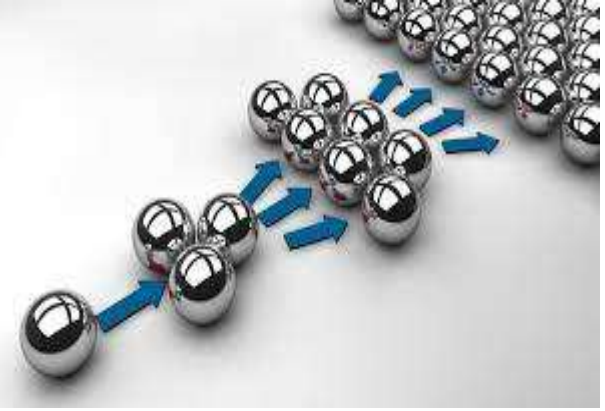


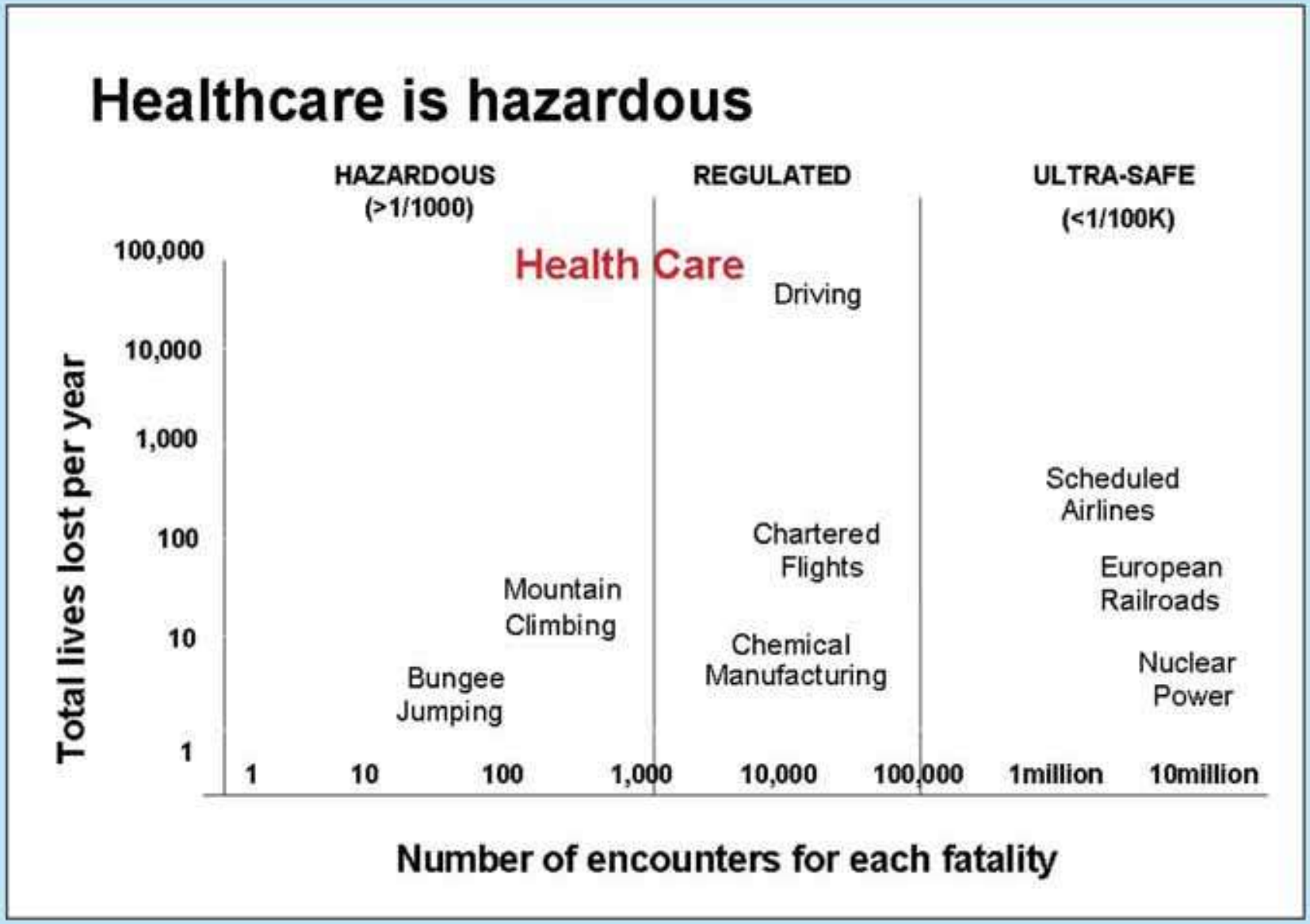
Simple Steps to NABH Accreditation

Dr. Lallu Joseph

Quality Manager & Assoc. GS, CMC Vellore

Secretary General, CAHO

Unnecessary, Expensive, Intrusion into autonomy, Waste of time, Who are they to tell us?



Source: 2002. IHI. Leape

WHO calls patient safety an endemic concern


EMERGENCY


ICU


Ward

Patient Safety ?????

We can all agree the practice of medicine was simple, maybe relatively ineffective but safe.

TODAY.....The practice of Medicine IS HIGHLY COMPLEX but effective

Way Forward...

