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Review Article

Quality Improvement through NABH Accreditation: A Review of Strategies for Preventing Medication Errors in Hospitals

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ABSTRACT

Quality Improvement (QI) is a systematic approach aimed at enhancing the performance of healthcare organizations by improving patient safety, service quality, and overall satisfaction. In India, hospital quality is assessed using established frameworks, particularly those developed by the National Accreditation Board for Hospitals and Healthcare Providers (NABH) under the Quality Council of India (QCI). In 2018, the National Health Authority introduced quality certification requirements under the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) to further strengthen healthcare standards and patient outcomes. This review highlights the role of NABH accreditation in improving healthcare quality and reducing medication errors through standardized protocols, continuous monitoring, and performance indicators. Additionally, the integration of Information Technology (IT) in healthcare systems can significantly minimize medication errors by enhancing communication, improving access to clinical information, and enabling real-time monitoring and decision support.

Keywords: Accreditation, Medication Errors, NABH, Patient Safety, Quality Improvement.

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INTRODUCTION

The Institute of Medicine defines quality in healthcare as the extent to which health services increase the likelihood of desired health outcomes and are consistent with current professional knowledge. This concept encompasses key dimensions such as patient experience, safety, effectiveness, efficiency, equity, and timeliness. Among these, patient satisfaction is widely recognized as an important indicator for evaluating healthcare quality (Afolabi *et al*., 2021; Atkinson *et al*., 2010; Elliott *et al*., 2021; Jain and Pareek, 2020).

Quality Improvement (QI) is a systematic and continuous approach aimed at enhancing healthcare performance through the establishment of standards, regular assessment, and implementation of corrective measures. Effective QI initiatives contribute to improved patient outcomes, increased staff satisfaction, and overall organizational efficiency (Varkey *et al*., 2007; Weiner *et al*., 2006).

Accreditation is a formal process by which an external body evaluates a healthcare organization against predefined standards to ensure compliance with quality and safety requirements. It serves as a structured mechanism for improving healthcare delivery by promoting accountability, standardization, and continuous quality enhancement (Alkhenizan and Shaw, 2011; Brubakk *et al*., 2021; Joseph, 2021).

In India, hospital quality is assessed through various regulatory frameworks, most notably those established by the National Accreditation Board for Hospitals and Healthcare Providers (NABH), which operates under the Quality Council of India (QCI) (World Health Organization, 2021). NABH standards were first introduced in 2006 and have undergone periodic revisions, with the fifth edition released in April 2020 (David and Valas, 2017; Jain and Bawa, 2017). These standards emphasize patient safety, quality of care, and continuous service improvement.

NABH accreditation standards are organized into ten major chapters, including Access, Assessment and Continuity of Care (AAC); Care of Patients; Management of Medication; Patient Rights and Education; Hospital Infection Control; Patient Safety and Quality Improvement (PSQ); Responsibilities of Management; Facility Management and Safety; Human Resource Management; and Information Management System. Collectively, these chapters comprise approximately 100 standards and over 600 objective elements, addressing both patient-centered care

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and organizational management aspects (Battu, 2020; Gadre *et al.*, 2022).

According to the World Health Organization, health is a fundamental human right. In line with this principle, the Government of India has implemented several initiatives to achieve Universal Health Coverage, ensuring access to quality healthcare services without financial hardship (Jain and Lodha, 2023). A key initiative in this regard is the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY), launched in 2018. This scheme provides health insurance coverage of up to ₹5 lakh per family per year for secondary and tertiary care hospitalization to economically disadvantaged populations, covering approximately 50 crore beneficiaries.

The National Health Authority, in collaboration with QCI, has introduced AB-PMJAY Quality Certification standards to enhance healthcare delivery and patient satisfaction across empaneled hospitals. These standards are categorized into three levels-Bronze, Silver, and Gold-encouraging progressive quality improvement. The certification framework is structured into five key domains: Key Inputs, Clinical Services, Support Services, Patient Care, and Health Outcomes (Chellaiyan *et al.*, 2020).

Studies such as those conducted by Susmit Jain *et al.* have evaluated the alignment between NABH accreditation standards and AB-PMJAY quality requirements in tertiary care hospitals, demonstrating significant overlap in domains related to patient safety, clinical governance, infection control, and medication management.

