



## **Cr 8.10. Accreditation or certification processes and their results are evaluated and used to make improvements**

Improving the country profile regarding health services and health care security, in the context of Directive 2011/24 / EU of the European Parliament and Recommendation 2009 / C151 / 01 of 9 June 2009 of the Council of the European Union on patient safety, including the prevention and control of infections associated with healthcare can lead to the attractiveness of the Romanian health system for EU citizens who choose to be treated in Romania.

Amid general desire on "providing and continuously improving quality of care and patient safety (...), standardization, evaluation of health services and accreditation of health" National Authority for Quality Management in Health aims obtaining regular feedback on the impact of the implementation of accreditation standards as well as establishing measures to improve them.

"Cycle I accreditation was an initiation of the entire health system in ensuring and improving the quality of care and patient safety. Based on experience, it has adopted the Second Edition of the hospital accreditation standards and identified ways to improve the evaluation process, accreditation and quality of hospital services and patient safety."<sup>1</sup>

"National Authority for Quality Management in Health wants to change the mentality in health care, focusing on quality of care and patient safety. The whole concept underlying the policy of quality health services promoted by NAQMH is based on principles in the field. "Dr. Vasile Cepoi, president of the National Quality Management in Health."<sup>2</sup>

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<sup>1</sup> <http://NAQMH.gov.ro/web/wp-content/uploads/2017/06/raport-final-v2.pdf>

<sup>2</sup> <http://NAQMH.gov.ro/web/autoritatea-nationala-de-management-al-calitatii-in-sanatate-a-inceput-demersurile-pentru-acreditarea-de-catre-societatea-internationala-pentru-calitate-in-sanatate-isqua/>



## **DS 8.10.1- The evaluation and accreditation process**

The declared mission of the Co.N.A.S. was "*coordinating a standardized evaluation process of the quality of the services provided by hospitals in order to improve the health status of Romanians*".

The purpose of the first accreditation cycle was, on the one hand, to raise awareness of the competent authorities involved in the management of the health system on the importance of ensuring the quality of the medical services provided by hospitals and, on the other, to alert the hospital management to the fact that the managerial performance does not it is limited to not recording arrears.

The planning, organizing and training of the staff in achieving the planned objectives, the coordination and the evaluation of the processes and the results are the condition of ensuring the efficiency and efficiency of the medical services, expressed by satisfying the expectations of the population and, implicitly, of the patients.

*The specific objectives for achieving this goal were:*

1. Elaboration of a set of hospital accreditation standards;
2. Preparation of a body of external evaluators, independent of any interest group that could vitiate the results of the evaluation;
3. Elaboration of a methodology for measuring the compliance with the accreditation standards, which will ensure correct results regarding the quality of the services provided by each hospital;
4. Evaluation of the 433 hospitals that, in order to provide services in the public health insurance system, it was necessary to obtain the accreditation within 5 years from the date of enrollment in this process.

The standards and the accreditation methodology were elaborated in collaboration with the Ministry of Health and approved by the Order of the Minister of Health no. 972/2010 ..

The evaluation process for accreditation was started according to a schedule approved by the Governing Board / Steering Committee.



**Table 1. Accreditation I vs Accreditation II**<sup>3</sup>

ACCREDITATION I	ACCREDITATION II
<p><b>Enrollment in the accreditation procedure:</b></p> <ol style="list-style-type: none"> <li>1. by the application form;</li> <li>2. term of registration - 1 year from the publication of the Order No. 972/2010;</li> <li>3. did not regulate the situation of newly established hospitals.</li> </ol>	<p><b>Enrollment in the accreditation procedure:</b></p> <ol style="list-style-type: none"> <li>1. by the application form;</li> <li>2. deadline for submission (application submission) <ul style="list-style-type: none"> <li>- Hospitals accredited: 1 year - 9 months before the expiration of the accreditation,</li> <li>- Hospitals not evaluated, but who have submitted an application - <b>NO MORE REQUIREMENTS NEED TO BE SUBMITTED;</b></li> <li>- Non-evaluated hospitals that submit, for the first time, the application for registration within 1 year from the publication of the Order - it is accredited in cycle II.</li> </ul> </li> </ol>
<p><b>Planning the evaluation visit for accreditation</b></p> <ol style="list-style-type: none"> <li>1. the requested period;</li> <li>2. the request for replanning.</li> </ol>	<p><b>Planning the evaluation visit</b></p> <ol style="list-style-type: none"> <li>1. establishing a maximum number of hospitals that can be evaluated / month / quarter (20/60);</li> <li>2. the date of the accreditation expiration and the first evaluation - <i>USP accredited;</i></li> <li>3. the results of the MONITORING process;</li> <li>4. compliance with the term of 5 years from the submission of the application - <i>for USP not evaluated in cycle I;</i></li> <li>5. the findings during the evaluation preparation stage;</li> <li>6. the request for replanning.</li> </ol>
<p><b>The stages of the process were not:</b></p> <ol style="list-style-type: none"> <li>1. defined;</li> <li>2. grouped according to the moment in which they take place;</li> <li>3. explained.</li> </ol>	<p><b>The evaluation and accreditation procedure comprises the following main steps:</b></p> <ol style="list-style-type: none"> <li>1. The preparation stage of the evaluation <ul style="list-style-type: none"> <li>• it starts with 1 year - 9 months before</li> <li>• takes place over a period of 7 months</li> <li>• dialogue between NAQMH and the hospital</li> </ul> </li> <li>2. The evaluation stage <ul style="list-style-type: none"> <li>• is initiated if the hospital has sent DOS</li> <li>• takes place over a period of 3 months</li> <li>• dialogue between C.E. and hospital</li> </ul> </li> <li>3. The accreditation stage <ul style="list-style-type: none"> <li>• is initiated after the completion of step 2</li> </ul> </li> </ol>

<sup>3</sup> Andrei Cosmin DAVID- Practical guide for preparing the assessment for accreditation in the second cycle of accreditation  
<https://slidesplayer.com/slide/14175632/>



	<ul style="list-style-type: none"> <li>•takes place over a period of 2 months</li> <li>• NAQMH and C.E. and hospital</li> </ul>
<p><b>Preparation phase of the evaluation visit - including the mandatory conditions for initiating the evaluation visit:</b></p> <ol style="list-style-type: none"> <li>1. transmission of FAE and annexes</li> <li>2. payment of the accreditation fee</li> </ol>	<p><b>Preparation phase of the evaluation visit - including the mandatory conditions for the start of the evaluation visit:</b></p> <ol style="list-style-type: none"> <li>1. introduction of the Hospital and CaPeSaRo Identification Card (<i>at all stages of the process</i>);</li> <li>2. the transmission to the NAQMH of the Required Required Documents (DOS) and of the additional ones necessary for the process (DS); DOS = FAE 1 + authorizations / approvals + procedures / protocols with major impact on patient safety + PO fee;</li> <li>3. preparation period of the visit - 7 months, the NAQMH-hospital dialogue is carried out through RRA-PE;</li> <li>4. remediation of non-conformities from "compliance plan for evaluation" - 30 days after receiving it;</li> <li>5. Snoozing of the evaluation visit OR</li> <li>6. establishment of the Evaluation Commission (EC)</li> </ol>
<p><b>Evaluation visit with the sub-stages:</b></p> <p><b>A) pre-visit</b></p> <ol style="list-style-type: none"> <li>1. initiation of the phase = 1 week before the actual visit;</li> <li>2. EC composition and the period and schedule of the visit;</li> <li>3. specific indicators.</li> </ol>	<p><b>The evaluation stage with the sub-stages:</b></p> <p><b>A) pre-visit</b></p> <ol style="list-style-type: none"> <li>1. initiation of the phase = 2 months before the visit - during this time the EC communicates with the hospital in order to identify and clarify all aspects related to the implementation of the MQ, including requesting the updating of the FAE (FAE 2 transmission) and additional documents to allow the improvements made by the measures established by the action plan realized by the SCM existing at the hospital level;</li> <li>2. specific indicators;</li> <li>3. The EC elaborates the "report containing the conclusions of the analysis of the documents transmitted by the hospital", on the basis of which the visit may be <b>CANCELED</b>;</li> <li>4. NAQMH meeting with the hospital management.</li> </ol>
<p><b>B) the actual visit</b></p> <ol style="list-style-type: none"> <li>1. the first contact with the EC was made at the opening of the visit;</li> </ol>	<p><b>B) the actual visit</b></p> <ol style="list-style-type: none"> <li>1. elaboration of some SANTINELA INDICATORS - the finding, during the visit, of their non-fulfillment leads to the <b>INTERRUPTION OF THE VISIT</b></li> </ol>



<p>2. during the visit, many documents were requested to justify the accomplishment of an activity - formalism; 3. Specific indicators.</p>	<p>2. redefining and introducing a new data collection technique - simulating processes for identifying clinical risks; 3. introduction (recognition) of new tools used for hospital accreditation (FIS, DOS, PRE, RE and RA) 4. completing the checklists in electronic format and uploading them to CaPeSaRo at the end of the interview (visible in real time for both the hospital, EC and NAQMH)</p>
<p><b>C) post-visit</b> 1. specific indicators; 2. PRE, objections, RE.</p>	<p><b>C) post-visit</b> 1. specific indicators; 2. PRE, 3. objections analyzed by NAQMH employees, 4. RE.</p>

## DS 8.10.2- Results of USP assessment and accreditation

### Cycle I vs. Cycle II

The measurement of the quality of the health services must reflect as effectively and in detail as possible their effectiveness and efficiency in each evaluated healthcare unit, identify the elements that adversely affect the quality and determine the confidence of the professionals that the compliance with the requirements of the accreditation standards determines the increase of the professional performance.