Accreditation

- **Best possible tool for achieving quality and patient safety.**
- **Accreditation is a process in which certification of competency, authority, or credibility is presented to an organization.**
- **A self-assessment and external peer assessment process used by healthcare organizations to accurately assess their level of performance in relation to established standards and then to implement ways to continuously improve it.**

Focus of Accreditation Standards

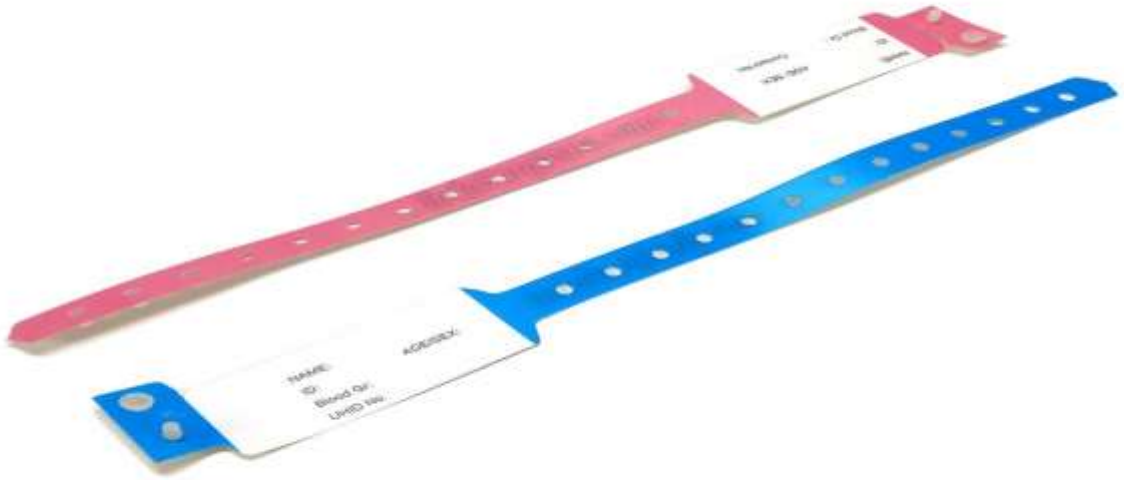
- Patient Safety
- Staff and employee safety
- Environment and community safety
- Information Education and Communication
- Measurement of Performance
- Organized around important functions

A doctor's tool kit for quality care and patient safety…

Simple measures saves lives…..

Patient Identification

- ID Bands
- UHID



Use of WHO Surgical Safety Checklist

SIGN IN

- ☐ PATIENT HAS CONFIRMED
  - IDENTITY
  - SITE
  - PROCEDURE
  - CONSENT
- ☐ SITE MARKED/NOT APPLICABLE
- ☐ ANAESTHESIA SAFETY CHECK COMPLETED
- ☐ PULSE OXIMETER ON PATIENT AND FUNCTIONING

DOES PATIENT HAVE A:

KNOWN ALLERGY?
- ☐ NO
- ☐ YES

DIFFICULT AIRWAY/ASPIRATION RISK?
- ☐ NO
- ☐ YES, AND EQUIPMENT/ASSISTANCE AVAILABLE

RISK OF >500ML BLOOD LOSS (7ML/KG IN CHILDREN)?
- ☐ NO
- ☐ YES, AND ADEQUATE INTRAVENOUS ACCESS AND FLUIDS PLANNED

TIME OUT

- ☐ CONFIRM ALL TEAM MEMBERS HAVE INTRODUCED THEMSELVES BY NAME AND ROLE
- ☐ SURGEON, ANAESTHESIA PROFESSIONAL AND NURSE VERBALLY CONFIRM
  - PATIENT
  - SITE
  - PROCEDURE

ANTICIPATED CRITICAL EVENTS

- ☐ **SURGEON REVIEWS:** WHAT ARE THE CRITICAL OR UNEXPECTED STEPS, OPERATIVE DURATION, ANTICIPATED BLOOD LOSS?
- ☐ **ANAESTHESIA TEAM REVIEWS:** ARE THERE ANY PATIENT-SPECIFIC CONCERNS?
- ☐ **NURSING TEAM REVIEWS:** HAS STERILITY (INCLUDING INDICATOR RESULTS) BEEN CONFIRMED? ARE THERE EQUIPMENT ISSUES OR ANY CONCERNS?

HAS ANTIBIOTIC PROPHYLAXIS BEEN GIVEN WITHIN THE LAST 60 MINUTES?
- ☐ YES
- ☐ NOT APPLICABLE

IS ESSENTIAL IMAGING DISPLAYED?
- ☐ YES
- ☐ NOT APPLICABLE

SIGN OUT

NURSE VERBALLY CONFIRMS WITH THE TEAM:

- ☐ THE NAME OF THE PROCEDURE RECORDED
- ☐ THAT INSTRUMENT, SPONGE AND NEEDLE COUNTS ARE CORRECT (OR NOT APPLICABLE)
- ☐ HOW THE SPECIMEN IS LABELLED (INCLUDING PATIENT NAME)
- ☐ WHETHER THERE ARE ANY EQUIPMENT PROBLEMS TO BE ADDRESSED
- ☐ SURGEON, ANAESTHESIA PROFESSIONAL AND NURSE REVIEW THE KEY CONCERNS FOR RECOVERY AND MANAGEMENT OF THIS PATIENT

