

Analysis of Hospital Performance Based on Quality Indicators

By

Aditi Bhatnagar

*Dissertation submitted in partial fulfillment of the requirements of the degree
MBA Hospital and Health Management*

Academic year, 2017-2019



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TO WHOMSOEVER MAY CONCERN

This is to certify that **Dr. Aditi Bhatnagar**, student of MBA Hospital and Health Management from The IIHMR University, Jaipur has undergone internship training at CK Birla Hospital, Jaipur from **4th February 2019 to 3rd 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 fulfilment of the course requirements.

I wish him all success in all her future endeavours.



Col.(Dr.) Ashok Kaushik

Dean, Academics and Student Affairs

The IIHMR University, Jaipur



Dr. P R Sodani

Pro- President

The IIHMR University, Jaipur

RBH/2019/May/HRD/262

Date:- 8th May 2019

To whom so ever it may concern

This is to certify that Ms. Aditi Bhatnagar has successfully completed her internship training in Quality department from 04th Feb. 2019 to 03 May 2019.

We found her sincere, punctual & hardworking. We wish her every success in her future and career.



Anupama Sharma

Head – HR & Training

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled "**Analysis of Hospital Performance based on quality indicators**" and submitted by **Dr. Aditi Bhatnagar** Enrolment No IIHMR-U/01/2017-19/0525 under the supervision of **Dr. P R Sodani** for award of MBA in Hospital and Health Management in Health and Hospitals of the University carried out during the period from **4th February 2019 to 3rd 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

THE IIHMR UNIVERSITY, JAIPUR
CERTIFICATE BY SCHOLAR

This is to certify all ethical issues have been considered while collecting data for my dissertation titled "Analysis of Hospital Performance based on Quality Indicators" at CK Birla Hospital, Jaipur. (February 2019).

A handwritten signature in blue ink, appearing to read 'Aditi', with a stylized flourish extending from the end.

Signature of student

Abstract

Title- Analysis of Hospital Performance based on Quality Indicators

Author- Dr. Aditi Bhatnagar

Objective- To determine the compliance of various quality indicators being measured for the continuous quality improvement in Rukmani Birla Hospital , Jaipur as directed by the NABH and the main reasons for outliers through collecting and compiling the data for various Key Performance Indicators, doing trend analysis of the same for 9 months from June 2018 to February 2019..

Methods- A descriptive analysis of the data was carried out including observation of the current trends and outliers present for the deviations. Secondary data was collected from the source through departmental manuals, HMIS, capture sheets , NABH guidelines and record registers. The research approach being implemented was quantitative in nature to determine the average trend being followed by the various parameters and any sudden changes in the trend with causes for the same. The analysis including collection, compilations and evaluation was done in period from February 4th to May 3rd, 2019. The departments included were- Emergency, Radiology, Nursing, Infection Control, IPD & IPE, ICU, Human Resource, Security.

Results - Compliance was considered before collecting the data and after compilation of the data. It was found that only two departments were 100% compliant before and after with respect to the data management according to NABH. All the other departments had initially low compliance which were made to work up and increase their compliance to maximum. There have been 6 indicators which have shown deviation once from the internal set target where as 9 indicators which have shown multiple deviations. The reasons for outliers leading to the deviations have been taken by the concerned departments.

Conclusion- Going through the various indicators of multiple departments, it was found that the hospital follows a strict adherence to the standards laid down by the NABH .But there were a few short comings, none of them being major, which can be corrected by giving necessary training to the concerned staff and strict implementation of the same. The analysis was found to be more than satisfactory which in turn defines continuous progress towards achieving the best.

KEYWORDS- Indicators, Compliance, Trend analysis, Observation, Departments, Quality, Continuous Improvement, Implementation, Deviations, Discrepancies, Internal Target

Acknowledgment

The Dissertation opportunity with Rukmani Birla Hospital, Jaipur was a great chance for learning and professional development. I am also grateful for having a chance to meet so many wonderful people and professionals who led me through this dissertation period.

I am highly grateful and would like to express my deepest gratitude and special thanks to **Dr. Pracheesh Prakash**, Unit Head, Rukmani Birla Hospital, Jaipur and **Dr. Vikram Singh Chouhan** , Medical Superintendant, who in spite of being extraordinarily busy with their duties, took time to guide and keep me on the correct path while arranging all facilities to make the project fruitful and allowing me to work at this esteemed organisation. I choose this moment to acknowledge their contribution.

I would like to extend my gratitude to **Dr. Sneha Mishra**, Assistant Manager medical admin and **Dr. Prerna Jain**, Senior executive medical admin for being the buddy throughout the project and extending their support at their maximum capacity for the completion of the dissertation.

I would also like to thank all the staff of medical admin and operation team to make this project a success.

I perceive this opportunity as a big milestone in my career development. I will strive to use gained skills and knowledge in the best possible way.

I would also like to thank my mentor **Dr. P R Sodani**, Pro-President, IIHMR University for his constant supervision and support in completing the project.

Sincerely,

Dr. Aditi Bhatnagar

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Abbreviations

OT	Operation Theatre
CT	Computed Tomography
MRI	Magnetic Resonance Imaging
OPD	Out Patient Department
MICU	Medical Intensive care unit
ICCU	Intensive Coronary Care Unit
SICU	Surgical intensive care unit
KTU	Kidney transplant unit
NICU	Neonatal intensive care unit
ER	Emergency
USG	Ultrasonography
BMD	Bone Mineral Density
PFT	Pulmonary Function Test
ECG	Electrocardiogram
EEG	Electroencephalogram
PCS	Patient Care Services

TQM	Total Quality Management
CQI	Continuous Quality Improvement
LOS	Length of Stay
BOR	Bed Occupancy Rate
TPA	Third Party Administrator
HAI	Hospital Acquired Infection
NABH	National Accreditation Board for Hospital and Health care Providers
IPE	In Patient Experience
MRD	Medical Record Department
BME	Bio Medical Engineering
F & B	Food & Beverages
CAUTI	Catheter Associated Urinary Tract Infection
CLABSI	Central Line Associated Blood Stream Infection
VAP	Ventilator Associated Pneumonia
SSI	Surgical Site Infection
HMIS	Health Management Information System

Introduction

Quality management seeks to improve effectiveness of treatments and increase patient satisfaction with the service. With an aging population and rising health care costs, quality management in health care is gaining increased attention. A health care system comprises small and large entities, such as pharmacies, medical clinics and hospitals, and all components need to provide quality service for the system to work properly. Effective quality management is focused on the needs of the patients because they are the ones who judge the effectiveness of treatments and the appropriateness of the service. Patient needs and expectations change over time; consequently, sound quality management calls for constant monitoring of the patients' progress and satisfaction with the service. This monitoring uses both objective and subjective means -- for example, medical test results and the patient's opinion of the effectiveness of treatments -- to judge the quality of the treatment approach.

Quality management is essentially about delivering consistent quality, which, in turn, requires reliable processes. Reliability requires the existence of performance goals, risk reduction procedures, quality improvement policies, quality measurement systems and reward mechanisms.[1]

With the increasing demands on hospitals for improved quality and lower costs, hospitals have been forced to reevaluate their manner of operation and quality assurance (QA) programs. Hospitals have been faced with customer dissatisfaction with services, escalating costs, intense competition, and reduced reimbursement for services. As a result, many hospitals have incorporated total quality management (TQM), also known as continuous quality improvement (CQI) and quality improvement (QI), to improve quality care and decrease costs. [2].

"A public recognition of the achievement of accreditation standards by a healthcare organisation, demonstrated through an independent external peer assessment of that organisation's level of performance in relation to the standards".

Accreditation benefits all stake holders. Patients are the biggest beneficiary. Accreditation results in high quality of care and patient safety. The patients get services by credential medical staff. Rights of patients are respected and protected. Patient satisfaction is regularly evaluated.

The staff in a accredited health care organisation are satisfied lot as it provides for continuous learning, good working environment, leadership and above all ownership of clinical processes.

Accreditation to a health care organisation stimulates continuous improvement. It enables the organisation in demonstrating commitment to quality care. It raises community confidence in the services provided by the health care organisation. It also provides opportunity to healthcare unit to benchmark with the best.

Finally, accreditation provides an objective system of empanelment by insurance and other third parties. Accreditation provides access to reliable and certified information on facilities, infrastructure and level of care.[3]

Organisations like the [Quality Council of India](#) (QCI) and its National Accreditation Board for Hospitals & Healthcare Providers have designed an exhaustive [healthcare](#) standard for [hospitals](#) and healthcare providers. This standard consists of stringent 600 plus objective elements for the hospital to achieve in order to get the NABH [accreditation](#). These standards are divided between patient centered standards and organization centred standards. NABH accreditation system was established in 2006 as a constituent of Quality Council of India (QCI). The first edition of standards was released in 2006 and after that the standards has been revised every 3 years. Currently the 4th edition of NABH standards, released in December 2015 is in use.

NABH (National Accreditation Board for Hospitals & Healthcare Providers) is a constituent board of [Quality Council of India](#), set up to establish and operate accreditation programme for healthcare organizations. Formed in 2005, it is the principal accreditation for hospitals in India.[4]

The Quality Indicators (QIs) are measures of health care quality that make use of readily available hospital inpatient administrative data.

Continuous Quality Improvement (CQI) is not a one time affair to achieve quality state, it is a constant and conscious effort to raise the standard of practice in all areas and process of the Hospital and sustain it for ever.

The Cycle of continuous quality improvement (CQI) goes like this –

- There should be established documentation system to collect data
- The sample size and frequency of data collection is defined
- The data has to be collected for various indicators across all departments or functions on a monthly basis. Target is set for each department based on National/International Benchmarks /data, if available. The target can also be set on three months data to begin with if the hospital is way behind the National/International Benchmarks/Targets. The target can be revised in phased manner gradually to scale to the level of National/International Benchmarks / Targets.
- Non performances/Under performances across departments who fall below set target is identified
- Root cause analysis done
- Suitable corrective action taken
- Effectiveness of corrective action taken is evaluated
- Corrective action will be modified if required
- Preventive action taken
- Effectiveness of the preventive action taken is evaluated
- If Consistency is maintained with respect to achieving defined target in a particular department or process, then new target is set after getting the consensus from all stake holders
- The target is increased by few notches to achieve it
- This cycle goes on and on improving the performances and quality of each and every department/process
- Various indicators are adapted and data captured on monthly basis for comparisons and analysis[5]

These quality indicators are compared against already established targets which are known as Benchmarks. These benchmarks evaluate the effectiveness of the process against certain set standards.

Benchmarking may improve hospital processes, though according to Van Lent et al. [6], benchmarking as a tool to improve quality in hospitals is not well described and possibly not well developed. Identifying meaningful measures that are able to capture the quality of care in its different dimensions remains a challenging aspiration [7].

The various Indicators being compiled and analysed against the benchmark in this study are:

- Emergency

Time for initial assessment of patients attending emergency services

Return to emergency department within 72 hrs with similar presenting complaints

- Nursing

Incidence of falls

Percentage of Near Misses

Nurse-patient ratio for wards(per shift)

Number of sentinel events reported, collected and analyzed within the defined timeframe

Appropriate Handovers during shift change (To be done separately for doctors and nurses)-
(per patient per shift)

Incidence of Patient identification errors

- Radiology

Number of reporting errors/1000 investigations

Rate of re-dos

Percentage of adherence to safety

precautions by employees working in diagnostics.

Waiting time for services for diagnostics(X-ray)

(Average value)

Waiting time for services for diagnostics (USG)

(Average value)

Waiting time for services for diagnostics (CT scan)

(Average value)

Waiting time for services for diagnostics (MRI)

(Average value)

- Infection Control

Catheter associated urinary tract infection rate

Ventilator associated pneumonia rate

Central line associated blood stream infection rate

Surgical site Infection rate

Compliance to hand hygiene

Incidence of blood body fluid exposures

Incidence of needle stick injuries

- Security

Number of variations observed in mock drills

- IPD

Length of Stay (LOS)

BOR

Time for discharge(cash)

Time for discharge(TPA)

In patient satisfaction rate

- ICU

Return to ICU within 48 hrs

- Human Resource

Percentage of attrition

Percentage of absenteeism

Percentage of employees who are aware of employees rights, responsibility and welfare scheme

Employee satisfaction index

LITERATURE REVIEW:

Health care associated infections (HAIs) cause substantial morbidity and mortality every year in the Australian health care setting. HAI reduction is a key goal of the Australian Commission on Safety and Quality in Health Care. This goal is shared by all Australian jurisdictions and by relevant professional organisations. For the past forty or so years Australia's approach to HAI measurement, prevention and control has been based on local infection control and surveillance programs. These programs are typically coordinated by an infection control practitioner. Despite the longevity of this model little is known about its structure, effectiveness or sustainability. There is a paucity of information about the current and ideal skills, education and resources of ICPs in health care settings.

<https://www.safetyandquality.gov.au/wp-content/uploads/2012/02/19101-LiteratureReview.pdf>

The performance of the healthcare system can be measured by many indicators, but it is difficult to improve them simultaneously due to the limited resources. A feasible way is to identify the central and influential indicators to improve healthcare performance in a stepwise manner. In this paper, we propose a hybrid multiple criteria decision making (MCDM) approach to identify key performance indicators (KPIs) for holistic hospital management. First, through integrating evidential reasoning approach and interval 2-tuple linguistic variables, various assessments of performance indicators provided by healthcare experts are modeled.

an empirical case study is provided to demonstrate the proposed approach for improving the efficiency of healthcare management. The results show that “accidents/adverse events”, “nosocomial infection”, “incidents/errors”, “number of operations/procedures” are significant influential indicators. Also, the indicators of “length of stay”, “bed occupancy” and “financial measures” play important roles in performance evaluation of the healthcare organization

<http://www.mdpi.com/1660-4601/14/8/934/pdf>

This study was carried out to evaluate quality of BMW management in 1100-bedded hospital attached to a tertiary care public institute in North India.

