Study on Gap Analysis of Daycare Hospital as per ACHS EQuIP6 Accreditation Guidelines

By

Ritika Jindal

Dissertation submitted in partial fulfillment of the requirements of the degree

MBA Hospital and Health Management

Academic year, 2017-2019

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INSTITUTE OF HEALTH
MANAGEMENT RESEARCH
(WHO Collaborating Centre for District Health System Based on Primary Health Care)

IIHMR UNIVERSITY

TO WHOMSOEVER MAY CONCERN

This is to certify that **Dr. Ritika Jindal**, student of MBA Hospital and Health Management/ Pharmaceutical / Rural Management from The IIHMR University, Jaipur has undergone internship training at **Thumbay Hospital daycare, University road, Sharjah** from 24th February, 2019 to 20th May, 2019.

The Candidate has successfully carried out the study designated to her during internship training and her approach to the study has been sincere, scientific and analytical.

The Internship is in fulfillment of the course requirements.

I wish her all success in all her future endeavors.

Dr. P.R. Sodani
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THUMBAY HOSPITAL
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ثومبي
THUMBAY
Growth Through Innovation

May 20, 2019

To Whom It May Concern

This is to certify that Dr. Ritika Jindal holder of Indian Passport Number M8533703 has undergone internship in our organization from 24th February 2019 till 20th May 2019, as a part of dissertation of her MBA in Hospital and Health Management program. She has completed the assigned project.

We wish all the best for her future endeavor.

For **Thumbay Hospital Daycare, Muwailah**

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CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **"A study on gap analysis of daycare hospital as per ACHS EQuIP6 accreditation guidelines"** submitted by **Dr. Ritika Jindal** Enrollment No. **651** under the supervision of **Ms. Seema Mehta**, Associate Professor, IIHMR University, Jaipur for award of MBA in Hospital and Health Management carried out during the period from 24th February, 2019 to 20th May, 2019 embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other institute or other similar institution of higher learning.

Signature

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INTRODUCTION

AIM:

To prepare Thumbay Hospital Daycare, Sharjah for accreditation by conducting gap analysis as per ACHS Standards.

OBJECTIVES:

i) To assess the existing system of the hospital as per the mandatory criteria of ACHS, EQUIP6.

ii) To identify and analyse the gaps in the existing system as per ACHS requirements.

iii) To recommend measures for increasing conformance to standards and facilitation to achieve ACHS accreditation

BACKGROUND:

Gap analysis is the initial step in the review of an organization. It can be measured against pre set standards or criteria as per the accrediting body or to check the compliance to the pre defined criteria.
The Gap analysis will help to understand how well the organization aligns with the criteria to be met for ACHS accreditation and identifying the areas of improvement in order to prepare the daycare hospital for accreditation.
The scope of improvement will mark up the level to which the organization needs to work to get accredited.

QUALITY

Quality in a hospital or healthcare organization is about, but not limited to:

- Meeting the expectations of Patients and Staff
- Patients and Employee Safety
- Patient Satisfaction
- Minimizing and preventing the risks
- Achieving desired health outcomes

What is Accreditation?

Accreditation literally means the process in which a certification of competency, authority or credibility is presented to an organization or institution by a professional association called as accrediting body.

Introduction to Hospital Accreditation

Healthcare or Hospital Accreditation is an external review of the quality of care and services.
Hospital accreditation has been defined as "A self-assessment and external peer assessment process used by health care organizations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve."

For organization striving to provide high quality care and services with a culture of safety and quality improvement, accreditation will be the natural outcome.

An accreditation system usually consists of the following components:

- Establishment of agreed standards expected of healthcare or organization.
- Development of a process for evaluation of the provision of services by or organization wishing to be accredited, which is conducted through survey by peer surveyors
- Conduct of the survey, a process that includes preparatory activities by the healthcare or organization such as collation of evidence of improvement, followed by an assessment by surveyors of the or organization compliance with the standards
- Award of accreditation and reporting of the results of survey to relevant bodies or the public as appropriate.

Benefits of Accreditation:

- Strengthens Patient Safety efforts in hospitals
- Improves risk management
- Helps to strengthen risk prevention strategies
- Improves incident management and reporting system
- Improves the focus on Patient satisfaction
- Accreditation strengthens the confidence of community the quality of healthcare services
- Builds the confidence of Insurers or third parties
- Demonstrates commitment to quality healthcare
- Stimulates Continuous Quality improvement efforts
- Opportunity for the hospital to benchmark
- Provides an edge over other competitors in the market

What is ACHS?

The Australian Council on Healthcare Standards (ACHS) is an independent, not-for-profit organisation, dedicated to improving quality in health care since its inception in 1974.

- ACHS and its EQuIP standards are accredited by the International Society for Quality in Health Care (ISQua).

- The ACHS' EQuIP6 Day Procedure Centres Program is a three-year quality assessment and improvement program for day procedure centres that supports excellence in consumer / patient care and services. 3rd edition of the Australian Council on Healthcare Standards' (ACHS) Evaluation and Quality Improvement Program (EQuIP6) for stand-alone day procedure centers, day hospitals, day surgeries and other facilities that do not provide overnight accommodation

EQuIP6 Day Procedure Centers has 3 functions, 10 standards, and 26 criteria:

- **The Clinical Function** sets out the models that are directly connected with clinical consideration.
- **The Support Function** contains benchmarks and criteria in which quality improvement requires clinical and corporate staff to cooperate, in some cases with help from internal staff and/or external advisors.
- **The Corporate Function** recognizes those guidelines and criteria for which the organization's governing body is predominantly responsible.

Function 1 – Clinical has four standards:

1.1 Access and continuity of care

1.2 Effective care

1.3 Safety

1.4 Consumer focus

Function 2 – Support has four standards:

2.1 Quality improvement and risk management

2.2 Human resources management

2.3 Information management

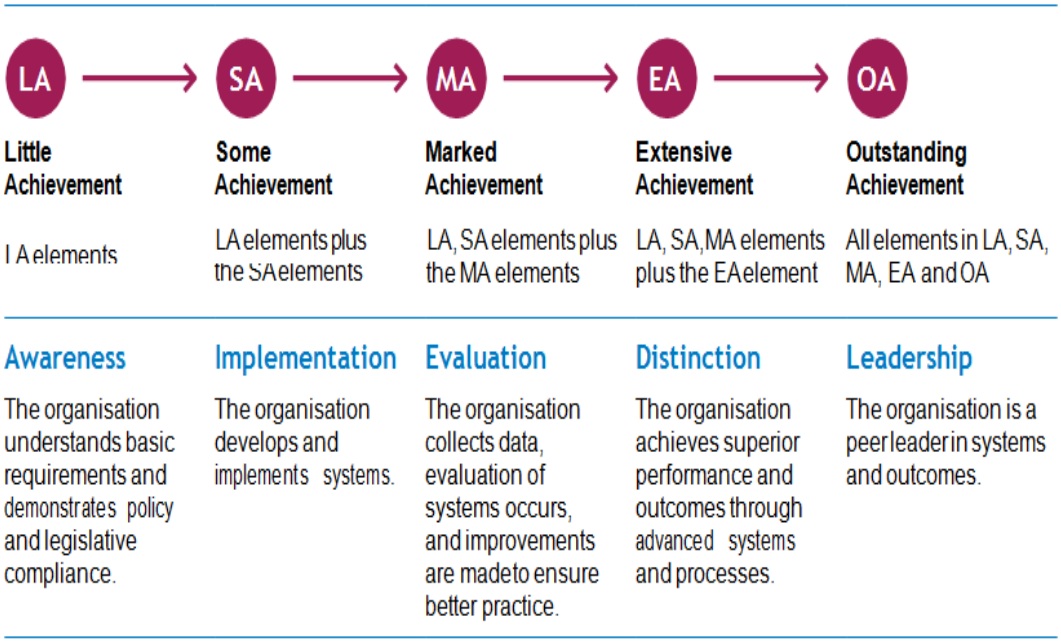
2.4 Research

Function 3 – Corporate has two standards:

3.1 Leadership and management

3.2 Safe practice and environment

Each of the 26 EQuIP6 Day Procedure centres criteria can have five possible levels of achievement:



LA – Little Achievement (Awareness)

SA – Some Achievement (Implementation)

MA – Marked Achievement (Marked Achievement)

EA – Extensive Achievement (Extensive Achievement)

OA – Outstanding Achievement (Outstanding Achievement)

EQuIP6 Day Procedure Centers has total 26 criteria, out of which 15 are mandatory criteria. All the mandatory criteria have been taken for the analysis in this study.