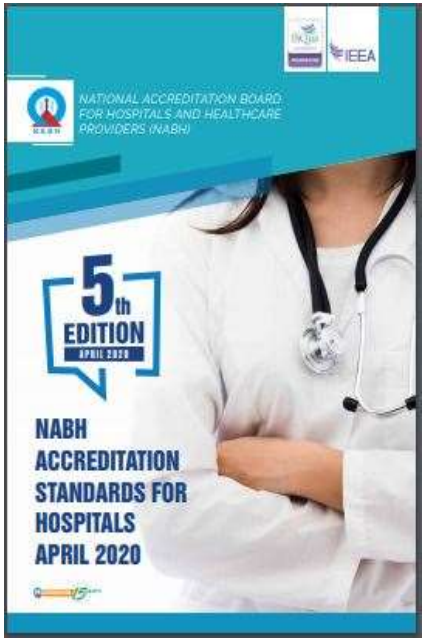
Safer Medication

NATIONAL ACCREDITATION BOARD FOR HOSPITALS AND HEALTHCARE PROVIDERS (NABH)

NABH is a Constituent Board of Quality Council of India (QCI)

HCO and SHCO

- Health Care Organization (HCO) - More than 50 beds
- Small Health Care Organization (SHCO) - Up to 50 beds
    - *Entry level accreditation – HCO & SHCO*
    - *Full accreditation – HCO & SHCO*



NABH Standards

NABH Standards	Entry Level		Full Certification	
	SHCO (1st Edn.)	HCO (1st Edn.)	SHCO (2nd Edn.)	HCO (5th Edn.)
Chapters	10	10	10	10
Standards	41	45	61	100
Objective Elements	149	167	289	651

Challenges in implementation

- Lack of awareness of standards
- Fear of the unknown
- Fear of exposing their vulnerabilities
- Old infrastructure and licenses
- Manpower requirement
- Standard Operating Procedures and Manuals
- Training of all categories of staff
- Inadequate resources

MANTRA

DO IT YOURSELF

DO NOT DELEGATE

1. Strong Management Commitment

- **Top management should actively involve**
- **Prepare the strategy for implementation**
- **Responsibility for implementation should lie with the top management**

2. Quality Coordinator

Choose the right person

Who are these super heroes ???

Quality Manager..

1. Knowledgeable
2. Team player
3. Team leader
4. Assertive
5. Listener
6. Perseverance
7. Learner
8. Work around people
9. Communicator
10. Trainer
11. Presenter
12. Manipulator
13. Always smiling
14. Should remain calm
15. Public relations
16. Impartial

3. Quality Team

Multi-disciplinary Team

4. Training on the Standards

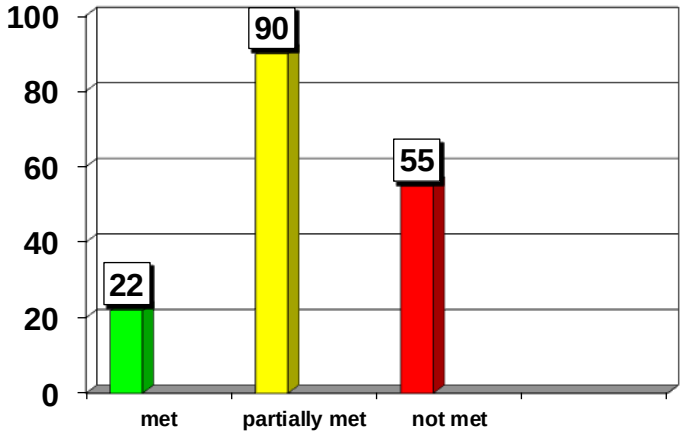
- Attend in-depth training program on NABH Standards
- Nominate three members atleast to attend the program – doctor, nurse and administrator
- Understand the intent of every objective element

