Study on Pre-post Implementation for Pre-entry Level Certification of SHCO for NABH Standards

By

Shrishti

Dissertation submitted in partial fulfillment of the requirements of the degree

MBA Hospital and Health Management

Academic year, 2018-2020

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Thankyou

Your faithfully

Dr shrishti

Table

LIST OF TABLE

LIST OF FIGURES

LIST OF ABBERVATION

AERB	Atomic Energy Regulatory board
BMW	Biomedical waste
ER	Emergency
HK	Housekeeping
ICN	Infection Control Nurse
NABH	National board of hospital and healthcare providers
OPD	Outpatient Department
OT	Operation theatre
PPE	Personnel protection equipment
USG	Ultrasonography
HLFPPT	Hindustan latex family planning promotion

ABSTRACT

Title- A study on pre-post implementation for pre-entry level certification of SHCO for NABH Standards

Background of study: 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 organisation level of performance in a relation to the standards.

Objective- To assess and analyse the gaps in quality compliance of the facility as per NABH standards to prepare it for further accreditation process by NABH at entry level certification.

Methodology- A NABH self-assessment toolkit was used for a survey of the hospital in terms of scope of services provided by the hospital, manpower, physical infrastructure, drugs and lab services. Hospital information was gathered by direct observation, review of hospital and clinical record and discussion with doctors.

Conclusion- Study shows that after implementation of the standards most of the gaps were corrected for NABH certification. Post implementation results show 45% of standards were compliant with compared to pre-implementation status when compliance was nil.

Keywords-Accreditation, NABH, Standards, Quality.

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About Organization: HLFPPT (Hindustan latex family planning promotion trust)

HLFPPT Partners for Better Health

HLFPPT is promoted by HLL Life care Ltd (a Mini Ratna PSU under the Ministry of Health and Family Welfare, GOI). It was founded in 1992 and is registered under the Travancore-Cochin Literary, Scientific and Charitable Societies Registration Act, 1955. For the last 25 years, we have been serving communities across India with health solutions and contributing towards Health System Strengthening through direct program implementations, technical assistance, and capacity building. Today, HLFPPT has emerged as India's leading organization in Reproductive and Child Healthcare and a pioneer in promoting public health through Social Marketing and Social Franchising strategies. Hindustan Latex Family Planning Promotion Trust (HLFPPT) is a national not-for-profit health services organization, working on the entire spectrum of RMNCH+A (Reproductive, Maternal, Newborn, Child & Adolescent Healthcare), including HIV Prevention & Control and Primary Healthcare.

SERVICES

Family Planning

HLFPPT contributes to National Family Planning Programme by:

- Social Marketing of contraceptives, thus offering increased basket of choice
- Counselling on family planning methods & empowering couples with informed choice
- Building capacities of health providers on family planning services
- Creating a network of affordable health facilities with family planning services

WASH

HLFPPT has forayed into promoting:

- Water, Sanitation & Hygiene (WASH) as per WHO guidelines
- Affordable drinking water solutions to underserved communities

Skill Development

HLFPPT aims to:

- Address the global shortage of skilled health professionals
- Contribute towards the Central Government's flagship Skill India Mission
- Develop a cadre of skilled human resources in healthcare & other allied sectors through quality trainings
- Offer sustainable livelihood options to the youth

CSR Partnerships

By aligning with the corporate sector, HLFPPT:

- Takes primary healthcare services to underserved communities
- Establishes Sustainable Models of Development that are replicable & scalable
- Provides technical assistance & advisory services to its corporate partners
- Facilitates project design & implementation
- Does advocacy with government agencies & local communities

HIV Prevention & Control

HLFPPT works for:

- Awareness on HIV prevention, early diagnosis & treatment
- Controlling HIV transmissions
- Facilitating a better life for PLHIV (people living with HIV)
- Advocacy efforts for the rights & social inclusion of PLHIV

Adolescent Healthcare

HLFPPT works for:

- Adolescent Reproductive and Sexual Health (ARSH) issues
- Government's Rashtriya Kishor Swasthya Karyakram (RKSK) as a National Training Partner
- Imparts Life Skills Education to the youth as per WHO guidelines
- Promotes menstrual health management among adolescent girls

Maternal & Child Healthcare

HLFPPT works for:

- Spreading awareness on pregnancy & new-born care among underserved communities
- Providing antenatal care, institutional deliveries, postnatal care, immunization, etc
- Managing a Social Franchising health network that offers quality MCH services
- Educating communities on exclusive breastfeeding, childhood diarrhoea management, etc

Rajasthan state profile

As per official census 2011 data Rajasthan has population of 6.8 cr out of total population of Rajasthan ,24.9 percent people live in urban region and 75.1 persent live in rural.

Bharatpur district

According to 2011 census, the district encompasses a geographical area of 5066 sq km and has a population of 25,48,462 persons

3. INTRODUCTION

QUALITY- Quality is the attribute of a service, that provides assurance that healthcare efforts will consistently do better, and it also distinguishing guidelines that health systems must apply across all the organizational functions and provide timely and prompt care.

Quality Management Programme in a Hospital

Requirement of able management skills, efficient number of copies of standards then, Identify the staff that have passion and enthusiasm towards implementation of quality of hospital. And Make a team with same mind and involvement of all staff is required, Regular training and briefing is required to understand the implementation processors.

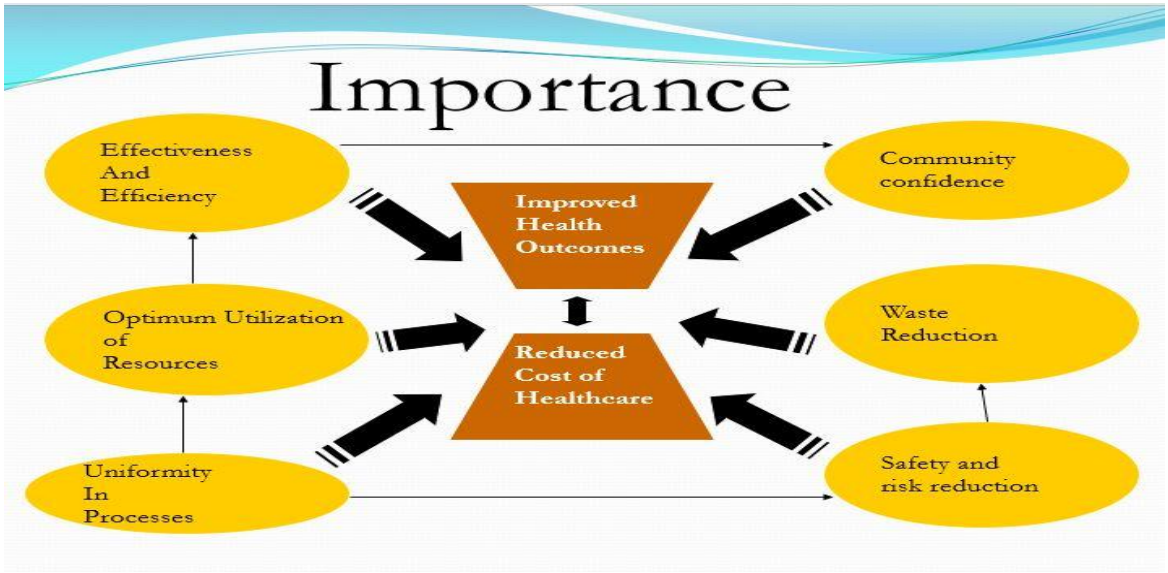
About NABH

NABH - National Accreditation Board for Hospitals & Healthcare Providers which is a constituent board of Quality Council of India, set up to establish and operate accreditation programme for healthcare organizations.

