NABH : A GAP ANALYSIS OF PROCESS OF ACCREDITATION

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HOSPITAL ACCREDITATION

- Hospital Accreditation is a public recognition by a National Healthcare Accreditation Body, of the achievement of accreditation standards by a Healthcare Organization, demonstrated through an independent external peer assessment of that organization's level of performance in relation to the standards.
- NABH Standards for hospitals, 4th Edition, December 2016 has been released. This standard has been accredited by International Society for Quality in Healthcare (ISQua). The approval of ISQua authenticates that NABH standards are in consonance with the global benchmarks set by ISQua. The hospitals accredited by NABH will have international recognition.

Outline of NABH Standards :

PATIENT CENTRIC	*MANAGEMENT CENTRIC*
1. Access, Assessment and Continuity of Care (AAC).	**6. Continuous Quality Improvement (CQI).**
2. Care of Patients (COP).	**7. Responsibility of Management (ROM)**
3. Management of Medication (MOM).	**8. Facility Management and Safety (FMS).**
4. Patient Rights and Education (PRE).	**9. Human Resource Management (HRM).**
5. Hospital Infection Control (HIC).	**10. Information Management System (IMS).**

NABH ACCREDITATION PROCESS

1. Self-Assessment
2. Application for accreditation
3. Pre - Assessment visit
4. Final Assessment of hospital
5. Issue of Accreditation Certificate
6. Surveillance
7. Re assessment

BENEFITS OF ACCREDITATION

Benefits for Hospitals

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

Benefits for Hospital Staff

The staff in an accredited hospital is satisfied lot as it provides for continuous learning, good working environment, leadership and above all ownership of clinical processes. It improves overall professional development of Clinicians and Para Medical Staff and provides leadership for quality improvement with medicine and nursing.

Benefits to paying and regulatory bodies

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.

RESEARCH QUESTION

What are the current gaps and compliances of hospital on four patient centric standards as compared to gaps and compliances of same standards at the time of final assessment for NABH accreditation?

OBJECTIVES

MAIN OBJECTIVE

To Assess all departments of Rungta Hospital, Jaipur as per the four patient centric standards.(Access, Assessment and continuity of care, Care of Patient , Patient rights and responsibilities & Hospital infection Control) and compare with Final assessment non-compliances.

SUB OBJECTIVES

- To identify gaps in the structure, process and outcome.
- To identify the compliances of current services with the four patient centric standards of NABH
- To Compare the non-compliances of Final assessment with the non-compliances of Pre surveillance assessment
- To suggests the required alterations in structure, processes and outcomes to reduce the non-compliances in surveillance

METHODOLOGY

STUDY DESIGN

- Descriptive study

STUDY LOCATION

150 Bedded Hospital , Jaipur , Rajasthan

Departments: OPD, Laboratory, Radiology and Imaging ,ICU, NICU, Wards, CSSD, Laundry, OT , Housekeeping, Pharmacy, Blood Storage etc

DATA COLLECTION TOOL

- Self- assessment toolkit of 4th edition of NABH
- Checklists

DATA COLLECTION TECHNIQUES

- **Primary Data:**
- Interviews with the Hospital staff
- Direct Observation
- Interview with the patients of Hospitals

Secondary Data

- Hospital policies and Manuals
- Records and HMIS of Hospital

STUDY TIME

12 weeks which includes preparing and filling checklist, Self-assessment tool kit and compiling data, gap analysis and final report completion

SCORING CRITERIA FOR TOOL KIT

Compliance to the requirement: 10

Partial compliance to the requirement: 5 (if any of the sample is found to be noncomplying out of total samples selected)