5. Form Committees

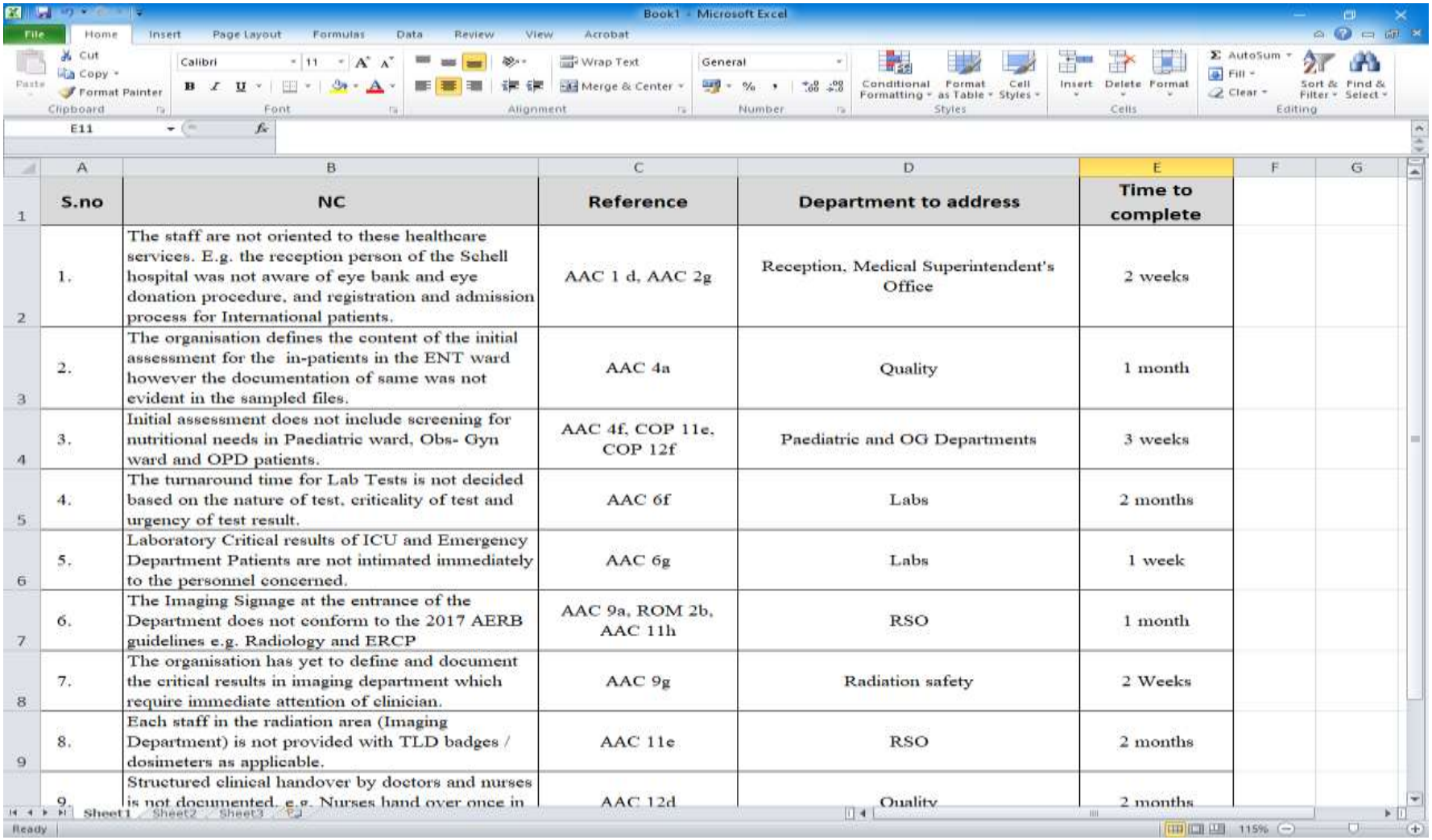
- **Multidisciplinary team for NABH implementation**
- **Form Committees**
  - Quality Committee
  - Safety Committee
  - Infection Control
  - Pharmacy
  - Transfusion
- **Form sub-committees depending on issues**

6. Baseline assessment to identify gaps

- **Conduct baseline assessment**
- **Scoring pattern: 0, 5, 10**
  - Fully met : 10
  - Partially met : 5
  - Not met : 0
- **Focus on “not met”**
- **Improve on “partially met”**
- **Monitor “fully met”**



7. Assign Responsibilities



S.no	NC	Reference	Department to address	Time to complete
1.	The staff are not oriented to these healthcare services. E.g. the reception person of the Schell hospital was not aware of eye bank and eye donation procedure, and registration and admission process for International patients.	AAC 1 d, AAC 2g	Reception, Medical Superintendent's Office	2 weeks
2.	The organisation defines the content of the initial assessment for the in-patients in the ENT ward however the documentation of same was not evident in the sampled files.	AAC 4a	Quality	1 month
3.	Initial assessment does not include screening for nutritional needs in Paediatric ward, Obs- Gyn ward and OPD patients.	AAC 4f, COP 11e, COP 12f	Paediatric and OG Departments	3 weeks
4.	The turnaround time for Lab Tests is not decided based on the nature of test, criticality of test and urgency of test result.	AAC 6f	Labs	2 months
5.	Laboratory Critical results of ICU and Emergency Department Patients are not intimated immediately to the personnel concerned.	AAC 6g	Labs	1 week
6.	The Imaging Signage at the entrance of the Department does not conform to the 2017 AERB guidelines e.g. Radiology and ERCP	AAC 9a, ROM 2b, AAC 11h	RSO	1 month
7.	The organisation has yet to define and document the critical results in imaging department which require immediate attention of clinician.	AAC 9g	Radiation safety	2 Weeks
8.	Each staff in the radiation area (Imaging Department) is not provided with TLD badges / dosimeters as applicable.	AAC 11e	RSO	2 months
9.	Structured clinical handover by doctors and nurses is not documented, e.g. Nurses hand over once in	AAC 12d	Quality	2 months

8. Ensure Involvement of Staff

- Identify Key Personnel in each area
- These individuals can be made as quality champions
- Train on the requirements of their areas

9. Prepare Implementation Checklist

CHRISTIAN MEDICAL COLLEGE VELLORE

QUALITY MANAGEMENT CELL

Cardiac Catheterization Laboratory

Audit done by: **Date:**

Displays	Yes/No	Remarks
Procedure room name (Bi-lingual)		
Mission, Vision Board		
Patient rights and responsibilities		
No smoking Board		
Bio Medical Waste Segregation posters (Latest)		
Hand hygiene posters		
Chemical safety poster (SDS sheet)		
Emergency contact display		
Emergency floor plan		
Radiation safety signage (2017 AERB Guidelines)		
Fire Exit		
Other signage		
Licenses up-to-date for LAB	**Yes/ No**	
P1 and P2 Lab- Allura xper FD 20/10(AERB licenses)		
P3 Lab- FD 10 clarity 520 (AERB licenses)		
Radiology Equipment		
TLD badges	**Yes/ No**	
Screening done once in 3 months		
Number of staff using TLD badges in procedure room		

Internal Inspection Proforma - Pharmacy

Pharmacy ..... Date.....

