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A Study of Gap Analysis between Perception of the Joint Advisory Group (JAG) and Staff Members of Endoscopy Unit Regarding Quality of Care in UK

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Abstract

Introduction: JAG is responsible for accrediting Endoscopy units in the United Kingdom. It inspects the endoscopy units and makes recommendations for meeting quality standards. This study looks at the gap in perception between staff members of the endoscopy unit and JAG with regards to quality in endoscopy.

Methods: A questionnaire was designed to measure perception of four outcomes namely; dignity, privacy, quality of endoscopy and resource utilisation. It is a prospective qualitative study.

Results: The responses came from 14 Nurses, 6 Health Care Assistant and 1 Receptionist. Altogether a total of 21 questionnaires were received back indicating the response rate of 91.3%. Almost all to more than three quarter (>75%) of the staff felt that changes brought in the endoscopy unit upon recommendations from JAG improved patient dignity, privacy, and quality of care. However roughly a quarter of the staff (23.8%) felt that neither separating admission from discharge bays nor creating gender specific recovery rooms had brought any change at all in the quality of care. Similarly at least 14.3% of staff felt that neither creating gender specific toilets nor separating visitor's room from admissions lounge brought any change to the quality of care. Furthermore, in the perception of 4.8 to 14.4% of the staff members, the effect of this on resource utilisation has been of no consequence.

Conclusion: There is a clear gap in understanding regarding quality, between JAG and staff members of the Endoscopy units who deliver the service hands on. Better communication between JAG and Endoscopy is warranted.

Keywords: Accreditaion; Quality measurement; Education; Communication; Quality improvement

Introduction

The Joint Advisory Group (JAG) is responsible for accreditation of endoscopy units in the United Kingdom [1]. A detailed report on how JAG undertakes accreditation of endoscopy units and how it has impacted upon quality in endoscopy [2] was published in 2011. JAG accreditation brings financial benefits for the units in the form of higher tariffs for procedure performed by accredited units compared to the non-accredited units. Training in Endoscopy is also recognised mostly if delivered in JAG accredited units. Trainees in return further bring financial support for the NHS Trusts. The JAG Accreditation pathway has four stages;

Stage 1: Pre-accreditation

Stage 2: Accreditation Visit

Stage 3: Annual Accreditation

Stage 4: Five Year Visit

Additionally the Global Rating Scale (GRS) was created in 2004 as a tool for quality assessment and improvement for the GI endoscopy units. GRS based assessment is done in four domains and each domain has specific items as listed below. Outcomes for these listed items are measured by giving 'YES' or 'NO' answers to the series of statements or by giving levels of achievements from level 'A' (Excellent) to 'D' (Basic). The endoscopy units must achieve at least level 'B' in all areas and aim for level 'A' in time. The four GRS domains and its items are as following:

1. Clinical Quality

- Consent process including patient information

- Safety

- Comfort

- Quality of the procedure

- Appropriateness

- Communicating results to referrer

2. Quality of Patient Experience

- Equality of access and equity of provision

- Timeliness

- Booking and choice

- Privacy and dignity

- Aftercare

- Ability to provide feedback to the service

3. Workforce:

- Skill mix review and recruitment

- Orientation and training

- Assessment and appraisal

- Staff and cared for

- Staff are listened to

4. Training:

- Environment and training opportunity

- Endoscopy trainers

- Assessment/ Appraisal

- Equipment and educational materials

After JAG inspection, the endoscopy units are mandated to implement their recommendations. Whereas there is plenty of data on how to measure patient satisfaction with endoscopy units and the procedures done [3], there is however very limited data to show how the Endoscopy unit staff members perceive quality. Furthermore there is not much published data on how the Endoscopy unit staff members feel about the JAG recommendations. This study aims to look at the perception and reaction of the staff members to JAG inspection and recommendations upon implementation.

Method

In September 2013 a district general hospital, with a busy endoscopy service, had the JAG assessment. This pointed to some areas that needed improvement as following:

The endoscopy unit had only one waiting room and toilet facility for the visitors.

A single bay was being used for both admission and discharge of patients.

A single recovery room was being shared by the patients of both sexes.

The toilet was being shared for patients of both sexes.

There was no private changing room.

On the GRS this endoscopy unit had achieved a 'NO' response to the following two questions.

There is separate gender specific changing facilities, with their own dedicated washing and toilets.

There are separate recovery rooms for males and females or room dividers.

The unit had also received levels 'C' or 'D' in the following questions.

There is basic monitoring of the patient's comfort to ensure care needs are met.

There is a facility for conversation before and after the procedure.

The unit offers a safe environment for patient care.

The unit has screens and/or curtains to provide privacy pre and post procedure

The unit has access to a quiet area which provides sufficient privacy to allow a conversation beyond the hearing of other patients

Gender separation is provided pre-procedure for patients who need to change clothes for their procedures.

In compliance with the JAG recommendations the NHS Trust therefore made structural changes to the Endoscopy unit so that; there was separation of admission and discharge bays, creation of recovery rooms with gender separation, separate discharge and waiting areas for the visitors, and having separate toilets for patients according to the gender.

We analysed the effect of this change on same members of the staff working at this endoscopy unit almost one year later. A questionnaire was designed to evaluate perception of endoscopy staff at this district general hospital regarding the impact of the reconfiguration. The questionnaire aimed to look at the effect of this reconfiguration on patient dignity, privacy, quality of care and resource utilization as perceived by the staff.

This was a prospective qualitative study and did not require ethics committee approval as it falls in the domain of service review.

Results

A total of 23 questionnaires were delivered in person to the members of the staff at the Endoscopy unit. They were told that participation was entirely voluntary and anonymous. The members of the staff comprised of a mixture of various professions. The response came from 14 Nurses, 6 Health Care Assistant and 1 Receptionist. Thus altogether a total of 21 questionnaires were received back indicating the response rate of 91.3%.

