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Dr. Naveen Malhotra Editor-in-Chief THE ICHA NEWS

Steering forward on the journey to build an equitable healthcare system through its mission of Patient Safety, ICHA continues to enlarge and expand in its outreach and scope. With an overwhelming response to the inaugural issue of our newsletter- The ICHA News, we solemnly present the second issue in the thread with the aim to infuse a sense of unity amongst our member by realigning our objectives.

Our country and its healthcare system is going through extreme and challenging circumstances. With the resurgence of COVID-19 pandemic in an explosive manner, all the health care providers have been challenged to stretch their capacity and push their limits. Times like these, call for a stronger than ever urge to come together and become a support group for one another.

ICHA Mitra, an initiative which was launched last year to address the concerns of frontline workers in the battle against the pandemic, has now taken the form of a mission. Day by day, increasing numbers of volunteers are signing up to extend their kind assistance and promote wellbeing in every way possible.

The article by Dr. Rajan Madhok - "What Next for Patient Safety" splendidly serves this purpose by calling attention to the prospective steps and their execution in the direction of patient centered care. The gargantuan task of ensuring safe and effective health care starts with identifying practical issues arising out of human error and formulating strategies to minimize these errors. In her article "Medication errors linked to Drug Name Confusion", Dr. Sangeeta Sharma has beautifully highlighted the impact of preventable medical errors and their role in quality improvement. The article by Dr Seema Bhargava focuses on an important topic on Vaccines for COVID 19 and its current perspectives and logistics.

There is a growing sense of responsibility, amongst our constituent associations and their representatives as well as our individual affiliates, towards the cause of uninterrupted care to the patients amidst the COVID-19 pandemic. Telemedicine, an endeavor designed to disseminate specialized healthcare in the remote areas has now become the need of the hour. We are pleased to feature the work done by Dr. Nirmal Surya and Dr. Kenshuk Marwah in the field of telemedicine by conducting seminars and symposia to spread awareness amongst the providers regarding current guidelines, ethical and legal aspects and online platforms available for teleconsultation.

We are deeply obliged by our keenly responsive members and hereby show our reverence towards them by sharing the glimpses of the inaugural ceremony of The ICHA News. We earnestly hope for incessant support from our esteemed fraternity in broadening this novel platform in all its nobility and in turn pledge to remain devoted to our tradition of providing common platform to all the spokesperson to share their wisdom and voice their concerns.

Dr. Naveen Malhotra

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Dr. Poonam Rajput CEO & Director ICHA

Team ICHA started the New year with a Bang!! The first quarter of 2021 was full of activity.

The long awaited news letter, ICHA e- News was launched on 17th January 2021 and it was very well appreciated by all members and they were enthusiastic in making contributions to it for future editions. This was indeed a step forward in establishing a channel of communication amongst our associates. Members were encouraged to convey relevant and necessary information via the e-news. It was decided to release the news letter quarterly and later increase the frequency if required.

Another milestone was achieved when ICHA launched its very own Telemedicine Academy on 14th March 2021. The start was well attended and the 4 hour long program covered important technical and legal issues in Telemedicine. In the months to come, the team will start the trainings in handling different specialties via the digital platform.

ICHA now is looking forward for participation of more and more affiliates, and an exchange of mutually needed best practices. For this we request our member affiliates to come forward and share their best practices in their respective fields and organisations.

We also aim to widen our affiliate base and reach out to many more and in this too we seek assistance from our existing affiliates to spread the word and await many others to contribute to our existing projects as well as suggest newer ventures.

The next important landmark will be the launch of the training modules in sustaining excellence in providing safer healthcare. The backend development of modules is in full swing and soon the date for the launch will be announced.

The slow and steady pace with which ICHA is moving forward is indeed heartening and gives a sense of pride and satisfaction to see the team so motivated and eager to do good for our own.

We will keep this spirit high and continue to Take ICHA Forward.

Dr. Poonam Rajput CEO & Director ICHA Director, Morpheus Healthcare Pvt Ltd Delhi



It is almost thirty years since the start of patient safety movement – which came about as a result of a number of initiatives separately in USA, Australia and the UK around the 1990s and which highlighted the problem of the harm being done to patients as a result of medical care. The first Institute of Medicine report assessed that medical harm itself was a leading cause of death and infact caused more deaths than motor vehicle accidents, AIDS or breast cancers in 1999, for example. A lot has happened over the last three decades with patient safety now firmly on the agenda of governments, health care professionals and managers, and the public. There are very comprehensive systems to measure the extent of the problem with detailed arrangements for implementing evidence based interventions reinforced by regulatory bodies. So the whole cycle for managing the problem is complete. Or is it? Is all this working or do we need to do something different?

Just consider this: for example, in the US by 2016 medical harm had increased and care itself was the third (*sic*) leading cause of death begging questions about whether all the effort had any effect. In the UK where I live, though retired now, successive reports continue to show failures, with good quality and safe care being more of a lottery with some providers doing better than others. Sadly in India, it is impossible to make any assessment of either the extent or impact in the absence of meaningful information – our report had negligible systemic impact (1).

Personally, I was despondent as I wanted to help promote best practices in India and particularly efforts to promote quality and safety and as an outsider (having deserted India soon after qualifying in 1980) had found it difficult to meaningfully contribute. However in ICHA I found a soulmate and since their first convention in 2005 I have been impressed with and grateful to ICHA for their persistence and leadership. The recent developments within ICHA with the renewed strategic direction and new governance and management arrangements has put it in a very strong position to make a real difference to health care in India.

