CHAPTER 15

A Study on Gap Analysis and Implementation of NABH Standards in the Critical Departments (ICU)

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INTRODUCTION

Accreditation is a process undertaken by external agencies to assess an entity's adherence to quality standards. It serves as a framework for improving the quality of an organization. In India, hospital quality is evaluated based on standards set by the National Accreditation Board for Hospitals & Healthcare Providers (NABH), a constituent board of the Quality Council of India (QCI). Introduced in 2006 and currently in its fifth edition, NABH standards emphasize patient safety and service delivery quality. These standards are categorized into 10 chapters, with five focusing on patients and five on healthcare organization management. Within these chapters, there are 100 standards evaluated through 651 objective elements. Recognizing health as a fundamental human right, the Government of India launched Universal Health Coverage (UHC) programs, including the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) in 2018. Administered by the National Health Authority (NHA), AB-PMJAY introduced Quality Certification standards in collaboration with the Quality Council of India, featuring bronze, silver, and gold levels [1].

Quality Management Systems (QMS) and Accreditation serve as versatile tools to ensure fairness in healthcare services and meet the growing expectations of the population. Achieving the optimal state of patient care is possible for healthcare institutions that prioritize compliance with accreditation standards such as those set by NABH and similar bodies. Gap Analysis emerges as a valuable tool for organizations to assess their actual performance against the expected or established standards. In this context, gap analysis involves a thorough examination where hospitals compare their existing policies, procedures, SOPs (Standard Operating Procedures), and

infrastructure with the defined standards set by accreditation bodies, such as the National Accreditation Board for Hospitals & Healthcare Providers (NABH). Established in 2006, the NABH accreditation system operates as part of the Quality Council of India (QCI) [2].

The Indian Society of Critical Care Medicine (ISCCM) initially formulated guidelines for Planning and Designing Intensive Care Units (ICUs) in 2001, with subsequent updates in 2007. These guidelines have been widely adopted in India, several developing nations, and major institutions, including the National Accreditation Board for Hospitals (NABH). While various international critical care professional bodies have their own position papers on ICU planning and design, ISCCM, being the professional body of intensivists in India, addresses the subject in a contemporary context. This involves considerations related to clinical practice, variability based on specialty and subspecialty, quality, resource constraints, and the institution's size and location. The primary aim is to establish a consensus document that reflects ISCCM's philosophy, ensuring the delivery of safe and quality critical care in India. This encompasses compliance with regulatory agencies, both national and international, and meets the needs of the general population. Additionally, the document emphasizes the promotion of training, education, and skill development in critical care [3].

RESEARCH QUESTIONS

1. What were the standard operating procedures typically followed in the intensive care unit?
2. To what extent did the ICU adhere to its standard operating procedures (SOPs)?

3. What discrepancies existed between the ICU's current practices and its established standard operating procedures?

RESEARCH OBJECTIVES

1. To evaluate AHI's standard operating procedures concerning inventory, laundry and linen, training and HR, cleaning, and quality control within the ICU.
2. To develop a checklist to assess the ICU's compliance with standard operating procedures.
3. To identify and analyse any disparities between the current practices observed in the ICU and its established standard operating procedures (SOPs).

RESEARCH METHODOLOGY

The study employed an observational and descriptive design conducted in ICU-1 (3rd floor) and NICU (2nd floor) of Jindal Multi-Speciality Hospital in Bharatpur, Rajasthan. Onsite data collection involved interviews with key stakeholders such as nurses, ward boys, and ICU patients. The procedures and regulations in place were thoroughly assessed, and a checklist based on Standard Operating Procedures (SOPs) was created to track activities. Process analysis identified key trends, triggers, potential gaps, and recognized issues. Action plans were formulated to address identified gaps, and an executive summary for the gap analysis presentation, along with overviews of stakeholder roles and responsibilities, were prepared. Daily compliance checks with SOPs were recorded in an Excel data sheet, and trend analysis, monitored periodically, was performed using Corrective and Preventive Action (CAPA) methods.

Microsoft Excel was utilized for data analysis throughout the study.

RESEARCH METHODOLOGY

The results obtained after utilizing the checklist for 2.5 months and collecting data over a 70-day period were categorized into three groups: infection control, clinical, and operational. The non-compliance rates varied across these categories, with infection control showing 10%, clinical 35%, and operational 55% non-compliance. Further analysis revealed specific cases of non-compliance within each department. For infection control, issues included inadequate BMW segregation and housekeeping shortcomings. Clinical processes showed lapses in patient care, initial assessment and reassessment, and documentation errors. Operational processes highlighted concerns such as problems with inventory, maintenance of critical instruments, and issues related to patient care policies. The study concluded that there were notable gaps between ideal SOPs and current procedures, prompting the selection of best practices for Jindal Super-Multi Speciality Hospital based on identified non-compliance areas. Specific attention was recommended for improvement in housekeeping, BMW segregation, patient care, and inventory management issues within the ICU.

CONCLUSION

The implementation plan for best practices in training and development programs involves prioritizing needs, focusing on compliance with NABH 5th standard guidelines, emphasizing customer service, and infection control in the ICU. Training modules are tailored to the diverse responsibilities of ICU staff, with continuous evaluation through surveys and skill

assessments. Unlicensed nurses and trainees aspiring to work in the ICU must undergo supervised training by the Nursing Superintendent in the absence of certification. For housekeeping, a daily checklist is maintained, and high-touch surfaces are regularly cleaned, with evaluations conducted by both ICU nurses and housekeeping supervisors. The Central Sterile Supply Department (CSSD) mandates certificates for staff and emphasizes effective communication with ICU staff to avoid stocking issues.

Addressing clinical gaps involves a week-long general induction for new doctors and nurses, emphasizing SOPs, quality indicators, and documentation practices. Continuous reminders are given to nurses for proper documentation, timely maintenance of medical records, and informing immediate family members of patient admission within two hours. Regular checks on the crash tray and hemodialysis, along with a dedicated full-time assistant nurse, ensure patient care. Prompt attendance by doctors, specialists, or surgeons is required for serious patient conditions, and transfer summaries prepared by doctors facilitate smooth patient discharge from the ward.

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