The level of compliance with the accreditation standards reflects the quality level of the health services offered by the hospital. For this reason, quality measurement tools must be constantly improved based on a step-by-step analysis of the results obtained.

The first cycle of accreditation of the sanitary units with beds, began in July 2011 and was completed in July 2016. In the first cycle of accreditation, a number of 433 public and private hospitals were evaluated, which required to register in this process, in order to be able to conclude,



according to the provisions of Law 95/2006 on health reform, a contract with the public insurance system.

The accreditation process was conducted on the basis of the first edition of the Accreditation Standards, which included a number of 11 references: strategic management of organizations, operational management of information, human resources management, care environment management, quality of services management, patient rights and communication, patient data management, health care management, risk prevention and management, nosocomial infection management, transfusion and transplant safety. The conformity of these references was evaluated using a number of 2479 indicators.

Of the 433 hospitals that went through the evaluation process from the first accreditation cycle, two sanitary units with beds obtained a compliance rate of less than 45% and were declared non-accredited.

The first cycle of evaluation and accreditation of hospitals was divided into three stages, according to the method of validation of the indicators and the method of calculating the compliance level: June 2011 - October 2014, October 2014 - September 2015, September 2015-June 2016 . Thereby,

- In the first stage (Lot I) a number of 77 sanitary units with beds were evaluated,
- In the second stage (Lot II) a number of 182 hospitals were evaluated,
- In the third stage (Lot III) a number of 174 hospitals were evaluated.

Step (group) I- was conducted between June 2011 - March 2013 and included a total of 77 hospitals evaluated. After March 2013, the accreditation process was blocked because, following the checks carried out, C.C. and A.N.R.M.A.P. appreciated that the procedures used by Co.N.A.S. for the selection of the evaluators did not comply with the principles and regulations O.U.G. no. 34 / 2006. Analiza quality measurement results with instruments that have been used in this step shows that more than 75% of hospitals have a level of quality evaluated over 85% and over 70% of them have the quality level of 90%.

**Table no. 1. Results obtained in the first stage of cycle I accreditation**

<b>Accreditation levels</b>	<b>Score obtained</b>	<b>Pondereea spitalelor</b>
<i>Unaccredited</i>	Below 45 %	0%



<i>Accredited</i>	45,00 % - 74,9 %	6,2%
	75,00 % - 84,9 %	18,5%
	At least 85%	75.3%
	over 90%	70%

### Group 1 distribution of hospitals

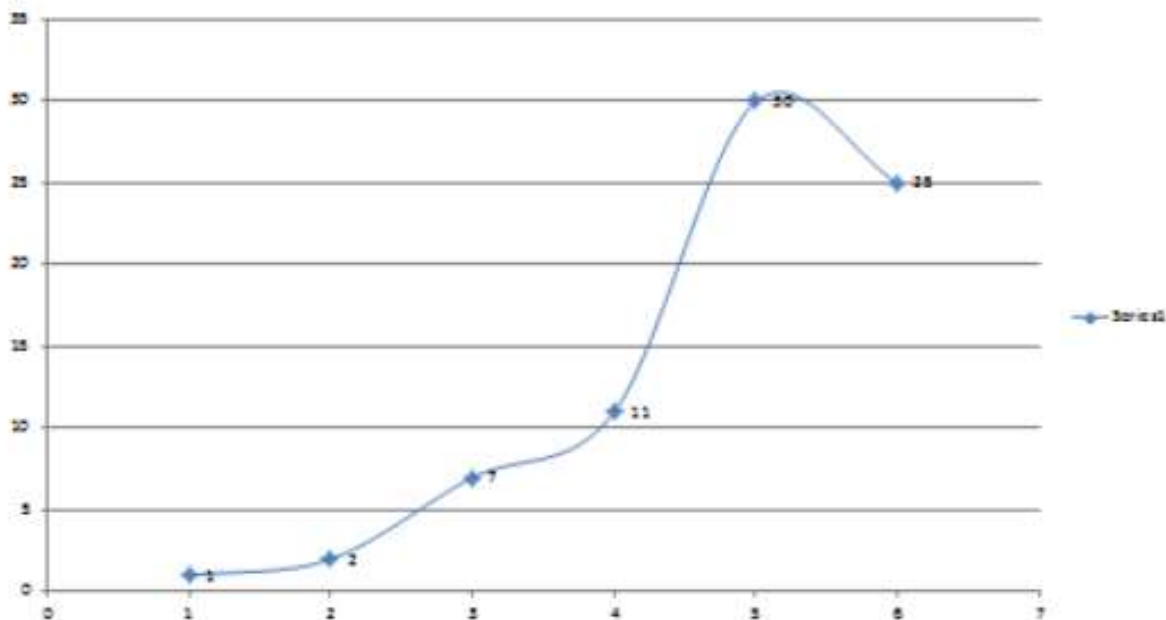


Fig. 1 - Distribution of the hospitals accredited in the first stage ( lot I ) according to the level of compliance with the accreditation standards.

**The second stage ( lot 2 )** took place between September 2014, when the evaluation process was resumed, following the harmonization of the internal regulations regarding the selection of the evaluators and the establishment of the evaluation commissions with the legislation in the field of public procurement, and the month of October 2015 which coincided with the establishment and organization of NAQMH and included a total of 182 hospitals.

The analysis of the results of the quality measurement with the instruments that were used in this stage shows that 71.43% of the hospitals evaluated have a quality level of over 85%.

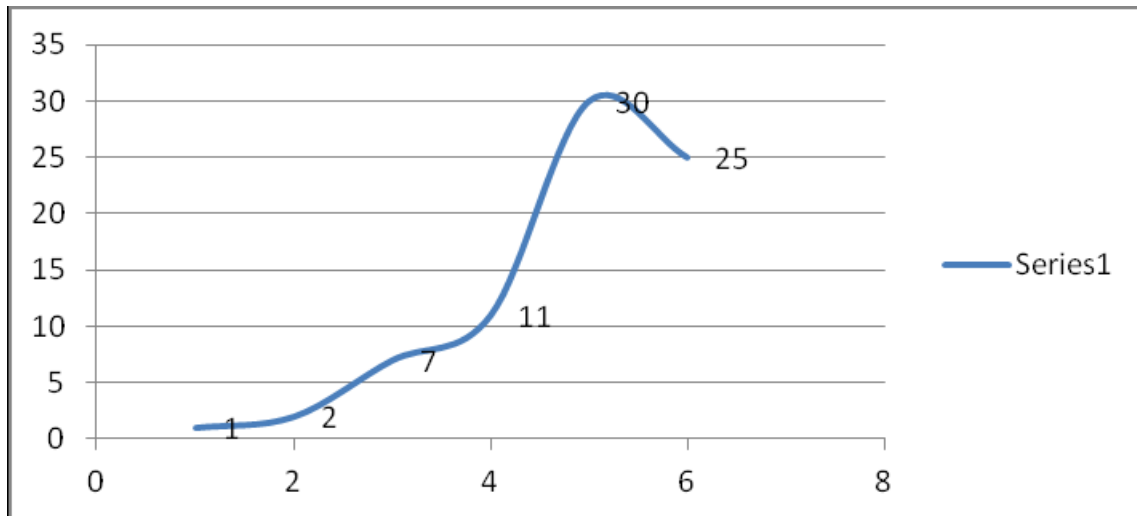


Fig. 2 Distribution of hospitals evaluated in the second stage (lot II) according to the level of compliance with accreditation standards

There is an increased level of compliance with the accreditation standards in stages I and II, when there were no:

1. prior training of managers and staff in hospitals in the field of quality management;
2. managers prepared to implement a quality system, in the absence of an organizational culture regarding quality.

In the absence of these conditions, the level of confidence in the objectivity of measuring compliance with the standards is low.

**The third stage ( lot 3 )** was conducted between November 2015 - July 2016 and comprised 174 hospitals. The analysis of the quality measurement results with the instruments used in this stage shows that only 6.9% of the hospitals evaluated have a quality level of over 85%.

