

NABH collaboration with Smile Train India for Patient Safety and Quality Improvement

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INTRODUCTION

Cleft lip is a birth defect in which a unilateral or bilateral opening in the upper lip between the mouth and the nose.

Cleft palate refers to A breach in the continuity of palate or A furrow in the palatal vault.

The etiology is thought to be multifactorial involving both genetic and environmental factors

To enhance the patient safety an MOU has been entered between Smile Train India and NABH, QCI

The current study reveals the data about the audit process at Smile Train Treatment Centers

AIM

The primary aim of this topic is to highlight the importance of patient safety in orofacial clefts surgery

To carry out the audits at Smile Train Treatment Centers through pre defined checklist

To ensure the patient safety measures are followed by the Smile Train Treatment Centers

Based on the scoring pattern, through live surgery observation final decision will be taken

Based on the observations, mid-term surveillance will be carried out to ensure patient safety.

METHOD

The methodology adopted in the study was through the data collection of the audits carried out.

The scoring pattern was kept as a criterion to analyze the final data.

The infrastructure, medical personnel, system/practices/protocol were captured

Auditors observed the live surgeries and based on that the data are captured in the checklist

The reports were presented in an expert committee in NABH and final decisions were given

RESULTS

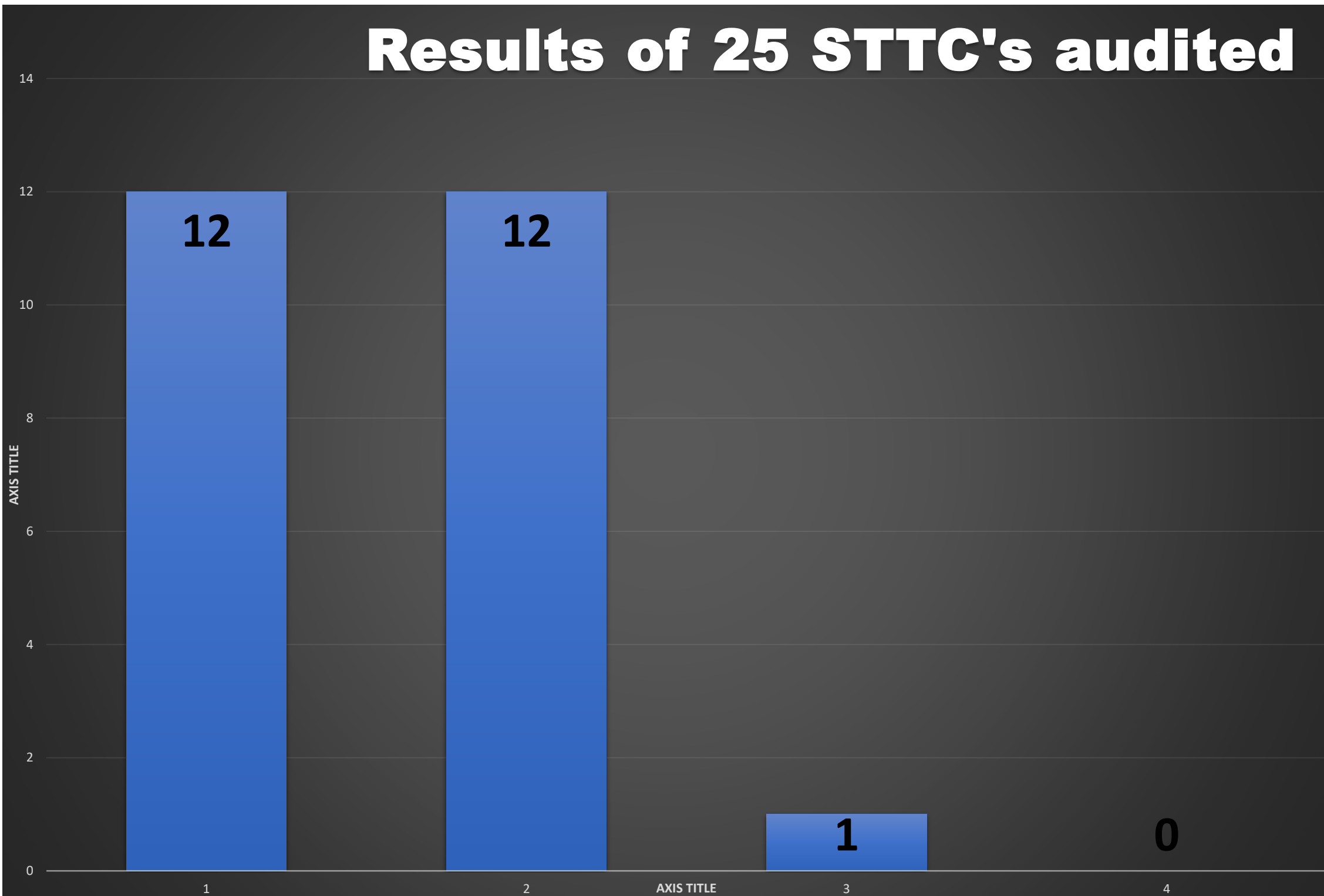
Based on the score the hospital may fall under 4 categories:

Category 1: Hospital has successfully completed the Smile Train Quality & Safety audit

Category 2: Partner hospital has completed the safety audit; however, they must meet missed mandatory requirements to successfully complete the safety audit

Category 3: The cleft surgery program should be temporarily suspended if they failed to meet the requirements

Category 4: Partner hospital is not in compliance with many of the mandatory requirements and it should be suspended immediately



Within 4 months of this audit a Mid term surveillance audit is conducted

The auditors will verify the advisories are complied or not

Patient safety and uniform care is ensured through all possible means

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CONCLUSIONS

It has been conducted meticulously with reference to infection control process, systems/protocols

The following are the a few areas of improvement:

- a. Emergency codes needs to be practiced
- b. To ensure 100% compliance in WHO Surgical Safety checklist
- c. Difficult airway trolley should be there which increases the patient safety
- d. To monitor the sentinel events in the hospital

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<https://www.smiletrainindia.org/what-are-clefts>

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