Displays	Available (Yes / No)	Remarks
Pharmacy name in two languages		
Entry restriction board		
Mission, Vision, Board		
Patient rights and responsibilities		
No smoking Board		
Bio- Medical Waste Segregation posters (Latest)		
Hand hygiene Posters		
Chemical safety poster (SDS sheet)		
Display of license		
Display of list of high risk medications		
Emergency contact display		
Emergency floor plan		
Fire Exit		
Other signage (Like Radiation, Electrical hazard, Cytotoxic etc)		
Medication Management	**Tick appropriately (Yes / No)**	**Remarks**
Room temperature maintained (AC) – 16 – 24°C	Yes / No	
Adequate lighting	Yes / No	
All medicines are stored as per manufacturer's recommendation	Yes / No	
LASA list specific to that pharmacy is available (Hardcopy or Softcopy)	Yes / No	
Look alike and sound alike medicines are indicated	Yes / No	

10. Statutory and legal requirements

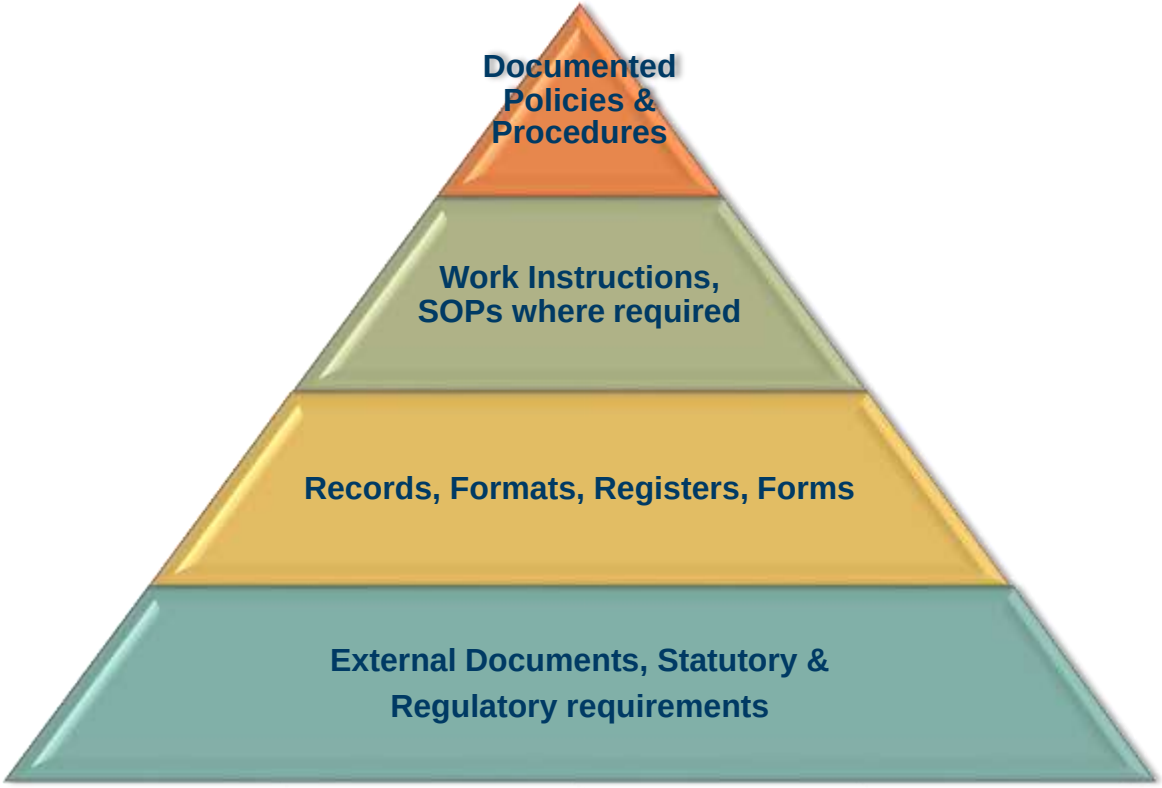
- Identify which are the relevant licenses to be obtained/renewed
  - Hospital Registration
  - Biomedical Waste authorization, Air, Water Consent
  - AERB licenses
  - Pharmacy licenses
  - Blood bank licenses
  - PC PNDT
  - MTP
  - Transplant licenses (if applicable)
- Identify what are the requirements to be fulfilled as per prevailing laws
- Assign responsibilities

11. Identify Infrastructural requirements

- Adequacy of fire detection, alarms and fire fighting systems
- Patient and material flow in CSSD and OT
- Special provisions like baby care room, play room, handicapped toilet as per the scope of the hospital
- Adequacy of equipments as per scope
- Prepare the plan for addressing them

12. Documentation

- Help the relevant stake holders in preparation of the policies and procedures that comply with the NABH standards
- Many sample documents available – customize to your hospital
- Standardize
- Keep them simple
- Trial and implement



13. Training

- **Prepare the Training Matrix and Training Calendar**
- **Identify and implement training requirements**
  - Identify Faculty
  - Plan training calendar, roll out training
- **Interact / educate the end users regarding the same**