NABH standards comprehensively address multiple aspects of healthcare delivery, including infrastructure safety, emergency preparedness, staff credentialing and training, infection prevention and control, medication safety, patient rights, and clinical service quality. These standards also incorporate key performance indicators such as rates of healthcare-associated infections, transfusion reactions, patient satisfaction, and waiting times, thereby enabling continuous monitoring and quality improvement. However, the implementation of NABH standards requires substantial organizational commitment, including trained personnel, extensive documentation, and dedicated quality management systems. Challenges such as increased administrative workload, need for skilled manpower, and resource constraints may impact effective implementation. Despite these challenges, NABH accreditation plays a crucial role in strengthening healthcare quality systems and enhancing patient safety in Indian hospitals.

Medication Errors

Preventing medication-related harm requires effective system-based controls involving pharmacists, prescribers, nurses, risk management personnel, administrators, patients, and regulatory agencies, as well as the pharmaceutical industry (Pop and Finocchi, 2016).

A medication error can be defined as any preventable event that may lead to inappropriate medication use or patient harm while the medication is under the control of a healthcare professional, patient, or consumer. Such events may be related to professional practice, healthcare products, procedures, or systems, including prescribing, order communication, product labeling, packaging, and administration (Wilson *et al.*, 1998).

Medication errors include any mistake occurring during the medication-use process, such as prescribing, transcribing, dispensing, administering, or monitoring (Kaushal *et al.*, 2004). These errors may involve deviations from the prescribed regimen, including omission of doses, incorrect dosage, or administration of unauthorized medications (Barker *et al.*, 1982). In general, a medication error refers to any discrepancy between the prescribed therapy and the medication actually administered to the patient (Assiri *et al.*, 2022; Barker *et al.*, 2002).

Medication errors can arise from irrational or inappropriate drug selection, poor prescribing practices, and illegible handwriting. Examples include overprescribing, underprescribing, and incorrect prescription writing. Errors may also occur during drug formulation, resulting in incorrect strength, impurities, or improper packaging. Furthermore, mistakes in dispensing, administration, and monitoring may lead to incorrect dose, route, frequency, or duration of therapy, as well as failure to appropriately adjust treatment when required.

The concept of failure in medication use involves the establishment of clear standards and guidelines for safe practice. All healthcare professionals involved in medication management should be familiar with these standards and implement appropriate measures to prevent or minimize noncompliance. Accountability at each stage of the medication-use process is essential to ensure patient safety.

Adverse Events and Adverse Drug Reactions

An adverse event is defined as any unexpected or unintended sign, symptom, or laboratory abnormality that occurs during patient care. It may include incidents such as accidents, unforeseen complications, or the worsening of a preexisting condition (Aronson and Ferner, 2005).

An Adverse Drug Reaction (ADR) refers to a harmful or unpleasant response resulting from the use of a medication (Ferner and Aronson, 2006). If an adverse event is not related to a drug, it is classified simply as an adverse event; however, if there is a suspected causal relationship with a medication, it is considered an ADR.

Medication errors may lead to adverse events, but not all adverse events are caused by medication errors. Similarly, not all

medication errors result in harm. For example, an error in drug administration may cause complications such as a hematoma due to improper cannula insertion. The relationship between medication errors, adverse events, and ADRs is often illustrated using a Venn diagram to show their overlap (Figure 1).

Prescribing Errors and Prescription Concepts

The term *prescription* has evolved to include both prescribing faults and prescription errors. Prescribing faults refer to failures in the prescribing process that may result in patient harm, similar to other medication-related errors. A clinically significant prescribing error is defined as an unintended deviation in drug selection or prescription writing that reduces the likelihood of timely and effective treatment and increases the risk of adverse outcomes. Identifying and analyzing all types of errors, whether clinically significant or not, is essential, as they reflect underlying system weaknesses and may contribute to future errors (Aronson, 2009a).

A prescription is a formal written order that specifies the medication, dosage, route, and timing of administration. A prescription error occurs when there is a failure in the writing process, leading to incorrect or incomplete instructions. Balanced prescribing involves selecting appropriate therapy tailored to the patient's condition while optimizing the benefit-risk ratio within the uncertainties of clinical decision-making (Barker and McConnell, 1962).

Classification of Medication Errors

Medication errors have been classified using various systems:

Early categorization system (1962) (Cipolle *et al.*, 1998).