In doing so, my view, is that ICHA should step back, reflect, take stock and then decide the practical measures. I tend to categorise problems as being simple or complex- getting to the moon was a simple problem since it was a technical issue while patient safety is a complex problem since it is a human behaviour issue. The danger is that by treating complex problems as simple we make them complicated and end up wasting resources – hence the more that is being done in the name of patient safety the less safe the public is. And to use one of the classical techniques of patient safety – to ask the 5 Whys, at each step why things are the way they are - one can get to the nub of the problem. If one applies this to patient safety, it seems to me that at heart it means promoting professionalism to ensure patient centric care – the values of humanity, trust, respect, care, compassion etc, which are the key ingredients of that elusive holy grail of culture.

Whilst India may have been slow in taking up the patient safety challenge it is now ready for it- the 'Jugaad' mindset with the resilience of its people to bounce back, to learn from others and leapfrog ahead, all supported by a receptive policy environment are good omens. The western world is also reviewing its approach with the WHO planning its strategy for this new decade and the prestigious JAMA reinforcing the need for transparency and rebuilding of the trust in physicians.

What does this mean practically then? It is essential that ICHA continues the work on the various training programmes to equip professionals with the necessary tools to promote safe practices in whichever specialty they are working in. In addition, not instead, however, it must invest in thought leadership to develop the leaders, who are able and interested in professionalism, humanistic values and reflective practice. Having discussed this with Dr Sangal, I believe that this is already planned and ICHA has established a network of faculty who are working on developing specific projects to take these forward, and I applaud you all for this foresight.

In closing, let me share this quote from my favourite book: Zen and the art of motorcycle maintenance

"I think if we are going to reform the world, and make it a better place to live in, the way to do it is not with talk about relationships of a political nature, Programs of a political nature are important end products of social quality that can be effective only if the underlying structure of social values is right. The social values are right only if the individual values are right. The place to improve the world is first in one's own heart and head and hands, and then work outward from there. Other people can talk about how to expand the destiny of mankind. I just want to talk about how to fix a motorcycle. I think that what I have to say has more lasting value."

This is in essence what Gandhiji had meant when he said: "*Be the change you want to see*", and having interacted with many of the ICHA leadership I know you already practise it but nothing succeeds like seeing these values in action. So continue to model the behaviours and practices you want to see – lead from the front, set an example; it will be fun and believe me very satisfying; its truly a win:win. Remember although professionals we are all also patients, so frankly we are doing this for ourselves – there is no 'They', it is 'Us'. Carpe Diem-I wish you the very best in your endeavours.

Rajan Madhok, UK

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 Madhok R, Sangal A, with others. Promoting patient safety in India: situational analysis and the way forward. National Medical Journal of India 2014 <u>https://www.researchgate.net/publication/272192815_Promoting_patient_safety_in_India_Situational_ana</u> <u>lysis_and_the_way_forward</u>



Dr. Sangeeta Sharma Director ICHA Chairperson ICHA Mitra Committee Professor & Head, Neuropsychopharmacology Institute of Human Behaviour & Allied Sciences President (Honorary), Delhi Society for Promotion of Rational Use of Drugs (DSPRUD)

Medication Errors Linked To Drug Name Confusion

Medicines are cornerstone of the management of most illnesses and save many lives if used appropriately. This success has resulted in a dramatic increase in the use of medication. Unfortunately, this increase in use has brought with it an increase in hazards, errors and adverse events associated with medication use. Also, over the years there is a massive increase in the number and variety of medications available in market. These medications have different routes of delivery and variable actions (long-acting, short-acting). Drugs often have several names.

Same brand for different medicines

Several brands of a generic medicine are available causing confusion. Vice versa also may further complicate and is dangerous when a same brand name is used for several different medicines such as Medzol inj. is given to two different pharmacological categories of drugs pantaprazole and midazolam. Other examples include same Medzole brand having different generic drug classes - itraconazole, esomeprazole. This problem is further compounded by one letter difference in the name Medzole-400 which contains albendazole. There is one letter difference in the brand names for example, but the contents are very much different such as Domstal OD (domperidone sustained release) and Domstal RD and Domstal O (domperidone plus omeprazole). Medication errors can occur due to confusion between brand names, generic names, and branded generic names like Toradol and tramadol. It is a fact that there are many lookalike sound-alike (LASA) drugs available in India that can result in medication errors. These errors could cause serious harm to patients or even death. Many patients are also taking multiple medications, adverse-effects and errors in dispensing/administration.



A tragedy waiting to happen?

Similar names for different medicines

Certain medication design factors or naming can also increase the risk of medication errors. Some medications can be easily confused, such as formulations that are similar in appearance (e.g. colour, shape). Medications with similar names can also be easily confusing. Examples Celebrex, Cerebryx and Celexa used for celecoxib (an anti-inflammatory), fosphenytoin (an anticonvulsant) and citalopram hydrobromide (an antidepressant) respectively; as well as ephedrin and epinephrine. Ambiguous labelling is another source of confusion. Different preparations or dosages of similar medication may have similar names or packaging. For example, phytonadione 1 mg and 10 mg are very similar looking. Some modified-release medications may differentiate themselves from the usual release form with a suffix. Unfortunately, there are many different suffixes in use to imply similar properties, such as slow release, delayed release or long-acting (e.g., LA, XL, CD, ER, SL, SA, CR, XT). Certain medication design problems lend themselves to administration errors, including labelling that is too small to read and difficult-to read dose information on vials.