Mandatory criteria

A mandatory criterion is one in which it is considered that the quality of health care provided or the safety of people could be at risk within the organization without the evaluation of the processes.

Mandatory criteria are those where a rating of Marked Achievement (MA) or higher is required to gain or maintain ACHS accreditation.

Source: The ACHS EQuIP6 Day Procedure Centre's Guide | Accreditation, Standards and Guidelines

RESEARCH METHODOLOGY

Study Design

Type of Study: Descriptive Observational Study

Location of Study:

Thumbay Hospital Daycare, University Road, Sharjah

Duration of Study:

The duration of this study is 3 months from 24th February 2019 to 20th May, 2019. It included preparation of checklist, data collection and analysis, dissemination of data to fill the gaps and final report compilation.

Means of Data Collection:

1. Primary Data was collected by direct observations, facility rounds and interviews of the key personnel involved.
2. Secondary data was collected by reviewing health records, SOPs, hospital reports, registers and other related documents.

Data Collection Tool:

- **Checklist**: A checklist was prepared including all the elements to be assessed as per the ACHS EQuIP6 Day Procedure Centers Guide.
- **Review of Records**: All the hospital SOPs, documents and health records were reviewed, pertaining to different criteria.
- **Interviews:** Face to face interviews of the key personnel involved were conducted as per the guidelines and requirements.

Methodology of Study:

In this study, gaps were identified as per the checklist by directly observing documentation and implementation on grounds of all the mandatory criteria of the clinical function as per the ACHS EQuIP6 Day Procedure Centre's Guide for initial two months. After identification of the gaps, an action plan was made and some of the gaps were closed by implementing the prepared action plan and post implementation results were analysed.

- LA Rating: Little Achievement. The elements for this rating comply for the Awareness and Documentation of the process.
- SA Rating: Some Achievement. The elements for this rating comply for the Implementation of the process.
- MA Rating: Marked Achievement. The elements in this rating comply only when the implemented processes are evaluated for the effectiveness of outcomes.

Scoring criteria (taken as assumption)
All the elements of each criterion were scored against each rating as:
0 – Not met
5 – Partially met
10 – Met
Compliance to each criterion was measured and areas for improvement were identified and action plan was made to close the identified gaps. Some of them were acted upon and after implementation, the compliance was measured again. The analysis has been done as per the checklist attached in Annexure.

Evaluation Criteria:

- Each Mandatory criterion should achieve Marked Achievement Rating (i.e. LA+SA+MA) or more to get the accreditation.

- 100 percent Compliance to LA, SA and MA elements are must to achieve the accreditation.

OBSERVATIONS & DISCUSSION ON THE FINDINGS

CLINICAL FUNCTION

Standard 1.1

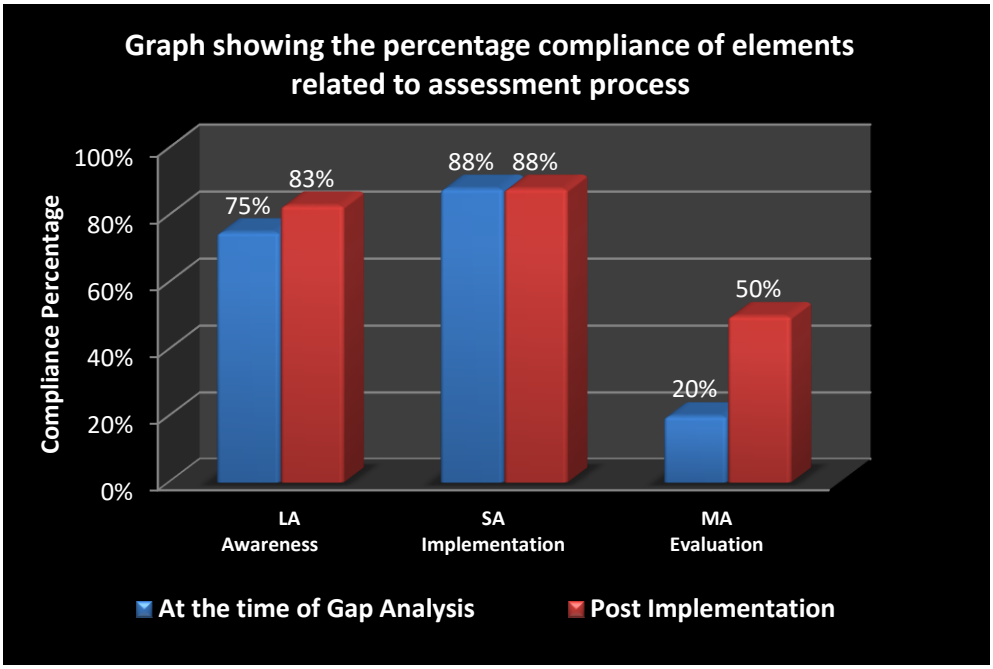
Continuity of Care

The standard is:
Consumers / patients are provided with safe, high quality care throughout the care delivery process.

This standard has 6 mandatory criteria.

Criterion 1.1.1

Assessment process ensures that the current and ongoing needs of the patients are identified.



Graph1: *Compliance Percentage of elements for each category (LA, SA, MA) related to the assessment process in the organization.*

1.1.1 GAPS IDENTIFIED:

1) There is an Assessment process in the hospital including Vitals assessment, Pain assessment and fall risk assessment. However, skin integrity evaluation is not formally included in the patient assessment policy. It is missing in the current assessment process for OPD Patients, but it is present in Initial Assessment Form for Daycare patients.

2) The organization does not have guidelines to identify the physiological/physical, cultural, spiritual and psychological and socioeconomic needs of the patients.

3) The organization does not have a well established regular monitoring and evaluation process to accurately improve the assessment process on timely manner.

4) The organization does not provide information brochures for Patients/ carers – Admission, Preparation for surgery, fall risk Prevention.

5) The organization does not conduct Medical Record Audits at regular intervals for the completeness.

6) The organization has well defined policy for Discharge process but it does not address the discharge of patients including Medico-legal cases.

7) The organization has well defined Discharge process but it does not address the following points :
   - Pickup person
   - travel distance to home
   -'no driving' policy
   - Conditions at home, such as stairs, access to toilet or bedroom

8) The discharge system is not evaluated so that implementation of required changes can be done.

9) The organization does not have an updated service directory of relevant referral health service providers that meet all the patient care needs (including ease of accessibility, timings, cost factor, etc.)

10) A list of relevant health care providers with their contact details is not present to facilitate appropriately directed referral communications.

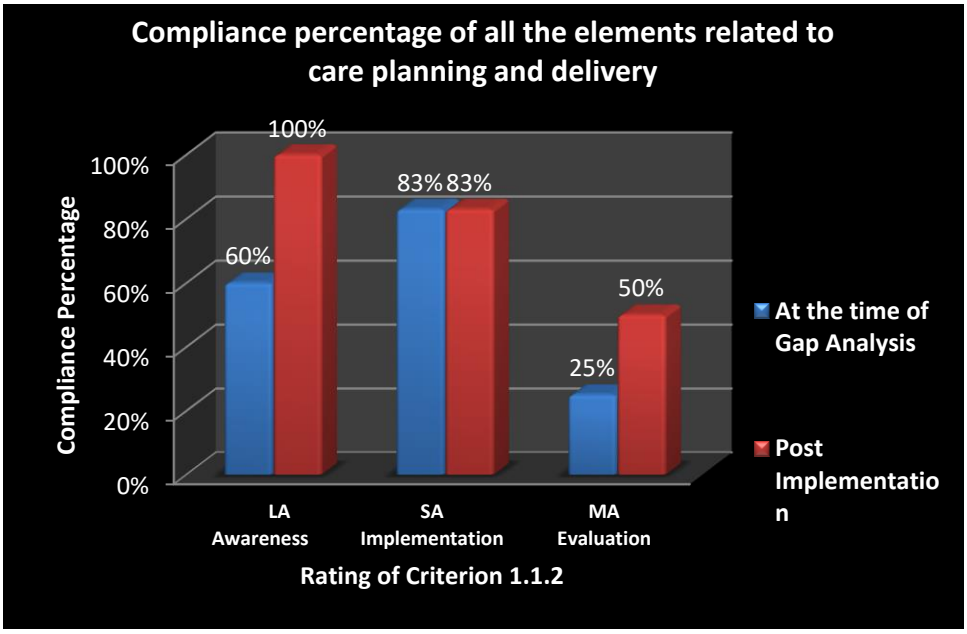
1.1.1. Recommendations or Action Plan to be implemented:

