DISSERTATION

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GAP ANALYSIS OF DISTRICT HOSPITAL IN ETAWAH AS PER NABH NORMS

BY

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UNDER THE GUIDANCE OF

Dr VINAY TRIPATHY

Post Graduate Diploma in Hospital and Health Management

(2012-2014)

International Institute of Health Management Research

2013

OCTAVO
SOLUTIONS PVT. LTD.
The Health & Hospital Consultants

The certificate is awarded to

Ms. DHEERAJ KANWAR

In recognition of having successfully completed her

Internship in OCTAVO SOLUTIONS PVT. LTD.

And has successfully completed her Project on

"GAP ANALYSIS OF DISTRICT WOMEN'S HOSPITAL, ETAWAH AS PER NABH STANDARDS"

Date: 30th April, 2014

Organisation: OCTAVO SOLUTIONS PVT. LTD.

She comes across as a committed, sincere & diligent person who has a strong drive & zeal for learning

We wish her all the best for future endeavours.

Vice President
Octavo Solutions P Ltd.

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FEEDBACK FORM

Name of the Student: Ms. Dheeraj Kanwar Shekhawat

Dissertation Organisation: Octavo Solutions Private Limited, New Delhi

Area of Dissertation: Gap Analysis of District Women Hospital, Etawah.

Attendance: 100% (Regular).

Objectives achieved:
* Drafted Time bound Action plans.
* Drafted Gap reports
* Assisted in daily office Activities.

Deliverables:
* Gap Analysis report
* Data for Quality indicators being monitored at Site

Strengths: Industrious, Punctual and confident girl.

Suggestions for Improvement:

Need to have a through knowledge for hospital work flow and activities so as to peform excellently. Wishing her all the best for future endeavours.

Organisation Mentor (Dissertation) Dr. Kriti Yadav

Date: 6th may | 2014

Place: New Delhi

Certificate Of Approval

The following dissertation titled **"GAP ANALYSIS OF DISTRICT WOMEN'S HOSPITAL, ETAWAH AS PER NABH STANDARDS"** at **OCTAVO SOLUTIONS PVT. LTD.** is hereby approved as a certified study in management carried out and presented in a manner satisfactorily to warrant its acceptance as a prerequisite for the award of **Post Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation.

Name	Signature
Dr. A.K. Agarwal	
Dr. Ramteke	
Ms. Anupama Sharma	

TO WHOMSOEVER MAY CONCERN

This is to certify that **Ms. DHEERAJ KANWAR** student of Post Graduate Diploma in Hospital and Health Management (PGDHM) from International Institute of Health Management Research, New Delhi has undergone internship training at **OCTAVO SOLUTIONS PVT. LTD.** from 1ST February, 2014 to 30th April, 2014

The Candidate has successfully carried out the study designated to her during internship training and her approach to the study has been sincere, scientific and analytical.

The Internship is in fulfillment of the course requirements.

I wish her all success in all his future endeavors.

Dr. A.K. Agarwal
Dean, Academics and Student Affairs
IIHMR, New Delhi

Dr. Vinay Tripathy
Assistant Professor
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Certificate from Dissertation Advisory Committee

This is to certify that **Ms. Dheeraj Kanwar,** a graduate student of the **Post- Graduate Diploma in Health and Hospital Management** has worked under our guidance and supervision. She is submitting this dissertation titled **"GAP ANALYSIS OF DISIRICT WOMEN'S HOSPITAL, ETAWAH AS PER NABH STANDARDS"** in partial fulfillment of the requirements for the award of the **Post-Graduate Diploma in Health and Hospital Management.**

This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

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Assistant Professor
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INTERNATIONAL INSTITUTE OF HEALTH MANAGEMENT RESEARCH, NEW DELHI

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled Graph Analysis of District hospital Etawah
and submitted by (Name) Dheeraj kanwar
Enrollment No. PG/12/026
under the supervision of Dr. Vinay Tripathy
for award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the period from 1st Feb 2014 to 30th April 2014.
embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.

Signature

Acknowledgement

My Institute - **International Institute of Health Management Research (IIHMR), DELHI** deserves the foremost appreciation for providing me the opportunities to understand my capabilities

The Gap Analysis Study in Dr.B.R Ambedkar District Women Hospital, Etawah, and Uttar Pradesh has been successfully conducted. It was an outcome of the dedicated & collective initiative of Uttar Pradesh Health Systems Strengthening Project (UPHSSP) and the Government of UP.

Our gratitude to **Shri Mayur Maheswari,** Project Director and his team in UPHSSP for initiating this wonderful effort

I would like to express my gratitude towards **Dr Kriti Yadav** for their kind co-operation and encouragement which help me in completion if this project.

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The team of Octavo Solutions Pvt. Ltd., New Delhi wants to express their profound thanks to all the distinguished leaders in the Dr.B.R Ambedkar **District Women Hospital, Etawah** who provided their untiring support in facilitating and guiding our team in the process of the gap analysis study.

The courtesy extended by **Dr. B.S. Agnihotri, CMS, Dr.B.R Ambedkar District Women Hospital, Etawah** needs to be appreciated. It was his leadership that enabled our team to complete the study within the specified time.

LIST OF TABLES

LIST OF CHARTS

Abbreviations

OSPL	Octavo Solutions Private Limited
NABH	National Accreditation Board for Hospitals and Healthcare Providers
QCI	Quality Council of India
ACHSI	Australian Council of Health Standard International
JCI	Joint Commission International
PERT	Program Evaluation and Review Technique
NHSRC	National Health Systems Resource Centre
NABL	National Accreditation Board for Testing and Calibration Laboratories
QMS	Quality Management System
ISO	International Organization for Standardization
BMW	Bio- Medical Waste
TLD	Thermo Luminescent Dosimeter
AMC	Annual Maintenance Contract
CMC	Comprehensive Maintenance Contract
ENT	Ear, Nose and Throat
CSSD	Central Sterile Supply Department
TSSU	Theatre Sterile Supply Unit
ICU	Intensive Care Unit
OPD	Out Patient Department
HIV	Human Immunodeficiency Virus
HOD	Head of Department
NOC	No Objection Certificate
PNDT	Pre- Natal Diagnostic Technique
AERB	Atomic Energy Radiation Board
EMO	Emergency Medical Officer
ECG	Electro Cardio Gram
BLS	Basic Life Support
ACLS	Advanced Care Life Support
EMSP	Emergency Medical Services Provider
UHID	Unique Hospital Identification Number

EQAS	External Quality Assurance Service
PPE	Personal Protective Equipment
CPR	Cardio- Pulmonary Resuscitation
OT	Operation Theatre
HVAC	Heating, Ventilation and Air-conditioning
SSI	Surgical Site Infection
GRN	Goods Receipt Note
UP PCB	Uttar Pradesh Pollution Control Board
HIC	Hospital Infection Control
HAI	Hospital Acquired Infection
UTI	Urinary Transmitted Infection
VAP	Ventilator Associated Pneumonia
ABC	Always Better Control
VED	Vital, Essential and Desirable
FSN	Fast- moving, Slow- moving and Non- moving
FIFO	First In First Out
MRD	Medical Record Department
ICD	International Classification of Diseases
MLC	Medico Legal Cases
AAC	Access, Assessment and Continuity of Care
COP	Care of Patients
MOM	Management of Medications
PRE	Patient Rights and Education
HIC	Hospital Infection Control
CQI	Continuous Quality Improvement
ROM	Responsibilities of Management
FMS	Facility Management & Safety
HRM	Human Resource Management
IMS	Information Management Systems

ORGANISATION PROFILE

Octavo Solutions Pvt. Ltd. (OSPL) a multidisciplinary Health & Hospital Management Consulting firm, established and managed by health management experts, supported in its initiatives and efforts by experienced and reputed experts in field (like Architecture, Engineering, Public Health, Bio-medical Engineering, Clinical Experts, National and International Quality Gurus, Project Management experts), who have successfully undertaken health, hospital and other infrastructure projects ranging from small nursing homes to large medical college hospitals, including public health. We are associated with a number of reputed consulting organizations and thus can draw upon qualitative and latest expertise as and when required. With our ongoing in-house research and quality improvement efforts, we always strive to be up-to-date and able to provide the client qualitative, cost effective and comprehensive solutions. Our experts have worked with QCI, JCI and Australian Council of Health Standard International (ACHSI) and donor-funded projects like, the World Bank and the distinguished clients served includes the Ministry of Health, Govt. of India; State Governments, Private clients, Corporate House & Charitable Hospitals. Octavo Solutions Pvt. Ltd. is the first Consulting firm registered with Quality Council of India (National Accreditation Board for Education and Training) for providing consulting services in field of Healthcare.

VISION: To focus on continuous development of processes for understanding the needs & expectations of the clients; leading to continual improvement and achievement of real client satisfaction. To redesign (existing) and develop (new) quality healthcare institutions and hospital with competitive process designs/models matching national and international standards.

MISSION: To become the leader in healthcare consultancy in India by providing value for money; effective, efficient solutions and hands on support.

Key Strengths and Salient Features of OSPL

The primary **strength** of our company is to partner the client organization to optimize resources & implement the improvement strategies successfully. An assignment begins with an accurate assessment of people, processes, performance and strategies. Our consultants define competitive strengths, threats and opportunities to define performance gaps and growth potential. To assure successful implementation and competitive advantage, we develop an execution action plan with essential controls for the management system under consideration, (PERT Chart). Unique Bottom-Up consulting **approach** of our consultants ensures success of our consulting assignments. This approach ensures that plans are accepted & practiced at all the levels of management. We have an unmatched 100% success rate for all the projects taken up so far in our journey.

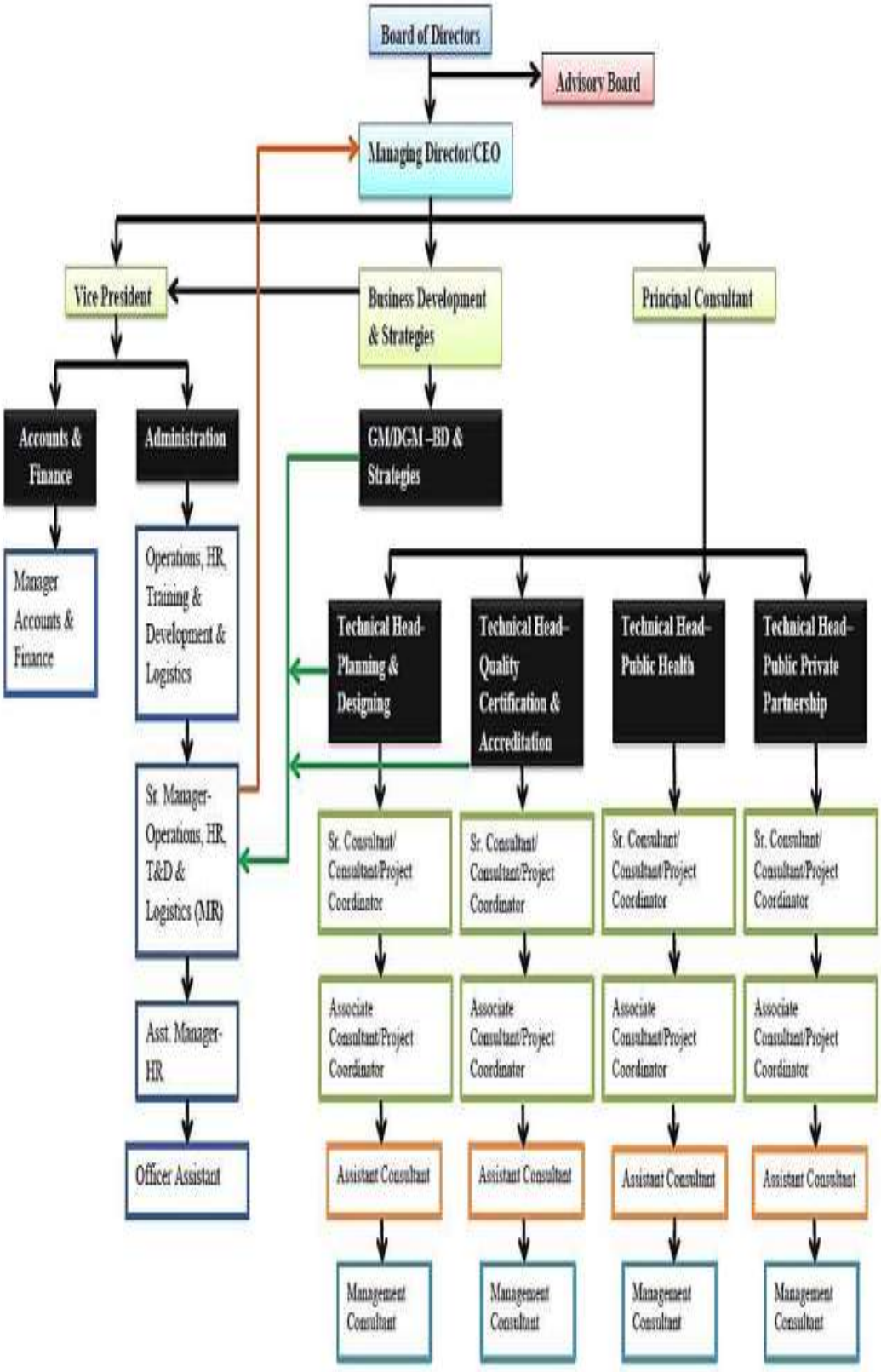
KEY STRENGTHS:

1. A **Private Limited Company**
2. Short listed firm with **NHSRC** (National Health Systems Resource Centre) under aegis of Ministry of Health & Family Welfare (Government of India)
3. **Talented Leadership** from leading institutes like
    - ❖ All India Institute of Medical Sciences (Delhi),
    - ❖ School of Planning and Architecture (Delhi),
    - ❖ Tata Institute of Social Sciences, (Mumbai)
    - ❖ Indian Institute of Health Management and Research (Jaipur)
    - ❖ Symbiosis Institute of Health Sciences (Pune)
    - ❖ Jamia Hamdard University (Delhi)
4. Great Team with all essential skills
5. Dr. Bidhan Das- Member, Technical Committee of NABH for drafting standards
6. Dr T.Venkatesh- Member, Technical Committee of NABL for drafting standards
7. Dr Bidhan Das has Standards for Primary Healthcare (NABH) to his credit which is on its (likely) first test in State of Gujarat
8. Dr. Bidhan Das- First ACHS International Surveyor (Australian Council for Health Standards) in India
9. OSPL is **SE-Asia Partners for ACHSI**
10. OSPL has presence in **14 states (**including Union Territories)
11. We have working offices at **7** different locations across India.
12. OSPL has one overseas **(International)** project to its credit.
13. In short span of just 4 years, OSPL has rendered its **consulting services to over 30,000 beds** within the healthcare sector
14. We have provided consulting services to over 100 Hospitals (bed range 30-1500), 07 Teaching Hospital & Medical Colleges, 01 Rehabilitation Hospital, 02 Dental Hospital & Colleges, 02 AYUSH Hospitals.
15. Combined Years of Experience of our Technical Personnel is 68 Man-Years in ISO/ NABL/ NABH/ QMS and Hospital Planning assignments. Our Key Personnel have rich experience of having conducted over 720 Audits/

Assessments and provided consulting services to 497 client organizations for establishing QMS.

16. We are one solution company for healthcare sector.

Organization Chart



EXECUTIVE SUMMARY

Gap Analysis is a tool to analyse the degree of compliance to any standard. Herein, this assignment the given district hospitals are analysed with reference to the NABH Standard (3rd edition).

The gap analysis as per NABH norms was done so as to assess the existing status of the hospital and prepare it for NABH accreditation. The gap analysis was done with the help of Self Assessment Toolkit. For getting the required data the various activities in the hospital were observed, policy manuals and records were referred and patients and hospital staff were interviewed. According to the toolkit the documentation and implementation of each objective element was checked and scores were given accordingly. After this the average scores for the standards and chapters were calculated. Then these were checked against the evaluation criteria. It was found that the analysis results did not match the required criteria and there were several gaps. Mainly the gaps were in the chapters of management of medication, quality management and information management system. Therefore, great effort and focus is required for fulfilling the gaps found and preparing the hospital for accreditation.

The whole report is prepared as under:

1. The scope of services provided by Dr.B.R Ambedkar District Women Hospital, Etawah has been reviewed and represented accordingly.
2. Identifies the significant gaps in terms of Structure, Process and Outcome observed in all the concerned areas.
3. The data on status of the existing Manpower, Equipment and Statutory requirements.
4. Any other data or information as deemed necessary.

The Key Findings identified are as follows:

1. All the Sanctioned posts are not filled up. Required posts like Dietician, Office supdt, Medical Records Technician, Registration clerk, Dhobi, Lab Technician, Driver etc are not included in the sanctioned posts.

2. The laboratory results are provided by the technician without being verified and reported by a Pathologist. There is No sanctioned post of Laboratory Technician. Currently one technician has been posted through NRHM. The laboratory functions till 2 pm after which the facility is usually on-call basis. Temperature monitoring of refrigerator not done in Lab on regular basis.

3. X-ray services are provided by the hospital. Both the fixed X-rays do not have the AERB Approvals (Site & Approval). There is no RSO appointed.

4. Wall fans are present in Operation Theatre. There is no HVAC system. Environmental controls are not monitored. Seepage was seen inside the OT.

Zoning is not proper. Major equipments like Defibrillator, Ventilator not available. No Central medical gas supply.

5. There is no dedicated CSSD in the hospital. TSSU is available in OT complex which takes care of the sterilization activities for OT. There is no dedicated person to perform sterilization activities, ward boy currently performs it.

6. Labour room has four tables in a room. There are no side screens between the tables.

7. The SNCU has been newly constructed and currently made functional. There is no Central Medical gas Supply and no central air conditioning. Training of Nurses in handling newborns, bio-medical waste management, was not evidenced. Parents/relatives were seen sitting and waiting outside the SNCU main unit. Toilets were found unclean and there are issues with respect to drainage in the bathroom.

8. There is well planned & equipped Blood bank in the hospital (common for male & Women Hospital). There is no AMC for the refrigerators. Staff could not demonstrate hand washing technique. The Blood bank license is under renewal process for more than last one year.

9. There is no provision of Central Medical gas Supply. Currently oxygen cylinders are used in areas like OT, emergency, wards, etc.

10. Ambulances services are usually looked after by the 108 & 102 vehicles. The Hospital has one Ambulance which is currently under repair. There is no sanctioned post of driver. The hospital vehicle does not carry emergency drugs in every transportation. The Hospital administration faces issues in managing fuel for the vehicles, since the required/allocated budget has not been disbursed at required periodicity.