NABH accreditation benefits all the stake holders. Patients are the biggest beneficiary. Accreditation also results in high quality standards that take care and patient safety. The patient gets services by expert medical personal. The Rights of patients are respected and protected. Patient satisfaction are regularly evaluated. The staffs working in an accredited hospital is stratified and it provides continuous learning process under an able working environment, strong leadership and above all ownership of the clinical process.

The Quality council of India and national accreditation board of hospital and healthcare providers have designed an exhaustive healthcare standard for hospital and healthcare providers. It consists of stringent 600 plus concerned elements for the hospital to achieve in order to get the NABH accreditation. These standards are divided between patient centric and organisation centric.

Importance of NABH



Definition for SHCO

Those healthcare organisations whose bed strength are up to 50, and have supportive and utility facilities that are appropriate and relevant to the services being provided by organization.

Benefits – Among all the stake holders, standards result in improved quality care and patient safety the patients are the biggest beneficiary. Patients are served by trained staff.

Benefits for SHCO The introduction of Pre- accreditation entry level standards for a SHCO will stimulate a journey towards continuous improvement.

Objective of the study

To assess and analyse the gaps in quality compliance of the facility as per NABH standards and to prepare it for further accreditation by NABH for the entry level certification.

5. REVIEW OF LITERATURE

For the purpose of the research the following literature are considered as useful for the study

Quality Council of India – With the rapid changes in the healthcare system, and revolutionary advancements in imaging. The quality council of India has therefore introduced standards for medical imaging services, focusing on the services, personnel, imaging- process, facility, environment, equipment, and documentations, as well as risk control and safety. This article deals briefly with the standards structured by the QCI for accreditation of imaging services.

The Overall opportunity-based composite score improved for the both non-accredited and accredited hospitals is (13.7% and 9.9%, respectively), but these improvements were significantly higher for non-accredited hospitals with an absolute difference :3.8 %. But no significant differences were found at disease level. The overall score increased significantly for non-accredited hospitals but not for accredited hospitals. The absolute difference between the improvement in the scores at non-accredited and accredited hospitals was not significant. Participating in accreditation was not associated with larger improvement in the performance measures for acute strokes, heart failures and ulcers.

Dr Praneet Kumar, According to him After the formation of NABH - the international society for quality healthcare the standards ISQUA joined in 2008. The technical committee has been working on attaining accreditation of NABH from ISQUA. “This would ensure that NABH’s systems and process are complaint with an international organisation, thus guaranteeing better documentation and process orientation ,It id expected that an ISQUA -accredited NABH would bring in more transparency and clarity in processes involved for medical value travel”.so far, hospital standards of only 11 countries are accredited by ISQUA.

Hospital accredited by the joint commission tended to have better baseline performance in 2004 than non-accredited hospitals. Accredited hospitals have larger gain over time and were significantly more likely to have high performance 2008 on 13 out of 16 standardized clinical performance measures and all summary scores.

Karuna Dev Sharma , 8(2012) in his study on “implementing Quality services in public sectors hospitals in India concluded that effective implementation of the quality management system, He addresses the major quality issues such as the staff deficit, lack of implementation of the health management and information system no interpersonal communication and other important unaddressed areas such as lack regular patients feedback and its evaluation,sterlization of care processes, patient safety, safe transport, continuity of care and will this facility improvement in public sector under NHRM

Dr mamta bharmbhatt 7(2011) her study refornces the fact that hospital adminstration need to gather systemstic feedback from their patients and to establish visible and transparent complaint processor so that patients compaliants can be adresses efectivelly and efficently they found that public sector hospital perfrom better than private sector inly in one dimenions namely relibility,where as private hospitals a better in physical,encounter,process,and policy dimension. Quality concern private hospital are better than public hospitals.

5.RESEARCH METHODOLOGY

Area of study

The study was undertaken for single SHCO hospital of Bharatpur District

SHCO- Small Healthcare Organisation are healthcare organisation less than 50 bed.

Study Design

Descriptive and cross-sectional study

Tools

Observation

Clinical record assessment

NABH self-assessment toolkit

Duration of study

Study conducted on Bharatpur district on the 3 months duration.

METHODOLOGY

Stage 1- NABH is a self-assessment toolkit used for a survey of the hospital in terms of scope of services provided by the hospital, manpower, physical infrastructure, drugs and lab services.

According to the self-assessment toolkit standard scores are given to each concerned area.

Score ‘0’- Non-Compliance

Score ‘5’-Partial Compliance

Score ‘10’- Complete Compliance

Stage 2- Observation and clinical record assessment were used to map out the various process of the hospital and to know the functioning of various department.

Stage 3- The Analysis done according to stage 1 & stage 2 are based on data collection. The report prepared reflected the process, infrastructure, equipment, and manpower. It also reflected the strength of the hospital and various gaps observed in the process and other parameters

-6 **Gap analysis**

Chapter 1: ACCESS, ASSESSMENT AND CONTINUITY OF CARE (AAC)	
AAC.1: The organization defines and displays the services that it can provide.	3.3
AAC.2: The organization has a documented registration, admission and transfer process.	0
AAC.3 Patients cared for by the organization undergo an established initial assessment.	1.6
AAC.4 Patient care is continuous, and all patients cared for by the organization undergo a regular reassessment.	5
AAC.5 Laboratory services are provided as per the scope of the hospital's services and laboratory safety requirements.	2.5
AAC.6 Imaging services are provided as per the scope of the hospital's services and established radiation safety programme.	NA
AAC.7 The organisation has a defined discharge process.	2.85
Average score	2.17

Table no.1

Maximum score -3

Average score-2.17

According to AAC chapter there were improper implementation of AAC in the organisations from the above table several gaps were analyse noncompliance was found in AAC.2and there were partial compliance in AAC1,AAC,AAC4,AAC5, AAC7 and AAC6 was not applicable ,were average score of chapter 2.17 which depicts that there is improper implementation of AAC chapter in the organisation, The services being provided by the hospital is not display clearly defined and displayed all staff is not oriented to the services, There is no standard policy and procedure documented registration, admission and transfer (stable or unable patients) process. Staff is not oriented to these services, no initial assessment and plane of care in patient area, Treatment of patient done but do not maintain documents, laboratory services provided by the hospital, but no safety requirement present in the hospital, No imaging service provide by the hospital, but USG service provide by the hospital, Discharge process are well fined but medicolegal cases are not mentioned.

Chapter 2: CARE OF PATIENTS (COP)	
COP.1: Care of patients is guided by accepted norms & practice.	0
COP.2: Emergency services including ambulance are guided by documented procedures.	1.6
COP.3: Documented procedures define rational use of blood and blood	1.6
COP.4: Documented procedures guide the care of patients as per the scope of services provided by hospital in Intensive care and high dependency unit.	3.3
COP.5: Documented procedures guide the care of obstetrical patients as per the scope of services provided by hospital.	1.6
COP.6: Documented procedures guide the care of paediatric patients as per the scope of services provided by hospital.	1.6
COP.7: Documented procedures guide the administration of anaesthesia.	2.2
COP.8: Documented procedure guides the care of patients undergoing surgical procedures.	2.85
Average score	1.84

Table no.2

Maximum score of COP -3.3

Average score of COP Chapter-1.84

According to COP chapter there were improper implementation of COP in the organisations from the above table several gaps were analyse noncompliance was found in COP1 and there were partial compliance in COP2, COP3,COP4,COP5,COP6, COP7,were average score of chapter 1.84. which depicts that there is improper implementation of COP chapter in the organisation, No document is signed by the concern doctor and hospital not likely to take medicolegal cases they referred these cases to government hospital staff is not oriented to scope of services, Blood and component transfusion done not documented, ICU is present inside the hospital but no standard protocol is recorded and Antenatal card, maternal nutritional card not present scope of services are not clearly defined, no document present for the paediatric care of patient and No polices, and procedure are documented for the care of patients undergone surgical procedure and no quality assurance programme oriented in OT.

