

**Draft**

**Strategic Paper  
for  
Developing**

**Hospital  
Accreditation  
in  
Bangladesh**

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## **Contents**

### **Executive Summary**

#### **Section – one- P.6**

Analyzing the national context

- a. Introduction
- b. Background

#### **Section-Two - P10**

- a. Major Challenge in implanting Hospital Accreditation System
- b. Reason for Implementing Hospital Accreditation System.

#### **Section- Three - P13**

- a. Context
- b. Policy Frame Work
- c. Vision
- d. Mission
- e. Goals
- f. Purpose
- g. Objective
- h. Key principal
- i. Type of Programme
- j. Roles & Responsibilities
- k. Constitution & Membership

#### **Section-Four - P21**

Developing the Hospital Accreditation Council

- a. Governing body
- b. Constitution
- c. Structure
- d. Roles & Responsibility
- e. Accreditation Management Office
- f. Representation
- g. Executive body
- h. Advisory Council for Task force
- i. Premises

#### **Section –Five - P24**

Developing Hospital Accreditation System

1. Standard Development
2. Guidance & Selection
3. Type of standard
4. Proposed standard
5. Scoring Methodology
6. Selection & Training of surveyor
7. Survey guide
8. Survey tool & report Template.

**Section- Six - P30**

Framework & Process for Accreditation

- a. Assessment principal
- b. Registration
- c. Pre-Assessment Programme
- d. Self Assessment
- e. Assignment Visit
- f. Recommendation
- g. period of Accreditation
- h. Assessment cycle
- i. QAP
- j. Fees
- k. Operational priorities
- l. Research & Dissemination
- m. Monitoring & Evaluation
- n. Management Information System
- o. Funding

**Section – Seven- P38**

Scope & Limitation

**Section- Eight- P39**

Immediate Action & Recommendation

**Section- Nine- P40**

Action Plan

**Section- Ten - P42**

Annexure- 1: Workshop proceedings.

Annex- - 2. Experience of Hospital Accreditation in other countries.

- a. JCAHO.
- b. URAC
- c. ACHS
- d. HAPNZ
- e. CCHSA
- f. HQS
- g. TAS
- h. HSA

Annex- 3: Reference.

4. Glossary of Term

## EXECUTIVE SUMMARY

"Developing Hospital Accreditation Programme in Bangladesh". is a draft document which is developed primarily by reviewing the document of different Hospital Accreditation Programme of different countries. During developing the document, the web sites of different Hospital Accreditation Programme also reviewed. After completion the review, a draft document has prepared for holding opinion seeking workshop in six divisional cities. Finally, A National Workshop held for finalization of the document and incorporating the opinion of different stakeholder of health care organization. This document provides organizational options for envisioned national accrediting organizations and considers important issues in operationalising the proposed system.

This document indicates:

- a. Present situation & major challenge for implementing the Hospital Accreditation system.
- b. Overview of the Hospital Accreditation System
- c. How to develop the hospital Accreditation programme in Bangladesh
- d. The implementation priorities.
- e. The Action Plan
- f. Review the different Hospital Accreditation programme of different country

Our proposal is a blueprint for the future rather than an operational manual. Specifying the details of the arrangements will be the task of the proposed National Accreditation council following consultation, development and piloting of the arrangements proposed in this report.

It is proposing that the new quality organization be a company limited by guarantee and registered as a charity; or be an autonomous body of the govt. to be empowered later by legislation. In this organization the members will be the representative bodies of the professional, ,specialists associations, teaching institutions and other parties involved and interested.

There will be 13- 15 members on the governing body (proposed accreditation council) and wide consultation will ensure an appropriate range of experience and expertise on the body. There would be national level organizations for implementing accreditation and national institutes for quality and standards could also be constituted. . The national level organization could be the body to build partnership and reach a consensus with the stakeholders, Generating policy and accreditation design by the above process. The organizations would act as the executive and training/support bodies at the local levels ( if developed later on), and would mobilize support and resources for their functioning at the local level, would implement the national body's recommendations.

The key objective is to attain effective, efficient and rational care in all health care organizations in Bangladesh. . The role of the body has been envisioned to be facilitatory, supportive and educative, rather than inspectatory. The organization should be constituted by the number of stakeholders concerned with health care.

The process of quality assurance of the organization is to build up a system that enables provision of quality health care based upon principles and practices of ethics, equity, redress, access, integration, partnership, sustainable use of resources, and cost-effectiveness. The main elements of the proposals for a credible and affordable process of quality assurance is , a national framework of quality should be developed to tailor assessment to the most critical areas of performance in the context of our political, cultural and financial constraints. The framework will also take into account, as far as possible, the requirements of other funding bodies, if any, professional and statutory bodies. The process of assessment should have significant benefits for health care institutions and it's customers and should be sufficiently flexible to accommodate wide variations in types of services provided. Standards of excellence should assure the management of ethical, humane, rational and competent care. The basic objective of the strategy of accreditation is to ensure that areas of critical importance to the delivery of quality health services are

evaluated by appropriate methods and methods are developed to confirm their efficacy, validity and reliability. The focus of accreditation should be on continuous improvement in the organizational and clinical performance of health services, not just the achievement of a certificate or award or merely assuring compliance with minimum acceptable standards.

A balanced system of assessment would involve on-site hospital surveys, an ongoing capacity to respond quickly and effectively to complaints and adverse events; development and application of standardized performance measures; and, a mechanism for conducting retrospective reviews of the appropriateness of hospital care. Taken as a whole, the process will assess the extent to which health care organizations are delivering safe health care effectively. It would indicate areas of strength and weakness, including aspects requiring attention; involve an evaluation of the validity and reliability of an institution's internal review procedures, and provide reassurance that each institution has in place effective arrangements for assuring optimal standards in the organization and has procedures securely in place which will enable it to continue to do so.

The assessment process will involve visits to institutions and result in reports published by the accrediting organization. Key performance indicators which will be submitted by the accredited hospital on a periodic basis will be a mandatory requirement to renew accreditation. This will confirm that institutions' internal quality assurance procedures are working effectively. Focus on those issues necessary for the funding bodies to secure their responsibilities for public accountability and public information.

## Section-One

### a. Introduction

Health systems currently operate within an environment of rapid social, economic and technological change. Such changes are expected to continue for the foreseeable future as a result of restructured economic and social policies, globalization of markets and enhanced worldwide communication. New insurance mechanisms, restructuring and health reform initiatives, privatization within the health sector, redistribution of human and other resources, reduced public funding, new technology, and many other factors may raise concern for the quality of healthcare. As a result of these health sector reforms, national health systems are coming under increasing scrutiny with a view to cost containment and quality improvement.

Hospital accreditation has been defined as "A self-assessment and external peer assessment process used by health care organizations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve" Critically, accreditation is not just about standard-setting: there are analytical, counseling and self-improvement dimensions to the process. Accreditation is a formal process by which a recognized body usually an independent body assesses and recognizes that a health care organization meets applicable predetermined and published standards. . A health care establishment is said to be "accredited" when the disposition and organization of its resources and activities make up a process which results in medical care of satisfactory quality. Accreditation implies confidence in a hospital by the population. In almost all cases this can be achieved without major investments in infrastructure.

Broadly speaking, there exist two types of hospital accreditation

- 1) Hospital and healthcare accreditation which takes place within national borders
- 2) International Health care organization

Accreditation can be the single most important approach for improving the quality of healthcare structures. In an accreditation system, institutional resources are evaluated periodically to ensure quality of services. Standards may be minimal, defining the bottom level or base, or more detailed and demanding. Accreditation standards are usually regarded as optimal and achievable, and are designed to encourage continuous improvement efforts within accredited organizations.

In all developed and developing countries, accreditation helps the hospital enhance patient care through continuous quality improvement process. It also strengthens community confidence by highlighting hospital's commitment to provide safe and quality care to the community. An accreditation decision about a specific healthcare organization is made following a periodic on-site evaluation by a team of peer reviewers, typically conducted every two to three years. Accreditation is often a voluntary process in which organizations choose to participate, rather than one required by law and regulation.

Hospitals are an integral part of health systems; by harmonizing standards in hospitals in line with other institutions and levels of care, continuity of care is improved and the healthcare network strengthened. Hospital accreditation is gaining prominence due to globalization efforts and especially trading in health services. Hospital accreditation is a system of ongoing consensus, rationalization and hospital organization. National ownership is crucial, both to lay the foundation and to maintain, from the beginning, a high degree of integrity and accountability of the national accreditation system.

While making use of accreditation as an incentive to improve capacity of national hospitals to provide quality care, countries need to work together to ensure that accreditation is protecting the national health system. Establishing national accreditation systems will help to ensure that hospitals, whether public or private, national or expatriate, play their expected roles in national health systems.

In most developing nations, private healthcare industry, though responsible for more than 80 per cent of healthcare delivery, is not very organized. There is no standardization of processes and quality of delivery. Private healthcare players want to evolve accreditation norms that will enable them to compete globally and get a major share of the medical tourism market.

National accreditation ensures that accreditation systems are developed in a way that upholds the principles of health for all. Such strategies include encouraging national debate to reach consensus on accreditation, developing guidelines at country level and establishing an advisory group to guide countries in addressing accreditation issues. Specific goals of hospital accreditation are usually determined by the type of national health system and its policies.

A fundamental tenet of all approaches to health services quality evaluation and management is that every system and process in an organization produces information that when collected and analyzed, can lead to improvement in the system or process. Depending on the scope and philosophy of the individual accreditation programme, accreditation standards may take a "systems" approach that is organised around key patient and processes, such as patient assessment, infection control, quality assurance, and information management.

There are specific features in any accreditation model which differ from other accreditation approaches and that are intended to help make the hospital accountable to the national health system. One of the areas of focus is to make an accreditation model that is comprehensive including promotive, preventive and curative standards wherever relevant. The model should entail a stepwise approach to accreditation, starting with a basic level, to be required for all hospitals, to a more sophisticated level.

## **b. Background**

The most important objectives include enhancing health systems, promoting continuous quality improvement, informing decision-making and ensuring accountability to national health policies. Country and culture-specific accreditation systems not only safeguard the country's primary healthcare, but they also involve fewer costs and are better accepted as compared to external international accreditation systems.

Hospitals and healthcare services are vital components of any well-ordered and humane society, and will indisputably be the recipients of societal resources. That hospitals should be places of safety, not only for patients but also for the staff and for the general public, is of the greatest importance. Quality of hospitals and healthcare services is also of great interest to many other bodies, including governments, NGOs targeting healthcare and social welfare, professional organizations representing doctors, patient organizations, shareholders of companies providing healthcare services, etc. However, accreditation schemes are not the same thing as government-controlled initiatives set up to assess healthcare providers with only governmental objectives in mind - ideally, the functioning and finance of hospital accreditation schemes should be independent of governmental control.

How quality is maintained and improved in hospitals and healthcare services is the subject of much debate. Hospital surveying and accreditation is one recognized means by which this can be achieved.

Quality is a crucial factor in health care, initiatives to address quality of health care have become world-wide phenomena. Many countries are exploring various means to methods to improve the quality of health care services. In Bangladesh, the quality of services provided to the population by both public and private sectors is questionable. The current structure of the health care delivery system does not provide enough incentives for improvement in efficiency.

Mechanisms used in other countries to produce greater efficiency, accountability, and more responsible governance in hospitals are not yet deployed in Bangladesh. The private sector health care delivery system in Bangladesh has remained largely fragmented and uncontrolled, and there is a clear evidence of serious quality of care deficiencies in their practices. Problems range from inadequate and inappropriate treatments, excessive use of higher technologies, and wasting of scarce resources, to serious problems of medical malpractice and negligence. Current policies and processes for health care are inadequate or not responsive to ensure health care services of acceptable quality and prevent negligence. A commitment to quality enhancement throughout the whole of the health care system involving all professional and service groups is essential to ensure that high quality in health care is achieved, while minimizing the inherent risks associated with modern health care delivery. One of the methods that is being proposed is accreditation system. The focus of accreditation is on continuous improvement in the organizational and clinical performance of health services, not just the achievement of a certificate or award or merely assuring compliance with minimum acceptable standards. The process of accreditation is envisaged to result in a process of fundamental change in the technical procedures of service delivery, in the appropriate use of available technologies, in the integration of relevant knowledge, in the way the resources are used, and in the efforts to ensure social participation. Quality Assurance should help improve effectiveness, efficiency and in cost containment, and should address accountability and the need to reduce errors and increase safety in the system.



In 1951, the American College of Surgeons, American College of Physicians, American Hospital Association, and the American Medical Association cooperated to form the Joint Commission on Accreditation of Hospitals to address the need to improve the quality of care in the United States of America. Today it is the primary instrument used by the United States Health Care Financing Administration to approve the transfer of medicine funds to hospitals. Only hospitals that have passed an accreditation process can receive payments. Countries in WHO regions have also employed this method, such as Egypt and Lebanon (EMR); Brazil and Argentina (AMR); Thailand, Taiwan and Indonesia (SEAR); England, France and Spain (EUR); South Africa (AFR); and Korea (WPR).

## Section-Two

### **a. MAJOR CHALLENGES IN IMPLEMENTING HOSPITAL ACCREDITATION**

The challenges in setting and measuring against standards are mostly technical; the challenges in making appropriate change are social and managerial. Accreditation is not an end in itself, but rather a means to improve quality. When implemented appropriately, accreditation can strengthen the fundamental leadership and steering role of national health authorities.