11. The wards remain unmanned due to lack of adequate number of nurses. Tablets are usually self-administered.

12. There is no dedicated HR department in the hospital. The administrative office (karyalaya) & CMS takes care of the relevant functions. Only one Jr Clerk looks after the karyalaya.

13. Medical Records department does not have a relevant person to look after the department (Qualified/trained Medical Record Technician/Clerk). Coding, Indexing, and Filing not evident. There is no destruction policy for medical records. The records does not have all relevant forms & formats like Consent forms (Surgery, Anaesthesia, etc), Medication chart, Intake /Output chart, TPR chart, etc. They are records are not kept in orderly manner in racks.

14. The consent for surgeries is taken by ward nurses on handwritten statements on the BHT (IPD) Records. Signature of patient and/or relatives was evident

during the visit however no signature of any surgeon, anaesthesiologist or nurse were seen.

15. The Hospital does provide Dietary services. The layout of the kitchen does not commensurate to the standard requirements. There is no posting of Dietician. Food is usually distributed through steel buckets. Food handlers do not undergo periodical health check-up.

16. Hospital infection control practices are not evident uniformly. There is no dedicated infection control nurse and there is no hospital infection committee and a hospital infection control manual. Culture sensitivity test not carried out in critical areas like OT.

17. Staff involved in direct care are not trained CPR.

18. Inventory control management (ABC, FSN, VED analysis) not done in the stores (Medical and General). There is no Drug & Therapeutic Committee in the Hospital. There is no well defined Drug Formulary; however medicine enlisted in Rate contracts are referred during requirement. Temperature monitoring not evident in any of the refrigerators inspected during the visit such as Medicine Store, Operation Theatres etc. Staff not aware on addressing Adverse Drug Reactions. “Look alike and Sound alike” drugs are not stored separately. Provision of security is not evident.

19. Staffs in Stores and in OT are not aware on specific storage and documentation requirements of narcotic and psychotropic substances as per the Act. Currently there is no such register and the drugs are not kept in double lock and key.

20. There is no adequately equipped and manned mortuary. There is small room in the campus outside the main building. There is no provision of freezer, water supply, round the clock security, etc. The floor had stains of blood during the visit.

21. Medical Audit and Clinical Audit not conducted at the hospital level.

22. Dedicated department for equipment management, facility management not evident. Stores (Pharmacist) currently address the issues relating to medical equipment maintenance. All major equipments are not covered under AMC/CMC and calibration is not done for any of the equipments.

23. The hospital does not comply with the necessary statutory & regularity requirements (except PNDT). Blood Bank License has expired on Dec, 2012 and still under renewal process.

24. Fire extinguishers (ABC type) have been installed in all the areas of the hospital however there is no provision of other fire fighting devices such as sprinklers, smoke detectors, etc.

25. There is no provision of dedicated toilets for the differently able people.

26. Alternative source of electricity is available but alternative source for water Supply is not there.

INTRODUCTION OF STUDY

Gap analysis is the initial step in the review of the available service delivery system. It is an efficient base to implement a modern management system. It can be measured against pre set standards. It reveals the areas of improvement in the existing service system. It focuses on the components of the management services and how effective they are.

The scope of improvement will mark the level up to which services are to be upgraded. Scope of improvement will give the percentage of progress needed to achieve the pre set standards.

NABH

National Accreditation Board for Hospitals & Healthcare Providers (NABH) is a constituent board of Quality Council of India, set up to establish and operate accreditation programme for healthcare organizations. The board while being supported by all stakeholders including industry, consumers, government, has fully functional autonomy in its operation.

ACCREDITATION

A public recognition of the achievement of accreditation standards by a healthcare organization, demonstrated through an independent external peer assessment of that organization's level of performance in relation to the standards.

Benefits of accreditation

Accreditation benefits all Stake Holders. **Patients** are the biggest beneficiaries. Accreditation results in high quality of care and patient safety. The patients get services by credential medical staff. Rights of patients are respected and protected. Patient satisfaction is regularly evaluated.

Accreditation to a **Hospital** stimulates continuous improvement. It enables hospital in demonstrating commitment to quality care. It raises community confidence in the services provided by the hospital. It also provides opportunity to healthcare unit to benchmark with the best.

The **Staff** in an accredited hospital are satisfied lot as it provides for continuous learning, good working environment, leadership and above all ownership of clinical

processes. It improves overall professional development of Clinicians and Paramedical staff and provides leadership for quality improvement within medicine and nursing.

Accreditation provides an objective system of empanelment by insurance and other **Third Parties.** Accreditation provides access to reliable and certified information on facilities, infrastructure and level of care.

PROBLEM STATEMENT

Gap analysis is a technique which uncovers any shortfall in some process or characteristics. It is done against the template or model. The technique is often used to discover where to invest efforts for the improvement. It compares the characteristics of the organization's operations against an appropriate model. Gap analysis highlights those areas where the requirements of the model are not fully realized and details the changes necessary. The required changes indicate the gap that exists between the organization's current operations and the desired state and which area is likely to be more responsive to improvement efforts. The hospital management can then judge which are as when improved would be most beneficial to the organization.

RATIONALE OF STUDY

An assessment report is a document, which evolves as per circumstantial requirement of the organization to know scope of activities required to meet standards to achieve project goal i.e. NABH accreditation status.

There is a requirement of measuring the performance of hospital. The performance can be measured once the standards or benchmarks for the same are available. The accreditation of healthcare facilities is concerned with assessing the quality of organizational process and performance using agreed upon standards.

The purpose of accreditation is to establish and encourage best practices, in the organization. It is based on the premises that there are certain actions which should be undertaken to create a good healthcare organization. Accreditation is a process by which an authoritative body gives a formal recognition that an organization is competent to carry out specific tasks.

AIM

To assess the services of Dr.B.R Ambedkar **District Women Hospital, Etawah** against the Pre set standards of National Accreditation Board for Hospitals & Healthcare Providers (NABH)

OBJECTIVES

1. To assess the existing service delivery system
2. To identify and analyze the gaps existing in the current practices in comparison with the NABH standards for effective management of hospital
3. To suggest viable recommendations as per the NABH guideline

REVIEW OF THE LITERATURE

Dr. Santosh Kumar, Brig. (Dr.) Swadesh Puri, Dr. S.D. Gupta in a study of Gap Analysis Report for Rehabilitation Center has found that is mainly a destitute centre having 20 beds for disable patients. Even though it is housed in poly clinic various sub specialties (such as Medicine, Surgery, ENT, Ophthalmology, and Dental) are available here which seems to be duplicity of resources. The centre does not proper diagnostic, inpatient or utility services (kitchen, laundry). There is no effective signage to guide the patient with in the center. The radiology department is virtually open from three sides causing radiation hazards to staff and patients. Even though it is the rehabilitation center it does not have even the basic physiotherapy equipments. The general housekeeping is very bad all toilets are broken and sinking. Almost all working areas are dirty and unhygienic to work or live. Wards are crowded and lack proper ventilation. Most of the bed linen was dirty. There is shortage of drugs. ICD classification is not used. CSSD has only one autoclave which is not sufficient for entire hospital. It lacks quality control measures. There is no disaster plan for the hospital

Dr. Santosh Kumar, Brig. (Dr.) Swadesh Puri, Dr. S.D. Gupta in a study of Gap Analysis Report for Ishtakal Hospital has found 2 types of Gaps.

1) Infrastructure related gaps
2) Process related gaps

Infrastructure related gaps are insufficient space, make shift buildings, improper signage, poor fire safety measure and disaster plan, piped medical gases not available, shortage of equipment and instruments, old and out of order equipments and

instruments, lack of biomedical equipment engineering cell. Most of the gaps related to infrastructure related need, external support from the ministry and bilateral donor agencies.

Most of the process related gaps can be worked out at the hospital level with proper training and hand holding. Process gaps related gaps were lack of mission/vision and patient charters, lack of training in hospital operations, lack of control over resources (such as funds, drugs and consumables, equipments, ordnance/general stores). Only few hospitals have quality control department however medical and nursing audits are not done. Equipments did not have AMC/CMC, utilization audit of equipment is not done, proper BMW Management system did not exist, security was not organized in three tier manner (outer ring, middle ring, inner ring).

K. Francis Sudhakar, M. Kameshwar Rao, T.Rahul (1Jan 2012) in a study on

"Gaps in quality of expected and perceived health services in public hospitals" was found that as regards tangibles in public hospitals services, there was a wide gap by 3 counts which was statistically significant. With regard to reliability, by 3 counts there is the gap. Such gap or difference in the quality scores was statistically significant. As regards responsiveness it was found that the gap found between them was by 3.0 units. Such gap was statistically significant. With regard to assurance, it was found that the gap was 3.0 units. Such gap was statistically significant. Lastly, with regard to empathy, it was found that the gap was found to be 3.0 units. Such gap was statistically significant.

RESEARCH METHODOLOGY

STUDY DESIGN

The study will be non – experimental evidence based in nature. The study will be based on observation made. It will be done broadly in the 2 parts.

1. Present status of the departments.
2. Comparison/ compliance with NABH Standards

DATA COLLECTION TOOLS

1. Interview and discussions with head of the departments.
2. Checklists
3. Observation
4. Using available information
5. NABH tool kit

STUDY TIME

Study time was of seven weeks which included preparing checklist, filling of checklist compiling data, Gap analysis and final report compilation

STUDY METHODOLOGY

In this study the important identified Gaps of the hospital have been mentioned and discussed. Available facilities of hospital compared against the set standards and scoring was done on a scale of 1to 10 to know the compliance, partial compliance and non compliance. For compliance, score 10 was given which defines the processes being followed are documented as well as implemented while partial compliance was given the score 5, defining that the processes are either documented or implemented. Similarly for non-compliance score 0 was given, which defines processes are not documented or nor implemented.

STUDY DATA

PRIMARY DATA: - To study the present status and functioning of departments, each section of the department will be studied individually by observing the set of activities performed by doctors, technicians, paramedical staff and clerical staff.

SECONDARY DATA: - Records of various departments.

SCOPE AND APPROACH

SCOPE:

1. To assess the following aspects at the Dr.B.R Ambedkar **District Women Hospital, Etawah** for their compliance with NABH standard (3rd edition):
    a. Infrastructure
    b. Manpower
    c. Equipment
    d. Licenses
2. To carry out a gap analysis between desired and existing level
3. To suggest recommendations for streamlining the processes

APPROACH:

1. Collection of primary data and secondary data from the hospital for assessing the Structure (civil work, manpower, equipment, licenses), Process (Policies and procedures) and Outcome so that gaps can be identified.
2. Structural works have been evaluated as per the minimum requirement of NABH.
3. Manpower for the hospitals has been compared with the work load.
4. Equipment gaps have been assessed on the basis of their utilization and available standards and guidelines

HOSPITAL PROFILE

SERVICES / DEPARTMENTS

GROUP A – CLINICAL SERVICES

- Obstetrics and Gynaecology
- Paediatrics and Neonatology
- Anaesthesiology

GROUP B: CLINICAL SUPPORT SERVICES

- Laboratory
- Radiology & Imaging
- Blood Bank

GROUP C: SUPPORT SERVICES

- Pharmacy
- General Store
- Kitchen & Dietary
- Laundry
- CSSD/TSSU
- Medical Records
- Ambulance
- Housekeeping Services
- Mortuary services

GROUP D: ADMINISTRATIVE SERVICES

- General Administration
- Account & Finance

BED DISTRIBUTION

Floor	Class/Department	Beds
Ground Floor	ANC	03
	PNC	05
First Floor	Ward 1	08
	Ward 2	08
	Ward 3	08
	Ward 4(RSBY)	08
	Ward 5	08
	Post –operative ward	08
TOTAL		**56**

Note: Sanction beds = 33

SIGNAGE SYSTEM

Signage's	Displayed (Yes / No / NA)	Bilingual (Yes / No / NA)	Pictorial (Yes / No / NA)	Remarks (if any)
Citizen Charter	Yes	No	NA	
Mission	No	No	NA	
Vision	No	No	NA	
Patients Rights & Responsibilities	No	No	NA	
Scope of Services	Yes	No	No	
Tariff List	Yes	No	NA	
Doctors list along with their Specialities and Qualifications	Yes	No	NA	
OPD Schedule of Doctors (Speciality, Timings and Day of Availability)	No	No	NA	
Biohazard Symbols	No	No	Yes	
Fire Exit Plan	No	No	No	
Floor Directory	Yes	No	No	
Wash Rooms (Differently Able)	No	No	No	
Toilets	Yes	No	No	

Ambulance Parking Area	Yes	No	No	
Drinking Water	Yes	No	No	
Health Education Related Signage (HIV & Immunization)	Yes	No	No	

STATUTORY REQUIREMENTS

Licenses	Status *(A / NA)	Available YES/NO
Building Occupancy/Completion Certificate	A	No
Fire License	A	No
License under Bio- medical Management and handling Rules, 1998.	A	No
NOC for Air & Water from State Pollution Control Board	A	No
Excise permit to store Spirit.	A	No
Permit to operate lifts under the Lifts and escalators Act.	NA	
Narcotics and Psychotropic substances Act and License.	A	No
Vehicle registration certificates for Ambulances.	A	Yes
Retail drug license (Pharmacy)	NA	--
PNDT Certificate	A	Yes
Site & Type Approval for X-Ray from AERB	A	No
License for Blood Bank	A	Yes (under renewal process)

MANPOWER

Sl. No	Designations	Sanctioned	NABH Norms	Actual	Vacant (As per Sanction)	Vacant (NABH)
DOCTORS						
1	Chief Medical Superintendent	01	01	00	01	01
2	SMO	01	--	00	01	--
3	Sr. Consultant	01	01	01	00	01
4	Gynaecologist	02	06	01	01	05
5	Paediatrician	01	01	00	01	01
6	Anaesthesiologist	02	02	01	01	01
7	Radiologist	01	01	00	01	01
8	Pathologist	01	01	00	01	01

9	EMO	02	--	00	02	--
10	Medical officers (MBBS)	--	05	07	--	00
SUB TOTAL		**12**	**18**	**10**	**09**	**11**
NURSING STAFF						
1	Matron/Nursing Superintendent	01	01	00	01	01
2	Nursing In-charge	01	06	01	00	05
3	Staff Nurse	05	35	03	02	32
4	ANM	02	--	02	00	--
SUB TOTAL		**09**	**42**	**06**	**03**	**38**
PARAMEDICAL						
1	Lab Technician	00	02	01	00	01
2	OT Technician	00	01	00	00	01
3	ECG Technician	00	01	00	00	01
4	MSW	01	01	00	01	01
SUB TOTAL		**01**	**04**	**01**	**01**	**04**
PHARMACIST						
1	Chief Pharmacist	02	03	02	00	00
2	Pharmacist	02		01	01	
SUB TOTAL		**04**	**03**	**03**	**01**	**00**
DIETARY						
1	Dietician	00	01	00	00	01
2	Cook	01	02	00	01	02
5	Kahar	01	02	00	01	02
SUB TOTAL		**02**	**05**	**00**	**02**	**05**
ADMINISTRATION						
1	Office Superintendent	00	01	00	00	01
2	Sr. Clerk	01	02	00	01	01
3	Jr. Clerk	01		01	00	
4	Data Entry Operator	01	01	01	00	00
5	HV	01	--	01	00	--
6	Registration clerk	00	01	00	00	01
7	Store keeper	00	01	00	00	01
8	Medical Records Clerk	00	01	00	00	01
9	Projectnist	01	--	00	01	--
10	Accountant	00	01	00	00	01
SUB TOTAL		**05**	**08**	**03**	**02**	**06**
CLASS 4						
1	Ward Boy	04	04	04	00	00
2	Ward Aaya	06	07	04	02	03
3	Sweepress	07	08	02	05	06
4	Chowkidar	02	11	01	01	10
5	Mali	01	--	00	01	--
6	Bhisti	01	--	01	00	--
7	Dhobi	00	02	00	00	02

9	Driver	01	02	00	01	02
10	Chaprasi	01	--	00	01	--
11	Attendant	01	--	01	00	--
SUB TOTAL		**24**	**34**	**13**	**11**	**23**
GRAND TOTAL		**57**	**114**	**36**	**29**	**87**

GAP ANALYSIS

OUT PATIENT DEPARTMENT

OPD is the first point of contact between the hospital and the community, and very commonly called “show window” of hospital. A well planned OPD plays a important role in building up the image of the hospital. A properly planned building with pleasant ambience makes the patient and their relative comfortable who are in search of solace and comfort for mitigating their suffering**.**

IDENTIFIED GAPS

STRUCTURAL	1. Unavailability of Enquiry counter 2. There is no availability of separate queue for differently abled patients 3. There is no availability of separate and functional toilet for differently abled patients 4. Citizen charter and Patient charter are not displayed 5. Calibration of BP apparatus, weighing machine and thermometer is not done 6. Unavailability of dedicated Registration clerk 7. There is no availability of nurse/s to direct patients to specific OPDs
PROCESS	8. UHID No. is not being generated for the patients 9. Tariff rates are not defined and made aware to the patients/ attendant
OUTCOME	Following indicators were not captured properly **10.** Patient satisfaction 11. Waiting time of OPD patients **12.** OPD utilization

AMBULANCE SERVICES

The ambulance is defined as a vehicle used for emergency medical care that provides:-

• A driver's compartment

• A patient compartment to accommodate an emergency medical services provider (EMSP) and one patient located on the primary cot so positioned that the primary patient can be given intensive life-support during transit

• Equipment and supplies for emergency care at the scene as well as during transport

• Safety, comfort, and avoidance of aggravation of the patient's injury or illness

• Two-way radio communication

• Audible and Visual Traffic warning devices

IDENTIFIED GAPS

STRUCTURAL	1. Inadequate communication system in ambulance 2. Unavailability of required equipments (stetho, sphygno, suction app, defib, monitor, oxygen cylinder) 3. Unavailability of required medicines 4. No proper maintenance of medical gas 5. Calibration of equipments is not done
PROCESS	6. Staff is not trained in BLS 7. Medication and equipment checklist is not maintained 8. Infection control practices are not followed

CASUALTY DEPARTMENT

The emergency departments of most hospitals operate 24 hours a day, although staffing levels may be varied in an attempt to mirror patient volume.

Due to the unplanned nature of patient attendance, the department must provide initial treatment for a broad spectrum of illnesses and injuries, some of which may be life-threatening and require immediate attention.