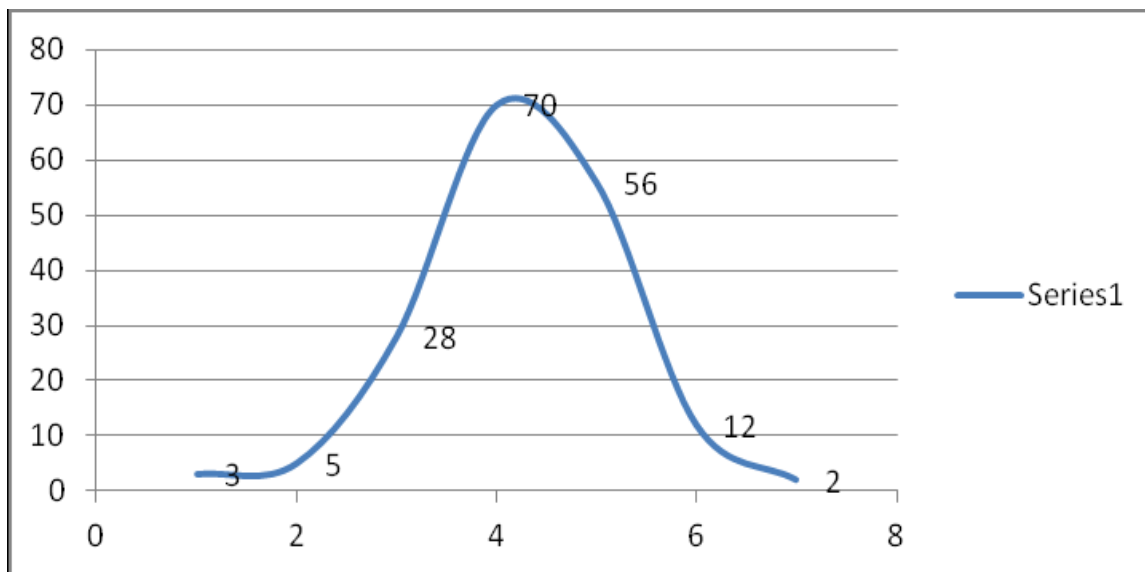


Fig. 3 Distribution of hospitals evaluated in stage III (group III) by level in compliance with accreditation standards

The average percentages for the implementation of the accreditation standards on the 3 stages (loturi) undergoing the analysis were decreasing: 89.77%, 88.10% and 72.21% respectively.

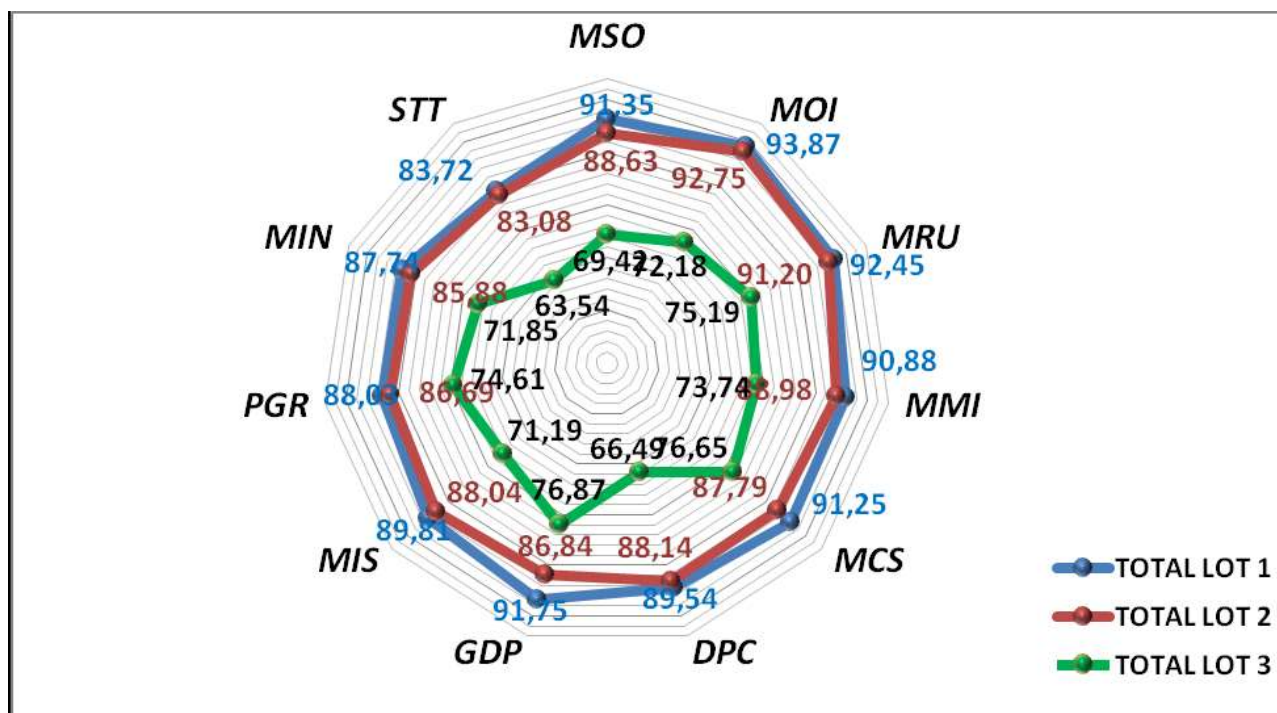




Fig. 4 Evolution of the percentage of compliance by the hospitals included in each of the 3 stages (lots) of the accreditation standards separately, by reference

SMO - Strategic Management of the Organization

OMI - Operational Management of Information

HRM - Human Resources Management

MCE - Management of the Care Environment

SQM - Service Quality Management

PCR - Patient Rights and Communication

PDM - Patient Data Management

HCM - Health Care Management

RPM - Risk Prevention and Management

MNI - Management of Nosocomial Infections

TTS - Transfusion and Transplant Safety

**Configuration sample ( lot ):**

- By hospital categories: similar structure from II M to V

	<b>I</b>	<b>IM</b>	<b>II</b>	<b>IIM</b>	<b>III</b>	<b>IV</b>	<b>unrated</b>	<b>V</b>
Lot I	6%	3%	1%	9%	16%	34%	0%	31%
Lot II	0%	4%	7%	10%	14%	35%	1%	29%
Lot III	3%	11%	5%	10%	12%	35%	3%	21%

- Pe tipuri de servicii: structura a variat, dar nu semnificativ

	<b>Chronic diseases</b>	<b>General</b>	<b>Specialty</b>	<b>Emergency</b>
Lot I	7,14%	48,57%	28,57%	15,71%
Lot II	4,40%	35,71%	41,21%	18,68%
Lot III	4,02%	41,38%	37,36%	17,24%
<b>Total</b>	<b>4,69%</b>	<b>40,14%</b>	<b>37,56%</b>	<b>17,61%</b>

**Scores obtained:**



- By hospital categories: the coefficient of variation of the scores by categories between lots change marginally

<b>I</b>	<b>I M</b>	<b>II</b>	<b>II M</b>	<b>III</b>	<b>IV</b>	<b>unrated</b>	<b>V</b>
91,6	90,2	94,1	92,0	94,1	87,3		88,0
	88,2	88,2	89,1	89,8	85,8	84,4	89,1
75,5	74,8	73,0	74,4	72,6	70,5	61,1	75,5
<b>82,7</b>	<b>79,6</b>	<b>82,2</b>	<b>83,4</b>	<b>84,4</b>	<b>79,8</b>	<b>66,9</b>	<b>84,5</b>

- The average scores between lots were similar

<b>I</b>	<b>I M</b>	<b>II</b>	<b>II M</b>	<b>III</b>	<b>IV</b>	<b>unrated</b>	<b>V</b>
100,00%	100,00%	100,00%	100,00%	100,00%	100,00%		100,00%
	97,82%	93,72%	96,92%	95,38%	98,32%		100,00%
82,46%	82,95%	77,58%	80,85%	77,15%	80,79%		85,81%

- By types of services: the scores were close between the types of hospitals, in each lot.

<b>Chronic diseases</b>	<b>General</b>	<b>Specialty</b>	<b>Emergency</b>
88	89	90	92
90	86	88	90
74	72	74	71
<b>84</b>	<b>81</b>	<b>83</b>	<b>82</b>

- The average scores between lots were uneven, but comparable.

<b>Chronic diseases</b>	<b>General</b>	<b>Specialty</b>	<b>Emergency</b>
100,00%	100,00%	100,00%	100,00%
102,77%	97,20%	98,65%	97,28%
84,69%	80,99%	82,73%	76,81%

The analysis of the three groups shows a lower percentage of the degree of compliance with the indicators included in the Accreditation Standards.

During this period those redundant indicators were reduced, correlations were made, evaluators were prepared and a unitary validation method introduced. Initially, all indicators were



evaluated during the evaluation visit. The value of the indicators in the final calculation of the compliance level was not differentiated according to the relevance in ensuring the quality and safety of the patient.

The level of compliance in the 3 lots was not influenced by the sample configuration. The reduction of the number of irrelevant indicators and the correlation of the indicators in order to establish the conformity of the services with the requirements described by the indicators has insignificantly influenced the level of compliance in relation to lot I.

The better training of the evaluators, the introduction of the unitary methods of validation of the indicators and of the scale from 1 to 5 to assess the level of compliance, significantly influenced the results of the level of compliance with the accreditation standards.

For these reasons, it was necessary to change the evaluation methodology and procedures. Indicators related to the same activity were correlated. Different values were given to the indicators depending on their relevance in ensuring the quality of services and patient safety. A special procedure for evaluating the intervention capacity was introduced in the emergency situations that occurred during the hospitalization.

Communication with hospitals has been improved by introducing a computer application. Thus, the hospitals uploaded the necessary documents during the period prior to the evaluation visit, and the evaluators could consult them, leaving with complete information about the hospital unit they were going to visit. The communication with the management of the hospitals that were entering the evaluation process was improved by organizing meetings before the evaluation committee's visit, in which the procedures were explained in detail.

