राजस्थान सरकार
राष्ट्रीय स्वास्थ्य मिशन राजस्थान,
चिकित्सा, एवं परिवार कल्याण विभाग, स्वास्थ्य भवन, तिलक मार्ग,
राजस्थान, जयपुर फोन नं. 0141–5110731, E mail ID : kayakalp.raj@gmail.com

क्रमांकः– F 50 (1) NHM/QA/2018/491 दिनांकः– 4/6/18

समस्त प्रधानाचार्य एवं अधीक्षक
मेडिकल कॉलेज एवं सम्बद्ध अस्पताल।

विषय :–राजकीय चिकित्सा संस्थानों में Infection Control and Quality Control Practices बढाने हेतु Culture Samples का Microbiological examination करवाने के सम्बन्ध में।

स्वास्थ्य एवं परिवार कल्याण मंत्रालय, भारत सरकार राजकीय स्वास्थ्य सुविधाओं पर गुणवत्ता आश्वासन कार्यक्रम (Quality Assurance) हेतु सहायता एवं सुगमता के लिए प्रतिबद्ध है जो कि राष्ट्र में जनस्वास्थ्य तंत्र की आवश्यकताओं को पूर्ण करे। प्रस्तावित Quality Assurance कार्यक्रम का मुख्य उद्देश्य राजकीय चिकित्सालयों में आने वाले रोगियों में संतुष्टि स्तर को बढ़ाना है एवं उनमें विश्वास जगाना है। यह मुख्यतया उन क्रियाकलापों को सम्मिलित करता है जिसमें गुणवत्ता मापदण्डों का निर्धारण एवं मापदण्डों के अनुरूप सेवाओं का मूल्यांकन एवं गुणवत्ता में सुधार करना है जिससे कि सेवाओं को प्रभावी एवं सुरक्षित बनाया जा सके।

इस कार्यक्रम में चिकित्सा संस्थानों के दो इर्न्टनल असेसमेंट कराये जाते है इसके पश्चात राज्य स्तर पर प्रशिक्षित टीम द्वारा चिकित्सा संस्थानों का असेसमेंट किया जाता है तथा जिन चिकित्सा संस्थानों को 70 प्रतिशत से ज्यादा अंक प्राप्त होते है उन चिकित्सा संस्थानों को स्टेट सर्टिफिकेट दिया जाता हैं तथा इसके पश्चात भारत सरकार द्वारा असेसमेंट कर 3 वर्ष का नेशनल सर्टिफिकेशन तथा 10,000/– रूपये प्रति बैड का Cash Incentive प्रतिवर्ष दिया जाता है।

उक्त कार्यकम से संबंधित लगभग 5000 बिन्दुओं पर बनी चैकलिस्ट में विशेष रूप से Infection Control Practices पर जोर दिया गया है। भारत सरकार द्वारा निर्धारित मापदण्डों तक पहुँचने के लिए विभिन्न विभागों (OT/ICU/NBSU/SNCU/Labour Room etc.) के Culture Samples का Microbiological examination मेडिकल कॉलेज एवं सम्बद्ध अस्पतालों द्वारा करवाया जाना है ताकि Quality Control एवं Infection Control Practices को सरकारी चिकित्सा संस्थानों में लागू किया जा सकें।

अतः आप सरकारी चिकित्सा संस्थानों से प्राप्त Culture Samples का जिले के मेडिकल कॉलेज एवं सम्बद्ध अस्पताल के Microbiology department के माध्यम से examination तथा Monthly Report अतिशीघ्र संस्थान तक भिजवाना सुनिश्चित करावें ताकि Quality Control समयानुसार किया जा सकें।

