VIEW FROM THE TOP

Tackling Accreditation as ‘An Exercise in Collaboration’

What’s your background and how did you begin working for DNV?

I worked for more than two decades in the utility industry doing and learning many different disciplines including millwright, welder, machinist, and I retired early from the industry as a master electrician. I have a bachelor’s of science degree from the University of Louisville, and I am also an ISO 9001 certified lead auditor. After retiring from the utility industry, I became an authorized Occupational Safety and Health Administration instructor and created my own training company. During this time, I also held positions as the safety director of an electrical contracting company and manager of a housing rehabilitation agency before beginning to work with my sister, Becky Wise.

How many hospitals are accredited through DNV?

As of today, DNV has 339 accredited hospitals in the United States. If the past is an indication, this number will continue to grow. DNV was just granted six more years of deeming authority by the Centers for Medicare & Medicaid Services, and we anticipate that fact also will add to our accelerating rate of acquiring new clients.

How would you summarize DNV’s approach to hospital accreditation? For example, what is DNV’s guiding philosophy when surveying hospitals? How does it differ from The Joint Commission and others?

I will discuss the DNV philosophy and leave it up to others to decide how this may differ from the approach of any other accreditation organizations (AO).

DNV considers the accreditation survey an essential tool in the continual improvement process of the DNV-client hospital. All of the characteristics of the DNV survey originate with this concept. The DNV survey is not a “test,” but an exercise in collaboration with the hospital to improve all of the hospital’s management systems, including the physical environment management systems.

Not only are the DNV surveyors aware that hospitals use the DNV accreditation survey as an instrument in the continual improvement process, but the DNV surveyors actively engage in this concept by using survey methods that promote collaboration. This is why virtually all DNV client hospitals will report that the DNV surveyors are cordial, thorough, and astute. Open and frank dialogue between the DNV surveyors and hospital staff is essential in the DNV survey process. Client hospitals learn that the DNV surveyors are not in the hospital to play “got ya,” but are there instead to “get to yes.”

Randy Snelling

POSITION
Chief Physical Environment Officer at DNV Healthcare, Inc.

HIGHLIGHTS
Snelling describes the DNV “philosophy” when it comes to accreditation and explains what hospitals can expect in a survey.
The DNV annual survey results in 1) the hospital being in a state of constant readiness as it engages in processes that sustain continual improvement, 2) the hospital staff becoming accustomed to the visits by the DNV survey team, 3) the hospital staff feeling comfortable with the DNV team and 4) enhanced follow-up communication between the client hospital and DNV survey oversight. 

How does a typical DNV survey work?

The typical DNV survey includes three team members: a clinician, a generalist, and a physical environment (PE) specialist. All DNV surveyors are certified ISO 9001 lead auditors. The clinician will investigate all clinical settings including patient care units, such as med-surg, intensive care, critical care, obstetrics, the emergency department, and high-acuity units.

The generalist will perform a review of the quality management system, medical staff, human resources, utilization review, and all ancillary/support systems, including but not limited to laboratory, medical imaging, rehab, pharmacy, purchasing, and dietary.

The physical environment/life safety surveyor will investigate all physical environment aspects—reviewing all of the PE management plans, such as biomedical engineering, as well as conducting a physical tour of the facility, including all off-campus areas under hospital control.

The DNV PE surveyor arrives and leaves with the survey team and in many cases is the survey team leader. DNV recognizes that the physical environment is as important to the overall function of the hospital as any of the other disciplines. Every survey day, the DNV team will compare notes. It is common for different members of the survey team to focus on the same processes in order to ensure that we are supplying the client hospital with a comprehensive review of any issue that arises. This is especially true with infection control/prevention (ICP) issues that frequently include all three surveying disciplines. It is common for the DNV PE surveyor to find as many noncomplying ICP issues as the clinical surveyor. This falls in line with new CMS emphasis on hospital-acquired infections.