S.No	Action Plan	Status
1)	Formally include Skin Integrity evaluation in the current assessment process by incorporating it in the Patient Assessment Policy and introducing it in EMR as well ensuring that relevant staff are educated in maintaining patient's skin integrity	Incorporated in Policy. Need to be implemented in EMR.
2)	Guidelines to identify the physiological/physical, cultural, spiritual and psychological and socioeconomic needs of the patients should be developed and relevant staff should be trained for assessing these needs of the patients.	To be developed and training to be done
3)	Develop a monitoring and evaluation process to accurately improve the assessment process on timely manner.	To be developed
4)	The organization should provide information brochures for Admission, Preparation for surgery, fall risk Prevention to patients/carers.	To be implemented
5)	Regular medical record audits should be conducted to maintain the compliance.	Conducted
6)	Discharge and handling of Medico Legal Cases should be	To be

	addressed in the Policy on Discharge of Patients.	addressed
7)	The Discharge process should address the following points : - pickup person - travel distance to home -'no driving' policy - conditions at home, such as stairs, access to toilet or bedroom All the points can be included in discharge checklist for proper documentation and implementation.	To be implemented
8)	The discharge system should be evaluated so that implementation of required changes can be done, as and when required. The Discharge system can be evaluated by -conducting clinical audits of the discharge summary and medical record audits of the discharge checklist. -obtaining Feedbacks from patient/carers at the time of discharge or follow up.	To be developed
9)	Updating the directory based on the scope of services catered by different TGAH. The same to be uploaded in HIMS	To be developed
10)	A list of relevant referral health care providers with their contact details should be available in HIMS to facilitate appropriately directed referral communication.	To be implemented

Criterion 1.1.2

Care is planned and delivered in collaboration with the consumer / patient and, when relevant, the carer to achieve the best possible outcomes.



Graph 2: *Compliance Percentage of elements for each category (LA, SA, MA) associated with Care planning and delivery in the organization.*

1.1.2 GAPS IDENTIFIED:

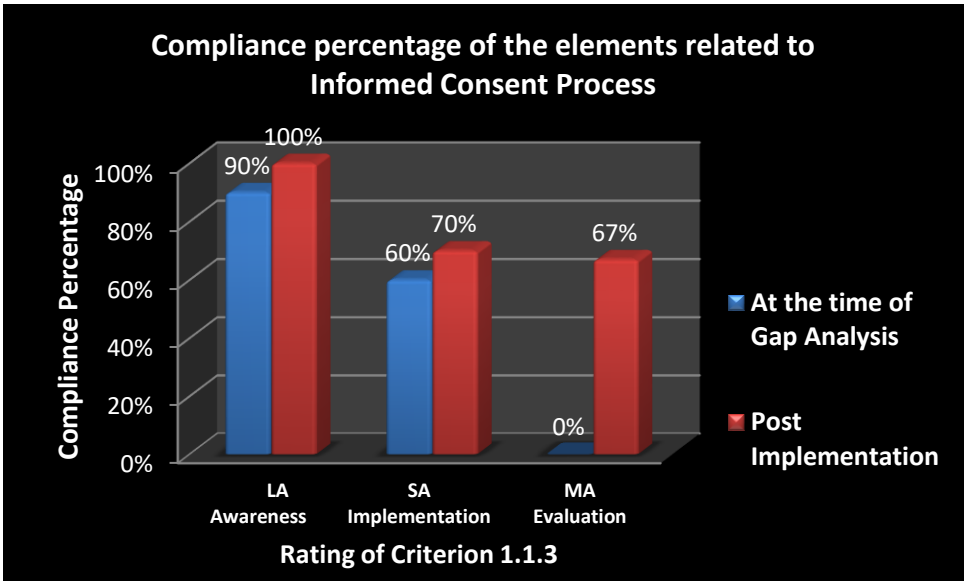
1) The organization does not have well defined clinical guidelines/ pathways which are used in care planning.
2) There is no evaluation process to monitor care planning and delivery.
3) There is no policy existing for mortality management describing appropriate action in the event of a sudden death.
4) There is a system to identify and manage clinical deterioration in consumers/patients which is addressed in Policy on management of deteriorating patients' condition. However, there are no records of formal Education and training is provided to staff about the system to manage deteriorating consumers / patients.

1.1.2 **Recommendations (or Action Plan to close the identified Gaps):**

S.No	Action Plan	Status
1)	The organization will maintain international clinical practice guidelines/clinical pathways to plan care of patients. These should be reviewed and updated regularly as per the requirements or changes in the laws.	Implemented
2)	Evaluation Process to monitor Care Planning and Delivery should be developed: Clinical Audits should be conducted to monitor care planning as per the clinical guidelines. Compliance to adherence of clinical practice guidelines should be regularly monitored.	To be developed
3)	A mortality management policy should be developed describing appropriate action in the event of a sudden death and it should be ensured that all the staff related to managing mortality cases know about the policy. After approval, the policy should be updated in HIMS for easy access to all the staff.	Policy Developed. Need to be implemented through HIMS.
4)	Formal Education and training should be provided to staff about the system to manage deteriorating consumers / patients and training should be assessed and documented.	To be implemented

Criterion 1.1.3

Consumers / patients are informed of the consent process, and they understand their rights and responsibilities and provide consent for their health care.



Graph 3: *Compliance Percentage of elements for each category (LA, SA, MA) related to informed consent process in the organization.*

1.1.3 GAPS IDENTIFIED:

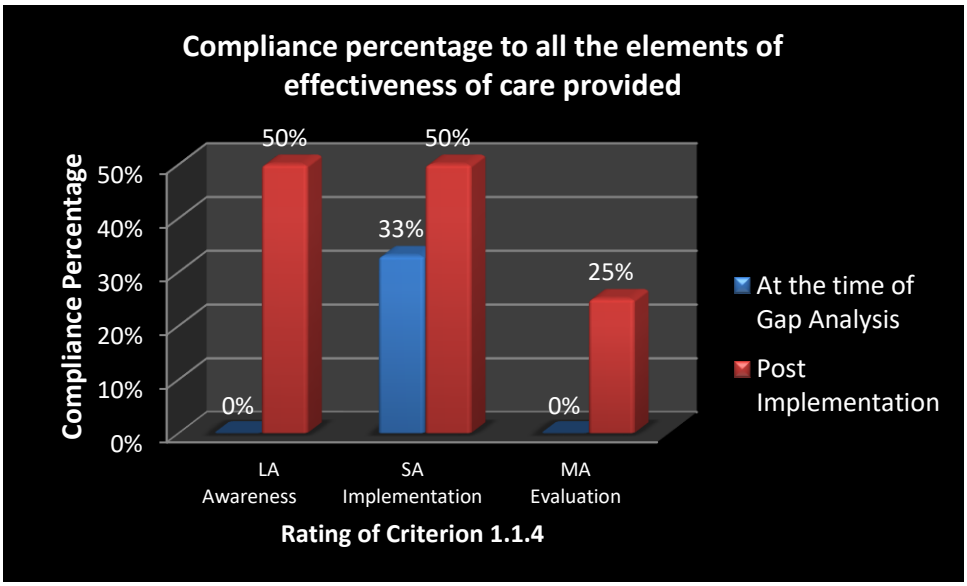
1) The organization has a well developed consent process defined in Informed Consent policy but the consent process is not evaluated to make the required improvements as and when required.
2) Health record audits were not conducted regularly to evaluate the consent process.
3) It was observed that the organization has displayed the Patients' Charter – Patients' rights and responsibilities in languages that are appropriate but it is not provided to consumers/ patients and carers.
4) It was observed that the relevant Staff does not inform patients and discuss with them or their carers' when appropriate about their rights and responsibilities. It was because the Staff was not trained on the same
5) Patients' rights and responsibilities are not informed to the patient and this system of informing is not evaluated to carry out improvements, as required.
6) Privacy and confidentiality policy is not in place.