It was found that summated mean percentage score of ‘Treatment Room of Wards’, which were used exclusively by resident doctors, was significantly lower than Operation Theatres

(p value: 0.033) and ‘Central Waste Collection Points of Wards’ (p value: 0.018) for the function of ‘mutilation of recyclable waste’ and it was significantly lower than all other areas (p value: 0.006 to 0.017) for the function of ‘disinfection of waste’.

It is concluded that more emphasis needs to be laid on ‘mutilation of recyclable waste’ and disinfection of waste’ by HCWs especially resident doctors

<https://link.springer.com/article/10.1186/2052-336X-12-69>”

Intervention	Focus	Setting	Design	Duration of intervention	Key findings	Reference
Organizational and systems improvements: Interactive development and placement of posters; distribution of alcohol based hand rub products; support from senior management	Hand hygiene, particularly alcohol based hand rubs	Representative sample of 4,000 hospitals, USA	Quasi-experimental, with regression modeling	3 year follow up after intervention	Consumption of alcohol hand rub by volume increased from 4 to 15 litres per 1000 patient days Hand hygiene compliance increased from 48% to 66% Infection rates decreased from 17% to 10%	Pittet et al 2000 [28]

surveillance, including: Epidemiological analysis; prioritisation of infection during ward rounds; feedback to staff; specialised infection control staff; improved staff to bed ratios	Urinary tract, surgical, bacteremic infections and pneumonia	Representative sample of 4,000 hospitals, USA	Quasi-experimental, with regression modeling	5 years	A maximum decrease in infection rates by 32% if all components implemented Most hospitals could only achieve reductions in infection rates of 6% Different combinations of components were optimally effective for different infections	Haley et al 1980 [42] Haley et al 1985 [40]”
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<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3113713/>”

Research Methodology

Research question

What is the compliance of various quality indicators being measured for the continuous quality improvement in Rukmani Birla Hospital , Jaipur as directed by the NABH and the main reasons for outliers.

Objectives

1. To Collect and compile the data for various Key Performance Indicators.
2. To do Trend analysis of indicators over a period of past 9 months in order to see the variations
3. To evaluate the outliers and the main reasons for the deviations and discrepancies.
4. To recommend methods to eliminate prospective errors and increase the compliance.

Materials and Methods

Study design- Descriptive and observational

Data type- Secondary Data

Research Approach- Quantitative

Period of study- February 4th to May 3rd, 2019

Duration of data to be analysed– June 2018 to February 2019

Inclusion Criteria-

- Emergency
- Radiology
- Nursing
- Infection Control
- IPD & IPE
- ICU
- Human Resource
- Security

Exclusion Criteria- MRD
OT
Blood bank
Research
OPD & OPE
F & B
BME
Laboratory
Clinical Pharmacology

Mode of Data collection

Secondary sources – Hospital Records
NABH Guidelines
Capture sheets
Hospital Policies and Manuals
HMIS of the hospital

Methodology

The secondary data was collected from all the above specified departments from their capture sheets or record registers. The raw data obtained was verified against the formula and the definition of the indicators as given by NABH from their original book. The definitions and capture process for numerator and denominator for each indicator was thus verified so as to make sure there is no lacking or discrepancy in the back end process.

The corrections of the mis interpretations or defaulted calculations and those in the wrong sample size adherence henceforth were done into the departmental record as well as in the main record in the quality department.

The processed data was then compiled according to a preformed format which was used to capture the data in tabulated form for the last 9 months starting from July 2018 to February 2019. The data compiled consisted of numerator and denominator which were verified and were evaluated in the form of the formula.

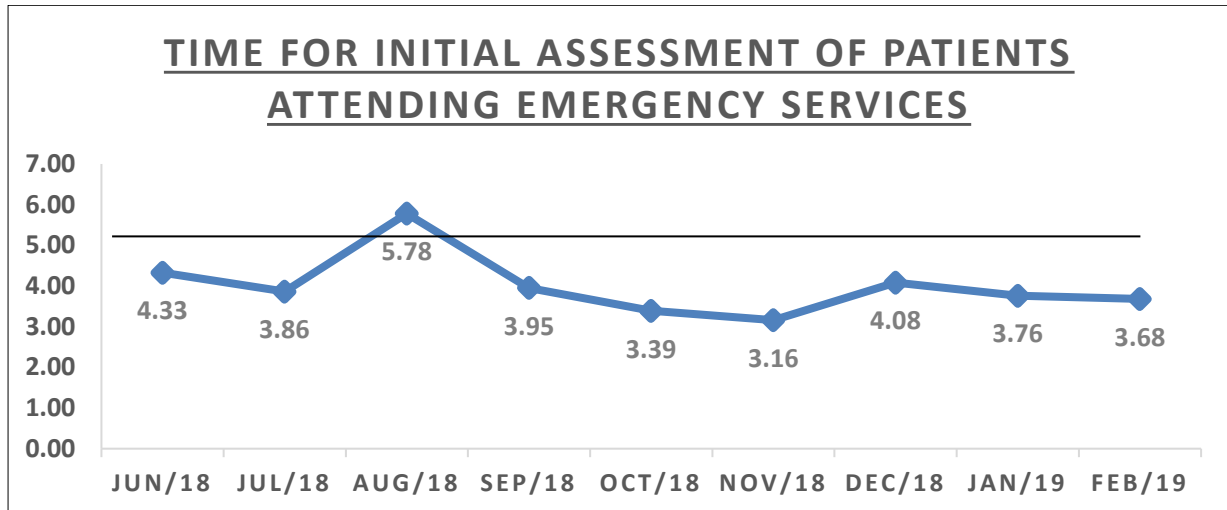
Once collected and compiled, the trend analysis was done for each and every indicator taking internal target as benchmark for standardising the analysis.

All the indicators for some specific months where the values were going above the benchmark and showed deviations were asked for outliers. The outliers were taken and analysed and cause for those specific incidents were captured. Interaction with specific department heads and coordinators was then done to find the lacking behind the occurrence of the outliers and interpretation and conclusion for deviation thus made.

Data Analysis and Interpretation

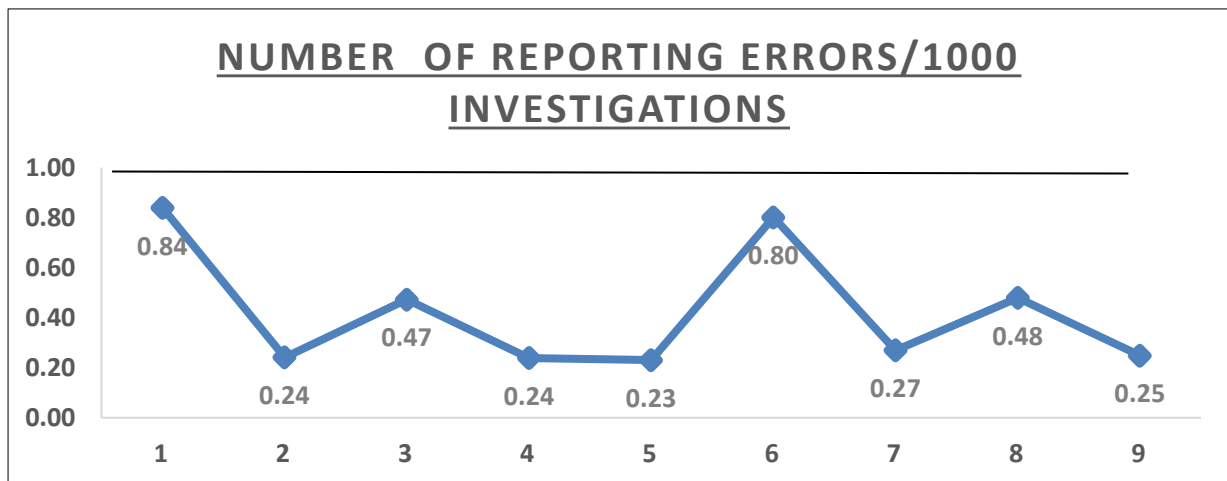
————— Represents Internal Target

Figure 1



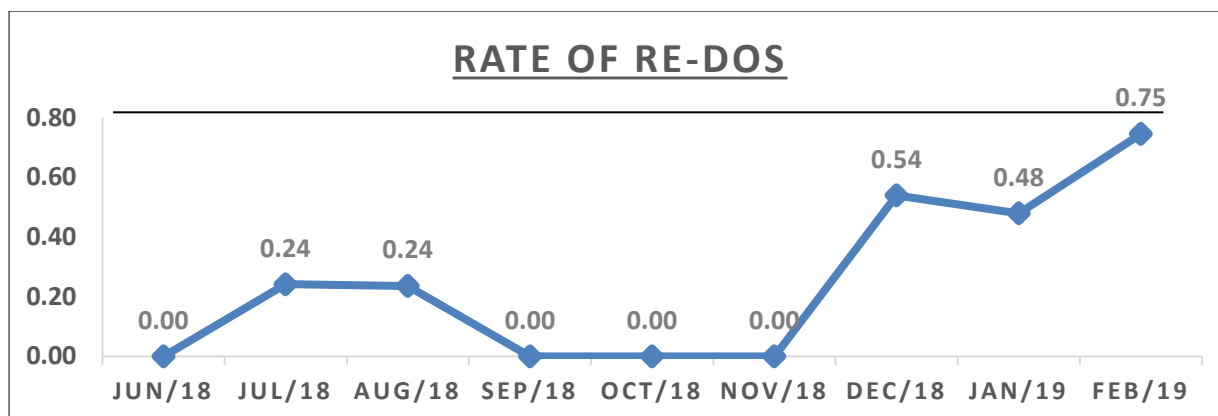
Interpretation- There has been only one incidence of non compliance which was due to the reason that the patient had accident so stabilising the patient took time. The average is 4 min.

Figure 2



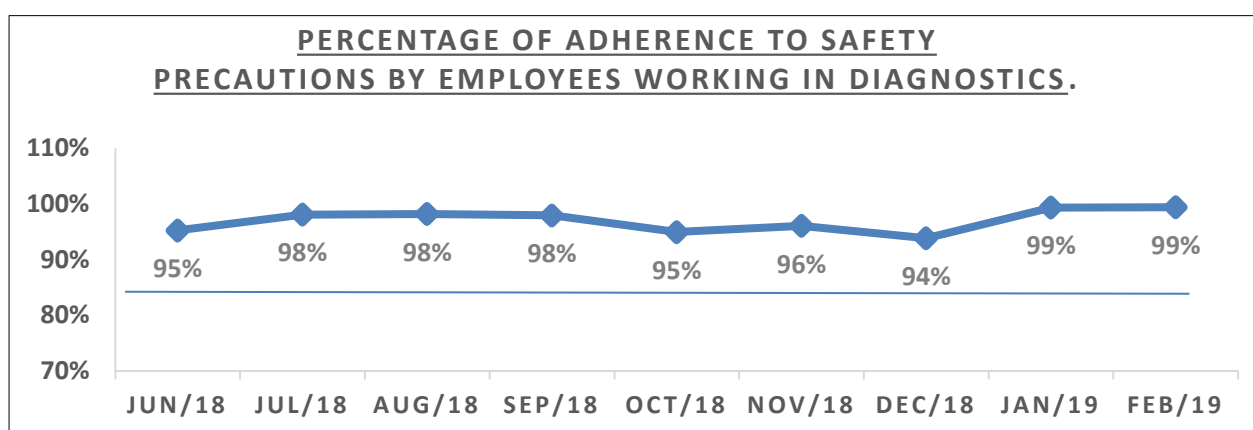
Interpretation- There has been an average trend of reporting errors with 2 spikes which were due to increased no.of patients in those months. There is no deviation from internal target

Figure 3



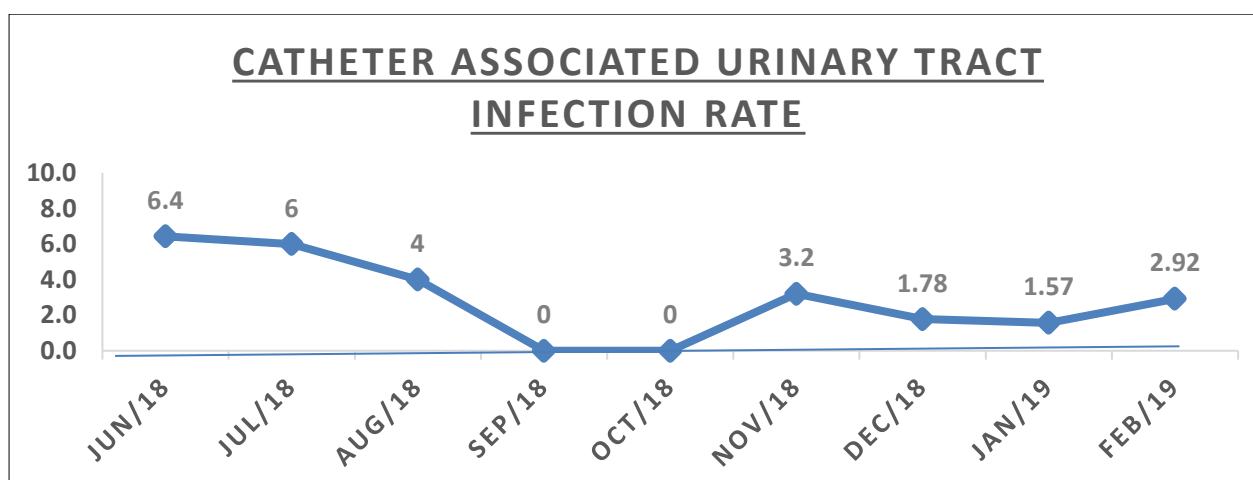
Interpretation- No deviation is there from the internal targets but there has been sudden increase from the last 3 months which is due to order of the newly appointed radiologist.