The biomedical management system staff can expect a very comprehensive interview from the DNV PE surveyor at every DNV survey. DNV client hospitals accept this challenge and have made praiseworthy improvements in their systems on the heels of the DNV visit. We at DNV are very proud of this segment of the DNV survey and feel that the DNV PE surveyors have substantially helped hospitals improve their biomedical management systems.

DNV does not track the number of findings during a survey as DNV does not enforce a “tipping point” of a certain number of findings that affects the hospital’s accreditation status.

| Why would a hospital want to become ISO 9001 certified? |

There are many reasons why an organization would desire to become ISO certified, including but not limited to: improved patient safety, better patient satisfaction surveys, improved management systems, enhanced internal communications including internal auditing, improved resource management, less redundancy/waste, and international recognition of the ISO standard.

It should be noted that DNV requires that hospitals become ISO compliant, not certified. All ISO-certified institutions are ISO compliant; however, to gain recognition of certification there is some additional application paperwork and a financial charge. The biomedical management system staff can expect a very comprehensive interview from the DNV PE surveyor at every DNV survey. DNV client hospitals accept this challenge and have made praiseworthy improvements in their systems on the heels of the DNV visit. We at DNV are very proud of this segment of the DNV survey and feel that the DNV PE surveyors have substantially helped hospitals improve their biomedical management systems.

DNV does not track the number of findings during a survey as DNV does not enforce a “tipping point” of a certain number of findings that affects the hospital’s accreditation status. This lack of a “tipping point” significantly helps the DNV surveyors to continue conducting in-depth interviews throughout the complete survey. Hospital staff continue to be forthcoming if they know that any finding as a result of their interview will not compromise the hospital’s overall accreditation status.

It should be noted that DNV requires that hospitals become ISO compliant, not certified. All ISO-certified institutions are ISO compliant; however, to gain recognition of certification there is some additional application paperwork and a financial charge. Many of the DNV-client hospitals acquire this certification while some do not. Certification provides a public recognition of ISO compliance. ISO 9001 is an internationally recognized standard, and many hospitals wish to have this recognition as it is a symbol of achievement in quality compliance.

This is true for DNV client hospitals in the United States and other countries. Pertinent to this conversation, hospitals have motivation to become NIAHO [National...
Integrated Accreditation for Healthcare Organizations accredited because inherent requirements for process improvement result in good outcomes specified in the CMS Conditions of Participation; hospitals are held accountable through the mechanisms required in ISO 9001 for internal audits, management review and corrective/preventive action; and the NIAHO accreditation process allows for hospital innovation to determine how each assures sustainable and safe best practices that support the goal of improved patient safety.

What’s the most common mistake you see hospitals and other healthcare facilities make in getting ready for a survey or during a survey?

I really cannot address what the hospitals are doing to prepare for the first DNV survey. However, for the second DNV survey, hospitals ensure that the procedures developed in their corrective action plans as a result of findings from the initial survey are in place. In addition, the hospital should have prepared pertinent documentation and/or evidence for surveyor review.

Perhaps the most disappointing characteristic that hospital staff display to DNV surveyors on our first visit is the anticipation of confrontation. It is unfortunate that over the years, consternation has become a dynamic in the hospital accreditation survey. However, within the DNV survey process, a confrontational atmosphere is not appropriate nor is it advantageous to anyone involved in the survey.

What’s the remedy to that problem?

This anticipation by staff of confrontation dissipates once the hospital staff witnesses the demeanor of the DNV team. The hospital staff learn that every year when the DNV survey team returns, the continual improvement process will be refined and augmented in a cordial and collaborative manner.

How have DNV-accredited hospitals responded to the CMS issue from late 2011?

DNV surveyed to the December 2011 clarification memo for a little over two months and then DNV requested and received permission from CMS to survey as we had previous to its issuance. The primary issue encountered in the two months of enforcing the CMS memo was disagreement between surveyor and hospital staff on the definition of “critical equipment.” Fortunately, CMS made the decision to take a closer look at the definition of critical equipment. Until this definition is published or some other directive is distributed by CMS, the DNV-client hospitals are not required to respond in any manner to the CMS issue from 2011.

If you had one piece of advice for biomeds, what would it be?