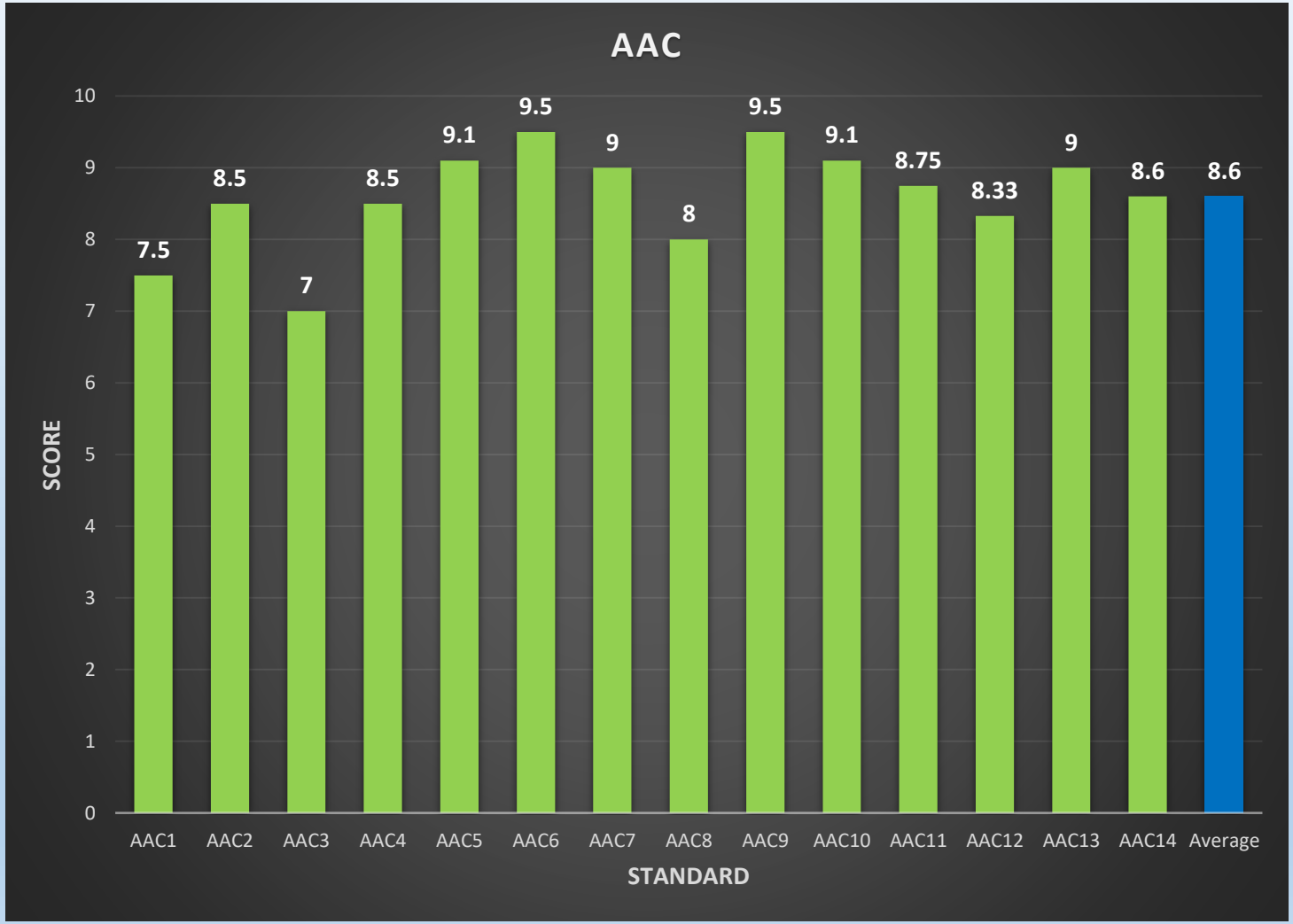
Non-compliance to the requirement: 0

Not Applicable: NA

Results

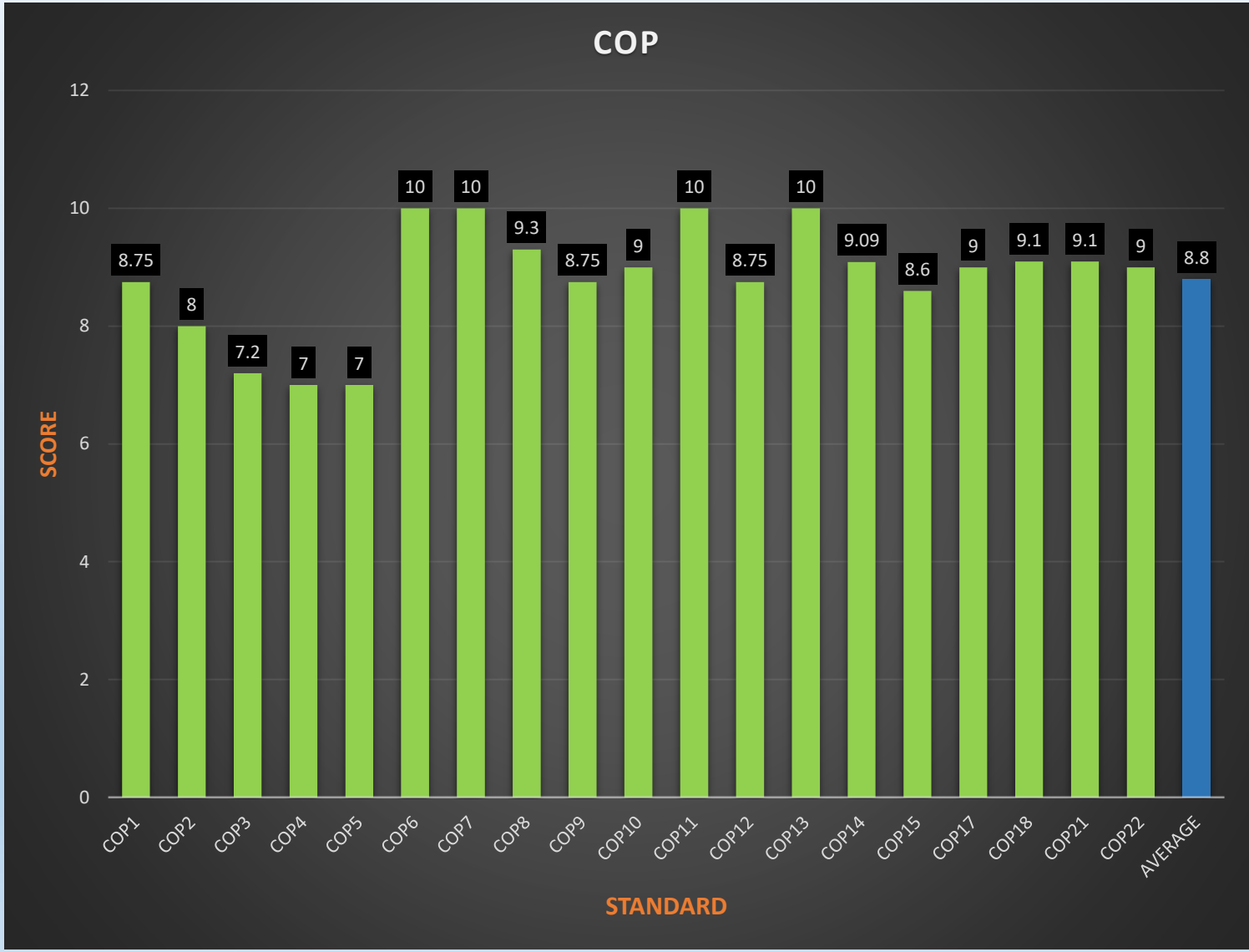
CHAPTER 1: ACCESS ASSESSMENT AND CONTINUITY OF CARE

Standard	Score
AAC1	7.5
AAC2	8.5
AAC3	7
AAC4	8.5
AAC5	9.1
AAC6	9.5
AAC7	9
AAC8	8
AAC9	9.5
AAC10	9.1
AAC11	8.75
AAC12	8.33
AAC13	9
AAC14	8.6
Average	8.6