Figure 4



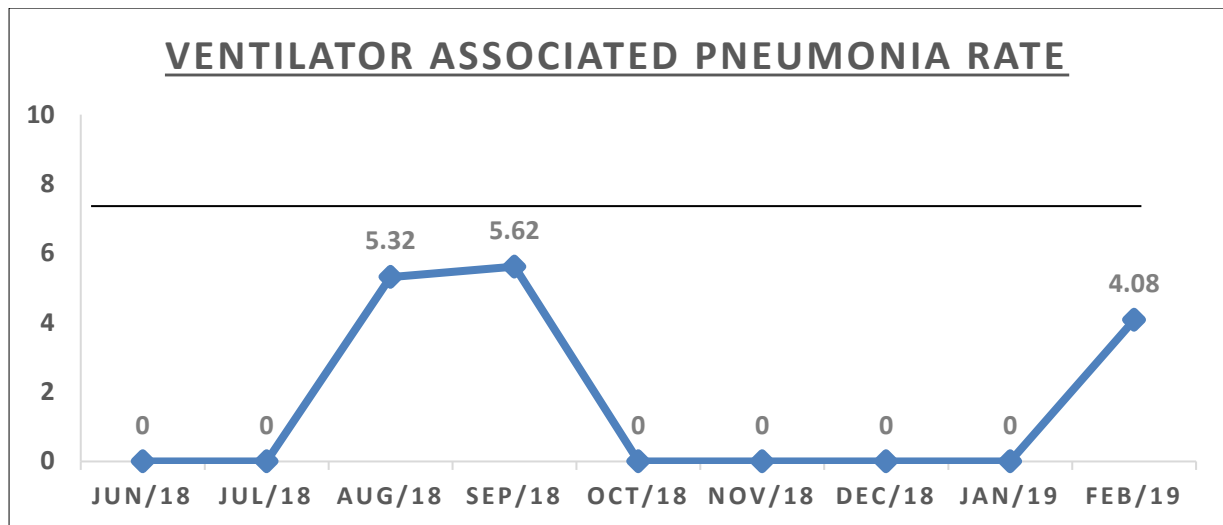
Interpretation- Each and every personnel in the radiology is following the guidelines given for safety precautions with a consistent trend.

Figure 5



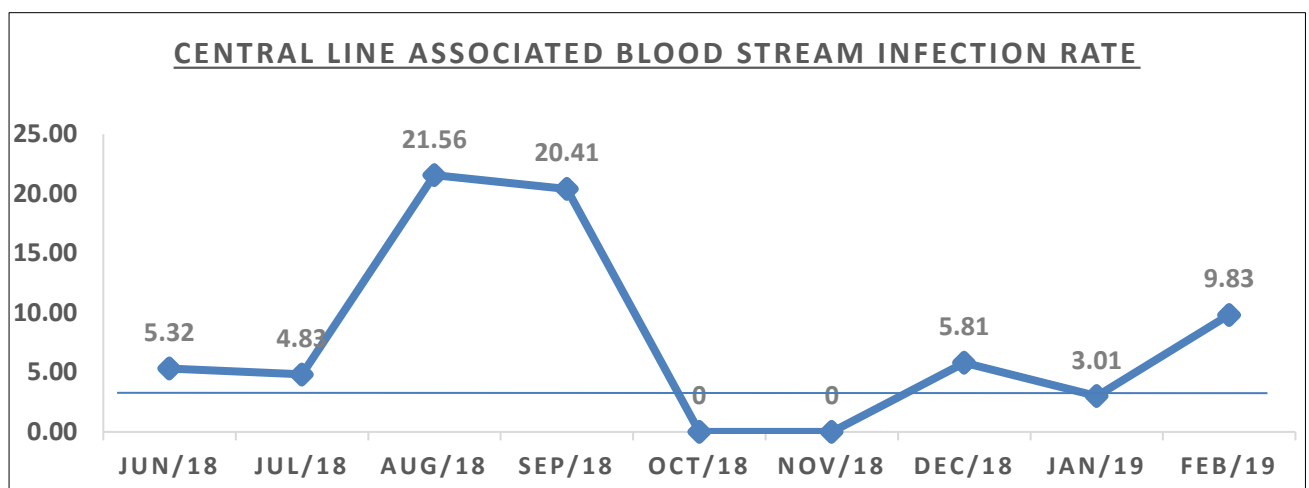
Interpretation- CAUTI was calculated taking only ICU patients whereas the Internal target formed covers whole of the hospital. And hence the target is being crossed in every instance.

Figure 6



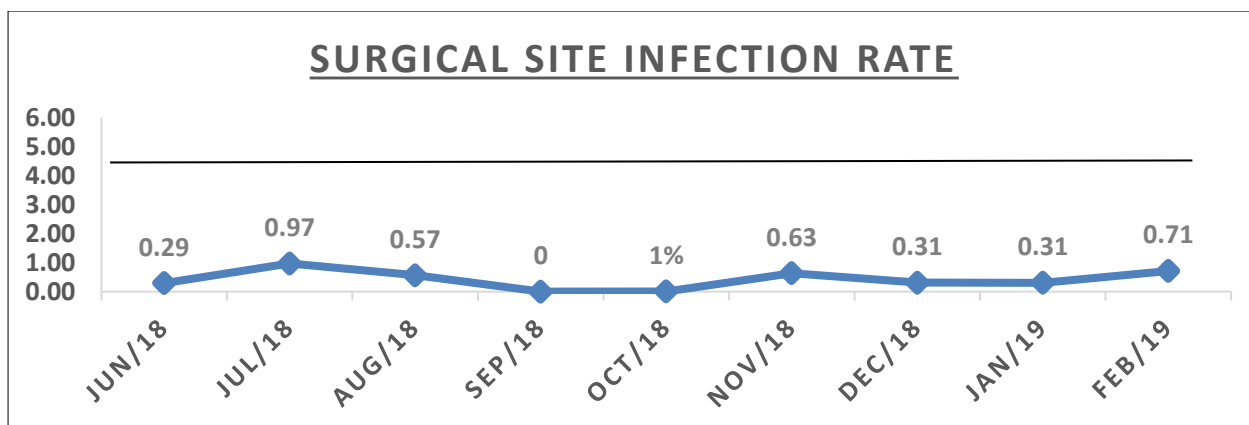
Interpretation- There has been 3 incidences where there has been an increase in VAP rate. For all the patients during that phase RCA was done and cause was evaluated.

Figure 7



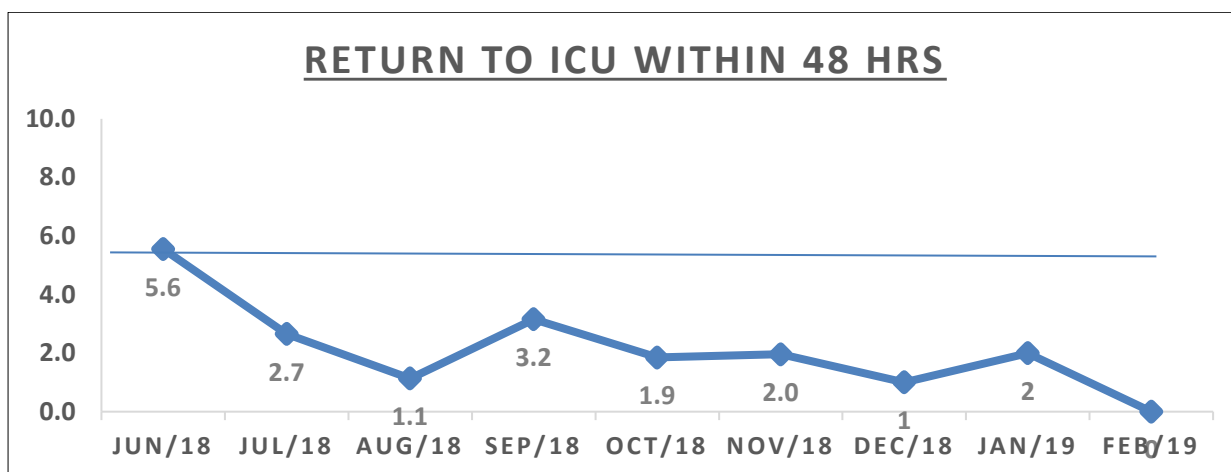
Interpretation- The patients admitted in ICU were only taken whereas it has to be done hospital wide hence a tremendous rise in the CLABSI rate.

Figure 8



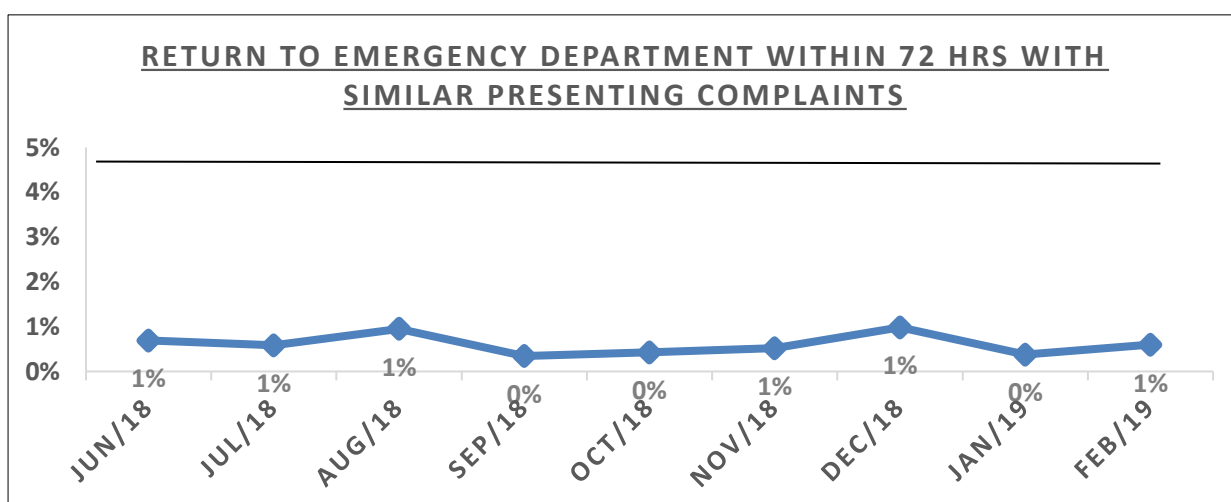
Interpretation- All the values are within the target range with a steady trend of 1% average.

Figure 9



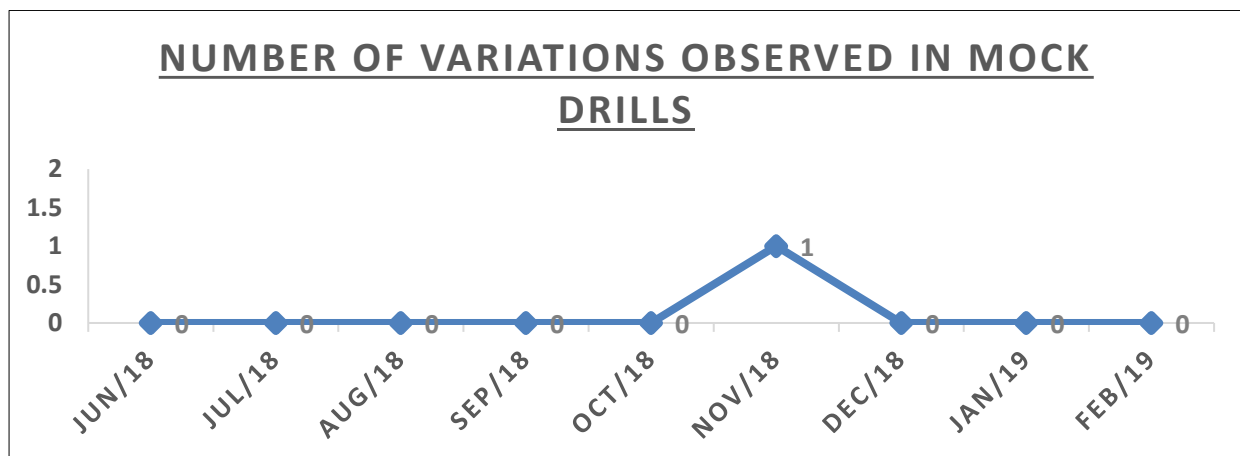
Interpretation- There has been only one instance of deviation from the target and the trend show a symmetrical pattern.

Figure 10



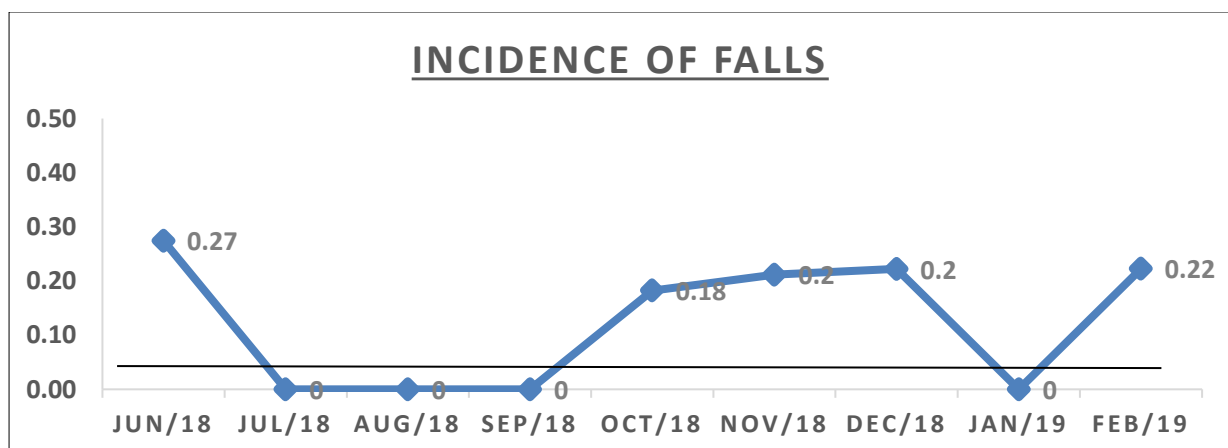
Interpretation- There has been a consistent trend of 1% being followed throughout the period which is also within the target.