This system broadly classifies medication errors into:

- **Known errors:** Errors that are recognized but may not always be reported.
- **Unknown errors:** Errors that go unrecognized, including omission, underdosing, or overdosing. These may also involve administration of an extra dose, incorrect dosage form, wrong medication, or incorrect timing.

Drug therapy model classification (Habibyar and Nazari, 2023)

According to this model, medication errors are categorized based on the stage of the medication-use process:

- Prescribing and transcribing errors.
- Dispensing errors.
- Administration errors.

Cause-based classification (Billstein-Leber *et al.*, 2018; Freedman *et al.*, 2002).

This system categorizes errors based on their underlying causes:

- **Omission errors:** failure to administer a required dose.
- **Commission errors:** administration of an incorrect dose or medication.
- **Discrepancies:** procedural deviations that do not result in dosing errors.

American Society of Health System Pharmacists classification (Cowley *et al.*, 2001; Leendertse *et al.*, 2008; Wittich *et al.*, 2014).

This classification identifies common contributing factors, including:

- Inconsistent Labeling or Packaging.
- Use of Similar-Sounding Drug Names.
- Equipment Malfunction.
- Illegible Handwriting.
- Transcription Errors.
- Dose Miscalculations.

Medication errors may occur at any stage, including prescribing, transcribing, dispensing, administering, and monitoring.

Causes of Medication Errors

The United States Pharmacopeia identifies several common causes of medication errors (Lesar *et al.*, 1997), including poor performance, failure to follow established procedures, communication breakdowns, transcription errors, improper documentation, flaws in drug distribution systems, lack of knowledge, calculation errors, data entry mistakes, and inadequate system safeguards.

Similarly, the Institute for Safe Medication Practices highlights additional contributing factors (Donaldson *et al.*, 2017), such as ineffective communication (including illegible handwriting and verbal misinterpretation), look-alike or sound-alike medications, improper use of decimal points or abbreviations, inefficient medication-use systems, poorly designed technologies, limited access to pharmacy services, workplace stress, insufficient patient information, and inadequate understanding of therapy.

Risk Factors for Medication Errors

Medication errors are influenced by multiple risk factors:

- Patient-related factors (Bates and Singh, 2018; Manias, 2018; Mekonnen *et al.*, 2016).

- These include impaired renal or hepatic function, cognitive impairment, presence of comorbidities, and polypharmacy.
- Healthcare professional-related factors.
- These include the use of non-standard abbreviations, cognitive biases, and inadequate clinical judgment

Detection and Reporting of Medication Errors

The detection and reporting of medication errors are essential for improving patient safety. Systematic reporting helps identify patterns, underlying causes, and areas requiring intervention, thereby supporting the development of effective prevention strategies.

Strategies for Prevention of Medication Errors

Several strategies can be implemented to reduce medication errors. Regulatory bodies such as the Food and Drug Administration recommend collaboration among healthcare professionals during drug naming, labeling, and packaging processes to minimize confusion.

Healthcare organizations should implement standardized protocols involving multidisciplinary teams to enhance medication safety. Effective communication systems-both written and verbal-are critical to ensure accurate prescribing, dispensing, and administration.

Pharmacists play a key role in preventing medication errors by staying updated with current knowledge, participating in continuing professional education, and engaging in drug utilization reviews and therapeutic monitoring. They should also provide guidance to prescribers and nurses regarding appropriate drug therapy and administration practices.

Clear and legible prescription orders are essential, and electronic prescribing systems should be used wherever possible. Healthcare professionals must verify all medication orders before administration and ensure proper patient identification.

Nurses are responsible for reviewing prescriptions, identifying potential drug interactions or duplications, and monitoring patient responses after drug administration. Patient education is equally important; patients should be informed about their medications, including their purpose, dosage, and potential adverse effects, and should communicate any allergies or concurrent medication use.

