

## QUALITY OF CARE IN NEPHROLOGY. THE ITALIAN ACCREDITATION MANUAL FOR EXTERNAL PEER REVIEW

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The main object of external peer review model developed by Italian Society of Nephrology is the evaluation of quality in providing a specialty care ( what we call “specialty/renal function” ) independently of the operating area it is concerned with, while pointing out how the process is patient-centred.

The first hypothesis we have tried to develop, was that high quality of service is to be looked for through the whole process of the specialty/renal function and that such process does not end in the operating area as such, but it covers all possible levels of health care provision: first assessment, care management, progression of chronic renal diseases, dialysis and transplantation replacement therapy.

Therefore the method differs from other excellence accreditation models, which adopt the organisation providing health care as their analysis unit. What is new, is considering health services rendered to renal patients not as a sequence of performances but as a co-ordinate process, overcoming the traditional organisation boundaries.

Our model aimed at improving both organisation and professionals’ quality and was based on the second hypothesis that there is a strict relationship between professional training, organising learning and care quality improvement.

The analysis of the process intends to point-out how the specialty service provision takes on specific characters according to the needs it wants to meet.

The analysis of renal function in comparison to structural and systemic analysis gave the opportunity to highlight that:

- the “flowing” process is patient-focused,
- the service provision passes through different operating areas ( Hospital, Out-patient department, Home care) and different Health Organisations, which are mutually linked, overcoming the dichotomy between structural and organisational systems and clinical and health service functions. This is usually the process the chronic renal patients pass through.

The manual was realized with a voluntary work by doctors and nurses operating in the Nephrology Departments and was produced as an essential further step of the Health care Organisations accreditation required by law in our Country, which adopts per se only minimum requirements; what was called Institutional or Authorizing Accreditation ( D.L. N. 502/1992 - art.8, comma 7 and D.L. N. 517/1993, D.P.R N. 37/1997 ).

The care effectiveness was guaranteed by the dynamic delivery of specialty care taking into account all the aspects of health care and by the development within the professional system of an evaluation mechanism that involved both doctors and nurses in the effort of identifying and agreeing on the criteria and indicators to comply with, for determining quality.

In detail, the delivery process of the specialty function of Nephrology, Dialysis and Transplant is analysed by using a double-entry matrix linking six operating areas (Ward, Transplant unit, Day hospital, Dialysis unit, Outpatients' department, home care ) to four area dimensions ( admission, planning and delivering care, discharge and follow-up ) through which the patient moves ( Table I ). As a result, the specialty function is divided into 24 sub-phases ( six operating area by four dimensions ).

The mission of renal function was expressed by the general criterion that Nephrology, Dialysis and Transplant practice must pursue the best health care outcome, while continuously taking into account quality assessment and respect for patients' needs and rights, according to the resources available.

The audit was performed by using specific criteria directing activities and behaviours, and by using indicators that measure the realization grade of the criteria themselves. Obviously, in every single sub-phase, only the criteria considered suitable for that sub-phase are evaluated. Moreover, in every single operating area, passing from one sub-phase to the other, the indicator related to the same criterion may change, thus providing the dynamic of the professional behaviour.

The specific criteria were grouped under two branches, each one focusing on a specific crucial aspect : - group A criteria are centred on the quality elements ensuring the technical-professional and organisation quality of health care; - group B criteria are centred on the patients and their expectations towards the service they receive.

The Group A criteria ( Table II) develop through typical performance measures: specialty, timely reply, continuity, integration, professional role and appropriateness, safety etc..

The Group B criteria ( Table II ) are adopted as a guarantee of the "perceived" quality of service and measure the power of communication : simple and easy admission, accessibility, system facilities and comfort, respect for patients' rights and for staff.

The criteria are expressed by means of Structural, Process and Outcome Indicators ( Fig. 1 ), with a prevalence, at present, of process and structural ones. In every single operating area their overall number varies according to relevance of adopted criteria in every sub-phase.

An appraisal method and a scoring mechanism that allow measuring performances in detail were also determined. Criteria and indicators are valued C, B and A according to

the grade of importance: Essential – Desirable – Excellent. Each single indicator is then assessed by awarding a compliance judgement divided into 4 degrees (satisfactory, acceptable, good, very good) or by making note of “not compliance” ( Table III ).

The weighing system supplies therefore an actual score that may be improved in the time, according to an increment-type assessment logic.

Actually, what is being appraised is not merely the compliance with a rule or a standard, but rather the performance of the functional area compared to other homogeneous areas in terms of resources or compared to changes brought about by it over time. Such a choice allows the chance to build up an analytical judgement for each dimension and for each area, producing an actual global scoring for renal function ( Table IV ).

26 Public Hospitals of the 21 cities participated in the activity.

The accreditation approach used has four important features:

- It is a voluntary system developed from bottom up
- It aims to promote quality assurance as well as quality improvement
- It shares ISQua-Alpha principles for standards
- It is an excellence model aimed at meeting both outcomes and stakeholders' needs.

In conclusion this model offers analytical guidelines for the improvement process and gives the advantage to develop ongoing improvement within the professional group.