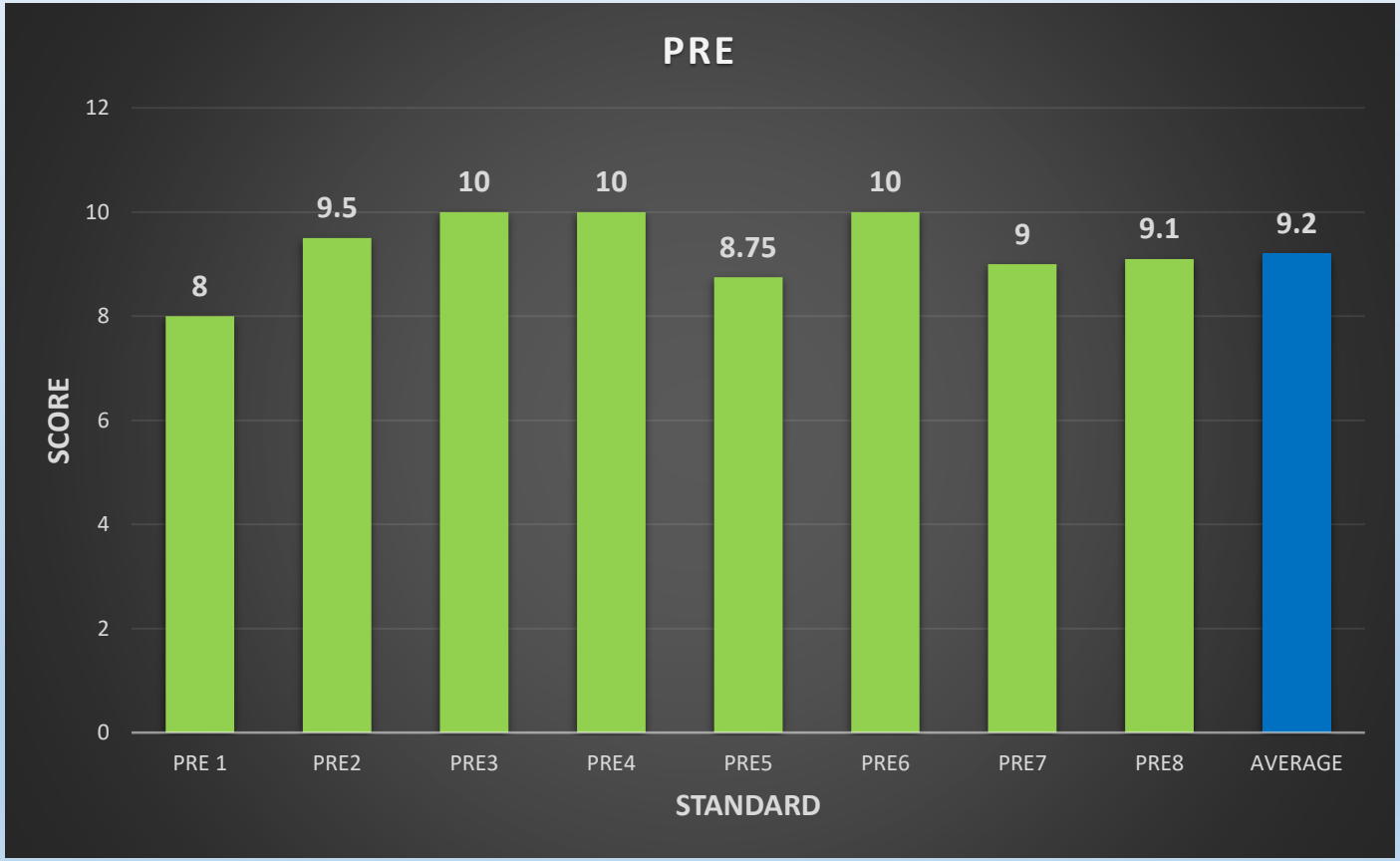
CHAPTER 2: CARE OF PATIENT

Standard	Score
COP1	8.75
COP2	8
COP3	7.2
COP4	7
COP5	7
COP6	10
COP7	10
COP8	9.3
COP9	8.75
COP10	9
COP11	10
COP12	8.75
COP13	10
COP14	9.09
COP15	8.6
COP17	9
COP18	9.1
COP21	9.1
COP22	9
AVERAGE	8.8



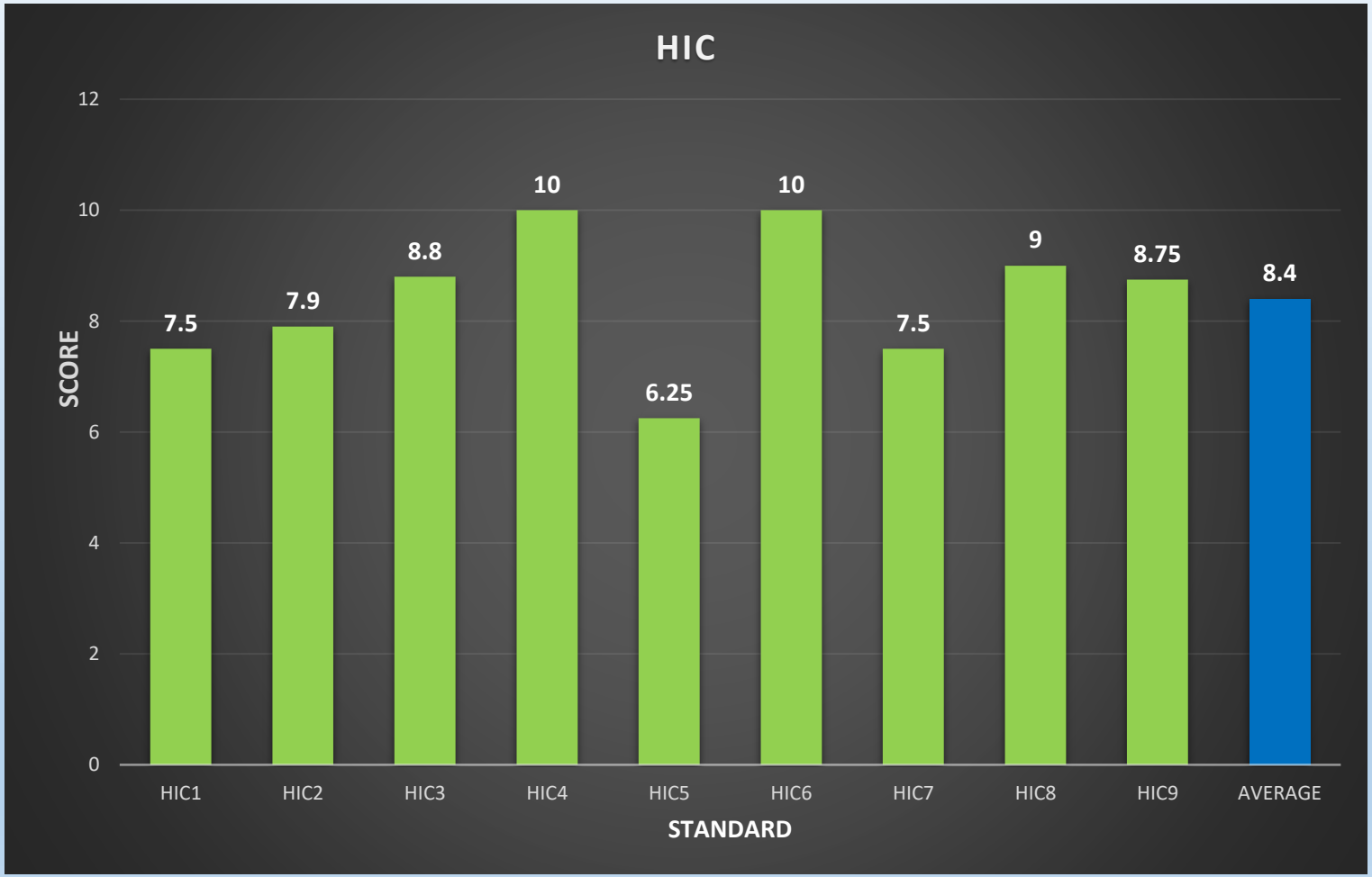
CHAPTER3: PATIENT RIGHTS AND RESPONSIBILITY

