory to improve its specificity and sensitivity. Scores were closely related to accreditation decisions.

They can be used as a decision aid, as a decision quality control mechanism, and as a tool to choose priorities for national quality improvement actions in HCOs.