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Table I – Accreditation manual for Nephrology

Operating Areas	Area dimensions			
	1. Admission	2. Planning care	3. Delivering care	4. Discharge and Follow up
a. Ward				
b. Transplant unit				
c. Day hospital				
d. Dialysis unit				
e. Outpatients				
f. Home care				

Table II - Specific criteria

*Criteria A* = assure the technical and organisation quality of performance

1. Specialty care
2. Timely reply
3. Continuity of health care
4. Outreach with other health providers
5. Responsibility and accountability of professionals
6. Audit and continuous quality improvement
7. Patients and professionals' safety
8. Research and development

*Criteria B* = assure the "perceived" quality of service

9. Simple and easy admission
10. Accessibility
11. System facilities and comfort
12. Respect for patients' rights
13. Respect for the staff as individuals and professionals

Table III – Scoring system for Criteria and Indicators

	A - Excellent	B - Desirable	C - Essential
Value	1.5	1	0.5
1. <i>Non compliant</i>	0.0	0.0	0.0
2. Satisfactory	0.6	0.4	0.2
3. Acceptable	0.9	0.6	0.3
4. Good	1.2	0.8	0.4
5. Very good	1.5	1.0	0.5

Table IV – Weighing card

OPERETING  
AREA  
A. WARD

AREA  
DIMENSION  
1. Admission

2. Charge

		value	compl.	score		value	compl.	score
	Criterion n. 1	0,5	x		Criterion n. 1	1,0	x	
	Criterion n. 2	0,5	x		Criterion n. 2	0,5	x	
	Criterion n. 3	0,5	x		Criterion n. 3	1,0	x	
	Criterion n. 4	1,0	x		Criterion n. 4	1,0	x	
	Criterion n. 5				Criterion n. 5	1,0	x	
	Criterion n. 6	1,5	x		Criterion n. 6	1,0	x	
	Criterion n. 7	0,5	x		Criterion n. 7	0,5	x	
	Criterion n. 8				Criterion n. 8			
	Criterion n. 9	1,0	x		Criterion n. 9			
	Criterion n. 10	1,5	x		Criterion n. 10	1,0	x	
	Criterion n. 11	1,0	x		Criterion n. 11	1,0	x	
	Criterion n. 12	1,0	x		Criterion n. 12	0,5	x	
	Criterion n. 13				Criterion n. 13	1,0	x	
<b>Actual score</b>					<b>Actual score</b>			
<b>Best score</b>				<b>8,8</b>	<b>Best score</b>			<b>8,6</b>
<b>Actual global score of Area</b>								
<b>Best global score of Area</b>				<b>33</b>				

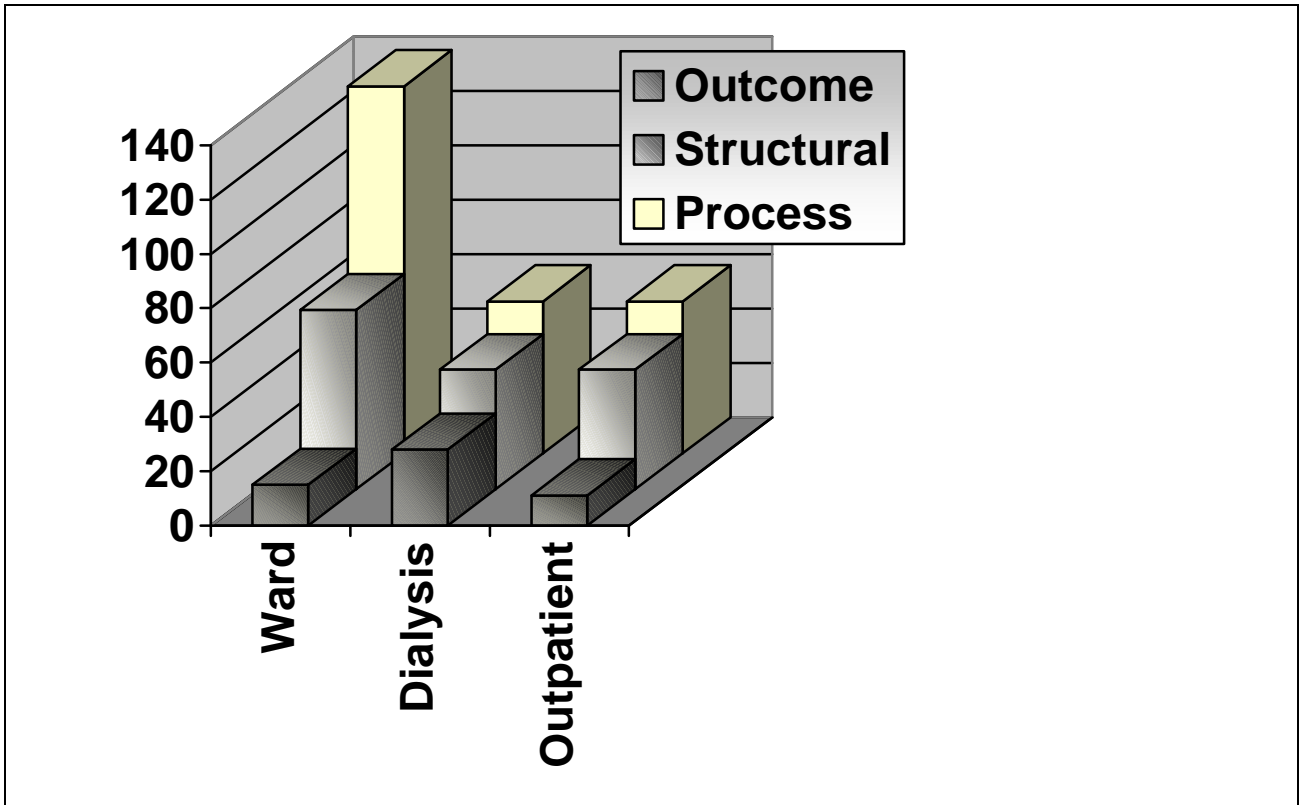


Fig. 1 – Structural, process and outcomes indicators

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