1.1.3 Recommendations (or Action Plan to close the identified Gaps):

S.No	Action Plan	Status
1)	Compliance with the consent process should be monitored and evaluated so that the strategies for improvement can be identified and implemented, if required.	Implemented
2)	Health record audits should be conducted regularly to evaluate or assess the quality of consent process.	Implemented
3)	The organization has displayed the Patients' Charter – Patients' rights and responsibilities in languages that are appropriate but the charter should also be provided to consumers/ patients and carers.	To be implemented
4)	Staff should be educated and trained about the provisions of Patients' rights and responsibilities to implement the system of informing and discussing patients' rights and responsibilities with patients or their carers.	To be conducted
5)	Patients' rights and responsibilities are not informed to the patient and this system of informing or discussing is important and should be evaluated to carry out improvements, as required.	To be developed
6)	Policy on privacy and confidentiality should be developed and it should be made available to all health professionals, other staff, volunteers and contractors to maintain the privacy and confidentiality of patients' health information and their personal privacy.	Policy Developed

Criterion 1.1.4

Outcomes of clinical care, including individual care episodes and the overall effectiveness of care, are evaluated by healthcare providers.



Graph4: *Compliance Percentage of elements for each category (LA, SA, MA) addressing the criterion related to outcomes of clinical care in the organization*

1.1.4 GAPS IDENTIFIED:

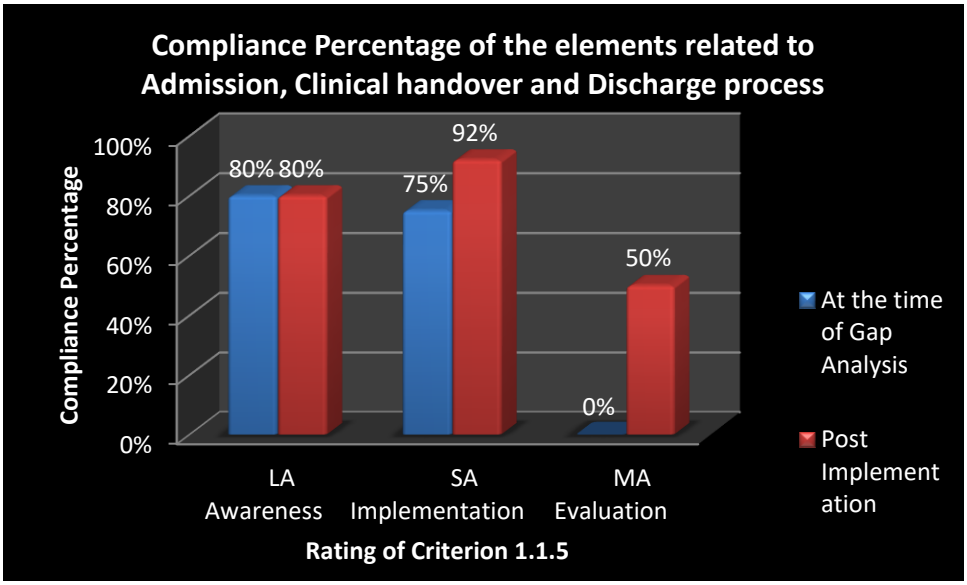
1) Guidelines addressing how the organization assesses the effectiveness of individual care episodes are not developed.
2) There is no process to assess the effectiveness of care and interventions.
3) There is a Process for consumer/patient and carer feedback but it needs to be streamlined for OPD and Daycare patients including the evaluation of the outcome of care or effectiveness of care from the patients' perspective.
4) Clinical care feedback from patients/ carers about clinical care provided to patients is not addressed in the policy or guidelines.

1.1.4 Recommendations (or Action Plan to close the identified Gaps):

S.No	Action Plan	Status
1)	Guidelines addressing how the organization assesses the effectiveness of individual care episodes should be developed and should be made readily available to staff through HIMS. Appropriate evaluation and monitoring of, quality indicators, patient feedback and staff compliance to different clinical pathways should assist the hospitals to accurately assess their patient outcomes and the effectiveness of care and services.	To be developed
2)	Have a process to assess the effectiveness of care and interventions. a. Evaluation of care plans and delivery. b. Audits of clinical pathways/care maps. c. Health professionals should discuss the outcomes of care with the patients and/or their carers prior to discharge and this should be documented. d. Appropriate evaluation and monitoring of, quality indicators, patient feedback and staff compliance to different clinical pathways should assist the hospitals to accurately assess their patient outcomes and the effectiveness of care and services.	To be developed
3)	Feedback from OPD and Daycare patients including the evaluation of the process and outcome of care. - Discharge and ongoing care of the patients should be discussed with patients/carers before leaving. - Feedback should be collected after discharge during follow up visit	To be developed
4)	Policy / guidelines on feedback from patients/ carers about clinical care provided to patients should be developed and be readily available to staff.	To be developed

Criterion 1.1.5

Processes for admission, clinical handover, transfer of care and discharge address the needs of the consumer / patient for ongoing care.



Graph5: Compliance *Percentage of elements for each category (LA, SA, MA) related to the admission, handover and discharge processes in the organization.*

1.1.5 GAPS IDENTIFIED:

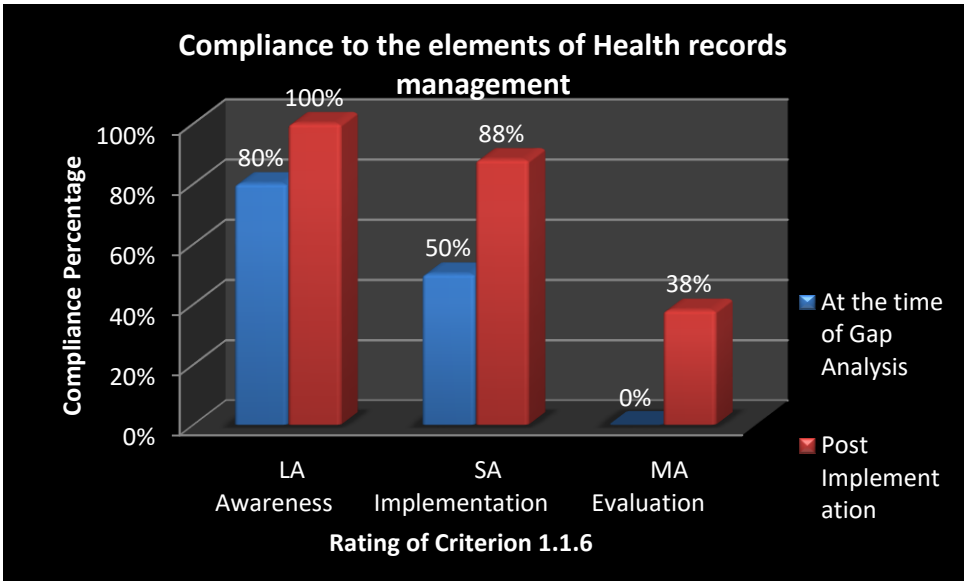
1) Criteria for Inclusion and/or exclusion cases for admission to the service are not clearly defined.
2) It was observed that the staff was not appropriately trained on the systems, software/templates and processes used for clinical handover, transfer of care and discharge.
3) The organization has SBAR-Situation, Background, Assessment, and Recommendation as a reporting system but it is not implemented.
4) Appropriate evaluation process for admission, clinical handover, transfer of care and discharge processes are not in place to allow for required improvements to take place.
5) Follow-up of at-risk consumer is not done formally.
6) Review of adherence to the processes is not done.