- Legal considerations: Executive orders, laws or regulations of the Ministry of Health & Family Welfare are important and useful, but should not be the paramount factor. In some cases, a change in Government can hinder implementation of the policy, even if it has just been announced by decree or through regulations, if the new Govt. does not consider it a priority to encourage the national process of accreditation for political reasons. Thus, the initiative is delayed until another Govt. presses the issue.
- Lack of an inter-institutional and independent National Commission on Hospital Accreditation. Such a commission is always the goal to be reached, although it is not easy to achieve consensus among the different actors in the public and private health sectors to work together with a common goal. Another threat is the appearance of multiple accreditation entities, competing among each other, and setting different standards, priorities, and fees. This can affect the entire accreditation process negatively, leading to the possibility that if a hospital is not accredited by one entity, it may be accredited by another, under different standards. It is essential to have uniformity; therefore there must be a National Commission that applies uniform accreditation standards to the whole country
- Lack of participation by the insurance sector. The role of public or private social security and private health insurance is vital for implementation, since the inclusion of accredited hospitals in their list of providers characterizes the importance of hospital accreditation as an instrument to ensure quality of care for the clients of these institutions. Private insurance companies are beginning to analyze this situation; however, many countries unfortunately do not yet have a process to tie national accreditation to contracts for hospital services.
- The non-application of minimum standards, as opposed to optimum standards. It is necessary to implement basic standards during the beginning of hospital accreditation development. This seems to be the most rational approach, since no country would be likely to have adequate and sufficient human and financial resources to correct deficiencies throughout all of its hospitals, whether structural or process-related, using optimum standards. Since the methodology anticipates that each hospital service will have increasingly complex standards, the highest level of standards would be considered ideal or optimal. Generally, professional associations, such as medical or nursing associations, always strive to establish optimum standards, although when starting to implement the accreditation process, they convince themselves that it is not possible to begin with very sophisticated levels. Consequently, very few hospitals, in the short term, manage to be in a position to implement optimum standards.
- Ensuring standards for all hospital services instead of for a few units. Approval of particular units or isolated programme has been supported by some groups, by those in charge of the programme for prevention and control of hospital infections, or isolated accreditation of hospital laboratories. A hospital may have a good programme in place to

control infections or a good clinical laboratory, but this does not always ensure that other services are in a position to be accredited, even using minimum standards.

- Ensuring sustainability of a national accreditation programme. Although accreditation may be voluntary on the part of hospitals, these institutions must have some incentive for accepting the accreditation process. In the United States, for example, the vast majority of hospitals survive as a result of patients covered by Medicare, or social security for the elderly. For a hospital to be contracted under Medicare, it must have prior accreditation from the National Accreditation Commission. Similar incentives for sustainability of this process will be required in country.

- Misperception of the role of surveyors. The accreditation process must always be viewed as an auxiliary and permanent educational activity for hospital staff, never as a bureaucratic inspection or critical audit in search of victims. The basic role of surveyors should always be seen as that of specialized consultants helping the hospital to overcome its managerial or technical difficulties. Assessment teams generally include a physician recognized for his/her skills, a nurse with far-reaching experience in hospitals, and an administrator with a solid background in hospitals. In many countries, most of the hospital administrators are physicians, but in the surveyor team they are only "administrators," leaving the clinical side to be observed by the physician on the team.

## **b. Reasons for implementing Hospital Accreditation**

Currently, there are great discrepancies in quality among different services of the same hospital, independent of the number of beds. Much government, semi-private and private health institutions seek a recognized accreditation system in order to cope with the newly emerging competitive environment of health care service delivery. Hospital accreditation processes have recently begun to be implemented in some countries in the region. Institutionalizing improved quality of care through accreditation requires more than a technical approach; more than the application of tools and methods. Failure to change the behavior of people and organizational attitudes is the commonest cause of ineffective quality initiatives. Sustained improvements often require a change in attitude and acquisition of a sense of ownership with regard to the quality of services provided by an organization. Many supporting factors are required to integrate accreditation into the structure and function of an organization. The challenges in setting and measuring against standards are mostly technical; the challenges in making appropriate changes are social and managerial. Sustainable quality needs a supportive environment of leadership, clarity of purpose and organization, in other words, a strong accreditation programme. Accreditation can be the single most important approach for improving the quality of health care structures.

Hospital accreditation is a method of ongoing consensus, rationalization and hospital organization. The first instrument for the explicit and objective technical evaluation of quality will be the accreditation manual. The creation of the National Accreditation Council should be of great importance. It should be a nonpolitical, multi-representational, and should undertake its work energetically, prudently and periodically. This entity will be responsible for the administration and policy-making of the accreditation system at the country level. It will be responsible for the setting of national standards for accreditation, adopting WHO guidelines for accreditation, identifying and training the surveyors, conducting and monitoring the site surveys and making the decisions related to the awarding of accreditation and maintaining it. It is essential to have uniformity; therefore, this body should apply uniform accreditation standards to be followed by state.

In spite of recommendations that the national accreditation Council will be multi-institutional, and include the most prominent and active players in the civic, public and private sectors of the national health sector, the presence of the Ministry of Health & family

Welfare is essential because of its authority and its capability of transferring resources within the process of national hospital accreditation. The mandate of such a I entity would be to ensure that national accreditation systems are competent to: monitor and evaluate adherence to national health system policy and responsiveness to current and future challenges; monitor and evaluate quality performance of health organizations /facilities on various levels; cover managerial and clinical aspects; enhance organizations' learning environment and quality improvement culture; and establish a national framework to take full responsibility for the accreditation initiative.

So, if we would be able to implement the Hospital Accreditation System, the following change would be visible as follows:

- It stimulates the improvement of care delivered to patients
- It strengthens community confidence in its hospital
- It reduces unnecessary costs
- It increases efficiency
- It provides credentials for education, internships, and residencies
- It can protect against lawsuits
- It facilitates acceptance by and funds from third-party payers

## **Section: Three**

### **Overview of Hospital Accreditation System**

There are three main systems to define standards, assess compliance and award formal recognition to successful institutions . These are increasingly used worldwide to regulate, improve and market health care providers, especially hospitals.

**Accreditation:** 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.

**Certification:** Formal recognition of compliance with set standards (e.g. ISO 9000 series for quality systems) validated by external evaluation by an authorized auditor.

**Licensure:** Process by which a government authority grants permission, usually following inspection against minimal statutory standards, to an individual practitioner or healthcare organization to operate or to engage in an occupation or profession.

Each of these systems is being adapted to meet the changing demands for public accountability, clinical effectiveness and improvement of quality and safety, but the most rapid development is in accreditation.

#### **a. Context**

Current policies and processes for health care are inadequate to ensure that health care delivery is of high quality and malpractice is prevented. The years of neglect and the lack of a comprehensive system for addressing quality issues in the health sector are quite well known.

The Government's commitment to quality health care for all needs to translate into sustainable mechanisms for the delivery of effective health care. It is the intention of this policy framework to put in place a system that will begin to make quality health care a reality for all who require it.

#### **b. Policy Framework**

**Constitution and Functioning:** Accreditation emphasizing participation of various stakeholders has the potential to be more successful than regulation. This partnership should provide a platform for consensus building based on the principle of sharing, democratic and transparent functioning. The effectiveness of the development and management of the organization will be enhanced through actively staff, key stakeholders, clients and potential clients in decision making about our strategic and service planning, management and service delivery processes and service evaluation. Consensus should be built between the stakeholders around the concept fo the national quality framework. There should be a balance in stakeholder representation on the board.

National Quality Framework: A broad and enabling national framework of quality should be developed to tailor assessment to the most critical areas of performance in the context of our political, cultural and financial constraints. The framework will also take into account, as far as possible, the requirements of other funding bodies, if any, professional and statutory bodies. To

develop a general conceptual foundation and framework for a process of quality assurance for guaranteeing commonality of approach to institutions, delineating the domains of quality to be measured and the development of a credible, effective and transparent system of accreditation, meaningful participation of the stakeholders is essential.

Assessment Process: A balanced system of assessment would involve on-site hospital surveys, both announced and unannounced; an ongoing capacity to respond quickly and effectively to complaints and adverse events; development and application of standardized performance measures; and, a mechanism for conducting retrospective reviews of the appropriateness of hospital care. It would also ensure that current systems of audit are maintained. It should promote internal evaluation and assessment processes as well as external assessment processes.

Ethics: Patients are increasingly and appropriately aware of healthcare issues, and desire participation in decisions affecting their health. The ultimate responsibility of a health care system is to the patient. Adherence to high standards, such as those related to timeliness of treatment, diagnostic accuracy, clinical relevance of the tests performed and interventions, qualifications and training of personnel, and prevention of errors, is an ethical responsibility of all hospital staff. Accreditation of health providers should ensure that the owners, managers and staff comply with ethical standards, such as maintenance of confidentiality of patient information, adherence to appropriate technical and professional standards regardless of cost pressures and avoidance of personal, financial and organizational conflicts of interest.

Developing National Standards: Standards should be defined by the national accreditation body and assessed by peer review. The process of developing valid, measurable and reliable national standards should be practical, should take place within realistic time frames and should emphasize transparency.

Stakeholders must be included and need to participate on an informed basis; where necessary, capacity building amongst stakeholders should take place, ensuring skills transfer, so as to achieve this goal. Specialists in fields relevant to quality and training should be invited to participate sensitively in the standard setting process. The use of a cross-section of international examples can be used in order to broaden thinking around developing national standards.

A detailed multi-year plan, which operationalises the process, should be developed. The detailed plan, facilitated by the MOHFW must aim at reversing the historic neglect of the private sector. This plan should, amongst other things, set clear targets, time frames and costing should be done. The

plan should also have a financial strategy. Most importantly, the plan must be a national plan, in which all stakeholders will participate and have joint ownership and responsibilities.

Development of projects or models that will further develop and implement the policy guidelines must be planned and facilitated.

### **c. Vision**

The following vision will be formulated: A quality conscious and accountable health care system within which all stakeholders have a say and that enables rational, effective, safe and cost-effective provision of care.

### **d. Mission**

This accreditation organization is committed to and exists to provide leadership in enhancing health care quality and to promote accountability and rationality in health care.

This mission will be achieved through

- a) Accreditation
- b) Partnership and Collaboration - promoting networking, partnership and collaboration between disciplines and organizations at regional, national and international level
- c) Research and Dissemination - promoting research which is of a quality and scale to achieve a national reputation in all fields and an international reputation in quality areas

encouraging and facilitating the development of multi disciplinary research groups which are of sufficient size and quality.

d) Training

e) Quality culture - Promoting innovative and flexible policies in the employment and development of staff

#### **e. Goals**

The main purpose of our policy is to help planners to promote, implement, monitor and evaluate robust practice in order to ensure that occupies a central place in the development of the healthcare system. In doing so it recognizes the roles to be played by a multiplicity of stakeholders from the govt. , non-governmental and private and economic sectors. Quality should be an integral part of the overall national health policy. It is believed that accreditation if sensibly designed can have a significant impact on improving quality and safety in health care; improving health outcomes; ensuring more equitable health service provision; enhancing management practices; and improving decision making. Such a system must be founded on equity, it must respect diversity, it must honour learning and strive for excellence, it must be owned and cared for by the communities and stakeholders it serves, and it must use all the resources available to it in the most effective manner possible. The national organization should promote the practice of holistic medicine and the integration of the various systems of medicine in the most beneficial manner.

Above all, the policy seeks to develop an enabling environment in which high quality of health care can flourish throughout the country. This is to be done through providing guidance to providers, rather than through control and prescriptive measures.

#### **f. Purposes**

- Quality improvement: using the accreditation process to bring about changes in practice
- that will improve the quality of care for patients;
- Informing decision-making: providing data on the quality of health care that various stakeholders, policymakers, managers, clinicians and the public, can use to guide their decisions;
- Accountability and regulation: making health care organizations accountable to statutory or other agencies, such as professional bodies, government, patient groups and society at large, and regulating their behavior to protect the interests of patients and other stakeholders.
- Standards are statements of expectation that define the structures, processes, and results that must be firmly established in an organization so that it may provide quality care. For example, *standard of structure* refers to equipment, physical area, support services, personnel; *standard of process* includes admission, nursing procedures, medical procedures, operational manuals, norms, routines, flows; and *standard of outcomes* covers mortality, morbidity, readmissions, complications, infections and client satisfaction (accessibility, information, personnel and facilities.). All these standards require evidence of performance (or qualitative indicators) that are simple, inexpensive and easy to observe by the surveyors. Currently, as well, many hospitals have a great variation in quality among their services, independently of their size.

#### **g. Objectives**

- Conduct comprehensive assessments of health care organizations in consonance with the national framework, for the promotion and maintenance of quality and standards.

- To engage and train conscientious surveyors and to develop training systems generally for accreditation surveyors.
- To promote accreditation, including its values, purpose and results to health care organizations, medical profession, patients and the community.
- To collaborate with relevant organizations.
- To regularly monitor and evaluate all aspects of the accreditation system and accreditation decisions and provide feedback on the standards.

#### **k. Key principal**

During the entire program development, a consensus will rapidly be reached that certain principle elements must be present for the program to succeed. For the accreditation initiative to be successful, the program should be accountable, credible, applicable, consistent, transparent, objective, and impartial of oversight.