Standard	Score
PRE 1	8
PRE2	9.5
PRE3	10
PRE4	10
PRE5	8.75
PRE6	10
PRE7	9
PRE8	9.1
AVERAGE	9.2



CHAPTER 5: HOSPITAL INFECTION CONTROL

Standard	Score
HIC1	7.5
HIC2	7.9
HIC3	8.8
HIC4	10
HIC5	6.25
HIC6	10
HIC7	7.5
HIC8	9
HIC9	8.75
AVERAGE	8.4



COMPARISION OF FINAL ASSESSMENT NCs & PRE SURVEILLENCE NCs

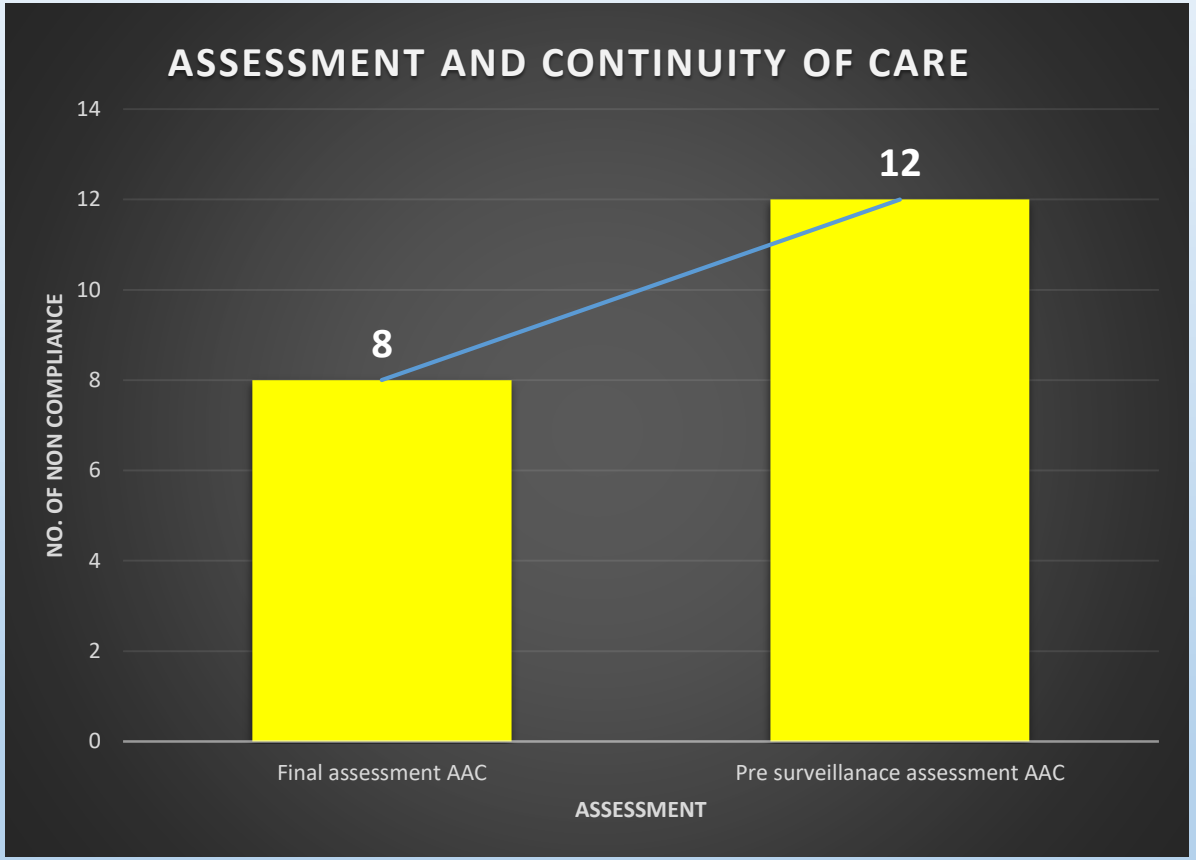
NABH FINAL ASSESSMENT REPORT			NABH PRE SURVEILLANCE		
AAC	ACCESS ASSESSMENT AND CONTINUITY OF CARE				
S.No.	Non-Conformances / Partial Non-conformance	Standards & Objective Elements	Non-Conformances / Partial Non-conformance	Standards & Objective Elements	Corrective / Preventive Action Taken
1			Staff are not oriented to service provided by hospital	AA1d	Regualar training of staff
2			No policies and procedure for managing patient during non availability of beds	AAC2e	Policy to be made & staff needed to be trained
3	The organization has not defined and documented the content of the initial assessment for the out–patients and emergency patients.	AAC 4a			
4	The plan of care does not include goals or desired results of the treatment, care or service.	AAC 4h	Care plan with desired outcome i.e Document & policy available but staff is not oriented to write desired outcome	AAC4h	Training of staff
5	For in-patients during reassessment the plan of care is not monitored and modified where found necessary.	AAC 5c			

