A study on
Gap analysis and closure of clinical non-compliances identified during NABH audit (2018)

Submitted by:
Ms. Jilu Kallada
Roll No – 0579
MBA HM-22

Contents

Introduction

- NABH accreditation system was established in 2006
- Constituent of Quality Council of India (QCI)
- To establish and operate accreditation programme for HCOs
- 1st edition of standards was released in 2006
- The standards were revised every 3 years
- Currently the 4th edition of NABH standards (December 2015) in use

Background

- P.D. Hinduja Hospital and Medical Research Centre was accredited by NABH for the first time in 2009
- P. D. Hinduja Hospital is the second hospital in the city to receive the NABH accreditation
- The latest audit was done by NABH in June 2018
- There were 58 non-compliances identified during the last audit
- The next NABH surveillance is due in Dec 2019

Research Question

What is the current status of the clinical non-compliances identified during NABH audit conducted in 2018?

Aim

To review and close the clinical Non-compliances identified during NABH Audit 2018

Objectives

- To identify the current status of clinical non-compliances identified during last NABH audit in June 2018
- To identify the reasons for the non-compliances in the identified areas
- To identify possible solutions for improving the compliance of the identified areas
- To implement the solutions identified to improve the compliance in these areas

Operational Definition

Accreditation - Accreditation is independent recognition that an organization meets the requirements of governing industry standards

Non-compliance - Non-compliance is the failure or refusal to comply with something (such as a rule or regulation)

Gap Analysis - Gap analysis involves the comparison of actual performance with potential or desired performance

Closure - During the follow-up audit, the auditor checks the corrective action that has been implemented for each non-compliance found during the original audit

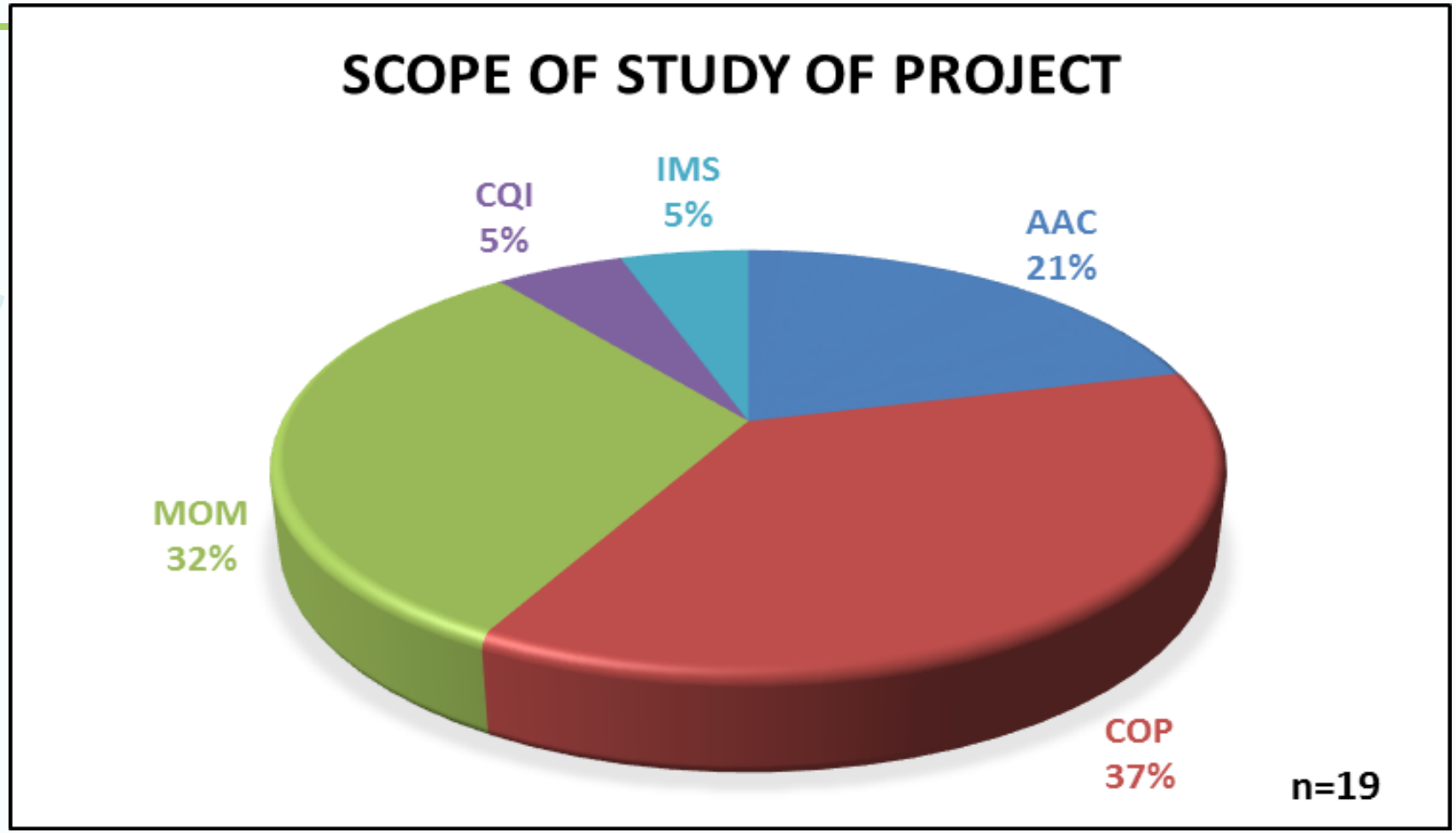
Methodology

- Descriptive cross-sectional study
- 4th February to 30th April 2019
- P. D. Hinduja Hospital and Medical Research Centre, Mumbai
- Non-probability Sampling (convenient sampling)
- Primary data - direct observation, information from employees and information from patients or relatives using semi-structured interview
- Secondary data – Hospital records like manuals, policy and procedure guidelines, patient records, HMIS and departmental registers