**Accountability:** For a national program to succeed and be self-maintaining there must be accountability. Accountability starts with an oversight organization that is accountable/responsible for the conduct, maintenance, and integrity of the program. Accountability also resides at the level of the health care facility director who is to be held accountable for ensuring that his or her facility meets and continues to meet the accreditation standards. Accountability then follows to the individual providers and staff who are held accountable for their part in meeting and maintaining compliance with the standards.

**Leadership:** Leadership must start at the national level with a commitment to make accreditation an integral part of a process to improve the quality of health care nation-wide. Leadership then is partially delegated to a national accreditation board and office to provide direction and guidance by taking the lead role in selecting, training, and certifying surveyors and overseeing the integrity of the survey process and the granting or denial of accreditation. Finally, and perhaps most importantly, is the leadership at the individual health care facility. Since meeting accreditation standards requires change in customary modes of behavior and since most people follow the direction of their leaders, facility leaders can make or break the process in their area of responsibility.

**Credibility:** To ensure credibility certain factors will be considered to be of paramount importance. First, the standards should specifically reflect our cultural and religious mandates. In other words, to simply adopt standards from another country or another area would not work. Second, while reflecting our unique culture, the standards should as closely as possible, reflect international norms and standards. In the future, an accredited hospital and its patients should be able to know that by being accredited in our country, the health care facility has demonstrated that it meets the intent of standards that would be expected of a hospital anywhere in the world. Third, many standards should require effort to be achieved. To simply adopt standards that reflect current practices would be of little value. A health care facility should be required to change and improve. Early in the development of standards there was a tendency to state that a proposed standard should not apply since "that is not how we do it here." However, commendably, these views were quickly overwhelmed by the majority of participants who responded "Yes, we know how we do it now. But how should we do it?" Fourth, the surveyors must be viewed as true experts who are impartial and free from personal or political agendas.

#### **h. Type of Programme**

One of the issues that is still being discussed is whether participation in the accreditation program should be voluntary or mandatory for health facilities. Several key questions are raised when addressing this issue: If voluntary, what is the incentive for a facility to



participate? If mandatory, should the mandate be to participate or to succeed? Should there be recognition only for success, or also for efforts even if not yet successful?

In most developed countries with a mature health care accreditation program, accreditation is voluntary. However, in these countries there are federal and local laws and regulations that ensure oversight of the quality of the care and the facility even if it is not accredited. In fact, in many countries much of the health care regulatory structure is modeled on the accreditation standards.

Therefore, even if a health care facility chooses not to seek accreditation, they are not free from some form of regulatory oversight. Thus, the incentive for becoming accredited is both philosophical (a desire to be measured and receive the recognition of meeting a rigid set of standards) and pragmatic (by being accredited some or all governmental inspections are eliminated).

However, in developing countries, this formal and universally applied government regulatory oversight does not exist. Therefore, except perhaps for private facilities that view accreditation as a "market advantage," there is little incentive to participate in a voluntary program.

Since the overall goal of the programme is to create a self-sustaining culture of improvement in health care, voluntary participation may well allow many facilities to cling to the status quo and deny that improvement is needed. The risk of the program being voluntary is that it will be embraced by only a few facilities and nation-wide improvement and change in culture and practice would not occur. For example, should a university or teaching hospital choose not to participate, then future generations of health care professionals trained there will continue to behave and practice in the "old" way and nation-wide improvement will be significantly delayed, potentially for many years. If, on the other hand, accreditation were made mandatory, all health care facilities would be required to participate. This approach would eliminate the question of incentives since it would be a requirement and the facility director would not have the opportunity of electing not to participate. However, not all health care facilities may now have the resources to meet all standards. In this case, the accreditation program may be introduced gradually and in stages. It may be advisable in the early stage of the program to provide a different level of recognition other than full accreditation to those facilities that are meeting the standards as best they can within the constraints of their resources. However, full accreditation should be reserved for those facilities that fully meet the accreditation standards. Patients should have the right to understand the accreditation status of the facility where they receive care.

For all the factors listed above, making participation in the accreditation process mandatory may be the preferable option. To accomplish this, several steps have been taken towards achieving legislation that will mandate accreditation for all health care facilities in the future

## **i. ROLES & RESPONSIBILITIES**

It would be the ultimate authoritative body responsible for health care quality in Bangladesh. It could where possible involve and evolve its strategies in consultation with the stakeholders. It would monitor quality improvement in the country and would support and guide the functioning of the organizations.

### **Roles**

- Policy making in consultation with stakeholders
- The national quality framework and accreditation process, in consultation with stakeholders
- Training, information dissemination, conducting relevant, problem based research
- developing implementation plans and monitoring.
- Co-ordination and supervision.
- Facilitate sharing of experiences and skills transfer.
- Mobilizing the human, physical and financial resources to strengthen state implementation plans.
- Making recommendations to the MOH&FW concerning quality aspects and matters relating and falling within their terms of reference.

## **j. CONSTITUTION & MEMBERSHIP**

The establishment of a credible accreditation body calls for representatives from the various stakeholders will be involved in the health care delivery system. This is necessary in order to make this system acceptable to all and to ensure its creditability since its inception. This partnership should provide a platform for consensus building based on the principle of sharing, democratic and transparent functioning. Care should be taken to allow each of the stakeholders to be equally represented.

The organization should be composed of representative from various groups concerned with health care. These groups include consumers (i.e. potential and actual users of health services), clinical service providers (mainly doctors, nurses and other health professionals), boards of governance and health service managers (predominantly at the hospital/network/area level) and purchasers

**Representatives from specialists associations:** The specialists associations should be involved as they have the required expertise. The specialists associations that need to be involved should be both from the medical (OB/Gyn., Surgeons etc) and non-medical fields (hospital administrators, x-ray technicians etc.). They would help in the setting up of standards and processes. At a later stage they could assist in providing inputs to the participating hospitals in upgrading their standards.

**Representatives from professional associations:** Representatives from the medical profession should be involved as they have a pivotal role to play in the provision of health care services. The representatives could be from among the association of consultants, general practitioners, nurses, technicians, etc.

**Representatives from consumer organizations:** As the consumer is the end user of a health care facility, any system which looks at quality should involve them especially when increasing attention is being paid to the issue of consumer rights.

**Representatives from Non Governmental Organizations (NGO's):** An accreditation body should represent an amalgam of interests. There is a need to involve NGO's doing work related to the hospital-based care as they have the expertise and knowledge of the present systems operating in the hospital.

**Representatives from MOHFW:** There is a need to involve the government level to ensure legitimacy of the accrediting body. The govt. should participate in these bodies to the extent necessary to ensure acceptance and public accountability of the accreditation system.

Representatives from insurance companies and financial institutions, legal professionals could be included. This in turn would help establish the creditability of the body.

**Individual Membership:** They may be drawn from the ordinary public with no more than an interest in supporting quality initiatives. These could include, among others

- Hospital managers and administrators
- Clinicians
- Nurses and other paramedical
- Chartered accountants
- Social Scientists
- Proactive social workers
- Environmentalists
- Public health specialists
- Research specialists
- Educators
- Students
- Any other

Those educated with professional qualifications and trained can be subdivided further to indicate recognition of individuals who are professionally qualified and those who are not. The former may be granted rights not available to the others. In other words there may be restrictions placed on those possessing only education and training but with no professional qualifications with regard to voting or such matters as holding high office. Categorization of the personal membership file can separate these two groups if it is so desired. Subscription rates may differ primarily to reflect the different requirements and range of services required by them.

**Honorary:** The organization may well wish to honour distinguished individuals who have made a major contribution to the profession or the organization itself. The methods open to it are limited. One, however, is the award of honorary membership. It usually carries with it free membership and certain other benefits.

**Institution / Organizational membership:** usually with a subscription rate much higher than individual rates. Care should always be taken to ensure that the national influence exerted by large bodies is not permitted to overwhelm the functioning of the state organization. Types of institutions that can become members are the following:

Health provider, health professional and consumer organizations, medical and nursing colleges willing to support quality in health care and accreditation can become members:

#### **Professional organizations**

- Medical and surgical councils and other such similar professional associations
- Teaching institutes
- Hospital owner's associations
- Consumer organizations
- NGO's working on quality
- Health insurance companies
- Pharmaceutical companies

Hospitals interested in accreditation could have a separate fee structure, incorporating costs of providing materials and training etc.

It will be found that some elements accrue to a body as it develops in size and the range of services it provides and the activities undertaken on behalf of its membership. The problem is to assess these elements and to reduce them in the interests of keeping a stream-lined and efficient operation. A useful maxim to apply then is - are they nice or necessary? The former can be dumped the latter cannot.

**Suspension of membership:** It is essential to ensure that a rule or bye-law exists and that it is operated to strike from membership those individuals, or institutions that delay beyond a stated period their payment of subscriptions. The organization may also consider the application of the practice of denying voting rights to those who have not paid the current year's subscription.

#### **Membership Entitlements**

##### **Personal**

- \* Provide continuing professional development opportunities for relevant persons;
- \* Provide channels of communication through the publication of a journal or newsletter.
- \* Entitlement to become surveyors on demonstration of competence.

##### **Institutional**

- \* Serve as a centre for information on quality & related activities;
- \* Encourage and promote regional and international co- operation between institutions and between the professional organizations. and interests representing them; Health Care Institution interested in accreditation

The membership fees should be based on the size and complexity of the organization. However, as a non-profit independent organization, the membership fees will be as low as possible.

Membership could provide support to health organizations in achieving accredited status.

The options could be the following:

- ▣ Self-assessment support
  - o Quality planning workbooks
  - o Tailored self-assessment tools
- ▣ On-site planning visit and education session for staff on accreditation
- ▣ One Organization-wide survey could be offered free for members
- ▣ Assisted development of quality action plan
- ▣ Progress visits
- ▣ Discount on scheduled workshops, conferences and publications
- ▣ Public relations support
- ▣ Access to the information services offered
- ▣ Internet membership support network

Additional surveys and education sessions are at the member organization's cost. Membership could entitle the organization to one survey in a two year period. If no accreditation is awarded after the survey and another survey is required within the two year period, that survey will be at a cost to the organization equivalent to an additional one year's membership fee. This will cover the direct costs of the survey only.

## Section- Four

### Establishing a National Accreditation Council

From this point, at which a country has decided what accreditation is expected to achieve and how it would fit into the future healthcare system. The roles and responsibilities will be defined initially to facilitate the structuring of the organization. Develop and evolve in establishing training institutions and modules for the accreditation process and liaison with other accrediting bodies. It could develop national level standards, guidelines & protocols. It could conduct research, documentation, information dissemination.. The accountability and audit of the accreditation bodies in terms of its functioning, relevance needs to be incorporated within the existing system.

**a. Governing Body for Accreditation Council:** The council would be the supreme authority, which would be the statutory body, entrusted with the responsibility of managing the organization. The basic premise of this framework is that it would be a result of discussions, debates on areas of concern, collaboration and transparency between related parties, and open communication among all the stakeholders.

▫ It would be the final authority in decision-making and an arbiter of major issues.

▫ It would provide a platform for the various stakeholders to meet.

Democratic participation of all members that allow expression of differing points of view is essential, with each member given equal voting rights. The participation of all stakeholders is to be ensured and mechanisms could be worked out for meaningful participation of consumer representatives also. Any member may raise issues of importance; issues may be graded in importance and be taken up in their order of importance. Evolving a consensus would be the guiding principle of all decisions. When serious differences of opinion occur, however, the decision of the majority would stand. The governing body would have to meet at least four times a year, with invited observers from the Government Health Departments, including Public Health.

**b. Constitution of the National Accreditation Council :** In it's composition, it would allow each of the stakeholders to be equally represented. This would prevent the council from being monopolized- and overtaken by dominant stakeholders. The composition of the body should be changed every year with a fresh set of nominations.

A chairperson and a secretary will be elected by this group would have tenures of 3 years each.

#### **c. Structure of Accreditation Council**

The member of the council will be included from various professions of health care services. When fully functional, the council should have a formal structure including:

p Chairperson

p Secretary

p Executive committee

p Subcommittees such as:

Standards development/revision to judge, approve, reject, or modify suggested changes by the accreditation management office. Survey process to review the results of survey and surveyors performance and recommend modifications to the process as needed based on experience Accreditation decision to approve, modify, or reject recommendations of the

accreditation management office Budget/Finance to approve fees and other financial fiduciary responsibilities.