By drawing up the report on the accreditation of the hospitals enrolled in the first cycle of accreditation, the aim is to know the level of implementation of quality management in the hospitals in Romania and at the same time to make available to the decision-makers the data necessary to adopt measures to improve the quality of the hospital medical services.

**The experience gained during this first evaluation cycle was also used in the achievement of the second edition of the Accreditation Standards, where the emphasis is on the clinical management and the rights of the patient.**

If the first edition of the Accreditation Standards has 11 references, the second edition has 3 references: Organizational Management, Clinical Management, Medical Ethics and Patient Rights and is structured according to the requirements of the organizational model and the processes specific to the hospitals activity.



*Objectives of the Standards:*

- the development strategy of the hospital to meet the needs of the communities served,
- the patients should be taken by the hospital within the limits of its mission and resources,
- the patient's safety is taken into the cage in all the processes of the hospital.

**The second edition of the Accreditation Standards has been accredited by ISQua and complies with the principles of the International Society for Health Quality - ISQua.**

The second edition of the Accreditation Standards was carried out by independent experts selected from the healthcare professionals, all interested parties were consulted during a long public debate process and was adopted with the consent of the stakeholders.

The activity of elaboration, approval and transmission of the accreditation reports for the sanitary units with beds that received the evaluation visit in the second cycle of accreditation was started in 2018. Thus, up to this date, 168 sanitary units have received the evaluation visit, and 105 of these were included in an accreditation category, according to Order 10/2018 regarding the approval of the categories of accreditation of the sanitary units with beds related to the second accreditation cycle, with the subsequent modifications and completions, also receiving the Report of accreditation.

Category I Accredited	Category II Accredited with recommendations	Category III Accredited with reservations	Category IV Accredited with low confidence	Category V Decision to extend the accreditation process	Category VI not accredited
0	24,76%	3,80%	3,80%	71,42%	7,61%

From the previous table it is observed that only 24.76% of the sanitary units to which the accreditation report was elaborated and transmitted were classified in category II of the accreditation and 71.42% were classified in Category V, Decision to extend the accreditation of the accreditation process, 23% of them have a compliance plan with the ASF.

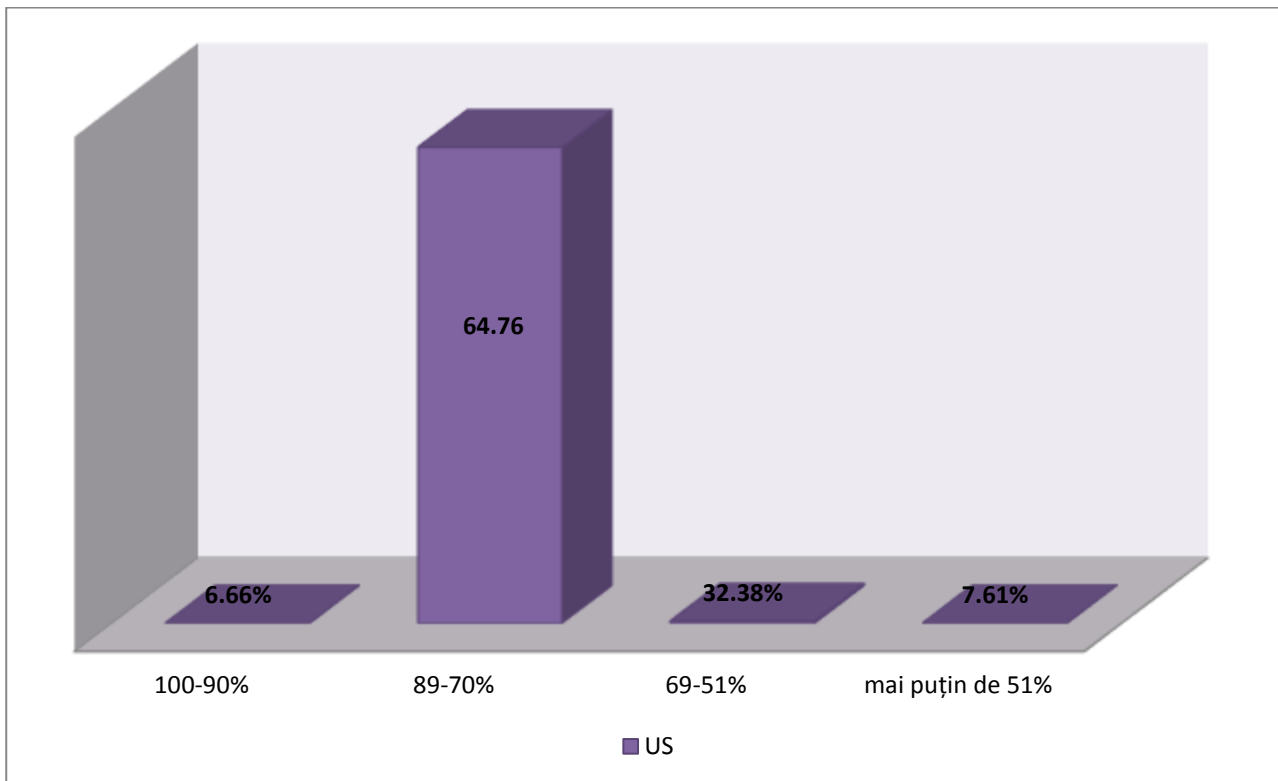


Fig. 5 US situation based on total score (%)

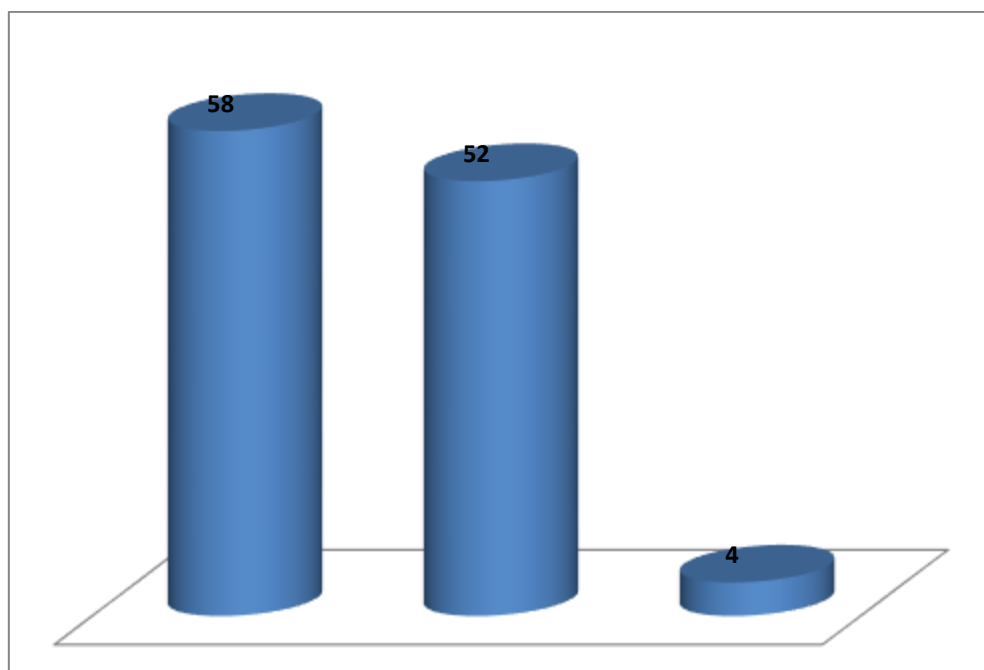


Fig. 6 US situation according to the indicators punctuated with (-10), (%)

A number of 58 US obtained percentages between 0.10-9.99% indicators (-10)%, and 4 US obtained a percentage of over 30% and 52 USP obtained a percentage between 10-29 %.