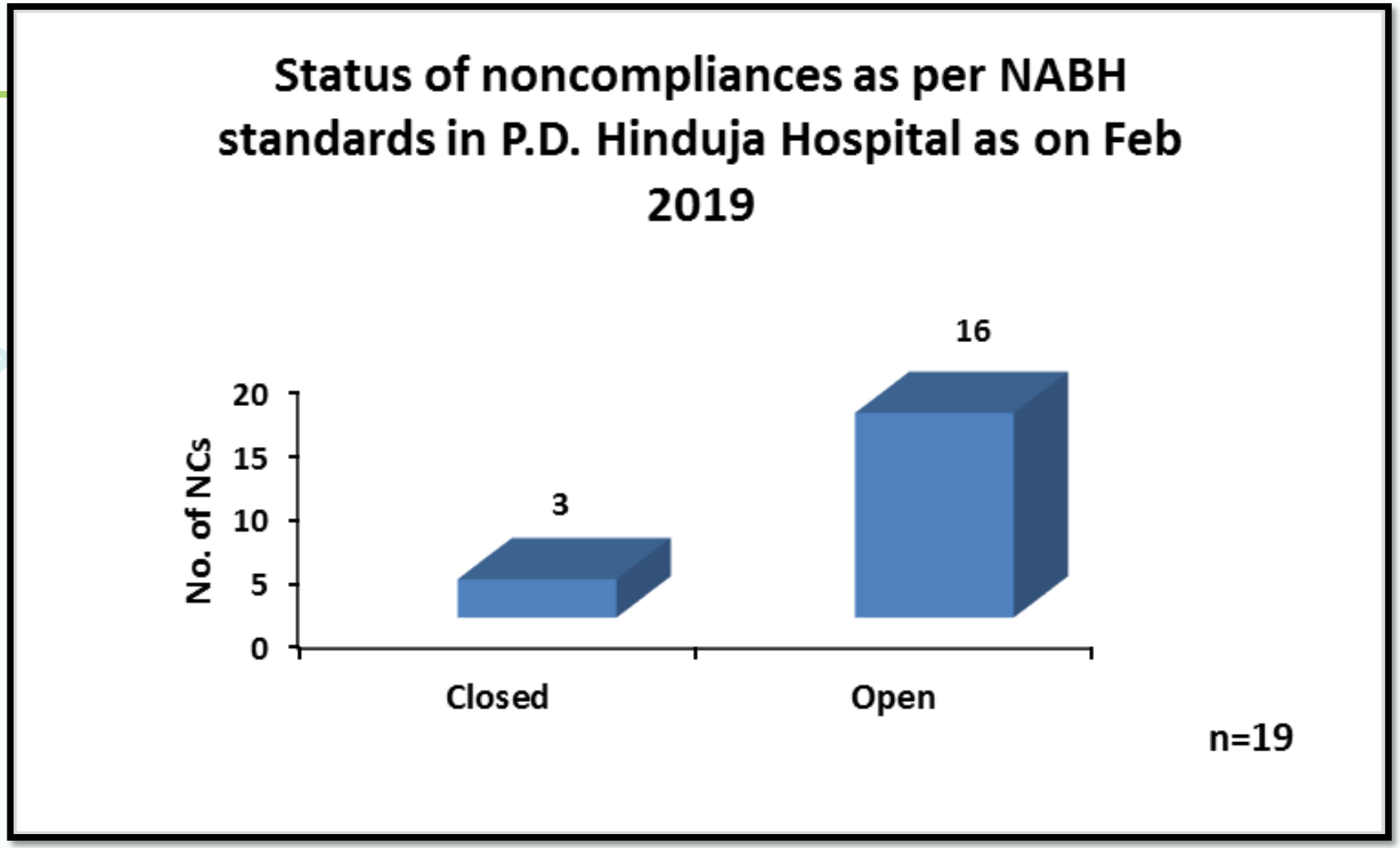
Sample Size and Sample Unit

Sample Size and Sample Unit			
Chapter	No. of Non-compliances	Sample Size	Sample Unit
AAC	4	95	Wards(65), ICU(30)
COP	7	72	ICU
MOM	6	95	Wards(65), ICU(30)
CQI	1	25	OT
IMS	1	No Sample size	MRD

Distribution of Non-compliances



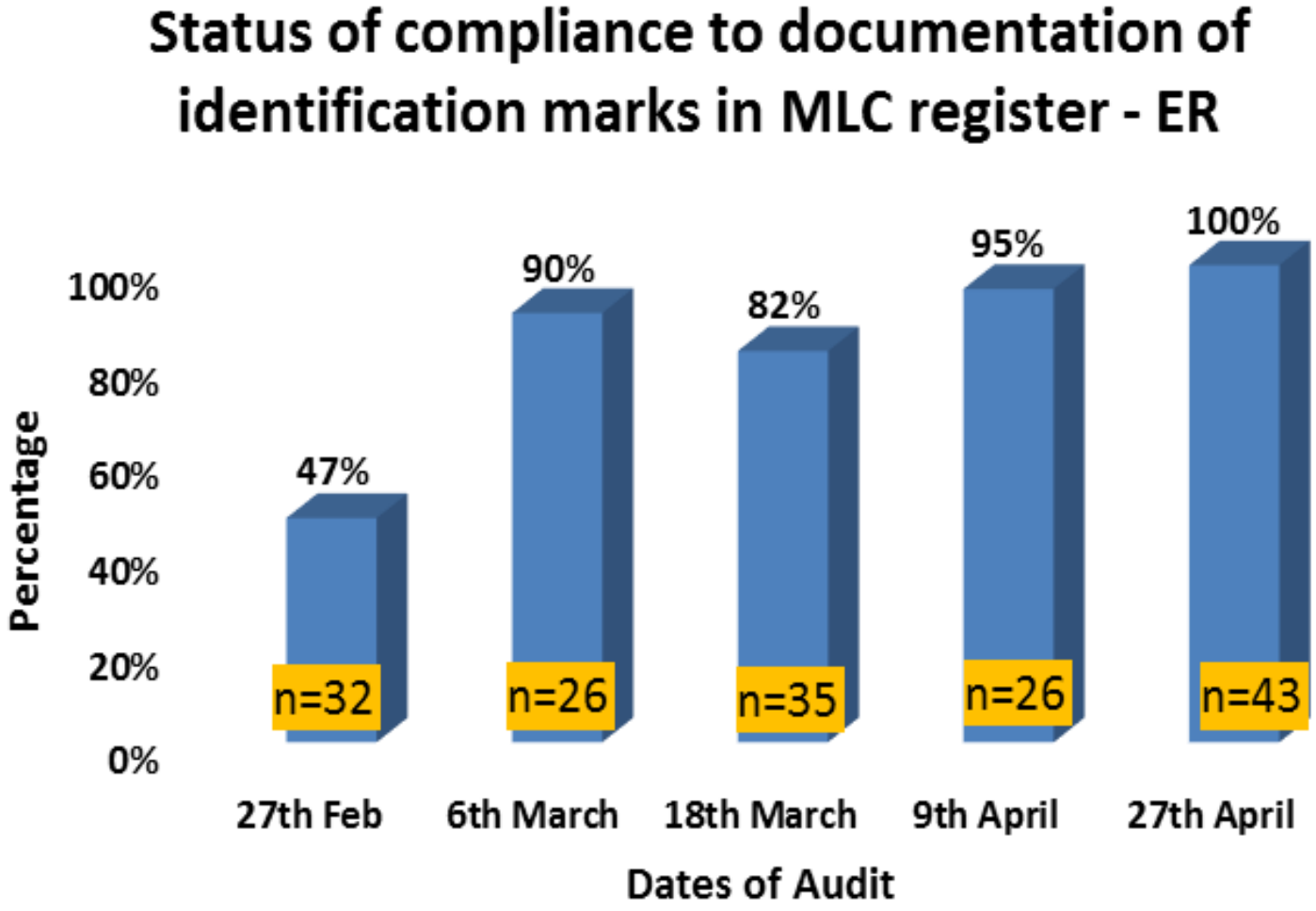
Findings


Status of noncompliances as per NABH standards in P.D. Hinduja Hospital as on Feb 2019
No. of NCs
20
15
10
5
0
3
16
Closed
Open
n=19