#### **d. Roles and Responsibilities of the National Accreditation Council :**

The main responsibility of the National Accreditation council ( NAC) is to oversee all health care accreditation programs and ensure the integrity and credibility of the accreditation process. To accomplish this, it should have the final authority on:

- p Accreditation decisions and authority to grant or deny accreditation to a health care facility
  - p Selection and certification of surveyors
  - p Approval of new or modified standards
  - p Interpretation of standards
  - p Scoring methodology
  - p Weighting of individual standards
  - p Determining the importance of individual standards as critical, core, or non-core (this is discussed in more detail later in this report)
  - p Overseeing the accreditation management office
- 10 Developing and Implementing an Accreditation Program

#### **e. Accreditation Management Office**

Since the council itself may not have the technical skill or professional knowledge to accomplish all these responsibilities, it should establish a formal accreditation management office. This office should have a full-time director reporting to the council and a support staff sufficient to fulfill the following functions:

- Provide administrative support to the NAC
- Manage the daily operations of the accreditation program
- Provide ongoing review of standards and proposed updating when needed
- Ensure quality control of survey reports. This involves reviewing the draft reports submitted by the survey team to ensure that they are complete and that all standards scored by the survey team as not fully met have adequate documented evidence to support this conclusion
- Make recommendations to the NAC about the proposed accreditation decision for surveyed organizations
- Formulate official interpretation of standards in response to questions from surveyors or health care facilities
- Train surveyors and recommend to the NAC those qualified to be certified Process applications for surveys
- Schedule surveys and determine duration of survey process
- Recommend to the NAC the fees for accreditation surveys, training courses, and publications
- Provide proposed annual budgets to the NAC
- Provide logistic support (travel and accommodations) to survey teams
- Provide and/or support training courses, including the preparation of printed materials for staff of health care facilities to learn about the standards and the accreditation process

#### **f. Representation**

Setting up the formal structure to advise and manage the Accreditation programme

- The structure of the council may be developed by the multidisciplinary representation for the council. The following bodies may be involved.
- One representative each from hospital owner's associations;
- One Representative from Diagnostic Owner Association
- One representative from BMA
- One representative from BPMPA
- One representative from BMDC
- One representative from Medicine associations
- One representative from Surgery associations

- One representative from Dental associations;
- One representative from Society for Hospital Administration ( SHAB)
- One representative from OGSB
- One representative from the nurses association;
- One representative each from two consumer's associations;
- One representative each from two NGOs;
- One representative from the MOHFW
- One Representative from DGHS

Other than the representatives of the hospital owner's associations, none of the other nominees are associated with private hospitals.

The chairperson and secretary's terms of office would be limited, as would the number of times they might be re-appointed.

**Balance of membership:** In respect of both initial and subsequent appointments to the council, we believe that it will be important to ensure that a balance is achieved, and maintained, among the various stakeholders. With this in mind a representative sub-committee could be appointed by the council, chaired by a member of the council, to be responsible for ensuring wide consultation concerning the appointment of members to the council.

**g. Executive Body:** The executive body would consist of the director of the accreditation body, assistant directors of various divisions and cells. This would be the constitution of the Executive Body. The Executive Body would be accountable and answerable to the council. It would be entrusted with the responsibility of implementing the decisions of the council. Reporting and financial-decision mechanisms will need to be established leading to the ultimate authoritative body. Its terms of reference could well include responsibilities for policy overviews and their planning and coordination and the allocation of resources. The executive body would be entrusted with the responsibility of implementing the decisions of the council. It would be accountable and answerable to the council. There could be separate chief executives appointed by the council to carry out the diverse functions.

Administrative Division with responsibility for statutorily - required activities - e.g. organizing elections, meetings and managing the financial affairs of the organization. It would be responsible for the general administration, which would include finances, human resources, operations, documentation and legal issues. The manner in which the body works, its terms of reference and its administration and servicing etc should receive careful attention. The creation, arrangement, appraisal, maintenance and preservation and access to the records forming that archive are tasks often overlooked in an organization and for which guidelines would be a useful tool. There is a need to develop effective processes for strategic planning, and integration of key management information. Separate sections need to be developed to meet management information needs. Plans to be developed to ensure greater availability and integration of consistent data for management information purposes. Assess major risks and prepare risk management strategies.

**h. Advisory committees and Task force:** The Council should also be served by advisory committees specially formed with specific terms of reference as per the need. It could be to define and review standards, assess applications, recommend surveyors and advise on major decisions. For matters relating to accreditation design, there could be discipline-specific Specialist Advisory Committees (SACs), constituted by the council as and when required. The Advisory Committees would provide advice to the Board as and when necessary. For matters relating to research and development, there is a multi-disciplinary Advisory Committee fulfilling a similar role. These committees rely on a major input from relevant specialist societies which have the right to nominate members. The specialty committee Chairmen will be appointed by the council. These committees report to the council and their recommendations would have to be approved by the council, which could also make the necessary clarifications and recommendations.

The purpose of these is to serve as task forces to bring together members with relevant knowledge and expertise to help to formulate policies and to provide advice on the conduct of activities.

Ideally they will draw on the reservoirs of expertise represented in the local specialist groups. These national level sub-organizations should be linked with the main board through cross representation of memberships. The size of the committees, sub-committees, task Forces will depend on the work they are established to perform.

## **Section: Five**

### **Developing the Accreditation system**

At this stage it is useful to set up a number of working groups to finalize standards and procedures in detail. All of these have already been defined in other countries and many of them are in the public domain, but local working groups are important:

- To review and modify external examples to local laws, organization and expectations;
- To demonstrate a commitment to consultation, transparency and inclusion;
- To harness the enthusiasm of potential quality leaders;
- To identify and involve pilot hospitals in developing and testing standards;
- To develop a cadre of informed representatives;
- To identify people who would be able and willing assessors.

#### **1 Standards development**

Here the best guidance is in the ISQua Principles, which describe key steps in the design, drafting, consultation, testing, authorization and revision of the standards and criteria, which will be used by the Governing body for assessing hospitals. Using these, the body should define its own principles for developing standards e.g.

- To map the scope of the hospital standards and define the boundaries;
- To adopt a patient-focused (horizontal) or management-focused (vertical)
- To exclude standards which are not relevant, understandable, measurable and achievable
- To introduce each group of standards with an overarching principle or statement of intent
- To follow each standard with criteria or measurable elements;
- To integrate or to separate the standards, the criteria, the self-assessment, the external assessment and the report format.

#### **2. Guidance on selection**

Principles and standards need to be:

- Relevant to hospitals nationally;
- Understandable by staff and by assessors (internal or external);
- Behavioural, referring to what people do and how activity is organized;
- Achievable now or within the near future.

Criteria, by definition, must also be measurable ; any assessor should be able to test the criterion by direct observation, by interviewing staff or by reading documented evidence. "Documented evidence" might include inspection of Standard Operating Procedures (SOPs), which give detailed specifications for routine work, but compliance with SOPs is not directly audited by assessors; having written SOPs does not itself prove compliance with standards – assessors must also find evidence that they are disseminated, understood, applied and effective.

For the purpose of developing a first draft manual of standards, these guidelines should be applied first to the principles, then to the standards and finally to the criteria.



The Agency should:

- Review available options for adapting existing international standards
- Define and publish the process and timetable for the development of standards, consultation, testing, and evaluation
- Develop a policy and procedures for reviewing and updating standards, weightings, ratings/scoring and supporting guidance.

### **3. Types of Standards**

- Consensus may be reached on dividing the standards into three categories: critical, core, and noncore.
- Critical standards are those that were considered so important to quality of care and the correct functioning of a hospital that no hospital could be accredited unless 100 percent of these standards were fully met.
- Core standards are those that were considered to be of great value, but that a hospital would not be expected to have to fully meet all of them to become accredited.

Non-core standards are those that represent laudable goals for the future, but that may take considerable time and gradual change in traditional approaches to reach. In other words, the non-core standards were "stretch" standards. Because it was recognized that every one of the core and non-core standards was not of equal importance, each was assigned a numerical weight from 1-5 with 5 being the most important and 1 being the least important.

### **4. Proposed Standard functional area included in the accreditation survey design for a hospital**

- a) Admission and Assessment
  - ❖ Admission Process
  - ❖ Admission Assessment
  - ❖ Medical Assessment
  - ❖ Nursing Assessment
  - ❖ Other Assessments
- b) Laboratory Services
  - ❖ Laboratory Processes
  - ❖ Blood Transfusion Process
- c) Radiology Services
  - ❖ Radiology Processes
- d) Pharmaceutical Services
  - ❖ Pharmacy Processes
  - ❖ Emergency Medications
  - ❖ Essential Drug List
  - ❖ Medication Use Data Collection
- e) Patient Care
  - ❖ Clinical Practices
  - ❖ Treatment Planned and implemented
  - ❖ Patient Education
- f) Patient Rights

- ❖ Patient respect and clear directions
- ❖ Patient rights and responsibilities
- ❖ Patient Satisfaction
- g) Continuity of Care
  - ❖ Transfer Processes
  - ❖ Continuity of Care Process
- h) Management of the Environment of Care
  - ❖ Fire Safety
  - ❖ Emergency Processes for Power
  - ❖ Epidemic and disaster plans
  - ❖ Potable water
  - ❖ Medical Equipment Management
  - ❖ Hazardous Material Management
- i) Infection Control
  - ❖ Infection control processes
  - ❖ Surveillance System
  - ❖ Staff Education on infection control
- j) Leadership
  - ❖ Operational Policies and Procedures
  - ❖ Resource Planning and staffing
  - ❖ Financial and Material Resource Management
- k) Quality Assurance
  - ❖ Quality Assurance Program
  - ❖ Staff participates in quality assurance
  - ❖ Data Collection and analysis
  - ❖ Surgical, OBGYN, and Other Invasive
  - ❖ Blood and Blood Components
  - ❖ Incidents involving patients or staff
  - ❖ Quality is improved
- l) Human Resources
  - ❖ Staffing Meets patient needs
  - ❖ Hiring processes
  - ❖ Staffing
  - ❖ Professional Licensure or Registration
  - ❖ Orientation
  - ❖ Ongoing education
  - ❖ Performance Appraisal
- m) Management of information
  - ❖ Patient Record
  - ❖ Anesthesia Record
  - ❖ Data collection with health management

## **5. Scoring Methodology and Accreditation Rules**

Each individual standard is scored on a three-point scale of 0, 1, and 2 or not applicable. A score of zero means that there is no compliance with the standard. A score of 1 means there is partial compliance and a score of 2 means full compliance. If based on its services, a standard does not apply to a facility, it is listed as non-applicable and this standard does not reflect on the final score.

Each individual standard also has a weight from 1-5. Therefore, each standard has a maximum attainable score, which is the weight times two. At the conclusion of the survey, each standard will have been assigned a score by the survey team. This score times the weight of that standard is the actual score for that standard. Then, the aggregate total of the actual scores for all the core standards divided by the aggregate maximum attainable

score for all the core standards becomes the aggregate percent score for the core standards. The exact same process is used for the non-core standards.

To be granted accreditation the facility must meet the following criteria:

- p One hundred percent of all critical standards must be fully met (score 2).
- p The aggregate score, as defined above, for the core standards must be 85 percent.
- p The aggregate score for the non-core standards must be 40 percent.

This scoring methodology gives maximum flexibility to the Accreditation body to foster continued improvement in health care facilities. For example, in the future, the Accreditation body could determine that some current core standards should be moved into the critical category and some non-core standards should be moved into the core category. The Accreditation body can also revise upward the weighting of standards. This flexibility allows the Accreditation body to gradually "raise the bar" and make accreditation a progressively more valuable tool for fostering improvement and change in traditional patterns of practice.

In addition to the numerical scoring rules, for the initial survey the facility must demonstrate that it has been in compliance with the requisite percent of the standards for a minimum of the six months prior to the survey. The intent of this "track-record" requirement is to ensure that the facility maintains compliance and does not view it as a one-time effort. Accreditation will be granted for two years. As the program matures, the track-record requirement will be expanded to at least one year and the duration of accreditation lengthened to three years.

## **6. Selection, Training & Certification of the Surveyor**

### **.Surveyors**

The role of surveyors is crucial to the credibility and sustainability of accreditation. The expert group recommended the following criteria for selection of the surveyors:

- Experts in the field (medicine, administration, nursing)
- Skills for interpersonal relationships
- Management experience
- Knowledge of standards and methodology
- Knowledge about quality assessment methods.

Surveyors should be trained in the following areas:

- Visits and teamwork, not inspection
- Handling of a daily agenda-time management
- Knowledge of standards and indicators
- Communication skills
- Handling difficult situations.
- Skills to describe findings in detail and precise summaries
- Ethical issues such as confidentiality and others.

### **Selection Criteria**

To be selected as a candidate for training as a surveyor, the individual should meet at least the following criteria:

- p The individual should be a volunteer with interest in and enthusiastic support for the accreditation process. Surveying experience should not be a requirement of the job.
- p The individual must have credible experience, such as at least 10 years of experience working in a hospital or PHC setting or both. If surveyors do not have actual "hands-on" experience, or experience was in the distant past, it becomes very difficult for them to relate to the "real world" of health care.
- p Must have good interpersonal and interviewing skills.

p Must have demonstrated ability to be an effective teacher. A surveyor is not just an inspector. They must be able to instruct staff how to meet the standards and effectively gain the confidence of the hospital personnel. In addition to these personal attributes, the selection of "candidate surveyors" should ensure representation from all health care sectors (university, teaching, specialty, private and PHC).

The selection should ensure a broad representation of health care professionals and not just doctors.

### **Training of Surveyors**

To ensure accountability of the program it needs to have a rigorous surveyors' training program that includes several steps. Each "candidate surveyor" should go through the following training steps:

1. Attendance of formal didactic course on the standards, the survey process, the surveyor guide, and the scoring methodology
2. Observation of at least one practice survey conducted by an experienced surveyor
3. Conduct at least one (or more if needed) practice survey under the observation and tutoring of an experienced surveyor
4. Conduct one evaluation survey under the supervision of experienced consultants
5. Pass a final written exam on standards and the use of the survey guide

Evaluation of their practical survey skills is based on evaluation of the following factors:

- p Ability to work cooperatively in a group situation
- p Ability to actively participate
- p Ability to listen without interrupting
- p Ability to convey a positive and helpful attitude
- p Knowledge and understanding of standards, survey process, and scoring rules
- p Interviewing skills
- p Correct interpretation of standards
- p Ability to teach

### **Certification Process of Surveyors:**

To receive National Accreditation Council certification as a qualified surveyor, the following steps must be completed:

1. Successfully complete steps 1 – 3 (above) of the training curriculum.
2. Successfully pass a written test on the standards and the survey process. It may be possible for highly motivated individuals who do intense self-study to meet these criteria without attending a formal didactic course required by step 1.
3. Have the endorsement and recommendation of the supervising experienced surveyor.
4. Conduct one final evaluation survey.
5. Selection, Training, and Certification of Surveyors
5. Obtain final NAC approval.