IDENTIFIED GAPS

STRUCTURAL	1. No separate entrance for the department 2. Emergency Crash Cart,Defibrillator,Cardiac Monitor are not available
PROCESS	3. Ability to perform acute blood test and receive results within one hour for Arterial blood gases, Full blood picture, urea and electrolytes, plasma, glucose, Blood levels for common overdose medication/agents, Coagulation studies is not present 4. Security staffs are not immediately available when required in the emergency room. 5. Electrical equipment (e.g. defibrillator) is not charged at all times. 6. Crash cart is not checked daily 7. Staff is not trained in BLS/ACLS
OUTCOME	8. Time for initial assessment of emergency patient is not being monitored

LABORATORY

Laboratory services are an integral and indispensible part of disease diagnosis, treatment, monitoring response to treatment, disease surveillance programs and clinical research.

a) It is place of work for testing patient's sample- for results, in favor of diagnosis and treatment.

b) According to NABL, the following classification can be used:

- Small Laboratory: A laboratory receiving up to 100 patients per day
- Medium Laboratory: A laboratory receiving up to 101-400 patients per day
- Large Laboratory: A laboratory receiving above 400 patients per day

IDENTIFIED GAPS

STRUCTURAL	1. No separate demarcation of sample collection area 2. Unavailability of pathologist
PROCESS	3. Scope of services are not defined 4. No proper maintenance of lab equipments 5. Calibration of equipments is not done 6. Unawareness of staff about the safety precautions 7. laboratory staff is not taking necessary precautions while handling samples 8. Improper management of BMW 9. Critical results are not defined, reported and documented 10. No surveillance for lab tests is carried out 11. EQAS is not being monitored 12. Lab reports are not signed by the pathologist 13. Turnaround time for lab reports is not being monitored 14. Temperature of refrigerator is not monitored
OUTCOME	Following indicators were not captured properly 15. Number of reporting errors per 1000 investigations 16. % of reports having clinical correlation with provisional diagnosis 17. % of adherence to safety precautions 18. % of redo's

RADIOLOGY AND IMAGING DEPARTMENT

The main objectives of the radiology department are:

a) To provide comprehension high quality imaging service

b) Establishment and confirmation of clinical diagnosis

c) Providing high quality therapeutic radiology

d) Commitment to training and research

e) Aiding in the effective implementation of therapeutic procedures

The radiology department of the hospital is located in the basement which is easily accessible from OPD and Emergency department. Services provided by the radiology department are X-RAY and USG

IDENTIFIED GAPS

STRUCTURAL	1. Unit does not have AERB (SITE/TYPE) approval 2. Change room is not available for patients 3. Radio-safety devices (TLD badges, Gonad shield, thyroid shield) are not available 4. Critical results are not defined, reported, and documented. 5. Radiation hazard symbol is not present
PROCESS	6. Radiology equipments are not calibrated 7. Quality Assurance program is not being followed 8. Turnaround time for reports is not being monitored
OUTCOME	Following indicators were not captured properly 9. Number of reporting errors per 1000 investigations 10. % of reports having clinical correlation with provisional diagnosis 11. % of adherence to safety precautions 12. % of redo's

OPERATION THEATRE

Operation theater (OT) is a specialized facility of the hospital where life saving or life improving procedures are carried out on human body, under strict aseptic conditions in a controlled environment by specially trained personnel to promote the healing and cure with maximum safety and comfort. Operation Theater must be designed scientifically to ensure sterility, easy maintenance and effective utilization of resources and manpower.

IDENTIFIED GAPS

STRUCTURAL	1. Unavailability of HVAC system 2. Proper zoning concept in OT is not followed 3. Unavailability of sufficient number of OT tables for the daily load 4. Unavailability of Crash cart,ECG monitor, defibrillator
PROCESS	5. Pre operative checklist is not being followed
OUTCOME	Following indicators were not captured properly 6. % of anesthesia related adverse events being monitored 7. % of anesthesia related mortality 8. % of modification in plan of anesthesia 9. % of unplanned ventilation following anesthesia 10. % of Surgical site infection rate monitored 11. Re Exploration rate 12. Re scheduling of surgeries

WARDS

An inpatient area is that part of the hospital which includes the nursing station, the beds it serves, storage and public areas needed to carry out nursing care. Since it is a home away from home for a patient, it requires holistic planning and designing to suit the requirements of seekers and providers of patient care

IDENTIFIED GAPS

STRUCTURAL	1. Emergency crash cart is not present in wards 2. Unavailability of color coded BMW bins 3. Adequate number of nurses are not present in each shift
PROCESS	4. Vitals of the patient are not checked every day 5. The nurses are not trained in BLS (CPR)

SNCU

IDENTIFIED GAPS

STRUCTURAL	1. Qualified doctor is not available round the clock 2. Uavailability of Central air condition 3. There is no separate area for carrying out sluicing activities
PROCESS	4. Infection control practices are not documented and followed 5. Quality assurance programme is not documented and implemented 6. Procedures for situation of bed shortages are not defined and followed 7. Policy for initial assessment and re-assessment of patient is not documented and present 8. Staff is not trained on resuscitation 9. All the equipments are not periodically inspected and calibrated 10. Documented procedures does not guide the referral of patients to other departments/ specialties
OUTCOME	Following indicators were not captured properly 11. SNCU utilization 12. Mortality Rate

TSSU

A Theatre sterile supply Unit CSSD is a hospital support service which is entrusted with processing and issue of supplies including sterile instruments and equipment used in various departments of the hospital. It receives, stores, sterilizes and distributes

IDENTIFIED GAPS

STRUCTURAL	1. Sufficient space is not available(0.75sq mts/bed) 2. layout does not follow the functional flow: Receiving, Washing, decontamination, drying, packing, loading, unloading, storing and issuing 3. Calibration of pressure meter of autoclave is not done 4. Racks are not present in the department 5. Technician is not present in TSSU 6. Transport trolley is not present for items
PROCESS	7. TSSU sterilization register is not present 8. Drums are not being labeled in TSSU 9. Chemical, biological and bowie-dick test are not performed 10. Recall system of items are not followed 11. Reuse policy for items are not available

MEDICAL RECORD DEPARTMENT

Medical Record Department of a hospital is dedicated for storing all the medical records of patients. A medical record could be defined as a clinical, scientific, administrative and legal document relating to patient care in which are recorded sufficient data written in the sequence of events to justify diagnosis and warrant treatment and end result

IDENTIFIED GAPS

STRUCTURAL	1. Sufficient space is not available for medical record department 2. Fire fighting system is not available in the unit 3. Qualified and trained MRD technician are not available in the department 4. Table and chair are not provided to the MRD technician 5. Adequate number of racks are not available for the storage of records
PROCESS	6. There is no functional flow at MRD : Receiving, assembling, deficiency check, coding, indexing , filing, issuing area 7. MRD Committee is not available 8. MRD audits are not being conducted 9. Records are not kept under lock and key 10. MRD Committee is not available 11. MRD audits are not being conducted 12. Records are not kept under lock and key 13. Hospital has no retention policy for documents 14. Destruction policy for records is not available 15. Pest control not done on a regular basis

OUTCOME	Following indicators were not captured properly 16. % of missing records are not monitored 17. % of records with ICD codification is not done 18. Percentage of medical records not having discharge summary is not monitored 19. Percentage of medical records not having consent form is not monitored

PHARMACY

The pharmacy is located near the main entrance to the Hospital. The department is manned by qualified pharmacists for round the clock.

IDENTIFIED GAPS

STRUCTURAL	1. Insufficient availability of racks for storage of items 2. There is no adequate ventilation and lighting in the department 3. No security system is installed 4. No proper demarcation of receiving, segregation and storing area 5. No proper temperature maintenance of refrigerator for storage of medicines 6. No provision for storage of Narcotic drugs is available
PROCESS	7. Items are not labelled and stored alphabetically 8. Pest control measures are not undertaken regularly 9. Sound Inventory control practices are not followed (ABC, VED, FSN,FIFO) 10. Unavailability of Drug and Therapeutic committee 11. Unavailability of Drug formulary 12. Adverse drug reactions are not analysed

OUTCOME	Following indicators were not captured properly 13. % of local purchase 14. % of stock outs 15. % of variation from the procurement process 16. % of goods rejected before GRN

BIO-MEDICAL WASTE MANAGEMENT

IDENTIFIED GAPS

PROCESS	1. There is no provision of regular health checkup for staff of this unit 2. There is no provision of regular health checkup for staff of this unit 3. Annual report is not submitted to UP PCB 4. Monitoring is not done for the amount of BMW generated

INFECTION CONTROL

IDENTIFIED GAPS

STRUCTURAL	1. A designated and qualified infection control nurse(s) is not present 2. A designated infection control officer is not present

PROCESS	3. The hospital does not implement any policies and/or procedures to prevent infection in patient care areas 4. The organization does not adhere to standard precautions at all times 5. Equipment cleaning, disinfection and sterilization practices and policies are not followed 6. Appropriate antibiotic policy is not established and implemented 7. The hospital does not have appropriate engineering controls to prevent infections 8. The hospital does not adhere to mortuary practices 9. The infection prevention and control programme is not updated in a year 10. HIC surveillance data is not collected regularly 11. Verification of data is not done on a regular basis by the infection control team 12. The surveillance activities does not include monitoring of the effectiveness of housekeeping services 13. HAI rates are not being monitored 14. Appropriate feedback regarding HAI rates are not provided on a regular basis to appropriate personnel 15. A hospital infection control committee and team are not formed 16. The personal protective equipment are not being used by the staff 17. Compliance with hand hygiene guidelines is not being monitored 18. Documented procedure for identifying an outbreak is not present 19. Implementation of laid down procedure is not done 20. No Documented procedure exists to guide the cleaning, packing, disinfection and/or sterilization, storing and issue of items 21. Isolation / barrier nursing facilities are not available
	1. Visit by the hospital authorities to disposal site neither done nor documented

PROCESS	22 Resources required for the infection control programme are not made available by the hospital 23 The organization does not earmark adequate funds from its annual budget for infection control activities 24 Appropriate "in-service" training sessions for all staff are not conducted 25 Appropriate pre and post exposure prophylaxis is not provided to all concerned staff members
OUTCOME	Following indicators were not captured properly 26 UTI rate 27 VAP rate 28 SSI rate 29 Central line associated blood stream infection rate

KITCHEN

IDENTIFIED GAPS

STRUCTURAL	1. Layout does not follow the functional flow: Receiving, storage, preparation, distribution and cleaning areas 2. Measures for fire detection/fire fighting are not installed in this unit 3. The person responsible for this department is not a qualified dietician or has supervision from a consultant dietician
PROCESS	4. Diet Sheet is not prepared by Dietician as per the treating Doctor's instruction on the patient's case sheet 5. Patient Case sheets are not checked by doctor and dietician/SN 6. Infection control practices are not followed

HOUSEKEEPING DEPARTMENT

IDENTIFIED GAPS

PROCESS	1. Training for infection control practices is not provided to the staff 2. Pest control methods are not being practiced by the Hospital 3. Periodical medical examination of staff is not being done

ENGINEERING AND FACILITY MANAGEMENT

IDENTIFIED GAPS

STRUCTURAL	1. Statutory requirements are not fulfilled 2. Up to date drawing, layout, escape route is not available and displayed 3. No designated individual for maintenance 4. Unavailability of staff round the clock for emergency repair 5. Unavailability of safety devices (Fire extinguishers, smoke detectors, sprinklers, grab bars, side rails, nurse CCTV, ALARMS ETC)

PROCESS	6. There is no mechanism for renewing licenses 7. Preventive and break down maintenance plan are not implemented 8. Alternate sources and their checking are not done 9. Response time is not monitored 10. Water quality reports are not maintained 11. Safety devices are not used by staff 12. Facility inspection rounds twice a year in patient care areas and once in non-patient care areas are not take place 13. Documentation of facility inspection report is not done 14. There is no safety education program for all staff 15. Safety committee is not present 16. Staff is not trained for disaster management and fire management 17. Mock drills are not conducted at periodic intervals and documented
OUTCOME	Following indicators were not captured properly 18. Number of variations observed during mock drills

LABOUR ROOM

IDENTIFIED GAPS

STRUCTURAL	1. No separate demarcation for septic and aseptic deliveries 2. Unavailability of Crash cart and ECG monitor 3. Unavailability of screens for privacy 4. Number of Labour tables are not appropriate for the daily load
PROCESS	5. Apgar Score is not being done for the patients

BLOOD BANK

IDENTIFIED GAPS

STRUCTURAL	1. Unavailability of qualified Blood Bank In-charge 2. Blood bank signage and schedule of charges are not displayed 3. Nurse is not present in the Blood Bank 4. All sections do not have bilingual signage

PROCESS	5. Bilingual consent for blood donation is not available 6. A list of all department staff is not exist and prominently displayed 7. Policies and procedures for blood bank are not available 8. Register of all recipient adverse reactions to blood and blood products are not maintained 9. Data is not collected regarding recipient adverse reactions is collated, analyzed and reported to the blood transfusion committee. 10. Work instructions are not visibly displayed and prominent
OUTCOME	Following indicators were not captured properly 11. % of transfusion reactions 12. % of blood and blood products wastage 13. % of component usage 14. Turnaround time for issue of blood and blood products.

SCORE ANALYSIS

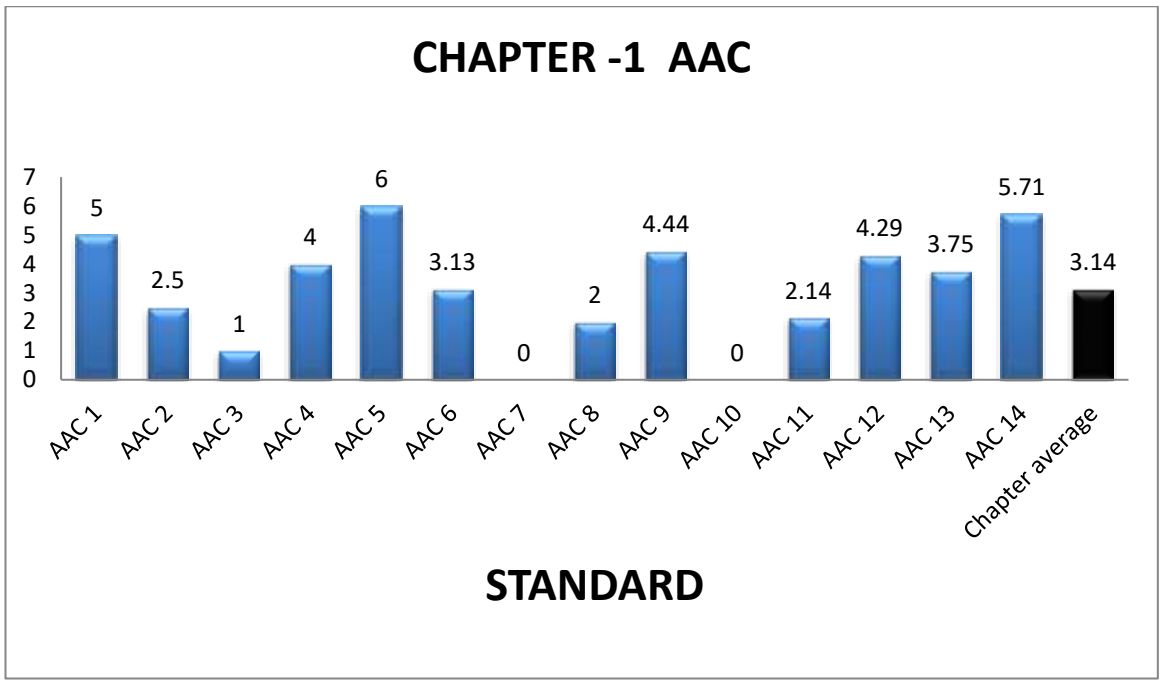
FINDINGS

After filling up of the NABH self- assessment toolkit the following scores were calculated:

1. The average score of each individual standard
2. The average score of each chapter
3. The average score of all standards

These scores and the findings of each chapter are being provided below:

Chapter 1: ACCESS, ASSESSMENT AND CONTINUITY OF CARE (AAC)	
AAC 1	5
AAC 2	2.5
AAC 3	1
AAC 4	4
AAC 5	6
AAC 6	3.13
AAC 7	0
AAC 8	2
AAC 9	4.44
AAC 10	0
AAC 11	2.14
AAC 12	4.29
AAC 13	3.75
AAC 14	5.71
Chapter average	3.14



INTERPRETATION

AAC 1. - The services being provided are clearly defined and are in consonance with the needs of the community but some services are partially display properly and staff is not properly oriented about services.

AAC 2. The organization does not have well defined documentation and policies and procedures for registration of patients. It does not have policies & procedures for managing patients during non availability of beds. The staffs are not uniformly oriented on the same.

AAC 3.The organization does not have appropriate mechanism for transfer or referral of unstable & stable patients. It does not address the staffs that are responsible during transfer.

AAC 4. Documentation has been done about initial assessment and plan of care, implementation is required.

AAC 5.Patient reassessed at regular intervals and documentation is also maintained but implementation is required.

AAC 6. The scope of laboratory services is not displayed at the entrance. There are documented policies and procedures for collection, identification, handling, safe

transportation, processing and disposal of specimens but not implemented. The list for outsourced tests is not available.

AAC 7.laboratory quality assurance programme has been not documented and also not implemented. Validation has not been done till date. Surveillance of test results is not being implemented. It also does not address periodic calibration and maintenance of all equipments.

AAC 8. Laboratory Safety programme has not been documented, and not implemented. The staff is not trained for the same.

AAC 9. The scope of radiology & imaging services are not displayed at the entrance of the Department. There are no documented policies and procedures for identification and safe transportation of patients to imaging services and the same are not implemented. Critical results are not intimated and the turnaround time is not being monitored.

AAC 10. The quality assurance programme is not documented and not implemented. It does not address validation of imaging methods and surveillance of imaging results. It also does not address periodic calibration and maintenance of all equipments.