Medication errors continue to represent a significant challenge in healthcare systems, arising from multifactorial causes involving

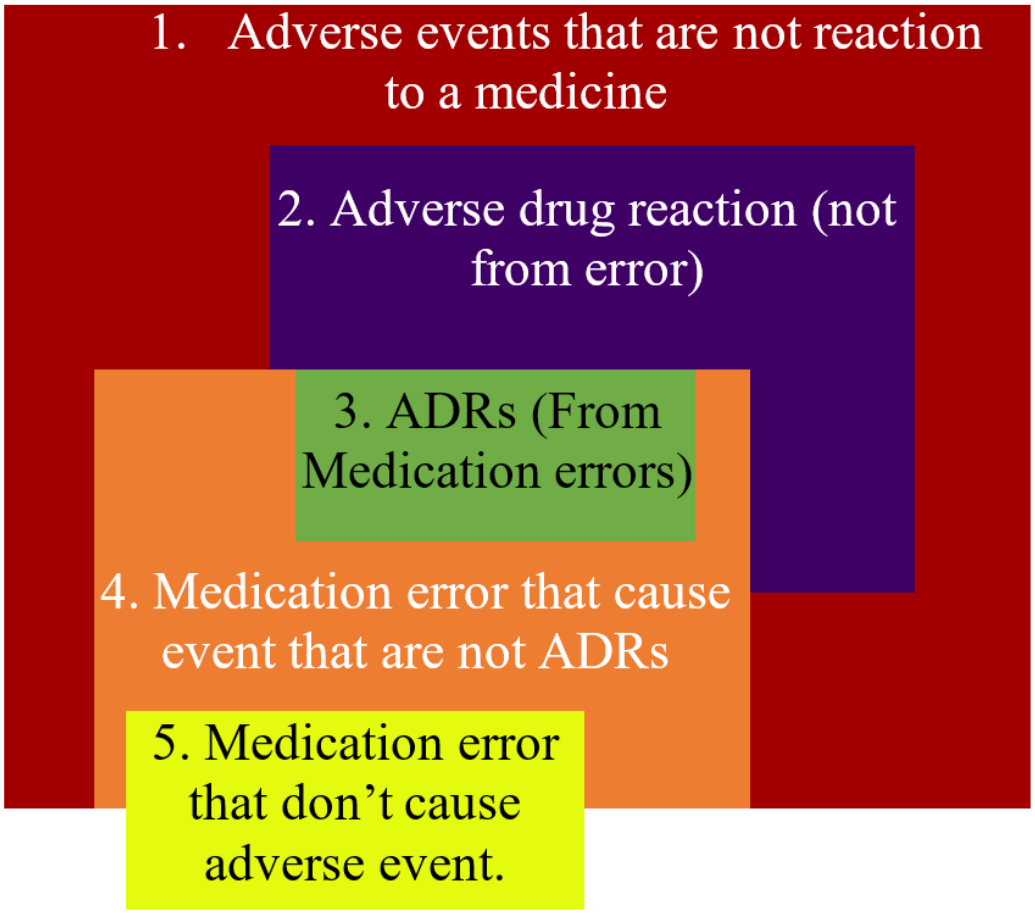

Figure 1: Relationship between adverse events, adverse drug reactions, and medication errors.

patients, healthcare professionals, and system-related factors. Effective classification, identification of risk factors, and the implementation of evidence-based preventive strategies are essential to minimize such errors and enhance patient safety. Strengthening communication, improving professional training, and adopting standardized protocols can substantially reduce the incidence of medication errors in clinical practice.

The National Accreditation Board for Hospitals and Healthcare Providers (NABH) plays a crucial role in improving healthcare quality by establishing structured standards and performance indicators. Although the implementation of NABH standards requires adequate financial resources and organizational commitment, it significantly enhances patient safety and quality of care. Hospitals achieving NABH accreditation are eligible to apply for higher levels of quality recognition under the AB-PMJAY, including Gold certification.

Furthermore, the integration of Information Technology (IT) in healthcare systems has the potential to improve medication safety by streamlining processes, enabling real-time error detection, and supporting evidence-based, patient-centered decision-making. However, the full benefits of IT can only be realized when all components of the healthcare system are effectively interconnected. Therefore, enhancing system integration and execution remains a key priority in modern healthcare. Clear definitions, robust systems, and coordinated efforts are essential to prevent medication errors and reduce adverse outcomes.

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ABBREVIATIONS

QI: Quality improvement; **NABH:** National Accreditation Board for Hospitals & Healthcare Providers; **QCI:** Quality Council of India; **AB-PMJAY:** Ayushman Bharat Pradhan Mantri Jan Arogya Yojana; **IT:** Information Technology; **AAC:** Access, Assessment and Continuity of Care; **PSQ:** Patient Safety and Quality Improvement; **ADR:** Adverse drug reaction.

CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.

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