✓Including doctors

Train, Train, Train

14. Initiate Audits

CHART DOCUMENTATION AUDITS

QUALITY TEAM

Institutional average				
MONTH	MAY	JUNE	JULY	AUG
Number of charts audited	340	282	415	286
General Consent				
Documentation of explanation of cost of treatment (Admission Order)	76	68	67	72
Documentation of explanation disease, prognosis, etc. to patient / relatives (Admission Order)	76	68	66	72
Doctors Initial Assessment/ History Sheet				
History documented	74	86	89	84
Assessment documented	74	87	89	83
Signed	58	60	55	48
Dated	49	70	43	45
Timed	27	24	19	17
Employment no.	57	56	52	47
Care Plan				
Care plan documented	76	53	59	46
Signed	76	51	52	43
Dated	74	48	44	37
Timed	69	37	37	32
Employment no.	75	50	52	41
Counter signed by the senior doctor within 24 hrs	15	25	18	14
Progress Note				
Progress note documented every day	81	52	56	61
Signed	79	68	74	72
Dated	76	67	78	76
Timed	69	58	66	65
Employment no.	81	67	74	77
Medication Orders				
Date	100	98	99	99
Time	24	20	17	16
Dose	100	100	99	99
Route	100	99	99	99
Frequency	100	100	99	96
Dr. Sign	100	100	99	100
Dr. Employment no.	100	97	99	100
No. of cancelled orders	276	303	412	282

STAKEHOLDERS

Comparison with previous audits (in %)

Year		2009	2011	2012	2016	2017	2018	2019
Documentation of	Drug Name in capitals	-	-	-	-	37	44	60
	Route	81	93	95	94	98	96	100
	Frequency	87	91	97	100	97	100	100
	Dosage	88	90	97	99	94	99	100
	Approved abbreviation used (for drug name, dose, freq, route, etc)	-	-	-	-	-	-	94
	Time	-	-	42	48	51	46	53
	Date	95	96	74	95	97	99	99
	Dr. Sign	91	94	98	99	99	100	99
	Dr. Employment number	15	45	74	85	94	93	94
Legibility	Drug name	-	-	98	94	99	99	98
	Dr. Employment number	-	-	-	45	71	71	65
Stop/cancelled orders	Struck at appropriate place	-	-	32	-	95	94	88
	Stop mentioned	-	-	26	-	74	68	79
	Signed	53	53	49	-	88	85	90
	Dated	-	-	-	-	35	27	26
	Employment number	-	-	-	-	63	60	56

15. Continuous Follow up

By Quality Manager

Quality Team

Committees

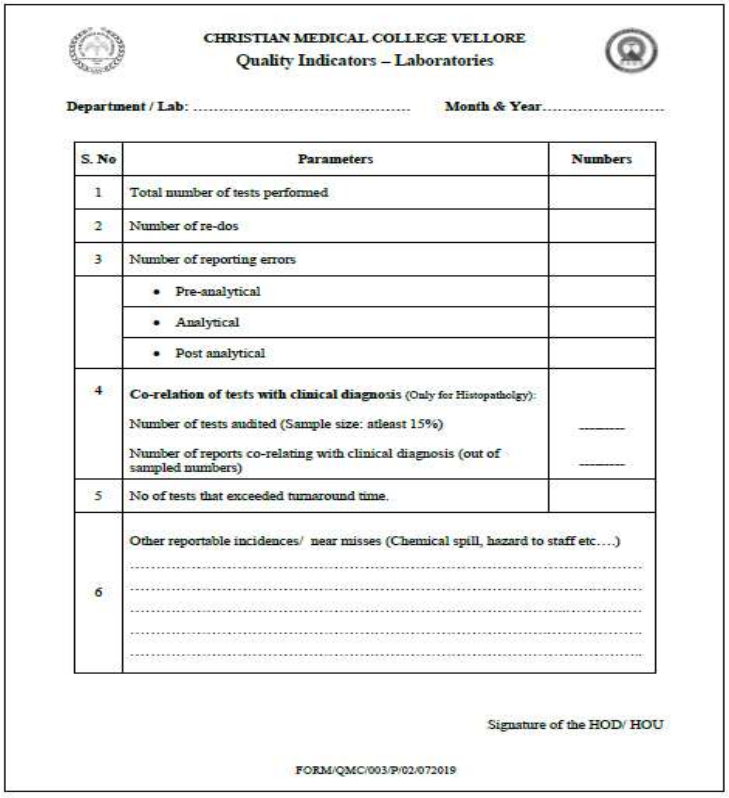
Documented

Presented to the Top Management

Follow up, Follow up, Follow up

16. Capture Indicators

- Start capturing basic and relevant indicators
- Explain the indicators and their relevance to the stakeholders
- Involve the stakeholders and analyze the data