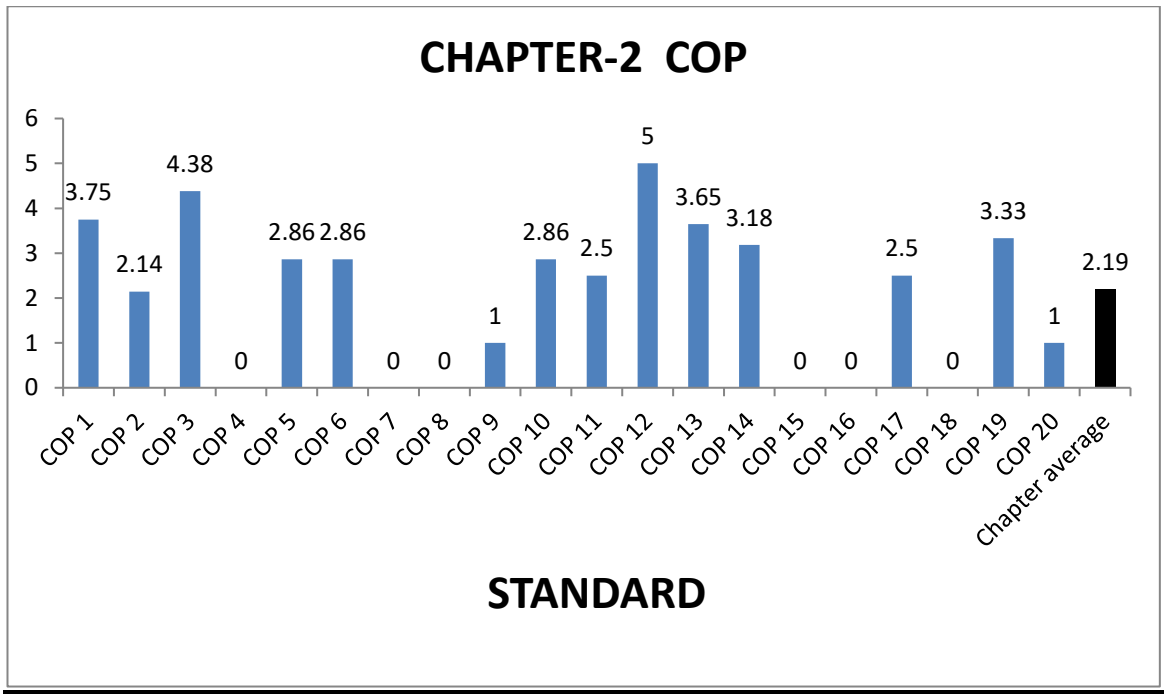
AAC 11 The radiation safety programme has not been documented and not implemented. Signages are not properly displayed in all appropriate location .The staffs are not trained on the same. Adequate number of safety devices (TLD batches) is not provided to the staffs

AAC 12. Procedure has not been documented about information sharing about care of patients, and implementation has not been done till date. There are no documented policies and procedures to guide the referral of patients to other departments/specialities but it is implemented.

AAC 13 The hospital discharge process has not been documented .Document of policies and procedures does not exist for coordination of various departments.

AAC 14. The hospital has defined and documented the content of discharge summary.

Chapter 2: CARE OF PATIENTS (COP)	
COP 1	3.75
COP 2	2.14
COP 3	4.38
COP 4	0
COP 5	2.86
COP 6	2.86
COP 7	0
COP 8	0
COP 9	1
COP 10	2.86
COP 11	2.5
COP 12	5
COP 13	3.65
COP 14	3.18
COP 15	0
COP 16	0
COP 17	2.5
COP 18	NA
COP 19	3.33
COP 20	1
Chapter average	2.19



INTERPRETATION

COP-1.Documentation of policy and procedures for uniform care of patients in all setting of the hospital and guided by applicable law, regulation and guideline has done as per NABH standard It is not documented but implementation has not done as per NABH standard.

COP-2.Emergency services provided by the organisation are well documented and implemented.

COP-3. Ambulance Services provided by the hospital need to be improved a lot. Ambulances are not well equipped.

COP- 4. Policies and procedures to guide the care of patients requiring cardio-pulmonary resuscitation are not available. Staffs are not trained uniformly and periodically updated in CPR. There is no committee related to CPR.

COP-5.The policy and procedure of guide nursing care has not been documented and not implemented. Care provided by nurses is not properly documented in the patient record.

COP-6. Polices to guide the performance of various procedures is not available and not implemented but only qualified personnel order, .plan, perform and assist in performing procedure. Documented procedures do not exist to prevent adverse events like wrong site, wrong patient and wrong procedure.

COP -7 There is no documented policies and procedures for rational use of blood and blood components. Staffs are not trained to implement the polices. The transfusion reactions are not analysed for preventive and corrective actions.

COP- 8. The organization does not have documented admission and discharge criteria for intensive care unit.. Infection control practices are not followed uniformly. Quality assurance programme for the ICCU is not implemented.

COP- 9. There is no documented policies and procedures to guide the care of vulnerable patients (elderly, children, physically and/or mentally challenged) and not implemented. Staffs are not trained uniformly to care for this vulnerable group.

COP-10. Hospital policy and procedure for obstetric services has not been documented and implementation of policy of maternal nutrition and monitoring performance of pre natal and post natal has not done. Hospital does not provide care for the high risk obstetric cases.

COP-11. The organisation has defined but not displayed the scope of paediatric services. The staffs those care for children are not trained for age specific competency. The children's family members are not uniformly educated about nutrition, immunization and safe parenting.

COP -12. There are no documented policies and procedures to guide the care of patients undergoing moderate sedation but implementation is there.

COP- 13 There is no documented policies and procedures for guiding the administration of anaesthesia. An immediate preoperative re-evaluation is done but not properly and documented. Adverse anaesthesia events are not recorded and monitored.

COP- 14 Policies and procedures are not documented for the care of patients undergoing surgical procedures and are not implemented. A brief of note that should be documented prior to transfer out of patient from recovery area is not documented.

COP-15 Policies and procedures for the care of patients under restraints (physical and/ or chemical) are not documented Staffs are not trained to control and restraint techniques.

COP-16. The policy and procedure guiding the management of pain has not been documented and not implemented Patient and family members are not educated uniformly on various pain management techniques.

COP- 17 The hospital provides documented policies and procedures to guide appropriate rehabilitative services but it is not properly implemented and there is lack of space and equipments to perform these activities.

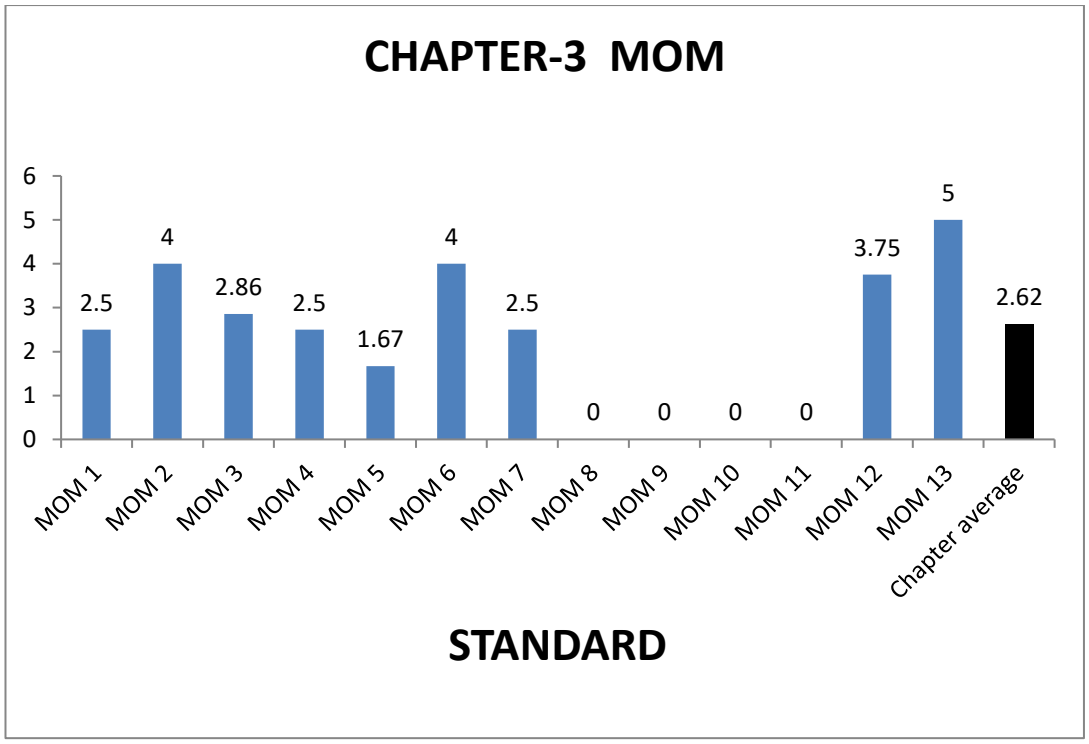
COP -18 Research activities are not carried out in the hospital. (NA)

COP-19 The organization does not have documented policies and procedures for nutritional therapy and are not implemented properly. Patients are not screened for nutritional needs uniformly although patients receive food according to their clinical needs

COP- 20. Policies for End of Life Care have not been documented, but hospital does not provide any specific facility for such care and the staffs are not trained on the same.

Chapter 3: MANAGEMENT OF MEDICATION (MOM)	
MOM 1	2.5
MOM 2	4
MOM 3	2.86
MOM 4	2.5
MOM 5	1.67
MOM 6	4
MOM 7	2.5

MOM 8	0
MOM 9	0
MOM 10	NA
MOM 11	NA
MOM 12	3.75
MOM 13	5
Chapter average	2.62



INTERPRETATION

MOM-1. Documentation has not been done regarding pharmacy services and usage of medication and not implemented. There is no multidisciplinary committee to guide the formulation and implementation of these policies and procedures.

MOM-2. Hospital formulary has not been developed and requires implementation to define process for acquisition of the medication.

MOM-3. There is no documented policies and procedures for storage of medications and not implemented. Sound alike and Look alike medications are not stored separately. Every medicine is not stored according to the manufacturer's recommendations

MOM-4. The organisation does not have documented policies and procedures for prescription of medications and for high risk medications but need to be implemented

MOM-5. Documentation has not been done for safe dispensing of medications. Implementation needs to be done. Prepared medication is not labelled prior to preparation of a second drug.

MOM-6. Documentation has not been done for medication administration and implementation is also required.

MOM-7. Documentation policies and procedure to guide the monitoring of patients after medication administration has not been done now. Organisation does not define those situations where close monitoring is required.

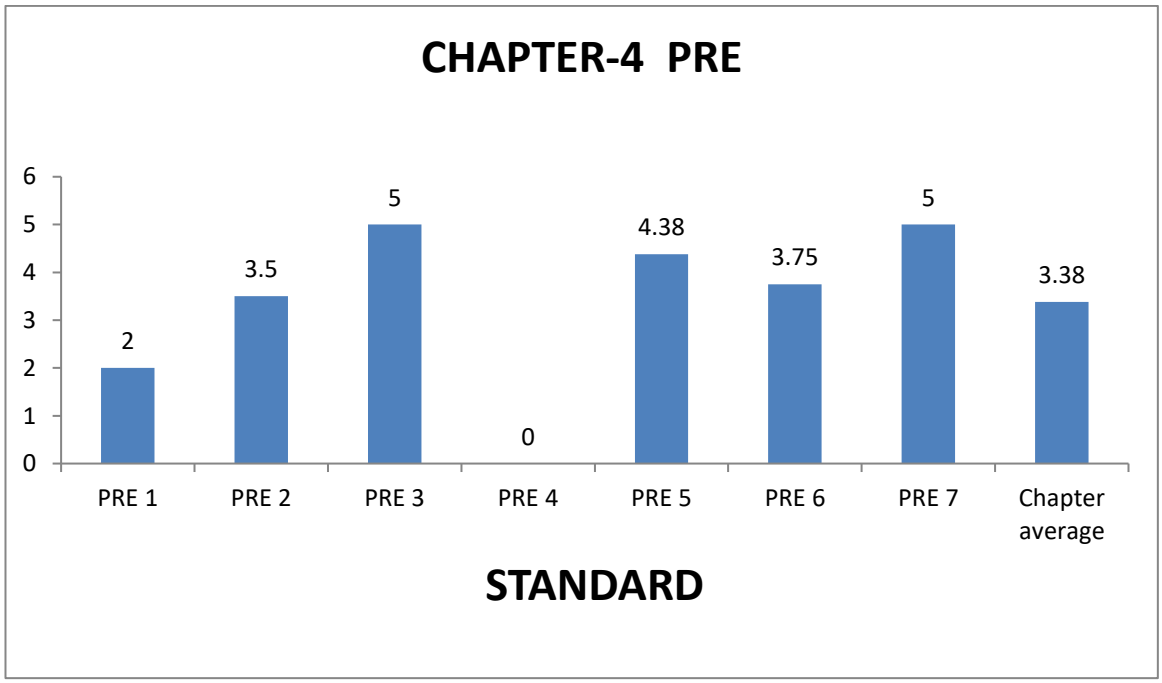
MOM-8. Documented procedures do not exist to capture near miss, medication error and adverse drug event and are not implemented. Adverse drugs events are not reported within a specified time frame. They are also not collected and analysed by multidisciplinary committee.

MOM-9. Narcotics are not used in hospital

MOM-10: Chemotherapeutic agents are not used in the hospital.
MOM- 11: Radioactive drugs are not used in the hospital.
MOM-12: Implantable prosthesis is not used in the hospital.

MOM- 13: There is no documented policies and procedures for use of medical gases and not implemented. Medical supplies and consumables are not kept in clean and safety environment

Chapter 4: PATIENT RIGHT AND EDUCATION (PRE)	
PRE 1	2
PRE 2	3.5
PRE 3	5
PRE 4	0
PRE 5	4.38
PRE 6	3.75
PRE 7	5
Chapter average	3.38



INTERPRETATION

PRI -1. Documentation of patient and family rights and responsibilities has not been done and not displayed, Staffs are not uniformly aware of their responsibility in protecting patient's rights.

PRI-2 There is no policy for Patient and family rights that support individual beliefs, values and involve the patient and family in decision making processes.

PRI-3. There are no policies to educate family members about expected results and possible complications and the same are not implemented.

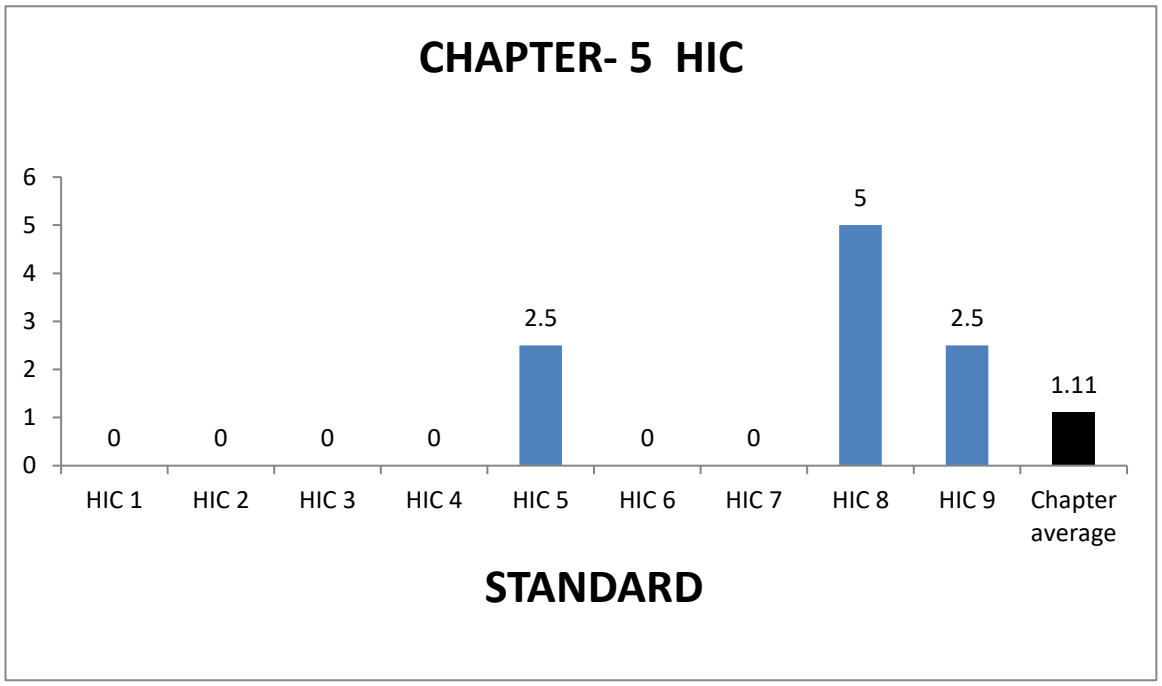
PRI -4.Informed consent policy is not documented and not implemented and staff is not uniformly aware about these policies.

PRI-5. The patient and their family members are not uniformly educated about the safe and effective use of medications and their potential side effects.

PRI-6. The patient and their family members are needed to be educated uniformly about the estimated costs of treatment but this policy is not implemented

PRI-7. The documentation of organization redressed procedure has not been done and not implementated.

Chapter 5: HOSPITAL INFECTION CONTROL (HIC)	
HIC 1	0
HIC 2	0
HIC 3	0
HIC 4	0
HIC 5	2.5
HIC 6	0
HIC 7	0
HIC 8	5
HIC 9	2.5
Chapter average	1.11



INTERPRETATION

HIC-1. The hospital infection prevention and control programme is not documented which aims at preventing and reducing risk of healthcare associated infections and not implemented properly. Hospital does not have infection control committee, infection control team and nurse.

HIC-2.Infection Control manual has not been documented, but some standards have to be documented and implementation is also required.linen and laundary management is improper and antibiotic policy need to be implemented

HIC-3.Survillance is not done on timely basis and record is also not maintained, but proper documentation and implementation is required.

HIC-4.The organization does not take actions to prevent or reduce the different risk of Hospital Associated Infections (HAI) in patients and employees and these policies are not documented.