Figure 11



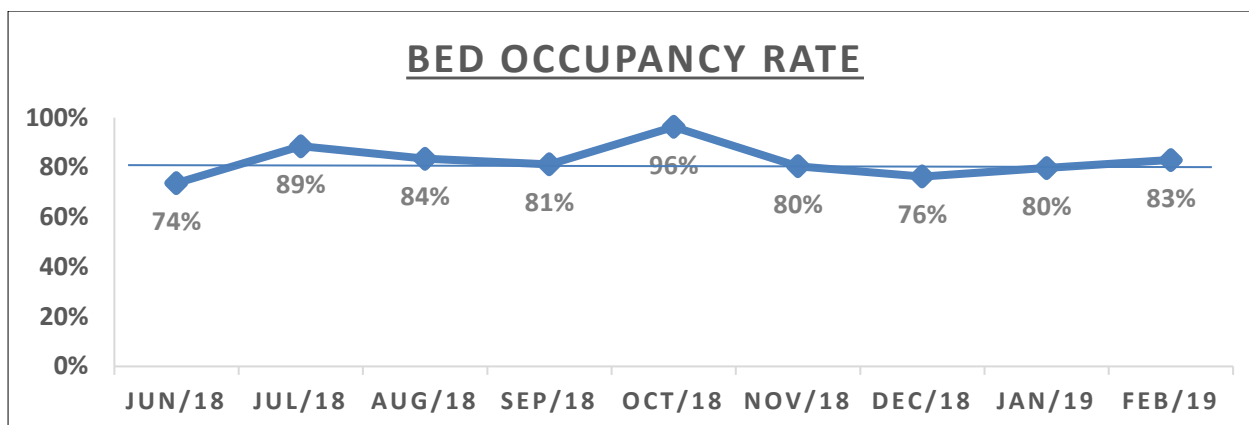
Interpretation – Only one deviation was found from the target which was traced to be process related while carrying out the drill.

Figure 12



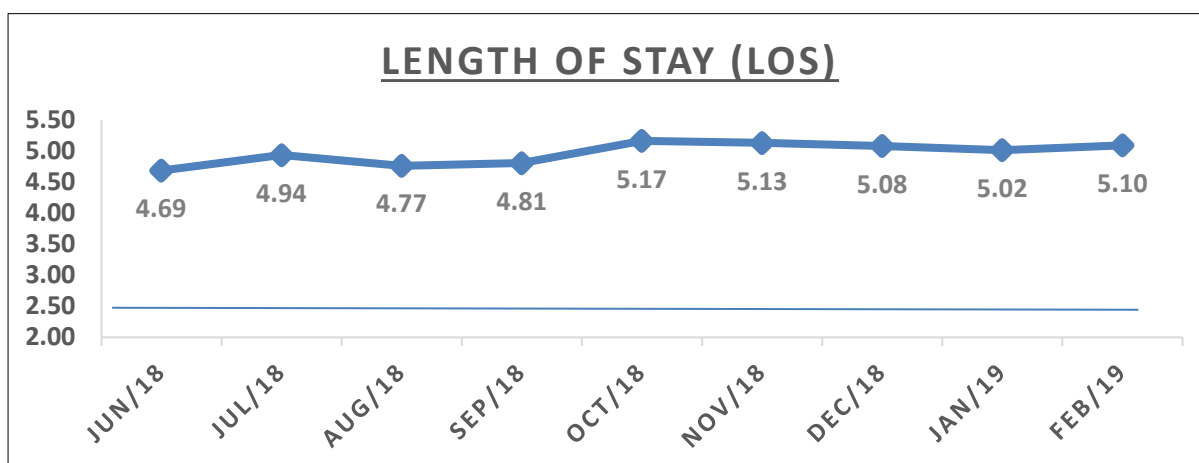
Interpretation – There have been multiple cases of falls which have various causes such as loss of balance, fall in washrooms, no assistance, jumping off the side rails.

Figure 13



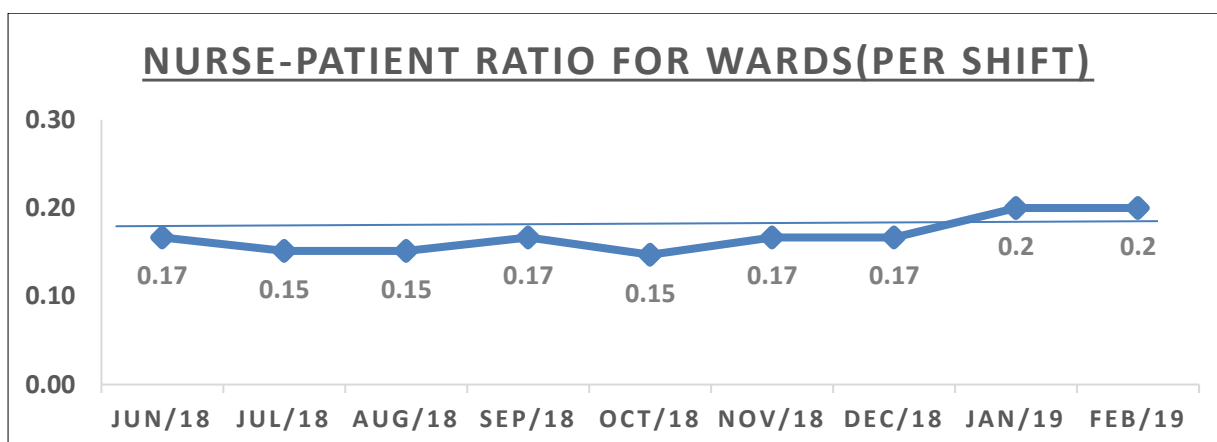
Interpretation – Decrease in trend has been seen due to less no. of OPD patients being converted to IPD patients in that month.

Figure 14



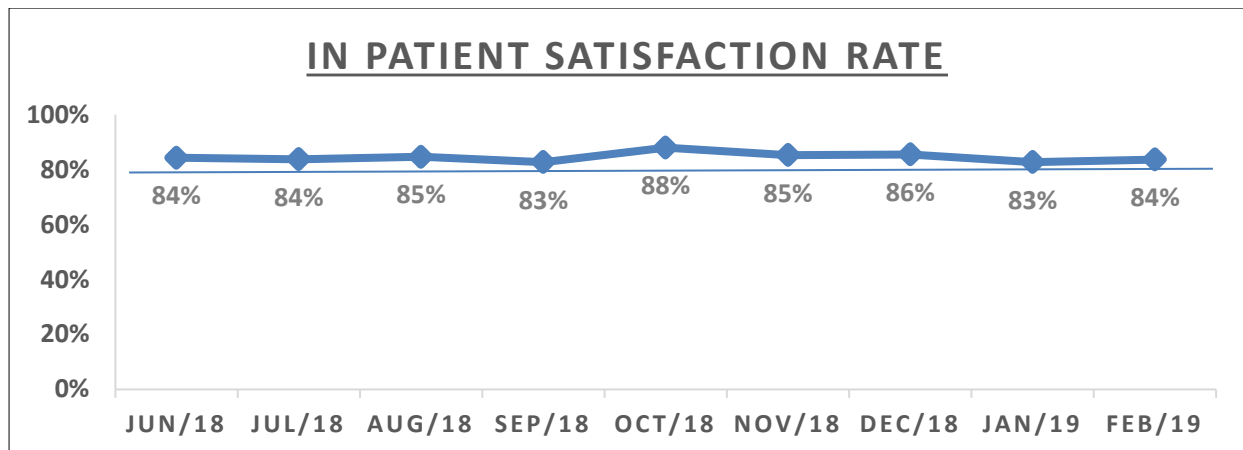
Interpretation – Constant deviation is seen by increase in the length of stay due to poor discharge planning and post operative complications, decreased nursing efficiency.

Figure 15



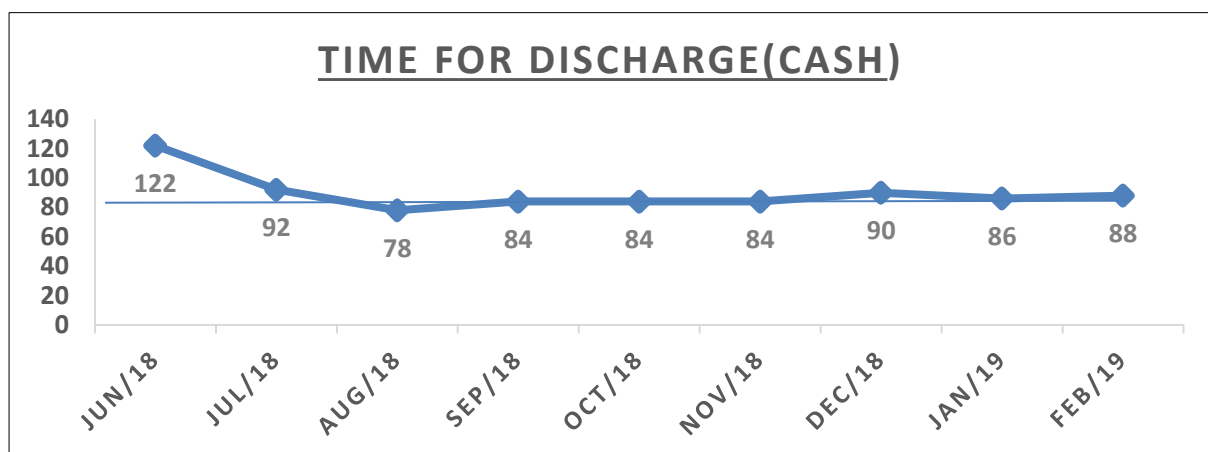
Interpretation- The nurse patient ratio available is less than the required one which is due to shortage of nursing manpower therefore keeping it below target.

Figure 16



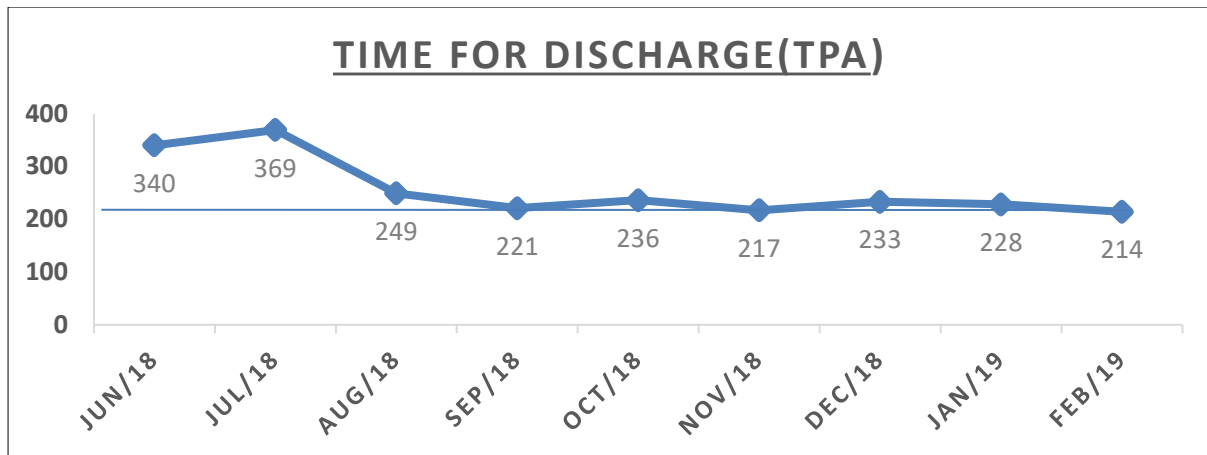
Interpretation – The satisfaction rate has been consistently above 80% continuously exceeding the target and maintaining the quality of care.

Figure 17



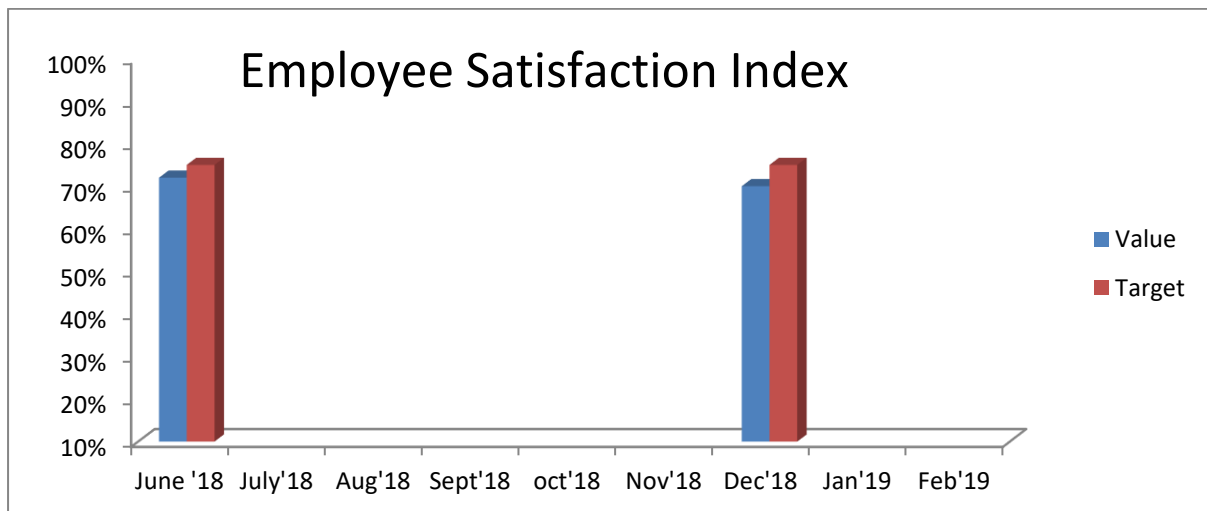
Interpretation – In the cases where there has been delay in the discharge of cash patients, the reason can be attributed to the delay in clearing and getting the cash and patient's understanding for the break up of the bill.

