Study to Assess the Gaps and Readiness of SHCOs for Manyata Assessment and NABH Pre Accreditation Entry Level Certification

By

Sandeep Yadav

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 Mr. Sandeep Yadav, student of MBA Hospital and Health Management from The IIHMR University, Jaipur has undergone internship training at Sanjeevani Hospital, Kotputli, Jaipur from 1st February 2019 to 31st May 2019.

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

The Internship is in fulfillment of the course requirements.

I wish him all success in all his future endeavors.

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The certificate is awarded to

Mr. Sandeep Yadav

In recognition of having successfully completed his Internship in the department of

Name of Department : Quality

And had successfully completed his project on

A study on gap analysis for Entry level NABH standards in small healthcare organizations

Date :1st February 2019 to 1st May' 2019

Organization : Sanjeevani Hospital

He comes across as a committed, Sincere & diligent person who has a strong drive & zeal for learning

We wish him all the best for future endeavors.

Dr. S.M. Yadav
Director & Medical Superintendent
Sanjeevani Hospital, Kotputli

Mr. Manish Kumar Yadav
HR Manager
Sanjeevani Hospital, Kotputli

THE IIHMR UNIVERSITY, JAIPUR

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled - A Study to assess the gaps and readiness of Small Healthcare Organizations for Manyata Assessment and NABH Pre Accreditation Entry Level Certification and submitted by Mr. Sandeep Yadav Enrolment No -0658. MBA -HM22 under the supervision of Dr S.D. Gupta for award of MBA in Hospital and Health of the University carried out during the period from 01-02-2019 to 31-5-2019 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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Mr. Mukesh Kumar Yadav

Quality manager

Sanjeevani Hospital, Kotputli, Jaipur

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INTRODUCTION

For NABH :

There are great improvements in the health care industry in last few years, that was seen by the decrease in IMR and MMR etc. (NFHS4). Patient Quality and safety is vital matter in today growing industry of health. It would not fulfill the requirement of rapid increasing our county's masses. A lot of small hospital have come up which may not have proper qualitative services to meet basic needs of health. Such SHCOs put extra burden in such nation. The patient now become aware of quality & do not hesitate in paying extra for good facility. Due to demanding preference of qualitative services the hospital has to mapping up the qualitative facility given by them.

At international platform international society for quality in healthcare (ISQua) is conducting for quality. International Society for Quality in healthcare is a international organization which was setup in year 1985. It's aim is to give qualitative services along with patient safety by different technique through different methods like motivating SHCOs, to aware and making a networks of accredited hospitals globally. Regional and national level HCOs get accreditation through International Society for Quality in healthcare globally via the "International Accreditation Programme". It also have responsibility for checking the organization's standard which will sets benchmark in hospital safety as well as qualitative care.

JCI is a U.S. based NPO body setup in the year of 1994, that set and makes standard and process to make a cultural ethic, quality along with safety in a body that enhance the care of patients process continuously and the results. It's the largest and oldest standard setting and accreditation body in HCOs in the US.

The NABH accreditation is for that organization (hospitals), which give treatments to the patient. HCOs in our country could be apportioned into 3 types based on bed numbers -

(a) C type SHCOs are situated at lot of places for easy reach. It has 50 or lesser beds and give primary care. Those are hospitals and clinics.
(b) B type HCOs have 51-100 beds, provided some specialty care; have some departments that includes some investigations facility. These could have arrangement to give basic care to patient and the relative.
(c) A type HCOs have greater than 100 bed strength, multi-specialty, used for more good diagnostic technology and attract Technical, having experience and qualitative experts.

There are around 50,000 HCOs working on national level as mentioned on website of NABH, where maximum could be termed as the SHCOs. The small Healthcare organization is defined by NABH, as these HCOs which has below 50 bed and have all medical facility, utility and supportive services as claimed by small Healthcare organizations.

The super specialty center gives service like: orthopedics, Neurology, and rheumatology etc. and should have qualified experts professionals with DM/Mch degree are also considered. The diagnostic centers and polyclinic get excluded. The NABH website provides information that Maximum HCOs (around 90%) have below 100 beds, so there was a demand to have specific guideline for SHCOs therefore these can apply easily for accreditation , get themselves certified as a destination of qualitative care. The standards for SHCO (small Health care organizations) is compiled after taking 41 standard of total 105 standards which have 149 objective element of total 686 elements of total of full NABH accreditation Programme (NABH standard 4th edition .2015) that is relevant for SHCOs.

It has been expected by the government that these small Health care organizations will fulfill to these entry-level pre accentuation standard and provide qualitative care and will make a qualitative culture in the country.

Entry level NABH Pre-Accreditation Standard for small Health care organizations contain 10 Chapters that have 41 standards that again have 149 objective Elements, keeping in view the small Health care organizations, so that they can easily implement it. Outline of National Accreditation Board for Healthcare and Hospital chapters are:

Patient centric standard:

1. Access, Assessment and continuity of care(AAC)
2. Care of Patient(COP)
3. Management of Medication(MOM)
4. Patent Right and Education(PRE)
5. Hospital Infection Control(HIC)

Organization Centric Standard:

6. Continuous Quality Improvement(CQI)
7. Responsibility of Management(ROM)
8. Facility Management and Safety(FMS)
9. Human Resource Management(HRM)
10. Information Management System(IMS)

The small Health care organizations, that get pre accreditation NABH entry level, shall start self assessment entry level NABH pre-accreditation standard after implementing for minimum 3 months before application submission and must confirm that it comply with the standard. After getting NABH entry level pre-accreditation, the HCOs should go for NABH progressive level and after then full accreditation. It also shows that commitment of the SHCOs toward continues improvement in care and quality up to it's full.

For Manyata:

FOGSI, in partnership with Jhpiego and supported by MSD for mothers, implemented a path-breaking initiative from 2013 to 2016 to improve quality of care in private sector through a structured quality improvement approach using standards of care. In the program, FOGSI in collaboration with Jhpiego and Govt. of India, Jharkhand and Uttar Pradesh developed a set of 27 clinical care standards consisting of essential key lifesaving practices at and around the time of childbirth. The key components of the program aimed at capacity building of provider specially nursing staff in the form of interactive trainings and on-site mentoring support. The program was implemented in more than 140 private sector health facilities in Uttar Pradesh and Jharkhand. The program showed impressive results with 120 of 140 institutions achieved scores higher than 70% on the standards at the end of 2 years of implementation. A valuable lesson from the program was the potential of formal recognition or linkages of facilities with quality of care certification systems as a means of sustaining the quality in the partnering facilities.

Moving forward, FOGSI and Jhpiego with continued support from MSD for mothers have come together to develop a focused quality assurance program for institutions providing maternity care in India. Under this initiative, FOGSI has developed a unified certification system termed as “Manyata” for the maternity institutes in India that can be implemented at scale. Manyata is a FOGSI’s initiative in partnership with Jhpiego which aims to create a robust quality improvement mechanism by helping private maternity care providers improve their quality of services and recognize those who consistently deliver quality care to the women they serve.

The Manyata program is presently being implemented in three states- Uttar Pradesh, Jharkhand and Maharashtra with collaboration with FOGSI chapters. The concerted mechanism will comprise of active engagement with participating facilities in Quality improvement journey, which includes intervention for 4-6 months for improving quality of care in the form of trainings, on-site mentoring and internal assessments to review progress. This would be followed by mandatory FOGSI led external assessment to certify that the facility is adhering to quality of care standards for in order to grant Manyata certificate.

FOGSI intends to improve quality of maternity care through use of Manyata Clinical Standards which coupled with capacity building initiatives, needs to be implemented across the engaged private sector healthcare facilities. With this, FOGSI aims to standardize clinical practices amongst providers enabling them to be confident, competent and empowered. The tools used in the Manyata initiative are intended to act as guide as well as to measure the progress achieved so for by means of periodic assessments and later for Manyata certification through external FOGSI assessment.

Manyata Clinical Standards :

A Clinical Standard is a quality statement that describes the care patients should be offered by health professionals and health services for a specific clinical condition in line with current best evidence. Standards of Care form the key component of the Manyata initiative and depict safe care practices to be adhered to at the target health facilities. The standards cover the full spectrum of care for various times during and after delivery including screening and early diagnosis of conditions, normal care processes, and early and comprehensive management of complication.