HIC-5.Facilities and resources provided to support the infection control programme are inadequate. Barrier nursing facility is not available

HIC-6. Outbreaks of infections are not documented

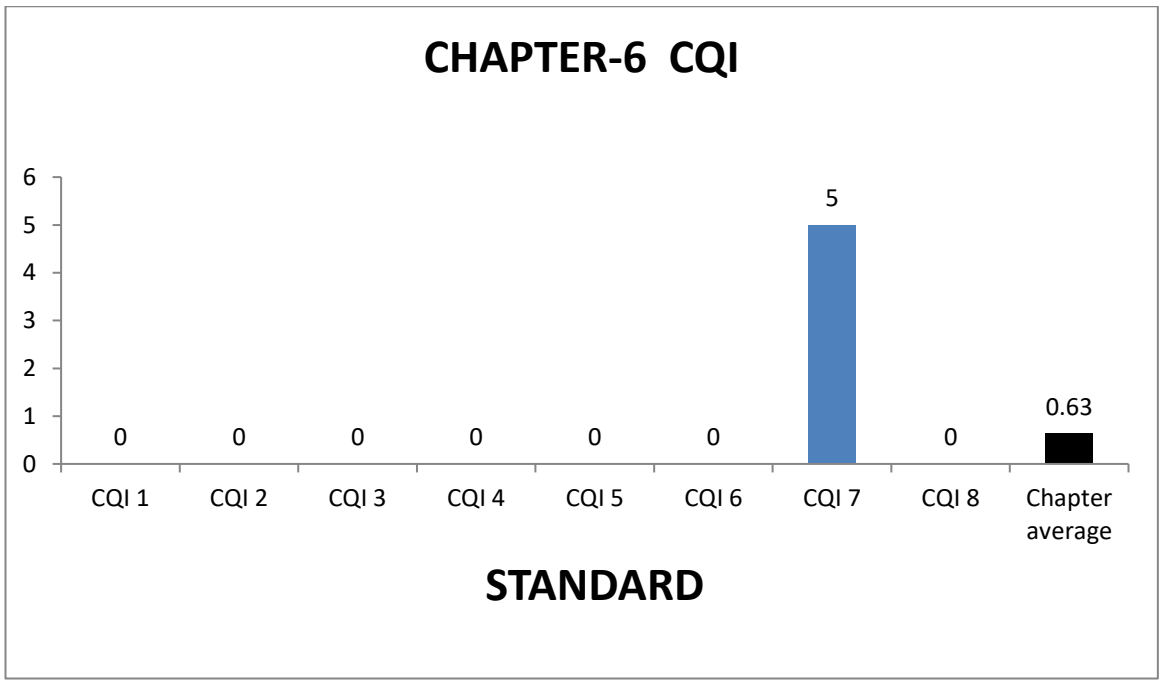
HIC-7. Documentation has not been done for procedures for sterilisation activities in the organisation but not implemented. There is no adequate space for sterilization

activities. Regular validation tests for sterilization (Bowie dick tape test and leak rate test) are not carried out No established recall procedure for sterile and non sterile items.

HIC-8. There is no proper segregation and collection of BMW uniformly from all patient care areas of the hospital. The hospital does not monitor that the BMW is transported safely within the time frame. Staffs are not provided with appropriate Personal Protective Equipments (PPE) for handling of BMW.

HIC-9. Infection control programme is supported by the management but it is not implemented properly. Policy of annual budget for HIC is not present and staff is not being trained for infection control practices.

Chapter 6: CONTINUOUS QUALITY IMPROVEMENT (CQI)	
CQI 1	0
CQI 2	0
CQI 3	0
CQI 4	0
CQI 5	0
CQI 6	0
CQI 7	5
CQI 8	0
Chapter average	0.63



INTERPRETATION

CQI-1. Structured quality improvement and continuous monitoring programme in the organization is not documented and implementation needs to be done. There is no established process in the organisation to monitor and improve quality of nursing and complete patient care.

CQI-2. Structured patient safety programme is not documented. There is no multidisciplinary committee to implement the programme. The organisation does not use two identifiers to identify patients across the organisation.

CQI-3. Safety and quality control programmes of the diagnostics services, invasive procedures, anaesthesia, and infection control have not been documented and need to be implemented although there is proper monitoring of use of blood and blood products. The organization does not identify key indicators to monitor the clinical structures, processes and outcomes which are used as tools for continual improvement have been documented and not implemented.

CQI-4. Key indicators to monitor the managerial structures, processes and outcomes which are used as tools for continual improvement have not been documented and need to be implemented. Monitoring does not include availability and content of medical records.

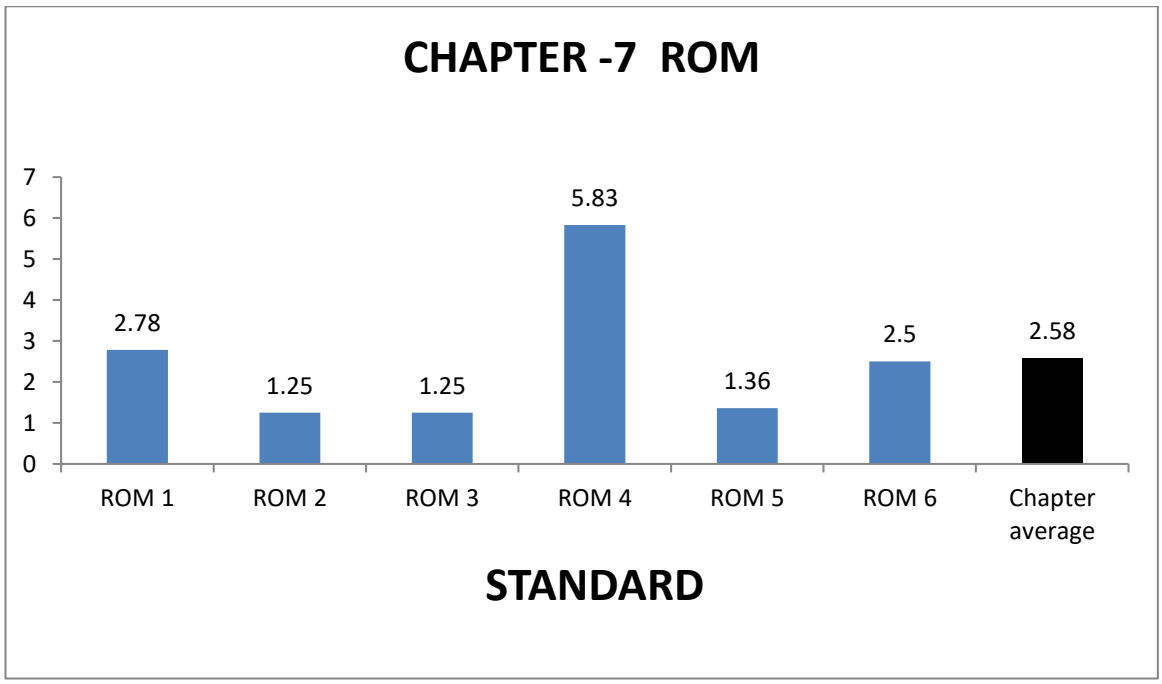
CQI-5. Management does not support and implements use of appropriate quality improvement, statistical and management tools in its quality improvement program

CQI-6. System for audit of patient care services has not been documented and need to be implemented. Patient and staff anonymity is not maintained and implemented and remedial measures are not implemented and documented.

CQI-7.There is no documented and implemented incidents reporting system and there is no process for the feedback collection and receiving complaints.

CQI-8. The organization does not have defined sentinel events and there is no established process for analysis of sentinel events.

Chapter 7: RESPONSIBILITIES OF MANAGEMENT (ROM)	
ROM 1	2.78
ROM 2	1.25
ROM 3	1.25
ROM 4	5.83
ROM 5	1.36
ROM 6	2.5
Chapter average	2.58



INTERPRETATION

ROM-1. Responsibilities of Management are defined. Organ gram of the hospital is not available.

ROM-2.The policy and procedure of the organization does not complies with the laid down and applicable legislations.

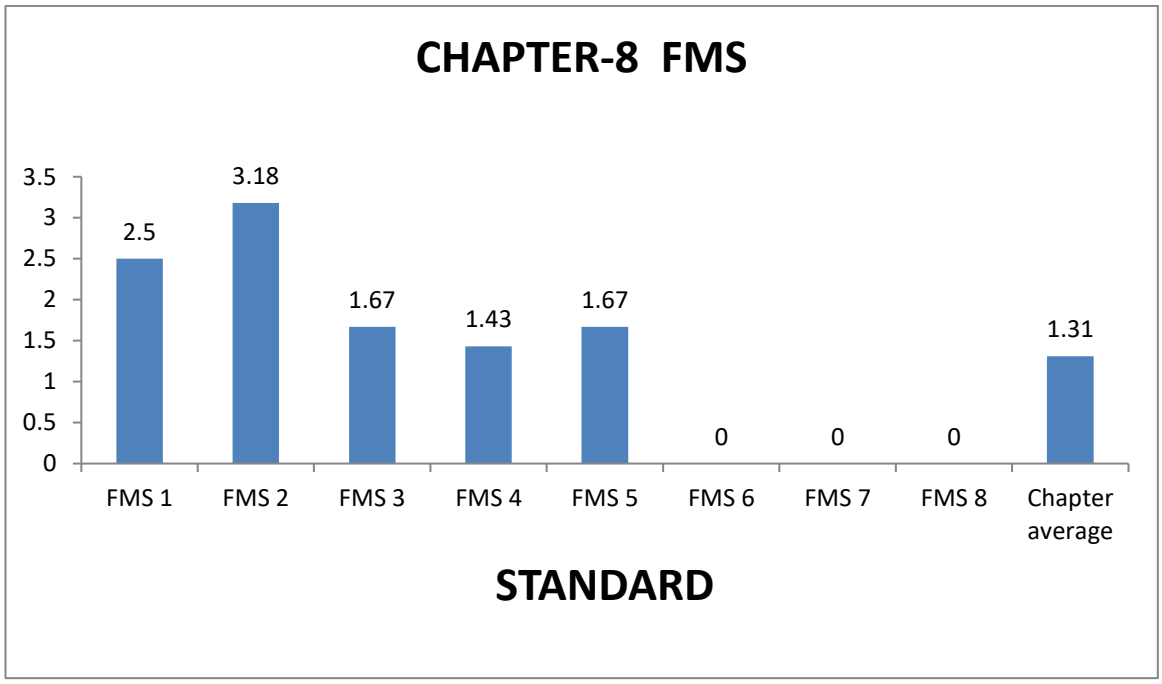
ROM-3. Services provided by each department are not documented and not displayed and staff is not oriented

ROM-4. Organization's Ethical Management needs to be improved.

ROM-5. A suitably qualified and experienced individual managerial heads the organization

ROM-6. Documentation of sentinel events has not been done The leaders are not aware of the risk management procedures followed in the hospital. There is no safety and risk management committee in the hospital to oversee the hospital wide safety programme. There is no system for reporting of internal and external process failures.

Chapter 8: FACILITY MANAGEMENT AND SAFETY (FMS)	
FMS 1	2.5
FMS 2	3.18
FMS 3	1.67
FMS 4	1.43
FMS 5	1.67
FMS 6	0
FMS 7	0
FMS 8	0
Chapter average	1.31



INTERPRETATION

FMS-1. The management is conversant with the laws and regulations and knows their applicability to the organization, but updating of amendments is required.

FMS-2. Documentation has not been done on the aspects to ensure safety of patients, their families, staff and visitors, and implementation is required

FMS-3. The organization has not documented a program for clinical and support service equipment management, and implementation is not done. Response times are not monitored for all the complaints received.

FMS-4. A plan for management of biomedical equipment has not been documented and not implemented. Proper logs are not maintained and there is no periodic calibration of equipments

FMS-5. The organization does not have documented programme for medical gases, vacuum and compressed air. Medical gases are not handled stored and distributed in safe manner.

FMS-6. The organization does not have plans for fire only and not for non-fire emergencies within the facilities. Fire safety plan needs a lot of changes. Staffs are not trained for their role in management of such emergencies and mock drills are not conducted.

FMS-7. Provision is not made for availability of medical supplies, equipment and materials during emergencies. Documented disaster management plan is not available and not implemented and staff is not trained.

FMS-8. Plan for management of hazardous materials has not been documented and requires implementation.

Chapter 9: HUMAN RESOURCE MANAGEMENT (HRM)	
HRM 1	2.5
HRM 2	0
HRM 3	2.5
HRM 4	0
HRM 5	5
HRM 6	2.86
HRM 7	2.5
HRM 8	2.5
HRM 9	5.83
HRM 10	5.83
Chapter average	2.95

INTERPRETATION

HRM-1 The organization does not have documented system of human resource planning and it is not implemented.

HRM-2. The organization does not have documented procedure for recruiting staff and orienting them to the organization's environment.

HRM-3. The organization does not have documented professional training and development programme for the staff. Training record is not maintained properly.

HRM-4. Staff members are not adequately trained on specific job duties or responsibilities related to safety .Staffs are not trained on risks within the hospital environment and to take actions to report, eliminate/minimize risks. Reporting processes for common problems, failures and user error does not exist.

HRM-5. An appraisal system for evaluating the performance of an employee is not implemented

HRM-6. The organization does not have documented disciplinary and grievance handling policies and procedures and not implemented.

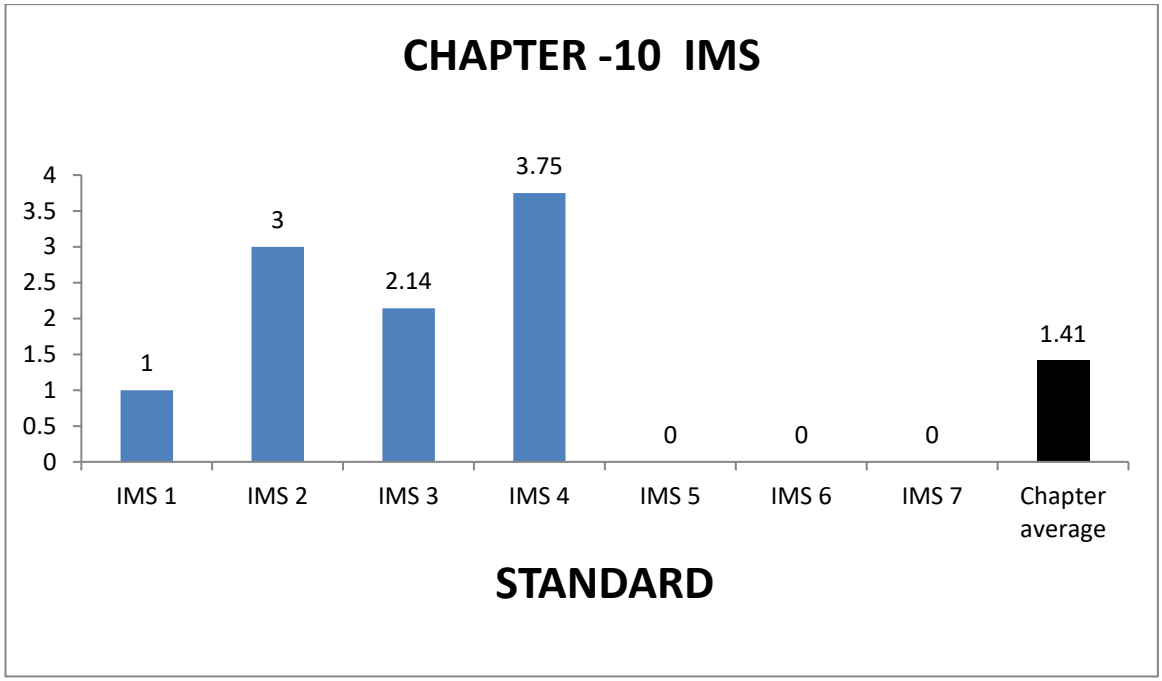
HRM-7. Documentation has not been done for regular health checkups of staff and addressing of occupational hazards and the same not implemented.

HRM-8. Documented personal record for each staff member is not maintained

HRM-9. There is no process for collecting, verifying and evaluating the credentials (education, registration, training and experience) of medical professionals permitted to provide patient care without supervision. Documentation has not been done for the process for authorising all medical professionals to admit and treat patients and provide other clinical services commensurate with their qualifications

HRM-10. There is no process for collecting, verifying and evaluating the credentials (education, registration, training and experience) of nursing staff. There is a process to identify job responsibilities and make clinical work assignments to all nursing staff members commensurate with their qualifications and any other regulatory requirements.

Chapter 10: INFORMATION MANAGEMENT SYSTEM (IMS)	
IMS 1	1
IMS 2	3
IMS 3	2.14
IMS 4	3.75
IMS 5	0
IMS 6	0
IMS 7	0
Chapter average	1.41



INTERPRETATION

IMS-1. Policies and procedures are not documented to meet the information needs of the care providers, management of the organization as well as other agencies that require data and information from the Organization.

IMS-2. Documentation is not done for processes for effective management of data and implementation has not done. Formats for data collection are not standardized.

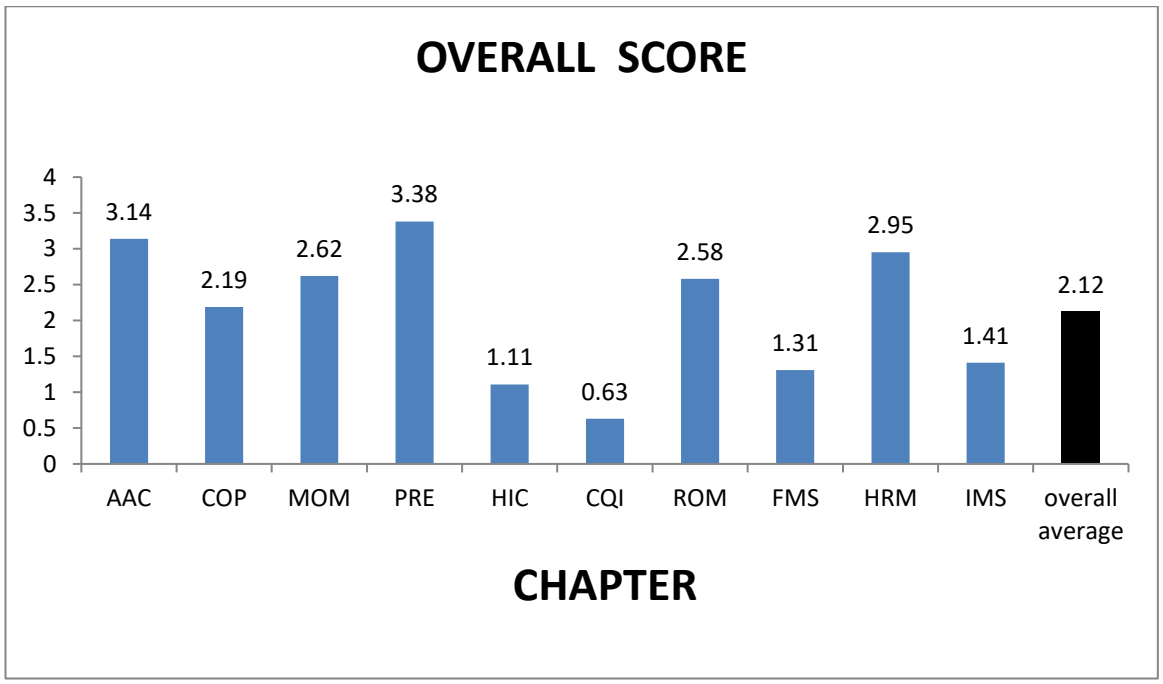
IMS-3. The hospital does not have complete document of accurate medical record for every patient. Every medical record doesn't have unique identifier. Entry in the medical record is not named, signed, dated and timed.Provision for 24 hours availability of patient record is not maintained.