The initial group of surveyors recommended for certification will be classified as either qualified surveyors and/or as qualified trainers for future surveyors. Yet to be determined is whether there

should be a third category – those who are qualified only to assist health care facilities prepare for accreditation, but will not conduct actual accreditation surveys themselves.

## **7. Surveyor Guide**

One of the problems the accreditation programs around the world is lack of consistency between surveyors. Although it is clear that surveyors must exercise judgment, the consensus was that some method should be developed to reduce the variability in the surveyor's interpretation of whether a standard was fully met, partially met, or not met.

A guiding principle incorporated in the surveyor guide is that surveyors should look for actual evidence of compliance with standards and not be content to simply accept a description that it is present.

A surveyor guide will be developed and reviewed with an expert committee from the DGHS and other sectors and consensus was reached on its format, content, and value.

The survey guide will follow the chapter outline of the standards themselves. For each chapter there shall be an introduction describing the survey activities, such as interviews and observations as well as any documents that should be reviewed. To guide the surveyor in reaching conclusions about the status of compliance with each standard there is a description of what evidence the surveyor should look for and how this evidence can be obtained or found. Following the description of the process the surveyor should use to obtain evidence about compliance with a standard is a detailed description of what evidence must be present to score the standard as fully, partially, or not met. The adherence to the rules found in the survey guide will reduce the variability of interpretation between individual surveyors and will guide the accreditation office in quality control of the survey reports to ensure that survey findings accurately reflect the scoring rules .

### **8.Survey Tool and Report Template and Automation**

Because facilities may require multiple consultative visits as they prepare for the actual accreditation survey, a survey tool and report format will be developed for survey/consultation visits. During preparation visits to a health care facility, the surveyor/consultant team is expected to score the current status of each standard that is applicable to the facility. For each standard that is not fully met, i.e., scored as zero or one, the surveyor/consultant team must document the specific findings that led to this conclusion and provide recommendations on what the facility might do to correct the deficiency. The survey tool and report template is similar to the actual accreditation survey except that only findings must be documented and recommendations are not required.

## Section- SIX

### **Framework & process for accreditation**

This section of the report contains a more detailed discussion of the proposed system of quality assessment, and sets out a number of recommendations for its future operation. It is divided into the following sub-sections:

#### Assessment

- Principles of assessment
- Registration
- The pre-assessment program
- The self assessment
- The documentation required for quality assessment
- The assessment visit
- Period of accreditation
- The assessment cycle
- Maintaining Accreditation.
- Public disclosure
- Fee structure.

The stakeholders should have significant benefits from the process of accreditation, the significant benefits being based on the priorities of each stakeholder. Priorities for the potential accretee are that it should experience accreditation as helpful, it should have a continuous relationship with the accrediting body, and the process should be minimally intrusive and expensive (Schryve, 1995).

Getting quality of care on to the agenda in a shared arena which brings together policy makers, professional bodies and service users. To facilitate continuous quality improvement by support health care institutions in discharging their responsibility for the maintenance and enhancement of the quality and standards of their health care provision To assure the safety and effectiveness of medical practice.

#### **a. Assessment Principles**

- ▯ Sufficiently flexible to take account of the dynamic and diverse nature of health care institutions, the variety of sources of evidence, and the changing environment within which they operate.
- ▯ The assessment process should recognize the positive aspects of the existing system, stimulate considerable debate on the strengths and weaknesses of practice, be a positive experience and identify areas where it can act to remedy particular problems or deficiencies.
- ▯ The quality assurance process itself should be under assessment and to ensure its continuing appropriateness to the achievement of the purposes of quality assurance set out above.

- Operate as cost-effectively as possible in order keep to a minimum the level of external demands on institutions.
- The assessment experience should be developmental rather than judgemental and foster a sense of 'ownership' and 'partnership' among all those involved.
- The assessment process should be integrative, relevant to all the stakeholders, and transparent.
- Systems should be available for moderation of assessment.

### **b. Registration**

Application by hospital and dispatch of :

- Application
- Self-assessment materials,
- Questionnaire (basic data on staff and activity, comprehensive checklist of criteria for compliance with standards)
- Detailed report on preparation for the survey for achieving compliance with the standards (optional) and the set of internal documents to be submitted-resource and activity data, internal audits, policies, procedures.

### **c. Pre-assessment Program**

▫To provide effective support required by hospitals to be able to implement the quality program.

Induction programme which introduces them to quality and the assessment procedures

Development of opportunities for experience

Provision of manuals, self assessment workbooks, information sheets on key assessment areas, survey visit information.

Self assessment support

Training of in-hospital staff to form a steering group/quality action team

▫ Provision of a professional service manager who provides support for survey preparation

▫Mock survey

▫Progress visits by a surveyor to support ongoing quality improvements.

### **d. Self-Assessment**

Self-assessment is regarded within the discipline of accreditation as a critical first step and as a developmental instrument. It gives an organization the opportunity to undertake a structured, critical and comprehensive assessment of its performance, improve the efficiency of its operations, enhance staff morale and teamwork and demonstrate to the facility's peers and the public a conscious and active effort to maintain high professional standards of care. Internal organisation and management needs can also be identified during this process. Self assessment will therefore provide the basis for continuing quality improvement - an integral part of the accreditation cycle. In addition, as the second cycle of assessment begins, institutions should use the initial self-assessment to describe how they have responded to their earlier quality assessment experience.

Self-assessment of this sort is consistent with practice in industry and with total quality management. Self-assessment also has the potential to play an important part in the enhancement of quality by encouraging staff to identify opportunities for improvement and to reflect critically on their part in ensuring the quality of health care.

The self-assessment document should set out clearly the aims and objectives of the assessment and give an account of how these aims and objectives are met. The document should be structured using the aspects of provision contained in the National Quality Framework which will be used also in determining the form of assessment visits, and in governing the structure of assessment reports.

The self-assessment should give an opportunity to the institution to identify any problems which may exist in health care delivery in a particular area of care, and to describe how it is addressing these problems. There should be no invitation to institutions to assess the overall provision in the cognate area, or individual aspects of that provision, in terms of any rating scale as organisations usually tend to overrate themselves and it has no value in the overall rating process. The selfassessment should highlight recently introduced or proposed

developments in the organisation of health care. The format of self-assessment should reflect institutional variations in each cognate area such as size, type and structure. In the second cycle of assessment visits, institutions should be invited to use the self-assessment to provide an account of how they have responded to their earlier Assessment experience. The length of time between the submission of the self-assessment document and the assessment visit should be as short as possible. Support services may be provided during the period of self assessment.

### **Documentation Required for Quality Assessment**

Review of documentation should include organizational policies and procedures, minutes, care plans, clinical records.

### **Recommendations**

The requirements of documentation made should be clearly able to enlighten the assessors and not result in loads of paper work.

Such documentation should not be requested where the burden on institutions is not clearly balanced by the enlightenment of assessors.

### **e. The Assessment Visit**

The Assessment division will devise a standard programme for visits. A timetable based on this programme it to be agreed between the assessors and the institution at the pre-visit meeting. Certain features of the programme will be determined by the nature of the cognate area and the institution's organizational arrangements.

The on-the site assessment will include review of documentation; interviews with directors, managers, committees and service teams; observation; assessment of client care through reading clinical notes; discussions with clients and families; and discussions with managers and health practitioners to verify any provisional findings. The surveyors hold a summation conference for management and staff at the end of the survey to outline their major findings and suggestions for future action.

All institutions should be subject to an institution-wide review once in each two year cycle, involving:

- ▣ Observations of care
- ▣ Meetings with groups of staff, including, for example, probationary staff, more senior staff and administrative and secretarial staff;
- ▣ Meetings with various support services – labs, x-ray, counseling etc;
- ▣ A meeting with a representative group of patients;
- ▣ Meetings with the head of the institution and managers, and
- ▣ Reading other documentation.

Taken as a whole, the process will assess the extent to which an institution is discharging its responsibilities for safe and effective health care effectively. It would indicate areas of strength and weakness, including aspects requiring attention; involve an evaluation of the validity and reliability of an institution's internal review procedures, and provide reassurance that each institution has in place effective arrangements for assuring academic standards in the institution.

### **f. Recommendations**

The programme should be flexible enough to allow assessors to give adequate consideration to complexities.

Review cycles for individual subject/speciality areas could be different in order to maintain speed and simplicity of the process. During the assessment, areas of duplication and overlap should be avoided.

Aspects of review could be classified as those that require continuing reassessment every few years and those not requiring reassessment at every visit in order to reduce the quantum of work and also to simplify the process.

At all times visits should be conducted in a spirit of co-operation and dialogue between assessors and institutional staff with clear communication and explanation of the assessment process. A distinction should be made, in the assessment of central services, between 'speciality specific' services and those services which are common to other areas. While it is appropriate that the first group should be assessed within the assessment of



each cognate area, the assessment of common services should be conducted without unnecessary duplication of effort or burden on institutions.

The introduction of a method for the systematic evaluation of the experiences of the major participants in the assessment process. Assessors and representatives of the institution are asked to complete a questionnaire which allows them to report on their experiences with the quality assessment process in each individual visit. Such feedback could be very helpful both in evaluating particular visits, and in monitoring the operation of the system as a whole.

#### **g. Period of Accreditation**

Accreditation is for two years, subject to continued implementation of the agreed Quality Action Plan (optional), and the maintenance of standards. If a survey reveals that there is a major risk to client, staff or visitor safety or there are significant deficits in a number of key areas, no accreditation status will be awarded. If there is an area of risk or a limited number of significant improvements needed to achieve the standards, and these can be actioned in a short timeframe, accreditation may be deferred until the risk is eliminated or the improvements have been made.

For those few applicants with major problems, approval of any sort is withdrawn until the difficulties have been corrected, and re-application is required.

If a provider is not granted two year accreditation it may appeal this decision on the grounds that the survey report is inaccurate or incomplete and that those inaccuracies or omissions were not due to shortcomings on the part of the provider during the survey.

#### **h. The Assessment Cycle**

The second cycle of assessment visits should be arranged initially on the basis of a two year cycle, but the length of the cycle should be reviewed in the light of the survey report. Where particular area is considered to be 'deficient' as a there would be a requirement for a further review visit in accordance with procedures to be laid down by the organisation.

Consultation with institutions on the definition of the cognate areas in which second assessment will take place should be undertaken.

Two years is a long period between reviews; a good deal can happen in that time. Having shorter cycles would greatly add to costs. Progress visits could instead be arranged as in New Zealand, to oversee developments

Progress Visits are made 12 months after the survey by a Quality Health surveyor (larger services will require more than one surveyor) and are designed to support ongoing quality improvements, confirm standards are being maintained or exceeded, review the organisation's achievements and outcomes in relation to its quality action plan, and assist with interpreting the intent of the standards. It also provides an opportunity to advise the client on new or revised standards pertinent to their next survey, and discuss significant changes in service delivery. The organization receives a report containing the findings of the progress visit and suggestions for improvement.

#### **Maintaining Accredited Status**

A self declaration form stating continuing compliance with the standards will be required. It is also incumbent upon the applicant to notify immediately of any substantial or important changes in staffing, service provision, organization, resources or performance as failure to do so may jeopardize the accreditation status. Guidance on what is considered "important" in this context should be available from the organization.

#### **Options to ensure compliance:**

A system of minimal reporting by participating hospitals could be arranged which could be half yearly/yearly. This would go into an MIS and a regional monitoring team could monitor progress. Interim reports by accrediting body every year on progress made in the quality initiative (optional) By using a limited core-group of indicators, with more frequent less-intensive visits (eg.six monthly or annually), the focus could be on achieving incremental and continuous quality improvements.

#### **i. Quality Action Plan**

After receiving the survey report, organizations are requested to draft a Quality Action Plan (QAP) that specifically addresses the surveyors' recommendations within a timeframe. This Quality Action Plan becomes an agreement between the organization and Quality Health. Accreditation may be withdrawn should action not be taken to address recommendations within the agreed timeframe.

### **Public Disclosure**

Careful attention would need to be given to how information in individual providers is handled, so that accreditation is not perceived by them as a punitive tool or as a way for taxation authorities to assess tax liability. Accreditation is not a substitute for regulation ; using the former as a tool for identifying and taking action against poor or dangerous PPs risks jeopardising its aims (Salisbury, 1997). In South America and the Caribbean, accreditation combines public dissemination of whether or not a facility has complied with a minimum set of standards, for which it receives accreditation, and confidential communication to the organization of its performance against higher standards (WHO, 1993). Where relevant, and in the light of the procedures of individual professional and statutory bodies, accreditation reports could be placed in the public domain by an institution.

## **J. Fees**

### **Accreditation Fees**

The accreditation fee structure could be composed of four elements: the application fee, the annual fee, the cost of a comprehensive on-site survey every three years, and the on-site education session. These four elements are detailed below (adapted from CC)

### **Application fee**

An initial one-time fee upon submission of the application form. This amount covers the administrative overhead costs related to the processing of the application and the shipping of standards documents and CCHSA related material to the applicant. This fee also signals the seriousness of the intent of the organization applying for accreditation.