1.1.5 Recommendations (or Action Plan to close the identified Gaps):

S.No	Action Plan	Status
1)	A list of patient admission inclusion and exclusion criteria should be developed as per the scope of serviced of the hospital.	To be developed and implemented
2)	Training of the staff should be conducted for the systems/ software used for the process of admission. Discharge and clinical handover.	To be continued
3)	SBAR system (Situation, Background, Assessment, and Recommendation) should be implemented organization wide whenever, clinical handover takes place.	To be implemented
4)	Develop appropriate evaluation process for admission, clinical handover, transfer of care and discharge processes to allow for required improvements to take place.	To be developed
5)	A formal process for follow up of at risk patients should be developed. This can be done by calling the identified patients post discharge.	To be developed
6)	The staff compliance to the adherence of process should be regularly monitored.	To be implemented

Criterion 1.1.6

The health record ensures comprehensive and accurate information is collaboratively gathered, recorded and used in care delivery.



Graph6: *Compliance Percentage of elements for each category (LA, SA, MA) related to management of Health records in the organization.*

1.1.6 GAPS IDENTIFIED:

1) Health professionals are provided with orientation but a regular ongoing education for health record creation and documentation is missing in the organisation's processes.
2) Health record audits are not conducted to monitor the completeness and legibility of the health records.
3) There is no system to monitor compliance with health record creation and documentation policies.
4) Health records are not evaluated to ensure about meeting medico legal requirements, documentation, guidelines and/or codes of practice, and improvements are made as required.
5) Evaluation of Health records is not done to ensure that the clinical content supports safe, quality care to make the improvements.
6) Health records are not evaluated for their legibility and completeness.
7) Timeliness of reports and review of information, tests and other clinical investigations is not evaluated, and improvements are made as required.

1.1.6 Recommendations (or Action Plan to close the identified Gaps):

S.No	Action Plan	Status
1)	Health professionals should be provided with orientation and ongoing education for health record creation and documentation. Orientation, training or review programs should be an ongoing process.	To be conducted again
2)	Health record Audits should be conducted in a proper way to improve quality of the documentation process in the hospital. • Health records are monitored for completeness and legibility, including: (i) the readability of written and printed material (ii) the use of black or blue ink (iii) for clarity of scans / photocopies (iv) the use of approved abbreviations only (v) no blank areas are left • Results of Health record audits should be communicated to staff and Training can be given to all the staff involved or training materials can be developed.	Implemented
3)	A system to monitor compliance with health record creation and documentation policies should be conducted by medical record audits.	To be developed
4)	Health records should be evaluated to ensure medico legal requirements, documentation, guidelines and/or codes of practice, so that improvements are made as required.	To be evaluated
5)	Evaluation of Health records should be done to ensure that the	To be

	clinical content supports safe, quality care to make the improvements.	evaluated
6)	Health records should be evaluated for their legibility and completeness.	Implemented
7)	Timeliness of reports and review of information, tests and other clinical investigations is not evaluated, so that improvements can be made as required.	To be implemented

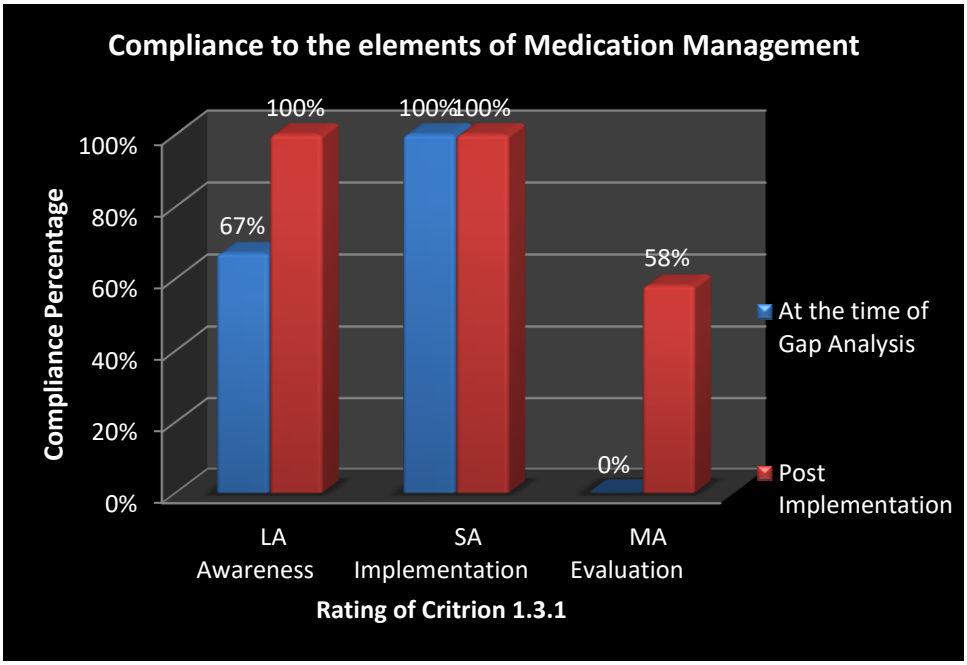
Standard 1.3

Safety Standard: The organization provides safe healthcare services to the patients.

This standard has two mandatory criteria.

Criterion 1.3.1

Medication management systems support the safe and effective use of medicines.



Graph7: *Compliance Percentage of elements for each category (LA, SA, MA) related to Medication management system in the organization.*

1.3.1 GAPS IDENTIFIED:

1) Policy / guidelines for standardized medication management system including the medication safety plan is not in place and not available to staff.
2) The organization-wide medication management system is not evaluated.
3) Medication documentation is not evaluated.

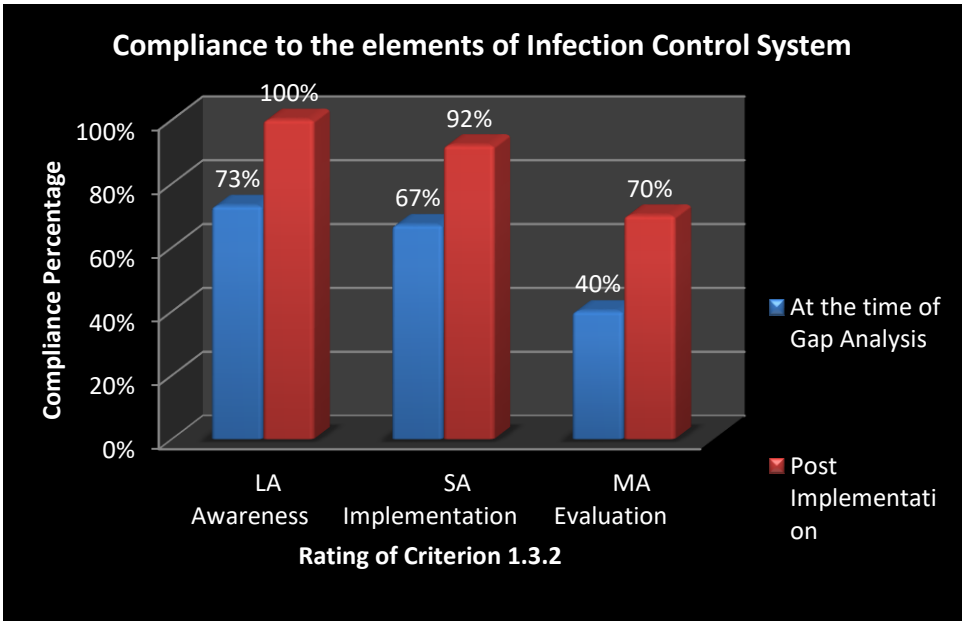
4) The system for distribution, storage and disposal of medications is not evaluated.
5) Medication incidents including near misses and adverse drug reactions are not analysed.
6) Education and training in medication management are not evaluated.
7) The information and education provided for consumers / patients and carers is not evaluated.