संलग्न प्रति

शासन सचिव
चिकित्सा स्वास्थ्य. एवं प.क. एवं
मिशन निदेशक, एनएचएम

क्रमांकः– F 50 (1) NHM/QA/2018/491 दिनांकः– 4/6/18

प्रतिलिपिः–

1. निजी सचिव, अतिरिक्त मुख्य सचिव, चिकित्सा स्वास्थ्य, एनएचएम।
2. निजी सचिव, प्रमुखसचिव, मेडिकल कॉलेज (शिक्षा)।
3. निजी सचिव, मिशन निदेशक, एनएचएम।
4. निजी सहायक, अतिरिक्त मिशन निदेशक एनएचएम।
5. निदेशक वित्त, एनएचएम।
6. निदेशक जनस्वास्थ्य/ आरसीएच।
7. परियोजना निदेशक एनएचएम।

Email-kayakalp.raj@gmail.com

8. डॉ रामबाबू जायसवाल, राज्य नोडल अधिकारी (क्वालिटी एश्योरेंस एवं कायाकल्प), एन.एच.एम।
9. राज्य कार्यक्रम प्रबन्धक, एन.एच.एम.।
10. सयुक्त निदेशक, समस्त संभाग।
11. समस्त मुख्य चिकित्सा एवं स्वास्थ्य अधिकारियों को भेज कर लेख है कि वे समस्त चिकित्सा संस्थान के Culture Samples का Microbiologcal examination मेडिकल कॉलेज एवं सम्बद्ध अस्पताल से करवाया जाना सुनिश्चित करावें।
12. समस्त प्रमुख चिकित्सा अधिकारियों को भेज कर लेख है कि वे अस्पताल के विभिन्न विभागों के Culture Samples का Microbiologcal examination मेडिकल कॉलेज एवं सम्बद्ध अस्पताल से करवाया जाना सुनिश्चित करे।
13. समस्त जिला कार्यक्रम प्रबन्धक।
14. सलाहकार – आईटी सम्बन्धित को ईमेल हेतु।

परियोजना निदेशक
एनएचएम

SECTION A

UNDERSTANDING QUALITY ASSURANCE

Introduction to **QUALITY**

The National Rural Health Mission (NRHM) was launched in the year 2005 with the goal " to improve the *availability of and access to quality health care for people, especially for those residing in rural areas, the poor, women and children.*" The Mission has led to considerable expansion of health services through rapid expansion of infrastructure, increased availability of skilled human resources and greater local level flexibility in operations, increased budgetary allocation and improved financial management. However, improvement in Quality of health services at every location has not been perceived, generally.

Perceptions of poor quality of health care may, in fact, dissuade patients from using the available services because health issues are among the most salient of human concerns. Ensuring quality of the services will result in improved patient / client level outcomes at the facility level.

Ministry of Health and Family Welfare, Government of India is committed to support and facilitate a Quality Assurance Programme, which meets needs of Public Health System in the country and is sustainable. Main focus of proposed Quality Assurance Programme would be enhancing satisfaction level among users of the Government Health Facilities and reposing trust in the Public Health System.