The most serious errors reported due to similar names involve high alert medications such as insulin (HUMALOG and HUMALOG 75/25; HUMULIN N and HUMULIN R HUMALOG 75/25 and HUMULIN 70/30; NOVOLOG 70/30 and NOVOLIN 70/30), opiate narcotics (morphine and meperidine; confusion between morphine immediate release and morphine sustained release (MS CONTIN); oxycodone and sustained release oxycodone (OXYCONTIN).

Strategies to reduce the errors

To reduce errors due to the drug names and confusion over the (LASA) medications, following is required:

• Generic (an approved official name) and brand names (chosen by the manufacturer) must be unique to prevent one drug from being mistaken for another when drugs are prescribed and prescriptions are

Medication Errors Linked To Drug Name Confusion

dispensed/administered. A central registry of the brand names should be developed.

- Undertaking from the pharmaceutical companies to not-to repeat the same trade names for different drugs.
- Guidelines for packaging and labelling particularly to avoid look alike preparations and auxiliary labelling in case of high-alert medicines.
- Eliminate/reduce LASA drugs on hospital formulary by identifying the possibility of name confusion and instituting safeguards to avoid confusion when adding a new product to organization's formulary.
- Separating products with look-alike names on storage shelves, computer screens, and on any printed prescriber or stock order forms and use auxiliary labelling to identify LASA.
- · Prescription by generic name written in capital letter.

Dr. Seema Bhargava Chairperson and Senior Consultant Department of Biochemistry & Professor GRIPMER, New Delhi

Vaccines For COVID-19 : Current Perspectives And Logistics

Mankind has lived with infections since life originated. In modern era, a vast zoonotic pool, ecological upheaval and globalisation will facilitate infections further. Woolhouse and Gaunt estimate at least 1500 pathogens have the capacity to infect human race in future. The attributes of the pathogens most likely to cause pandemics have been surmised generally. These are likely to be RNA viruses, with non-human reservoirs and a broad host range and potential for human to human transmission.¹ Pandemics have caused untold misery, death and destruction and wreaked indescribable horrors on mankind down the generations. Bubonic Plague with over 100 million deaths, Spanish Flu with over 50 million deaths, AIDS with 35 million deaths and counting, sear the collective human memory. Advances in virology, microbiology, genetics specifically and vaccine technology generally present us with the hope that the current Covid-19 pandemic will be cut short before it runs its entire malevolent course.²

To understand the vaccines for Covid-19, one must understand a few features of the SARS coronavirus 2. On 11th February, 2020, International Committee on Taxonomy of Viruses (ICTV) named the virus "severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)", while on the same day WHO named the disease caused by this virus as "Covid-19" on basis of guidelines given by the World Organisation for Animal Health (OIE) and the Food and Agriculture Organization of the United Nations (FAO).^{3,4}

SARS CoV-2 was named thus due to its genetic resemblance to the corona virus that caused the SARS outbreak of 2003.

SARS-CoV-2 is an enveloped, non-segmented, positive sense RNA virus 29,881 basepairs in length. It contains four structural proteins (S, E, M, and N) and sixteen non-structural proteins (nsp1–16). The S (spike) protein is a glycoprotein protruding in the viral surface which facilitates binding of envelope viruses to host cells by attaching to angiotensin-converting enzyme 2 (ACE2) receptors. ACE2 receptors, though maximally expressed in the lower respiratory tract alveolar cells, are also expressed in the upper esophagus stratified epithelial cells, enterocytes of the ileum and colon, cholangiocytes, myocardial cells, kidney proximal tubule cells, and bladder urothelial cells. The N (nucleocaspid) protein is localized in the endoplasmic reticulum-Golgi region and is attached to the nucleic acid material of the virus; hence it is involved in the viral replication cycle, and the cellular response of host cells to viral infections. The M (membrane) protein determines the shape of the virus envelope. It binds to the other structural proteins. On binding to the N protein, it stabilises the nucleocaspid and the N protein-RNA complex. The E (envelope) protein is the smallest of the structural proteins and is involved in the virus. Neutralising any of these proteins leads to inactivation of the virus.

In accordance with this several vaccines have been developed all over the world, targeting different proteins of the virus.

Vaccines stimulate the body's adaptive mechanism to produce antibodies against a specific infective agent, thereby preventing occurrence of disease caused by that infective agent. When a large number of the population is vaccinated, it is termed 'herd' immunity and this tends to break the cycle of transmission of the infective agent due to non-availability of a transmitting host. This was first observed when small pox was eradicated from the



whole world; now polio and tetanus have also been eliminated in most parts of the world. However, diseases such as measles have seen a rise in number of cases, probably due to vaccination hesitancy in the last decade. Interestingly, the percentage of population who need to be immune to achieve herd immunity varies with the disease. For measles, 95% of the population need to be immunized to achieve herd immunity, and for polio this threshold is 80%. However, the threshold for Covid-19 is not known as yet.^{8,9}