IMS-4. The medical record contains a copy of the discharge summary duly signed by appropriate and qualified personnel but the medical record does not reflects continuity of care

IMS-5. Policies and procedures are not in place for maintaining confidentiality, integrity and security of information, proper implementation is not there.

IMS-6. Documented policies and procedures do not exist for retention time of records, data and information. Implementation is needed in proper way.

IMS-7.. The organization does not carries out review of medical records to find out the timeliness, legibility and completeness of medical records and appropriate corrective and preventive measures are not undertaken.



ANALYSIS

1. Pre-accreditation entry level:

Conditions for qualifying to this award are as below:

• All the regulatory legal requirements should be fully met.

• No individual standard should have more than two zeros.

• The average score for individual standard must not be less than 5.

• The average score for individual chapter must be more than 5.

• The overall average score for all standards must exceed 5.

The validity period for pre-accreditation entry level stage is from a minimum 6 months to a maximum of 18 months. It means that a hospital placed under this award cannot apply for assessment before 6 months.

2. Pre-accreditation progressive level:

Conditions for qualifying to this award are as below:

• All the regulatory legal requirements should be fully met.

• No individual standard should have more than two zeros.

• The average score for individual standard must not be less than 5.

• The average score for individual chapter must be more than 6.

• The overall average score for all standards must exceed 6.

The validity period for pre-accreditation progressive level stage is from a minimum 3 months to a maximum of 12 months. It means that a hospital placed under this award cannot apply for assessment before 3 months.

3. Accredited:

Conditions for qualifying for accreditation are as below:

• All the regulatory legal requirements should be fully met.

• No individual standard should have more than one zero to qualify.

• The average score for individual standards must not be less than 5.

• The average score for individual chapter must not be less than 7.

• The overall average score for all standards must exceed 7.

The validity period for accreditation is 3 years subject to terms and conditions.

ON COMPARING THE HOSPITAL PRESENT STATUS WITH CRITERIA OF NABH PRE ACCREDITATION ENTRY LEVEL WE FIND:

1) There are individual standards with more than two zero.
2) There are many standards having average score less than 5.
3) There are many individual chapters having average score less than 5.
4) Overall average of all the standards does not meet the criteria as it is less than 5.

With the above analysis it is clear that the hospital is not fulfilling the pre-accreditation entry level criteria.

RECOMMENDATIONS

Key recommendations are as follows:

1. Required number of manpower Should be deployed. All the sanctioned posts Should be fulfilled and Required posts like Dietician, Driver, Medical Records Technician, Registration clerk, dhobi, Office supdt. etc Should be introduced in the manpower list/sanctioned post.

2. Round the clock facility Should be available in the hospital to look after the Bio-medical engineering, engineering and maintenance. AMC & Calibration of equipments Should be done and monitored for all major equipments.

3. The hospital Should comply and renew at required intervals all the applicable statutory and regulatory requirements.

4. Dedicated full time Pathologist Should be deployed so as to strengthen the existing Laboratory services and provide proper report to the patients.

5. The X-Ray department Should have the AERB approvals. The "Form F" used in the USG Should be properly filled covering all the points mentioned in the form. Radiation hazard symbol Should be prominently displayed in the radiology department.

6. The Operation Theatre Should be as per the NABH Guidelines i.e. Modular OT with HVAC and HEPA filters, etc (for details please refer to OT guidelines). Minor Structural changes should be done to earmark the clean zone in OT complex.

7. Since the SNCU has been recently made functional, all the staff involved in patient care Should be periodically trained in care of new borns, infection control practices, effective documentation, inventory management, CPR, etc. One more paediatrician should be provided to ensure effective treatment and care of the patients round the clock.

8. Provision of Central Medical gas Should be done. Medical gases like Oxygen, Vaccum and compressed air Should be supplied to all the relevant areas such as Operation Theatres, Emergency, wards, etc. Gas manifold room can be made in one of the existing room in the ground floor in the Labour room area since the Labour Room, ANC & PNC units would be shifting to the newly constructed building very soon.

9. A qualified and trained Pathologist Should be available at the Hospital. Critical results Should be defined and reported to concerned authority in time. Infection

control practices Should be practiced strictly. The scope of services Should be clearly defined and displayed.

10. CSSD Should be developed with all the necessary functional areas such as receiving area, washing area, cleaning area, storage and dispensing area etc. validation tests Should be carried out to ensure the quality of sterilization.

11. Concerned staff (OT, Stores, etc) Should be trained in proper management of Narcotics as required by law. This Should primarily include the storage, labelling, usage and documentation of such drugs.

12. Responsible person Should be deployed to look after the Human Resource Practices. Dedicated person Should be there to look after the Training & Development for all categories of staff.

13. Medical Records needs a significant improvement. Forms such as initial assessment, Plan of care, Doctors Notes, Nursing Notes, Consent Forms (General, Surgery, Anaesthesia, High Risk Pregnancy, etc), Operative Notes, Anaesthesia monitoring sheet, Medication chart, Intake /Output chart, etc Should be developed and incorporated. A detail Discharge Summary Should be provided to the patient mentioning the details such as the complaints, provisional diagnosis, Investigations done, final diagnosis, Medications administered, Procedure performed, condition during discharge, contact details in case of emergency, etc.

14. The organization Should define and practice the Medical records Destruction policy in order to shred off the old unintended files. The files Should be properly filed, coded, indexed and stored in MRD.

15. Qualified and Trained person (Medical Records technician/clerk) Should be deployed in the department.

16. Well planned Dietary department Should be established with defined functional areas and unidirectional flow of process in the department. This can be developed in the existing kitchen area itself. Dieticians Should be appointed to provide clinical diet to the patients.

17. Ambulance Should be adequately equipped as per the requirements of Basic life Support (BLS type). A checklist Should be maintained for the drugs and equipment and Should be monitored regularly. The concerned staff Should be trained in BLS (CPR). Adequate resources (manpower, equipment, fuel, etc) Should be provided to ensure uninterrupted ambulatory service.

18. Adequate number of nurses (as recommended in manpower list) Should be deployed so as to ensure nursing care in wards and other areas.

19. Infection control practices Should be uniformly implemented across the hospital. An Infection Committee Should be formed and an infection control nurse Should be deployed. All the staff involved in direct/indirect patient care Should

be trained on effective hand washing techniques and use of personal protective devices.

20. Full Fire Fighting system Should be established including smoke detectors, sprinklers, etc. All staff Should be trained on Fire Management. Mock drill should be conducted at periodic basis.

21. CPR (BLS) training Should be conducted for all the Doctors, Nurses, and Paramedics.

22. Provision of security services Should be done, especially in areas like OPD, wards, emergency/LR, OT, Mortuary, etc

23. Hospital signages Should be made bilingual with proper direction and pictorial wherever applicable. Floor exit plans Should be displayed in each floor. The hospital Should also clearly mention whether the hospital provides services towards High Risk Pregnancy. Since the hospital has close circuit camera system, it Should be clearly mentioned in relevant areas informing the public that they are “under constant surveillance”.

CONCLUSION:

The analysis shows that there are many gaps in the hospital as per NABH norms. Documentation and implementation is required. As the hospital wishes for NABH accreditation so it must be prepared according to the evaluation criteria for assessment. There are different stages of accreditation which needs to be fulfilled by the organization. As of now the hospital does not fulfills the criteria for entry level according to which no standard must have more than two zero and the average score of individual standard must not less than 5 and the average score for individual chapter must be more than 5.we conducted gap analysis to analyze the present status of the hospital and concluded that the hospital is not ready for the pre assessment. Thus the hospital is presently not prepared for pre – assessment and requires great effort and focus on the weak points so as to cover the gaps and to be prepared for getting NABH accreditation

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ANNEXURE

DEPARTMENTAL GAPS

1 EMERGENCY

S. No.		Yes	No	Remarks
STRUCTURE				
1.	Whether the triage area is marked separately	√		
2.	Does the Emergency department have a separate entrance?		√	Common entrance to that of labour room
3.	Is the Emergency signage visible from the road with proper lighting and signs?	√		
4.	Is the doctor available round the clock for emergency care of patients?	√		
5.	Is there a nurse available round the clock for emergency care of patients?	√		One nurse available on each shift.
6.	Does the number of trolleys and wheelchairs commensurate to the needs?	√		One each
7.	Does the emergency room retain a list of all staff that contains Name, Contact details, Designation?	√		
8.	Is Doctor's name and contact number kept posted at all times in the emergency room?	√		Documented & displayed
9.	Is there an appropriate waiting area for the relatives of the patient?	√		
10.	An appropriately qualified staff member is scheduled to manage triage activities.	√		
11.	Is Emergency Crash Cart available?		√	
12.	Defibrillator		√	
13.	Cardiac Monitor		√	
14.	Emergency drugs	√		
15.	Resuscitation bags (i.e. AMBU) of various sizes	√		
16.	Oral Airways of various sizes	√		
17.	Laryngoscope with various blades	√		
18.	Laryngoscope replacement batteries and bulbs.	√		
19.	Endotracheal tubes of various sizes.	√		
PROCESS				
20.	Is there a system to review all imaging	√		Radiologist available

	by a radiologist within 24 hours			between 8 am to 2pm.After 2 pm on call basis
21.	Ability to perform acute blood test and receive results within one hour for Arterial blood gases, Full blood picture, urea and electrolytes, plasma, glucose, Blood levels for common overdose medication/agents, Coagulation studies.		√	Lab performs only anti natal profile. Rest of the investigations are sent to male hospital. Lab technician is available on call after 2 p.m
22.	Security staffs are immediately available when required in the emergency room.		√	No provision of security staff
23.	Electrical equipment (e.g. defibrillator) is charged at all times.		√	No defibrillator
24.	Is Crash cart checked daily regarding regular testing?		√	There is no crash cart in the department
25.	The documentation from a medico-legal and treatment view point is detailed, professional and accurate.	√		
26.	Are the separate registers maintained for medico legal cases, discharge, admissions to ward?	√		
27.	Is BMW segregated and handled properly.	√		
28.	Is Triaging of the patients done?	√		
29.	Does the initial assessment of the patient take place?	√		
30.	Are the patients attended by attendants when they come or when they are transferred to wards?	√		
31.	Is staff trained in BLS/ACLS		√	
OUTCOME				
32.	Time for initial assessment of emergency patient		√	Not Monitored

Note: This department shares in common with the labour room.

2 AMBULANCE

S.no	Description	Yes	No	Remarks
STRUCTURE				
1	Adequate communication system exists in ambulance		√	
2	Required equipments (stetho, sphygmo, suction app, defib, monitor, oxygen cylinder) are available in the ambulance.		√	Oxygen cylinders in all the ambulances. Equipments & emergency medicines are available only in 108 & 102.
3	Required medicines are available in the ambulance.		√	
4	Is Vehicle license available?	√		
5	Is driver license present?	√		
6	Maintenance of the medical gas (oxygen) to 90% of the total capacity.		√	
7	Calibration of Equipments present		√	Calibration not done for any equipment in the hospital.
PROCESS				
8	Is staff trained in BLS		√	Trained in 108 & 102
9	Is Medication and equipment checklist maintained		√	There is no such checklist.
10	Is infection control practices followed		√	

3 OPD

Sl. No.	Description	Yes	No	Remarks
STRUCTURE				
1	Availability of enquiry counter		√	
2	Availability of registration counter	√		
3	Availability of separate queue for Differently able.		√	
4	Availability of designated waiting area with adequate sitting arrangement	√		Adequate number of chairs available.
5	Availability of drinking water facility	√		Supplied through RO plant
6	Availability of separate and functional toilet for differently able.		√	
7	Availability of fan & lights in waiting area	√		
8	Is the Scope of services displayed?	√		Painted on wall.
9	Is citizen charter and Patient charter displayed		√	
10	Is list of doctors along with OPD Timings displayed	√		Single specialty services are being provided.
11	Are the different OPD rooms numbered	√		
12	Is there provision of patient privacy in the consultation room	√		Side screens available.
13	Is BP apparatus with stethoscope present	√		
14	Is weighing machine present	√		
15	Is thermometer present	√		
16	Is calibration of BP apparatus, weighing machine and thermometer		√	

17	Availability of dedicated registration clerk		√	No dedicated registration clerk. Ward boy performs the task
18	Availability of nurse to direct patients to specific OPDs		√	No staffing of nurse in OPDs.
PROCESS				
19	Is UHID generated for all patients		√	
20	Is separate registration done for old and new OPD patients	√		
21	Is the tariff rates defined and made aware to the patients/ attendant			NA
22	Is patient privacy maintained during consultation time	√		
23	Is the staff aware of all the information like Doctors OPD timings, charges etc	√		
OUTCOME				
24	Monitoring of waiting time		√	
25	OPD patient satisfaction survey		√	

4 LABORATORY

Sl. NO	**Description**	**Yes**	**No**	**Remarks**
Structure				
1	Is laboratory present in hospital? (In house/ outsourced)	√		
2	Specify the functional units of laboratories present in the hospital	ANC profile. (Hb%, Blood group, urine, Albumin sugar, UPT, HIV,VDRL)		
3	Is there continuous water	√		

	supply to this unit?			
4	Is adequate drainage system present in this unit?	√		
5	Is there provision for hand washing facility in this unit?	√		Basins with working taps available. Soaps for hand washing.
6	Is there provision of personal protective devices for staff?(if yes mention the name)	√		Apron, Mask & gloves
7	Is the staff qualified and competent in knowledge and skill?	√		The technician is qualified and reasonable experienced
8	Is there separate area available for sample collection?		√	Single room Lab
9	Is pathologist available?		√	
10	Are BMW bins present in the department?	√		Blue, Yellow, Red & PPC
11	Is there power back up facility available	√		DG connection & UPS
PROCESS				
12	Is the scope of services defined		√	
13	Is maintenance of laboratory equipments done?		√	There is no AMC /CMC
14	Are laboratory equipments calibrated?		√	
15	Is laboratory staff aware about the safety precautions while handling samples?		√	
16	Is laboratory staff taking necessary precautions while handling samples?		√	Labeling done on samples. Gloves mask used.

17	Is BMW segregation done as per BMW guidelines?		√	Syringes with used/undestroyed needle in Red bucket
18	Is critical results defined, reported, and documented.		√	
19	Is surveillance for lab test being carried out		√	
20	Is EQAS being monitored		√	
21	Laboratory reports are signed by Pathologist.		√	There is no pathologist available
22	Is labeling of sample done?	√		Numbering done
23	Is time frame defined for dispatching lab reports?	√		The reports are dispatched same day by 2 pm.
24	Is turnaround time for lab reports monitored?		√	
25	Is MOU available for outsourced tests			NA
26	Is temperature monitoring of refrigerator is done?		√	Thermometer was available in refrigerator & a monitoring sheet was also evident however the same is not regularly monitored and documented
OUTCOME				
27	Number of reporting errors per 1000 investigations		√	
28	% of reports having clinical correlation with provisional diagnosis		√	
29	% of adherence to safety precautions		√	
30	% of redo's		√	

Note: MP, Widal, etc

5 RADIOLOGY & IMAGING (X-Ray & USG)

(Common with Male hospital)

S. No.	Description	Yes	No	Remarks
STRUCTURE				
1	Is this unit has AERB (SITE/TYPE approval)		√	
2	Are basic facilities for staff present? (toilet/drinking water/change room)	√		
3	Is the staff qualified and competent in knowledge and skill?	√		Qualified and experienced Radiologist & Radiographer but not registered as a RSO
4	Is there a change room available for patients?		√	
5	TLD badges available (Are they sufficient in number)		√	
6	Lead glass available (Are they sufficient in number)	√		
7	Lead apron available (Are they sufficient in number)	√		
8	Gonad shield available (Are they sufficient in number)		√	
9	Thyroid shield available (Are they sufficient in number)		√	
10	Is radiologist available?	√		3 radiologists
11	Is critical results defined, reported, and documented.		√	
12	Radiation hazard symbol is present		√	
13	PNDT license is available	√		

PROCESS				
14	Is maintenance of radiology equipments done?	√		AMC
15	Are radiology equipments calibrated?		√	
16	Is radiology staff aware about the safety precautions?	√		Lead apron, lead screen
17	Is radiology staff taking safety measures?	√		Only lead Apron. No gonad shield, thyroid shield.
18	Quality Assurance program is followed or not		√	
19	Radiology test requisition form is signed by doctor.	√		
20	Radiology reports are signed by Radiologist.	√		
21	Is time frame defined for dispatching reports?	√		Given same day by 2pm
22	Is turnaround time for reports monitored?		√	
OUTCOME				
23	Number of reporting errors per 1000 investigations		√	
24	% of reports having clinical correlation with provisional diagnosis		√	
25	% of adherence to safety precautions		√	
26	% of redo's		√	

6 WARDS

SL.NO	Check points	Yes	No	Remarks
Structure				
1	Is Medical Gas Facility available in the ward?	√		No centralized supply, only oxygen (portable) cylinders available
2	Are basic facilities for staffs present (toilet/ drinking water)?	√		4 bathrooms & 04 latrins in 1st floor wards.
3	Is needle cutter present in each ward?	√		
4	Emergency crash cart is present in the ward?		√	
5	Color coded BMW bins are present in each ward?		√	Was not evident in 1st floor wards. They are kept in ground floor
6	Is there a nursing station in the ward?	√		
7	Is there adequate number of nurses in each shift?		√	No dedicated nurse in wards in any shift
8	Racks are present to store linen?	√		
9	Wash basin is present in each ward.	√		
10	PPE is provided in each ward?	√		Only gloves are provided
PROCESS				
11	Is staff aware of the admission process?	√		
12	Does the cleaning of the department take place?	√		Three times in a day
13	Are the vitals of the patient		√	

	checked every day?			
14	Administration of medication is done by qualified nurse?	√		Not in all cases. Usually tablets are self administered.
15	Indent of medicines and other items is placed by nurses regularly?	√		Daily.
16	PPE is used by the nurses?	√		
17	Are the BMW segregated at the point of generation?	√		
18	Does the nurse on duty record the details of the patient in the BHT on a daily basis?	√		
19	Are the nurses trained in BLS(CPR)		√	
20	Is infection control practices being followed	√		Partially
21	Is bio medical waste management practice followed	√		
22	Is the staff aware about transfer IN/OUT system	√		
23	Is cost estimate for treatment provided to the patient/attendant			NA
24	Is discharge process defined and documented?	√		