Closed Non-compliances as on Feb 2019

SN	STANDARD / OE	ASSESSOR'S OBSERVATION	CORRECTIVE ACTION TAKEN	OBSERVATION
1	COP 17 a	The period of validity of a restraint order by the doctor has not been defined. The restraint form has the monitoring entries for 4 days, for a single order.	Restraint policy updated for doctors review after 24 hours	Each of 72 orders for restraints audited had restrain form and consent by relatives
2	COP 9 b, c	Discharge criteria for ICU, based on physiological parameters, have not been defined, and consequently the staff are not aware	Protocol for discharge from ICU has been updated to include physiological based parameters /criteria. ICU doctors have been updated regarding the same	Protocol for discharge from ICU present in the ICU manual with physiological criteria for discharge
3	CQI 3 e	Data collection for monitoring the appropriate use of prophylactic antibiotics, does not include whether the antibiotic is used as per antibiotic policy.	The compliance of the prophylactic administration of prophylactic antibiotic within specific time would be done on a monthly basis by the OT manager. The appropriateness of the antibiotic is captured and presented on a yearly basis by the infection control team	OT Manager maintains monthly record of compliance to administration of prophylactic antibiotic within specific time and appropriateness of the antibiotic is captured by HIC team annually

Open Non-compliances as on Feb 2019



N	CURRENT STATUS	RECOMMENDATIONS
e ol. 27th ation on th d. iance 95% 9th	Closed. 100% Compliance.	• Addition of printed headings for thumb impressions in MLC register. • Checking MLC register for completion by Asst. Consultant- ER • Counter checking of MLC register for completion by Mr. Ravi Kenkre on daily basis . • Periodic Audits by quality department for adherence to protocol.

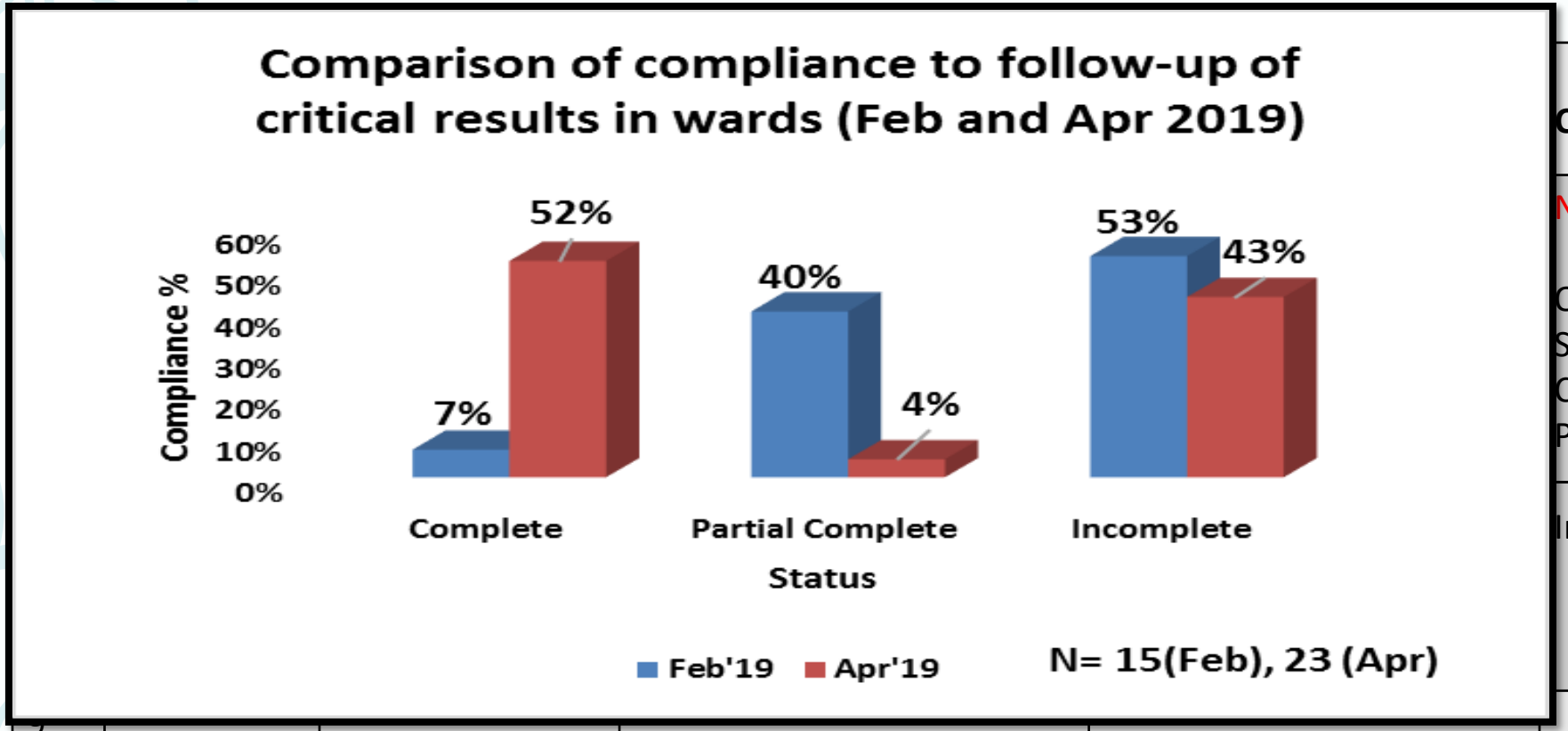
SN	STANDARD / OE	ASSESSOR'S OBSERVATION	CORRECTIVE ACTION TAKEN	OBSERVATION (FEB)	CURRENT STATUS	RECOMMENDATIONS
2	AAC 9 f, g	Critical results have been defined for MRI, but no register documenting the information to the patient care area is maintained.	Standardized 'critical result reporting register' maintained for all sections including MRI. Circular stating the importance of critical reporting acknowledged by all doctors	MRI - Critical Register present but not filled since May 2018. JMS are responsible for filling the register. Could not find other department's registers.	Closed. Critical register maintained since month of Feb 2019 in USG, CT and MRI departments.	• Use of software to capture the information by integrating CARE, PACS and use of tablet to inform the respective doctor.
3	COP 5 b	Evidence of appropriate training on cardiopulmonary resuscitation was lacking. There was no prompt response to initiate a code blue and start compressions in the code blue drills conducted during the assessment.	CPR training by dedicated CPR training team at least twice a month. All doctors and nurses will undergo refresher course annually, HR L&D team shall coordinate and ensure all relevant staff are covered.	CPR Training did not happen in last two months due to POSH training (Feb & March). Nurses are aware of CPR code activation process.	Closed. Resumed CPR training every fortnight since 22nd March.	• Refresher trainings annually • Uploading CPR training video on intranet • Periodic Mock drills