Variolation, a type of immunization, is the practice of infecting people with low doses of smallpox and it generally induces a mild form of the disease, which prevents the person from being re-infected. Historically, it probably dates back to ancient India, where it was practiced (1000 BC). It was also witnessed in China in the 16th Century where unattenuated live pathogen was inoculated. In the ensuing decades and centuries, several attempts were made towards prevention, but it was only in 1796 that the first vaccine against small pox was made by the English physician Edward Jenner. Later, Louis Pasteur furthered the concept through his work in microbiology. This form of immunization was called vaccination as the first vaccine was developed against a virus that affected cows (Latin: vacca means cow).¹⁰⁻¹⁴

While most vaccines are injectable, there are a few that are given orally, as live attenuated virus (e.g. polio, rotavirus, cholera) to produce immunity in the bowel. Again, most vaccines are given before the individual contracts the disease, but there are a few exceptions, e.g. vaccines for rabies, AIDS, Alzheimer's disease, etc. These enable a rapid immune response without the harmful effects of the disease per se.¹⁵⁻¹⁷

The development of a vaccine is a tedious process and typically takes 10-12 years including the trials of efficacy and safety. Before being allowed for use on humans, vaccines are run through computer algorithm models to predict their interaction with the immune system, and are tested on cells in a culture. The next stage is testing these vaccines in animals, including mice, rabbits, guinea pigs, and monkeys. Once the vaccine is declared safe in animals, then the human three-phase trials begin. In phase I trials, about 20 individuals are given the vaccine and observed for adverse reactions, the goal being to assess its safety. Once safety is ascertained, in phase II trials, the vaccine is administered to 50 to several hundred individuals and assessed for its safety, efficacy and optimum dosage. When a vaccine emerges as safe and efficacious on basis of these two phases of trials, phase III trials are allowed, which focus on the efficacy of the vaccine in hundreds to thousands of subjects. Only after this phase is completed is the vaccine approved by drug regulatory authorities and licensed for routine use in the general public. Most vaccines undergo a fourth phase of trial while in use amongst general public for collection of data and further evaluation and documentation of safety and efficacy.¹⁸

However, to combat the pandemic, development of the vaccines against SARS CoV-2 has been fast-tracked with these being made available to the public within 10 months.

Here it would be pertinent to mention the types of vaccines that have been made:

- Inactivated vaccines which use a form of the virus that has been inactivated or weakened so it doesn't cause disease, but still generates an immune response.
- Messenger RNA (mRNA) vaccines use genetically engineered RNA to generate a protein that itself safely prompts an immune response.
- Subunit, recombinant, polysaccharide, and conjugate vaccines
- Toxoid (protein-based) vaccines which use harmless fragments of proteins or protein shells that mimic the COVID-19 virus to safely generate an immune response.
- Viral vector vaccines which use a safe virus that cannot cause disease but serves as a platform to produce corona virus proteins to generate an immune response.

The first vaccine, an adenovirus vectored vaccine was launched by China (CanSino Biologics Inc.) on 29th February, 2020, just 2 months after the earliest cases of Covid-19 were reported in Wuhan, followed by isolation of the causative virus and elucidation of its genome. A double-blind randomised, placebocontrolled phase II trial for evaluation of immunogenicity and safety was conducted in June, 2020. Following a single dose of this vaccine, seroconversion of 96% was achieved on day 28. Phase III trial, conducted in four countries, has just been completed.^{19,20}

As of now, there are at least seven vaccines that have been developed against SARS CoV-2. Amongst these, a few which have been approved by the respective drug regulatory authorities in USA, UK and India are the mRNA (messenger ribonucleic acid) BNT162b2 developed by Pfizer-BioNTech, the mRNA 1273 developed by ModernaTX Inc (in collaboration with National Institute of Allergy and Infectious Diseases), the adenovirus vector ChAdOx1 nCov-19 (chimpanzee adenovirus) or AZD1222 developed by AstraZeneca, in collaboration with the Oxford University.

There are seven other vaccines that have been developed. Russia launched its recombinant adenovirus 5 vector-based and adenovirus 26 vaccine (Sputnik V) in August 2020. Janssen Pharmaceuticals, a subsidiary of Johnson and Johnson, developed another mRNA vaccine (Ad26.CoV2.S). An inactivated SARS-CoV-2 vaccine (BBV152) was developed in the Indian Council of Medical Research-Institute of Virology in Pune, India.^{21,22}

The BNT162b2 vaccine is a lipid nanoparticle (LNP)-encapsulated mRNA encoding the full-length spike protein anchored on the membrane of SARS-CoV-2. Administered as a two-dose vaccine at an interval of 3 weeks, it confers 95% (95% CI: 90.3-97.6%) efficacy with mild side-effects and a low incidence of severe adverse events, as elucidated in an ongoing multinational, placebo-controlled, observer-blinded, pivotal efficacy trial. One of the major drawbacks of this vaccine is the storage and transport requirement of -70°C.²³The vaccine mRNA 1273 is also a LNP-encapsulated mRNA encoding the Spike protein of SARS-CoV-2. The schedule is two doses given 4 weeks apart. In a phase 3 randomized, observer-blinded, placebo-controlled trial conducted at 99 centers across the United States with 30,420 participants, its efficacy was 94.1% (95% CI: 89.3-96.8%) with moderate transient reactogenecity.²⁴