Figure 18



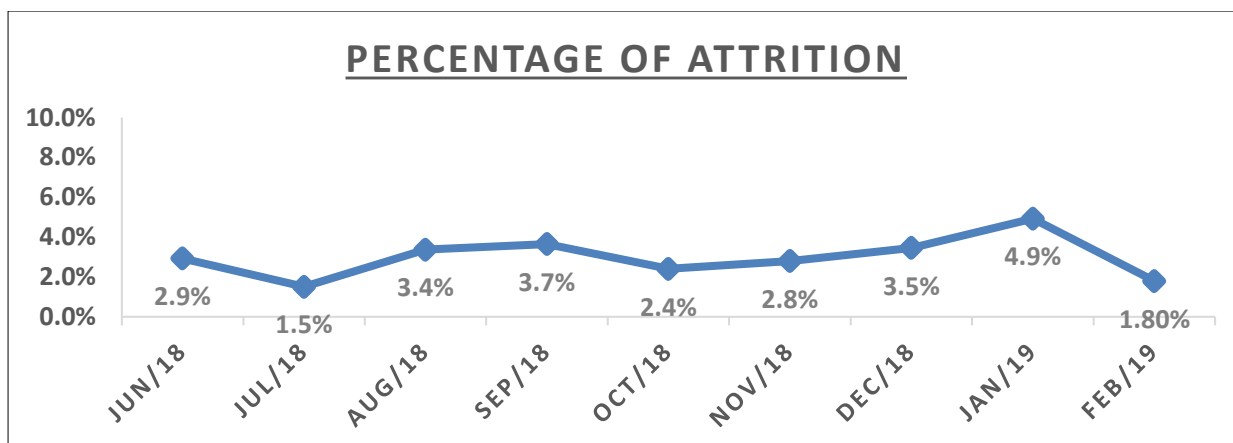
Interpretation – For TPA patients, the main reason for delay lies in the back end clearing of the bills from the insurance company. Apart from this, the trend line is constant.

Figure 19



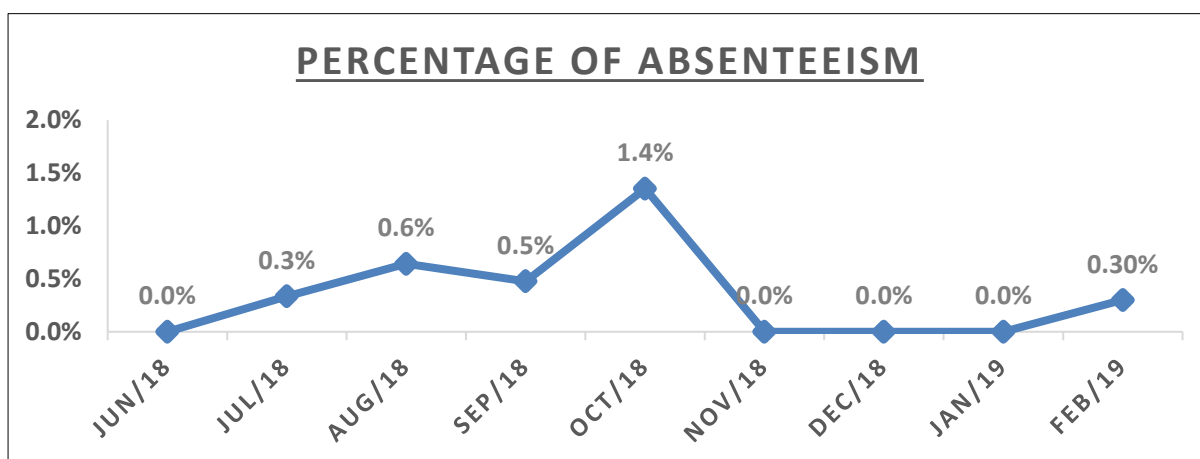
Interpretation – Satisfaction rate should be 75%. The trend shows less rate before and even degrading in the current one. This may be attributed to various reasons such as politics, work environment, supervisor support etc.

Figure 20



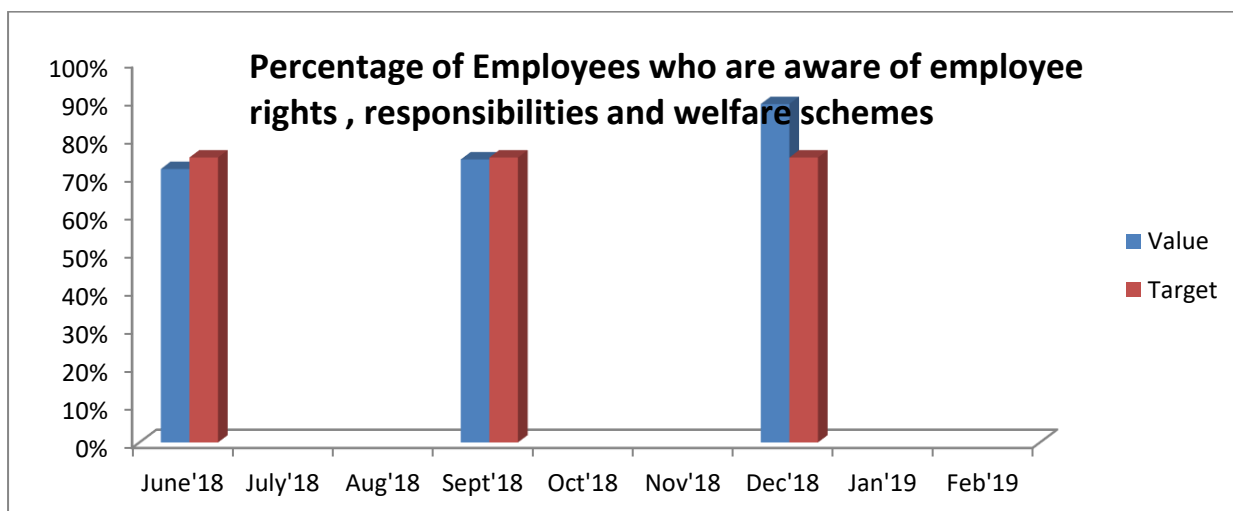
Interpretation – variation is seen in the attrition rate with a sudden downfall in the month of February 2019. This can be attributed to increased pay scale and better job responsibilities.

Figure 21



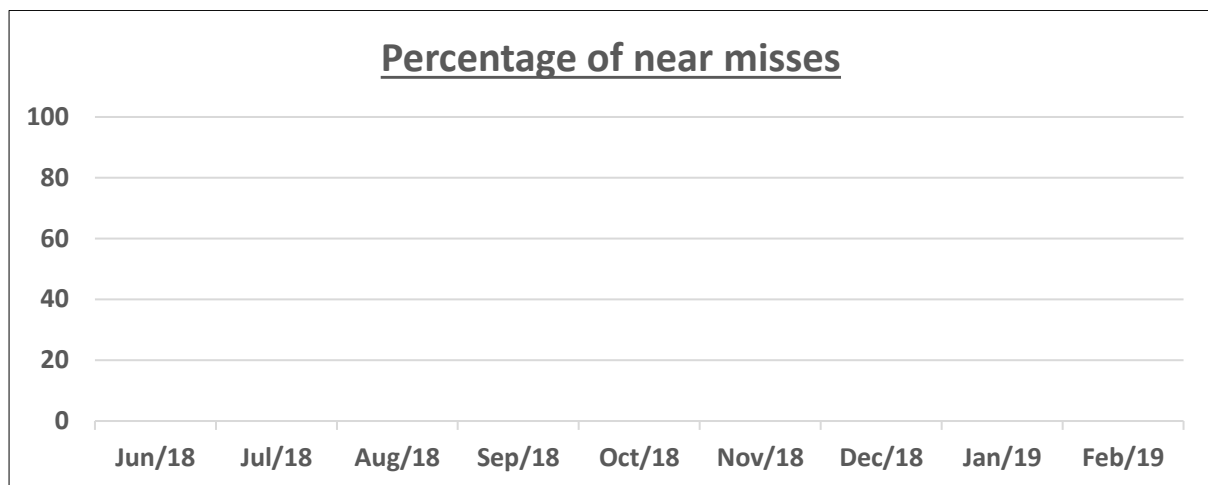
Interpretation – The spike in the trend was due to holidays because of festival season. After there has been a decline in the trend.

Figure 22



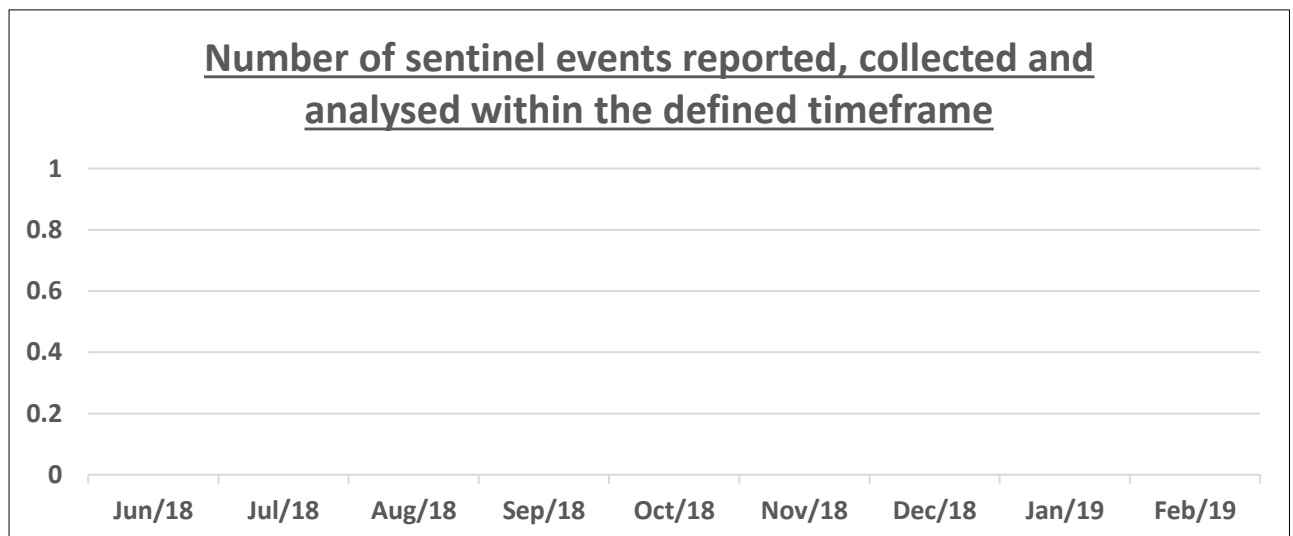
Interpretation – There has been a rise in the trend of awareness among employees from 72% to 75% to 89%.

Figure 23



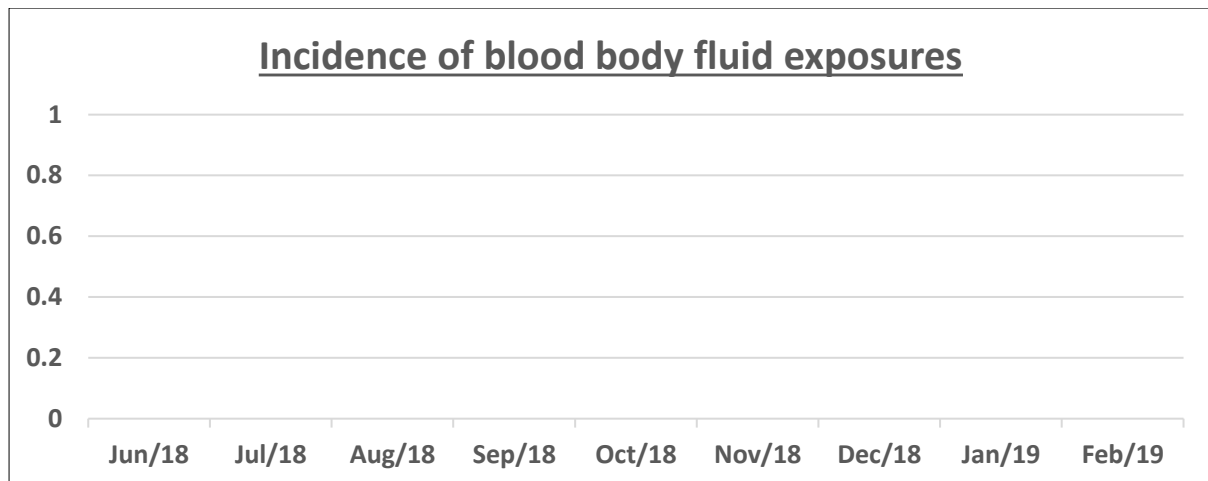
Interpretation- There has not been any reported incidence of near misses in the specified period.