8 SNCU

STRUCTURE				
Sr. No	**Description**	**Yes**	**No**	**Remarks**
1	Is the required equipments available (Baby Warmers, Phototherapy Unit, Emergency resuscitation kit, Nebulizer (baby), multi para monitors, central line connection, pulse oxymeter(baby), glucometer, oxygen concentrator, etc)	√		No central medical gas supply. Rest medical equipment details mentioned in Equipment list (heading 12)
2	Is qualified doctor available round the clock?		√	1 paediatrician appointed. Usually available for morning and evening rounds. Available 24 hrs on-call basis
3	Qualified and trained nurses available.	√		Qualified but special training have not been provided yet.
4	Is Central air condition available		√	1 split AC available
5	Is Electricity back-up facility (DG) available?	√		
6	Is there a dedicated Breast feeding area?	√		
7	Is there dedicated Duty room for Doctors & Nurses?	√		
8	Are there toilets for doctors & nurses?	√		
9	Are there changing rooms for doctors & nurses?	√		
10	Are there provisions of Hand washing facilities (basin & soaps/disinfectants) in patient care areas?	√		
11	Is there separate area for carrying out sluicing activities?		√	

PROCESS				
12	Are the admission and discharge criteria for SNCU and high dependency units defined?	√		
13	Is the staff trained to apply these criteria?	√		
14	Are the infection control practices documented and followed?		√	
15	Procedures for situation of bed shortages are defined and followed?		√	
16	Is the staff aware about the end of life care policy?	√		
17	Is Quality Assurance Program being documented and implemented?		√	
18	Are the policy for initial assessment and re-assessment of patient documented and present?		√	
19	Is the staff trained on resuscitation?		√	
20	Does who care for children have age specific competency?	√		
21	Are emergency medications available all the time and replenished in a timely manner when used?	√		
22	Are all the equipments periodically inspected and calibrated?		√	
23	Documented procedures guide the referral of patients to other departments/ specialties?		√	
24	Are the instructions for proper hand washing displayed and followed by the staff?	√		

25	Are the adequate PPE like gloves, masks, cap, and apron available and used by the staff?	√		
OUTCOME				
26	SNCU utilization	√		
27	Mortality Rate	√		

7 LABOUR ROOM

Si. No	Description	Yes	No	Remarks
Structure				
1	Are there separate areas demarcated for septic and aseptic deliveries?		√	
2	Does the Labour room have a toilet facility?	√		
3	Are number of Labour tables present appropriate for the daily load?			4 tables in labour room
4	Is continuous water available for the unit?	√		
5	Does the Labour Room have a hand washing facility?	√		
6	Is scrubbing area present for the Labour Room staff?	√		
7	Is the fire fighting system available in the unit?	√		
8	Is the changing room available for the doctors and nurses?	√		
9	Is there a continuous power back up for Labour Room?	√		Inverter & DG

10	Is the Labour Room having a demarcated New Born Care Area with the appropriate equipments?	√		Warmer in labour room. SNCU in first floor.
11	Does the Labour Room have any sterilization equipment?	√		
12	Are there Disposable Delivery Kits in required quantities?	√		
13	Does the Labour Room have a Crash Cart?		√	
14	Is there an ECG monitor?		√	
15	Does the Labour Room have adequate Oxygen supply as per demand?	√		
16	Is the staff provided with the Personnel Protective Devices/ Equipments?	√		Gloves & masks
17	Does the Labour Room have round the clock coverage by Trained Nurses/ Mid wives for conducting supervised deliveries?	√		
18	Are there screens for privacy?		√	
19	Are there Cusco's vaginal speculum (each of small, medium and large size); Sim's vaginal speculum – single & double ended - (each of small, medium and large size); Anterior Vaginal wall retractor; Sterile Gloves; Sterilized cotton swabs and swab sticks in a jar with lid; Kidney tray for keeping used instruments; Bowl for antiseptic solution; Antiseptic solution: Chlorhexidine 1% or Cetrimide 2% (if povidone iodine solution is available, it is preferable to use that); Chittle forceps; Proper light source / torch	√		
20	Are Bio Medical Waste Management followed?	√		

21	Are Work Instructions prominently displayed?	√		
22	Does the Labour Room Register have a record of referred cases?	√		Separate register for referral cases.
23	Is the part preparation of the patient done before the operation?	√		
24	Are the number of Labour Room instruments counted before and after use?	√		
25	Are Partograms used for all patients?	√		Filled up partograms were evident during visit.
26	Is Labour Room disinfection done after every procedure?	√		Approximately 3 times a day with bleach solution.
27	Is APGAR SCORE being used?		√	
28	Are Standard Operating Procedures being followed for Induction of Labour and progress of labour?	√		Not documented in the form of SOP.
29	Is Maternal mortality rate monitored?	√		
30	Is still birth rate monitored?	√		

9 OT

S. No.		**Yes**	**No**	**Remarks**
STRUCTURE				
1	Is HVAC System present inside OT		√	
2	Is proper Zoning concept followed(Clean zone, protective zone, sterile zone, and disposal zone)		√	Space available however distinct earmarking of zones not available.

3	Is the number of OT tables present in the hospital appropriate for the daily load	√		One table in main OT.
4	If any OT has got more than one OT table		√	
5	Does the OT have a hand washing facility	√		
6	Is the fire fighting system available in the unit	√		ABC type fire extinguishers only
7	Is continuous water available for the unit?	√		
8	Is the changing room available for the doctors and nurses	√		
9	Is there a continuous power back up for OT	√		Inverter & DG Set
10	Does the OT have a crash cart		√	
11	Does the OT have defibrillator		√	
12	Does the OT have an ECG monitor		√	
13	Does the OT have oxygen supply	√		Portable cylinder
14	Does the OT have shadow less OT light	√		
15	Is the staff provided with the personnel protective devices	√		Apron(plastic), mask, caps & gloves are provided.
16	Is scrubbing area present for the OT staff	√		
PROCESS				
17	Is the consent for the surgery and anesthesia taken from the patient	√		There is no pre defined, standardized consent form for surgery & anesthesia. However hand written consent is taken from the patient/relative. Printed formats for ligation &

				tubectomy are available.
18	Is the OT list prepared	√		
19	Is the OT booking being done	√		
20	Is the preparation of patient done before the operation	√		
21	Does the nurse enter the patient details in the OT register	√		
22	Are the number of OT instruments counted before and after operation	√		
23	Is OT disinfection done after every procedure	√		Carbolization of tables & trolleys done after each case. Fumigation done twice a week.
24	Is the pre anesthesia check up done by the anesthetists	√		
25	Is pre, intra, post operative notes are documented	√		Not in a standard format.
26	Is infection control practices being followed in OT	√		Partially.
27	Is pre operative checklist being followed		√	No checklist
28	Is bio medical waste management practices being followed	√		
OUTCOME				
29	Is % of anesthesia related adverse events being monitored		√	
30	% of anesthesia related mortality		√	
31	% of modification in plan of anesthesia		√	
32	% of unplanned ventilation		√	

	following anesthesia			
33	Is % of Surgical site infection rate monitored		√	
34	Re Exploration rate		√	
35	Re scheduling of surgeries		√	

10 BLOOD BANK

(Common with Male Hospital)

Si. No	Description	Yes	No	Remarks
STRUCTURE				
1	Is the required layout available: (Reception, examination room, bleeding room, refreshment room, blood separation and storage area and doctors room?)	√		
2	Is power back up available	√		DG & Inverter
3	A full time qualified Blood Bank In-charge manages the blood collection/distribution department.		√	Till 2 pm, rest on call.
4	A couch/cot is provided during venipuncture & the correct equipment for blood agitation/ volume measurement is present	√		Wooden couch evident.
5	Refrigerators, insulated carrier boxes with ice pack, warmers, Bio mixers, Tube scale, Component separator if applicable, Thawing bath, Centrifuge and freezers are in adequate quantity	√		No component separator, whole blood only
6	Blood bank signage and schedule of charges are displayed		√	
7	Blood Bank Technician is present	√		
8	Nurse is present		√	

9	All sections have bilingual signage		√	Only hindi
10	Separate counselling section is present	√		Currently not earmarked
PROCESS				
11	Is bilingual consent for blood donation available		√	In hindi
12	If patients are educated and given counselling.	√		No separate counsellor is deployed
13	Donors are appropriately screened prior to blood donation.	√		
14	Evidence is present that blood is cross matched, labelled, recipient identified, compatibility level noted, units dispensed.	√		
15	Refrigerators, warmers and freezers must have temperature monitoring devices which are monitored daily	√		Twice in a day
16	A list of all department staff exist and is prominently displayed		√	
17	Is Policies and procedures for blood bank available		√	
18	Appropriate disposal of blood and blood products are done as per BMW management rules	√		1% sodium hypochlorite is being used.
19	A blood collection/issue register exists.	√		
20	Is blood transfusion committee in existence	√		
21	Donated blood is labelled appropriately with adhesive labels.	√		
22	Register of all recipient adverse reactions to blood and blood products are maintained		√	

23	Data collected regarding recipient adverse reactions is collated, analyzed and reported to the blood transfusion committee.		√	
24	Work instructions are visibly displayed and prominent		√	
OUTCOME				
25	% of transfusion reactions		√	
26	% of blood and blood products wastage		√	
27	% of component usage		√	
28	Turnaround time for issue of blood and blood products.		√	

11 PHARMACY

Si. No	**Description**	**Yes**	**No**	**Remarks**
Structure				
1	The racks are available in sufficient number to store the items		√	Racks require in both main store & Substore
2	There is adequate ventilation and lighting in the department		√	No adequate ventilation
3	There is a security system available at the department		√	
4	Fire detecting & fire fighting systems are available at department	√		Only extinguishers (ABC type)
5	There is no water seepage/ dampness	√		
6	All items storage areas are marked and labeled	√		

7	There is a receiving area; segregation and storing area		√	
8	Is refrigerator for storing medicines(2-8 degree C) available		√	Temperature monitoring NOT done.
9	Is qualified and trained staff available	√		Pharmacist
10	Provision for storage of narcotic drugs(double lock and key system)		√	Staff not aware
PROCESS				
11	The items are labeled & arranged as per alphabetical order.		√	
12	Pest/rodent control measures are regularly under taken		√	
13	Is stock register maintained properly	√		
14	Verification of stock is done every six months.	√		Twice in 2013 evident during visit
15	Is sound Inventory control practices followed (ABC, VED, FSN,FIFO)		√	Expiry register available
16	General items required by the hospital are purchased from vendors registered by management	√		
17	Is there a Drugs and therapeutics committee in the hospital?		√	
18	Is hospital drug formulary available		√	State government rate contract & ESI rate contract items are followed
19	Is adverse drug reactions are analyzed		√	
OUTCOME				
20	% of local purchase		√	

21	% of stock outs		√	
22	% of variation from the procurement process		√	
23	% of goods rejected before GRN		√	

12 BIOMEDICAL WASTE MANAGEMENT

Bio-medical waste Management				
Sl. No	**Description**	**Yes**	**No**	**Remarks**
STRUCTURE				
1	Availability of colour coded Foot operated Bins at point of BMW generation	√		
2	Availability of coloured plastic bags	√		
3	Display of work instructions at the point of segregation	√		Mostly painted on walls
4	Is needle destroyer present	√		
5	Availability of PPE(Personal Protective Equipments) with biomedical waste handlers	√		Gloves & mask
6	Availability of sodium hypochlorite solution and puncture proof boxes	√		
7	Availability of safe mode of transportation	√		Trolley is available
8	Is Temporary storage area available	√		
PROCESS				
9	Is segregation of BMW at point of	√		

	generation			
10	Is the route for transportation of waste separate from the general traffic area		√	The common route is followed for the transportation.
11	Is there provision of regular health checkup for staff of this unit?		√	
12	Usage of PPE by staff is being practiced	√		
13	Is Annual report submitted to UP PCB		√	
14	Is monitoring done for the amount of BMW generated		√	

13 HOSPITAL INFECTION CONTROL

S.No	Description	Yes	No	Remarks
STRUCTURE				
1	A designated and qualified infection control nurse(s) is present?		√	
2	Adequate and appropriate facilities for hand hygiene in all patient care areas Provided?	√		Hand washing sinks & soaps available at all patient care areas.
3	Are adequate and appropriate personal protective equipment, soaps, and disinfectants available?	√		Soaps, hypochlorite solutions , gloves & masks are provided.
4	A designated infection control officer is present?		√	
PROCESS				
5	Does the hospital implements policies and/or procedures to prevent infection in these areas?		√	

6	Does the organization adhere to standard precautions at all times?		√	
7	Equipment cleaning, disinfection and sterilization practices as polices?		√	
8	An appropriate antibiotic policy is established and implemented?		√	
9	Hospital adheres to laundry and linen management processes?	√		
10	Hospital adheres to kitchen sanitation and food handling issues?	√		
11	Does the hospital have appropriate engineering controls to prevent infections?		√	
12	Does the hospital adhere to mortuary practices?		√	
13	Is the infection prevention and control programme updated at least once in a year?		√	
14	Is the HIC surveillance data collected regularly?		√	
15	Is the Verification of data done on a regular basis by the infection control team?		√	
16	In cases of notifiable diseases, information (in relevant format) is sent to appropriate authorities?	√		
17	Tracking and analyzing of infection risks, rates and trends		√	
18	Do the surveillance activities include monitoring the effectiveness of housekeeping services?		√	
19	HAI rates monitored?		√	
20	Appropriate feedback regarding HAI rates provided on a regular basis to appropriate personnel?		√	

21	A hospital infection control committee and team are formed?		√	No such committee
22	Are the personal protective equipment used correctly by the staff?		√	Gloves & Mask
23	Compliance with hand hygiene guidelines monitored?		√	
24	Documented procedure for identifying an outbreak present?		√	
25	Implementation of laid down procedure done?		√	
26	Documented procedure guides the cleaning, packing, disinfection and/or sterilization, storing and issue of items?		√	
27	Isolation / barrier nursing facilities are available?		√	
28	Appropriate personal protective equipment used by the BMW handlers?	√		Only Gloves
29	Visit by the hospital authorities to the disposal site done and documented?		√	
30	Does the hospital makes available resources required for the infection control programme		√	
31	Does the organization earmarks adequate funds from its annual budget for infection control activities?		√	
32	Appropriate “in-service” training sessions for all staff at least once in a year conducted?		√	
33	Appropriate pre and post exposure prophylaxis is provided to all concerned staff members?		√	

OUTCOME				
34	UTI rate		√	
35	VAP rate		√	
36	SSI rate		√	
37	Central line associated blood stream infection rate		√	

14 CSSD / TSSU

SL.NO	DESCRIPTION	Yes	No	Remarks
STRUCTURE				
1	Is sufficient space available(0.75sq mts/bed)		√	No CSSD functional. TSSU available with OTs
2	Does the layout follow the functional flow: Receiving, Washing, decontamination, drying, packing, loading, unloading, storing and issuing?		√	
3	Autoclaves are present?	√		1 vertical
4	Calibration of pressure meter of autoclave is done?		√	
5	Racks are present in the department?		√	
6	Technician is present in CSSD?		√	No trained technician, ward boy acts the TSSU technician
7	Sterilizer drums are present?	√		
8	Is decontamination solution present?	√		
9	Transport trolley present for items?		√	

PROCESS				
10	CSSD sterilization register present? (receipt/Issue)		√	
11	Labeling of drums in CSSD takes place?		√	
12	Is chemical, biological and bowie-dick test performed		√	
13	If recall system of items followed		√	
14	If reuse policy for items available		√	

15 BIOMEDICAL ENGINEERING

SR. No		**Yes**	**No**	**Remarks**
STRUCTURE				
1	Does bio medical engineering department exist		√	Handled by store person(Pharmacist)
2	Does the department is managed by a qualified person		√	Handled by store persons(Pharmacist)
3	Is Central supply system for bio medical gases exist		√	
4	Is Safety devices available	√		Fire Extinguishers only (ABC type)
5	Is the department manned by 24 hours		√	
6	Preventive maintenance and calibration		√	
7	Review of Preventive Maintenance record as per checklist like Anesthesia ventilator, IABP etc.		√	
8	Traceability of calibration report		√	

9	Is there a documented procedure for equipment replacement and disposal?		√	
10	Equipments are inventoried and proper logs are maintained as required.		√	
11	Training of staff when new equipment is installed (HRM 3b)	√		
12	Documented Preventive and breakdown maintenance plans		√	
13	Color coding of pipelines		√	There is no gas manifold department available in the hospital
OUTCOME				
14	% of downtime of critical equipments		√	

16 ENGINEERING AND MAINTENANCE

SR. No	**Description**	**Yes**	**No**	**Remarks**
	STRUCTURE			
	Various statutory requirements			
	o Fire			
	o Diesel storage			
	o Liquid oxygen and storage of medical cylinders.			NA
	o Boiler			NA
	o Lift			NA
1	o Water (ETP/STP)		√	NA

	o Air (DG sets)			
2	Up to date drawing, layout, escape route present and displayed?		√	
3	Various required signage's displayed?	√		Not uniform, not pictorial, not bilingual ; painted on walls
4	Designated individual for maintenance present?		√	
5	Presence of staff round the clock for emergency repairs		√	
6	Alternative source of water and electricity	√		DG & Inverter for electricity; No alternative source for water
7	Availability of (personnel) safety devices		√	
8	Availability of safety devices (Fire extinguishers, smoke detectors, sprinklers, grab bars, side rails, nurse CCTV, ALARMS ETC)	√		Only Fire Extinguishers(ABC type)
PROCESS				
9	Mechanism for renewing licenses		√	
10	Preventive and break down maintenance plan implemented?		√	
11	Alternate sources and their checking done?		√	
12	Response time monitored?		√	
13	Water quality reports		√	
14	Are staff using safety devices		√	
15	Facility inspection rounds twice a year in patient care areas and once in non-patient care areas		√	
16	Documentation of facility inspection report		√	

17	Safety education program for all staff		√	
18	Safety committee present		√	
19	Is staff trained for disaster management and fire management		√	
20	Are the mock drills conducted at periodic intervals and documented		√	
OUTCOME				
21	Number of variations observed during mock drills		√	

17 STORE

Si. No	**Description**	**Yes**	**No**	**Remarks**
STRUCTURE				
1	The racks are available in sufficient number to store the items	√		
2	There is adequate ventilation and lighting in the department		√	
3	Is there a qualified/ trained personnel available	√		
4	Fire detecting & fire fighting systems are available at department	√		No detectors, Only Fire Extinguishers (ABC type)
5	There is no water seepage/ damp in the store	√		
6	There is a receiving area; segregation and storing area		√	
PROCESS				
7	The items are labeled & arranged at designated place.		√	