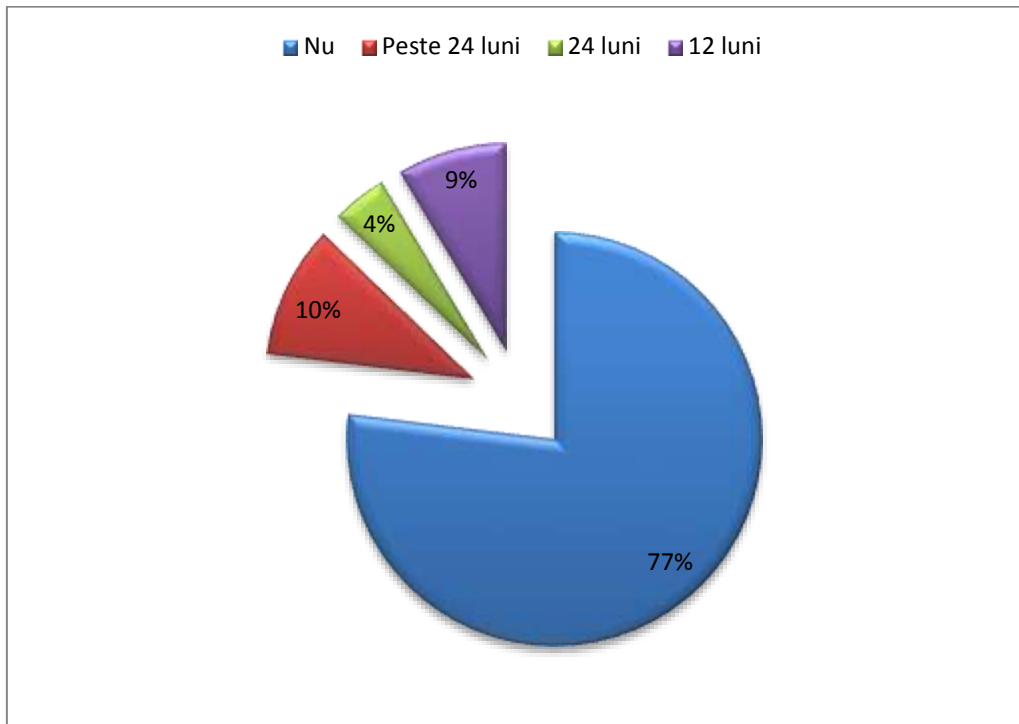


Fig. 7 US situation according to ASF compliance plan

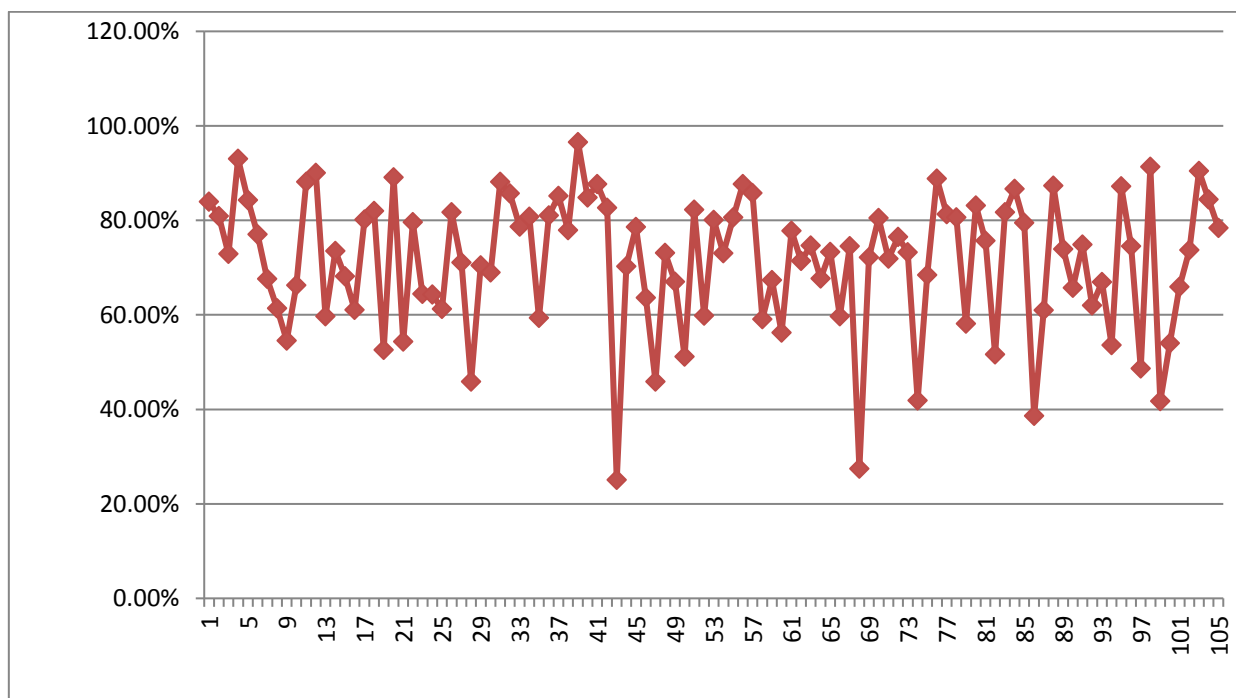


Fig. 8 US situation according to the score obtained

US classification in the 5th Category Decision to extend the accreditation process, was caused by the fulfillment of less than 51% of one or more standards, the USP having the obligation that within a maximum of 1 year from the communication of the results to apply for a new classification accreditation category. The classification is carried out after the correction by the US of both the indicators that are the subject of the Nonconformity Chart, as well as those indicated with (-10).

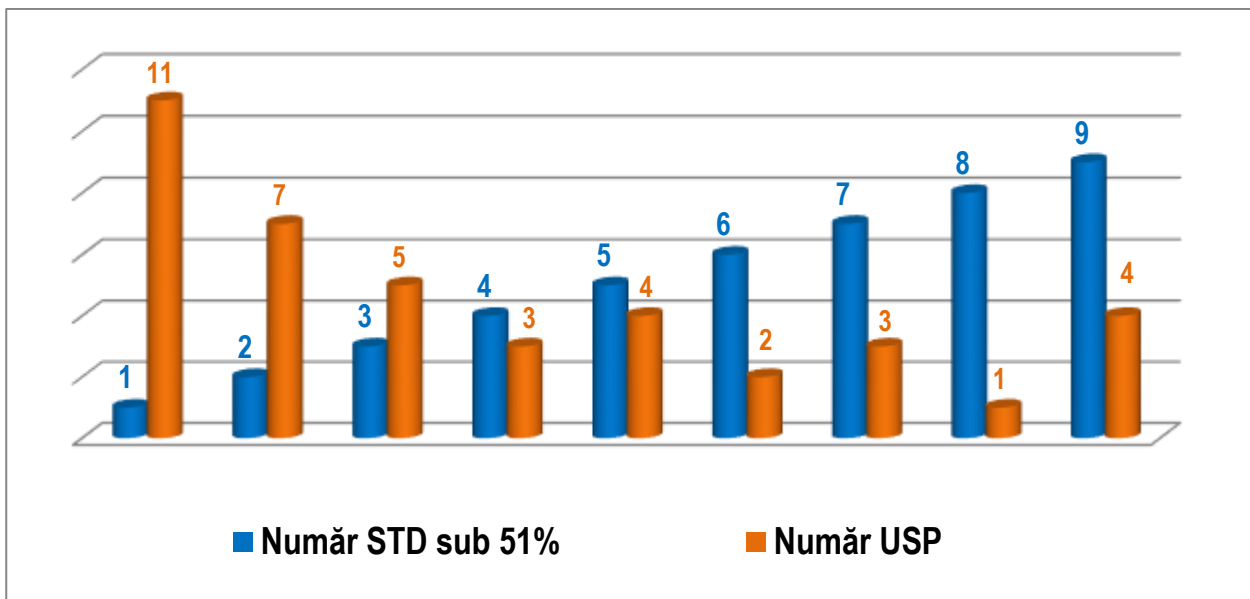


Fig. 8 US classified in the 5th Category Decision to extend the accreditation process according to the number of standards met below 51%.

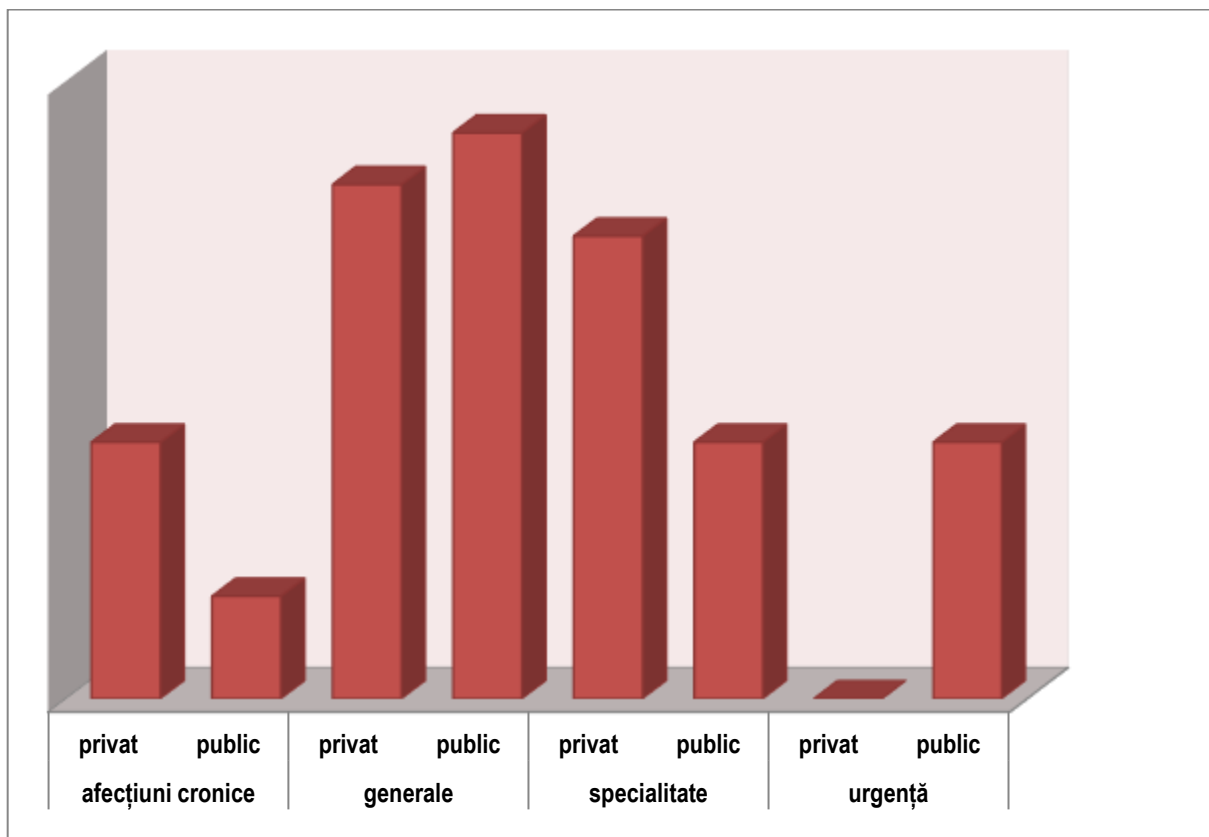


Fig. 9 US accredited, depending on the specific pathology and the regime of the property