Chapter 3: MANAGEMENT OF MEDICATION (MOM)	
MOM.1: Documented procedures guide the organization of pharmacy services and usage of medication.	0
MOM.2: Documented policies & procedures guide the storage of medications	2
MOM.3: Documented procedures guide the prescription of medications.	1.25
MOM.4: Policies & procedures guide the safe dispensing of medications.	2.5
MOM.5: There are defined procedures for medication administration	4
MOM.6: Adverse drug events are monitored.	0
MOM.7: Documented policies & procedures govern usage of radioactive drugs.	NA
Average score	1.6

Table no.3

Maximum score of MOM-2

Average score of MOM Chapter-1.6

According to MOM chapter there were improper implementation of MOM in the organisations from the above table several gaps were analyse noncompliance was found in MOM6,MOM1 and there were partial compliance in MOM2,MOM3,MOM4,MOM5 and MOM7 was not applicable ,were average score of chapter 1.6 which depicts that there is improper implementation of MOM chapter in the organisation, There is no documented procedure guide for the organisation of the pharmacy services are usage of medication and Hospital formulary has not been developed There is no policy of storage of medication they are safe from theft but according to NABH standard look a like sound alike should place separately. Documentation need to be done for prescription of medication and there is a need to be define the high-risk medication and process to prescribe them. Document need to be done for the safe deepens of medication. Documentation has been done for medical administration, but it is incomplete and not in legible hand wittering. Adverse drug event are not documented and monitored in the hospital. Radioactive drugs are not used in the hospital.

Chapter 4: PATIENT RIGHTS AND EDUCATION (PRE)	
PRE.1: Patient rights are documented displayed and support individual beliefs, values and involve the patient and family in decision making processes.	0
PRE.2: Patient and families have a right to information and education about their healthcare needs	7.5
Average score	3.25

Table no.4

Maximum score of PRE-7.5
Average score of PRE-3.25
According to PRE chapter there were improper implementation of MOM in the organisations from the above table several gaps were analyse noncompliance was found in PRE 1 and there were partial compliance in PRE2, and, were average score of chapter 3.25 which depicts that there is improper implementation of PRE chapter in the organisation, There is no documentation and signages about protection of patient, family rights and supporting their and involving the patient and family in decision-making, Patient family is well educated about the disease and the language they can easily understand.

Chapter 5: HOSPITAL INFECTION CONTROL (HIC)	
HIC.1: The hospital has an infection control manual, which is periodically updated and conducts surveillance activities.	0
HIC.2: The hospital takes actions to prevent or reduce the risks of Hospital Associated Infections (HAI) in patients and employees.	1.6
HIC.3: Bio-medical Waste (BMW) management practices are followed.	0

Table no.5

Maximum score of HIC-5

Average score of HIC chapter-1.6

According to HIC chapter there were improper implementation of HIC in the organisations from the above table several gaps were analyse noncompliance was found in ,HIC1,HIC 3and there were partial compliance in HIC2 were average score of chapter 1.6 which depicts that there is improper implementation of HIC chapter in the organisation, Hospital don't have infection control committee, infection control team and manual. There is no surveillance system for infection control. There is no documented and periodic survey had been done. And no monitoring of urinary tract infection, surgical site infection, respiratory infection has been done. Hand hygiene practice not followed no immunisation of staff done.no standard NSI procedure is followed, Organisation has not take any action to reduce hospital acquired infection of patient and employee. There need to be hepatitis vaccination for the staff of hospital. Biomedical waste is not properly segregate and final disposal of waste of done according to guidelines.

Chapter 6: CONTINUOUS QUALITY IMPROVEMENT (CQI)	
CQI.1: There is a structured quality improvement, patient safety and continuous monitoring programme in the organization.	0
CQI.2: The organization identifies key indicators to monitor the structures, processes and outcomes which are used as tools for continual improvement.	0
Average score	0

Table no 6

Maximum score of CQI-5
Average score of CQI chapter -0
None of the component was found to be working.

Chapter 7: RESPONSIBILITIES OF MANAGEMENT (ROM)	
ROM.1: The responsibilities of the management are defined	3.23
ROM.2: The organization is managed by the leaders in an ethical manner.	6.25
ROM.3: The organization has set up multi-disciplinary committees to oversee specific areas of quality and patient safety.	0
Average score	3.20

Table no.7

Maximum score of ROM-6.25

Average score of ROM Chapter -3.20

According to ROM chapter there were improper implementation of ROM in the organisations from the above table several gaps were analyse noncompliance was found in ROM3,and there were partial compliance in ROM1,ROM2 were average score of chapter 3.20 which depicts that there is improper implementation of ROM chapter in the organisation, Responsibility of management need to be defined there is no departmental classification inside the hospital. A suitable candidate is need to require, Organisation need to setup the committee for quality and patient safety.

Chapter 8: FACILITY MANAGEMENT AND SAFETY (FMS)	
FMS.1: The organization's environment and facilities operate to ensure safety of patients, their families, staff and visitors.	2
FMS.2: The organization has a program for clinical and support service equipment management.	0
FMS.3: The organization has provisions for safe water, electricity, medical gas and vacuum systems	6.7
FMS.4: The organization has plans for fire and non-fire emergencies within the facilities.	0
Average score	2.17

Table no.8

Maximum score of FMS-6.7

Average score of FMS Chapter-2.17

According to FMS chapter there were improper implementation of FMS in the organisations from the above table several gaps were analyse noncompliance was found in FMS2,FMS4 and there were partial compliance in FMS1,FMS3 ,were average score of chapter 2.17 which depicts that there is improper implementation of FMS chapter in the organisation Documentation need to be done in aspect of ensure safety of patients, their families, staff and visitors. training need to be done in for safety measures and programme for clinical and support service, equipment management, prevention, calibration and maintance need to be done periodically. The organisation has provisions for safe water, electricity, medical gas but no vacuum system is present. No fire exit plan present training need to be done for fire and disaster management.

Chapter 9: HUMAN RESOURCE MANAGEMENT (HRM)	
HRM.1: The organization has staffing commensurate with patient care needs	2.5
HRM.2: There is an ongoing programme for professional training and development of the staff.	0
HRM.3: The organization has a well-documented disciplinary and grievance handling procedure.	0
HRM.4: The organization addresses the health needs of the employees	0
HRM.5: There is documented personal record for each staff member	2.5
Average score	1

Table no.9

Maximum score of HRM-5
Average score of HRM Chapter-1
According to HRM chapter there were improper implementation of HRM in the organisations from the above table several gaps were analyse noncompliance was found in HRM2,HRM3,HRM4 and there were partial compliance in HRM1,HRM5,were average score of chapter 1 which depicts that there is improper implementation of HRM chapter in the organisation, The organisation do not have document system and also has not the human resource department and Documentation need to be done employee right and responsibility, socialisation and orientation need to be done and training programme for professional training not to be done organisation need to have develop well documented disciplinary and grievance need to be documented. There is no system for the health check-up of the staff need to implement the annual healthcheckup And Record of staff are maintained but not as per NABH standards.

Chapter 10: INFORMATION MANAGEMENT SYSTEM (IMS)	
IMS.1: The organization has a complete and accurate medical record for every patient	0
IMS.2: The medical record reflects continuity of care.	0
IMS.3: Documented policies and procedures are in place for maintaining confidentiality, integrity and security of records, data and information.	0
IMS.4: Documented procedures exist for retention time of records, data and information.	0
Average score	0

Table no.10

Maximum score-5

Average score of IMS Chapter-0

none of component was found to be working.