Figure 24



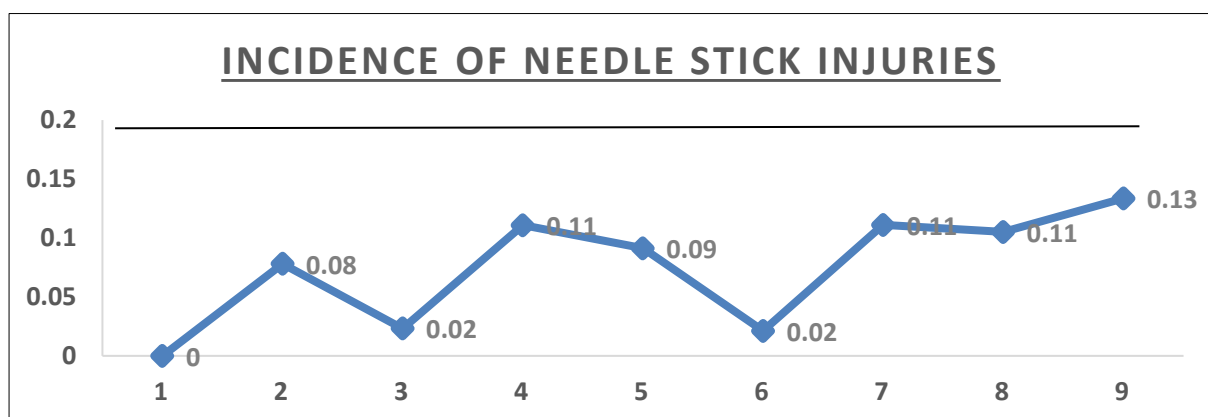
Interpretation- There has not been any reported incidence of sentinel events in the specified period.

Figure 25



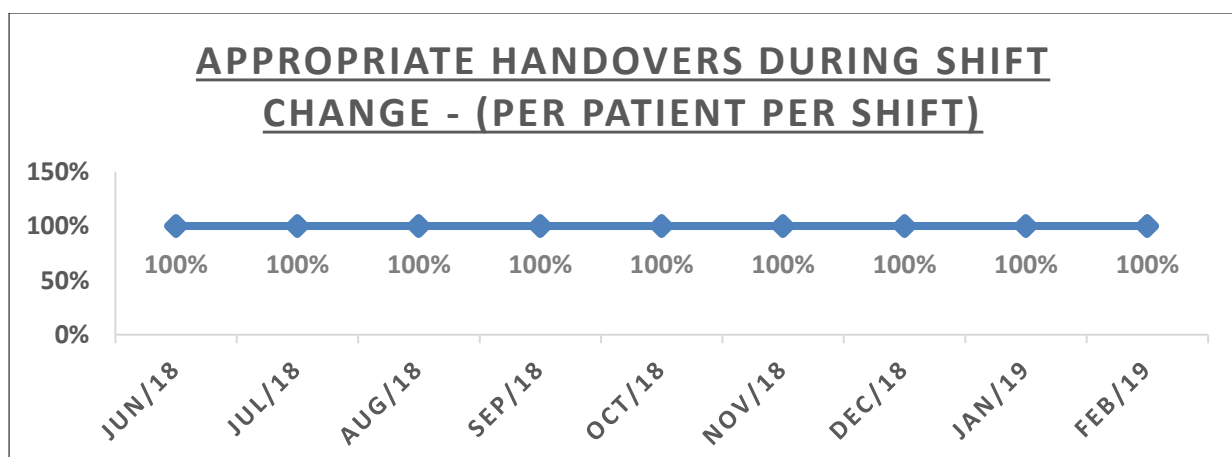
Interpretation- There has not been any reported incidence of blood body fluid exposure in the specified period.

Figure 26



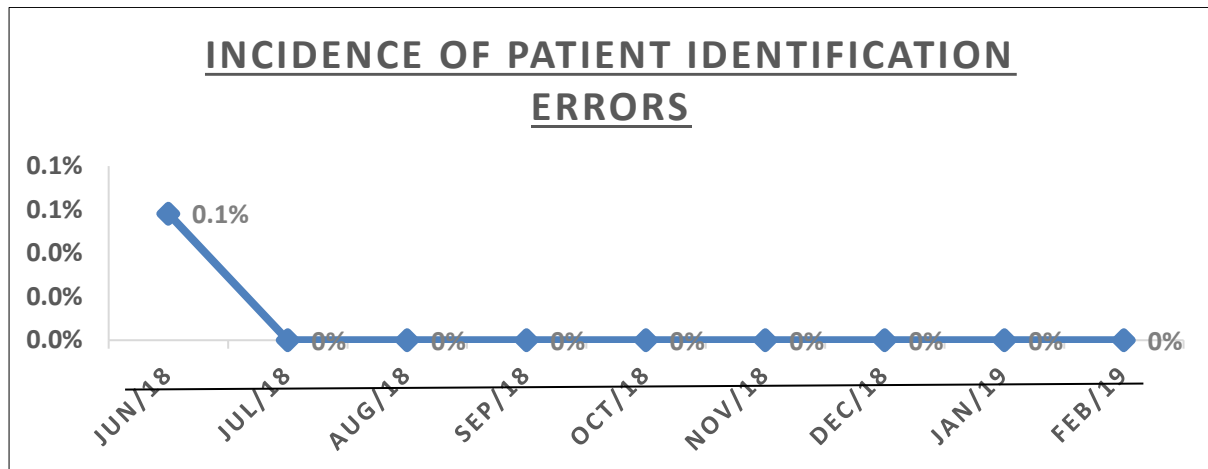
Interpretation- All the values have been within target but the trend shows frequent ups and downs with more towards the upper side.

Figure 27



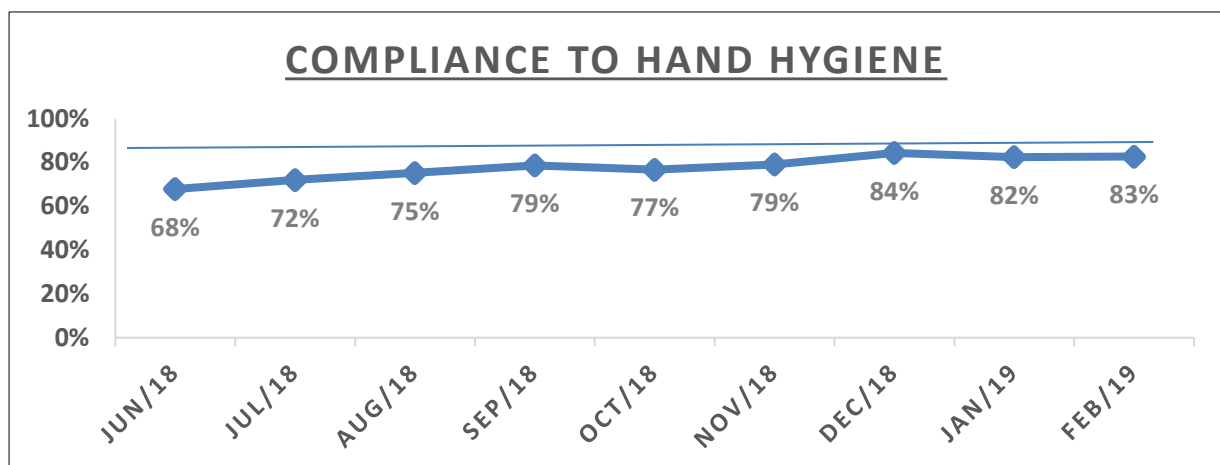
Interpretation- 100% compliance is found in all the chances available for handover all throughout the period of analysis.

Figure 28



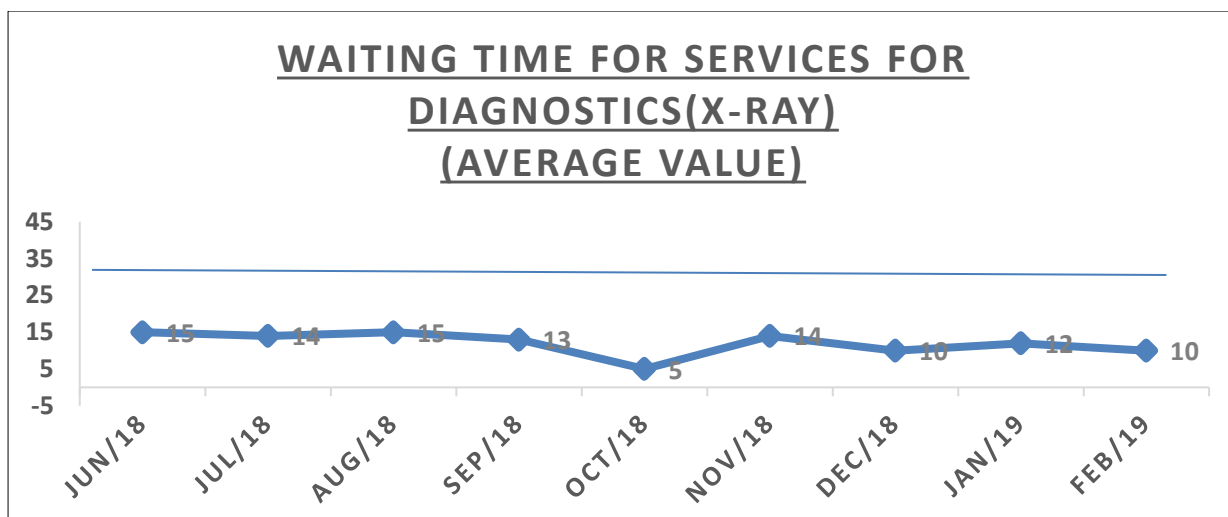
Interpretation- one incidence has been reported in the month of June 2018 for patient identification error due to similar name and lost tag.

Figure 29



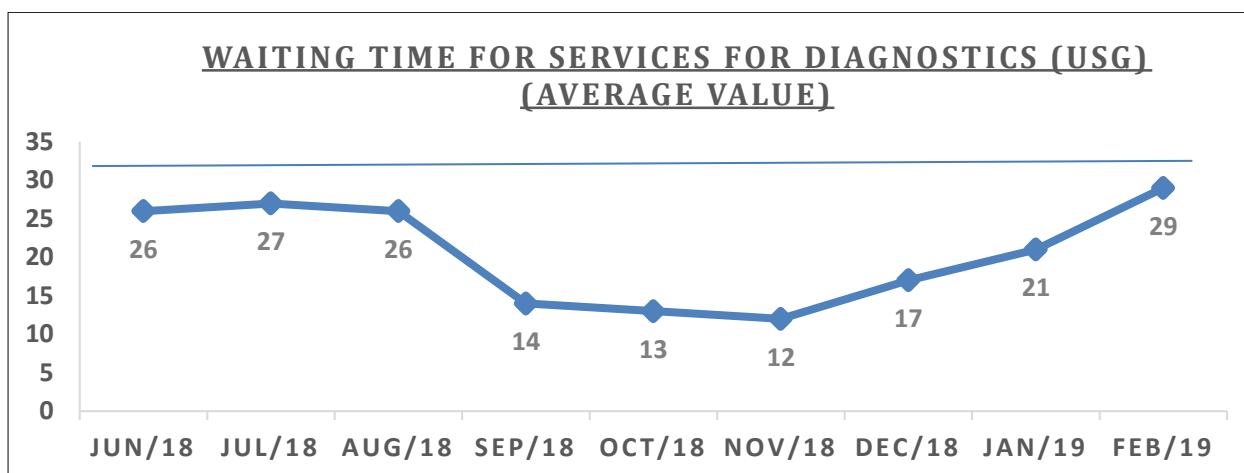
Interpretation – According to trend analysis , there is continuous increase in the compliance to hand hygiene but it is still below the internal target mentioned.

Figure 30



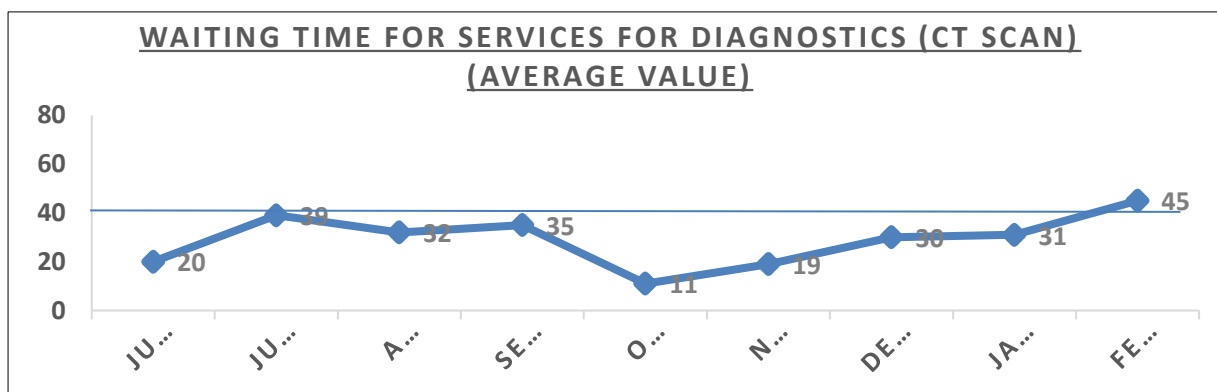
Interpretation – TAT for X ray is maintained at a constant average value with a steady trend

Figure 31



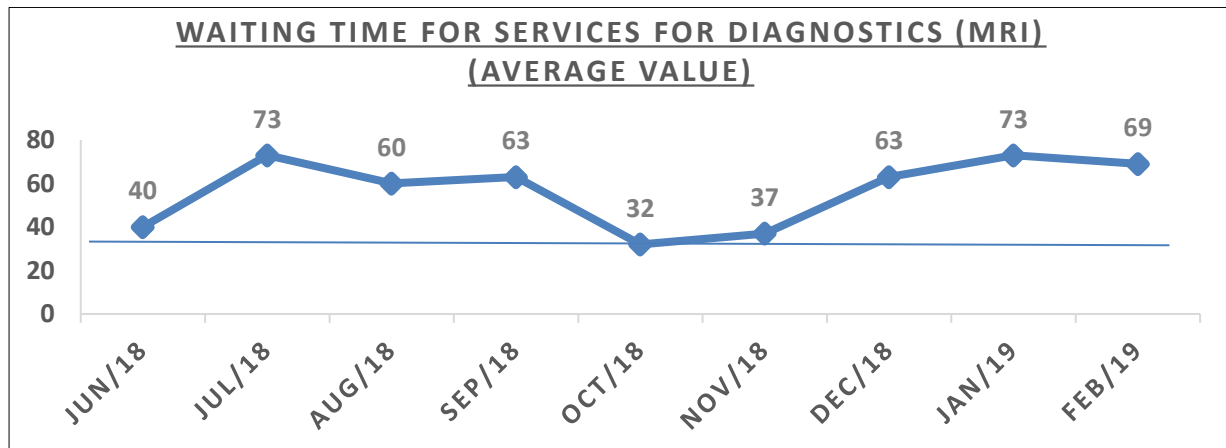
Interpretation- TAT for USG was recorded with a decrease in the trend and then slow rise which is still under the internal target.