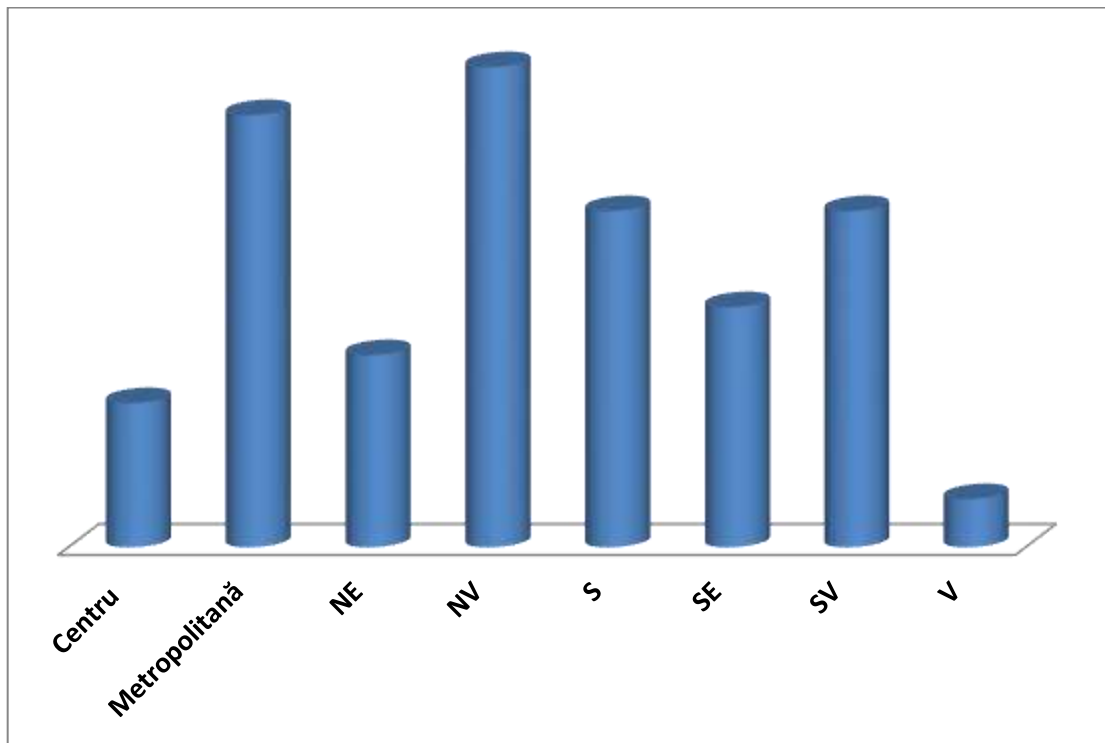


Fig. 10. US accredited, depending on development regions



### **DS 8.10.3-Examples of improvements made**

In the context of the knowledge of the realities of hospitals but also of the public perception regarding the quality of the hospital medical services, deficiencies were analyzed and certain **measures were taken to improve the evaluation and accreditation process, as follows:**

1. The number of indicators has been reduced;
2. The indicators related to the same activity were correlated;
3. Different values were given to the indicators depending on their relevance in ensuring the quality of the patient's health services and safety;
4. Introducing a procedure for evaluating the intervention capacity in emergencies during the hospitalization;
5. Improving the means of communication with hospitals by using a computer application;
6. Improved communication with the hospital management which are in the evaluation process, by organizing meetings preceding the assessment visit;
7. Elaboration, adoption and approval of the Second Edition of hospital accreditation standards.
8. Elaboration and transmission to the DSP, respectively the tutelary authorities, of the information regarding the results obtained in the first accreditation cycle by the subordinate USP. Thus, the level of fulfillment of the accreditation standards, grouped by reference chapters, as well as the level of fulfillment of the references that led to the classification of the sanitary units in the "Accredited" category, according to the Order of NAQMH President no. 85/2016 *regarding the approval of the categories of accreditation of the sanitary units with beds related to the first cycle of accreditation and of the model of the certificate of accreditation of the sanitary units with beds, with the subsequent modifications and completions.*
9. In view of the collaboration between NAQMH and the health units evaluated during the validity of the accreditation certificate, recommendations have been elaborated and transmitted by the NAQMH as a result of the non-conformities identified following the evaluation process for accreditation, in order to take the necessary measures to remedy them. The recommendations were elaborated based on the non-conformities found in the evaluation process, the critical indicators for patient safety were identified regarding:



### **9.1. The state of cleanliness and functionality of the common spaces (including toilets)**

- The institution must ensure the maintenance of the equipments and installations by performing their sanitation in accordance with an established program;
- The health unit must permanently improve the quality of the medical and hotel services by adopting the measures derived from the analysis of the data collected from the patient satisfaction questionnaires.

### **9.2. Use of protective equipment adapted to the activities performed**

- Permanent evaluation of working conditions and adoption of a plan of measures for their improvement, which also includes the purchase of protective equipment for all staff employed;
- Protecting patients and visitors within the program for the prevention of infectious risk by equipping and using the hospital equipment having different colors on the risk sections (ATI, Operator Block, etc.), the lack of which entailing the increased risk of infections associated with healthcare such as and misinformation of patients, respectively of caregivers;
- Periodic training of the technical personnel within the sanitary unit regarding the use of the protective equipment in order to prevent unwanted risks and events.

### **9.3. Infections associated with healthcare**

- Continuous monitoring of the situation of infectious risks (therapeutic, anesthetic, operative) in order to prevent risks and unwanted events;
- Providing the health unit for the rapid diagnosis of infections associated with healthcare in order to increase the diagnostic, prevention and control capacity of the AMI;
- Record in the medical documents of allergic reactions to antibiotics; the absence of allergy testing for antibiotics, or anti-tuberculosis determines the prescription and use of unjustified antibiotics, allergy to antibiotics being a major problem due to significant morbidity and mortality;
- Training of the personnel on the use and maintenance of the equipment in the operating rooms, in compliance with the regulations regarding the disinfection and sterilization of the equipment.

### **9.3. Hospitalization – discharge of patients**

- The sanitary unit with beds must provide the necessary facilities for the reception, registration and admission of patients through:
  - the organization and equipping at the guard room of the isolation spaces for the patients with potential infectious risk,



- signaling emergency room / hospitalization office;

- Organizing the emergency service for the triage, investigation and prioritization of patients in serious condition by implementing regulations regarding emergency triage as well as monitoring the waiting time from the time of hospitalization to the establishment of the first health care;
- Introduction in the Regulation of Organization and Functioning of the provisions regarding informing the relatives in case of deterioration of the patient's health, including at the occurrence of the death.

#### **9.5. Transport and administration of blood and blood products**

- The health unit must fulfill the criteria necessary to authorize the Blood Transfusion Unit by the Public Health Authority in accordance with the legislation in force;
- Creation of the blood transfusion unit in the hospital, authorized by the Public Health Authority, according to the legislation in force and the organization of the blood transfusion activity in the health unit;
- Respect process steps transfusion through the implementation procedure of harvesting pretransfusion blood samples from the patient tested pretransfusion checking blood or blood products received and issued as orders, registration results, the inputs and outputs of the blood bank, establishment and management of therapy transfusion;
- Respecting the stages of the transfusion process by implementing regulations regarding the administration of blood and derivatives.

#### **9.6. Food safety - storage, preparation and transport conditions**

- Quality control of the food (organoleptic, quantitative, qualitative), attribution of the chief doctor on duty / the coordinating guard on the hospital, which must be recorded in the Internal Regulation;
- Providing food circuits to consumers in compliance with hygiene rules by appointing staff for the distribution of food on each section;
- The health unit must evaluate and permanently improve the services of food supply and storage, as well as those of the food preparation, taking into account the analysis of the data collected from the patient satisfaction questionnaires;
- Providing circuits at the level of the food block in compliance with HACCP principles (risk analysis and determination of critical control points);
- The health unit must ensure and guarantee that the processes carried out within the unit are not harmful to the physical, internal and external environment.



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**9.7. Transport of patients inside the hospital in safe conditions and especially their transport to aseptic areas.** Unrestricted access patient within the hospital, except for sectors at risk, ensuring existing line for rail corridors and signaling prohibitions hospital access.

**10. Development of the CaPeSaRo IT application for: (Annex1)**

- Data collection by the evaluators during the visit,
- Increasing the efficiency of the process of analyzing the collected information, necessary for issuing accreditation reports; Generarea automată a raportului de acreditare;
- Automatic generation of the non-conformity remediation graph;
- Uploading and sending the Accreditation Report to the hospital in PDF format.