FOGSI leadership reviewed globally available standards of care to device specific set of 16 clinical standards to be used for Manyata initiative which are relevant to Indian settings. The set of clinical standards include evidence based, high impact practices focusing on intra-partum and immediate post-partum care.

Each standard consists of two important components—a standard statement and a set of essential elements. The standard statement is a statement related to a normative clinical practice in support of routine care or identification or management of complications. Each essential element describes a component of care/clinical practice under that standard. Essential elements are objective statements, and compliance to them can be assessed by the means of one or more verification criteria included in the standards- based assessment tool. The detail list of clinical standards annexed as **Annexure 1**. FOGSI will insure implementation of these 16 clinical standards during quality improvement journey in enrolled facility and the assessment for Manyata certification will be conducted on the core 14 clinical standards focusing on intra-partum care.

As given in the assessment methodology, the assessor will use either of the methods or combinations to verify the status of verification criteria listed under each standards statement. Wherever possible, assessor should try to use observation as preferable method for decision making. The standards and related verification criteria to be assessed objectively and based on the overall response, the assessor will mark the standard "Yes" for met and "No" for unmet standards. The standard no. 1 (related to ANC) and 16 (C-section) are non-scoring standards and will not be taken into account for calculating qualifying score for Manyata Certification.

The facility should score at least 12/14 (85%) core clinical standards to quality for Manyata Certification.

NPMU team will compile the assessment results on the basis of Manyata Score sheet submitted by FOGSI assessor. The NPMU team will share the list of qualified facilities (scored 85% or above) to FOGSI leadership for issuance of Manyata Certificate after screening of necessary administrative requirements.

If the facility scores less than 70%, the facility will get a window of 3 months to address the identified gaps and have to re-apply through Manyata website for conducting re-assessment. The cost towards re-assessment will be borne by the concerned facility. The facilities scoring above 70% but less than qualifying score will get a months' time to close the identified gaps and upload the documentary evidence on Manyata website for review of NPMU team. If NPMU finds those evidences satisfactory, then NPMU team will close the non-compliant gaps and update the score of facility on website and proceed for the issuance of Manyata Certificate.

The certificate can be sent by post – or may be awarded in any function or ceremony which happens in FOGSI. The validity of Manyata certificate will be 2 years from the date of awarding subject to demonstrated adherence of QI processes

Process Flow on the day of Assessment :

The NPMU team will schedule the assessment in consultation with assigned assessor and facility in-charge and also prepare for related logistics to ensure successful completion of assessment. Facility has to ensure that at least 70% of clinical (doctors & nurse) should be available on the day of assessment. This section elaborates the sequence of key processes/activities taken up by the FOGSI assessor on the day of assessment.

Step 1: Once the assessor reach the facility should go to the reception area and ask for facility in-charge and have one to one introductory meeting

Step 2: Assessor will ensure availability of clinical staff and organize a briefing meeting with available staff to discuss the process of assessment which includes different area planned to visit, assessment methods- physical verification, observation, record review etc. Since the clinical standards focuses on the practices and resources required for intra-partum and immediate post-partum care, therefore the labor room of facility is the preferred and most suitable place of carrying out the assessment in the facility

Step 3: The clinical standards have essential elements which can be verified through observations, physical verification, provider interaction (Doctors and Nurses) and records review (case sheet, registers etc.). The standards are designed in a way that it automatically leads to progressive steps starting from preparation for safe delivery to post-partum care. However, assessor can start assessment with any standards of choice if needed. The following steps are suggested to carry out the assessment on standards:

- Assessor may follow the sequence of standards to carry out the assessment as per the assessment checklist
- Assessment shall be preferably conducted in the labor room of facility by using simulation models or actual client if consented.
- Facility will ensure availability of at least 70% of clinical staff on the day of assessment and all can participate in the assessment process.
- Assessor shall verify the clinical practices by observing the skills on models or client (if consented) and also simultaneously physically verify the availability of supplies and functional instruments, equipment in labor room.
- As given in assessment checklist, Assessor may direct their questions to relevant staff nurses or doctors depending upon the protocol of facility.
- Assessor can also use innovative ways of assessments such as simulation drills, building case scenario between the ongoing clinical staff assessments.
- Assessor can also review the case sheets, labor room register etc. to verify the actual implementation of practices by staff.

Step 4: Once the assessor complete the assessment and conclude the observation, a de-briefing meetings will be called by assessor to share the observations and feedback with all available staff of facility.

Summarizing and sharing of the assessment findings :

Upon completion of assessment and marking of scores in the assessment tool, assessor will debrief the facility in-charge and key staff on overall experience and assessment findings. During the debriefing assessor will share the final scores and qualifying status with facility in-charge. The summary score will be shared with NPMU for record keeping and further action (**Annexure 2**. Manyata Scoring Sheet). The assessor will also share the detailed observations on unmet standards along with course of action suggested to facility in the Assessor Feedback Form (**Annexure 3.** Assessors feedback form for the facility) . The both the forms- Manyata scoring sheet and Assessor feedback form will shared with facility as well as with NPMU team for further monitoring and surveillance activities.

1.1 RATIONALE

The population level in urban area and rural areas are 30% and 70% respectively (censes 2011). These population prefer to go government hospitals which do not have basics facilities and which are overcrowded instead of private practitioners whose charges are too high. But due lack of presence of doctors, medicines, and quality care , they are forced to go private hospitals. The gap of this supply and demand is fulfilled by private hospitals and nursing homes by charging higher cost. The private hospital's share in total number of beds of hospital is 40% and out of total number of healthcare organization is 74% (by KPMG report, 2017). Private doctors who are present have high consultation charge which put a lot of extra burden on the pocket expenditure for poors.

Total Number of Healthcare organization in our country is around 50,000. There are 201 Healthcare organization and 29 small Healthcare organization (less than 50 beds) are NABH accredited. Additionally , 397 large HCOs and 123 small HCOs are in the process of gaining accreditation. It indicates that a very small portion of Healthcare organization are having quality (NABH) certification. One of the reason could be that NABH Accreditation is Voluntary quality certification Programme.

The NABH (National Accreditation Board for Hospital and Healthcare) accredited or NABH pre-accreditation entry level healthcare service providers should be allowed for cashless service.

Using this toolkit, the organization can compare themselves to the standards mentioned and can analyze where they stand. This study aims to study the compliance of the organization to the standards mentioned in the pre-accreditation entry level. For the case of study the organization are divided into4 mages on basic of time period.

(a) Those small Healthcare organizations, which got entry, level NABH pre-accreditation(stage 4)

(b) Those small Healthcare organizations, which are completely ready for pre-assessment for entry level NABH(stage3)

(c) Those small Healthcare organizations 2 months post filling application before entry level pre-accreditation(stage 2)

(d) Those small Healthcare organizations which have just filled the application(stage 1).

For Manyata gap assessment all those SHCOs are taken which are taken for the study of gap analysis of NABH entry level pre accreditation. These SHCOs are categorized in category 1, 2, 3 according to level of completion percentage of score achieved. These are as follows:

Category 1 : Those SHCOs which have low percentage score (i.e. below 70 % score)

Category 2 : Those SHCOs which have low percentage score (i.e. below 70 % score) at the time of previous score but have medium percentage score (i.e. more than equal to 70% but less than 85 %)

Category 3 : Those SHCOs which have low percentage score (i.e. below 70 % score) at the time of previous score but have high percentage score (i.e. more than 80 % score) at the time of current score.

CHAPTER 2
REVIEW OF LITERATURE

One of the study on accreditation of hospitals in low and middle income country, it was found that accreditation of hospital was developed at first in US by the American college of surgeon close to 100 year ago. First it slowly spread to other countries but it get acceleration in the1980 and 1990. Chiefly in English –speaking developed countries. In a handbook complied by Apollo Hospital, Dhaka, Bangladesh, it says that accreditation by JCI is an effective quality evaluation and management tool for ensuring a safe care environment which help continuous improvement process to reduce risk to patient and staff. There are total 16 chapters in which, 8 are patient centered chapters, 6 are organization management centered chapter and 2 are academic medical center hospital chapters.