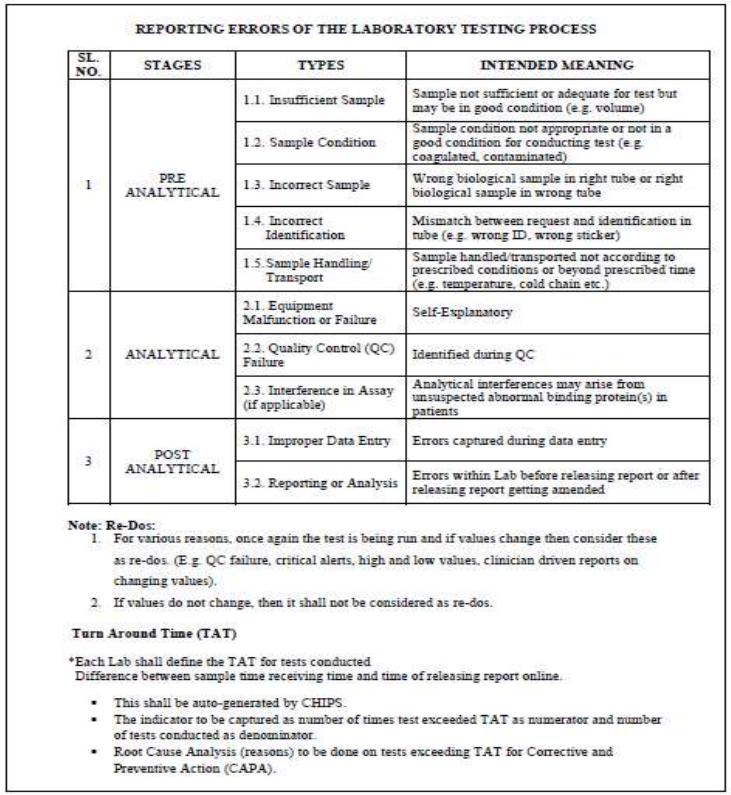
CHRISTIAN MEDICAL COLLEGE VELLORE
Quality Indicators – Laboratories

Department / Lab: ..... **Month & Year**.....

S. No	Parameters	Numbers
1	Total number of tests performed	
2	Number of re-dos	
3	Number of reporting errors	
	• Pre-analytical	
	• Analytical	
	• Post analytical	
4	**Co-relation of tests with clinical diagnosis** (Only for Histopathology): Number of tests audited (Sample size: atleast 15%) Number of reports co-relating with clinical diagnosis (out of sampled numbers)	--------- ---------
5	No of tests that exceeded turnaround time.	
6	Other reportable incidences/ near misses (Chemical spill, hazard to staff etc….)	

Signature of the HOD/ HOU

FORM/QMC/003/P/02/072019



REPORTING ERRORS OF THE LABORATORY TESTING PROCESS

SL. NO.	STAGES	TYPES	INTENDED MEANING
1	PRE ANALYTICAL	1.1. Insufficient Sample	Sample not sufficient or adequate for test but may be in good condition (e.g. volume)
		1.2. Sample Condition	Sample condition not appropriate or not in a good condition for conducting test (e.g. coagulated, contaminated)
		1.3. Incorrect Sample	Wrong biological sample in right tube or right biological sample in wrong tube
		1.4. Incorrect Identification	Mismatch between request and identification in tube (e.g. wrong ID, wrong sticker)
		1.5. Sample Handling/ Transport	Sample handled/transported not according to prescribed conditions or beyond prescribed time (e.g. temperature, cold chain etc.)
2	ANALYTICAL	2.1. Equipment Malfunction or Failure	Self-Explanatory
		2.2. Quality Control (QC) Failure	Identified during QC
		2.3. Interference in Assay (if applicable)	Analytical interferences may arise from unsuspected abnormal binding protein(s) in patients
3	POST ANALYTICAL	3.1. Improper Data Entry	Errors captured during data entry
		3.2. Reporting or Analysis	Errors within Lab before releasing report or after releasing report getting amended

Note: Re-Dos:

1. For various reasons, once again the test is being run and if values change then consider these as re-dos. (E.g. QC failure, critical alerts, high and low values, clinician driven reports on changing values).
2. If values do not change, then it shall not be considered as re-dos.

Turn Around Time (TAT)

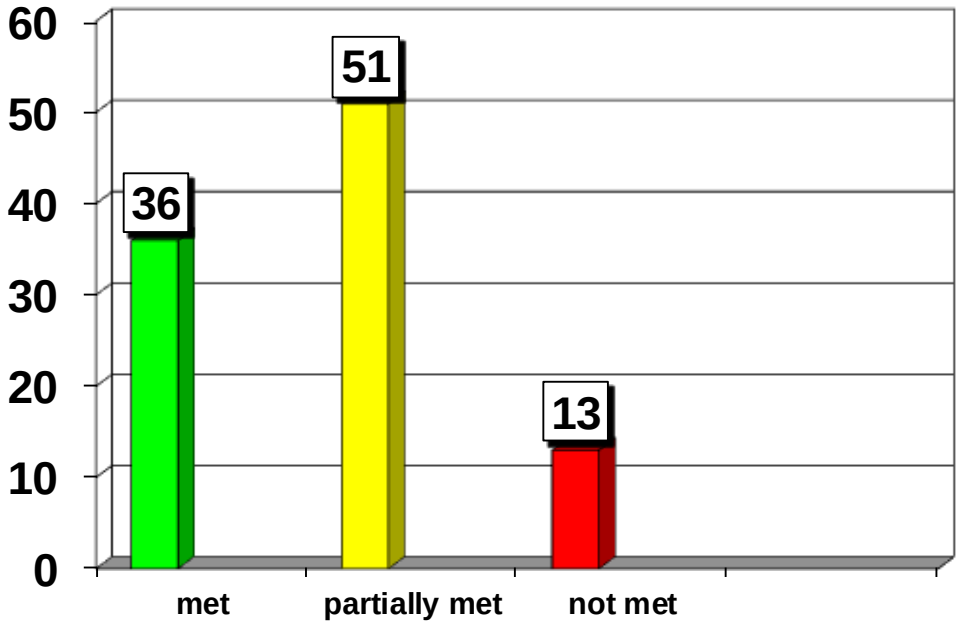
*Each Lab shall define the TAT for tests conducted
Difference between sample time receiving time and time of releasing report online.