6			The organization lay down the guidelines and implement processes to identify early warning signs of change or deterioration of clinical condition for prompt treatment	AAC5f	policy to be made & staff needed to be trained
7			Safe transportation of sample (sample box not available)	AAC6e	purchase of sample box Training to the staff for safe transportation
8			Lab test are not available within the time frame	AAC6f	Staff training and circular
9	The laboratory quality assurance program does not include EQAS w.r.t Microbiology.	AAC 7a			
10	The HCO has not appointed a RSO; display signages for Radiation Safety are not as per norms; some of the radiation workers are not declared on E-LORA website. There is no established Radiation Safety Programme.	AAC 9a; AAC 11			

11			Surveillance of imaging results are not done	AACd10	
12	Discharge summary does not incorporates instructions about when to obtain urgent care.	AAC 14f	Discharge summary does not incorporates when to obtain urgent care	AAC13f	Circular to residents and format modification
`13			Proper handing over and taking over is not proper of Doctors, no documents regarding their handing and taking over exist.	AAC12d	Format for handing over and taking over for doctors
14			Transfer of patients are not in safe manner(strechers are used without side rails and chairs without belt)	AAC12e	Training of staff

			No Discharge policy for absconded patients	AAC13b	Policy to be made & staff needed to be trained
			Discharge time taken is not monitored	AAC13e	Regular Discharge Audits
	In case of death, the summary of the case does not include the cause of death.	AAC 15g			

STANDARD	NCS
Final assessment AAC	8
Pre surveillanace assessment AAC	12



NABH FINAL ASSESSMENT REPORT					
COP	CARE OF PATIENT				
S.No.	Non-Conformances / Partial Non-conformance	Standards & Objective Elements	Non-Conformances / Partial Non-conformance	Standards & Objective Elements	Corrective / Preventive Action Taken
1	The organization has not adopted evidence based medicine and clinical practice guidelines to guide uniform patient care.	COP 1d			
2	Policies and procedures to address handling of medico-legal cases is not as per legal requirements.	COP 2b			
3			Staff need to be train on procedures Emergency services	COP2f	Training to staff
4			No policy on patient brought dead on arrival of hospital	COP2j	Policy and training to staff

5			Ambulance space is not marked	COP3a	Ambulance area has to be marked
6			Ambulance is not properly equipped	COP3c	Purchase of all equipment as per checklist
7			Ambulance is not checked on daily basis	COP3e	a Nursing staff should give dedicated responsibility of Ambulance
8			Checklist is not followed for ambulance	COP3f	
9			Emergency medicine are not checked prior to dispatch for cases	COP3g	

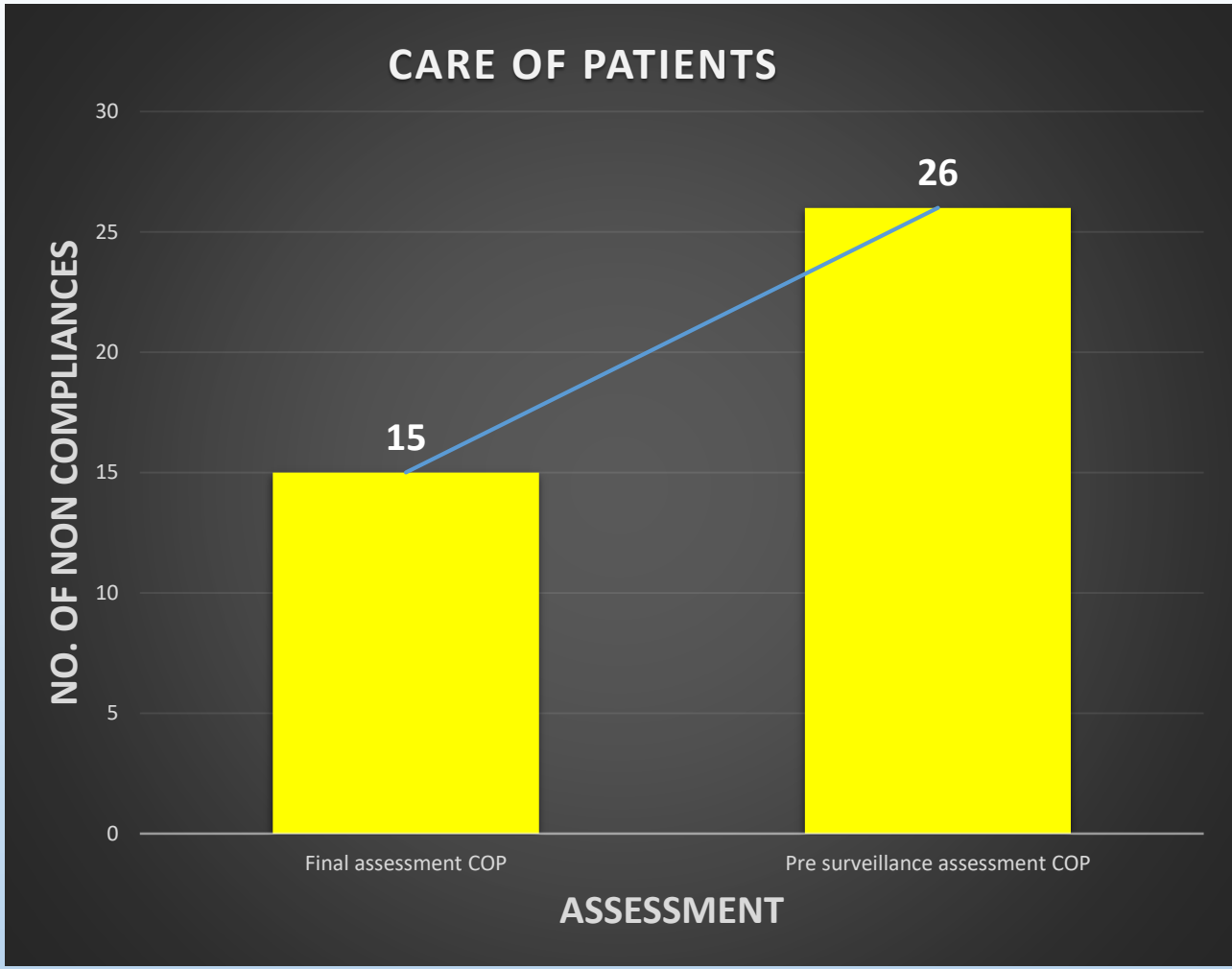
10			Employees are not trained in Code yellow	COP4a	Code yellow training and mock drills
11	Staff providing direct patient care are not found to be trained and periodically updated in cardio pulmonary resuscitation.	COP 4b	Staff providing direct patient care are not found to be trained and periodically updated in cardio pulmonary resuscitation.(Certificate expired)	COP4b	BLS and ACLS trainings
12			Availibility of medical supplies, equipment and material during emergency	COP4c	Policy and training to staff
13	A post-event analysis of all cardio-pulmonary resuscitations is not done by a multidisciplinary committee.	COP 4d	A post-event analysis of all cardio-pulmonary resuscitations is not done by a multidisciplinary committee.(not done)	COP4d	Regular committee meetings
14			No corrective and preventive measures based on Post event analysis are done	COP4e	CAPA should be prepared and followed
15	Nursing services do not reflect current standards of nursing services and practice, relevant regulations and the purposes of the services.	COP 5b			

