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Editorial

Accreditation of Armed Forces Hospitals: An Imperative now

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Accreditation of healthcare facilities has finally found its place in the Indian healthcare scenario. Though the global movement began in the early 1950 with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in USA, it took a few decades to permeate across other countries. In India, the seeds of accreditation of hospitals as a national effort were planted with the release of the 1st edition of Standards of the National Accreditation Board for Hospitals and Healthcare Providers (NABH) in 2006.

Hospital accreditation is a voluntary, externally observed conformance to laid down standards of an institution or organization by their peers in the industry. In legal terms, accreditation differs from certification.¹ Certification in this context is a process wherein the licensed certifying authority certifies and gives assurance regarding the availability of skill in a person or meeting the laid down requirement, standards or guidelines for a particular facility to operate.²

Accreditation therefore is at variance to certification by the following – accreditation is voluntary, assessment is against laid down/written standards which are recognized by a body authorized to carry out recognition of standards, assessment done by peers who are external to the organization being assessed, designed to stimulate continual improvement and periodic evaluation.³ Classically, accreditation is not just about standard setting – there are analytical, counselling and self improvement dimensions to the process. Simultaneously, the process of accreditation is also based on promoting the practice of evidence-based medicine, patient safety, quality promotion, protection of rights of the patients as well as clinical governance and management development. The overarching theme or purpose of accreditation of healthcare organizations is to continually improve its structures, processes and outcomes so as to ensure safety of the patients, environment, facilities and all stakeholders.

Accreditation of hospitals historically owes its genesis to Dr Ernest Codman who first proposed a mechanism to track patients being treated for tuberculosis at a sanitarium in England in 1910.⁴ This led to creation of the American College of Surgeons (ACS) in 1913. In 1918, the ACS began conducting onsite hospital inspections to determine facility-level compliance with the ACS internally developed documents – “Minimum Standards for Hospitals” – activities which presaged the formation of the Joint Commission on Accreditation of Hospitals (JCAH) 33 years later.⁵ The organization subsequently changed its name to the JCAHO in 1987–1988 and established the Joint Commission International (JCI) in 1994 to reflect an expanded scope of activities.

The early paradigm of managed care or prepaid group practice in the US led to the emergence of the Health Maintenance Organisations (HMO) which began to roll out health plans for their members. The external performance measurements of these emerging health plans were minimal and the dominant player was the JCAH which began offering accreditation to hospitals and published the first set of standards for hospital accreditation. In 1965, the US congress had passed amendments, which included JCAHO accreditation for hospitals to be eligible to participate in the Medicare and Medicaid programs. Various political, fiscal and social strategies of the governments of the times led to other countries also establishing their own standards for hospitals and healthcare provider accreditation. Many countries now have their own accreditation standards like Canada, Malaysia, Australia, Singapore, UK, France, etc. in addition to international arms of others like JCI. The Indian healthcare industry though had been participating in ISO Certification and JCI accreditation – in very small numbers over the past 12 years – yet developed the national standards under the Quality Council of India (QCI) through the NABH only in 2006.

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In the Indian context, healthcare services were in short supply and under such circumstances quality often takes a back seat.⁶ The early 1990s saw emergence of the corporate sector in healthcare which triggered the demand for “quality in healthcare”. In 2006, the first edition of the NABH standards was released and in the years since NABH has revised the standards every 3 years and currently the 4th edition of the standards are in use. These standards are promulgated once approved by the International Society for Quality Assurance (ISQua). To date, NABH has accredited 465 hospitals both private and public and 636 hospitals are in the process for accreditation. NABH carries out accreditation for different types of health care providers of different system of medicines (allopathy, AYUSH, dental, lab sciences, imaging centres, etc.).⁷ NABH has also established Pre-accreditation Entry Level and Progressive Level certification as a run up to a complete accreditation. In addition, there are various component programmes like SAFE-I and Nursing Excellence standards, which enable hospitals to approach the quality paradigm in incremental steps.

The process for accreditation begins with the decision of the management to seek accreditation for its hospitals. Thereafter, a series of events occur as per a schedule which is briefly enumerated below:

The applications and accreditation under NABH requires payments of some fees depending on the number of hospital beds and facilities.⁸

Relevance for Armed Forces Hospitals – Service hospitals have very strong foundations in quality of care due to well established SOPs, policies and rules. The documentation of

care, investigations, treatment and record keeping are all well established. Clinical decision making, ethical practice of medicine, disciplined work force all contribute to strengths of the service hospitals in extending quality care to its clientele.