7.Implementation of standards

Here in, the gap is identified will be taken up the strategically and short term, long term goals will be identified in liaison with the hospital, special consideration of the department is given, and action plane is prepared, need to monitor by internal expert.

7.1 Formation of implementation of quality department and project team

Establish the quality Department-it is help to improve health outcomes.

1.HOD quality-involvement of head of department is important to smoothening the function.

2.Quality executive- quality executive ensure the implement processor and check the physical requirement required in a hospital.

3.Establishment of project team-establishment of committee like POSH, Blood transfusion,

4. Gravience committee to prevent the violence.

5.Medical Director – As head of organisation, is responsible for all the managerial and clinical activities.

6.Medical superintendent-To organize accreditation process of the hospital like NABL, NABH etc, ensure that health check-up camps both inside and outside the hospital

7.Lab in charge-Ensure the calibration of instrument and physical requirement.

8.Pharmacy in charge-Ensure the procurement of drugs and monitor the drug adverse effect inside the hospital.

9.ICN nurse -Ensure the hospital acquired infection and help to minimise the risk of infection.

10.Quality manager -quality executive ensure the implement processor and check the physical requirement required in a hospital

11.Hospital administrator-Hospital administrator handle the administrative part of hospital.

12.Human resource manager- Ensure the role and responsible to the staff and provide them training time to time.

7.2 Implementation parameter/accreditation parameter

We were work on this parameter for accreditation

DOCUMENTATION	To provide policies sops and apex manuals
TAINING	To provide the training format to staff Hospital wide training Departmental training Training question paper to the staff show the impact of understanding
FORM AND FORMATE	Review the clinical record and non-clinical forms
INFRASTRUCTURE/LICENSE	All legal documents are required Hospital registration number Land permit is required.
QUALITY INDICATOR	Quality indicator for all department is required Monthly statistical representation Data analysis and interpretation
SIGNAGE	Infection control signages For hospital direction signage Government mandatory signage

Fig 7.1 Plane to do

7.3 Establish the committee

To promote multidisciplinary and collaborative decision-making action authorities in the hospital we established 8 committees and disturbed the role and responsibility to each committee.

The hospital had following committee to ensure the patient safety

1.Quality improvement committee-

Role and responsibility

quality executive ensures the implement processor and check the physical requirement required in a hospital including the budget.

2.Grievance redressal and disciplinary action committee

Role and responsibility

To ensure no violence occurred in hospital premises and safety of patient.

3.Drug and therapeutic committee

Roles and responsibility

To formulate and implement the policies and procedures relating to pharmacy services and medication usage.

4.Safety committee

Role and responsibility-

To identify a potential safety and security risks to patients, staff, and visitors in all phases of activities.

To conduct facility inspection round to ensure safety minimum twice a year.

5.Infection control committee

Role and responsibility- infection control committee should carry out the following responsibility to prevent and minimize e the potential nosocomial infections to patients and staff,

6.Posh committee-

Role and responsibility-

prevent discrimination and sexual harassment in the hospital.

Recommend appropriate punitive action against the guilty party by the director.

7.Clinical committee

Role and responsibility-

Prevent the medical error and adverse drug events.

8.Blood transfusion committee

Role and responsibility

To review handling and administration of blood and its components.

Review of transfusion reactions.

7.4 Licences and Legal compliance

Registering under hospital act- the registration under the clinical establishment act,2017

It is enacted by the central government and is being adopted by the state of India.

Pollution control certificate and agreement-Agreement for air, water and BMW

AERB licenses- For the x -ray machine and radiology department.

NOC for fire department- approved by fire department is required for small hospital to prove that the hospital would not cause any harm or loss of life.

Drug and pharmacy licenses-this comes under a drug and cosmetic controller. there are different licenses for medical shops. Requirement for obtain this licenses refrigerator, Air-condition.

MOU -Mutual Aid Memorandum of Understanding is voluntary agreement among the hospital members.

PNDT- act 1994 is an act of the parliament of India enacted to stop female foeticides and arrest the declining sex ratio in India.

MTP/ Degree license-the MTP act allows for termination of pregency up to 20 weeks.

7.5 Organogram

Before the implementation staff is unaware about their roles and responsibility so that we implement the organogram for the hospital

It is a diagrammatic representation of the administrative set up which easily shows the lines of the command, control and responsibility, staff relation job grouping and communication of any organisation.

ORGANOGRM

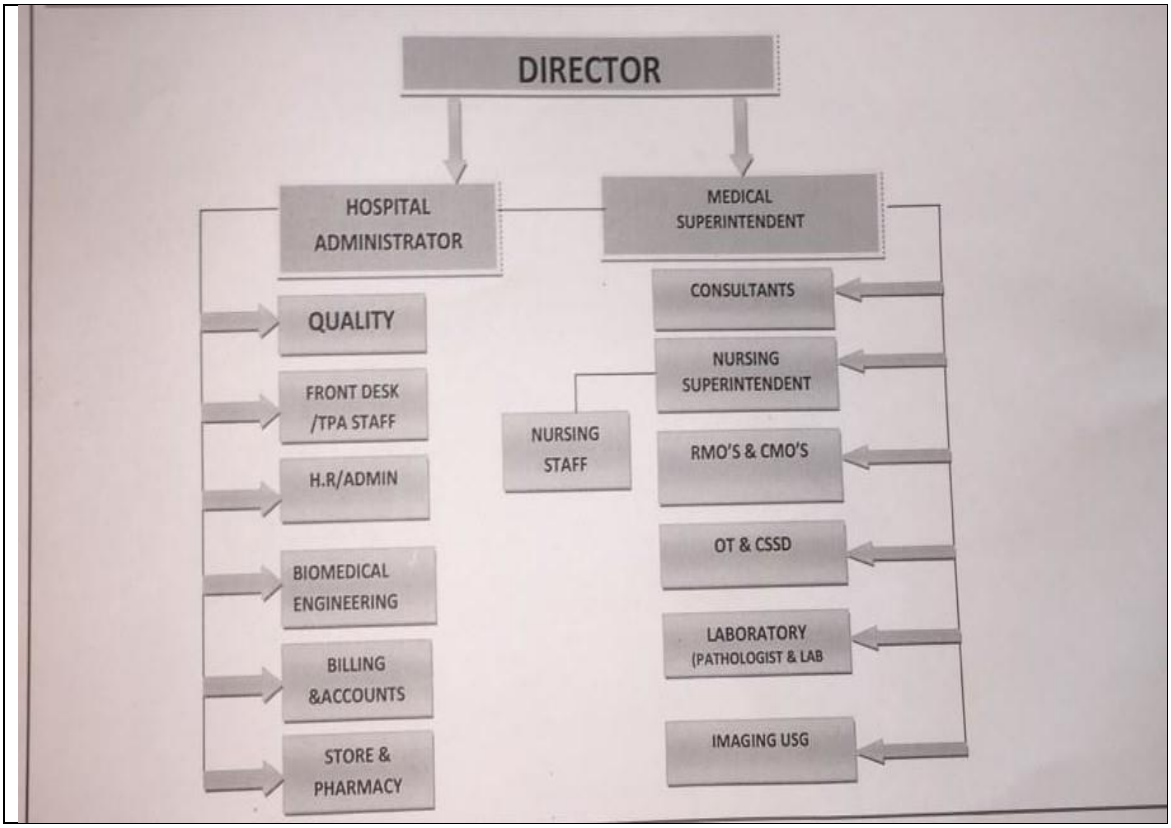


Fig 7.2 Organogram of hospital

7.6 Policies and procedures

Develop the documents including the quality manual, to establish the optimal functionality of any organisation is necessary to follow the instruction is required.