SN	STANDARD/ OE	ASSESSOR'S OBSERVATION	CORRECTIVE ACTION TAKEN	OBSERVATION (FEB)	CURRENT STATUS	RECOMMENDATIONS
4	IMS 5 c	Although there is a system to issue case sheets to doctors from MRD, the return of issued case records to doctors, is not appropriately captured. As per a report generated, more than 2000 case records have not been returned since January, 2018. Some of them have been found on physical verification in the storage area.	All the unreturned files were cleared as per the attached report for the period since jan'2018 to 1st june'2018. There are 31 cases still pending which are related to deficiency completion, indoor cases and court cases. Initiated a methodology to send a note to the respective consultants with the list of unreturned files after 2 days of patient's consultation.	There is no documentation of protocol for tracing the missing files. The missing files are traced when the patient comes for next consultation or gets admitted in PDHH. Reminders are sent to Consultants every 15 days to return the files to MRD.	Closed. Protocol for tracing missing files updated in MRD Manual	Periodic audit for compliance to the given protocol

SN	STANDARD/ OE	ASSESSOR'S OBSERVATION	CORRECTIVE ACTION TAKEN	OBSERVATION (FEB)	CURRENT STATUS	RECOMMENDATIONS
5	AAC 1 c	Obstetrics is not in the scope of services provided by the HCO. Although this has been displayed at the OPD, there is no display at the IVF centre	This was closed during assessment. the following posters were displayed - 'WE DO NOT HAVE OBSTETRIC/ MATERNITY SERVICES' PUT UP IN IVF CENTRE'	Mentioned signage is not displayed in IVF Centre	Submitted bilingual content for the signage to marketing department after consultation with respective department	One time closure
	AAC 1 c	The hospital does not have a positive pressure isolation room facility to care for patients with burns, and therefore does not admit such patients. This has not been displayed	'WE DO NOT ADMIT BURN PATIENTS' put up in casualty	Mentioned signage in English language present at entrance of Casualty	Submitted bilingual content for the signage to marketing department after consultation with respective department	One time closure

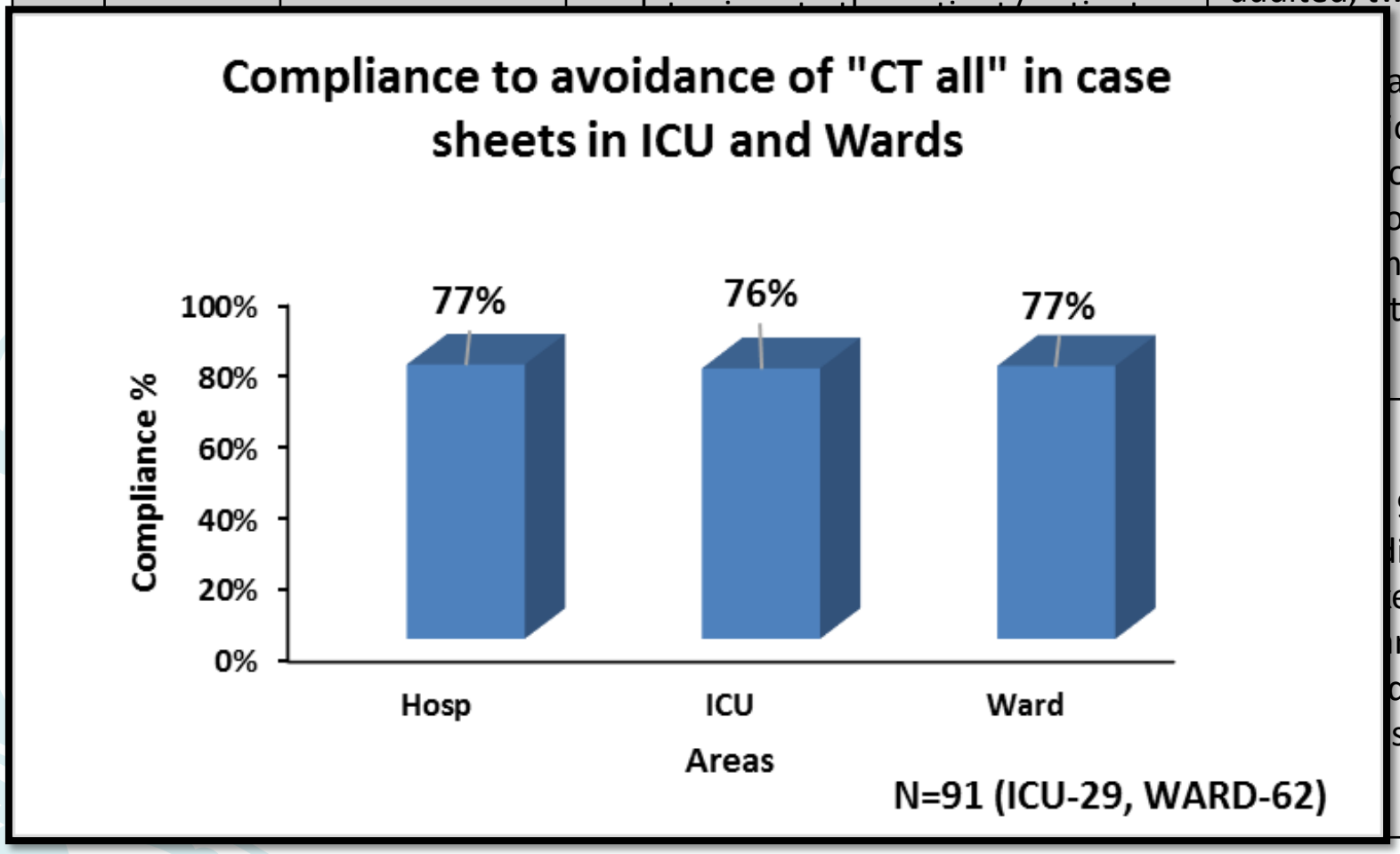
SN	STANDARD/ OE	ASSESSOR'S OBSERVATION	CORRECTIVE ACTION TAKEN	OBSERVATION (FEB)	CURRENT STATUS	RECOMMENDATIONS
6	AAC 9 f, g	Turn around time for the various imaging modalities and critical results have not been defined in radiology	The following posters were displayed in imaging - DISPATCH TIME FOR IMAGING REPORTS	Turn around time for imaging tests are defined. Temporary A4 size print-out for the same is displayed near X-ray department.	Submitted content for the signage to marketing department after consulting the respective department	One time closure

SN	STANDARD/ OE	ASSESSOR'S OBSERVATION	CORRECTIVE ACTION TAKEN	OBSERVATION (FEB)	CURRENT STATUS	RECOMMENDATIONS
7	AAC 2 f	There is no system in the OPD to ensure that access to the healthcare services is prioritised according to the clinical needs of the patient.	To prioritize access to healthcare services in the OPD as per the clinical needs of the patients, nursing and other hospital staff is trained to recognize the signs and call for assistance in form of the rapid response team and if required the CPR team. in addition to the same, posters are put up in the OPD to create awareness for patients to ask for help -'IN CASE YOU REQUIRE URGENT MEDICAL CARE, PLEASE CONTACT THE NURSE AT YOUR LOCATION'	Vital parameters of OPD patients are not checked on arrival in OPD. Weight is checked for patients who can stand on their own. Nurses assess the patients by observing when they come to OPD with the voucher and while measuring their weight. Nurses could not specify the parameters they check during visual assessment. Patients on wheel chair or stretcher are kept near the consultants cabin in the corridor. Nurses are aware about the activation process for code blue and RRT. Mentioned poster is put up only in two locations (waiting area on 2nd floor - 3rd and 4th Wing.	27th April 2019: Nurses observe– general appearance, gait, breathing pattern of patient. Patients on wheelchair and stretcher are observed on arrival. Relatives inform nurses in case of deterioration in patient's condition. Additional mentioned signage to be displayed in waiting areas. Submitted bilingual content for the signage to marketing dept.	• Checking vitals of all patients on wheelchair and stretcher. • Periodic audit by quality department for the same.