### **Annual Fee**

The annual fee paid by health service organizations is based on the operating budget that they submit to the organisation each year. This fee supports the cost of the activities involved in operating the accreditation program and is not directly related to the cost of conducting surveys. The activities associated with operating the program are: research and development, representation, and office overhead.

### **Survey Fee**

Participating organizations undergo a full accreditation survey every three years design an approach to the survey to ensure that the objectives of both parties are met. As well, the type of organization and the range of care and services provided determines the size and composition of the survey team and the time required to conduct the survey.

### **Education Session Fee**

It is recognized by health service organizations that an education session is an essential component of achieving the most benefit from participation in the program. Participation in an education session, developed by the organisation in consultation with each institution undergoing assessment should be strongly encouraged. These sessions are provided on a cost recovery basis and include a small administrative fee for the development of customized materials and agenda. Accreditation is a resource-intensive process and pilot programmes should focus on those, possibly a minority of, private clinics and hospitals that offer a range of inpatient and outpatient services, have a high turnover of patients and indicate an interest in participating. Because accreditation visits require external teams of trained surveyors, and focus on organisational indicators of practice, it is unlikely to be feasible or suitable for small facilities or single-handed practices. A two-stage process may be undertaken to phase in accreditation at both the outpatient and in-patient levels.

Principles which characterise the successful introduction of accreditation systems include : a process of consensus-building between government, professionals and purchasers, and the application of concepts of quality and implementation processes which are appropriate to the local context and current performance of the health services. Perhaps, the biggest initial obstacle to introducing accreditation is the resources necessary to initiate the process. The organisation should publish a timetable for assessments. This timetable would assist institutions in planning their monitoring and assessment arrangements.

## **h. OPERATIONAL PRIORITIES**

The immediate priorities for creating an enabling environment and infrastructure are the following:

1. The resourcing of the organisation and developing a resourcing policy
2. Analyzing cost implications and developing budgets and projections including strategies to obtain the necessary resources
3. Facilitating the development of a legislative framework for the provision of quality care .
4. The governing board of the council is to be established
5. The first board would appoint the first chief executive after advertisement of the position.
6. Piloting projects
7. Create and implement a multi-year plan.
8. Implementation to be phased after prioritization
9. Establishing operational goals and targets within clear time frames
10. Clarifying roles for stakeholders that are appropriate and the context in which these functions are to be performed
11. Establish a National Institute for training and national standards bodies;

## **i. RESEARCH AND DISSEMINATION**

Research would be an essential activity in order to ensure credibility of the assessment process and to keep abreast to the changes in the regional and international health, technology and quality scenario. The dissemination of issues regarding accreditation would play a vital role in the development of quality consciousness in the health care system of the country.

### **Objectives**

- Develop and refine methods of assessment including scientific, economic and social tools
- Develop and refine tools of assessment.
- Detect changes in medical practice, consumer perceptions, and give renewed direction to the assessment process
- Conduct comprehensive assessments of medical technologies considering their scientific, economic, social, ethical and legal implications and to perform evaluations at the request of providers and third parties
- Surveillance of use of drugs, devices and medical interventions

Develop an agenda of problem-oriented research topic alternatives on which the members could vote and prioritize. This should lead to a comprehensive research agenda. Advisory councils/ Research committee- may be set up for research into priority areas, with representation of the specialists associations, may be set up for on-going research responsive to needs. Working in partnership with a range of research agencies and institutions.

### **Dissemination Objectives**

- To provide, in explicit public format, information on the quality assurance program, standards, their development etc.
- Creating a reliable database on identified quality issues to facilitate interventions
- To enable staff, members and trainees to have access to all sources of published information on quality to support their learning, teaching and research activities, using a range of means including access arrangements with other institutions, electronic access, and any other appropriate means.
- To encourage the development and use of more extensive resource-based learning.
- Production of high quality publications on identified issues.
- Develop book and journal stock in quality and areas of particular need
- Develop electronic resources in order to extend range and coverage by providing a high quality and fast network infrastructure
- Provision of access to electronic resources in the form of bibliographic, numerical, scientific and full text databases, either locally or remotely located. The active management of the collections (acquisition, withdrawal, stocktaking and optimal deployment), by Information Services and academic staff in partnership, to ensure that the resources are relevant and appropriate to the training and research programme.

### **Web Site**

Responsibility for maintaining and developing the hardware and software environment of the web site lies with Information Services, who also train departmental contributors. Departments are responsible for maintaining their own entries. The immediate priorities are to have a wide base of contributors while maintaining and improving the quality and currency of the information content, to encourage use of the web as a platform for innovative learning and teaching applications, and to develop the web site as a powerful external marketing tool for the courses, research activity of the organisation.

### **Publications**

To develop comprehensive audio-visual media and communication materials for the support of all educational, meeting and conference activities, and training in their effective use.

- Accreditation manual and survey protocols for all programs recognized and notification of revisions;
- Self assessment manuals and workbooks
- Listings of accredited providers, including accreditation status and survey due date;
- Immediate notification of serious situations that may jeopardize patient safety identified upon survey;
- Notification of organizations placed in conditional, preliminary accreditation, or nonaccreditation status, including follow up plan of correction;
- Educational opportunities, staff and/or provider briefings;
- Input into standards development process and representation on the organisation's Task Forces or work groups as available;
- Active information-sharing practices that can include survey findings, complaint tracking and so forth.
- Serious complaints or sentinel event information

## **j. MONITORING AND EVALUATION**

Assessment and review of performance is essential, because knowledge of performance stimulates improvement. Monitoring and evaluation of institution's efforts to integrate quality systems will be monitored by monitoring teams. There could be a minimum necessary MIS which could guide the process. It would involve selection of key indicators and also submission of the involved health care providers of minimum essential information to the organisation on a periodic basis.

### **Objectives**

- Oversee implementation of quality systems

- Monitor the quality of accredited organizations through the prioritization and investigation of complaints received from various sources, reports of sentinel events, and out of compliance notifications

Regional monitoring team will oversee quality systems implementation in hospitals. Whilst the institutions will assess their own performance, the regional team monitors performance over time

and therefore can compare institutions, rank them and give feedback at the regional forum.

#### Monitoring should be carried out using a comprehensive checklist.

The regional monitoring team will provide supportive supervision by:

- Frequent monitoring of institutions
  - Assisting in problem identification, analysis and solution
  - Advising on implementation strategies,
  - Responding to new problems
  - Encouraging high performance by comparing institutions and promoting best practice.
- Members of the regional monitoring team should be trained as QA facilitators. Members of the team should be drawn from the regional levels so that there are resource people available in the districts.

#### Key performance indicators which will be submitted by the accredited hospital on a periodic basis will be a mandatory requirement to renew accreditation. This will:

- Confirm that institutions' internal quality assurance procedures are working effectively.
- Focus on those issues necessary for the funding bodies to secure their responsibilities for public accountability and public information.

### **K. MANAGEMENT INFORMATION SYSTEMS**

A comprehensive MIS for the storage and retrieval of descriptive and evaluative data and information flowing from participating institutions is useful and is a priority. The MIS could also pull together the fragmented and duplicated health related data collection activities currently practiced. MIS for

- Documentation and information systems
- Drug information system for doctors
- Newsletters, journal publications, conferences organize regular for quality
- Information skills training to staff
- Organizing seminars and conferences.

#### Performance Indicators

A set of minimum indicators of the achievement of the goals of the organisation should be defined to ensure a standardization and uniform analysis of data collected by an MIS.

#### Influencing Public Policies

- Carrying out policy research and analysis on issues identified for influencing, which have a major bearing, positive or negative, on quality, rationality and accountability in health care.
- Networking, coalition building
- Capacity building
- Information dissemination

### **I. Funding:**

Stable financial resources are critical to the existence of the body and for the proper functioning

of the body. Therefore it is important that the organization operates programs with sustainability

in mind. Initial funding for the organization could come from grants.

Ongoing financial support could include

▮ Survey fees for assessment paid by participating providers. The advantage of this option is that it would capitalize on the private sector initiative and interest. Disadvantages of this option include potential problems with funding.

- Possible public funding: A combination of private and public sector involvement could be essential for any system of accreditation of hospitals.
- Membership fees: Contributions from medical associations, member pharmaceutical companies, leading corporate hospitals? Such contributions raise important questions about the influence that such bodies may have on the accreditation process.
- Third party payers: In the near future, third party payers would be interested in paying for relevant information. Also, if the accreditation system proves itself to be credible and reliable, insurance companies may use accreditation as tool to decide which health care organizations to reimburse. Therefore it could be a priority that such information that could inform these also should be available and its quality should be ensured.
- Grants from various bilateral / multilateral funding agencies, state governments, philanthropic organizations, corporate sponsorships etc.
- Other options could include Public share holding, alliance with international quality organizations, and income generating activities.

## **Section- Seven**

### **SCOPE AND LIMITATIONS**

This document is not a blueprint for establishing organizations for accreditation at the national level since this document provides a framework and suggests options for establishing them. Some major aspects that need to be understood are that this concept is new in Bangladesh due to the elements of no legislative support, involvement of stakeholders, voluntarism and absence of such an organization in the country.. Various factors affecting the functioning of an accreditation system, such as the group dynamics among the stakeholders as well as the existing social, political and economic ground realities need to be taken into account while implementing it. Much would depend on the involvement and initiative of the stakeholders. The accreditation system itself should be an outcome of discussions and debates on issues of concern among all the stakeholders. Collaboration, transparency between related parties and open communication are the hallmarks of the system whose framework we are proposing. Only then would it be meaningful and viable.

This document is an attempt to lay down principles and guidelines for implementing the formation of an accrediting body that is credible, and transparent. The policies and processes related to the development of a credible, effective and transparent system of accreditation has been discussed in the various sections of the document. Within this framework, the group has sought to identify critical areas of weakness. Options have been proposed that would best serve the needs of implementing quality systems keeping in mind the nuances of the health care system in our country. Further there is no time frame suggested since it would be based on the initiative and support the panel receives from various quarters. It should be noted also that this document provides only the organisational and policy options and broad framework for implementing accrediting systems. This is not attempting to provide a complete framework required in implementing a quality program.

Strong leadership and clear aims for improvement are the need of the hour. Commitment by the MOHFW will provide important national leadership in coordinating and focusing ongoing safety and quality enhancement efforts so that all of us receive the highest quality health care achievable. A commitment to quality enhancement throughout the whole of the health care system involving all professional and service groups is essential to ensure that

high quality in health care is achieved, while minimizing the inherent risks associated with modern health care delivery.

## Section-Eight

### Immediate action & Recommendation

**Implementing hospital accreditation** The following steps are suggested further :

1. Orientation of national authorities within the Ministry of Health & Family welfare and other stockholders on concept, methodology, benefits and expected outcomes of Accreditation
2. Launching of the accreditation process by establishing a National Accreditation Council (NAC) by the Ministry of Health & Family welfare.
3. Presentation of the accreditation draft policy to the national accreditation committee
4. Contact with the country leadership by the national accreditation committee.
5. Review and adaptation of the WHO manual by the national accreditation committee.
6. First national seminar on hospital accreditation, "Validation of standards and evidence of performance (qualitative indicators)".
7. Selection of public and private, large and small hospitals as pilots.
9. National seminar on hospital accreditation, "Presentation of the accreditation process in pilot hospitals"
10. Establishment of a permanent multi-institutional national commission/council representing health care providers, independent or semi government organization, universities, insurance companies and/or community representatives.
11. Initial formal surveyor training.

### RECOMMENDATIONS

1. Conduct an intensive programme awareness-raising campaign, including capacity building, dissemination of concepts and seeking commitment, to promote accreditation of health care delivery services.
2. Exert all possible effort to include accreditation in strategic national health plans.

3. Issue regulations necessary to ensure credibility of the national accreditation programme.
4. Determine the requirements for financing and sustainability of the national accreditation programme and identify necessary financial resources and potential funding sources.
5. Develop national expertise in quality improvement and accreditation.
6. Organize an expert group meeting to address: surveyor training package; awareness package; and development of the manual.
7. Facilitate exchange of information on country initiatives and progress in accreditation programmes among countries of the Region.

## **Section-Nine**

### **Proposed Action Plan for Hospital Accreditation**

#### **Step -1**

- Review the existing hospital Accreditation system in different countries of the world with an aim to formulate draft proposal for the implementation of Hospital Accreditation system in Bangladesh
- Holding workshop with different stakeholder to seek opinion
- Development of proposal on Hospital Accreditation with the incorporation of different stake holder's voice / opinion.
- Sharing the proposal with the professional organization like BMA, Nursing association etc and finalization
- Sending complete proposal to the MOHFW for approval.