2.1 Quality in Health Care

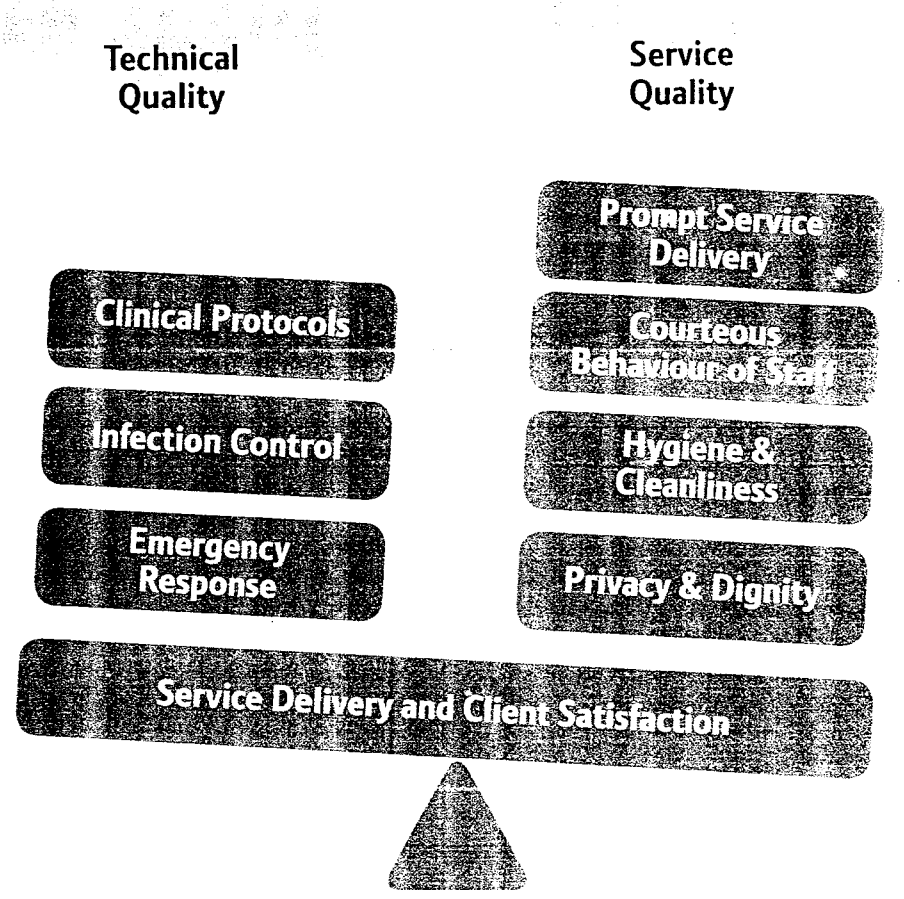
Quality in Health System has two components:

Technical Quality: on which, usually service providers (doctors, nurses & para-medical staff) are more concerned and has a bearing on outcome or end-result of services delivered.

Service Quality: pertains to those aspects of facility based care and services, which patients are often more concerned, and has bearing on patient satisfaction.

Few common issues have been elaborated in Figure 2.1.

Fig 2.1: Sub-Components of Quality



Working definition- WHO defines Quality of Healthcare services in following six subsets:

a. **Patient-Centred:** delivering health care, which takes into account preferences and asp of the service users, and is in congruent with their cultures. It implies that patients are a dignified and courteous behaviour. Their reasonable belief, practices and rights are res

b. **Equitable:** delivering health care which does not vary in quality because of p characteristics such as gender, caste, socioeconomic status, religion, ethnicity or geog location.

c. **Accessible:** delivering health care that is timely, geographically reasonable, and provi setting, where skills and resources are appropriate to the medical need.

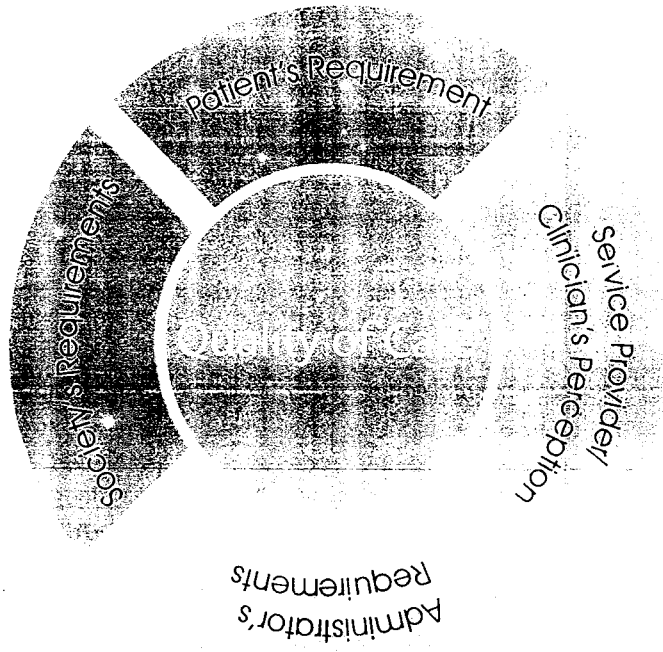
d. **Effective:** delivering health care that is based on the needs, and is in compliance to a evidences. Therefore, observance of treatment guidelines and protocols is impor ensuring the quality of care. The delivered health care results into the improvec outcomes for the individuals in particular, and community in general.

e. **Safe:** delivering health care which minimizes risks and harm to the users.

f. **Efficient:** delivering health care in a manner which maximizes productivity out of the d resources. The wastes are avoided.