There is a huge requirement of standardized provision of quality care in health care organization. This is provided by NABH standards. It is clear that many organizations post achievement of NABH accreditations get relaxed and not compliant to standards. But a search gap can be seen as no much study has been performed on the gap assessment of SHCO comparing them at various stages of pre accreditation entry level NABH and ager entry level NABH pre- accreditation. This project aim at doing the gap assessment of small healthcare organization at various stages of pre-accreditation and after achieving entry level NABH pre- accreditation and comparing the finding so obtained.

FOGSI, in partnership with Jhpiego and supported by MSD for mothers, implemented a path-breaking initiative from 2013 to 2016 to improve quality of care in private sector through a structured quality improvement approach using standards of care. In the program, FOGSI in collaboration with Jhpiego and Govt. of India, Jharkhand and Uttar Pradesh developed a set of 27 clinical care standards consisting of essential key lifesaving practices at and around the time of childbirth. The program was implemented in more than 140 private sector health facilities in Uttar Pradesh and Jharkhand. The program showed impressive results with 120 of 140 institutions achieved scores higher than 70% on the standards at the end of 2 years of implementation. A valuable lesson from the program was the potential of formal recognition or linkages of facilities with quality of care certification systems as a means of sustaining the quality in the partnering facilities.

CHAPTER 3
METHODOLOGY

3.1 AIM :

To assess the gaps of Manyata and NABH Pre Accreditation Entry Level Certifications in SHCOs.

3.2 Objective:

- To identify gaps as per the Manyata and entry level NABH pre-accreditation for SHCOs.
- To Compare the compliance of Manyata Standards and NABH Pre Accreditation Entry Level Certification Standards, between starting and end of study period.
- To identify the relationship between Manyata and NABH Pre Accreditation Entry Level Certification.
- To give recommendations and suggestions for filling the gaps in SHCOs to get accredited from Manyata and NABH Pre Accreditation Entry Level Certification.

3.3 Study Design: Design is Descriptive cross-sectional study.

- **Definition of SHCO:** It is defined as those healthcare organizations ,with less than 50 beds.
- **Definition for Pre-accreditation entry level NABH standards:**
  NABH Pre-accreditation entry-level standards for SHCO includes 10 Chapters that have 41 Standards that again have 149 Objectives Element.
- **Operational definition for Manyata Certification :**
  Manyata certification for facilities has 16 standards (stnds) containing 57 objective elements(OE), that are again having 112 verification criteria which every facility can easily implement.

3.4 Study Location and Duration The study was done in Small healthcare organizations in Jaipur and nearby regions for duration of 3 months.

3.5Sampling Frame: All those SHOs that are getting consultancy service from HLFPPT, Jaipur. As of now there are approx.. 120 SHCOs that are getting consultancy service from HLFPPT.

3.6 Sampling size:12 SHCO in Jaipur and nearby region out of 120 projects which HLFPPT is handling

3.7 Sampling Technique : Sampling is Non-probability , where convenient sampling was done, as these SHCOs were assessed during three months time out of total sampling frame.

3.8 Data collection : Data collection tool

For NABH :

Pre-accreditation entry level NABH self assessment toolkit which includes 5 chapters for patient centric and 5 organization centric chapters.

First 5 chapters for patient centric are as follows:

- Chapter 1: AAC (Access, Assessment and Continuity of care)
- Chapter 2: PRE (Patients' Rights and Education)
- Chapter 3: COP (Care of Patients)
- Chapter 4: MOM(Management of Medications)
- Chapter 5: HIC (Hospital Infection Control)

Remaining 5 chapters of organization centric are as follows:

- Chapter 6: CQI (Continuous Quality Improvement)
- Chapter 7: ROM(Responsibility of Management)
- Chapter 8: FMS (Facility Management and Safety)
- Chapter 9: HRM (Human Resource Management)
- Chapter10:IMS (Information Management System)

For Manyata :

Manyata clinical standards : Annexure 1 and Manyata Assessment Scoring sheet was used which includes 1st standard for Antenatal Care, Standard 2 to 6 for Admission, Standard 7 to 13 for Delivery, standard 14th for Beyond Delivery, standard 15 for Postnatal Care Standard and standard 16th for C-Section.

Antenatal Care :

Standard 1 : Provider screens for key clinical conditions that may lead to complications during pregnancy. (To be verified only among booked cases)

At Admission :

Standard 2 : Provider prepares for safe care during delivery (to be checked every day)

Standard 3 : Provider assesses all pregnant women at admission

Standard 4 : Providers conducts PV examination appropriately

Standard 5 : Provider monitors the progress of labor appropriately

Standard 6 : Provider ensures respectful and supportive care

At Delivery :

Standard 7 : Provider assists the pregnant woman to have a safe and clean birth

Standard 8 : Provider conducts a rapid initial assessment and performs immediate new-born care (if baby cried immediately)

Standard 9 : Provider performs Active Management of Third Stage of Labor (AMTSL)

Standard 10 : Provider identifies and manages Postpartum Hemorrhage (PPH)

Standard 11 : Provider identifies and manages severe Pre-eclampsia/Eclampsia (PE/E)

Standard 12 : Provider performs new-born resuscitation if baby does not cry immediately after birth

Standard 13: Provider ensures care of new-born with small size at birth

Beyond Delivery:

Standard 14 : The facility adheres to universal infection prevention protocols

Postnatal Care Standard :

Standard 15 : Provider ensures adequate postpartum care package is offered to the mother and baby – at discharge

C-Section :

Standard 16 : Provider reviews clinical practices related to C-section at regular intervals

3.9Data Collection Method

The Pre-accreditation entry level NABH self-assessment toolkit was used for data collection, where for assessing some objective elements, observation was required, for some other elements reviewing of SHCO manual, records and policies was needed and in few, interview with the hospital staff and patients was required. The toolkit of NABH consist of:

1) Implementations (No/Yes): Weather the objectives are implemented in the department or not.
2) Documentation (No/Yes): If the objective is implemented, weather there is proper documentations regards same or not.
3) Evidences: If proper documentation of the said objective is available, then evidence will be collected regarding the same.
4) Scores (10/5/0): Once all the above criteria is fulfilled score would be given as follow
    - Compliances to the requirements: 10
    - Partial compliances to the requirements: 5

- Non-Compliances to the requirements :0
- Not applicable :NA

The Manyata clinical standards : Annexure 1, 2. 3 and Manyata Assessment Scoring sheet was used for assessing objectives element and data collection, observation was required, for some other element reviewing records and policies was required and in some, interview with the hospital staff and patient was required . The Manyata Annexure 1,3 and Manyata score sheet consist of :

1. Remarks : where all comments regarding compliance was written
2. Final Response : where "Yes" for met compliance and "No" for unmet compliance for the standards.
3. Score and percentage : where obtained marks recorded (like 1 marks for fully compliance of any one standard) and percent is calculated. If percent goes more than equal to 85 % than facility will be eligible to get Manyata certification.
4. Unmet Verification Criteria : where any unmet compliance of standard is recorded followed by assessor's comment.

Inclusion criteria and Exclusion criteria for SHCOs: The inclusion Criteria was SHCOs getting consultancy from HLFPPT, Jaipur and the exclusion criteria was SHCOs except Jaipur district.

Data Analysis : The data collected by interview and observations of the staff and also after comparing the SHCOs with Manyata Annexure 1, 2, 3 and self-assessment toolkit for pre-accreditation entry level NABH standard. It was analyzed quantitatively form on excel workbook. The analysis depicts that, the SHCOs that are going for assessment in 4-5 month time) are maximum compliant to standard, while those Small Healthcare organizations which has Just filled the application are less compliant. The Small Healthcare organizations, that obtained the NABH entry level pre-accreditation, are less compliant compared to those Small Healthcare organizations, that are about to go for assessment.

Ethical Consideration:

The importance and Purpose of study would be conveyed on the individual. An informed consent will be taken before starting the survey. The respondent get informed that the study is for academic purposes only .It has been assured to respondent for their volunteer involvement . All the data will be confidential which can be used only for study purpose without any harm to the respondent.

CHAPTER 4
RESULTS

Results of gap assessment done for NABH entry level pre accreditation :

The results received from gaps assessment done for SHCOs, is prescribed in graphs form. These graph are received through quantitative data-analysis on workbook of excel. A line graph is also plotted to show the comparision and similarity between NABH Entry Level Pre-Accreditation. There are 12 SHCOs that get selected out oh120 SHCOs which are getting consultancy services from HLFPPT, Jaipur.