Fortunately, this would not happen to the vast majority of biomed managers, but I think that these managers should develop their policies and procedures by envisioning sitting in a witness chair defending them. They should hold their own policies up to this kind of tough scrutiny, using all of their expert staff and other appropriate staff throughout the organization. The biomed managers in DNV hospitals should be communicating and coordinating with other departments, and they must realize that customer feedback for them will come from the clinicians and not the patients.

In the DNV-accredited hospital, most of the issues listed below will require the attention of senior leadership because these cannot be managed solely by the biomed department. Senior leadership must facilitate communication and supply the resources to ensure that all of these procedures listed below conform and are communicated throughout the hospital to all appropriate staff. The policies or procedures that will fall under the biomedical equipment management system may include but not be limited to such issues as:

- A process to ensure that end-user clinical staff can identify nonconforming equipment
- Processes by which staff is informed of contagious equipment prior to maintaining it
- A process to verify purchased product
- A process for handling calibration equipment that is found to be out of parameters
- A process to trace equipment that has been calibrated by nonconforming equipment
- Ensuring all calibrating equipment is...
traceable to NIST or another national/international standard
- Documentation to support equipment that is not traceable
- A process by which equipment suspected in patient harm is manipulated and stored
- A process to find “unable to locate” equipment in an appropriate time frame
- A process to respond to alerts and recalls
- A process to segregate soiled and clean equipment
- Control of methods by which equipment is brought into the hospital
- Tracking equipment that comes or goes with patients in a disaster event
- Documented proof of staff competence including contracted staff
- Documentation of all training
- All equipment, including equipment in off-campus sites, that is used in the care of hospital patients, under control and inventoried regardless of ownership of the equipment

**What advice would you offer medical device manufacturers in terms of helping to improve patient safety?**

I am not in a position to give advice to medical device manufacturers. However, I can report an observation that I have made as an ISO auditor and an accreditation surveyor. I have heard considerable conversation, especially since the CMS memo from 2011 about the difference between manufacturer’s recommendations and the maintenance strategies applied through the development of risk assessments by hospital staff and hospital-contracted vendors.

Most of the equipment manufacturers are ISO 13485 compliant, which requires that they consider customer feedback. It seems to the outside observer that the communication involving this feedback between the manufacturer and end-user could be better. Be it the manufacturer or the end user, I have no conclusion on which end of the communication needs to be improved.

All of the parties involved should use this required feedback process to enhance their mutual communication. Of course, any improvement in this communication process will enhance patient safety.

**I understand this is something of a family business for you in that you work with your sister. What does she do, and how do the two of you work as a team?**

NIAHO was the idea of Becky Wise, my sister, back at the turn of the century. Becky and her son-in-law, Patrick Horine, formed a core group of very dedicated people and began their pursuit to become an AO. After eight hard-fought years, this great idea became a deemed AO, DNV Healthcare Inc. I am proud to say that I was part of that core group of dedicated folks that persevered through lean times to get to this point.

While working as an AO surveyor, Becky became frustrated that the accreditation process did not help hospitals improve. She also felt that the survey processes did not effectively differentiate between hospitals that did patient care well and those that did not. She surmised that a hybrid set of requirements that incorporated CMS Conditions of Participation with the ISO 9001 standard could detect underachieving hospitals and in the same process help those hospitals utilize the accreditation process as a method for improvement. That hybrid set of requirements became the National Integrated Accreditation for Hospital Organizations or NIAHO requirements.

Becky and I began working together well over a decade ago, conducting mock surveys and consulting for hospitals through a healthcare consulting firm that she owned with Patrick Horine. At the same time, I owned a safety training firm and it was a natural fit that I covered the physical environment for their purposes. Without getting into the full history, it suffices to say that we were a small fish with a great idea that eventually was swallowed by Det Norske Veritas (DNV).

Becky left DNV Healthcare Inc. last year to start her own consulting company, Wise Quality America, although on some matters she still works closely with DNV. I fully enjoyed our working relationship as she is a great mentor with a quick smile and is as knowledgeable about hospitals as anyone I have ever met. ■