#### **Step-2**

- Developing of policies, procedure and rules by the MOHFW on the basis of proposed proposal

#### **Step-3**

- Setting up the formal structure to advise and manage the Accreditation programme
- The structure may be developed by the multidisciplinary representation. The following bodies may be involved.
- One representative each from hospital owner's associations;
- One Representative from Diagnostic Owner Association
- One representative from BMA
- One representative from BPMPA
- One representative from BMDC
- One representative from Medicine associations
- One representative from Surgery associations
- One representative from Dental associations;
- One representative from Society for Hospital Administration ( SHAB)
- One representative from OGSB
- One representative from the nurses association;
- One representative each from two consumer's associations;
- One representative each from two NGOs;
- One representative from the MOHFW



- One Representative from DGHS

#### **Step-4**

- Formation of National Accreditation Council

#### **Step-5**

- Developing and Testing Standards and Designing the survey process.
- Draft performance standards for hospitals are to be developed by the working group. The draft standard is to be send to all hospitals as well as key stakeholder association for comments and feedback. The final standards may be
  - Admission and Assessment
  - Laboratory Services
  - Radiology Services
  - Pharmaceutical Services
  - Patient care
  - Patient rights
  - Continuity of care
  - Infection control
  - Leadership
  - Quality Assurance
  - Management of information
  - Human resource.
  - Management of the environment of care

- **Step-6**

- Formation of Surveyors by recruiting and training.

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- **Step-7**

- Consultative survey

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- **Step-8**

- Developing the accreditation database format.

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- **Step-9**

- Conducting full accreditation survey
- The accreditation survey will cover 13 functional areas ( Proposed)

### **Different activities needed to complete for a hospital to be accredited**

Accredit survey  
Internet survey  
Whole system QA  
Indicator Monitoring  
Strategic plan, QA, CQI implementation  
Risk Management, Work simplification  
Team Building, Training  
SWOT, Customer Need Analysis  
Quality Structure Building

## Section-Ten

### **Annex=1**

#### **Workshop overview of developing Hospital Accreditation plan**

Total number of planned workshop: 06  
Total number of workshop conducted: 06

Duration of each workshop: 02 days

#### **Venue of the workshop:**

Dhaka divisional workshop: DGHS conference room  
Khulna workshop: Khulna Medical College  
Rajshahi workshop: Rajshahi Medical College Hospital  
Barisal: Barisal Medical College.  
Chittagong: Chittagong Medical College Hospital  
Sylhet : Sylhet MAG Osmani Medical College

Participant : Different categories of doctors from Medical colleges, Hospitals, District hospital, UHC and DGHS

#### **Workshop activities:**

A programme schedule has been designed with registration at the beginning and followed the workshop schedule (Annexure-2 may be seen).

**Sessions** were divided into 4 in number - Opening, Technical, Plenary and Closing.

**Opening session** was designed with Principal / Director of Host Medical College Hospital as the chairperson , Director Hospitals & Clinics, DGHS, as a chief guest and Dr. S.A.J. Md.Musa DPM ( Training), Hospital Services, DGHS as the facilitator. After recitation from Holy Qur'an, participants were invited for self-introduction. Facilitator introduced the workshop outlining its objectives, programme schedule and norms to be

followed. Finally the chairperson closed the session with words of welcome to the guest resource persons and attending participants.

**Technical Session,** was designed with Principal, Host Medical College as Chairperson at session. Dr. SAJM Musa, DPM ( training), DGHS and Dr. Md. Aminul Hasan, DPM, Hospital Services, DGHS alternatively worked as Facilitator at sessions. The topics covered in the technical session were as follows:

1<sup>st</sup> day: The Medical Practice and Private Clinics and laboratories ordinance 1982, Concept of Accreditation

2<sup>nd</sup> day: Accreditation in other countries, Accreditation Process & Model in different countries, Action plan of Hospital Accreditation, Chronology of Milestone.

Finally participants exercised in 4 groups each on one of these priority issues ( A,B,C,D) identified as above towards formulation of recommendation and the process was assisted by the resource person, DGHS and Group leaders. Reading the supplied material , discussion and group works held to maximize the participants involvement. The sessions were full of brain storming discussions.

Each group was given a topic to discuss with ultimate goal to formulate recommendations. The recommendations were really excellent in terms of reality and practicability which were further improved through the comments and suggestions put in the open discussion sessions.

**Plenary session:**

Plenary session was designed with Line Director, IHSM, DGHS as the chairperson, Dr. SAJ.M. Musa DPM ( Training) DGHS, was the facilitator. Their sincere efforts was a driven force to energize all concerned. Group Leaders presented recommendation on respective topic and invited the plenary for open discussion.. Presentations were made using audio visual media. Each of the presentation were followed by such discussion and received resourceful inputs from the learned audiences. Thus the recommendation on each of the priority issues were finalized.

**Closing session:**

Closing session was designed with Director (Health) of the Division as the Chairperson and Workshop Coordinator as the Facilitator. In this session chairperson invited for participants words and in response representatives of participants expressed their observations with their gratitude for arranging such workshop and also provided valuable suggestion for further improvement.

## **Annexure 2**

### **REVIEWS OF OTHER COUNTRY EXPERIENCES**

#### **UNITED STATES OF AMERICA**

##### **1. Joint Commission on Accreditation of Healthcare Organizations (JCAHO)**

Mission: To continuously improve safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations.

Short history: Developed from the end result system of hospital standardization" in 1910. The JCAHO is the first institution created to evaluate hospitals and the largest one. It was created in 1951 as Joint Commission on Accreditation of Hospitals and later renamed as Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Its accreditation work continued the activity of the American College of Surgeons that started in 1919 called the Hospital Standardization Programme.

##### **Type of provider / service targeted**

Health Care Networks Hospitals  
Long Term Care Facilities  
Behavioral Health Care and Related Services  
Home Care Agencies  
Ambulatory Care Facilities  
Clinical and Pathology Laboratories

##### **Nature of accreditation: Voluntary,**

**Type of organization:** nationally recognized non-profit accrediting organization Method of setting standards: In consultation with health care experts, providers, measurement experts, purchasers and consumers. Updated every two years.

**Type of standards:** In February 1997, the Joint Commission launched ORYX: The Next Evolution In Accreditation to integrate the use of outcomes and other performance measures into the accreditation process.

##### **Method of assessment:**

1. Hospital to request a survey application
2. After return of the application, the hospital receives a complimentary copy of Comprehensive Accreditation Manual for Hospitals (CAMH).
3. Initial survey: four-month track record of compliance with JC standards.
4. Surveyors evaluate compliance with each of the standards using a five-point scoring scale. scores are first summarized into performance areas by applying aggregation rules. These rules are formulas that consolidate the scores for a group of related standards into a single performance area score.
5. If interested in practicing continuous accreditation: perform ongoing self-assessments

**Compliance:**

1. To validate compliance with the standards on an ongoing basis, unannounced surveys of 5% of accredited hospitals (chosen randomly).
2. At the Triennial surveys, surveyors look for a 12-month track record of compliance.

**Functioning of the body:** Governed by a 28-member board of commissioners, more than 200 professional organizations are involved in the Liaison Network.

Membership of the body: Includes nurses, physicians, consumers, medical directors, administrators, providers, employers and labor representatives, health plan leaders, quality experts, ethicists, health insurance administrators, educators.

**Policy/ legislative support:**

1. To obtain Medicare certification through a process known as "deemed status."
2. Reliance for licensure purposes for hospitals and other types of provider organizations in many states that have adopted statute or regulation to use accreditation by a national recognized and/or state recognized private accrediting organization as demonstrating compliance with licensure requirements.
3. In addition, the Joint Commission also monitors and, when appropriate, seeks to influence federal legislative activity through its Washington, D.C. office.

**Involvement of consumers:**

1. Consumers involved in setting of standards.
2. A public information interview (PII), is available to patients and their families, patient advocates, consumers, organization personnel and others, during each full on-site survey.
3. An organization scheduled for survey is required to post public notices at least 30 days in advance of the scheduled survey. Individuals requesting a PII forward their requests in writing to the Joint Commission. The Joint Commission's survey team conducts the PII, considers the information gathered in the PII along with the team's findings during the survey process in making the accreditation decision.
4. The Joint Commission's toll free complaint hot line, (800) 994-6610, allows patients, their families, caregivers and others to report their concerns regarding quality of care issues at accredited health care organizations. The Office of Quality Monitoring evaluates each complaint relating to quality of care issues addressed by the accreditation standards.

**Supportive activities**

1. Sponsors education programs
2. provides relevant publications
3. offers standards related educational support for the organizations it accredits
4. Comprehensive guide on the internet- Quality Check.

## 2. URAC (AMERICAN ACCREDITATION HEALTHCARE COMMISSION)

**Mission:** Central mission is to promote the accountability of health care organizations, especially organizations that provide managed care services.

Type of provider / service targeted

The entire spectrum of managed care services

1. HMOs
2. PPOs,
3. case management organizations,
4. workers' compensation managed care

**Nature of accreditation:** Voluntary

**Type of organization:** Nationally recognized, Non profit charitable organization. Method of setting standards: Member organizations of URAC, and experts from across the country debate and discuss what standards are appropriate for a particular aspect of managed care. The standards development process is very inclusive and broad-based.

**Method of assessment:**

URAC offers ten different accreditation programs for managed care organizations, each focusing on a different aspect of managed care.

1. Submit documentation of compliance with each standard.
2. This documentation is then reviewed by a member of urac accreditation staff, who works with the applicant to resolve any issues that have been identified.
3. Urac staff then visit the applicant to ensure that its operations are consistent with the documentation submitted.
4. Finally, the application is reviewed by the accreditation committee and the executive committee, which are composed of representatives of urac's member organizations.

Compliance: Accreditation status may be rescinded if an accredited company is unable to comply with URAC Standards.

**Functioning of the body:** Include representation from the range of health care stakeholders: employers, consumers, providers, regulators, and health care organizations.

**Membership of the body:** URAC membership includes a balance of organizations representing providers, regulators, business, consumers, and the managed care industry and the worker's compensation

**Selection of assessors:** The Accreditation Committee consists of representatives from URAC member organizations and industry experts.

**Marketing:**

1. Encourage accredited companies to use the appropriate URAC accreditation logos on their printed materials,
  2. Communicate their accreditation status to member/patients, employers, purchasers, providers, and anyone else who deals with the company
- Length of programme: 2 years  
accreditation Policy/ legislative support: regulators in over half of the states recognize the URAC's accreditation, purchasers and consumers recognize  
Involvement of consumers:

1. URAC standards are widely circulated for public comment and beta-tested before they become final.
2. Web site NRCCPH

**Supportive activities:**

1. Research projects to assess and identify new approaches to improve performance measurement in a variety of health care settings.
2. Publishing cutting edge books on the health care delivery system.

## **AUSTRALIA**

### **3. ACHS (AUSTRALIAN COMMISSION ON HEALTHCARE STANDARDS)**

**Mission:** To develop a national system of accreditation for hospitals and continually improve the quality of health care in Australia.

**Short history:** Established as The Australian Council on Hospital Standards in 1974 by the Australian Medical Association (NSW Branch) and the Australian Hospital Association (Victorian Branch).

Type of provider / service targeted

- Public and private hospitals
- Community health care centres
- Aged care facilities
- Home and community nursing services
- Day procedure facilities
- Aerial medical services
- Ambulance services
- Rehabilitation centres
- Other health care providers

**Nature of accreditation:** Voluntary and not explicitly linked to third party payment.

**Type of organization :** Independent not-for-profit organization.

**Method of setting standards:** The ACHS Performance and Outcomes Service (POS) has a primary role of developing objective measures of the management and outcome of patient care in Australia's acute health care organisations. This has been achieved through collaboration with the various Australian Medical Colleges and associations, by developing clinical indicators'.

The ACHS POS has identified three basic requirements when developing clinical indicators:

1. That they be relevant to clinical practice
2. That the relevant data are available
3. That the measure is achievable

The development process which is followed by the POS when developing clinical indicators involves a series of stages.

**Type of standards:** Clinical indicators are defined as measures of the clinical management and outcome of patient care'. They are not exact standards against which hospitals must measure their clinical performance, but rather are designed as flags which can alert to possible problems or opportunities to improve patient care. They are a measurement tool to assist in assessing whether or not a standard in patient care is being met. Outcomes such as morbidity from particular procedures are measured by some indicators, while others measure processes, such as compliance with criteria for management of a particular condition. The sets of indicators are reviewed annually with the relevant College and additions, deletions or enhancements are made.

### **The ACHS Evaluation and Quality Improvement Program**

EQuIP provides a framework for effective delivery of health services. The ACHS Education and Support Service aims to help organisations improve the quality of care they deliver using the ACHS Evaluation and Quality Improvement Program (EQuIP).

Effective use of EQuIP requires the whole organisation to be committed to improving its performance and assists health care organisations to:

- develop strong leadership
- enjoy a culture of continuous quality improvement
- focus on customers
- focus on outcomes
- strive to be the best
- improve overall performance

**Selection of assessors:** Recruited from the senior ranks of the health care industry, most of whom are volunteers. . A rigorous selection process is applied to eligible candidates, (at least five years' recent experience in a health care organization at a senior level). Initial appointments are made for two years after which a review determines reappointment for a further term of four years. Volunteer surveyors make a commitment to ten days of surveying per year.

**Training of assessors:** assessors attend annual update sessions and, for newly appointed surveyors, orientation sessions. Surveyors are required to comply with a Code of Conduct. Performance criteria are monitored regularly and organisations are asked for formal feedback on various aspects of their surveyors.

**Involvement of consumers:** A cohort of consumer surveyors will be trained in the coming year. Initially the consumer surveyors will take part in the accreditation of mental health organisations.