Figure 32



Interpretation – TAT for CT has been maintained much below the target value with slight ups and down in the trend reaching its maximum at 45 min.

Figure 33



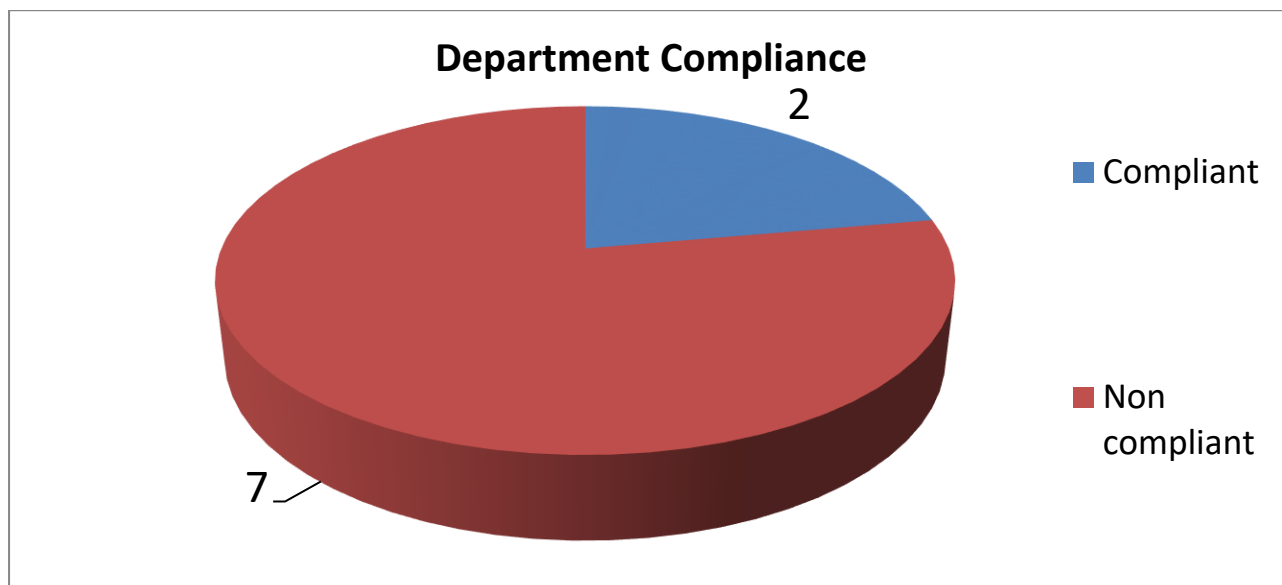
Interpretation –There has been decreasing and increasing trends in the TAT for MRI due to no. of patients coming for the test leading to deviation in some cases.

Observations

This deals with the department wise observations which were considered for immediate corrections.

The hospital authority accepted and implemented the same for improving quality of care in the hospital.

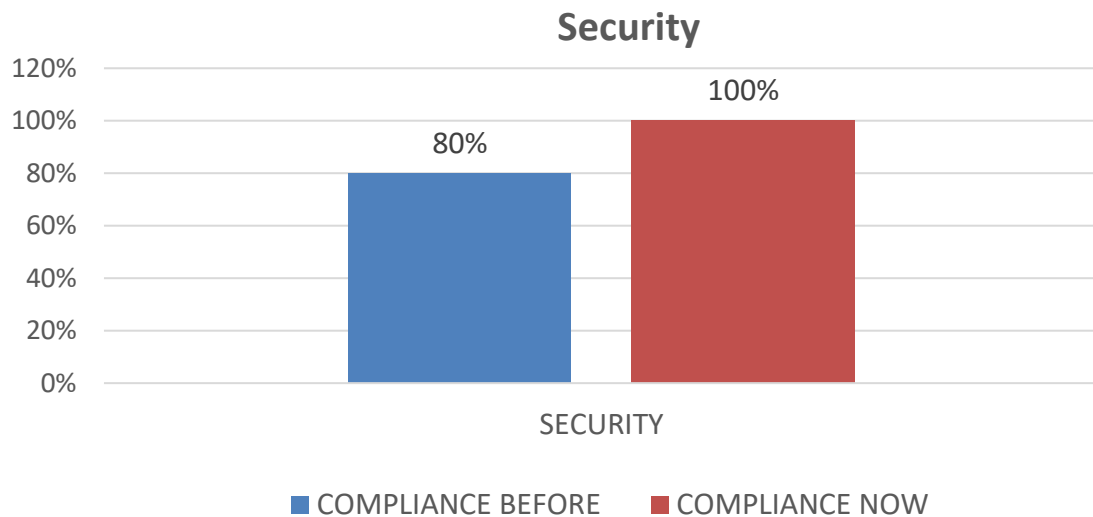
The initial observation that was made related to the compliance of departmental indicators to NABH standards were as follows:



Department	Status
OPE	100% Compliance
Infection Control	100% Compliance

Department	Status
Security	80% Compliance
Nursing	20% Compliance
Emergency	70% Compliance
IPD	30% Compliance
Radiology	30% Compliance
ICU	20% Compliance
Human Resource	40% Compliance

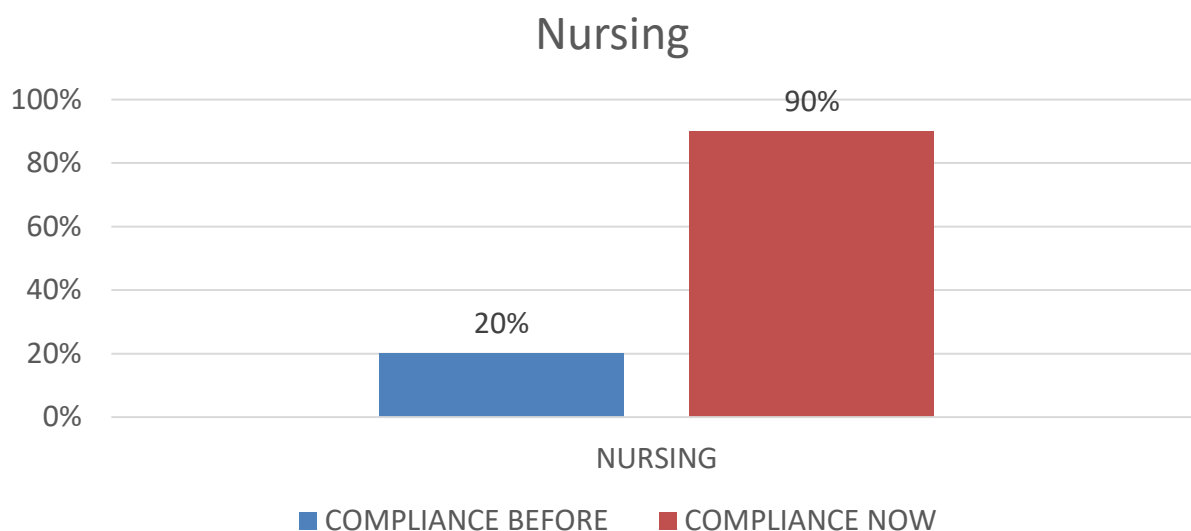
The key observations made with respect to CQI indicators are:



Observations	Correction done
Reasons for outliers, if present, was not given	Asked to either attach the RCA or mention it in the Quality sheet
Final values not mentioned properly	Appropriate format was told and corrections were made
Not mentioned anything in the numerator/denominator or if nothing is significant	Values to be taken as zero if no incidence is there - corrected

Challenges

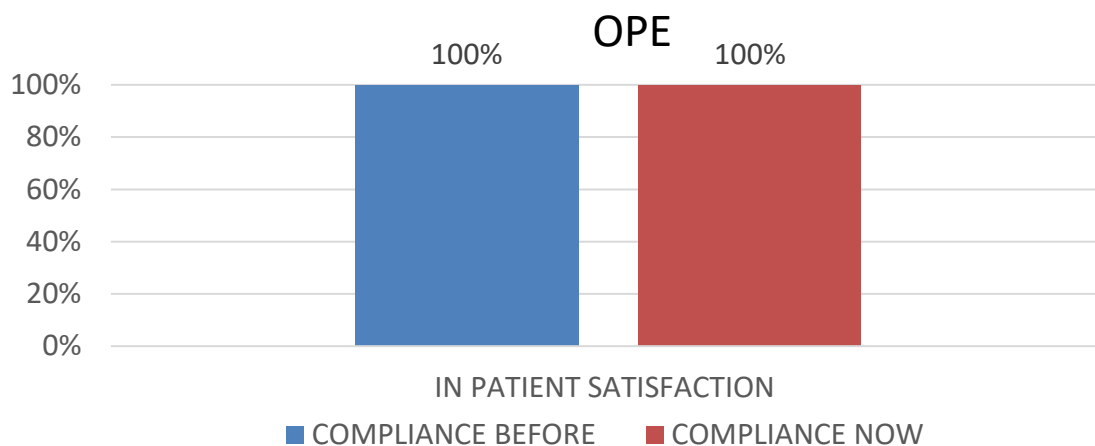
- Data was available but was not prepared. Had to get it prepared
- RCA was not attached. Analysis will have to be done by sorting of files



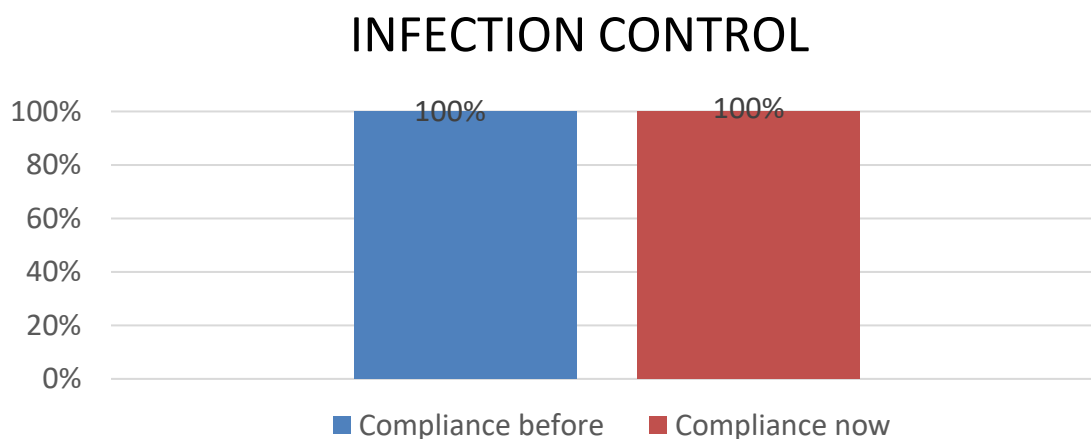
Observations	Corrections done
• Nurse-patient ratio was not mentioned and no interpretation done	Formula verified with NS and clarification regarding the same done and corrected
• Sentinel events were calculated wrong	Validation was done correcting it to original values
• Handover data was not given	Data rechecked and interpretation done
• Near miss incidents were not correlated with total no. of incidents	Detailed explanation of the formula given and near misses calculated
• Patient identification was miscalculated	Re calculation done and corrected
• Discrepancy in target value for ratios	Intimated and asked for correction

Challenges-

- First raw sheets were unstructured
- Each and every indicator has to be explained thoroughly