16	Documented guidelines for various clinical procedures are not evidenced.	COP 6a	Documented guidelines for various clinical procedures are not evidenced.	COP7a	Guidelines for various clinical procedures
17			Staff is not trained for blood and blood product related policies	COP7h	Traaining of staff
18	Staff is not trained to apply admission and discharge criteria for its intensive care and high dependency units.	COP 8c	Staff not trained on admission and discharge criteria from ICU and HDU	COP9c	Trainings of residents
19	Policies and procedures for the care of elderly, children, physically and/or mentally challenged are not documented and are in accordance with the prevailing laws and the national and international guidelines. The HCO does not have licence under the Mental Health Act.	COP 9a			OUT OF SCOPE
20	The organization has not defined and displayed whether high risk obstetric cases can be cared for or not.	COP 10b			
21			All staff are not trained in care of vulnerable patients	COP10e	Training to staff

22	The organization has not defined and displayed the scope of its Pediatric services.	COP 11b	No display of scope of pediatric services	COP12b	Scope of pediatric services
23			No age specific competency of care givers for children	COP12d	
24	The pre-anaesthesia assessment does not result in formulation of a documented anaesthesia plan.	COP 13c			
25	Documented policies and procedures to prevent adverse events like wrong site, wrong patient and wrong surgery are not evidenced - practice of filling of surgical safety checklist needs to be strengthened, site marking is not always done.	COP 14d			
26			The type of anesthesia and anesthetic medication used are not documented in patient record	COP14i	Circular to anesthetist and training to nursing staff of OT
27			Adverse anesthesia events are not monitored	COP14k	

28			Patient, personnel and material flow does not confirm to infection control(There is no direct route of instrument from CSSD & nursing staff keep on coming from OT during procedure)	COP15h	Circular to ICN and CSSD staff
29	The quality assurance program of operation theatre does not include daily monitoring of humidity and temperature are not evidenced.	COP 14k	Quality assurance of OT does not include post fumigation culture to lab from outside hospital for controls	COP15k	Search NABL lab start the process
30	Patients with pain are not found to undergo detailed assessment and periodic re-assessment.	COP 16c			
31	Care in the rehabilitative services is not found to include functional assessment and periodic re-assessment.	COP 17c			
32			Training regarding restraints is not regular and staff is not updated in control and restraint techniques	COP17e	Training of staff
33			patient and family are not educated on various pain management techniques	COP18f	Training of NursingStaff
34			Food handling is not very safe manner	COP21e	Regular audits and training
35			Training on end of life care needed	COP22e	Training of staff