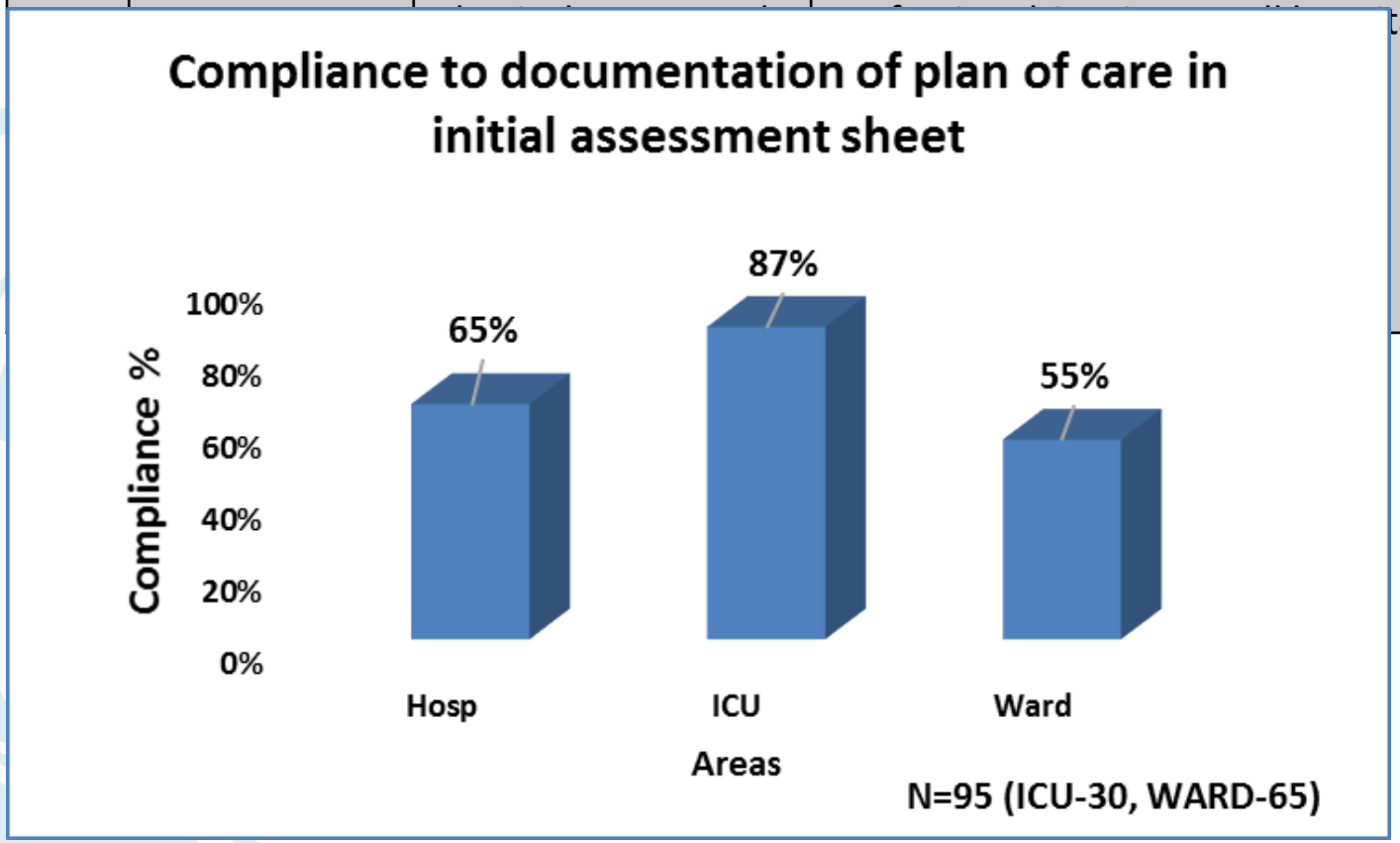


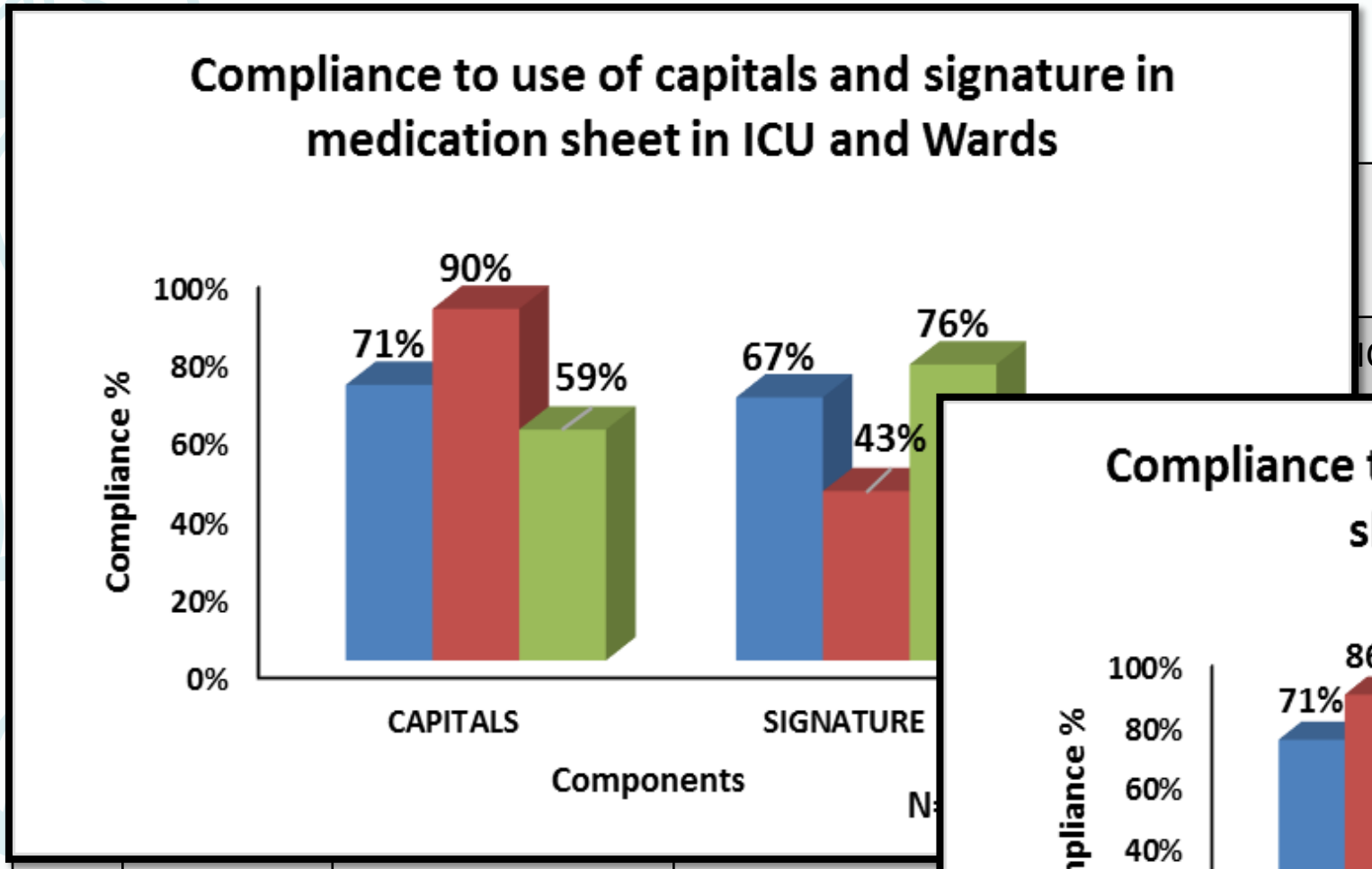
					CURRENT STATUS	RECOMMENDATIONS
					Not Closed. Out of 23 Samples, Complete – 52%, Partial Complete – 4%, Incomplete- 43%	• Periodic audit for adherence to guidelines • Periodic training on guidelines to be followed
	COP 5 c	There is no real time recording of events during a CPR	Real time recording of the CPR activities will be done for all CPR calls from the time the CPR call is given till completed as per pre-defined checklist which will be a part of the CPR form.	It has not been decided who is responsible for the documentation in the team.	Not Closed. Escalated to DPS Office. DPS office forwarded the message to consultants. They will be discussing it in MSAC	Provision of name tags mentioning role of each team member in CPR Team. E.g. Airway, Chest Compressions, IV Medications, Documentation, etc