For NABH gaps study, all 12 SHCOs are classified into four categories:

1. Fresh start Project(1 to 2 weeks)
2. 2months after start of project
3. SHCOs going for NABH entry-level Pre-Accreditation in about 4-5 months
4. SHCOs which get certified for NABH entry-level Pre-Accreditation approx 2 months before.

Permission has been taken from HLFPPT, Jaipur as well as from all SHCOs for keeping their confidentiality.

All SHCOs taken for the study purposes are less than 50 beds hospital that are located in Jaipur and Jaipur Rural which include multispecialty Hospitals, Nursing Homes etc. Hospital are coded as A ,B ,C and so on due to ethical reasons. All SHCOs are categorized into four Parts according to time period from NABH entry level pre-accreditation certifications.

Stage 1, 2and 3 are before NABH entry level Pre Accreditation while stage4 is after NABH entry-level pre-accreditation. Following are categorization of SHCOs into stages :

Stage 1 : Those SHCOs which just started preparation for NABH entry-level pre-accreditation process. It include SHCO A, SHCO B, SHCO C.

Stage 2 : Those SHCOs which has started preparation 2 months before for NABH entry-level pre-accreditation. It includes SHCO D, SHCO E, SHCO F.

Stage 3 :All those SHCOs that there is NABH entry level pre accreditation assessment in about 4-5 months. It includes SHCO G, SHCO H, SHCO I.

Stage 4 : All those SHCOs that already get NABH entry-level pre-accreditation certification approx 1 month before. It includes SHCO J, SHCO K, SHCO L.

Tabular categorization of stages and SHCOs :

Sr. No.	Stages	Status	Time Spended for Hospital Readiness for NABH Pre-accreditation	Code Name (Hospitals)
1	Stage 1	Before Assessment	1-2 weeks	A,B, C
2	Stage 2	Before Assessments	Approx. 2 Months	D ,E ,F
3	Stage 3	Before Assessments	Approx. 3-4 Months	G,H,I
4	Stage 4	After Assessment	Around 1 Month after NABH Pre-Accreditations	J, K,L

The data was taken using NABH entry level pre accreditation toolkit which comprises of 10 Chapters incorporating 41 Standards and include 149 Objective Elements.

Stage 1 SHCOs :A,B,C :

Graphical presentation of the data :

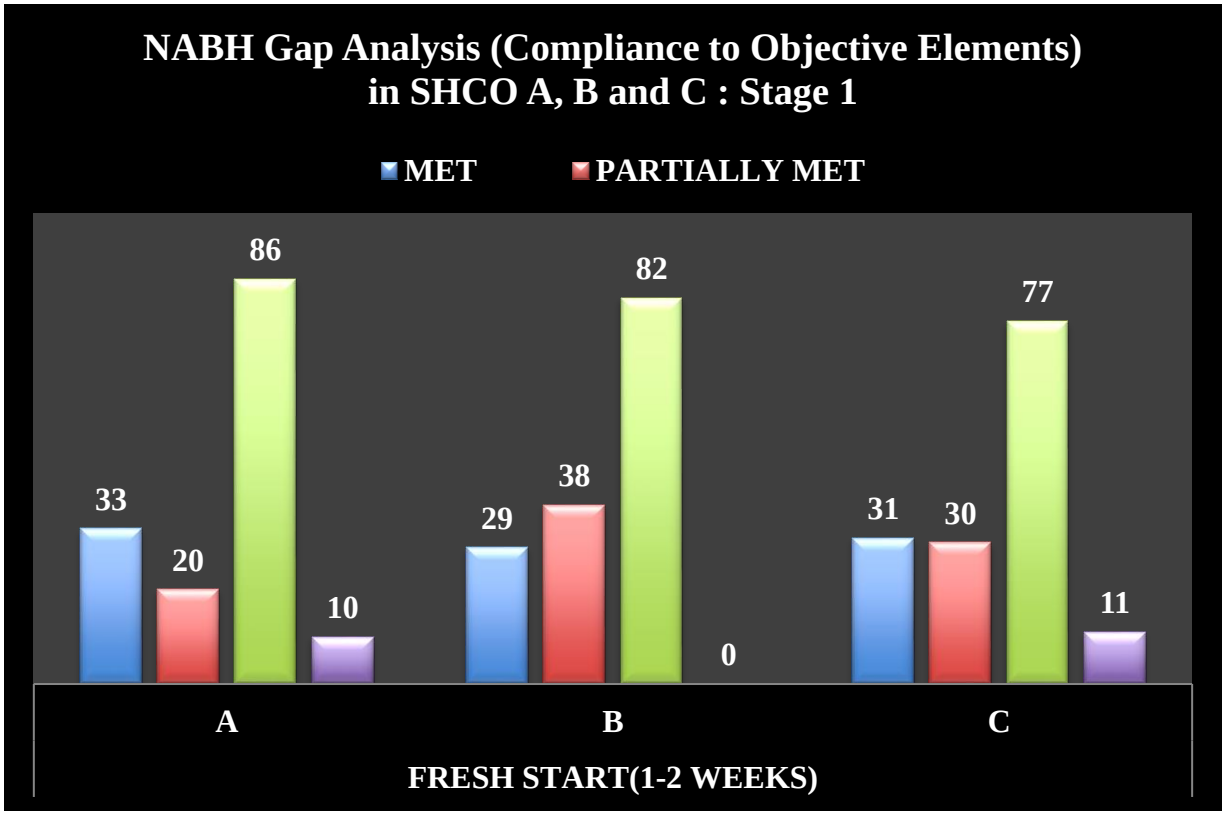

Figure 4.1

The Figure No. 4.1 depicts, Stage 1 includes three SHCOs A, B and C. It depicts that SHCOs following under stage 1 have 75 – 90 objective elements are non met compliances whereas 30- 40 objective elements are met compliances. SHCOs A, B and C have 20-38 objective elements are partially met. SHCO A is at better position than SHCO B and SHCO C because it's "met" and "partially met" compliance of objective element are higher. There are 149 objective elements which are required to be met. This figure at last depicts that all three SHCOs of stage 1 have very less compliance of objective elements met as they has just applied for NABH entry level pre-accreditation.

Stage 2 SHCOs :D,E,F :

Graphical presentation of the data :