STANDARD	NCs
Final assessment COP	15
Pre surveillance assessment COP	26

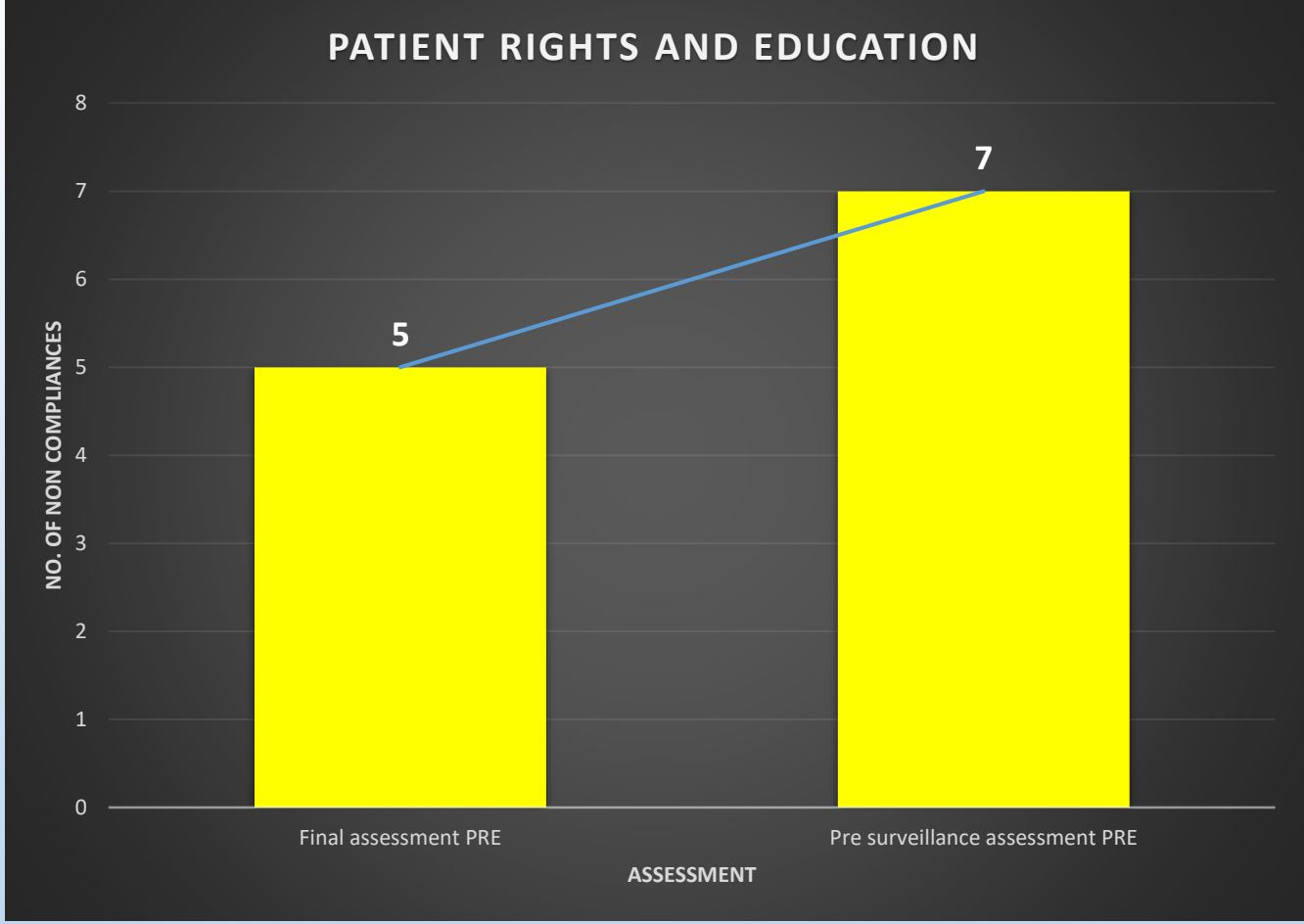


NABH FINAL ASSESSMENT REPORT					
PRE	PATIENT RIGHTS AND RESPONSIBILITY				
S.No.	Non-Conformances / Partial Non-conformance	Standards & Objective Elements	Non-Conformances / Partial Non-conformance	Standards & Objective Elements	Corrective / Preventive Action Taken
1			Patients and families are not explained of their rights and responsibilities	PRE1b	Staff training
2			Staff are not aware of protecting patients and family rights	PRE1d	Staff training
3			Privacy during examination in some of OPD Clinics because of opaque glass walls of OPD clinics	PRE2b	In OPD clinics the site of examination should be concealed

4	Patient and family rights do not include protection from physical abuse or neglect.	PRE 2c			
5	Patient and family rights do not include right to complain and information on how to voice a complaint.	PRE 2g	Patient and family rights do not include right to complain and information on how to voice a complaint.	PRE2h	A patient redressal system needed
6	Documented procedure does not incorporate the list of situations where informed consent is required and the process for taking informed consent.	PRE 4a			
7			patient and/or family not explained about food drug interaction	PRE5b	Circular to Dietician and Doctors
8	Patient and/or family are not found to be educated about immunizations.	PRE 5d			

9			Patient and/or family are not explained about preventive healthcare infections	PRE5f	Training to staff
10	There is no evidence of a mechanism to make patient and/or family members aware of the procedure for lodging complaints.	PRE 7b			
11			The hospital does not have any system to monitor and review the implementation of effective communication	PRE8e	