#### **Supportive activities**

1. Present a national education program
2. Advise and consult on health care quality improvement
3. Publish books and other resource materials
4. Offer library and information services on quality in health care



## **NEW ZEALAND**

### **4. HEALTH ACCREDITATION PROGRAMME FOR NEW ZEALAND (HAPNZ)**

**Mission** : Promote, measure and recognize quality and to promote excellence in the health and disability support sector. It provides the framework for establishing and maintaining quality care, services and safety.

**Short history**: HAPNZ has been developed by Quality Health New Zealand. It's standards incorporate the features of ISO9001 relevant to health and disability services. The Quality Health model has been developed for health services, is written in health and disability terminology, and has over 70 years of practical experience.

**Type of provider / service targeted**

- Hospitals,
- Rest homes,
- Mental health services,
- Community and home care services,
- Hospices,
- Voluntary welfare organisations,
- Primary care services,
- Maori health providers and
- Retirement villages

**Nature of accreditation**: a voluntary program used by providers to guide the complex process of quality improvement;

**Type of organization**: Independent non-profit incorporated society established by the health sector  
**Method of setting standards**: Developed in consultation with providers, consumers, funders, and professional organisations and medical colleges, and thus have credibility with them.

**Type of standards:**

The whole spectrum of client service –  
Clinical standards,  
Client rights,  
Management and clinical systems, and Management leadership.

**They cover all the dimensions of quality –**

Access, Appropriateness, Participation, Effectiveness, Efficiency Safety and Continuity, and incorporate a strong consumer focus.

They meet the requirements of the health and disability sector standards.

A set series of 5 criteria are available for each of the 48 indicators that cover all the domains suggested by the Goodfellow Quality Assurance Unit. Some of these indicators include minimum standards, reflecting legislative requirements and the criteria that are

regarded by the practice standards working Party as critical. Other criteria and their standards are goals that give practices a range of ideas about what could be achieved and not necessarily what should or must be achieved.

#### **Method of assessment:**

The purpose of the Quality Health model is continuous quality improvement, not just compliance with minimum standards. HAPNZ member organisations are guided and supported by Quality Health through a three year cycle comprising of the following elements

1. CLIENT SERVICE PLAN: This plan details services to be provided by Quality Health
2. SELF-ASSESSMENT: Of achievements and outcomes regularly to improve performance. Six months before a survey and a progress visit, to complete and return a self-assessment to Quality Health
3. SELF-ASSESSMENT SUPPORT SERVICE
4. **SURVEY:** Organization-wide survey by health peers who provide feedback on overall performance. They review
  - Documentation
  - Interviews with directors, managers, committees and service teams;
  - Observation; assessment of client care through reading clinical notes;
  - Discussions with clients and families; and discussions with managers and health practitioners to verify any provisional findings.

Surveyors assess:

- whether organisations have selected indicators which reflect the services they provide,
- data collection and verification processes used, how the organisation has determined if further action or review is necessary, what
- specific actions and reviews implemented to improve the quality of patient care as a result of indicator monitoring,
- the outcomes

#### **5. SURVEY REPORT**

##### 6. QUALITY ACTION PLAN

After receiving the survey report, organisations are requested to draft a Quality Action Plan (QAP) that specifically addresses the surveyors' recommendations within a timeframe.

##### 7. QUALITY HEALTH NEW ZEALAND ACCREDITATION

Organisations that successfully achieve Quality Health New Zealand standards through participation in HAPNZ

##### 8. ANNOUNCEMENT OF ACCREDITATION

PROGRESS VISIT-18 months after the survey, designed to support ongoing quality improvements, confirm standards are being maintained or exceeded, review the organisation's achievements and outcomes in relation to its quality action plan, and assist with interpreting the intent of the standards.

This is in sharp contrast with most other quality certification models which tend to be inspectorial in nature, mandated by purchasers, and concerned with minimum compliance with contractual or statutory requirements. ACCREDITATION - A JOURNEY, NOT AN ENDPOINT.

Compliance: Awarding accreditation status and other certificates of endorsement and achievement Accreditation may be withdrawn should action not be taken to address recommendations within the agreed timeframe.

**Membership fees:** Based on the size and complexity of organisation, staged over a three year period, the annual membership fee is fixed for three years on joining the programme. Membership entitles the organisation to one survey in a three year period.

**Selection of assessors:** Our surveyors are health professionals who provide a largely voluntary service. Leading health practitioners and managers, not full-time auditors who are detached from the "real life" issues of service delivery.

**Supportive activities:** HAPNZ membership provides the following tools and services over a three year cycle:

- Self-assessment tool tailored for your services
- Accreditation standards appropriate to your services
- Self-assessment support
- On-site planning visit and education session for staff on HAPNZ and accreditation
- Assisted development of quality action plan
- 20% discount on scheduled Quality Health education workshops and publications
- 30% discount on a pre-survey review
- Public relations support
- Access to the Quality Health quality network
- Internet membership support network (still to be developed)
- HAPNZ forums and conferences.

Additional standards and education sessions are at the member organisation's cost.  
Information provision: Clinical Indicator Comparative Results Service

**Support to hospitals:** Work in partnership with health providers - to assist them to improve the quality of care and services they provide to their clients.

## CANADA

### **5. CANADIAN COUNCIL ON HEALTH SERVICES ACCREDITATION (CCHSA)**

**Mission:** To promote excellence in the provision of quality health care and the efficient use of resources in health organizations throughout Canada.

**Short history:** The CCHSA was incorporated in 1958 to set standards for Canadian health care organizations and assess their compliance against these standards.

**Type of provider / service targeted: Has specific accreditation programs for**

Acute care,  
Long term/continuing care,  
Mental health, rehabilitation,  
Community health,  
Regionalized health organizations,  
Cancer treatment centres,  
Home care and  
Regional health organizations.

**Method of setting standards:** Collaboration with the health care community and related stakeholders..

**Type of standards:** The assessment is designed to address processes, outcomes, and structures with the focus on continuous improvement within the health service delivery system. One of the requirements of CCAP is that organizations identify and monitor performance indicators as part of their efforts to improve the quality of their care and service. Council is most interested in how teams develop, use, and refine performance indicators {{ performance of their core processes (client care, support services, leadership and management) and outcomes}} that are meaningful to them and to their clients.

**Method of assessment:** Peer review and a self-assessment process that focuses on ways to continuously improve the health care system. The survey is planned in partnership with the organization and recognizes areas of excellence as well as areas for improvement. The principle of self-assessment is the fundamental basis of accreditation. It serves as the mechanism by which an organization can assess its own performance, on an ongoing basis, against a set of nationally developed standards.

CCHSA does not use the indicator data to make an assessment of an organization's performance as there is insufficient knowledge about the relationship between indicator results and quality of care and services.

**Selection of assessors:** There are 4 steps in the surveyor selection process as outlined below.

1. Application
2. "360-degree" reference check. Confidential references are required

An interview - thorough assessment of their suitability to surveyor candidates.

3. Behavioural assessment (during orientation)

4. Internship: On successful completion of all elements of the selection process

The internship phase spans two surveys. At the conclusion of the internship period, council will make a decision about appointment as a full surveyor. A competency dictionary provides complete descriptions of the CCHSA surveyor competencies.

**Training of assessors:** CCHSA has a credentialing process for surveyors and provides ongoing education and evaluation of surveyors. Council has established a Code of Ethics to govern the behaviour of individuals carrying out the functions/activities of Council.

**Other activities:**

The AIM Project is under way to:

Revise the framework of the accreditation program, the standards, indicators, rating scale,

survey, supporting material, survey report, and accreditation recognition.

The revised standards will continue to assess the following within an organization:

The quality of care and service, leadership, and support services

Quality improvement

Risk management.

Development of standardized performance indicators. The revised accreditation program will assess how well organizations use the indicator data to understand and improve their processes and outcomes.

## UNITED KINGDOM

### 6. HEALTH QUALITY SERVICE (previously The King's Fund Organizational Audit)

**Mission:** To improve quality of management in the NHS

**Short history:** The King's Fund Organisational Audit was created in 1989, to evaluate general hospitals. Became an accreditation program in 1995, 4 years after being launched as an organizational development initiative.

**Type of provider / service targeted**

Acute general hospitals and teaching hospitals Mental health, learning disabilities, community services units

**Nature of accreditation:** Voluntary

**Type of organization :** Independent health care charity.

**Method of setting standards:** Continual revision of standards by specialists and working groups.

**Type of standards :** Focus on organizational systems and processes for the delivery of health care.

**Method of assessment**

Internal assessment of systems and processes in the delivery of health care.

1. Voluntary application by hospital
2. Assigned co-ordinator from the KF assists the hospital through 12 months of preparation for the final survey
3. Steering group appointed within hospital, participatory learning
4. Mock survey, then the final survey
5. Surveyors write down their impressions and discuss with hospital authorities.

Compliance: Awarding or deferring accreditation

Financing of the body: The program covers basic operational costs, with some overheads being subsidised by the charity, king edward's hospital fund.

## **7. TRENT ACCREDITATION SCHEME**

**Mission:** Development for organisations and staff.

**Short history:** Evolved from the HAS, but is now, entirely separate.

**Type of provider / service targeted:** Community hospitals and other services.

**Nature of accreditation:** Voluntary.

**Type of organization:** Operates in the trent region.

**Method of assessment:** Submission of documentation from the participating facility.

1. Pre-survey by the lead surveyor.
2. Main survey, lasting 2-3 days
3. Includes a night visit.

**Compliance:** The board awards full, conditional or deferred accreditation, based on the survey report, which includes recommendations for change, some of which are compulsory in order to achieve accreditation and commendation of good practice.

**Membership of the body:** Members of the board include CEO's, consultants, senior nurses and GP's from across the region.

**Financing of the body:** Funded within the NHS, on a budget of £30,000 per annum, and at present, is free to participants.

**Selection of assessors:** elected from participating trusts, on recommendations of their CEO's, must have relevant experience as hospital managers or other senior professional within the NHS. The scheme is managed by a core staff of two with around 70 voluntary external peer reviewers.

**Training of assessors:** They are assessed and attend annual training workshops run by the TAS.

**Involvement of consumers:** Surveys may involve patients and public

## United Kingdom

### 8. HEALTH SERVICES ACCREDITATION

**Mission:** Its purpose is the identification and publication of National Service Standards for adoption within the NHS, and the objective measurement of their practical achievement through a freely available Accreditation Programme.

**Short history:** Health Services Accreditation (HSA) is a programme developed and operating within the United Kingdom National Health Service (NHS). It was established under the aegis of the UK Department of Health. A new organisation, United Kingdom Accreditation Federation (UKAF) is being developed to draw together the mutual interests of more than 30 accreditation organisations.

**Method of setting standards:** Developed by working groups of health care professionals, represented by the royal colleges and other professional bodies, and patient representatives.

**Type of standards:** Specific, achievable, clinical standards, reflecting EBM. Assesses specific areas of health care and their supporting services.

**Method of assessment:** A HSA accreditation visitor and a clinician from the appropriate field, confirm or deny the evidence gathered by staff to demonstrate achievement of the standards it claims to meet.

**Compliance:** Rather than awarding an accreditation, HSA presents the service with a statement of endorsement, listing all possible standards and specifying which are met by that service.

**Functioning of the body:** Run by 11 full time staff, and up to 2000 health care workers have contributed to the development of standards. Based on the internet, the HSA co-operative links. health care providers, health authorities, representatives of patient interests and individual clinicians and managers who develop the programme and use its materials.

**Financing of the body:** A total of 19 modules in service areas are available, each of which costs between £1500 and £2350, which together with the central NHS finance funds the scheme.



### **Annexure-3**

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## **Annexure 4**

### **GLOSSARY of TERMS**

**EFFECTIVENESS:** The extent to which something achieves its aim.

**EFFICIENCY:** Delivering maximum services with minimum expenditure of resources.

**EQUITY:** Ensuring fairness and lack of discrimination in access to health.

**HEALTH SERVICES:** All services designed to improve health and well- being.

**INDICATOR:** Aspect of service selected for measurement.

**MANAGEMENT QUALITY:** Most efficient and productive use of resources.

**MEASUREMENT:** A numeric value given to an attribute which facilitates comparison with standards.

**MONITORING:** Observation and recording of events over time.

**MULTI-DISCIPLINARY TEAM:** A group of people working together from different professions.

**OUTCOME:** The end result of effect of care

**PATIENT QUALITY:** What the patient expects from health services

**PATIENT SATISFACTION:** Extent to which patient expresses positive attitudes to health services in general

**PEER ASSESSMENT:** A process whereby the performance of an organisation, individuals or groups are evaluated by members of similar organisations or the same profession or discipline and status as those delivering the services"

**PROCESS:** All components of health care delivery including diagnosis, treatment, after care etc

**PROFESSIONAL QUALITY:** Whether health services meet the needs as defined by professional standards

**QUALITY:** The degree of excellence or fitness for purpose of a service

**QUALITY ACTION TEAM:** A group of people working together to identify and implement procedures for quality improvement.

**QUALITY ASSURANCE:** A systematic and planned approach to assessing, monitoring and improving quality of health services within available resources constraints on a continuous basis.

**QUALITY ASSURANCE CYCLE:** Sequence of related activities comprising of appraisal, action and improvement.

**QUALITY SYSTEM:** Defines the roles, responsibilities and procedures within the organisation in order to ensure that staff are able to and do carry out quality assurance.

**STANDARD:** Specification of expected or desired measurable attributes of a product or service.

**STRUCTURE:** Availability and quality of human and physical resources.

**TARGET:** Statement of expected performance