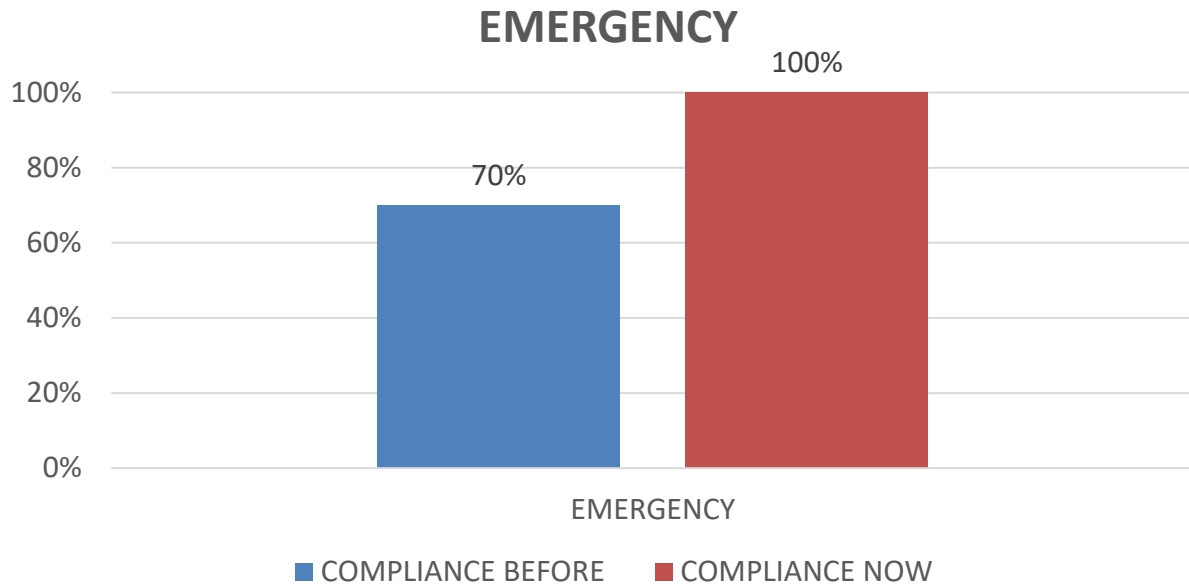
Observation	correction
Data was available and prepared	None



Observation	Correction
Numerator Denominator not available for initial months	Asked to provide the same- given
Hand hygiene data not evaluated	Concerned person was intimated and the data evaluated

Challenges

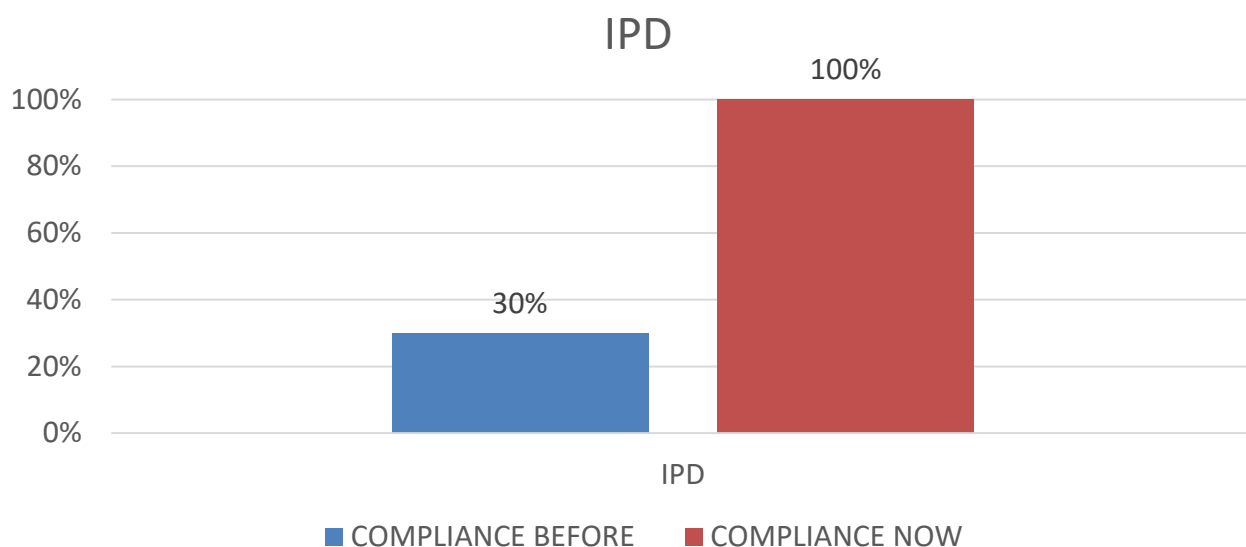
- Data to be retrieved from previous mails as it was indirect data



Observations	Corrections done
Unstructured data was there without any format	Processing of the data with complete format
Numerator and denominator was not mentioned	Numerator and denominator were provided with proper format
Target not mentioned	Intimated to concerned person corrected
RCA was not mentioned	Requested for the same and given thereby

Challenges

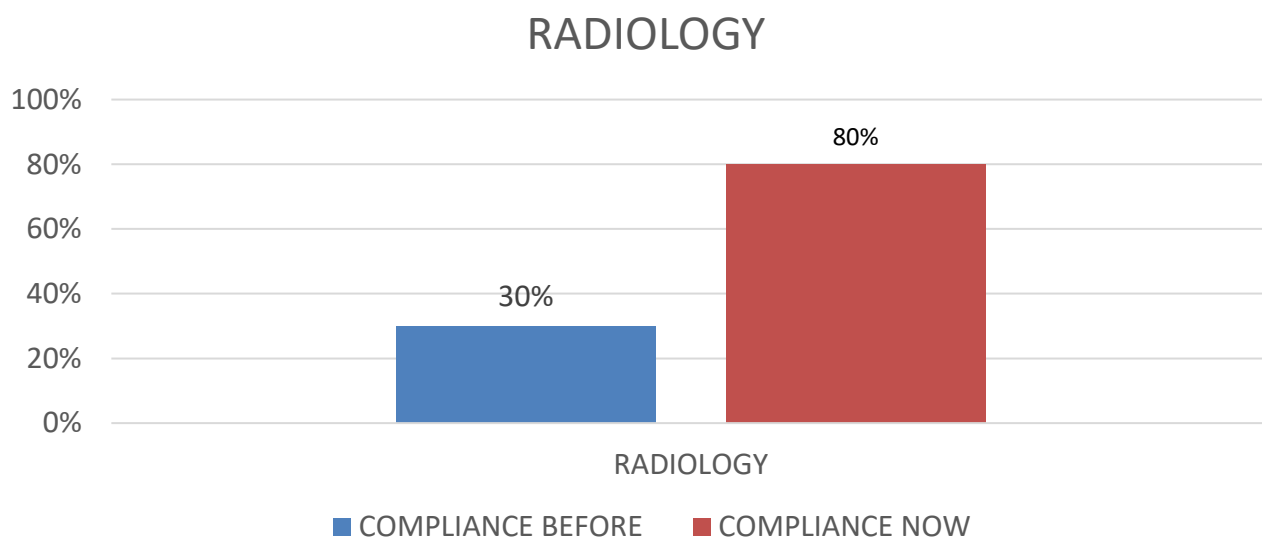
- Multiple follow up to retrieve data
- Misinterpretation of the indicators



Observations	Corrections done
Unstructured data was there without any format	Processing of the data with complete format
Numerator and denominator was not mentioned	Numerator and denominator were provided with proper format
Outliers not mentioned	Intimated to concerned person

Challenges

- Multiple follow up to retrieve data
- Unstructured data

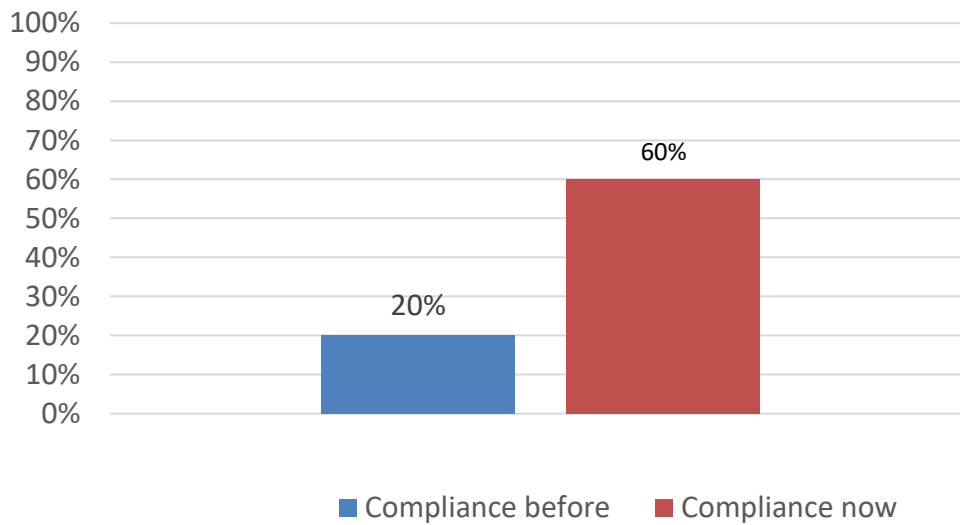


Observations	Corrections done
Unstructured data was there without any format	Processing of the data with complete format
Numerator and denominator was not mentioned	Numerator and denominator were provided with proper format
Target not mentioned	Intimated to concerned person

Challenges

- No single point of contact
- Multiple follow up to retrieve data

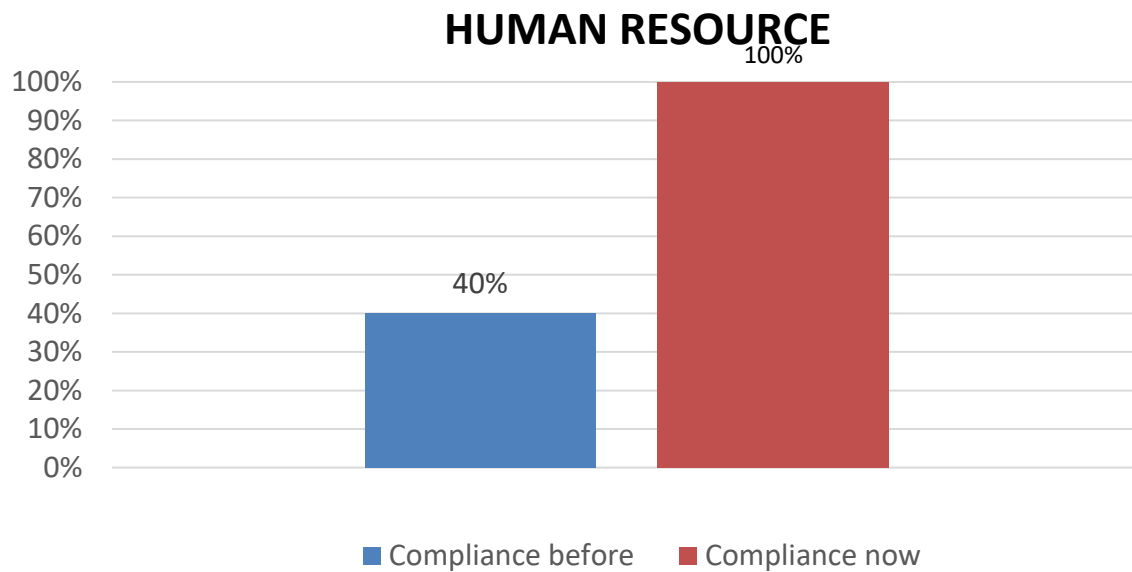
ICU



Observation	Correction
Indicators indirectly maintained	Proper format and correct way of recording was formulated
50% of the indicators not captured	List of indicators to be maintained compulsory was given. Monitoring was done to make sure required data is being captured
Staff was unaware about the indicators	Training session on NABH awareness was Organised with the help of quality manager.

Challenges

- NO SPOC
- Quality sheet not maintained
- Unstructured data



Observation	Correction
Indicators not maintained in the required format	Proper format and correct way of recording was formulated
Data being worked upon in back log	Pending data was asked for completion to match with the timeline
Targets and sample size not being followed	NABH awareness was organised providing relevant information for capturing the indicators.

Challenges

- Pending Data
- Quality sheet not maintained
- Unstructured data

RECOMMENDATIONS

1. There should be a training organised for NABH awareness as many of the new staff which have joined post NABH accreditation are not aware about the standards and protocols of the same.
2. The importance of providing quality care should be circulated among each and every individual working in the hospital and the importance of NABH in the regulation of the same.
3. There is no single person of contact present in the departments who can compile and monitor the departmental data for the purpose of quality indicators.
4. There should be a QUALITY CHAMPION that should be assigned in each and every department so that proper management and monitoring of the data pertaining to the indicators can be done.
5. In some cases, the departments have not given any outliers for deviations. It should be made sure that the RCA are done collectively by the concerned department along with the Quality team.
6. A revision of the internal targets or benchmarks should be done so that those indicators which are consistently getting lower results than targets may achieve initial targets first and then the higher targets.
7. Revision of the Quality Manual to be done as the targets being followed are the one given there.
8. There has to be a set documented guidelines for establishing the internal targets and that should be present and circulated with all the departments of the hospital.
9. Monthly meetings should be conducted for all the departments to study the trend of the ongoing indicators and what corrections and amendments needs to be done for the proper goal achievement.
10. Random and frequent audits to be done to monitor the compliance and take corrective and preventive actions for the discrepancies found.
11. Staff education for minimising any kind of incident and proper reporting of the same should be done.
12. A proper format or method should be devised for capturing and evaluating the departmental data incorporating the quality team also.

CONCLUSION

Patient Safety is one of the major key areas for a hospital to provide proper and quality care to its patients. Accreditation is one of the means to assure the same that without any of the lacking or obstacles, the patient safety is not being compromised. Accreditation authority makes sure through continuous surveillance and audits that there is no loop hole in the standards of care being provided to the incoming patients as well as the staff working there.

Going through the various indicators of multiple departments, it was found that the hospital follows a strict adherence to the standards laid down by the NABH which is the accrediting body there.

But there were a few short comings, none of them being major, which can be corrected by giving necessary training to the concerned staff and strict implementation of the same.

The analysis was found to be more than satisfactory which in turn defines continuous progress towards achieving the best.

Therefore it can be concluded that a few of the recommendations needs to be implemented so that the highest level of care can be provided overcoming all the obstacles, rest all being completely positive towards the Goal.

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