Document necessary according to NABH chapters

Policy of admission and discharge process

Policy of blood transfusion

Policy of anaesthesia consent

Policy of infection control

7.7 Facility findings

Before implementation we found out that there were many deformities inside as well as outside the facility infrastructure was not properly constructed, so we worked on the infrastructure and implemented the entrance facility.

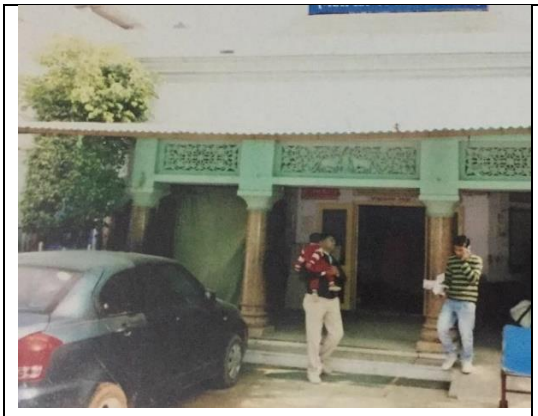


Fig 7.3 BEFORE

AFTER

Before implementation there was no proper way for entrance there is no parking facility available.

After implementation organisation have proper parking facility with the proper signages are display and having large visitors area.

Fig7.4 BEFORE

AFTER

Before implementation there was no safety belt present on the stretcher and not proper area to store.

Stretcher and wheelchair.

After implementation there is proper way to use safety belt with stretcher with proper area of storage.

7.8 Training

During the implementation interact with Nurse and doctor and educated them to provide some training related to NABH.

Fig 7.5Traing on infection control

Fig 7.6 Training on fire safety

Following training run in the hospital

1. Infection control training
2. NABH training
3. fire safety training
4. child abduction.
5. code blue.
6. spill management.
7. medication error

7.9 Signages

Displayed the necessary signages inside or outside the hospital and educate the doctor and nurses.

Patient right and responsibility board and scope of service is displayed, and other necessary IEC material displayed in OPD area.

Hand hygiene and BMW is displayed in their proper area.

Radiation safety displayed in x-ray area to prevent mother and child from harmful rays.

Fig 7.7
No smoking

Fig 7.8
Signages for the BMW

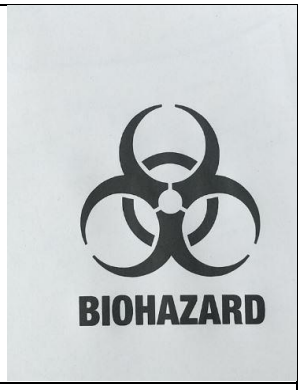


Fig 7.9
Signages for the biohazard

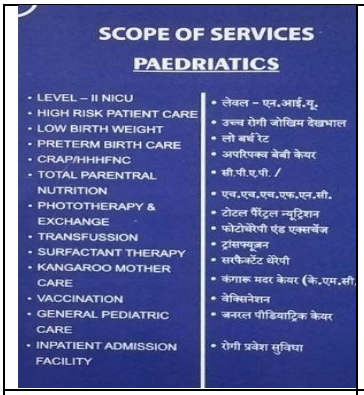


Fig 7.10
Signages of scope of services

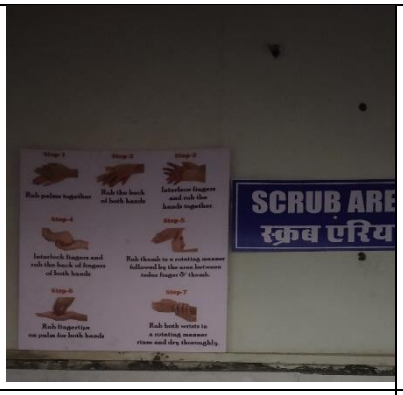


Fig 7.11
Signages of hand hygiene in different Area

Fig 7.12
Signage for radiosafty

7.10 Forms and format

We implement forms and format for the hospital.

There are following forms is essential according to NABH standards are introduce in the patient record:

1.Patient history and initial assessment.

2.Nursing assessment.

3.Doctor assessment.

4.Pre and Post Anaesthesia check-up.

5.Surgical Safety Checklist.

6.Pre-operative checklist.

7.Treatment sheet

8.Discharge Summary.

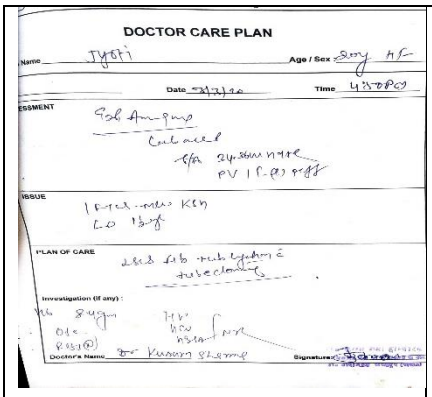


Fig 7.13 doctor care plane

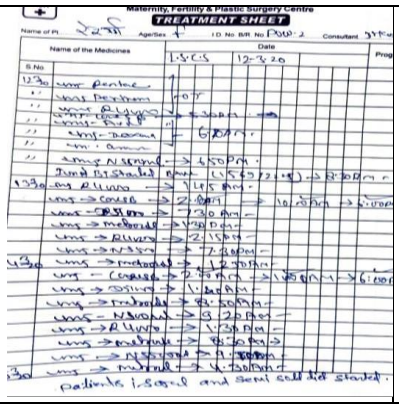


Fig 7.14 treatment sheet

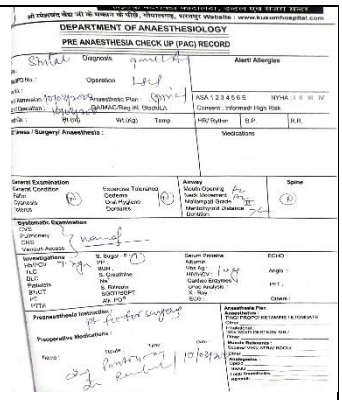


Fig 7.15paranaesthesia sheet

7.11 Implementation of emergency code

We implement five codes in the hospital

List of Emergency Code

Codes	Conditions
Red	Fire
Blue	Medical emergency
Pink	Child abduction
Yellow	spill
Orange	External disaster

7.12 PERSONNEL FILES – HUMAN RESORCE DEPARTEMENT

Human resources management is the practice for the recruiting, hiring, deploying and managing an organization employee.

We developed HR department which deals with employee's dress code, employee id etc

We prepared personnel file for each employee of the hospital which contains following documents.

Document required	
Employee profile	Yes/No
Appointment letter	Yes/No
Annual health check-up	Yes/No
Medical staff fitness check-up	Yes/No
Employee health record-blood group, cbc, x ray if reports	Yes/No
Staff last qualification record	Yes/No
Staff identification	Yes/No
Employee vaccination record	Yes/No
Job description	Yes/No

7.13 Quality indicator

We select 18 clinical and 17 managerial quality indicator to access the improvement to each department of the hospital.

There are following indicators.

List of clinical quality indicator.

S.no	Clinical indicator	Formulae
1.	Urinary tract infection	(Number of urinary Cather associated UTIs in a month/Number of urinary catheter days in that month) x1000
2.	Surgical site infection	Number of patients developing SSI in a period/Total number of clean surgeries performed in that period)x100
3.	Mortality rate	(Number of deaths/Number of discharges and deaths) x100
4.	Percentage of unplanned OT surgery	Number of unplanned returns to OT/Number of patients operated) x100
5.	Percentage of transfusion reaction	(Number of transfusion reaction /Number of transfusion) x100

List of managerial quality indicators.