In an analysis including data of 23,848 subjects from four ongoing blinded, randomised, controlled trials done across the UK, Brazil, and South Africa, the ChAdOx1 nCov-19 vaccine or AZD1222 was found to be safe. In the two arms of this study, one received two standard doses and the other received a lower dose followed by a standard dose, both being in two diverse settings where the interval between the doses was 12 weeks in the UK and ≤ 6 weeks in Brazil. Those who received both standard doses showed 62.1% (95% CI: 41·0–75·7%) efficacy while those who received a low dose followed by a standard dose showed 90.0% (95% CI: $67\cdot4-97\cdot0\%$) efficacy. This intriguing response could probably be explained thus: when a viral-vector vaccine is administered, in addition to generating an immune response against the spike protein of the corona virus, there is also a generation of antibodies against the vector per se. When the second dose is administered, these latter inactivate some of the virus vector itself, thus resulting in a lower antibody response.²⁵

In another study, the ChAdOx1 nCov-19 vaccine was demonstrated to be protective against B.1.1.7 (spike protein) as well as non-B.1.1.7 variants of Covid-19.²⁶

In a preliminary study including 43,783 participants, Ad26.CoV2.S from Janssen has been shown to be approximately 67% effective in preventing moderate to severe/critical COVID-19 occurring at least 14 days after vaccination 66% effective in preventing moderate to severe/critical COVID-19 occurring at least 28 days after vaccination. Additionally, the vaccine was approximately 77% effective in preventing severe/critical COVID-19 occurring at least 14 days after vaccination and 85% effective in preventing severe/critical COVID-19 occurring at least 28 days after vaccination and 85% effective in preventing severe/critical COVID-19 occurring at least 28 days after vaccination.

The Sputnik V is a hybrid vaccine comprised of two different adenoviruses (Ad 26 and Ad5) for its prime and booster doses given 21 days apart. This apparently enhances efficacy to 91.6% (95% CI 85.6–95.2), as elucidated in a randomised, double-blind, placebo-controlled phase III trial involving 16,427 participants from 25 hospitals and polyclinics in Moscow.²¹

BBV152 or covaxin is an inactivated virus-based vaccine against COVID-19 formulated with a toll-like receptor (TLR) 7/8 agonist molecule (IMDG) adsorbed to alum (Algel). It has been developed by ICMR Institute of Virology, Pune and is manufactured by Bharat Biotech. Phase I and II trials with two doses of two strengths elucidated seroconversion in 98.3% (95% CI: 95.1-99.6%) subjects who received two doses of higher strength (6g) at an interval of 4 weeks. These trials included 23000 individuals. It was also found that 69.5% (95% CI: 53.7-89.9%) subjects exhibited persistent immune response with neutralising antibody titres at 3 months after the second dose (6g).²²

Having detailed the efficacies of the major COVID-19 vaccines currently available, it deserves mention that currently there are 184 vaccines in the preclinical development phase and 88 in the clinical development phase.²⁸

Currently, there has been a global rush for vaccination of all populations. Initial vaccination hesitancy was soon surpassed by vaccination eagerness. Despite that, increasingly new cases are being reported every day, with peaking numbers at different time points in different continents, often due to different variants.

On basis of the efficacy data mentioned above, can we identify any of these vaccines as more effective? It is actually tempting. But one has to remember that "each measure of efficacy comes with a degree of uncertainty, and trials might have differing definitions of important criteria, such as what constitutes a 'severe' bout of COVID-19 compared to a 'moderate' one". Also, as each vaccine has been studied at a different time in a different country/countries, each trial can only give a glimpse of the possible protection conferred by that vaccine against different variants. Moreover, in the current scenario, as important as it is to consider the efficacy of these vaccines, equally important are the logistics of supply – cost, cold-chain requirement, availability, durability of the protection and their ability to counter emerging variants.²⁹

Currently, in India, the number of new cases have increased phenomenally, contributing rapidly to a total of 15,061,919 cases as of the morning of 19th April, with current number of active cases being 1,929,329 and the number of vaccines 123,852,566. However, as reported in the Times of India, "The national death rate (or case fatality rate) stood at 1.22% and has been dropping marginally despite the rise in cases". This might indicate that ³⁰⁻³² though reports regarding the course and severity of the current wave of covid-19 are anecdotal, it would be pertinent to mention several observations made by different clinicians:^{33,34}

• The current cases proceed to lung involvement within the first 4-5 days as opposed to the second week as was seen in the first wave of this pandemic

• From affecting mostly the older population and those with co-morbidities, it is now affecting the younger healthy population

• The inflammatory response is more severe

• Yet, severity of the disease is possibly lower given the lower case fatality rate. This has steadily improved – from 3% in June, to currently 1.3%.

When covid has affected those who were already vaccinated, the severity was mitigated.

Is it possible that younger people are more susceptible in the current wave of the pandemic because the vaccination schedule targeted the elderly preferentially?

Is it probable that the vaccine, while not preventing the disease altogether, does in fact protect against severity of the disease?

It is too early to answer these questions; till all the current data is collated together, we can only surmise. Hence, we must continue with all the necessary precautions as well as the vaccinations, which constitute the best measures of preventing/mitigating Covid-19 as per current knowledge.