SN	STANDARD / OE	ASSESSOR'S OBSERVATION	CORRECTIVE ACTION TAKEN	OBSERVATION (FEB- MAR)	CURRENT STATUS	RECOMMENDATIONS
10			The ICU doctors will note on the patient record on a daily basis regarding the	Out of the 20 cases audited, two of ation of on in ondition of them nentation tient's	Not Closed. Escalated to DPS Office. DPS office forwarded the message to consultants. They will be discussing it in MSAC	Addition of printed statement mentioning update given to relatives about patient's condition in daily ICU note sheet with space for relative's signature.
				91 Case dited, e "CT me" d in 23% s.	Not Closed. Escalated to DPS Office. DPS office forwarded the message to consultants. They will be discussing it in MSAC	

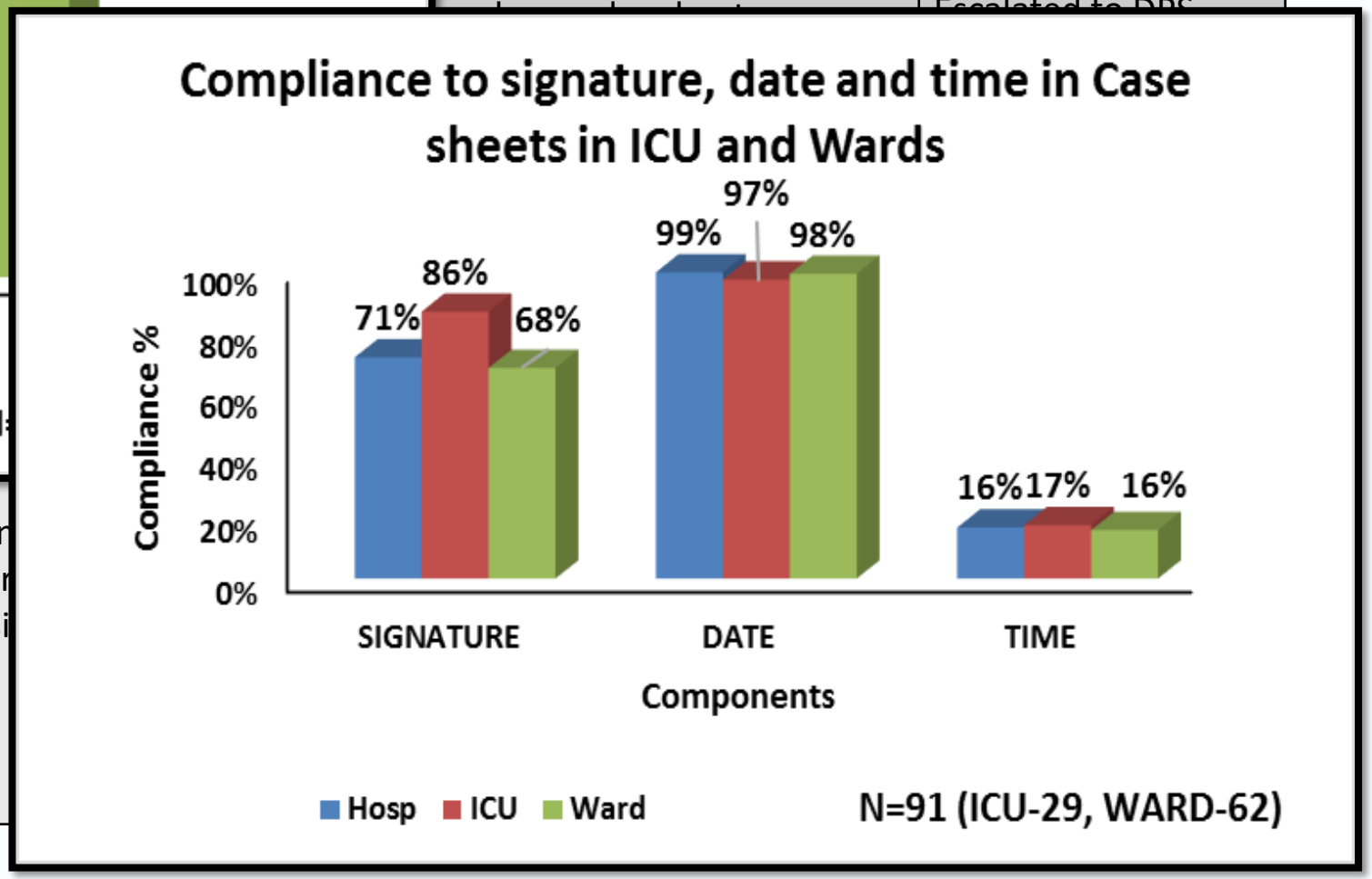


SN	STANDARD/ OE	ASSESSOR'S OBSERVATION	CORRECTIVE ACTION TAKEN	OBSERVATION	CURRENT STATUS
12		Although the care	Communication sent by Director tal	ICU - 87% (N=30) WARD - 55% (N=65) ER - 0% (N=26) Compliance Doctors write plan of care/action in the initial assessment sheet but fail to mention the desired outcome.	Not Closed. Escalated to DPS Office. DPS office forwarded the message to consultants. They will be discussing it in MSAC