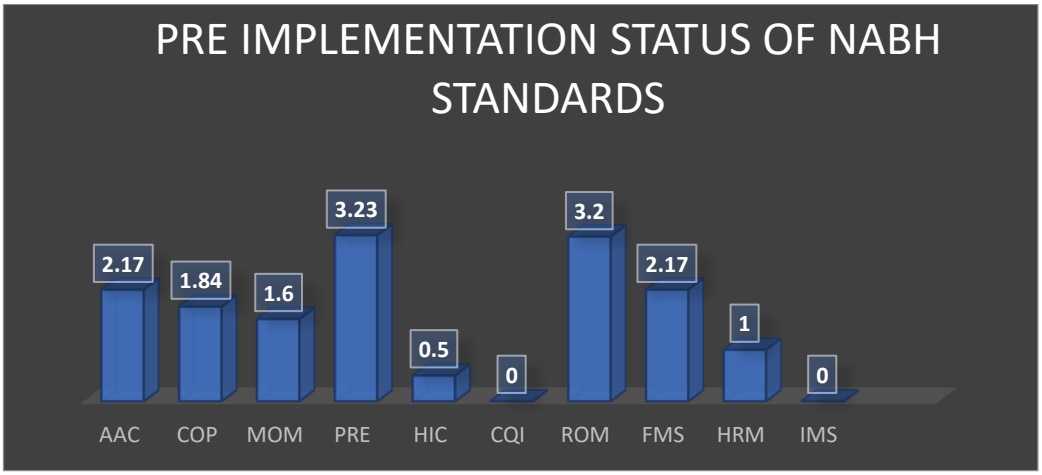
S.no	Managerial indicator	Formulae
1.	Incidence falls	Number of falls/number of death and discharge)x100
2.	Bed occupancy rate	Number of inpatient days in given month/Number of available bed days in that month)x100
3.	Average length of stay	Number of inpatient days in a given month/Number of discharge and death in that month)x100
4.	Employee satisfaction index	(score achieved /maximum possible score) x100
5.	Percentage of missing records	Number of missing record/Number of records)x100

7.14 Other findings

During the internal audit these things were found.

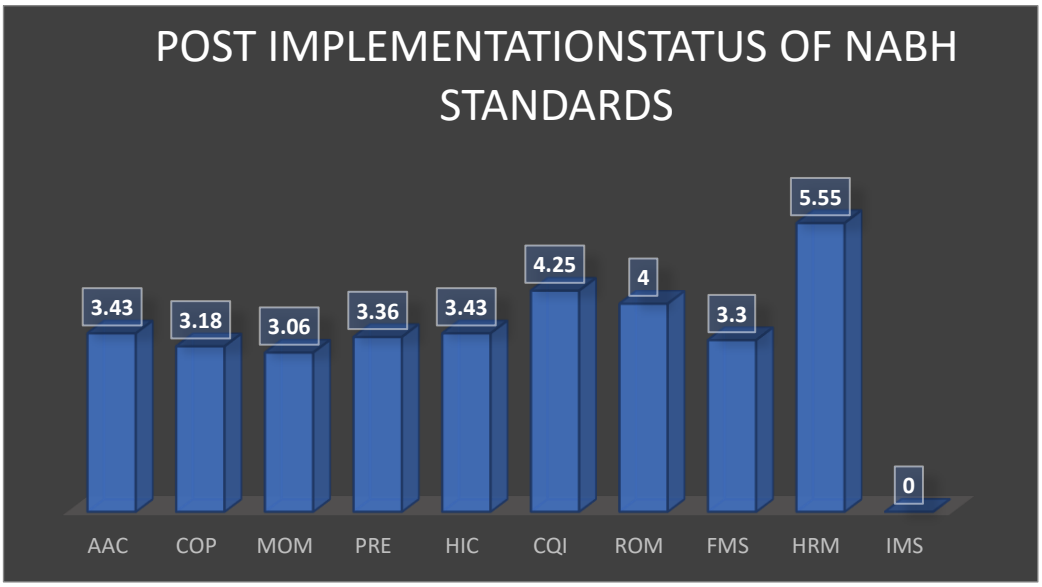
- Patient satisfaction survey performed for their feedback.
- Autoclaving of instrument start every morning before OT procedure.
- PPE kit provide to the staff after consulting to owner of the hospital
- Daily check on availability of linen on every bed in the word
- Hand hygiene poster displayed in all nursing station
- Prepared the LASA, high risk medicine chamber on pharmacy.
- Assigned the person to maintain the register of lab, DG, Autoclave, prevention and maintance.
- Water culture, OT, labour room culture sample taken and make the culture report file.
- Hand overtaken over register maintained.
- Biomedical waste management training given to staff, with display of BMW poster.
- Display scope of services in laboratory.
- Procurement of needle cutter done.
- Make the expiry box inside the pharmacy
- Improvement of infrastructure is done

9.Result and finding



Average score of every chapter indicate compliance of standards in beginning of study

We found that in the beginning of the study most of NABH standard were not met with the criteria of NABH certification. And score was less than 2.



Average score of every chapter indicate compliance of standards after implementation work

After the implementation most of NABH standards score was 5 and which met with the criteria of NABH entry level certification.

10 .Recommendation

- Need to revise the documentation in case of partial compliance
- Regular training should be conduct in part of IPD files
- Side rails of patient bed should be present.
- Construction should be complete as soon as possible
- Curtains for bed present.
- Orientation and training should conduct for the new employee.
- Conduct the committee meeting every month.
- Clinical audit should be done regularly.
- Need to conduct infection control training for patient safety.

11.Conclusion

- Study shows that after implementation of the standards most of the gaps and findings close as required for NABH certification.
- Post implementation results show 45% of standards are compliance with respect to pre implementation study where compliance of standards were all most 0%.
- Now hospital ready is NABH standards of pre entry level certification.

References

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ANNEXURE

SELF ASSESMENT TOOLKIT

Organisation is required to provide self-assessment report in the format 'Self-Assessment Toolkit' given below. All the entries are to be properly filled up. Regarding scoring following criteria would be applicable.

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

Evaluation Criteria:

•Overall score of minimum 50% in all standards

• Overall score of minimum 50% in each chapter

SELF ASSESSMENT TOOLKIT

Elements			Documentation (Yes/ No)	Implementation (Yes/ No)	Evidence (cross reference to documents/ manuals etc.)	Scores (0/ 5/ 10)
Chapter 1: ACCESS, ASSESSMENT AND CONTINUITY OF CARE (AAC)						
AAC.1: The organization defines and displays the services that it can provide.						
	a	The services being provided are clearly defined.				
	b	The defined services are prominently displayed.				
	c	The staff is oriented to these services.				
AAC.2: The organization has a documented registration, admission and transfer process.						
	a.	Process addresses registering and admitting out-patients, in-patients and emergency patients.				
	b.	Process addresses mechanism for transfer or referral of patients who do not match the organizational resources.				
AAC.3 Patients cared for by the organization undergo an established initial assessment.						
	a.	The organization defines the content of the assessments for the out-patients, in-patients and emergency patients.				
	b.	The organization determines who can perform the assessments.				
	c.	The initial assessment for in-patients is documented within 24 hours or earlier.				
	d.	Initial assessment of inpatients includes nursing assessment which is done at the time of admission and documented.				