2.2 Quality as Perceived by Different Stakeholders

Although everyone values quality, but perceives it differently. Patients, Communities (Society), Cl and Administrators have different definitions of quality.



Patient's Requirement: Although patients are deeply concerned, how good clinical care is, but very often, they themselves are not able to judge the technical aspect of the care. Patients are mostly concerned about the issues, other than clinical guidelines & protocols. Usual expectations of patients are given in the Table 2.1.

TABLE 2.1: EXPECTATIONS OF PATIENTS

Care	Cure
1. Clean and inviting atmosphere	1. Correct, speedy, low cost & lasting treatment
2. Courteous behaviour	2. Emergency response
3. Personalised approach	3. No new diseases
4. Psychological well-being	4. No harmful procedure/complication

Users' experiences of health care in a facility, whether personal or shared, have a major impact in their decision of seeking the services at a particular facility. People do not wish to go to a facility where they receive rude treatment.

Society's Definition: At the broader societal level, the definition of quality of care reflects concern of cost effectiveness, equal access and equity in service delivery, transparency and extent of out of pocket expenditure. Society also perceives quality in terms of protection of health rights specialty of marginalized and vulnerable populations.

Healthcare Providers: Clinicians, who provide healthcare services, tend to equate quality of care with technical performance. Often for health care providers, the desired outcomes are related to successful treatment of patients with reduction in morbidity, mortality and disability limitation. For example, doctors' expectation of quality services is that investigation reports are available on time, drugs are available in the dispensary, and patients are getting cured timely.

Governments/Administrators Definitions: An administrator perceives quality in terms of optimal and rational utilization of resources, maximum satisfaction by the users of health facility, delivery of all components under the health programmes, compliance to treatment guidelines & clinical protocols, and improvement in the health status of population.

Framework of **QUALITY OF CARE** (QOC)

3.1 QOC

Well frame-work for assessing the quality of care on the well accepted '*Donabedian mo* classifies QOC in terms of three aspects – structure, process, & outcome.

a. Structure: Structural aspect of QOC includes material resources like infrastruc and equipment; and Human Resources such as availability of adequate number o who have requisite knowledge and skills. Evaluation of the quality that reli structural elements implicitly assumes that well qualified people with well app well organized settings will provide high quality care. However, it is not alwa Also, it is acknowledged that in the Public Health System, full compliance to ir and HR norms may not be possible. However, after meeting the minimum infrast HR norms for a Public Health Facility, it would be logical to expect a minimum q available services at the Public Health Facility. The proposed system strives to p within these constraints.

b. Process: Care can also be evaluated in terms of processes & sub-processes, delivery the care. This refers to what takes place during its delivery – such as registration of a patient is done, and s/he is attended, courteous behaviour o providers, especially of doctors & nurses, conduct of examination with respec confidentiality and for patient's right, etc.

c. Outcome: The other aspect of quality of care can be assessed in terms measurements, which denote to what extent goals of the care have been achi

All three aspects of the QOC have different connotation to different stakeholders, viz. Pat providers and Health System, as given in Table 3.1.