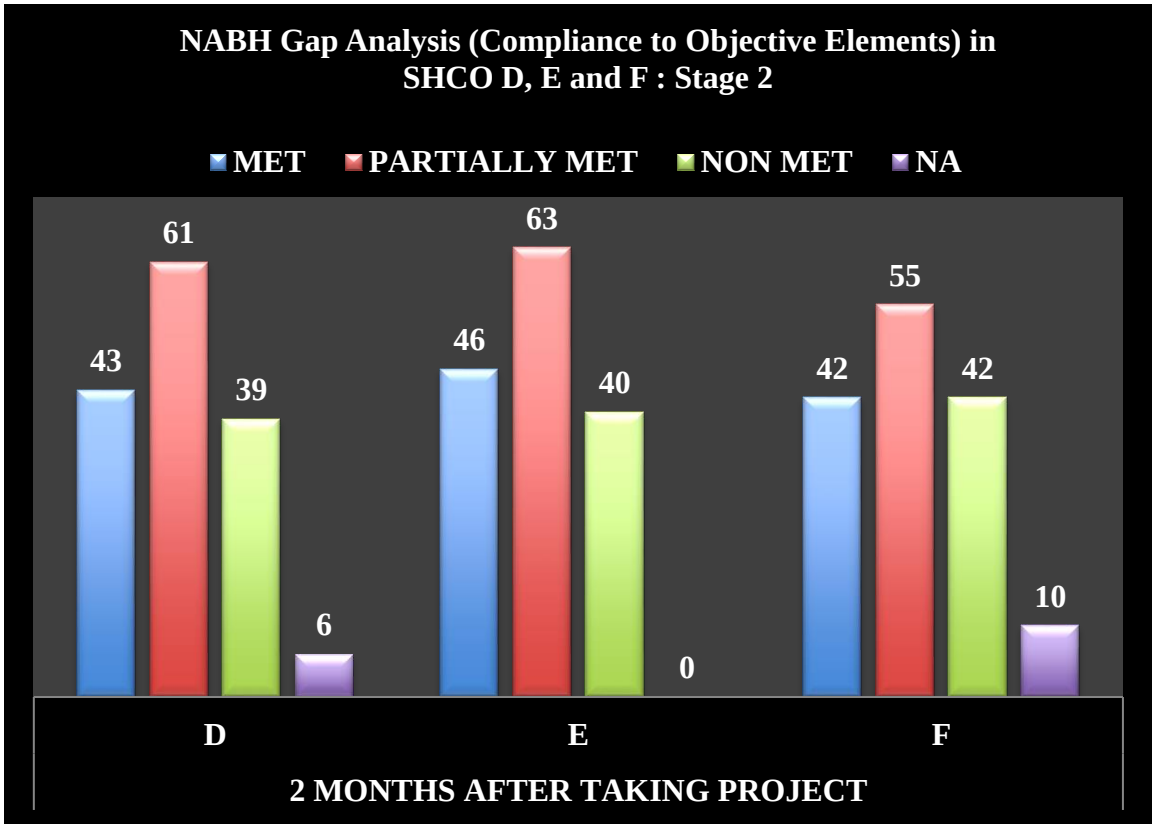

Figure 4.2

The Figure No. 4.2 depicts, Stage 2 includes three SHCOs D, E and F. It depicts that SHCOs following under stage 2 have 39 – 42 objective elements are non met compliances whereas 42- 46 objective elements are met compliances. SHCOs D, E and F have 55 - 63 objective elements are partially met. SHCO E is at better position than SHCO D and SHCO F because it's "met" and "partially met" compliance of objective element are higher. There are 149 objective elements which are required to be met. This figure also depicts that all three SHCOs of stage 2 also have not much compliance (although greater than SHCOs of stage 1), of objective elements met as they worked approx. 2 months for NABH entry level pre accreditation certifications.

Stage 3 SHCOs :G,H,I :

Graphical presentation of the data :

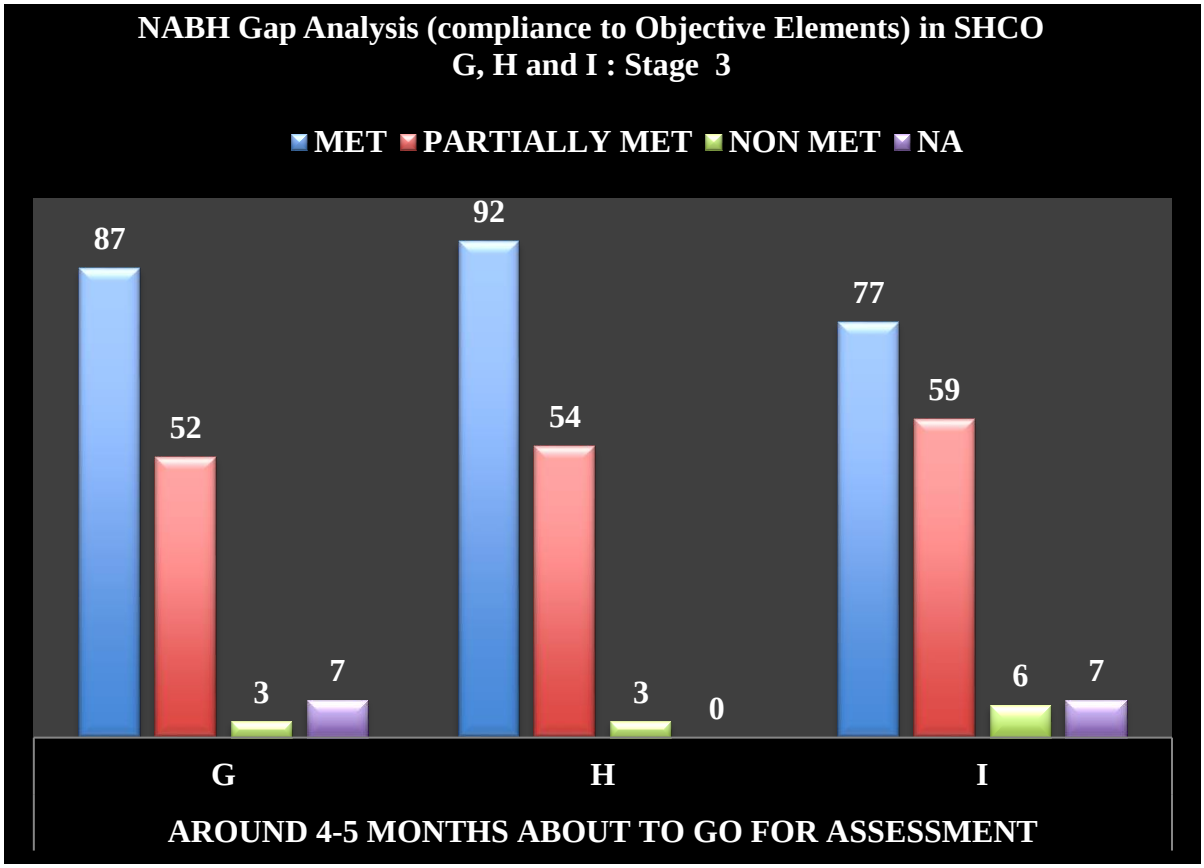

Figure 4.3

The Figure No. 4.3 depicts, Stage 3 includes three SHCOs G, H and I. It depicts that SHCOs following under stage 3 have 3 – 6 objective elements are non met compliances whereas 77- 87 objective elements are met compliances. SHCOs G, H and I have 52 - 59 objective elements are partially met. SHCO H is at better position than SHCO G and SHCO I because it's "met" compliance of objective element are higher. There are 149 objective elements which are required to be met. This figure depicts that all three SHCOs of stage 3 have many compliances, of objectives element met as they are mostly prepared for NABH entry level pre accreditation certifications in 3 – 4 Months. This stage has highest compliance met compared to remaining 3 stages as they focusing on continuous quality improvement.

Stage 4 SHCOs :J,K,L :

Graphical presentation of the data :