However, the service hospitals are not uniform in their practice, and standardization of care-processes have become diluted over several decades. As medical care became more complex and technology driven over the last two decades, it progressively became more intricate, error prone and at times fatal or caused severe harm to patients. Complexity of care also requires integration of multiple specialties and subspecialties leading to multiplicity of diagnostic and therapeutic interventions. The large spectrum of drugs in use began to present with adverse drug events, which further complicated care. Invasive interventions, hospital-acquired infections, wrong site surgeries, inappropriate antibiotic usage, medication errors, contaminated drugs and devices, breakdown of medical equipment, patient self harm and suicides, diagnostic errors, etc. began to occur with alarming frequency. Though, there is no documented data of the frequency of these occurrences in service hospitals, yet on ground experiences suggest that such events are occurring at a frequent interval indicating recurrent system failures, which are not finding corrective or preventive measures.

In the Indian context as in the Armed Forces hospitals, data on such occurrences were not captured, analyzed and preventive measures, therefore, were rarely put in place. Medical errors whenever reported in the service hospitals were investigated to “pin point responsibility” and normally result in administrative or disciplinary action against the presumed perpetrator of the “offence”. Awareness that most errors occur due to multiple fault lines and failures of systems and processes has still not found favour across our hospitals.

There is currently a lack of a coherent and cohesive mechanism to monitor the performance of the healthcare institutions of the armed forces. Despite an “Annual Inspection” which includes technical and administrative review of the working of hospitals, the in-depth review to quantify the performance is lacking and simply stated – what is not measured, cannot be improved. Few hospitals attempt any kind of internal audits and limited measurements of performance and outcome measures are in place even in tertiary care hospitals. Hence, the armed forces hospitals, though built on strong quality foundations, have failed to keep pace with continual quality improvement across all facets of hospital functions and care delivery processes.

Globally and in the national healthcare horizon, accreditation is finding greater acceptance even by governmental agencies. Most private and government hospitals in the advanced countries mandate accreditation for being eligible to participate in national health plans and programmes. In India, the Central Government Health Scheme (CGHS) and the Ex-servicemen Contributory Health Scheme (ECHS) now mandate hospitals to be accredited for participation in their respective medical care plans. Health insurance companies too prefer accredited hospitals to participate in their plans and have different premium and payment schedules for such hospitals. As a growing pan-India movement the accreditation programme has progressed rapidly in the past decade.

The Armed Forces too has deliberated on the need for accreditation since 2006–2007. A number of doctors of the Armed Forces Medical Services (AFMS) have been trained as assessors and are well versed with the accreditation programme of NABH. Hospitals such as Command Hospital (AF), Bangalore and Military Hospital, Bareilly have undergone the process for accreditation already. Another 8 (eight) hospitals of the ten identified were required to prepare for the quality management system (QMS) and doctors and nurses from these hospitals received an initial 3 day familiarization on the standards at the Department of Hospital Administration at the Armed Forces Medical College (AFMC). However, the QMS has not been taken further in these hospitals for want of trained manpower and other resources. Deliberations at higher echelons have debated on the need for accreditation for service hospitals and views have spanned the entire spectrum – including the urgent need for QMS being endorsed and others expressing their scepticism about the QMS. A proposal titled “Quality and Patient Safety Management System” (QPSMS) finally found favour and was accepted for implementation by the Medical Services Advisory Committee (MSAC) in 2013. The progress since then has not been as rapid and extensive as was envisioned then.

The entire process of accreditation requires committed, knowledgeable leadership and hand holding throughout the process of accreditation. Hospitals need to establish multiple committees empowered to lead the implementation and in the Armed Forces setting – a commitment by the hierarchy to support the hospital as it transits into a more efficient and safe organization is an imperative for successful implementation.

Studies on the impact of accreditation have revealed a mixed bag of results. Whereas the satisfaction and confidence of nurses have been found to be significantly improved,⁹ the clientele satisfaction has not been consistently documented.¹⁰ However, most hospitals have shown a significant improvement in patient safety initiatives, data keeping and analysis, practice of evidence based medicine, implementation of clinical pathways and reporting of errors amongst others.¹¹

These benefits by themselves should be a stimulus enough for service hospitals to seek accreditation. More so now that graded levels of accreditation are possible in the journey towards safe hospitals and improved performance. Further, the AFMS has no metrics for comparing itself with other hospitals – private or public, and no comparative data is available to assess the quality or performance of its hospitals

against any national or international benchmarks or standard of care. The process of accreditation would ensure that performances are measured, goal setting and benchmarking would take place, good practices would be implemented and corrective or preventive measures to avoid harm to any stakeholder would become a regular concern.

An incremental growth in quality measures and patient safety is eminently feasible and desirable, even more so as a strategic objective for the future. The armed forces hospitals have already been held culpable for medical negligence and patient harm by various courts in the country. Given the increased awareness of the clientele, it is only prudent that service hospitals quickly adopt quality standards of the nation and implement them with all vigour.

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