TABLE 3.1: QOC IN TERM OF INPUTS, PROCESS & OUTCOME

Stakeholders	Inputs	Process	Outcome
Patients' Expectations	▪ Barrier Free Access - Prompt & courteous services - No exclusion on the basis of caste and socio-economic status ▪ Clean & Inviting environment at the health facility ▪ Availability of services ▪ Availability of drugs and consumables	▪ Minimal waiting time & Prompt referral, if required ▪ Good behaviour by service providers ▪ Privacy & confidentiality ▪ Grievance Redressal ▪ Access to Information and involvement in decision making for the care	▪ No out of pocket expenditure ▪ Availability of services as guaranteed ▪ High Patient Satisfaction ▪ Treatment and Cure
Service Providers Requirements	▪ Adequate and planned infrastructure ▪ Serviceable & calibrated Equipment ▪ Availability of Quality Drugs ▪ Human Resource in numerical adequacy with knowledge and skills ▪ Enabling Work Environment	▪ Adherence to clinical Protocols ▪ Infection Control Practices ▪ Training and Skill Development ▪ Safe and effective Nursing care	▪ Low Mortality, Morbidity, complications, and Referrals, etc. ▪ Effectiveness of the care in term of average length of stay, bed occupancy, etc. ▪ Adverse drug reactions and Hospital acquired infection ▪ Employees' Satisfaction
Health Systems Requirements	▪ Allocation of adequate resources ▪ Facilities provide full range of services ▪ Adequate Technical Support	▪ Efficient logistics management ▪ Monitoring and Supervision ▪ Effective implementation of programmes	▪ Optimal utilization of resources ▪ Measurable deliverables of programmes ▪ Improvement in Health Indicators ▪ Enhanced Productivity in terms of volume

3.2 Quality Assurance

American Society for Quality refers to Quality Assurance as "*planned and systematic activities, which are implemented in a quality system, so that quality requirements of a product or service would be fulfilled*". It essentially entails doing a set of activities that include defining quality standards and assessing, monitoring and improving the quality of services against those standards, so that the care provided is as efficient, effective and safe as possible.

Four Principles of Quality Assurance

- Quality Assurance is oriented toward meeting the needs and expectations of the patients.
- Quality assurance focuses on the systems and processes.
- Quality assurance uses data to analyse service delivery processes.
- Quality assurance encourages a team approach to problem solving and quality improvement.

Quality Assurance (QA) in Public Health is a cyclical process involving following major compo

a. Setting up Standards and Measurable elements.

b. Assessment of health facilities against the set standards.

c. Analysing the problems.

d. Preparing and implementing action plan.

3.3 Quality Improvement (QI)

Quality improvement is an interdisciplinary process, which is designed to raise the stan delivery of diagnostic, therapeutic, rehabilitative and preventive measures in order to r restore or improve health outcomes of individuals and population. It also looks at the c of facility treatment – courteous behaviour, clean premises, minimal waiting time, patien etc.

Critical steps of Quality Assurance:

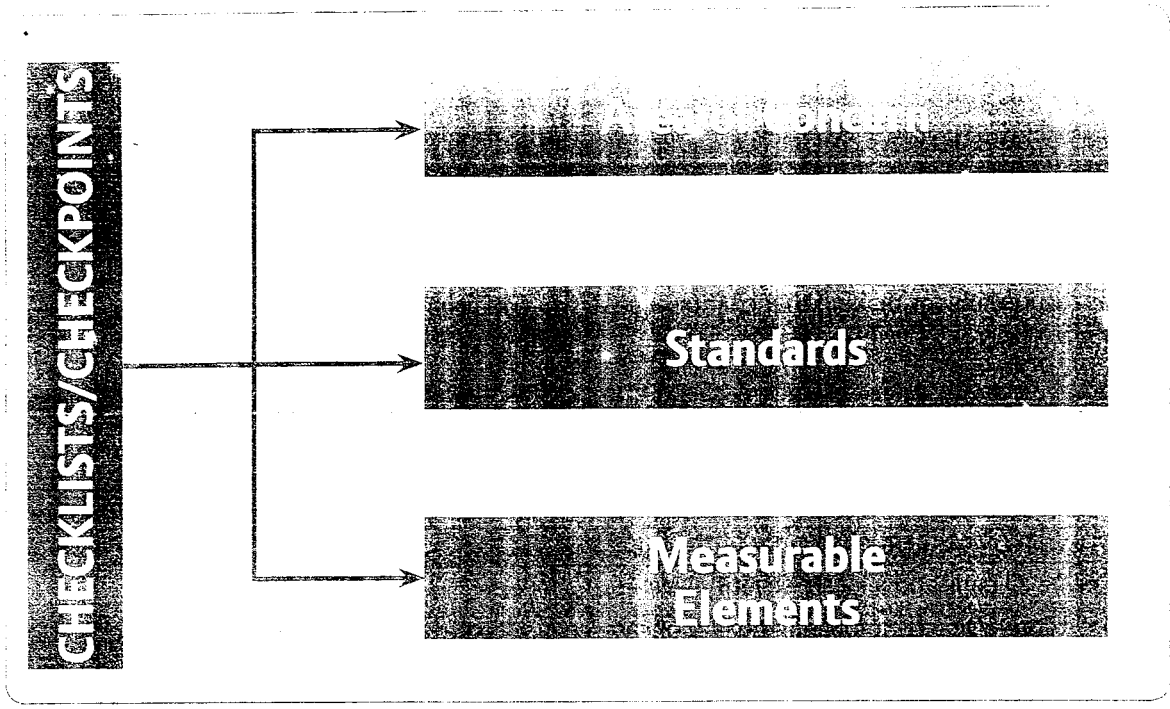
Following steps would be required to be taken for implementing a credible Quality at Public Health Facilities -