Dr. Nirmal Surya Chairman ICHA Telemedicine Academy MD, DNB(Neuro), FIAN Director ICHA Chairman Surya Neuro Center

ICHA Telemedicine Academy (ICHA TMA) Inaugural Symposium (14 MARCH 2020)

The technological advancements of the 21st century and the crisis of COVID-19 pandemic has had immense impact on India's healthcare industry, and this has also resulted in many breakthrough developments. The healthcare ecosystem has become one of the most diversified and largest sectors in India. COVID-19 pandemic has caused significant disruptions in the healthcare value chain and has tremendously halted the routine access of patients to healthcare institutions. To keep up with the advancements it is important to resort to telemedicine practice which facilitates distant consulting of patients through digital media. Telemedicine practice will continue to find its feet beyond this pandemic especially for patients with chronic disorders, those from distant locations, and those seeking to follow up with their consultation. On 14th March 2020, an inaugural symposium by Telemedicine Training Academy was conducted to facilitate nationwide enrollment, training and certification of medical professionals on Telemedicine practices in a consistent manner.

The Indian Confederation for Healthcare Accreditation (ICHA) emphasized on the significant need to institutionalize the Telemedicine Training Academy. This was hosted in collaboration with industry sponsors for digital platforms and structured bodies to support the execution of this initiative.

The opening address was delivered by Dr. Poonam Rajput and Dr. Nirmal Surya.

Dr. Sanjay Sood who was invited as the chief guest and Colonel (Dr) Ashwini Goel who was invited as the guest of honor delivered the inaugural speech for the symposiym. The symposium hosted a range of perceptive talks by some of the prominent doctors in the country. The panel of chairpersons comprised of Dr. Lalan Bharti, Dr. Naveen Malhotra, Dr. Dheeraj Khanna, Dr. Anand Vasudev, Dr. Partha Ray, Dr. Neeraj Mishra, Dr. Sanjay Wadhwa, and Dr. Kenshuk Marwa.

The symposium comprised of a range of insightful talks followed by an interactive question-answer session. Dr Nirmal Surya commenced this intriguing session by sharing some of his profound experiences regarding telemedicine consultation. He shed light on its positive impact that can greatly revolutionize the present medical industry. He emphasized the importance of the audio recording feature, enabled by telemedicine guidelines, especially during digital consultation. "Patients get overwhelmed during the video calls by the technology they are engaging with while communicating with the doctor. Due to this they tend to forget their prescription dosages and special instructions delivered by the doctor. During such times, the audio recording comes in extremely handy both to the doctor as well as the patient", Dr. Surya said. Indeed, due to the treatment compliance ensured by this feature, the treatment gap has been brought down from 75 percent to 25 percent. This has also positively boosted the drug (prescription) adherence by the patients. He further shared his experience collaborating with various telemedicine centers to serve maximum patients especially those residing in the remote areas. With insightful use of data and supervised training, telemedicine can be leveraged to its fullest potential.

This especially helps in bridging the gap between majority of patients living in rural India and telemedicine facilities that are well established in the urban India. Government of India has been consistently making

efforts to merge the primary healthcare centers and thereby serve the rural population.

The telemedicine guidelines prescribed by the World Health Organization were thoroughly discussed by Dr. Sunil Shroff.

The purpose: To provide clinical support.

Intention: To overcome geographical barriers, connecting users who are scattered across various location.

Involves-Use of various types of information technology.

Goal- to improve health outcomes.

Interesting discussion on the evolution of telemedicine rendered intriguing insights on how necessity is the mother of invention. In today's time, the COVID-19 pandemic has facilitated the re-emergence of telemedicine to serve humanity globally.

Dr. Sunil Shroff presented a brilliant perspective on how telemedicine is a function of bandwidth latency and how that eventually determines what complexity of care that a doctor can deliver. The Indian Space Research Organization has connected several small hospitals and remote clinics via their impeccable satellite network. This support by ISRO has tremendously facilitated the boom of telemedicine in India. Telemedicine has led to the unfolding of "digital health" which is the convergence of all digital technologies with healthcare, and it is aimed at enhancing the efficiency of healthcare. Digital health enables a platform for providing healthcare everywhere and reaching those living in the obscure, remote corners of India.

In simpler words, telemedicine is an enabler of healthcare access and affordability. Covid-19 pandemic has positively impacted the Telehealth in India in many ways. It has brought healthcare in sharp focus and has also highlighted the deficiencies in the system. Additionally, it has improved computer literacy of both patients and physicians and made them feel more empowered. It has also made us realize the importance of self-care to minimize the load on healthcare systems. It has been no wonder that the Arogya setu app was among the most downloaded apps in 2020.

Telemedicine can be a great boon in the following categories of specialties:

- · Treatment of chronic diseases such as diabetes and heart conditions.
- Everyday care such as flu, skin problems, infections etc.
- · Mental health
- · Transition of patients from secondary care to primary care
- · Specialist care.

Telemedicine guidelines were passed and gazetted on 14th May 2020 to practice safe telemedicine. These guidelines enable the use of telemedicine into the everyday practice- it outlines practical advice to doctors so that all models of care are encouraged.

The seven elements of telemedicine guidelines were highlighted to ensure clarity on the compliance. It is pertinent to get all the information regarding past history or records and speak to their concerned healthcare worker or a family member. Telemedic consultation should not be done in the place of physical examination when required. Two types of consultations:

- 1) First consult
- 2) Follow up consult

The government of India appreciates that the ease of use and extensive acceptance makes the mobile phone a valuable tool in the implementation of this tele-health solution for both Synchronous and asynchronous consultation. Mobile healthcare apps have played a crucial role in integrating the healthcare ecosystems to serve maximum patients across the country. Various facets including booking e-appointments, going

through the patient's e-history, uploading documents/images/videos, procuring e-consent, providing econsultation, e-prescription and obtaining e-payments, are well taken care of using a single provision of a mobile application.