1.3.1 <u>Recommendations (or Action Plan to close the identified Gaps):</u>

S.No	Action Plan	Status
1)	Policy / guidelines for standardized medication management system including the medication safety plan should be developed and made available to all the staff through HIMS.	Policy Developed
2)	The organization-wide medication management system should be evaluated by conducting regular audits and improvements should be carried out as required. Audits of : • Standardized medication documentation and abbreviations • Medication error rates • Adverse reaction rates • Prescribing choices Medication usage / wastage Regular audits should be conducted to ensure that health professionals prescribing medications comply with current best-practice guidelines	Audits to be conducted
3)	Medication documentation is evaluated through medical record audits. Audit findings should be disseminated to the respective health professionals to improve the documentation process.	Implemented
4)	The system for distribution, storage and disposal of medications should be evaluated through facility rounds of the medication system and regular checks by pharmacist. Store, transport and distribute medications safely. - There is a process to monitor and audit staff compliance with policy and procedure, and appropriate remedial action is ensured in the event of non-compliance.	Implemented
5)	Medication incidents, near misses and adverse drug reactions should be reported and analyzed and further strategies to reduce medication errors or incidents related to medications should be made and implemented. Medication error rate, adverse drug reactions reporting system should be in place.	Implemented
6)	Education and training in medication management should be evaluated through staff interviews and improvements should be made as required.	Implemented
7)	The information and education provided for consumers / patients and carers should be evaluated.	

Criterion 1.3.2

The infection control system supports safe practice and ensures a safe environment for consumers / patients and healthcare workers.



Graph 8: *Compliance Percentage of elements for each category (LA, SA, MA) related to Infection Control system in the organization.*

1.3.2 GAPS IDENTIFIED:

1) Policy / guidelines addressing infection control including the infection control plan is present but it doesn't address the following:

- Antimicrobial stewardship and appropriate use of antibiotics
- Notifiable diseases
- Outbreak management

2) Health professionals and other staff are not provided with orientation/training and ongoing education about infection risks and their responsibilities in preventing infection.
3) Strategies for prevention of any infection are not incorporated at all stages of planning including facility or hospital planning, construction or renovation.
4) Infection risks, control strategies and safety requirements are not communicated to consumers / patients and carers.
5) Compliance with the infection control policy / guidelines is not monitored and evaluated.
6) The infection control system, including all aspects of the infection control plan, is not evaluated.
7) Maintenance and monitoring of environmental factors relevant to infection control are

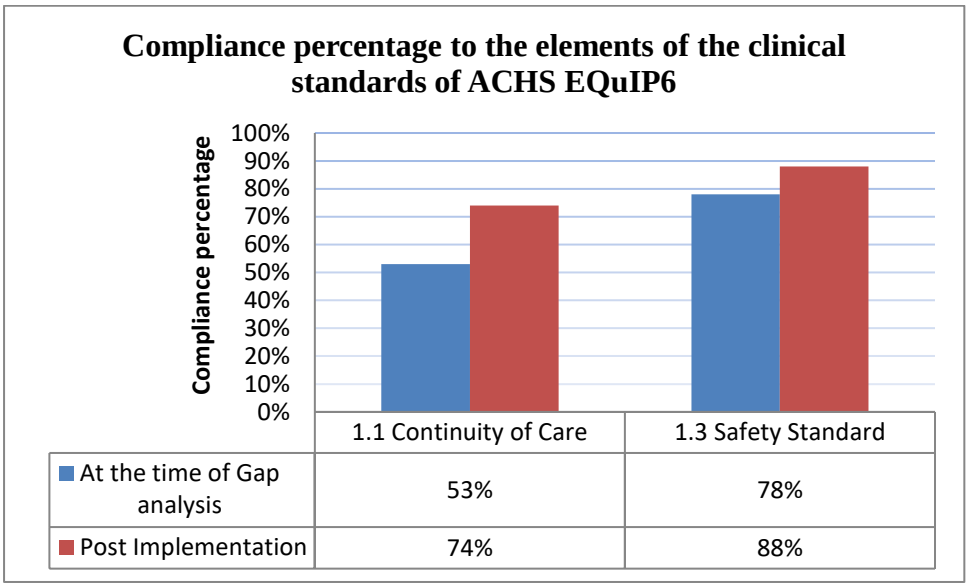
not evaluated.

1.3.2 Recommendations (or Action Plan to close the identified Gaps):

S.No	Action Plan	Status
1)	Policy / guidelines addressing the infection control plan including including the following points should be developed should be developed. • Antimicrobial stewardship and appropriate use of antibiotics • Notifiable diseases • Outbreak management	Policy Developed
2)	Health professionals and other staff should be provided with orientation and ongoing education about infection risks and their responsibilities in preventing infection.	Training conducted
3)	Strategies for prevention of any infection should be developed and incorporated at all stages of planning including facility or hospital planning, construction or renovation.	Developed
4)	Infection risks, control strategies and safety requirements should be communicated to consumers / patients and carers through information brochures or pamphlets and education material displayed around the hospital. Hand hygiene demo classes were conducted for patients providing the hand hygiene brochures.	Implemented
5)	Compliance with the infection control policy / guidelines should be monitored and evaluated	To be implemented
6)	The infection control system, including all aspects of the infection control plan, should be evaluated through various audits like laundry visits, hand hygiene audits, antibiotic program.	Implemented
7)	Maintenance and monitoring of environmental factors relevant to infection control should be evaluated. It can be done through facility rounds focusing on the environmental factors.	To be implemented

RESULTS:

The overall compliance percentage of the hospital to all the criteria was 53% for 'Continuity of care standard' and 78% for 'safety standard'. Some of the gaps were filled and post implementation, the compliance percentage increased to 74% for 'Continuity of care standard' and 88% for 'safety standard'.



Graph: *Compliance percentage of mandatory criteria of clinical standards as per ACHS EQuIP6 guidelines.*

CONCLUSION

Gap analysis of the Daycare hospital helped the Quality Department to identify the gaps and working towards the closure of identified gaps as the first step to finally achieve the ACHS Accreditation.

Major Gaps were identified and some of the gaps were closed by implementing the action plan developed for the identified gaps. Major Policies have been drafted but some of the gaps still need to be closed.

The daycare hospital is approximately 60 – 70% compliant to the LA and SA category but there were lapses observed in specifically the MA category as the compliance percentage to the elements to achieve MA rating was approximately 30%. With the implementation of some action plans, some gaps have been filled and compliance percentage has increased to approximately 80% for the clinical function. As per ACHS, it is mandatory to achieve Marked Achievement (MA) in all the mandatory criteria. So, the organization needs to develop and implement the Evaluation processes for the policies and processes to comply to the elements in order to achieve accreditation. The daycare hospital needs to close all other identified gaps and achieve 100% compliance in order to fulfill the accreditation requirements.

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- www.achs.org.au
- https://www.achs.org.au/programs-services/nsqhs-standards-2nd-edition/
- https://www.achs.org.au/media/46775/national_standards_gap_analysis_report_n51_orgs_website_commentary1.pdf
- https://accred.ha.org.hk/hosp_accred/overview/130125_Report%20on%20Pilot%20Scheme%20of%20Hospital%20Accreditation.pdf

ANNEXURE

Standard 1.1: Consumers / patients are provided with safe, high quality care throughout the care delivery process.					
Rating	**ELEMENTS**	**Criterion (Met/Partially Met/Not Met)**	**Gaps found (if any)**	**Post Implementation Score**	**Action Taken**
Criterion 1.1.1 **Assessment ensures current and ongoing needs of the consumer / patient are identified.**					
LA	a)The organization has well defined Registration and Admission Process. The registration process includes all the necessary details that provide a comprehensive overview of the patient.	10		10	
	b) The organization has well defined Assessment process.The organization defines the content of the assessments for the out-patients, day care patients and emergency patients.	10		10	
	c) Guidelines to direct the assessment of the physical, spiritual, cultural, psychological and social needs of consumers/patients are readily available to the staff.	0	No Guidelines	5	Guidelines prepared, included in the required forms. Staff need to be trained.
	d) Guidelines are available on the specific needs of vulnerable consumers/patients and population groups.	10		10	
	e) Referral Systems to other relevant health service providers are in place.	10		10	
	f) Healthcare providers use a formal risk assesment process to assess skin integrity and risk of falls of patients/consumers.	5	Fall risk assessment is done but skin integrity assessment is not documented	5	Skin Integrity process included. Training will be conducted.
	LA	75%		83%	
SA	a) Consumers/ Patients are involved in the assessment	10		10	