a. **Setting up Quality Standards, Measurable Elements & Check-lists:** To provide cor high-quality services, the foremost requirement is to set quality standards against w performance can be measured. These standards must meet the specific requirements health system and encompassing all three aspects of Quality of care i.e. Structure, Pro outcome.

Action planning for the gap assessed against checkpoints needs to be fulfilled within a set time frame and assigned a score during the assessment process. These checkpoints would be compiled in form of departmental check list, so the compliance to all relevant standards for a department of healthcare facility can be checked systematically, objectively and in a user-friendly way. This process should be reviewed periodically for compliance and further improvement. The checkpoints can be of two types, 'essential', one which are non-negotiable and would be required to be adhered by the facility for being quality certified and 'desirable' wl optional and should be fulfilled in due course.

QA was first introduced into mo medicine by a British nurse, Flor Nightingale, who assessed the quality of care in military hospit She introduced the first standarc in nursing care; these resulted in dramatic reductions of mortality in hospitals.

For example, one of the standards for RCH services would be "Facility has established pro for Antenatal care as per guidelines". For this standard there would be a set of mea elements and further checkpoints that would objectively assess the compliance to this st and score antenatal care at the facility accordingly. The assessment would be done with assessment tools e.g. Check list for OPD, Laboratory Services, Pharmacy, etc. where all r checkpoints pertaining to Antenatal care would be arranged according to standards and mea elements.



Relationship Between different elements of measurement system

Quality Assurance Standards have been developed at national level which have 70 standards categorized into 8 broad areas of concern i.e. Service provision, Patient Rights, Input, Support Services, Clinical Care, Infection Control, Quality Management and Outcome.

A set of Standards & Measurable Elements for a District Hospital is given in **Section 'D'**. Checklist for measurement of these standard are given in Assessors Guidebook.

b. **Quality Assessment:** This is an activity that measures various elements of service provision against pre-determined standards of care. Such an assessment provides an understanding of the areas where the actual position falls short of the set standards. It includes both periodic reviews in terms of internal scoring of a health facility, followed by assessment by the external assessors, who themselves are not directly responsible for the implementation, so as to avoid a 'conflict of interest situation'.

c. **Identification of gaps and areas of improvement** is an important and integral part of assessment. It is also important to conduct a 'root-cause analysis' of the observed gaps, so that real & sustainable solutions are found. Gaps should be categorised in term security viz: High, moderate, Low.

d. **Action planning:** The most important step following the 'assessment and gap identification' is developing **time bound action plan** for traversing the gaps. Action planning for critical gaps and low hanging fruits should be prioritised.

   It is imperative that for each gap found above, corrective measures are defined along with the person responsible to take action and the time frame for the same. If the observed gaps are many, phased action plan may be developed.

e. **Follow-up Assessment:** After passage of an agreed time-frame, **follow-up assessment** is required to be done to ensure that the plan has been adhered and the gaps have been closed. As the elements related to quality are dynamic in nature, gaps may be found in those areas

also, where none existed in the past /previous assessment (s). Therefore it is impo repeatedly assess a facility for incremental changes for the improvement.