As per the telemedicine guidelines of 2020, e-prescriptions should be done with utmost caution and discretion. Prescribing without diagnosis or provisional diagnosis may be counted as professional misconduct. Dr Lakshmi Narsimhan delivered an excellent talk on conduction of remote patient examination. Interesting inputs regarding Tele-Triage and Tele-Pharma were shared by Dr. Lavanian Doriairaj. Importance of legal and ethical aspects regarding various aspects of Telehealth were delineated by Dr. Shiju Veetil. Mr. Pankaj Sindhu highlighted the importance of digitizing healthcare and resorting to telemedicine platform training. After a round of question-answer session, MCQ, and certification by Dr. Sanjay Wadhwa and Dr. Kenshuk Marwah, vote of thanks address was delivered. The symposium proved to be of great value and thought-provoking guidance that can be leveraged by doctors across the country to adapt to the constantly evolving digital needs in the healthcare sectors. The insights shared and thoroughly discussed will definitely help doctors and all healthcare providers to bridge the gap and flourish in the era of healthcare digitization.



Will Telemedicine Practice Stay Beyond Pandemic?



















Invitation **INAUGURAL CEREMONY** THE ICHA NEWS

Official E-Newsletter of Indian Confederation for Healthcare Accreditation

> 17 January 2021 11 AM - 12 Noon

PROGRAMME				
Time	Торіс	Speaker		
11:00 AM	Meeting called to order			
11:00-11:05 AM	Welcome Address	Dr. Poonam Rajput, CEO ICHA		
11:05-11:10 AM	Editor-in-Chief Address	Dr. Naveen Malhotra, Director ICHA		
11:10-11:25 AM	Release of Newsletter by Chief Guest	Dr. (Maj Gen) S. Venkataraman Retd, VSM		
	Address by Chief Guest			
11:25-11:58 AM	Felicitations	Directors ICHA and Invited Guests		
11:58-12:00 Noon	Vote of Thanks	Dr. Disha Gupta. Assistant Editor. The ICHA News		

With Best Wishes

Dr. Naveen Malhotra Director

Dr. Poonam Rajpu

CEO

Indian Confederation for Healthcare Accreditation **On Behalf of Board of Directors & Technical Councilors ICHA**

www.icha.in

Link: Join Zoom Meeting:

https://us02web.zoom.us/j/86094573247?pwd=SmJKQIA1Zk5pKzhQNVpwNTd0bzRVZz09 Meeting ID: 860 9457 3247 Passcode: ICHA

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D.



Dr. Sangeeta Sharma Director ICHA Chairperson ICHA Mitra Committee



Dr. Poonam Rajput CEO & Director ICHA





From the Editor's Desk



Dr. Naveen Malhotra Editor-in-Chief THE ICHA NEWS

"Quality is never an accident. It is always the result of intelligent effort" - John Ruskin "Quality over quantity" is the well-known mantra advocated by many professional leaders. But when it comes to healthcare it is imperative to aim for both- quality care for everyone. While there is a wellestablished system of policy design and implementation, working towards achieving universal outreach of health services, quality healthcare is often left upon the individuals to be practiced on a voluntary basis and the resulting disparity in the standards of care generates friction amongst the healthcare providers and the beneficiaries.

It is this understanding which led to the promulgation of this idea to bring together all the stakeholders in



























Chat

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From OS Status subdetwarks to tempore My Heartest Congratulations to deer D Naveen Malectors and the Team. This Insugural e-NEWS Letter is very impressive, and rich is content. I will be glad to contribute to the next issue. If you agree.

From We to Everytere THAME YOU SIR FOR KIND WORDS. YOUR ARTICLE IS KEENLY AWAITED

From DR SADEW WAZE-WA to Everyone Thank you very much for your positive response.

from Chalment Six In Everyone I congratulate Dr. Akhil Sanghal, Exceller work he has done to bring this group to this level. ICHA is really a great organization











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Join ICHA



Dr. Virendra Sharma Director ICHA Chairman Membership Committee

Dear Office Bearers of Subscribing Member Associations of ICHA,

You are requested to please spread awareness about ICHA, its work being done like ICHA Mitra project and other ongoing projects amongst members of your association. Please promote them to join ICHA and contribute actively.

The ways to join forces together:

- 1. Organizational Affiliates
- 2. Individual Affiliates
- 3. Friends of ICHA
- 4. National Associations as Subscribing Members.

Unity is strength. COVID-19 Pandemic has highlighted the need even more starkly.

To join please visit our website www.icha.in

Thank You.

Dr. Virendra Sharma

Director ICHA Chairman Membership Committee Consultant Anaesthesiologist Vivekananda Polyclinic & Institute of Medical Sciences, Lucknow Treasurer ISA National

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CONSTITUENT ASSOCIATIONS / INSTITUTIONS

List of ICHA's Constituent Associations / Institutions recognized as apex bodies in their respective fields.