	process. The organization has an effective approach to involve patient in their initial admission assessment to ensure appropriate management as per patient's care needs and expectations				
	b) A support person/ carer is involved in assessment whenever practicable.	10		10	
	c) Planning for transfer of care/ discharge commences at assessment, is multidisciplinary when necessary, and coordinated.	10		10	
	d) Relevant staff are educated in performing assessment process including maintaing skin integrity and falls risk prevention and management.	5	Training to be conducted	5	Training to be conducted
	SA	88%		88%	
MA	a) The assessment process is evaluated and improvements are made as required.	0	No process of evaluation	5	Fall risk quality indicator, incident management system, regular audits
	b) Processes for identifying, assessing and managing vulnerable consumers/ patients and groups are evaluated, and improvements are made as required.	10		10	
	c) Planning for transfer of care/discharge is evaluated to ensure that it: (i) routinely occurs (ii) is multidisciplinary when required (iii) includes referral to specialty services when required (iv) meets consumer/ patient and carer needs.	0	No process of evaluation	0	
	d) Referral Systems are evaluated, and improvements are made as required.	0	No process of evaluation	5	Process developed, need to be implemented

	e)The discharge system is evaluated and implementaion of required changes is done.	0	No process of evaluation	5	Process developed, need to be implemented
	MA	20%		50%	
Criterion 1.1.2 Care is planned and delivered in collaboration with the consumer / patient and, when relevant, the carer to achieve the best possible outcomes.					
LA	a) Guidelines for care planning and delivery are based on current professional standards and evidence-based practice, and are readily available to staff.	0	Clinical practice guidelines are not available	10	Clinical practice guidelines submitted by the HODs.
	b) Care planning addresses the specific needs of vulnerable consumers / patients and population groups.	10		10	
	c) Care is provided in response to consumer / patient needs in a timely manner and in accordance with relevant policy / guidelines.	10		10	
	d) There is a system to identify and manage clinical deterioration in consumers / patients.	10		10	
	e) A policy exists for mortality management which is consistent with legislation, common law and policy.	0	No policy on mortality management	10	Policy developed
	LA	60%		100%	
SA	a) Care planning and delivery are based on the assessment of consumer / patient needs, in partnership with the consumer / patient and their carer.	10		10	
	b) Care is coordinated, planned and delivered by skilled and trained health professionals within a multidisciplinary team with an identified team leader.	10		10	
	c) Care planning, decisions, actions and changes are documented in the consumer / patient health record, and are regularly reassessed.	10		10	

	d) The consumer / patient is regularly informed about their health status, and provided with information that allows them to understand their care, care delivery options, and changes to their care plan.	10		10	
	e) Relevant health professionals and staff are trained in medical emergency first response techniques.	10		10	
	f) Relevant staff are educated about the mortality management policy	0	No training	0	Training to be conducted
	SA	83%		83%	
MA	a) Compliance with guidelines and practices for care planning and delivery is monitored and evaluated, and improvements are made as required.	0	No process of evaluation	5	Process developed, need to be implemented
	b) The care planning and delivery process is evaluated, and improvements are made as required.	0	No process of evaluation	5	Process developed, need to be implemented
	c) The system to identify and manage deteriorating consumers / patients is evaluated, and improvements are made as required.	0	No process of evaluation	0	Evaluation Process to be developed
	d) Evaluation of consumer / patient satisfaction including satisfaction with the environment in which care was received	10		10	
	MA	25%		50%	
Criterion 1.1.3 **Consumers / patients are informed of the consent process, and they understand their rights and responsibilities and provide consent for their health care**					
LA	a) Policy / guidelines addressing consent are consistent with relevant legislation, standards, guidelines and/or codes of practice, and are readily available to staff.	10		10	
	b) Health professionals are educated about the consent policy / guidelines and how to obtain	10		10	

	informed consent.				
	c) Consumers / patients and carers are provided with information on recommended investigations, treatment or procedures, the risks involved and the costs, in appropriate formats / languages.	10		10	
	d) Policy / guidelines / charters addressing consumer / patient rights and responsibilities are consistent with relevant legislation, standards, guidelines and/or codes of practice, and are readily available to staff.	10		10	
	e) The procedure for consumer access to their health records is documented and communicated to consumers / patients.	5	Training to be conducted	10	Training conducted
	LA	90%		100%	
SA	a) Consent is obtained for investigations, treatments or procedures and any associated costs, and for the communication of consumer / patient information, in accordance with the organisation's policy / guidelines.	10		10	
	b) There is a process to manage: (i) when consent cannot be given at the appropriate time (ii) when the consumer / patient does not have the capacity to provide consent (iii) provision of consent by someone other than the consumer / patient (iv) the limits of consent.	10		10	
	c) The organisation provides consumers / patients and carers with a copy of the rights and responsibilities document.	0		5	Document developed, need to be implemented.
	d) Staff discuss rights and responsibilities with the consumer / patient and when appropriate, their carer.	0		0	Training to be conducted, need to be implement

					ed.
	e) All staff sign confidentiality agreements	10		10	
	SA	60%		70%	
MA	a) The consent process is evaluated, and improvements are made as required.	0	no evaluation process	10	Evaluation Process developed and medical record audits conducted.
	b) Compliance with the consent process is monitored and evaluated, and strategies for improvement are identified and implemented as required.	0	no evaluation process	10	Evaluation Process developed and medical record audits conducted.
	c) The system to inform consumer / patient rights and responsibilities is evaluated and improvements to documents and practices are made as required.	0	no evaluation process	0	Evaluation Process to be developed
	MA	0%		67%	
Criterion 1.1.4 Outcomes of clinical care, including individual care episodes and the overall effectiveness of care, are evaluated by healthcare providers.					
LA	**a)** Guidelines addressing how the organisation assesses the effectiveness of individual care episodes are readily available to staff	0	No Guidelines	0	
	b) The organization has well defined Evidence-based policies and clinical practice guidelines	0	No Clinical practice guidelines	10	Clinical practice guidelines submitted by the HODs.
	c) Policy / guidelines for providing feedback about clinical care to consumers / patients and carers are readily available to staff.	0	No policy	5	Need to be included in the patient feedback policy

	d) Consumers / patients and carers are informed of how to give feedback on the care provided	0	No training	5	Tra
	LA	0%		50%	
SA	a) Formal processes are implemented across the organisation for the review of clinical care.	0	No process	0	
	b) Prior to discharge, health professionals discuss the outcomes of care with the consumer / patient and their carer, and this is documented.	10		10	
	c) Feedback is sought from consumers / patients and carers regarding the delivery of care and services	0	Feedback is taken but not regarding the delivery of care and services.	5	Feedback process developed, need to be implement ed.
	SA	33%		50%	
MA	a) Individual and group consumer / patient care and outcomes data (including 'at risk' patients) are evaluated and improved as required.	0	No Evaluation process	0	
	b) The results of organisation-wide clinical audits are reviewed by relevant health professional groups and used to support the evaluation and improvement of health care.	0	No clinical audits	0	
	c) Consumers / patients and when appropriate, carers participate in the evaluation of care.	0	No evaluation process	5	Process developed, need to be implement ed
	d) Feedback from consumers / patients and carers informs the organisation's evaluation of the effectiveness of its care and services.	0	No process	5	Process developed, need to be implement ed
	MA	0%		25%	