What does not work?	What works?
While external pressures and punitive measures may bring about initial improvement in the desired direction, no change can be sustained till the people responsible for making that change accept it as their own.	At the facility, a motivated team, which understands the need for quality and the standards set for it. It strives to make the needed changes within its capacity, and ensures that it remains that way.

Summary of Assessment Process:

1. Make an Assessment of severity of the Gaps
2. Collate all gaps and allocate severity level
   a. High – Directly impacting quality of care - e. g. closure of Operation Theatre
   b. Moderate – Indirectly impacting quality of care – e. g. Non-segregation of Biomedical
   c. Low – May impact quality of care – e. g. Non-calibration of scale
3. Phasing of Actions – Initially action planning for high priority gaps should be done
4. Allocate resources, define timeline and allocate responsibility
5. Review progress
6. Plan for preventive Action

Points to Remember .....

- Quality Assessment is a cyclical process.
- It is a **continuous** process, and not a one-time effort.
- It is an **incremental** process where improvements are added with each cycle.
- It is primarily an **internal** process, driven by motivated staff of the facility.

1 **Setting up Organizational Framework**
(Merger/Reconstitution of DQAC, SQAU, DQAU, DQAU, DQT etc.)

2 **Empanelment of Assessors**

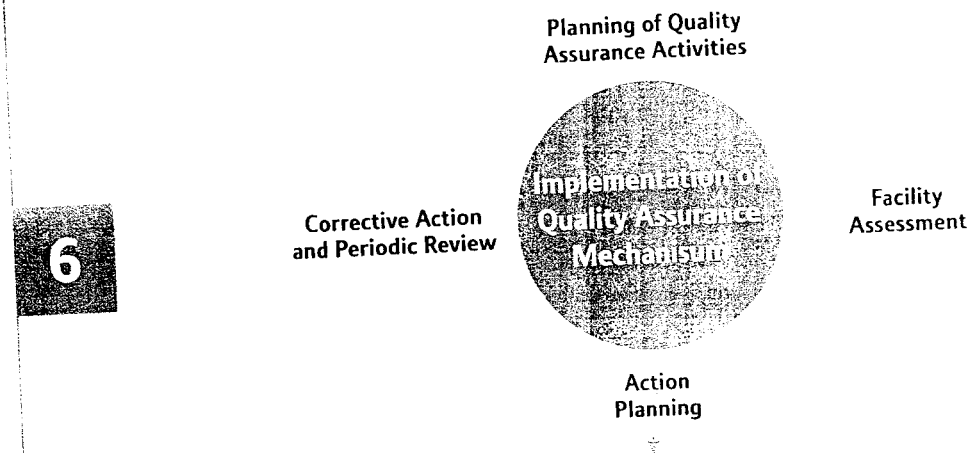
3 **Adaptation of Standards and Measurement System**
(Customization of measurable elements, Checklist and scoring system as per state needs

4 **Training and Capacity Building**
(Awareness workshop, Assessor Training, External Assessor Training, Training for Servic
providers)

5 **Facility Level Quality Improvement**

- Internal Assessment
- Key Performance Indicatiors
- Rapid Improvement Events
- Standard Operating Procedures
- Patient Satisfaction Survey
- Quality Policy & Objectives
- Medical & Death Audits
- Calibration & EQUAS

6



7 **Certification & Accreditation**

DQAC recommends to SQAU for State Level Certification

On-Site assessment of & Certification by SQAC

SQAC recommends to Director NRHM for National Accreditation

Visit to facility by Empanelled assessors & NHSRC team for assessment

If score is more than 70% NHRSC recommends Director NRHM for Accreditation

Director NRHM issues the accreditation

8 **Sustenance & Incentives**
Facilitation and recognition of achievement Financial Incentives
Recertification after every three years