AAC.4 Patient care is continuous and all patients cared for by the organization undergo a regular reassessment.						
	a.	During all phases of care, there is a qualified individual identified as responsible for the patient's care who coordinates the care in all the settings within the organization.				
	b.	All patients are reassessed at appropriate intervals.				
	c.	Staff involved in direct clinical care document reassessments.				
	d.	Patients are reassessed to determine their response to treatment and to plan further treatment or discharge.				
AAC.5 Laboratory services are provided as per the scope of the hospital's services and laboratory safety requirements.						
	a.	Scope of the laboratory services are commensurate to the services provided by the organization.				
	b.	Procedures guide collection, identification, handling, safe transportation, processing and disposal of specimens.				
	c.	Laboratory results are available within a defined time frame and critical results are intimated immediately to the concerned personnel.				
	d.	Adequately trained personnel perform, supervise & interpret the investigations.				
	e.	Laboratory personnel are trained in safe practices and are provided with appropriate safety equipment/ devices.				
	f.	Laboratory tests not available in the organization are outsourced.				
AAC.6 Imaging services are provided as per the scope of the hospital's services and established radiation safety programme.						
	a.	Scope of the imaging services are commensurate to the services provided by the organization.				
	b.	Imaging signages are prominently displayed in all appropriate locations.				
	c.	Imaging results are available within a defined time frame and critical results are intimated immediately to the concerned personnel.				

	d.	Imaging personnel are trained in safe practices and are provided with appropriate safety equipment/ devices.				
AAC.7 The organisation has a defined discharge process.						
	a.	Process addresses discharge of all patients including Medico-legal cases and patients leaving against medical advice.				
	b.	A discharge summary is given to all the patients leaving the organization (including patients leaving against medical advice).				
	c.	Discharge summary contains the reasons for admission, significant findings, investigation results, diagnosis, procedure performed (if any), treatment given and the patient's condition at the time of discharge.				
	d.	Discharge summary contains follow up advice, medication and other instructions in an understandable manner.				
	e.	Discharge summary incorporates instructions about when and how to obtain urgent care.				
	f.	In case of death the summary of the case also includes the cause of death.				
Chapter 2: CARE OF PATIENTS (COP)						
COP.1: Care of patients is guided by accepted norms & practice.						
	a	The care and treatment orders are signed and dated by the concerned doctor.				
	b	Critical Practice Guidelines are adopted to guide patient care wherever possible.				
COP.2: Emergency services including ambulance are guided by documented procedures.						
	a	Documented procedures address care of patients arriving in the emergency including handling of medico-legal cases.				
	b	Staff should be well versed in the care of emergency patients in consonance with the scope of the services of hospital.				

	c	Admission or discharge to home or transfer to another organization is also documented.				
	d	Ambulance is appropriately equipped.				
	e	Ambulance(s) is manned by trained personnel.				
COP.3: Documented procedures define rational use of blood and blood products.						
	a	Documented policies and procedures are used to guide the rational use of blood and blood products.				
	b	Documented procedures govern transfusion of blood and blood products.				
	c	The transfusion services are governed by the applicable laws and regulations.				
	d	Informed consent is obtained for donation and transfusion of blood and blood products.				
	e	Procedure addresses documenting and reporting of transfusion reactions.				
COP.4: Documented procedures guide the care of patients as per the scope of services provided by hospital in Intensive care and high dependency unit.						
	a	Care of patients is in consonance with the documented procedures.				
	b	Adequate staff and equipment are available.				
COP.5: Documented procedures guide the care of obstetrical patients as per the scope of services provided by hospital.						
	a	The organization defines the scope of obstetric services.				
	b	Obstetric patient's care includes regular ante-natal check ups, maternal nutrition and post-natal care.				
	c	The organization has the facilities to take care of neonates.				

COP.6: Documented procedures guide the care of pediatric patients as per the scope of services provided by hospital.					
a	The organization defines the scope of its pediatric services.				
b	Provisions are made for special care of children by competent staff.				
c	Patient assessment includes detailed nutritional, growth, and immunization assessment.				
d	Procedure addresses identification and security measures to prevent child/ neonate abduction and abuse.				
e	The children's family members are educated about nutrition and immunization				
COP.7: Documented procedures guide the administration of anesthesia.					
a.	There is a documented policy & procedure for the administration of anesthesia.				
b.	All patients for anesthesia have a pre-anesthesia assessment by a qualified/ trained anesthetist.				
c.	The pre-anesthesia assessment results in formulation of an anesthesia plan which is documented.				
d.	An immediate preoperative re-evaluation is documented.				
e.	Informed consent for administration of anesthesia is obtained by the anesthetist.				
f.	Anesthesia monitoring includes regular and periodic recording of heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation, airway security and patency and End tidal carbon dioxide.				
g.	Each patient's post-anesthesia status is monitored and documented.				
h.	Defined criteria are used to transfer the patient from the recovery area.				
i.	Adverse anesthesia events are recorded and monitored.				

COP.8: Documented procedure guides the care of patients undergoing surgical procedures.					
a.	Surgical patients have a preoperative assessment and a provisional diagnosis documented prior to surgery.				
b.	An informed consent is obtained by a surgeon prior to the procedure.				
c.	Documented procedure addresses the prevention of adverse events like wrong site, wrong patient and wrong surgery.				
d.	Qualified persons are permitted to perform the procedures that they are entitled to perform.				
e.	The operating surgeon documents the operative notes and post-operative plan of care.				
f.	The operation theatre is adequately equipped and monitored for infection control practices.				
g.	Patients, personnel and material flow conform to infection control practices.				
Chapter 3: MANAGEMENT OF MEDICATION (MOM)					
MOM.1: Documented procedures guide the organization of pharmacy services and usage of medication.					
a	Documented procedure shall incorporate purchase, storage, prescription and dispensation of medications.				
b	Documented procedures address procurement and usage of implantable prostheses.				
MOM.2: Documented policies & procedures guide the storage of medications.					
a	Documented policies and procedures exist for storage of medication				
b	Medications are stored in a clean, safe and secure environment, and incorporate manufacturer's recommendations.				
c	Sound alike and look alike medications are stored separately.				

	d	Beyond expiry date medications are not stored/used.				
	e	List of emergency medicines is defined, stored, and available all the time.				
MOM.3: Documented procedures guide the prescription of medications.						
	a	The organization determines who can write orders.				
	b	Orders are written in a uniform location in the medical records.				
	c	Medication orders are clear, legible, dated and signed.				
	d	The organization defines a list of high risk medication & process to prescribe them.				
MOM.4: Poilicies & procedures guide the safe dispensing of medications.						
	a	Medications are checked prior to dispensing, including the expiry date to ensure that they are fit for use.				
	b	High risk medication orders are verified prior to dispensing.				
MOM.5: There are defined procedures for medication administration.						
	a	Medications are administered by trained personnel.				
	b	Prior to administration medication order including patient, dosage, route and timing are verified.				
	c	Prepared medication is labelled prior to preparation of a second drug.				
	d	Medication administration is documented.				
	e	A proper record is kept of the usage, administration and disposal of narcotics and psychotropic medications.				
MOM.6: Adverse drug events are monitored.						

	a	Adverse drug events are defined & monitored.				
	b	Adverse drug events are documented and reported within a specified time frame.				
MOM.7: Documented policies & procedures govern usage of radioactive drugs.						
	a	Documented policies and procedures govern usage of radioactive drugs.				
	b	Policies and procedures include the safe storage, preparation, handling, distribution and disposal of radioactive drugs.				
Chapter 4: PATIENT RIGHTS AND EDUCATION (PRE)						
PRE.1: Patient rights are documented displayed and support individual beliefs, values and involve the patient and family in decision making processes.						
	a.	Patient rights include respect for personal dignity and privacy during examination, procedures and treatment.				
	b.	Patient rights include protection from physical abuse or neglect.				
	c.	Patient rights include treating patient information as confidential.				
	d.	Patient rights include obtaining informed consent before carrying out procedures.				
	e.	Patient rights include information on how to voice a complaint.				
	f.	Patient rights include information on the expected cost of the treatment.				
	g.	Patient has a right to have an access to his / her clinical records.				
PRE.2: Patient and families have a right to information and education about their healthcare needs.						
	a	Patients and families are educated on plan of care, preventive aspects, possible complications, medications, the expected results and cost as applicable.				