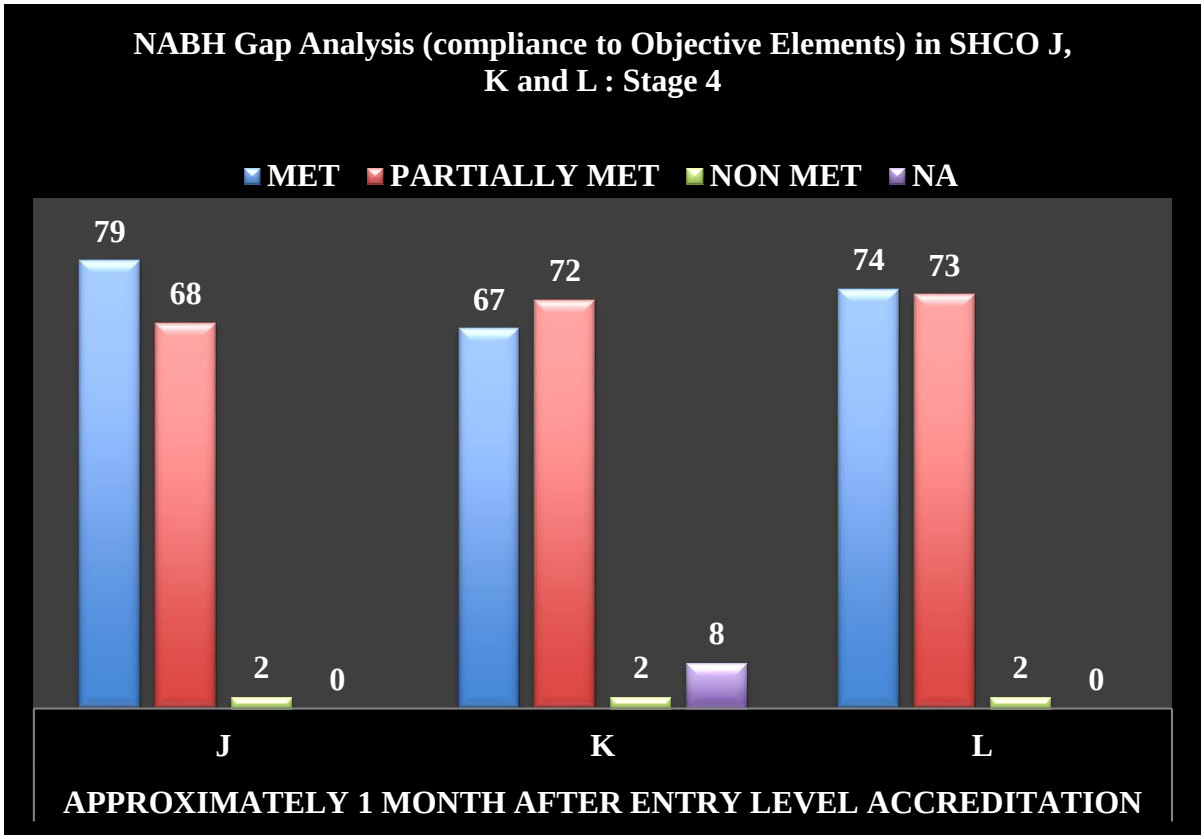

Figure 4.4

The Figure No. 4.4 depicts, Stage 4 includes three SHCOs(J,K andL). It depicts that SHCOs following under stage 4 have 2 objective elements are non met compliances whereas 67- 79 objective elements are met compliances. SHCOs J, K and L have 68 - 73 objective elements are partially met. SHCO J is at better position than SHCO K and SHCO L because it's "met" compliance of objective element are higher. Although SHCO L have higher partial met compliance to objective elements. There are 149 objective elements which are required to be met. This figure depicts that all three SHCOs of stage 4 have reducing compliance, of objective elements met as they already get NABH entry level pre accreditation certifications 1 Month before.

Results of gap assessment done for Manyata :

The gap assessments done on SHCO for Manyata is represented in form of graph. It can be done through collection of data with the help of annexure A, B, C of Manyata through quantitative analysis of data through excel workbook.
All those SHCOs are taken which are taken for the study of gap analysis of NABH entry level pre accreditation. These SHCOs are categorized in category 1, 2, 3 according to level of completion percentage of score achieved. These are as follows:

Category 1 : Those SHCOs which have low percentage score (i.e. below 70 % score) at the time of previous score (baseline score or starting of study i.e. 1/3/2019, whichever is earlier) and current score (score at the end of study i.e. 31/05/2019). These SHCOs have low score as they have recently started work on NABH and Manyata. SHCOs A, B, and C have new start of about 1-2 weeks while SHCOs D was working since past 2 months.

Category 2 : Those SHCOs which have low percentage score (i.e. below 70 % score) at the time of previous score (baseline score or starting of study i.e. 1/3/2019, whichever is earlier) but have medium percentage score (i.e. more than equal to 70% but less than 85 %) at the time of current score (score at the end of study i.e. 31/05/2019). These SHCOs have currently medium score as they have worked on NABH and Manyata for about 2 months (i.e. SHCO E and F) and 4 to 5 months before NABH entry level pre accreditation assessment (SHCOs G and H).

Category 3 : Those SHCOs which have high percentage score (i.e. more than 80 % score) at the time of previous score (baseline score or starting of study i.e. 1/3/2019, whichever is earlier) and at the time of current score (score at the end of study i.e. 31/05/2019). These SHCOs have currently high score as they have worked on NABH and Manyata up to 4 to 5 months before NABH entry level pre accreditation assessment (SHCOs I) and up to 1 month latter after getting NABH entry level pre accreditation (SHCOs J, K and L).

So, category 1 hospital have worked on Manyata for least time compared to category 2 and category 3. Similarly, category 2 have worked on Manyata lesser time compared to category 3.

Due to least spending of time by the category 1 SHCOs , their compliance to Manyata verification criteria met are least and falls under the category Low (previous recoded score) to Low (current recorded score). Due to medium time spending by category 2 SHCOs, their compliance to Manyata verification criteria met are better (from category 1 SHCOs) and falls under the category Low (previous recoded score) to medium (current recorded score). Due to highest time spending by category 3 SHCOs, their compliance to Manyata verification criteria met are best (from category 1 and category 2 SHCOs) and falls under the category Low (previous recoded score) to high (current recorded score).

Tabular Categorization of SHCOs (percentage-wise) :

Facility Categorization (Manyata Percentage scores)				
Category	**Trend of Score**	**Scores**	**Quality Improvement**	**Facilities :**
Category 1	**Low To Low**	**Always below 70 %**	**Unsatisfactory**	**A, B, C, D**
Category 2	**Low to Medium**	**< 70 % to > =70 % but less than 85 %**	**Require more efforts**	**E, F, G, H**
Category 3	**Low to High**	**< 70 % to > = 85 %**	**Satisfactory**	**I, J, K, L**

Category 1 : SHCOs Showing verification Criteria Met for Manyata Assessment (Less than 70 %) during Previous survey and Current survey.

Graphical presentation of the data :

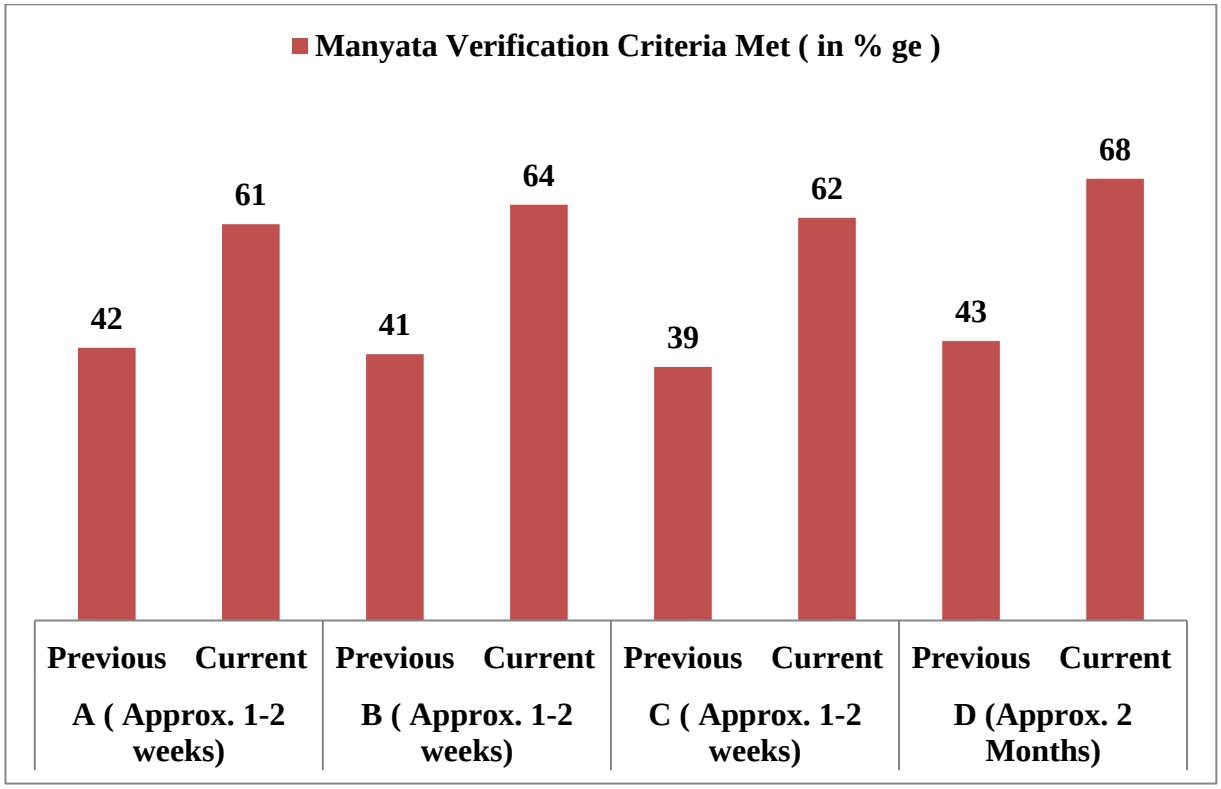

Figure No. 4.5

The graph no. 4.5 depicts that SHCOs A, B and C has taken has taken approx. 1-2 weeks for Manyata assessment preparations whereas SHCO D has taken approx. 2 month for Manyata assessment preparations. Therefore current Manyata verification criteria Met in SHCO D have highest. Comparing between SHCOs A, B and C, SHCO B is at better position as Manyata verification criteria met is highest among the three SHCOs.