(IASO)

Indian Society of Hospital Waste



Indian Federation for Neurorehabilitation(IFNR)

Management (ISHWM)



(POSI)

(n)

The Indian Association of Gastrointestinal Endosurgeons (IAGES)

Association of Physicians of India (API)

All India Ophthalmological Society (AIOS)

Paediatric Orthopaedic Society of India

Indian College of Pathologists (ICP)

Nursing Research Society of India (NRSI)

The Indian Hospital Pharmacist's Association (IHPA)





All India Institute of Local Self-Government (AIILSG)

The Indian Institute of Architects (IIA)

GVK EMRI (Emergency Management and Research Institute)

Consumer Association of India (CAI)



Association of Minimal Access Surgeons of India (AMASI)



ACBM

Association of Medical Consultants (AMC)

ACBM Association of Clinical Biochemists and Microbiologists

Indian Society for Health Care Risk Management (ISHCRM)



The Federation of Obstetric & Gynecological Societies of India (FOGSI)



Academy of Hospital Administration (AHA)



Indian Cooperative Oncology Network (ICON)



Indian Association of Dermatologists, Venereologists and Leprologists (IADVL)



Indian Society of Psychiatric Nurses (ISPN)

India (ACBI)

Association of Clinical Biochemists of



Indian Pharmacy Graduates' Association (IPGA)

Consumer Coordination Council (CCC)



The Brain & Spine Foundation (BSF)



IMA - College of General Practitioners (IMACGP)



IMA Hospital Board of India (IMAHBI)



Association of Health and Hospital Administrators (AHHA)



HEALTH EDUCATION LIBRARY FOR PEOPLE (HELP)



Delhi Society for Promotion of Rational Use of Drugs(DSPRUD)

Research Society of Anaesthesiology Clinical Pharmacology(RSACP)



Indian Confederation for Healthcare Accreditation is a professionally owned and driven Not-for-Profit organisation incorporated as a Section 25 Company. The basic aim of ICHA is to strengthen our health system using modified accreditation as a tool. Addressing the complexities of healthcare system comprehensively requires a collaborative team effort by all stakeholders.

ICHA is the National multi-stakeholder Confederation of National Associations/ Institutions for establishing validated excellence in healthcare in India in line with similar bodies in all developed countries. ICHA comprises all stakeholder groups across the health sector, viz. Providers, Receivers and users, Payers and funders, Educators and regulators.

Currently, all the major National Associations/Institutions of Medical Sciences and practitioners (Clinical, Lab, Admin), Nursing, Pharmacy, Therapy, Consumers, Management and Architects are our subscribers. All the Associations/Institutions are well established and are recognized as apex bodies in their respective fields.



ICHA logo depicts its mission of Patient Centred Healthcare. We seek to address Patient Safety concerns by placing patient safety at the top of all stakeholders' agenda- be it the healthcare receiver, the provider and every stakeholder groups across the health sector. Patient Safety is the hallmark of excellence and our chosen path to achieve excellence.



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Team ICHA

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OBITUARY



Dr. Arun Raizada

(12/11/1948 - 10/01/2021)

We are very saddened to hear the demise of our senior fellow colleague, Dr. Arun Raizada (Former Director Indian Confederation of Healthcare Accreditation). On behalf of the ICHA family, we wish to convey our sincere condolences to his family, friends, professional colleagues, juniors and students and pray to the almighty that his soul may rest in peace. We are sorry to have lost such a dynamic & senior member from our community due to post covid-19 complications. He gave more than 50 Years of continuous service to the field of diagnostics and health care in India.

Dr. Arun Raizada, did his M.Sc. in Biochemistry from Lucknow University and PhD in Medical Biochemistry from G R Medical College, Gwalior. He started his career as a researcher as Assistant Research Officer, Department of Biochemistry, P.G.I. Chandigarh from 1971 to 1974.

He moved to Delhi and joined as Senior Demonstrator, Department of Biochemistry, Lady Harding Medical College, New Delhi from 1974 to 1988. In this period of 14 years, he taught Clinical Biochemistry to MBBS & MD students of the Department. During this time he was also actively involved in research in collaboration with Vallabh Bhai Patel Chest Institute, Delhi. Later he moved on to become the Head of Biochemistry at the Escorts Heart Institute, New Delhi. In year 2009 he joined as Head, Department of Biochemistry Medanta – The Medicity, a multispecialty healthcare provider at Gurugram. Under his able supervision Medanta got their NABH, NABL & JCI accreditation done.

Presently, he was rendering his service as Vice President (Quality), POCT services at Lucknow. He was fully active during covid-19 pandemic period and was also instrumental in bringing in NABL accreditation to various UP Govt Hospitals & medical colleges as well as institutes like AIIMS Rishikesh.

He was the past president of ACBI and ACBI fellow. He worked as Director, ICHA. He was also a certified technical assessor by NABL. He was the recipient of various prestigious awards and honors, including A. J. Thakur Award for Distinguished Services in Clinical Biochemistry and Laboratory Medicine, Health icon award-2019 for excellence in health care by UP Govt., Bharat Excellence Award 2013 by Friendship Forum of India, Bharat Jyoti Award by India International Friendship Society, Rajiv Gandhi Excellence Award and best citizen of India via International publishing house.

The ICHA and Community of biochemists in India mourns the passing away of Dr. Arun Raizada.His presence will be immensely missed. We pray to the almighty that his soul may rest in peace.