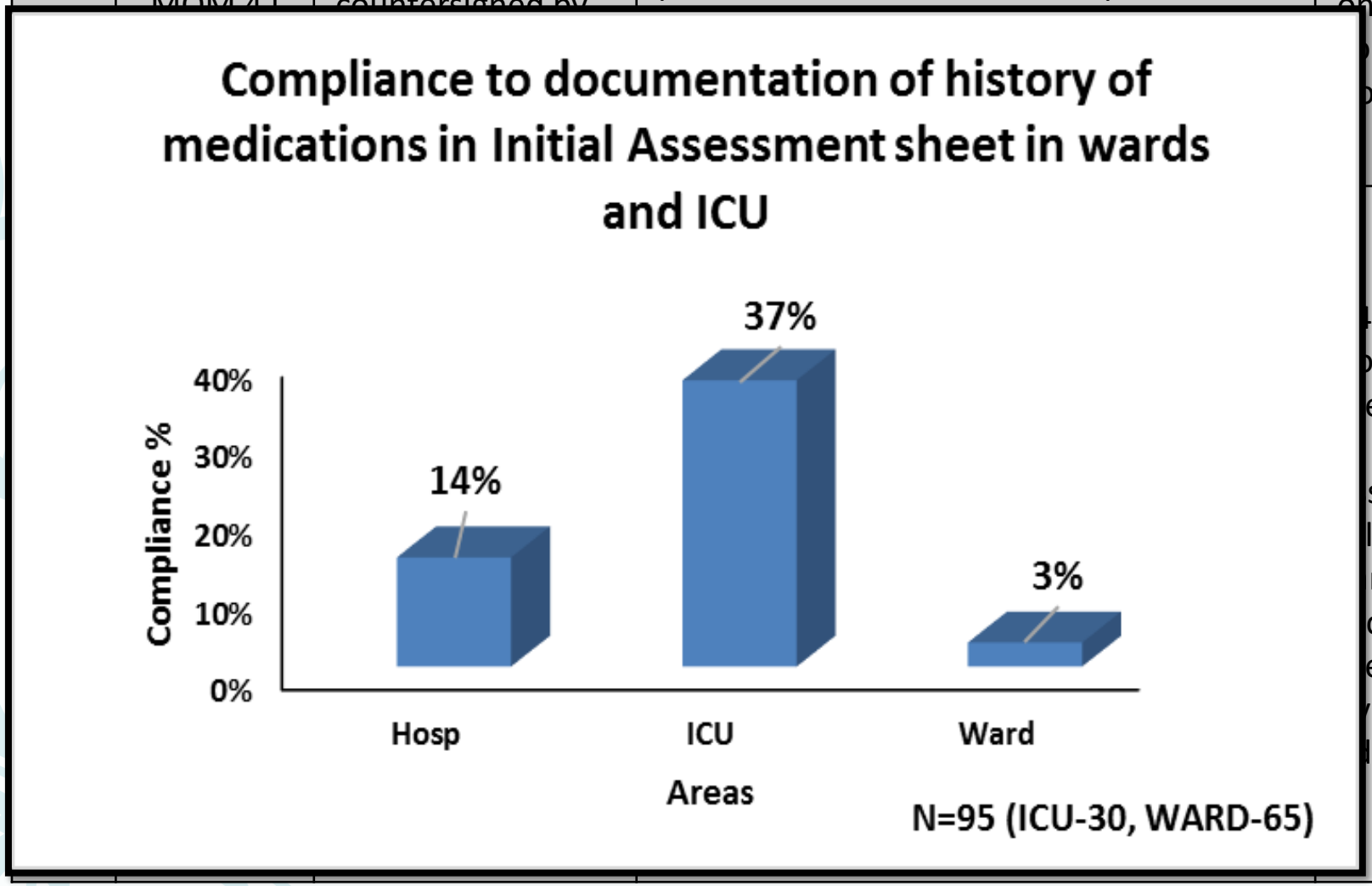


OBSERVATION	CURRENT STATUS
ICU Doctors prescribes drugs	Not Closed. Escalated to DPS



	MOM 4 g	Doctors' signatures were not evidenced in some case sheets	Communication professional ser doctors endorsi

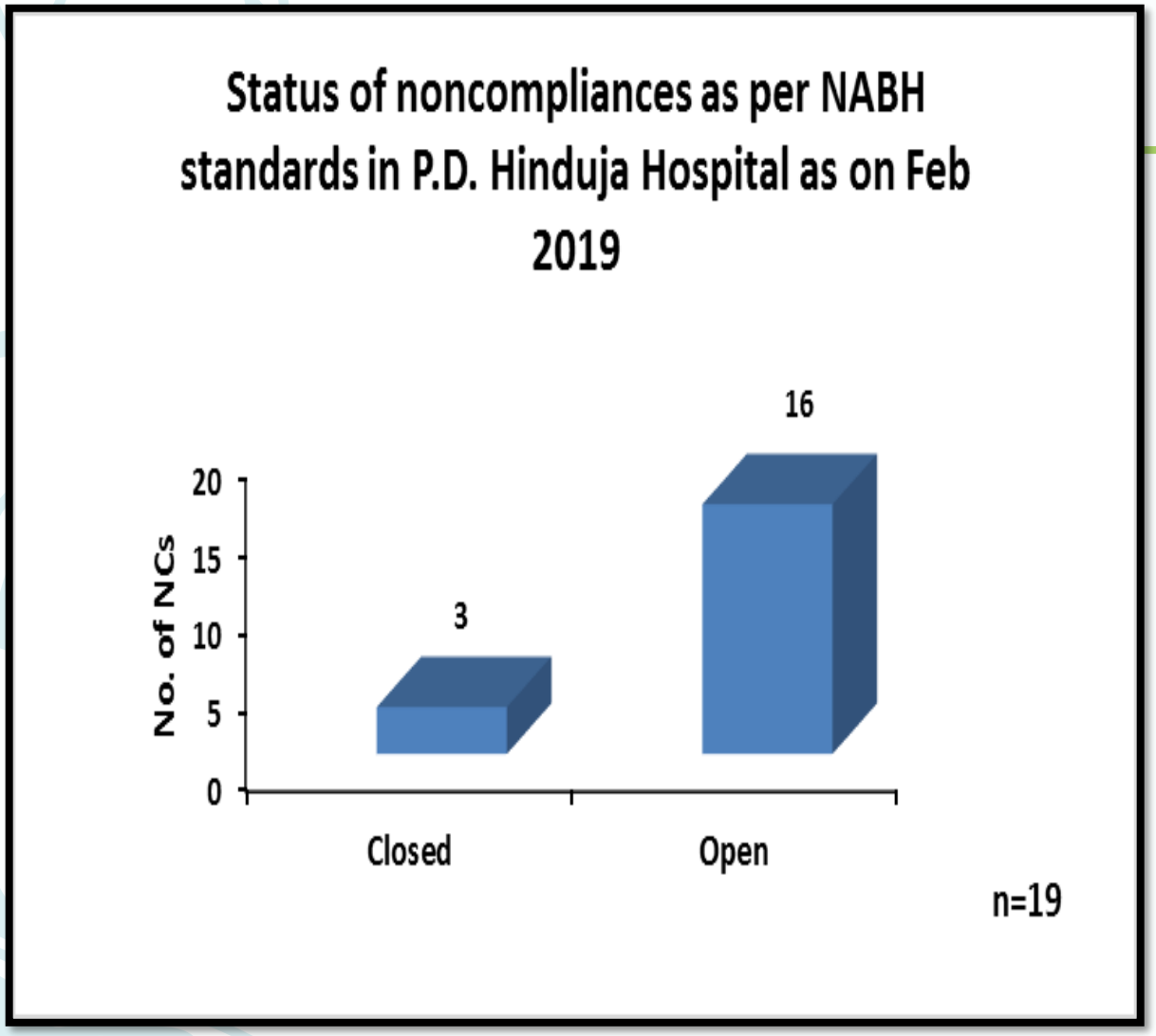
SN	STANDARD/ OE	ASSESSOR'S OBSERVATION	CORRECTIVE ACTION TAKEN	OBSERVATION	CURRENT STATUS
15	MOM 4.i	Verbal orders were found not countersigned by	Communication sent by director professional services to all hospital doctors	Out of 13 verbal orders audited, only 4 were countersigned by doctor	Not Closed. Escalated to DPS Office. DPS office forwarded the message to consultants. They will be discussing it in MSAC
				4% Compliance in documentation of medication history initial assessment sheet. 32 nursing Kardex audited recorded medications taken patients before admission.	Not Closed. Escalated to DPS Office. DPS office forwarded the message to consultants. They will be discussing it in MSAC



