Quality & Accreditation: National & International Models

Day & Date:	Saturday, 7th May 2016
Time:	11:15 am to 12:15 pm
Venue:	Auditorium, Symbiosis International University, Lavale campus, Pune
Speaker:	Dr. Prabhu Vinayagam
Report prepared by:	Ms. Shivika Gupta, Student, MBA - HHM (2015-2017)
	Ms. Thia Sunny, Student, MBA - HHM (2015-2017)

Dr. Prabhu Vinayagam is the Founder and CEO of Alliance Asian Health and has been in the position of manager Director JCI Asia Pacific. He believes in transforming healthcare into high reliability organisation & this is the vision of Alliance Asian Health. We have always come across many cases where due to medical negligence patient dies. If we want to go into next level of healthcare delivery system in India, this won't be acceptable. Healthcare has to work holistically to reduce medical errors in hospitals. Thus a change and transition is needed to bring high reliability organisation where accountability also plays a very crucial role.

The journey of healthcare as you recollect was that the doctor and nurse played a very critical role and the advice given was accepted, but now this has change patient are well informed about the disease pattern and the outcome. So the need of this hour is continuous improvement in the health which is also the key to success.

In Australian healthcare industry the accountability play more important role than knowledge, if the systems are in place than you do a better job and thus reliability is obtained.

If the system has proper structure, well defined processes then the outcome has to be fruitful. He also trusts in the fact that, "*If you want small changes, work on your behavior; if you want quantum leap changes, work on your paradigms."*

Dr. Prabhu Vinayagam showcased the good and bad thing globally in the past 50 years of medical fraternity, such as beta blockers for Heart attack patients, early elective deliveries, central lines infection control ,few accreditations and total quality management etc.

But Hospital care is more challenging due to complexity of system and this put patients into more risk for errors.

Routine safety processes fail such as

- Hand hygiene
- Medication administration
- Patient identification
- Communication in transitions of care

Uncommon, preventable adverse events such as

- Surgery on wrong patient or body part
- Fires in ORs, retained foreign objects
- Infant abductions, inpatient suicides

Thus High Reliability is the consistent performance at high levels of safety over long periods of time (Chassin, Loeb 2011).

We also see high reliability is needed in the most critical industry such as Nuclear power, aviation, petroleum and chemical industries, aircraft carriers, wildfire fighting, space flight where failure to perform can mean the death of some or all of the team. Challenges are faced by this organization also but the error are comparatively less when compared to healthcare.

High reliability means proactively sharing learning experience and information throughout the organization and to break down the silos. This has to be consistent procedure and the target should be on patient care and not on success.

The problem in the hospital is there is no cross functional interaction between different department, such as IPD, Radiology or Laboratory. One should understand the inter dependability of different department to work in uniform and trust, to reduce medical errors and adapt safety culture.

What is a Safety Culture of an organization? It is the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management. Organizations with a positive safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures.

Leadership required for safety culture can be achieved if there is trust and the weight of trust is that every error should be reported and awarded. Monitor compliance with the safety culture standards:

- Provide people and other resources
- Spend time on this; make it clear this is a priority
- Coach, inspire, communicate, motivate; a good CEO is acutely aware of the risks involved and is not irrationally optimistic that everything is ok
- Leaders give the signals on safety culture

Then the process can be changed to avoid the errors and patient safety can be assured. A safety culture within health care can be defined as the summary of knowledge, attitudes, behaviors and beliefs that staff share about the primary importance of the well-being and care of the patients they serve, supported by systems and structures that reinforce the focus on patient safety. Root cause analysis can be the done by identifying human and system error.

The safety culture standards compliance should:

- Have a patient safety plan
- Develop an annual report card
- Have a patient safety committee
- Educate all staff – near miss is an error
- Do we agree?
- Engage the board
- Engage the medical staff

Here Accreditation comes to your rescue and puts you in path to adopt the right processes. National and International Accreditation both strive for quality and patient safety. Dr. Prabhu

believes that the accreditation body should collaborate and work together. They are not over one another, instead it should be continuous power first national and then international standard measures can be implemented.

The strength of accreditation methodology are as follows:

- It is implemented organization-wide
- Focuses on systems, not individuals
- Stimulates quality culture in the organization
- Focus on improving structures e.g. facilities and staffing and reducing variation through more systematic implementation of processes
- Greater sustainability as it requires periodic re-evaluation against standards
- Incentive to improve to meet standards as accreditation standards are revised

There are various studies in JCI accredited hospitals of Spain, Jordan, Asturias which showed results of strategically significant improvements based on 3 indicators, return to ICU within 24 hours of discharge, Staff turnover per year, completeness of medical records and total annual savings per accredited hospital = $87,600.

He concluded the session by giving solution to how one can implement processes in its own organization. It cannot be just copy cut or paste from other association instead from your own culture built process that best suits the organization.