Category 2 : SHCOs Showing verification Criteria Met for Manyata Assessment (More than equal to 70 % but less than 85 %) during Previous survey and Current survey.

Graphical presentation of the data :

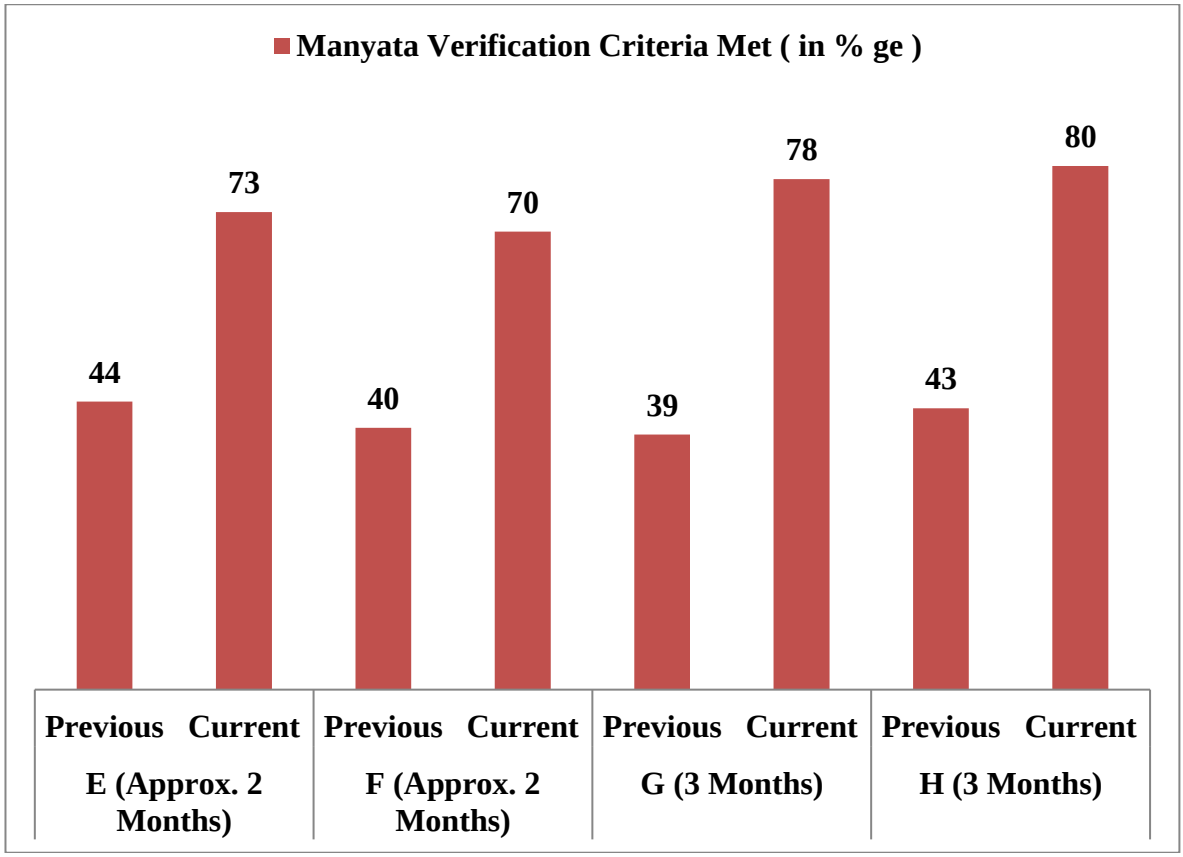

Figure No. 4.6

The graph no. 4.6 depicts that SHCOs E, F has taken has taken approx. 2 months for Manyata assessment preparations whereas SHCO G and SHCO H has taken approx. 3 month or more for Manyata assessment preparations. Therefore current Manyata verification criteria Met in SHCO H have highest. Comparing between SHCOs E, F and G, SHCO G is at better position as Manyata verification criteria met is highest among the three SHCOs.

Category 3 : SHCOs Showing verification Criteria Met for Manyata Assessment (More than 85 %) during Previous survey and Current survey.

Graphical presentation of the data :

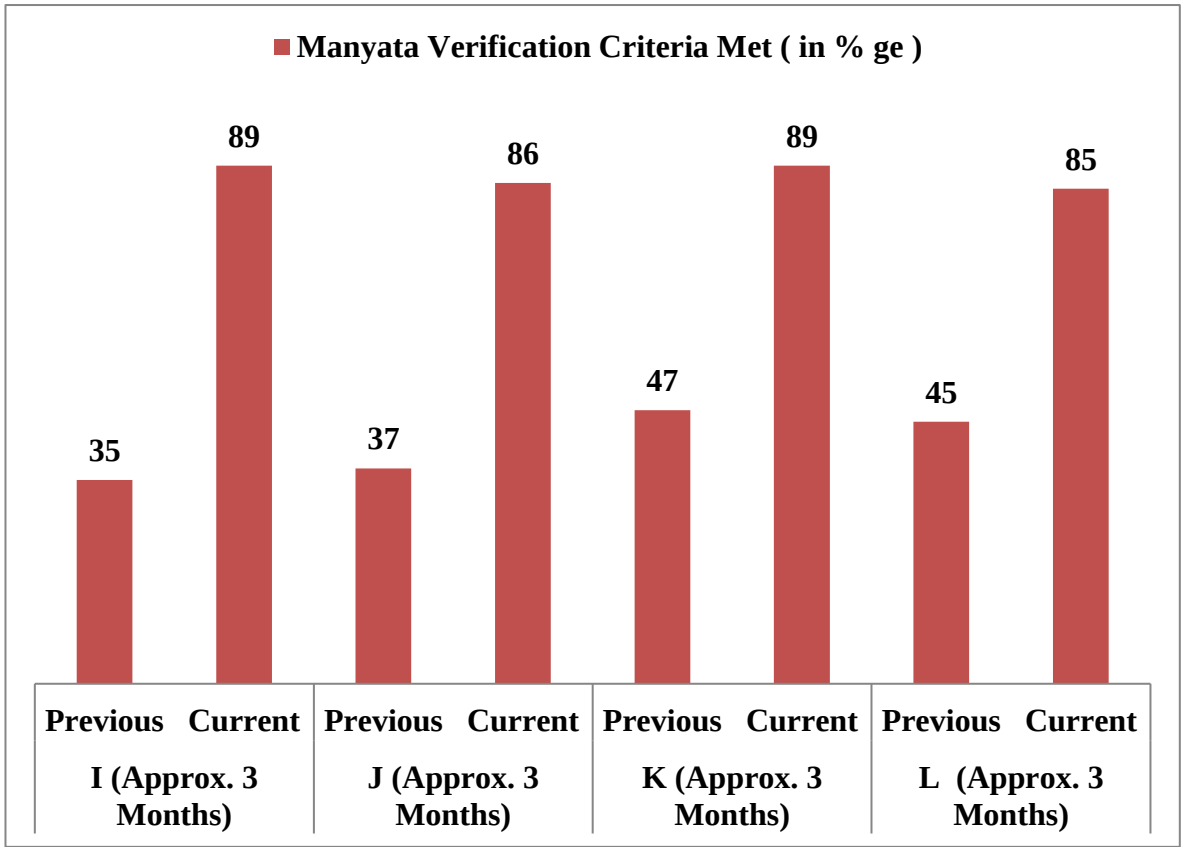

Figure No. 4.7

The graph no. 4.7 depicts that SHCOs I, J, K and L has taken has taken approx. 3 months and more for Manyata assessment preparations in which SHCO I and SHCO K have highest (i.e 89 %) current Manyata verification criteria Met. Comparing between SHCOs J and L, SHCO J is at better position as Manyata verification criteria met is highest among the two SHCOs.

Comparison of NABH Objective Elements Met with Manyata Verification Criteria Met :

The line diagram is depicting SHCOs A, B, C, D, E, F, G, H, I, J, K, L according to stages on X axis whereas Y axis shows compliance of objective elements in percentage of NABH entry level pre accreditation and Manyata certification.