*Annex 1 to THE METHODOLOGY OF REGISTRATION AND PLANNING OF THE SANITARY UNITS WITH BEDS IN THE ACCREDITATION PROCEDURE CYCLE II*<sup>4</sup>

## **Use of the CaPeSaRo IT application for communication in the evaluation and accreditation process**

The CaPeSaRo solution is a computer application taken over by the NAQMH and made available to the health units to optimize the transmission of the information (documents) necessary to prepare the evaluation visit for accreditation.

This tool is intended to be useful both to the health units, which can upload in electronic format the documents requested by the evaluation commissions, as well as to the NAQMH structures and to the evaluators who can consult these documents in the foreseen stage.

Also, in the next stages of its development and adaptation, the application will be useful to the above-mentioned structures and in the periodic monitoring process.

As presented, the CaPeSaRo solution is a much more complex computer application whose functionalities, due to the high volume of work generated by the hospital accreditation process, were initiated for:

- A. "The layout containing the hospital data"
- B. "Self-Evaluation Sheet"
- C. "Annexes F.A.E"
- D. "Indicators supported by the existence of documents, depending on the checklists from which they come"

*Note: The CaPeSaRo team is working on the implementation of new modules, among which are the following:*

- "The results of the accreditation process "
- "Monitoring activity "

### **Procedure for using the self-assessment form module**

1. The sanitary units send to the N.A.Q.M.H., on the e-mail address *evaluate@NAQMH.gov.ro*, the document entitled *USP Identification Sheet*.

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<sup>4</sup> <https://NAQMH.gov.ro/web/wp-content/uploads/2015/10/capesaro-tutorial-1.pdf>



2. The CaPeSaRo team records in the application the information provided by the health unit through the USP Identification Card, including those regarding the person designated for accessing and uploading documents in the CaPeSaRo application (*name and surname, telephone number and e-mail address.* ).
3. The application generates a username and password which will be sent to the communicated email address.
4. Accessing the CaPeSaRo application can be done in several ways:
  - a. Direct from the N.A.Q.M.H. website, accessing the "ACCESS APPLICATION CAPESARO" button



- b. Directly accessing the address [www.capesaro.gov.ro](http://www.capesaro.gov.ro).
- c. By clicking on the link in an e-mail confirming the registration, which receive username and password.

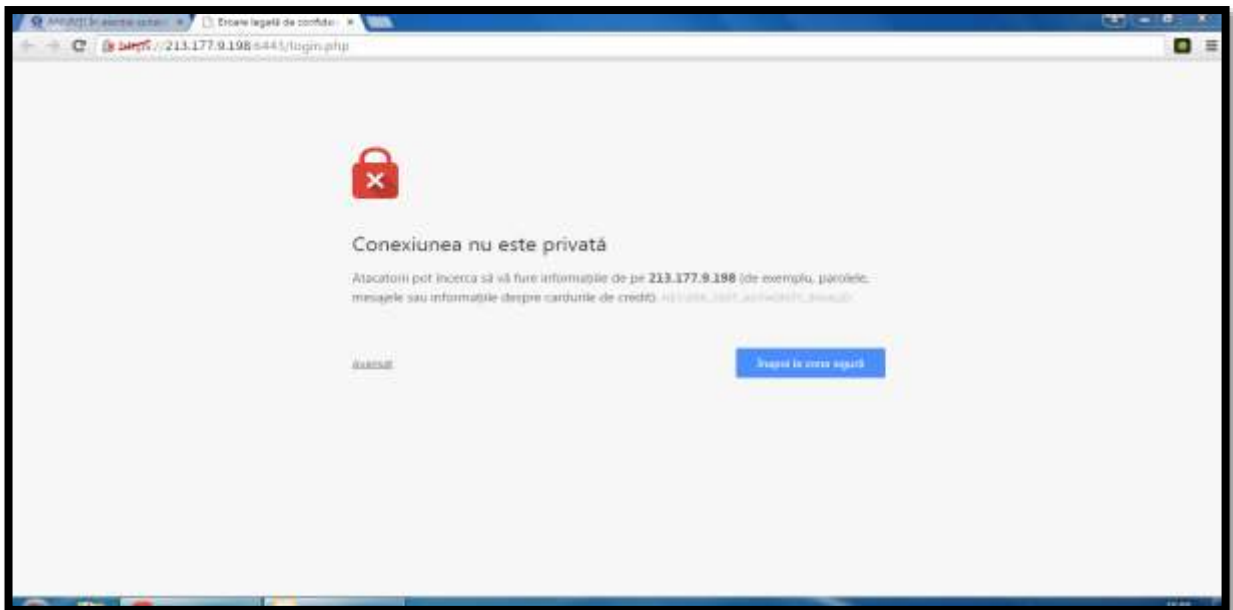
### Instructions for accessing and uploading documents in the CaPeSaRo computer application on the NAQMH website

1. Enter the username and password received on the e-mail communicated in the login box;
2. The page corresponding to the self-assessment sheet will open;
3. By accessing the link from point A, you can download, if necessary, the self-assessment sheet that you complete according to the instructions in the sheet;



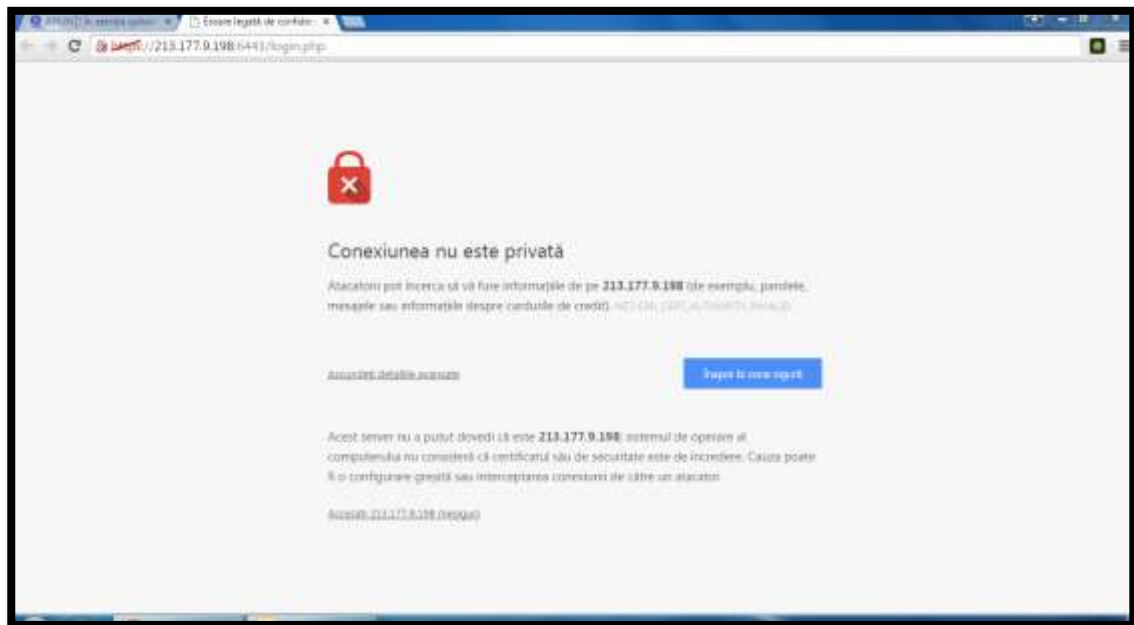
4. After completing, scanning and saving the completed file, press the "Upload file" button then select the document saved from your computer and press "save";
5. In the same way all the additional documents are loaded;
6. At the end, press the "Send documents" button;
7. A new window will open informing you that the documents have been sent;
8. Exit the application by pressing the "Logout" button;
9. If you want to view uploaded documents, you can log in again to the application and click the link to view the document. If, for various reasons, you want to change an already uploaded file, you can do so by clicking the "upload file" button and upload the new document that will delete the old one. We recommend that you keep the original of the last document uploaded in the application for verification by the commission of evaluators;
10. *It must be taken into account that the responsibility for the accuracy of the uploaded data lies with the health unit. As a result, in the case of communicating more users, we will only register as one user from your unit, generally the quality manager or someone from the IT department / service.*

Because both the NAQMH website and the CaPeSaRo application are hosted on the STS servers, due to their special security protocols, when accessing the application by any of the above methods, the following page may be opened:





Click on the "Advanced" link and the page opens:



Click at the bottom of the page on the link "Access 213.177.9.198 (unsure)" and the login page will open where you enter the access data received in the registration confirmation email.

After logging in, the following page opens, from which you can download the self-assessment form that can be completed and the other required documents can be uploaded:



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### Fișa de auto-evaluare

A. Descărcăți și/sau fișa de auto-evaluare pe care vă rugăm să o completați conform instrucțiunilor din pagina 2 a fișei  
B. Încărcati fișa completată aici

**Documente suplimentare**

Documentele suplimentare ce trebuie încărcate fișa de auto-evaluare (vezi pagina 2 a fișei) vor fi accesate folosind butonul de mai jos.