Criterion 1.1.5 Processes for admission, clinical handover, transfer of care and discharge address the needs of the consumer / patient for ongoing care					
LA	a) P olicy / guidelines addressing admission, clinical handover, transfer of care and discharge are readily available to staff.	10		10	
	b) The organisation has clear inclusion and/or exclusion criteria for admission to the service	0	Citreria to be developed	0	Citreria to be developed
	c) Results of investigations follow the consumer / patient through the referral system.	10		10	
	d) Arrangements with other health service providers and the carer are made with consumer / patient consent and input, and confirmed prior to transfer of care or discharge.	10		10	
	e) Discharge information is recorded in the consumer / patient health record.	10		10	
	LA	80%		80%	
SA	a) Processes for admission, transfer of care and discharge ensure continuity of care and timely notification between referrers and health service providers.	10		10	
	b) There is an effective, organisation- wide system for admission, clinical handover within the organisation, which ensures that all necessary information about the consumer / patient is communicated.	10		10	
	c) The organization has consistent reporting systems, such as SBAR (Situation, Background, Assessment, Recommendation)	5		10	Process implement ed
	d) There is evidence to demonstrate that external health service providers receive timely notification about consumers / patients discharged to their care.	10		10	
	e) Discharge information is discussed with the consumer / patient and the carer, and a	10		10	

	discharge summary is provided.				
	f) Formalised follow-up occurs for at-risk consumers / patients	0		5	Process developed, need to be implemented
	SA	75%		92%	
MA	a) T he processes for admission, clinical handover, transfer of care and discharge are evaluated, and improvements are made as required.	0	No evaluation process	5	Evaluation process deveped, need to be implemented
	b) The system for providing discharge and referral information to consumers / patients and external health service providers is evaluated, and improvements are made as required.	0	No evaluation process	5	Evaluation process deveped, need to be implemented
	c) The system for follow-up of at-risk consumers / patients is evaluated, and improvements are made as required.	0	No evaluation process	5	Evaluation process deveped, need to be implemented
	MA	0%		50%	
Criterion 1.1.6 **The health record ensures comprehensive and accurate information is collaboratively gathered, recorded and used in care delivery**					
LA	a) Policy / guidelines addressing health record documentation are consistent with relevant legislation, standards, guidelines and/or codes of practice, and are readily available to staff.	0	No policy	10	Policy developed
	b) Every consumer / patient has a health record with a recognised unique identifier.	10		10	
	c) Health professionals are provided with orientation and ongoing education in the organisation's processes for health record creation and documentation.	10		10	

	d) Authorised internal and external health professionals have access to information about the consumer / patient in accordance with relevant privacy legislation.	10		10	
	e) Consumers / patients are provided with information on how to access their health records.	10		10	
	LA	80%		100%	
SA	a) There is a system to monitor compliance with health record creation and documentation policies.	0	No process of evaluation	5	Process developed, need to be implement ed
	b) Health professionals use the health record to document and communicate all aspects of care delivery in accordance with the organisation's policy / guidelines.	10		10	
	c) Health records are monitored for completeness and legibility, including: (i) the readability of written and printed material (ii) the use of black or blue ink (iii)for clarity of scans / photocopies (iv) the use of approved abbreviations only (v) that no blank areas are left	0	No monitoring	10	Medical record audits conducted
	d) Results of reviews and clinical consultations are made available to health professionals at the point of consumer / patient care	10		10	
	SA	50%		88%	
MA	a) Health records are evaluated to ensure that they meet medico-legal requirements, professional documentation standards, guidelines and/or codes of practice, and improvements are made as required.	0	No evaluation process	5	Process developed, need to be implement ed
	b) Health records are evaluated to ensure that the clinical content supports safe, high quality care, and improvements are made as required.	0	No evaluation process	0	

	c) Evaluation of the completeness and legibility of the health record is addressed through the use of audits, and improvements are made as required.	0	No evaluation process	10	Audits conducted
	d) Timeliness of inclusion of reports and information from reviews, tests and other clinical investigations into the health record is evaluated, and improvements are made as required.	0	No evaluation process	0	
	MA	0%		38%	
		53%		78%	
1.3 Safety Standard : The organisation provides safe care and services					
Criterion 1.3.1 **Medication management systems support the safe and effective use of medicines.**					
LA	a) Policy / guidelines for medication management are consistent with relevant legislation, standards, guidelines, and/or codes of practice, and are readily available to staff.	0	No Guidelines	10	Policy developed
	b) Health professionals have access to published guidelines for medication management.	0	Guidelines not updated in HIMS	10	Updated on HIMS
	c) A standardised list of approved abbreviations for medications is used throughout the organisation.	10		10	
	d) Medication documentation is in an appropriate and standardised format throughout the organisation.	10		10	
	e) Medications, including temperature-sensitive medications, are distributed, stored and disposed of securely and safely in accordance to manufacturer's instructions, legislation and organisational guidelines.	10		10	
	f) Written and verbal information is provided to consumers / patients about their new	10		10	

	medications.				
	LA	67%		100%	
SA	a) A standardised system for medication management, including the safe use of high-risk medications, is implemented throughout the organisation.	10		10	
	b) Procedures are implemented to reduce the risk and severity of medication incidents.	10		10	
	c) The organisation supports health professionals, consumers / patients and carers in the identification and reporting of medication incidents, near misses and adverse drug reactions.	10		10	
	d) Health professionals are trained in medication management practices relevant to their role and responsibilities.	10		10	
	e) Education is available for consumers / patients and their carers about prescribed medications, to encourage ongoing safe use of medications and compliance after discharge	10		10	
	SA	100%		100%	
MA	a) The organisation-wide medication management system is evaluated, and improvements are made as required.	0	No evaluation process	5	Process developed, need to be implemented
	b) Medication documentation is evaluated, and improvements are made as required.	0	No evaluation process	10	Medical record audits conducted
	c) The system for distribution, storage and disposal of medications is evaluated, and improvements are made as required.	0	No evaluation process	10	Process implemented
	d) Medication incidents, near misses and adverse drug reactions are analysed and trended, and further strategies to reduce	0	No evaluation process	10	Process implemented

	medication incidents are implemented.				
	e) Education and training in medication management are evaluated in consultation with relevant staff, and improvements are made as required.	0	No evaluation process	0	
	f) The information and education provided for consumers / patients and carers is evaluated, and improvements are made as required.	0	No evaluation process	0	
	MA	0%		58%	
Criterion 1.3.2 **The infection control system supports safe practice and ensures a safe environment for consumers / patients and healthcare workers**					
LA	a) Policy / guidelines addressing infection control are consistent with relevant legislation, standards, guidelines and/or codes of practice, and are readily available to staff.	10		10	
	b) The infection control plan includes:	-		-	
	(i) hand hygiene and aseptic technique	10		10	
	(ii) antimicrobial stewardship and appropriate use of antibiotics	0	No policy	10	Policy developed
	(iii) notifiable diseases	0	No policy	10	Policy developed
	(iv) outbreak management	0	No policy	10	Policy developed
	(v) transmission precautions and occupational exposure prevention and management	10		10	
	(vi) sharps management	10		10	
	(vii) sterilisation and reprocessing of instruments and devices.	10		10	
	c) The infection control plan addresses environmental factors, including:	-		-	
	(i) cleaning services	10		10	

	(ii) food safety and kitchen cleaning	NA		NA	
	(iii) linen handling and laundry services	10		10	
	(iv) relevant equipment and plant.	10		10	
	d) The infection control plan is approved, supported and properly resourced by management.	10		10	
	e) Health professionals are supplied with equipment and an environment that enables them to comply with the infection control policy / guidelines.	10		10	
	f) Health professionals and other staff are provided with orientation and ongoing education about infection risks and their responsibilities in preventing infection.	0	No training	10	Training conducted
	g) External service providers, students and visitors are advised of the organisation's infection safety requirements	10		10	
	LA	73%		100%	
SA	a) The infection control system, including the infection control plan, is managed and monitored by a multidisciplinary infection control committee and/or team.	10		10	
	b) Infection prevention strategies are integrated into all stages of healthcare planning, including health facility planning, construction and refurbishment.	10		10	
	c) There is a planned and documented schedule of regular maintenance and/or monitoring of the environmental factors associated with infection control.	10		10	
	d) There are documented risk reduction and containment measures for identified infections.	10		10	
	e) Health professionals and other staff are trained in infection prevention and control strategies relevant to their role and	0	No training	10	Training conducted

	responsibilities.				
	f) Infection risks, control strategies and safety requirements are communicated to consumers / patients and carers.	0	No communication	5	Information materials developed
	SA	67%		92%	
MA	a) Compliance with the infection control policy / guidelines is monitored and evaluated, and improvements are made as required.	0	No evaluation process	5	Process developed, need to be implemented
	b) The infection control system, including all aspects of the infection control plan, is evaluated, and improvements are made as required.	0	No evaluation process	5	Process developed, need to be implemented
	c) Maintenance and monitoring of environmental factors relevant to infection control are evaluated, and improvements are made as required.	0	No evaluation process	5	Process developed, need to be implemented
	d) Education and training in infection prevention and control are evaluated in consultation with relevant staff, and improvements are made as required.	10		10	
	e) The effectiveness of communication of infection risks, control strategies and safety requirements to consumers / patients, carers, visitors, students and external service providers is evaluated, and improvements are made as required	10		10	
	MA	40%		70%	