Line diagram presentation of the data :

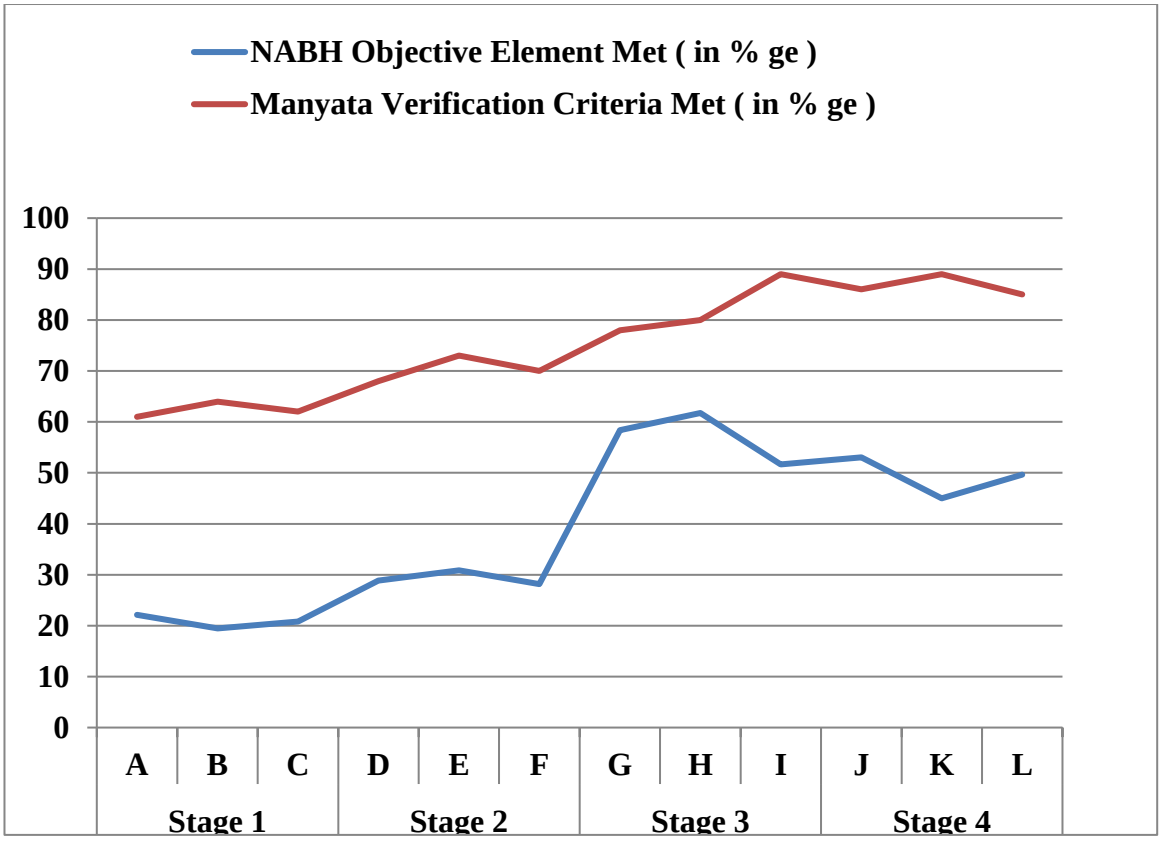

Figure No. 4.8

The figure no. 4.8 shows that SHCOs of stage 1st (i.e. A, B and C) have very low compliance of objective elements met as per Manyata and NABH entry-level pre-accreditation certification. SHCOs of stage 2nd (i.e. D, E and F) have better compliance of objective elements met as per Manyata and NABH entry-level pre-accreditation certification compared with stage 1 SHCOs. Stage 3 (i.e. SHCOs G, H and I) have highest compliance of objective elements met as per Manyata and NABH entry-level pre-accreditation certification. Stage 4 (i.e. SHCOs J, K and L) showing declining compliance of objective elements met as per Manyata and entry-level NABH pre-accreditation certification.

According to increased in time spend by SHCOs on Manyata and entry level NABH pre-accreditation certification, the compliance of objective elements also increases.

CHAPTER 5
CONCLUSIONS

SHCOs who recently started for NABH entry level pre accreditation and Manyata preparation has to put more efforts to improve compliance of objectives element met.

Stage 1st (SHCO A, SHCO B and SHCO C) as compared to other SHCOs have least compliance as they have just started for NABH entry level certification process. Stage 1 SHCOs have least compliance of objective elements compared with other stages SHCOs. Some of the reason may be unawareness and ignorance of quality importance for patient safety and care. Some of common problems are : Non availability of bilingual signage, Absence of documentation, Absence of trainings etc.

Stage 2nd (SHCO D, SHCO E and SHCO F) have better compliance of objectives element as they are into the process for about 2 months and they have started to improve on compliance to entry level standards. These SHCOs wants to inculcate their quality maintaining standards and wants a better position in the hospital industry. Some of common problems are : Absence of documentation, Absence of trainings , Absence of committee forming, absence of proper follow up process for which they are getting trainings etc.

Stage 3rd (SHCO G, SHCO H and SHCO I) are having greatest compliance to objectives element, as they are ready for real assessments by NABH entry level certification process. These organization make sure that they leave no mistakes, for getting the pre-accreditation NABH entry level. These SHCOs showed their bestest and puts maximum effort to be compliance to the standard. Some of common problems are : regular checking up right practices like cleaning with bleach solution by using wringer trolley etc.

Stage 4 SHCO J, K and L which already get NABH pre-accreditation showed that their compliances to objectives element reduced and partial-element compliances rises. It's a little worried situation. This is because proper documentation is available, but failure in implementation which results in partial objective element to get increase instead of full compliance of objective elements. Some of common problems are :

- In spite of proper training to staff, proper follow up has not be taken.
- Expiry medicines has not been separated.
- LASA has not been kept at proper place.
- Fridge temperature Monitor checklist not filled by staff.
- High risk Medicines are not kept locked into safe.
- Waste has not been segregated as per Bio Medical waste rules in proper color coded dustbin.
- Autoclave and sterilization registers is available but not maintained.
- PPE (personal Protective Equipment) not followed by all staff member on regular basis.
- Blood spill kit is not used by the facility.
- Steps and Moments of hand hygiene not followed by staffs.
- Emergency Codes not used by facility in case of emergencies.

Under category 1, the SHCOs A, B, C and D as compared to other SHCOs have least verification criteria met. These Facilities never worked for quality improvement Manyata. These require proper trainings from the initial level of quality improvement.

Under category 2, the SHCOs E, F, G and H are have better verification criteria met. These facilities have proper signage but have lack of availability of all legal as well as HR documentations.

Under category 3, the SHCOs I, J, K and L have greatest verification criteria met. This is because most of the Verification criteria for Manyata Assessment are already met while improving quality as per NABH standards. Some of these are like:

- preparations of all trays of Labour Room.
- preparation of all medicine kits
- availability of new born corner
- PPE
- hand hygiene
- infection control trainings etc.

RECOMMENDATIONS :

- Facilities should opt for both accreditations (NABH and Manyata) as they get two certifications for quality at the less efforts.
- Facilities in category 1 should more focus on fundamental things observation and correction of regular practices. like : staff trainings, signage, availability of all registers and forms.
- Facilities in category 2 should more focus on assessing the gaps as per the toolkit of NABH and Manyata.
- Facilities in category 3 should more focus on continuity and monitoring of all compliances.
- More Trainings should be given so that staff can follow safe and qualitative practices.
- Mock Drills should be conducted for hospital staff so that they can handle emergency situation easily.
- Higher authority of hospital should have active participation in the qualitative improvement of the hospital.
- Proper records should be available in all documents on time to time basis.
- Transfer in and transfer out should be regularly practiced for High risk medicines and manifolds etc.
- All staff should be motivated on regular basis for filling complete documents with their date, seal and signatures.
- All indicators of quality should be recorded regularly for proper monitoring.
- Patient feedback should be taken so that hospital can improve their satisfaction by putting efforts into their grievance solutions.

SHCOs serving to a very big segment of patients which needs to improve their quality as well as safety for their patients. This can be done with efforts for the fulfillment of objective elements of NABH and Manyata.

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