STANDARD	NCs
Final assessment PRE	5
Pre surveillance assessment PRE	7



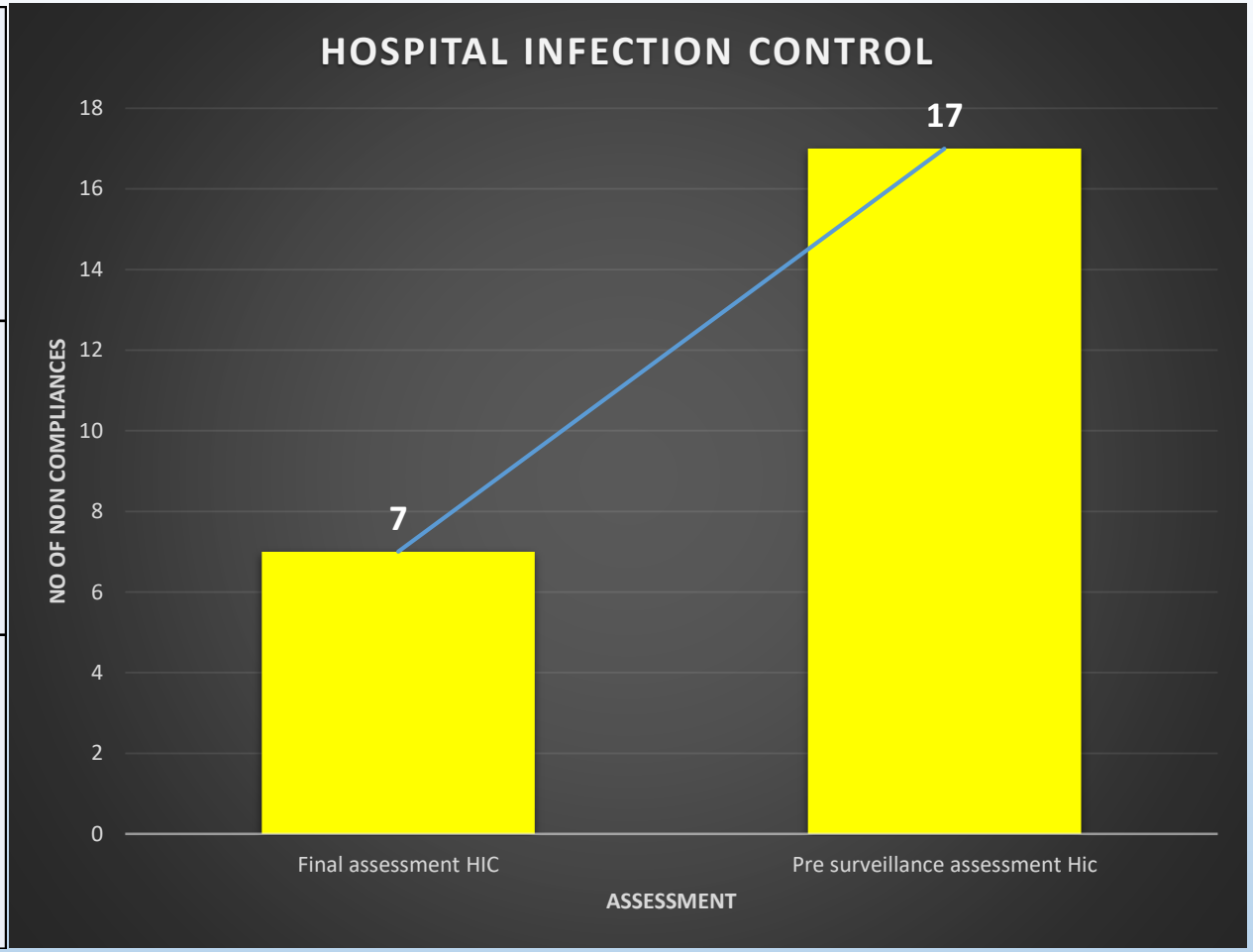
	NABH FINAL ASSESSMENT REPORT		PRE SURVEILLANCE REPORT		
HIC	HOSPITAL INFECTION CONTROL				
S.No.	Non-Conformances / Partial Non-conformance	Standards & Objective Elements	Non-Conformances / Partial Non-conformance	Standards & Objective Elements	Corrective / Preventive Action Taken
1			Infection control program required updation	HIC1b	Updation required
2			Hospital has a designated infection control officer but JD not attached with the file	HIC1e	Notice to HR department
3	The hospital does not have a designated infection control nurse(s) as part of the infection control team.	HIC 1f	The hospital has designated infection control nurse but JD not attached in the file	HIC1f	Notice to HR department

4			Hospital does not adhere to standard precaution all the times	HIC2b	Training to incharges and regular audits
5	An appropriate antibiotic policy is not found to be established and implemented.	HIC 2g	The organization does not implements the antibiotic policy and no monitoring on rational use of antimicrobials	HIC2h	Circular and antibiotics audit
6	The organisation is not found to have appropriate engineering controls to prevent infections.	HIC 2j	Fumigation machines not working and fumigation is also not effective	HIC2k	Fumigation machine maintenance
7			Food handling and kitchen sanitation issues	HIC2j	Regular audit and training to kitchen staff
8			Housekeeping procedures are not up to the mark	HIC2l	Circular to housekeeping incharge , Checklist for housekeeping & regular audit

9			Surveillance of hand hygiene is poor	HIC3e	Regular training and audits by ICN
10	The organisations actions to prevent and control HAI in patients need to be greatly strengthened - all Oes included.	HIC 4			
11			adequate and appropiate personal protective equipment are not provided	HIC5a	Circular to store and purchase department
12			Hand washing area not present in procedure room of OPD	HIC5b	Report to management for provision
13			Isolation ward is inside the ICU and barrier nursing is followed	HIC5b	Training on barrier nursing
14	Appropriate pre and post exposure prophylaxis is not found to be provided to all staff members concerned.	HIC 5d			

15	space and appropriate zoning for sterilization activities.	HIC 7a	and appropriate zoning for sterilization activities.		
16			Proper issues area is not there in the CSSD	HIC7b	Reconstruction of CSSD
17	Reprocessing of instruments and equipment is not covered in the sterilization program.	HIC 7c			
18			there is no recall policy implemented for the break down of sterilization	HIC7f	Policy and training to staff
19			appropiate personal protective measures are not used by all staff handling biomedicel waste (Rubber multiutility gloves are not used by Biomedical waste handler)	HIC8e	Training and regular check by Supervisors
20			Shortage of PPE	HIC9a	Proper demand from all departments and audits

STANDARD	NCs
Final assessment HIC	7
Pre surveillance assessment Hic	17



CONCLUSION

- There is a NABH surveillance due for the hospital in month end of MAY,2018. According to the study for four standards no individual standard has ZERO and no individual standard have average below 7.

- Non-Compliances have increased from final assessment Non-compliances. Hospital is going for NABH surveillance and all Non-compliances of final assessment have not closed yet and other non-compliances as per NABH 4th edition are seen. This implies that hospital for NABH accreditation prepare themselves only for the Accessors visit and on routine basis the desired standards are not maintained
- This shows that NABH periodic visits to HCO are not effective in maintaining Quality.

RECOMMENDATIONS

- Accreditation of Hospital is mandatory for Empanelment with various TPAs, ECHS, CGHS etc. To get empaneled, hospitals try for accreditation and hire consultants to maintain all standards as per the requirement of standards of NABH. However, when they get NABH certificate, the standards are not adhered to on routine basis.
- By the time, NABH surveillance or reassessment which occurs after a gap of at least 18 months takes place, hospitals do not maintain the desired status. The derive to maintain the standards occur only when there is surveillance. This shows that NABH periodic visits to HCO are not effective in maintaining Quality on a continuous basis. It should be a continuous process so that HCO adhere completely to the desired quality services
- Gaps were observed during the project as per NABH guidelines but these gaps can be removed by little effort of management and employees. Willingness of the management in terms of implementation and supplies and regular training for the staff can resolve many of the gaps.

THANK YOU