	b	Patients are taught in a language and format that they can understand.				
Chapter 5: HOSPITAL INFECTION CONTROL (HIC)						
HIC.1: The hospital has an infection control manual, which is periodically updated and conducts surveillance activities.						
	a	It focuses on adherence to standard precautions at all times.				
	b	Cleanliness and general hygiene of facilities will be maintained and monitored.				
	c	Cleaning and disinfection practices are defined and monitored as appropriate.				
	d	Equipment cleaning, disinfection and sterilization practices are included.				
	e	Laundry and linen management processes are also included				
HIC.2: The hospital takes actions to prevent or reduce the risks of Hospital Associated Infections (HAI) in patients and employees.						
	a	Hand hygiene facilities in all patient care areas are accessible to health care providers.				
	b	Adequate gloves, masks, soaps, and disinfectants are available and used correctly.				
	c	Appropriate pre and post exposure prophylaxis is provided to all concerned staff members.				
HIC.3: Bio-medical Waste (BMW) management practices are followed.						
	a	The hospital is authorised by prescribed authority for the management and handling of Bio-Medical Waste.				
	b	Proper segregation and collection of Bio-Medical Waste from all patient care areas of the hospital is implemented and monitored.				
	c	Bio-Medical Waste treatment facility is managed as per statutory provisions (if in-house) or outsourced to authorised contractor(s).				
	d	Requisite fees, documents and reports are submitted to competent authorities on stipulated dates.				

	e	Appropriate personal protective measures are used by all categories of staff handling Bio-Medical Waste.				
Chapter 6: CONTINUOUS QUALITY IMPROVEMENT (CQI)						
CQI.1: There is a structured quality improvement, patient safety and continuous monitoring programme in the organization.						
	a	There is a designated individual for coordinating and implementing the quality improvement and patient safety programme.				
	b	The quality improvement and patient safety programme is a continuous process and updated at least once in a year.				
	c	Hospital Management makes available adequate resources required for quality improvement and patient safety programme.				
CQI.2: The organization identifies key indicators to monitor the structures, processes and outcomes which are used as tools for continual improvement.						
	a	Organization may identify the appropriate key performance indicators in both clinical and managerial areas.				
	b	These indicators shall be monitored.				
Chapter 7: RESPONSIBILITIES OF MANAGEMENT (ROM)						
ROM.1: The responsibilities of the management are defined						
	a	The organization has a documented organogram.				
	b	The organization is registered with appropriate authorities as applicable.				
	c	The organization has a designated individual(s) to oversee the hospital wide quality and safety programme.				
ROM.2: The organization is managed by the leaders in an ethical manner.						

	a	The management makes public the mission statement of the organization.				
	b	The leaders/management guide the organization to function in an ethical manner.				
	c	The organization discloses its ownership.				
	d	The organization's billing process is accurate and ethical.				
ROM.3: The organization has set up multi-disciplinary committees to oversee specific areas of quality and patient safety.						
	a	These committees include Quality and Safety, Infection Control, Pharmacy and Therapeutics, Blood Transfusion, and Medical Records.				
	b	The membership, responsibilities, and periodicity of meetings shall be defined.				
Chapter 8: FACILITY MANAGEMENT AND SAFETY (FMS)						
FMS.1: The organization's environment and facilities operate to ensure safety of patients, their families, staff and visitors.						
	a	Internal and External Signage's shall be displayed in a language understood by the patients and families.				
	b	Maintenance staff is contactable round the clock for emergency repairs.				
	c	There the hospital has a system to identify the potential safety and security risks including hazardous materials.				
	d	Facility inspection rounds to ensure safety are conducted periodically.				
	e	There is a safety education programme for relevant staff.				
FMS.2: The organization has a program for clinical and support service equipment management.						

	a	The organization plans for equipment in accordance with its services.				
	b	There is a documented operational and maintenance (preventive and breakdown) plan.				
FMS.3: The organization has provisions for safe water, electricity, medical gas and vacuum systems.						
	a	Potable water and electricity are available round the clock.				
	b	Alternate sources are provided for in case of failure and tested regularly.				
	c	There is a maintenance plan for medical gas and vacuum systems.				
FMS.4: The organization has plans for fire and non-fire emergencies within the facilities.						
	a	The organization has plans and provisions for detection, abatement and containment of fire and non-fire emergencies.				
	b	The organization has a documented safe exit plan in case of fire and non-fire emergencies.				
	c	There is a maintenance plan for medical gas and vacuum systems.				
	d	Mock drills are held at least twice in a year.				
Chapter 9: HUMAN RESOURCE MANAGEMENT (HRM)						
HRM.1: The organization has staffing commensurate with patient care needs.						
	a	The mix of staff is commensurate with the volume and scope of the services.				
	b	Staff recruitment process is well defined.				
HRM.2: There is an ongoing programme for professional training and development of the staff.						
	a	All staff is trained on the relevant risks within the hospital environment.				

	b	Staff members can demonstrate and take actions to report, eliminate/ minimize risks.				
	c	Training also occurs when job responsibilities change/ new equipment is introduced.				
HRM.3: The organization has a well-documented disciplinary and grievance handling procedure.						
	a	A documented procedure with regard to these is in place.				
	b	The documented procedure is known to all categories of employees in the organization.				
	c	Actions are taken to redress the grievance.				
HRM.4: The organization addresses the health needs of the employees						
	a	Health problems of the employees are taken care of in accordance with the organization's policy.				
	b	Occupational health hazards are adequately addressed.				
HRM.5: There is documented personal record for each staff member						
	a	Personal files are maintained in respect of all employees.				
	b	The personal files contain personal information regarding the employees qualification, disciplinary actions and health status. The disciplinary procedure is in consonance with the prevailing laws.				
Chapter 10: INFORMATION MANAGEMENT SYSTEM (IMS)						
IMS.1: The organization has a complete and accurate medical record for every patient						
	a	Every medical record has a unique identifier.				

	b	Organization identifies those authorized to make entries in medical record.				
	c	Every medical record entry is dated and timed.				
	d	The author of the entry can be identified.				
	e	The contents of medical record are identified and documented.				
IMS.2: The medical record reflects continuity of care.						
	a	The record provides an up-to-date and chronological account of patient care.				
	b	The medical record contains information regarding reasons for admission, diagnosis and plan of care.				
	c	Operative and other procedures performed are incorporated in the medical record.				
	d	The medical record contains a copy of the discharge note duly signed by appropriate and qualified personnel.				
	e	In case of death, the medical records contain a copy of the death certificate indicating the cause, date and time of death.				
	f	Care providers have access to current and past medical record.				
IMS.3: Documented policies and procedures are in place for maintaining confidentiality, integrity and security of records, data and information.						
	a	a. Documented procedures exist for maintaining confidentiality, security and integrity of information.				
	b	Privileged health information is used for the purposes identified or as required by law and not disclosed without the patient's authorization.				
IMS.4: Documented procedures exist for retention time of records, data and information.						
	a	Documented procedures are in place on retaining the patient's clinical records, data and information.				

b	The retention process provides expected confidentiality and security.				
c	The destruction of medical records, data and information is in accordance with the laid down procedure.				