- This shall be auto-generated by CHIPS.
- The indicator to be captured as number of times test exceeded TAT as numerator and number of tests conducted as denominator.
- Root Cause Analysis (reasons) to be done on tests exceeding TAT for Corrective and Preventive Action (CAPA).

17. Keep updating the champions and all staff

- Continuous update to all staff on overall progress- through meetings, newsletters etc.
- Keep them engaged
- Update the departments and stakeholders on the levels of compliances
- Celebrate successes

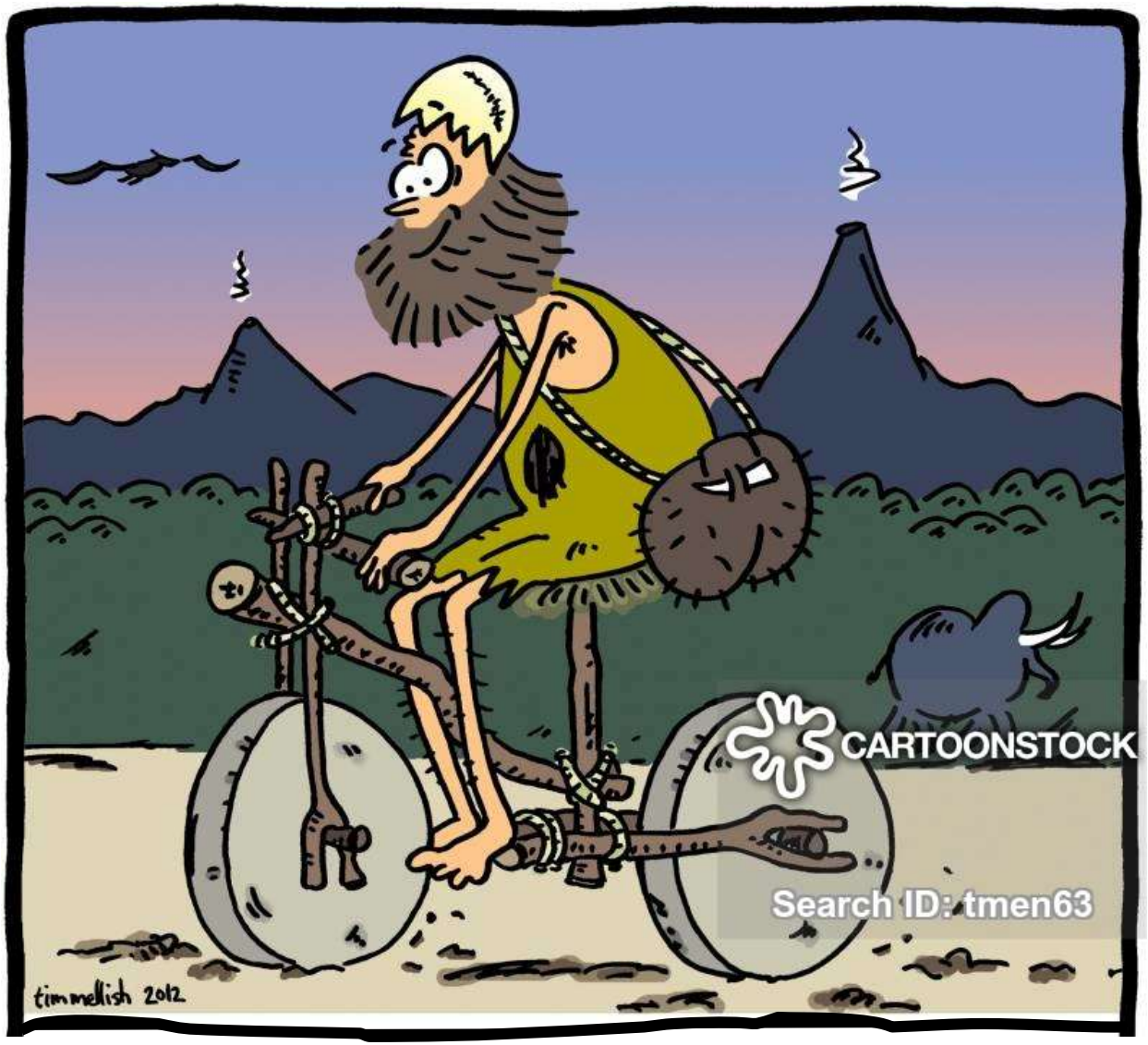
18. Do an internal assessment/ invited external assessment



Submit Your Application

Points to Remember

- **Every Non-Compliance is an opportunity for improvement**
- **Accept NCs and improve on them**
- **Do not close NCs for the sake of closure**
- **Never get disheartened - Change in culture/ practice takes years**
- **Always remain positive – “Never give up”**
- **Continue to learn**
- **Establish the system for continuous monitoring and sustainability**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timmellish 2012

Systems awareness and systems design are important for health professionals, but are not enough. They are enabling mechanisms only.

It is the ethical dimension of individuals that is essential to a system's success.

Ultimately, the secret of quality is love.

You have to love your patient…., you have to love your profession, you have to love your God.

If you have love, you can then work backward to monitor and improve the system.

Avedis Donabedian