Table 1 shows responses in relation to perceived effect on patient dignity, privacy, quality of care and resource utilisation upon separation of admissions and discharge bays. It shows that all staff felt that patient dignity had improved but 23.8% felt there was no change in quality of care and another 14.3% felt it had made no change to resource utilisation.

	Dignity	Privacy	Quality of care	Resource utilization
Improved	21 (100%)	20 (95.2%)	16 (76.2%)	18 (85.7%)
Worsened	0	0	0	0
No change	0	1 (4.8%)	5 (23.8%)	3 (14.3%)

Table 1: Separation of admission and discharge bay.

Table 2 shows responses in relation to perceived effect on patient dignity, privacy, quality of care and resource utilisation upon creation of gender specific recovery bays. It shows that all staff felt that patient dignity had improved but 23.8% felt there was no change in quality of care and another 9.6% felt it had made no change to resource utilisation.

	Dignity	Privacy	Quality of care	Resource utilization
Improved	21 (100%)	20 (95.2%)	16 (76.2%)	19 (90.4%)

Worsened	0	0	0	0
No change	0	1 (4.8%)	5 (23.8%)	2 (9.6%)

Table 2: Creation of gender specific recovery room.

Table 3 shows staff responses in relation to perceived effect on patient dignity, privacy, quality of care and resource utilisation upon separation of discharge bay and waiting area for visitors. It shows that all staff felt that patient dignity had privacy had improved but 14.3% felt there was no change in quality of care and another 4.8% felt it had made no change to resource utilisation.

	Dignity	**Privacy**	**Quality of care**	**Resource utilization**
Improved	21 (100%)	21 (100%)	18 (85.7%)	20 (95.2%)
Worsened	0	0	0	0
No change	0	0	3 (14.3%)	1 (4.8%)

Table 3: Separation of discharge lounge and visitors waiting area.

Table 4 shows staff responses in relation to perceived effect on patient dignity, privacy, quality of care and resource utilisation upon separation of toilets based upon the patient's gender. It shows that 14.3% staff felt that patient dignity had privacy had not improved and another 14.3% each felt that there was no change in quality of care or resource utilisation.

	Dignity	Privacy	Quality of care	Resource utilization
Improved	18 (85.7%)	18 (85.7%)	18 (85.7%)	18 (85.7%)
Worsened	0	0	0	0
No change	3 (14.3%)	3 (14.3%)	3 (14.3%)	3 (14.3%)

Table 4: Having separate toilets for patients according to gender.

Conclusions

Separation of discharge and admission bays is deemed important by the JAG and increasingly there is a demand for gender specific bays and toilets. It is desirable to have visitor's waiting rooms separate from the patients discharge lounges. Many endoscopy units are struggling to find physical space to be able to do so. Even some of the new built endoscopy units are unable to meet this requirement. Interestingly this study has demonstrated that significant number of staff do not feel that these actions can improve quality of care for patients or resource utilisation, but all of them believe that it will not worsen the outcomes.

Discussion

This qualitative study has looked at how members of the staff at endoscopy department perceive the recommendations made by JAG for the purpose of accreditation. The objective of JAG is to provide patients with good quality of clinical care in endoscopy, which provides the patients a good experience, is done by well trained staff with correctly appraised skills. Of the domains, we have chosen; dignity, privacy, and quality of endoscopy and resource utilisation are the main measurable outcomes for this study. The study has an excellent response rate of above 90%. Almost all to more than three quarter (>75%) of the staff feel that changes brought in the endoscopy unit upon recommendations from JAG have helped improve patient dignity, privacy, and quality of care whether it is by separating discharge from admission bays, creating gender specific toilets and recovery rooms, or having different rooms for visitor's waiting and patient admissions. However in the perception of 4.8 to 14.4% of the staff members, the effect of this on resource utilisation has been of no consequence. Notably, not a single member of the staff thought that the changes had made the situation any worse and that recommendations had either positive or a neutral effect on patient dignity, privacy, quality of care and resource utilisation.

Notably however almost a quarter of the staff (23.8%) felt that neither separating admission from discharge bays nor creating gender specific recovery rooms had brought any change at all in the quality of care. Similarly at least 14.3% of staff felt that neither creating gender specific toilets nor separating visitor's room from admissions lounge brought any change to the quality of care. All these findings are worth consideration because separate sex toilets and wards have been deemed as important measurable parameters of quality by the Health Department. Similarly a lot of emphasis has been placed by various stake holders in quality of care towards separating patient and visitors spaces as well as having different spaces for different streams of patients.

Thus there seems to be a gap in understanding of what is meant by quality of care when JAG measures it and when the actual members of the staff who directly deliver the service perceive it. For example, some health care workers felt that structural reconfiguration of the endoscopy units incorporating all these separate areas according to gender or point of care would require geographically increasing the physical space of the unit. This can be fine most days but on the days when the unit is under-staffed due to unforeseen circumstances (e.g. sick leave etc.) it would be difficult to cover this over stretched area.

So what could be the solutions to the problem? Obviously there seems a discrepancy in the regulatory body and the staff working in the service that it regulates, with regards to concept of quality in endoscopy. Better communication by the Regulatory body to the endoscopy staff regarding the logic and the evidence behind their recommendations may help. The endoscopy staff can be better equipped by further training in quality of care issues in endoscopy. More engagement of JAG with the endoscopy staff and taking their views on board in determining quality may be useful. Not the least, but it may be that JAG has to relook how it understands quality of care in endoscopy. No doubt more qualitative studies are needed to make a gap analysis.

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