Summary of Results

SN	STANDARD / OE	STATUS (APRIL 19)	CLOSURE DATE	RESPONSIBLE PERSON
1	COP 2 c	Closed		
2	AAC 9 f, g	Closed		
3	COP 17 a	Closed		
4	COP 5 b	Closed		
5	COP 9 b, c	Closed		
6	CQI 3 e	Closed		
7	IMS 5 c	Closed		
8	AAC 1 c	In process	May-19	Marketing Manager
9	AAC 1 c	In process	May-19	Marketing Manager
10	AAC 9 f, g	In process	May-19	Marketing Manager
11	AAC 4 h	Open	Oct-19	Director of Professional Services
12	AAC 2 f	Open	May-19	Nursing Manager
13	AAC 9 g	Open	Jun-19	Nursing Manager
14	COP 5 c	Open	Oct-19	CPR Team, ICU head, DPS
15	COP 9 h	Open	Oct-19	Director of Professional Services
16	MOM 4 f	Open	Oct-19	Director of Professional Services
17	MOM 4 g	Open	Oct-19	Director of Professional Services
18	MOM 4 i	Open	Oct-19	Director of Professional Services
19	MOM 4 l	Open	Oct-19	Director of Professional Services

Conclusion


Status of noncompliances as per NABH standards in P.D. Hinduja Hospital as on Feb 2019
No. of NCs
20
15
10
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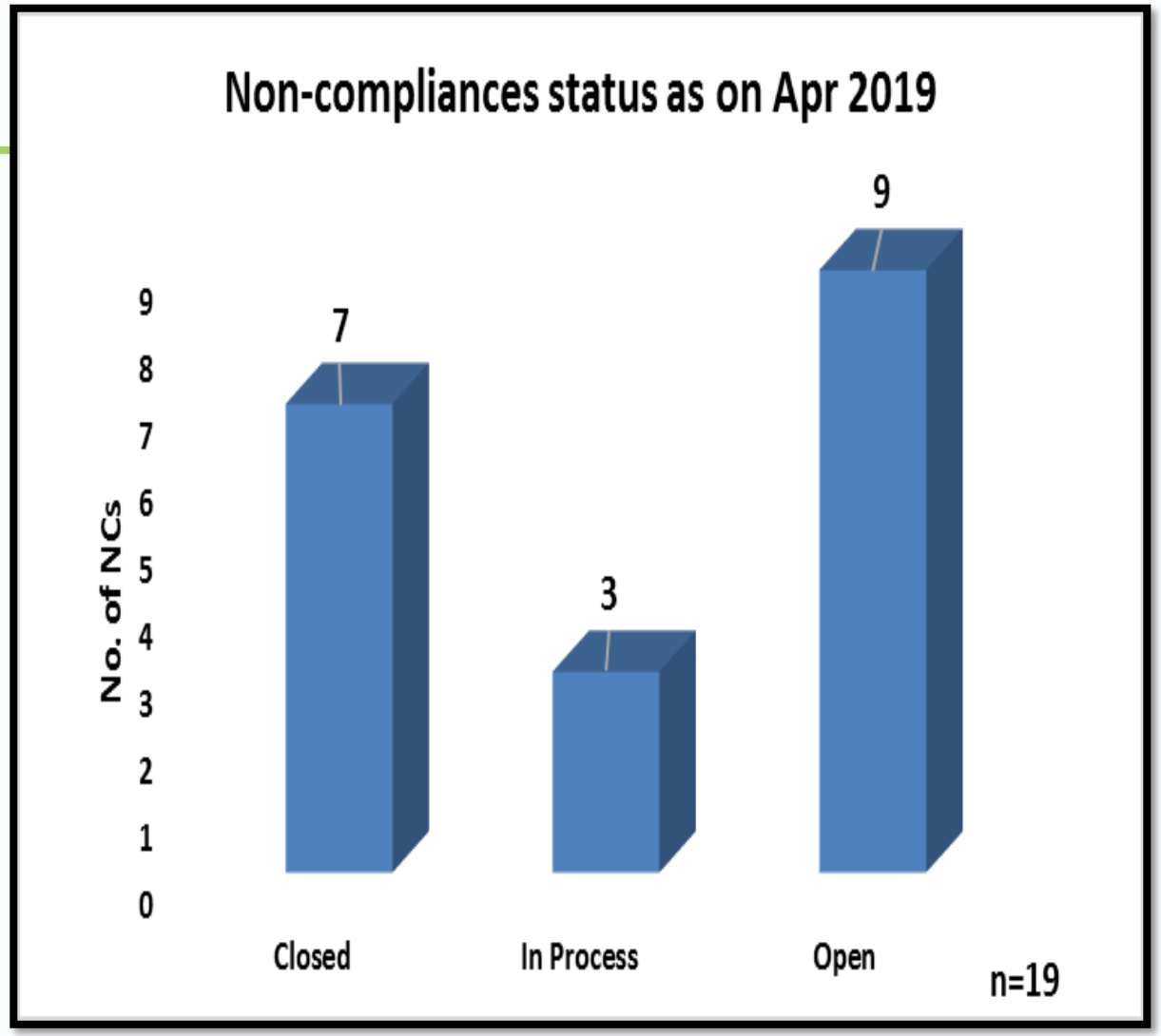
0
3
16
Closed
Open
n=19


Non-compliances status as on Apr 2019
No. of NCs
9
8
7
6
5
4
3
2
1
0
7
3
9
Closed
In Process
Open
n=19

Recommendations to improve adherence to documentation

- Positive reinforcement through SMS by identifying the departments with maximum compliance to documentation on monthly or quarterly basis.
- Acknowledging the departments/ team adhering to documentation protocol during events like Quality week
- Monthly programmes emphasising on one aspect of documentation.

E.g. A month emphasising on use of Capital letters on drug order sheet,

A month emphasising on reconciliation of medications.

- HIS for documentation

THANK YOU