**ATENȚIE!**  
Trebuie să încărcați fiecare din cele 15 documente de mai jos, apoi să apăsați butonul trimite documente

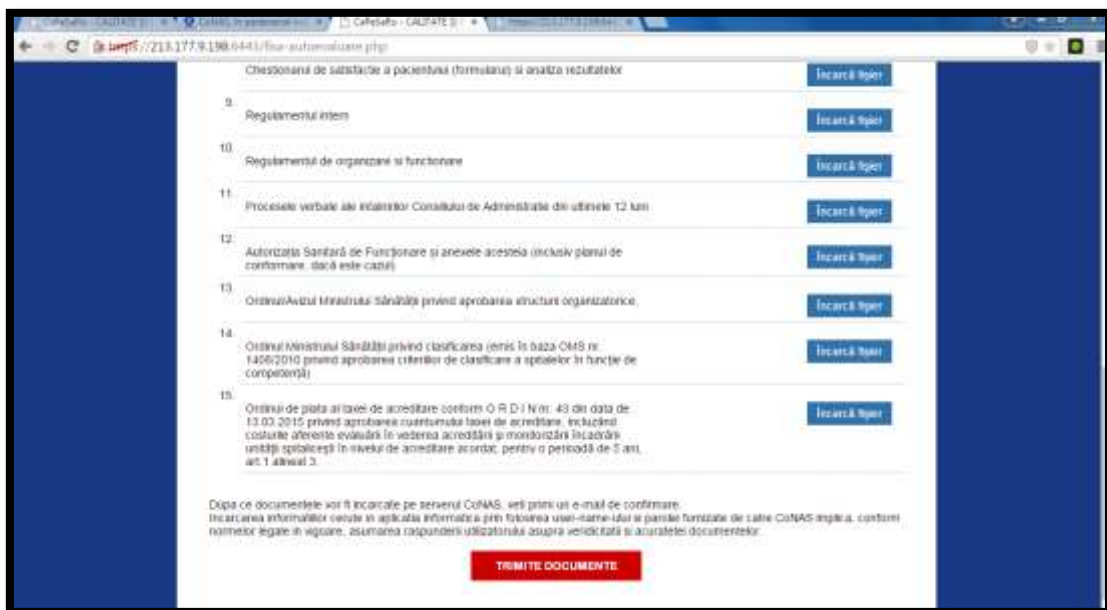
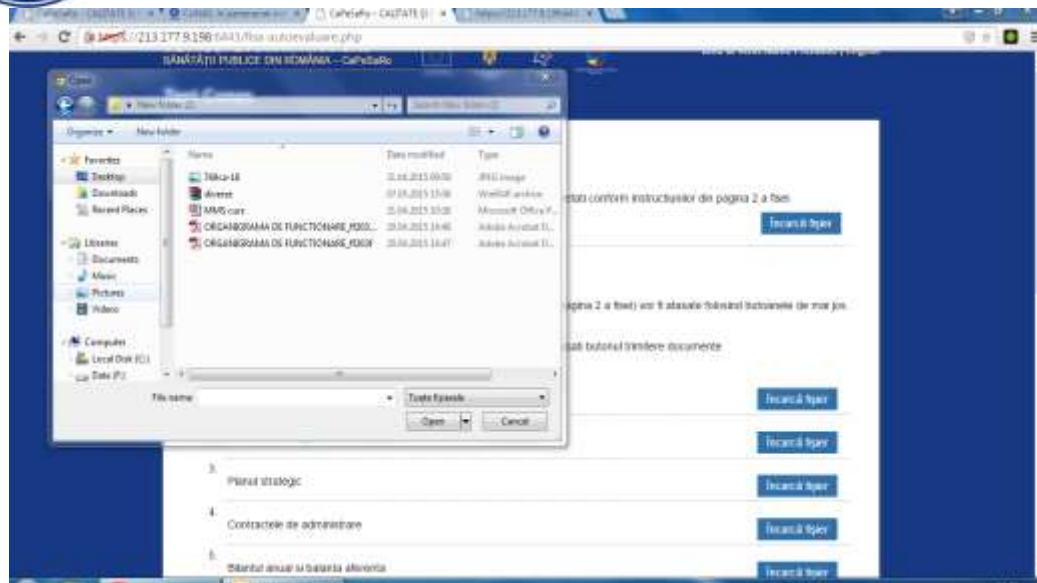
1.	Organigrama	Încarcă fișă
2.	Planul de management	Încarcă fișă
3.	Planul strategic	Încarcă fișă
4.	Comunicatele de administrare	Încarcă fișă
5.	Statutul asan și baza de asan	Încarcă fișă
6.	Ultimele exerciții bugetare	Încarcă fișă
7.	Chestionariul de satisfacție a angajaților (formularul) și analiza rezultatelor	Încarcă fișă
8.	Chestionariul de satisfacție a pacienților (formularul) și analiza rezultatelor	Încarcă fișă
9.	Regulamentul intern	Încarcă fișă
10.	Regulamentul de organizare și funcționare	Încarcă fișă
11.	Procesul verbal al ședinței Consiliului de Administrație din ultimele 12 luni	Încarcă fișă
12.	Autorizație Sanitară de Funcționare și anexele acestora (inclusiv planul de confirmare, dacă este cazul)	Încarcă fișă
13.	Credința Actului Medical sau RMZ și/sau planul aprobării structurii organizatorice	Încarcă fișă
14.	Ordnul Ministerului Sănătății privind clasificarea permis în baza Ordnului nr. 4409/2010 privind aprobarea criteriilor de clasificare a spitalelor în funcție de competență	Încarcă fișă
15.	Credința de plată al taxei de acreditare conform O R D I N I I nr. 43 din data de 13.03.2015 privind aprobarea regulamentului taxei de acreditare, incluzând costurile aferente acordării în vederea acordării și monitorizării frecvenței unorghi epistolești în momentul de acreditare acordat, pentru o perioadă de 5 ani, art. 5 alineat 3.	Încarcă fișă

Dupa ce documentele vor fi încărcate pe serverul CONAS, veți primi un e-mail de confirmare încărcării informațiilor cerute în aplicația informatică prin folosirea user-ului și parolei furnizate de către Consiliul Implicat. Conform normelor legale în vigoare, asumarea răspunderii verificărilor asupra veridicității și acurateții documentelor.

**TRIMITE DOCUMENTE**

By clicking the "Upload file" button next to each document, a dialog box opens asking you to select the document from your computer and upload it to the application. This step must be repeated for each document separately.

After uploading the documents, in whole or in part, access the button at the bottom of the "Send documents" page:



Depending on the file size, uploading it may take longer. Therefore we recommend that you do not close your browser until:

- change the "Upload file" button to "View document"
- the appearance next to the uploaded document of the "Edit file" button, the application display of the message:



### Fișa de auto-evaluare

A. Descărcați de aici fișa de auto-evaluare pe care vă rugăm să o completați conform instrucțiunilor din pagina 2 a fișei  
B. Încarcăți fișa completată aici

[Modifică fișă](#) [Vezi document](#)

### Documente suplimentare

Documentele suplimentare ce trebuie încărcate: amonați fișă de auto-evaluare (vezi pagina 2 a fișei) vor fi analizate folosind tuboanele de mai jos.

**ATENȚIE!**  
Trebuie să încarcăți fiecare din cele 15 documente de mai jos, apoi să apăsați butonul trimite documente

- Organigrama [Modifică fișă](#) [Vezi document](#)
- Planul de management [Modifică fișă](#) [Vezi document](#)
- Planul strategic [Încarcă fișă](#)
- Contactele de administrare [Încarcă fișă](#)
- Statal anul și bilanțul aferență [Încarcă fișă](#)

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#### Fișa de auto-evaluare

Încărcarea și transmiterea documentelor dumneavoastră s-a încheiat cu succes!

Pentru orice întrebări referitoare la acest modul al aplicației vă rugăm să ne contactați pe adresa [capesaro@conas.gov.ro](mailto:capesaro@conas.gov.ro)

Înapoi

- and receipt by mail of the confirmation of the upload of the documents.

**Fișa de auto-evaluare**  
CoNAS [capesaro@conas.gov.ro]  
Sunt: J 07.05.2015 15:40  
To: [REDACTED]

**Încărcarea și transmiterea documentelor dumneavoastră s-a încheiat cu succes!**

Pentru orice întrebări referitoare la acest modul al aplicației vă rugăm să ne contactați pe adresa [capesaro@conas.gov.ro](mailto:capesaro@conas.gov.ro)



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We recommend that you upload your documents in .pdf format. If more documents are required, they can be uploaded archived.

By uploading the documents in the CaPeSaRo application by using the username and password provided by it, the documents are considered valid without other authentications (stamp signatures, etc.), the responsibility of their authenticity and accuracy being returned to the uploader.

If changes have been made to a document after it has been uploaded, it can be updated by accessing the "Edit File" button. Thus in the application will be visible the last document uploaded.

For the evaluation visit for accreditation you have to prepare and make available to the evaluation commission all documents uploaded in original (hard-copy format) signed and stamped.

Section C: "Indicators supported by the existence of some documents, according to the checklists from which they come":

- In this section the user uploads all the protocols, procedures and documents necessary to be viewed by the evaluators in order to prepare the evaluation visit or to complete the lists / indicators that are analyzed and validated in the forecast.
- The documents are uploaded in electronic format, preferably pdf, without the need to scan pages with signatures / stamps.