8	Items such as radiographic films, spirits etc (which are inflammable) are stored in a separate location.		√	
9	Inventory recording system is present either computerized or on register	√		On register
10	Frequently used items are arranged and located in most easily accessible area.		√	
11	Pest/rodent control measures are regularly under taken	√		
12	Lead time in issuing material to the department are recorded		√	
13	Stock Turnover details are calculated on a monthly basis.	√		
14	If sound inventory control practices followed (ABC/VED/FSN/FIFO)		√	
15	Is condemnation policy followed?	√		
16	Is there a purchase and condemnation committee in the hospital?	√		
17	A comparative list of rates of potential suppliers maintained	√		
OUTCOME				
18	% of stock outs		√	
19	% of goods rejected before preparation of GRN		√	
20	% of variation from procurement process		√	

18 KITCHEN/DIETARY

Sl. No.	**Description**	**Yes**	**No**	**Remarks**
	STRUCTURE			

1	Does the layout follow the functional flow: Receiving, storage, preparation, distribution and cleaning?		√	
2	Is there continuous water supply (Hot/ Cold) to this unit?	√		
3	Is adequate drainage system present in this unit?	√		
4	Is there DG power supply to this unit?	√		
5	Dedicated refrigeration areas exist to ensure food preservation	√		
6	Is dedicated food storage area exist	√		
7	Are measures for fire detection/fire fighting installed in this unit?		√	
8	The person responsible for this department is a qualified dietician or has supervision from a consultant dietician.		√	
PROCESS				
9	Health check up of all staff is done at least once a year.		√	
10	Record maintained for food materials	√		
11	If nutritional Assessment done for all the patients		√	
12	Diet Sheet is prepared by Dietician as per the treating Doctors instruction on the patient's case sheet.		√	
13	Each patient's Case sheet are checked by doctor and dietician and changes made in their diet depending on their condition		√	No dietician appointed
14	Food distribution to patients occurs in covered trolleys	√		
15	Is infection control practices followed		√	

19 HUMAN RESOURCE

S. No.	Description	Yes	No	Remarks
STRUCTURE				
1	Is the HR department present		√	Looked after by the Office staff(karyalay) & CMS
2	Are racks available to store the documents?	√		
PROCESS				
3	HR Manpower planning		√	As per the state norms
4	Job description and specification		√	Not found documented
5	HR recruitment		√	As per the state norms
6	HR induction and training		√	
7	HR record keeping	√		
8	HR welfare-staff & family		√	
9	Performance appraisal	√		Confidential report (CR) is sent to the state for all staff
10	Disciplinary procedure	√		As per service rules
11	Staff grievance redressal	√		As per service rules
12	Mention the types of forms available in this department?	EL, ML, Joining, GPF etc.		
13	If pre employment health checkup and annual health check up is being done		√	Only pre-employment examination done
14	Is Training In-charge present in the hospital?		√	
15	Is regular training conducted by the hospital?		√	

16	Is credentialing and privileging of doctors and nurses being done	√		Only credentialing personnel files
17	Are records of training being maintained?		√	
OUTCOME				
18	Employee attrition rate is monitored?		√	
19	Is the employee absenteeism rate monitored		√	
20	% of employee provided pre exposure prophylaxis		√	
21	Is employee satisfaction survey being done and analyzed?		√	
22	% of employee who are aware of employee rights and responsibilities and welfare schemes		√	

Note: Staffing of the newly developed SNCU is not mentioned in the above list. 1 paediatrician and 6 nurses have been deployed in this unit.

20 MEDICAL RECORDS DEPARTMENT

S. No.	**Description**	**Yes**	**No**	**Remarks**
STRUCTURE				
1	Is the sufficient space for medical record department available		√	BHT's are dumped in a room where other store materials are also kept.
2	Is proper ventilation present in the department		√	
3	Is the fire fighting system available		√	There are fire extinguishers in the

	in the unit			OPD lobby but not in or outside the concerned room
4	Is qualified and trained MRD technician available in the department		√	Pharmacist who looks after the main store oversees this room.
5	Is table and chair provided to the MRD technician		√	There is no such table or chair neither there is a space to keep it.
6	Is adequate number of racks available for the storage of records		√	
PROCESS				
7	Is the functional flow at MRD : Receiving, assembling, deficiency check, coding, indexing , filing, issuing		√	
8	Is ICD coding method used for complete and incomplete files		√	
9	Are the MLC cases/dead cases stored separately under lock and key	√		
10	Is the retrieval of the records easy		√	
11	Is deficiency checklist is followed		√	No such checklist used
12	Is MRD Committee available		√	
13	MRD audits is being conducted		√	
14	Are the records kept under lock		√	
15	If the hospital has retention policy for documents		√	
16	Are the forms and formats standardized	√		There is one pager BHT & discharge slip.
17	Is the destruction policy for records		√	

	available			
18	Is pest control done on a regular basis		√	
OUTCOME				
19	Is number of births/deaths monitored	√		
20	Is number of diseases notified to the local authority	√		
21	% of missing records		√	
22	% of records with ICD codification done		√	
23	Percentage of medical records not having discharge summary		√	
24	Percentage of medical records not having consent form		√	

21 LINEN/LAUNDRY

S. No.	Description	Yes	No	Remarks
STRUCTURE				
1	Number of linens as per no of beds (3 sets)	√		More than 3 sets
2	(If laundry services are in house) Is there continuous water supply to this unit?	√		
3	(If laundry services are in house) Is adequate drainage system present in this unit?	√		
4	Is disinfectant available for infected linen? Specify the name	√		Bleach solution
5	Separate covered trolley for transporting dirty linen & washed linen available?		√	No trolleys available

6	Heavy duty rubber gloves, mask available to the linen handlers		√	
PROCESS				
7	Are linen items being replenished when contaminated	√		
8	Are linens are changed at least once daily?	√		
9	Segregation of soiled &contaminated linen is being done	√		
10	Sluicing of soiled linen is being done? (Specify location where sluicing is being done – ward or laundry)	√		Sluicing is done in wards with bleach solution
11	Packing of the soiled &contaminated linens in separate bags & labeling/color coding is being done		√	
12	The number and type of linen handed over is entered on the dirty linen register	√		The register is maintained in wards
13	Linens are transported in covered trolley		√	No trolley
14	The number and type of linen handed over to the laundry by the ward boy is entered in laundry register.	√		
15	The clean linen is handed over to the ward boy against the received sign of Ward boy in the same laundry register.	√		Received by nursing staff
16	The ward boy is handing over the clean linen to the nurse In charge in the ward against the issue register.			NA
17	Disinfection of decontaminated linen (Especially high risk areas) done	√		With bleach solution
18	Dirty linens & clean linens are stored in separate areas	√		
19	Are they following hand washing practices?	√		

20	Are they using disinfectant while washing contaminated linens?	√		
21	PPE are used by staff while handling soiled linens?	√		Only gloves

22 HOUSEKEEPING

S. No.	Descriptions	Yes	No	Remarks
STRUCTURE				
1	Does the housekeeping being provided with the personal protective equipment(dedicated gownslippers/masks/gloves/head cover)	√		Only gloves
2	Does the housekeeping staff have basic facilities like (toilet/drinking water/change room)	√		
PROCESS				
3	Are the hand washing and floor washing agent being used?	√		Agents are not being provided in sufficient number
4	Is the house keeping staff being trained in the infection control practices		√	
5	Is staff using PPE	√		Only gloves
6	Is daily cleaning schedule available	√		Once in each shift
7	Are the staff aware about the preparation of cleaning solutions	√		
8	Is the pest control methods being practiced		√	
9	Is the medical examination of staff being done periodically		√	

23 SECURITY

No dedicated securities staff evident in the hospital however police staff (02) appointed from local police station are available.

24 MORTUARY

There is a dedicated room outside the main building named as Mortuary. It is just a vacant room without any freezer or any other necessary equipment. There was no water supply and blood spills were evident on the floor.

SELF ASSESSMENT TOOLKIT

SELF ASSESSMENT TOOLKIT			
Elements			**Scores**
Chapter 1: ACCESS, ASSESSMENT AND CONTINUITY OF CARE (AAC)			
AAC.1: The organization defines and displays the services that it provides.			
	a	The services being provided are clearly defined and are in consonance with the needs of the community.	5
	b	The defined services are prominently displayed.	5
	c	The staff is oriented to these services.	5
			5
AAC.2: The organization has a well-defined registration and admission process.			
	a	Documented policies and procedures are used for registering and admitting patients.	0
	b	The documented procedures address out- patients, in-patients and emergency patients.	0
	c	A unique identification number is generated at the end of registration.	0
	d	Patients are accepted only if the organization can provide the required service.	10
	e	The documented policies andprocedures also address managing patients during non-availability of beds.	0
	f	The staff is aware of these processes.	5
			2.5
AAC.3: There is an appropriate mechanism for transfer (in and out) or referral of patients.			

	a	Documented policies and procedures guide the transfer-in of patients to the organization.	0
	b	Documented policies and procedures guide the transfer-out/referral of unstable patients to another facility in an appropriate manner.	0
	c	Documented policies and procedures guide the transfer-out/referral of stable patients to another facility in an appropriate manner.	0
	d	The documented procedures identify staff responsible during transfer/referral	0
	e	The organization gives a summary of patient's condition and the treatment given	5
			1
AAC.4: Patients cared for by the organization undergo an established initial assessment.			
	a	The organization defines and documents the content of the initial assessment for the out–patients, in-patients and emergency patients	5
	b	The organization determines who can perform the initial assessment.	5
	c	The organization defines the time frame within which the initial assessment is completed based on patient's needs	0
	d	The initial assessment for in-patients is documented within 24 hours or earlier as per the patient's condition as defined in the organization's policy	5
	e	Initial assessment of in-patients includes nursing assessment which is done at the time of admission and documented.	5
	f	Initial assessment includes screening for nutritional needs	5
	g	The initial assessment results in a documented plan of care	5
	h	The plan of care also includes preventive aspects of the care where appropriate	0
	i	The plan of care is countersigned by the clinician in-charge of the patient within 24 hours.	5
	j	The plan of care includes goals or desired results of the treatment, care or service	5
			4
AAC.5: Patients cared for by the organization undergo a regular reassessment			
	a	Patients are reassessed at appropriate intervals.	5
	b	Out-patients are informed of their next follow up where appropriate.	10
	c	For in-patients during reassessment the plan of care is monitored and modified where found necessary.	5
	d	Staff involved in direct clinical care document reassessments.	5
	e	Patients are reassessed to determine their response to treatment and to plan further treatment or discharge.	5
			6

AAC.6:Laboratory services are provided as per the scope of services of the organization.			
	a	Scope of the laboratory services are commensurate to the services provided by the organization.	5
	b	The infrastructure (physical and manpower) is adequate to provide for its defined scope of services.	5
	c	Adequately qualified and trained personnel perform, supervise and interpret the investigations.	5
	d	Documented procedures guide ordering of tests, collection, identification, handling, safe transportation, processing and disposal of specimens.	0
	e	Laboratory results are available within a defined time frame.	5
	f	Critical results are intimated immediately to the concerned personnel.	0
	g	Results are reported in a standardized manner.	5
	h	Laboratory tests not available in the organization are outsourced to organization(s) based on their quality assurance system.	0
			3.13
AAC.7:There is an established laboratory quality assurance programme			
	a	The laboratory quality assurance programme is documented.	0
	b	The programme addresses verification and/or validation of test methods.	0
	c	The programme addresses surveillance of test results.	0
	d	The programme includes periodic calibration and maintenance of all equipment.	0
	e	The programme includes the documentation of corrective and preventive actions.	0
			0
AAC.8:There is an established laboratory safety programme.			0
	a	The laboratory safety programme is documented.	0
	b	This programme is aligned with the organization's safety programme.	0
	c	Written procedures guide the handling and disposal of infectious and hazardous materials.	0
	d	Laboratory personnel are appropriately trained in safe practices.	5
	e	Laboratory personnel are provided with appropriate safety equipment / devices.	5
			2

AAC.9: Imaging services are provided as per the scope of services of the organization.			
	a	Imaging services comply with legal and other requirements.	5
	b	Scope of the imaging services are commensurate to the services provided by the organization.	5
	c	The infrastructure (physical and manpower) is adequate to provide for its defined scope of services.	5
	d	Adequately qualified and trained personnel perform,supervise and interpret the investigations.	10
	e	Documented policies and procedures guide identification and safe transportation of patients to imaging services.	0
	f	Imaging results are available within a defined time frame.	10
	g	Critical results are intimated immediately to the concerned personnel.	0
	h	Results are reported in a standardized manner.	5
	i	Imaging tests not available in the organization are outsourced to organization(s) based on their quality assurance system.	0
			4.44
AAC.10:There is an established Quality assurance programme for imaging services.			
	a	The quality assurance programme for imaging services is documented.	0
	b	The programme addresses verification and/or validation of imaging methods.	0
	c	The programme addresses surveillance of imaging results.	0
	d	The programme includes periodic calibration and maintenance of all equipment.	0
	e	The programme includes the documentation of corrective and preventive actions.	0
			0
AAC.11:There is an established radiation safety programme.			
	a	The radiation safety programme is documented.	0
	b	This programme is aligned with the organization's safety programme.	0
	c	Handling, usage and disposal of radio-active and hazardous materialsis as per statutory requirements.	5
	d	Imaging personnel are provided with appropriate radiation safety devices.	5
	e	Radiation safety devices are periodically tested and results documented.	0
	f	Imaging personnel are trained in radiation safety measures.	0

	g	Imaging signageare prominently displayed in all appropriate locations.	5
			2.14
AAC.12: Patient care is continuous and multidisciplinary in nature.			
	a	During all phases of care, there is a qualified individual identified as responsible for the patient's care.	5
	b	Care of patients is coordinated in all care settings within the organization.	5
	c	Information about the patient's care and response to treatment is shared among medical, nursing and other care providers.	5
	d	Information is exchanged and documented during each staffing shift, between shifts, and during transfers between units/departments.	5
	e	Transfers between departments/units are done in a safe manner.	5
	f	The patient's record (s) is available to the authorized care providers to facilitate the exchange of information.	5
	g	Documented procedures guide the referral of patients to other departments/ specialities.	0
			4.29
AAC.13:The organization has a documented discharge process.			
	a	The patient's discharge process is planned in consultation with the patient and/or family.	10
	b	Documented procedures exist for coordination of various departments and agencies involved in the discharge process (including medico-legal and absconded cases).	0
	c	Documented policies and procedures are in place for patients leaving against medical advice and patients being discharged on request	0
	d	A discharge summary is given to all the patients leaving the organization (including patients leaving against medical advice and on request).	5
			3.75
AAC.14: Organization defines the content of the discharge summary.			
	a	Discharge summary is provided to the patients at the time of discharge.	5
	b	Discharge summary contains the patient's name, unique identification number, date of admission and date of discharge.	5
	c	Discharge summary contains the reasons for admission, significant findings and diagnosis and the patient's condition at the time of discharge.	5
	d	Discharge summary contains information regarding investigation results, any procedure performed, medication administered and other treatment given.	5
	e	Discharge summary contains follow up advice, medication and other instructions in an understandable manner.	5
	f	Discharge summary incorporates instructions about when and how to obtain urgent care.	5
	g	In case of death, the summary of the case also includes the cause of death.	10

			5.71
	SCORE OF CHAPTER – 01		**3.14**
Chapter 2: CARE OF PATIENTS (COP)			
COP.1: Uniform care to patients is provided in all settings of the organization and is guided by the applicable laws, regulations and guidelines.			
	a	Care delivery is uniform for a given health problem when similar care is provided in more than one setting.	5
	b	Uniform care is guided by documented policies and procedures	0
	c	These reflect applicable laws, regulations and guidelines	5
	d	The organization adapts evidence based medicine and clinical practice guidelines to guide uniform patient care.	5
			3.75
COP.2: Emergency services are guided by documented policies, procedures, applicable laws and regulations.			
	a	Policies and procedures for emergency care are documented and are in consonance with statutory requirements.	0
	b	This also addresses handling of medico-legal cases.	5
	c	The patients receive care in consonance with the policies.	0
	d	Documented policies and procedures guide the triage of patients for initiation of appropriate care	0
	e	Staff are familiar with the policies and trained on the procedures for care of emergency patients.	0
	f	Admission or discharge to home or transfer to another organization is also documented.	5
	g	In case of discharge to home or transfer to another organization a discharge note shall be given to the patient.	5
			2.14
COP.3: The ambulance services are commensurate with the scope of the services provided by the organization.			
	a	There is adequate access and space for the ambulance(s).	10
	b	The ambulance adheres to statutory requirements.	10
	c	Ambulance(s) is appropriately equipped.	5
	d	Ambulance(s) is manned by trained personnel.	5

e	Ambulance (s) is checked on a daily basis.	5
f	Equipment are checked on a daily basis using a checklist.	0
g	Emergency medications are checked daily and prior to dispatch using a checklist.	0
h	The ambulance(s) has a proper communication system.	0
		4.38
COP.4: Documented policies and procedures guide the care of patients requiring cardio-pulmonary resuscitation.		
a	Documented policies and procedures guide the uniform use of resuscitation throughout the organization	0
b	Staff providing direct patient care are trained and periodically updated in cardio pulmonary resuscitation.	0
c	The events during a cardio-pulmonary resuscitation are recorded.	0
d	A post-event analysis of all cardio-pulmonary resuscitations is done by a multidisciplinary committee.	0
e	Corrective and preventive measures are taken based on the post-event analysis.	0
		0
COP.5: Documented policies and procedures guide nursing care.		
a	There are documented policies and procedures for all activities of the Nursing Services.	0
b	These reflect current standards of nursing services and practice, relevant regulations and the purposes of the services.	0
c	Assignment of patient care is done as per current good practice guidelines.	0
d	Nursing care is aligned and integrated with overall patient care.	5
e	Care provided by nurses is documented in the patient record.	5
f	Nurses are provided with adequate equipment for providing safe and efficient nursing services.	5
g	Nurses are empowered to take nursing related decisions to ensure timely care of patients.	5
		2.86
COP.6: Documented procedures guide the performance of various procedures.		
a	Documented procedures are used to guide the performance of various clinical procedures.	0
b	Only qualified personnel order, plan, perform and assist in performing procedures.	5

c	Documented procedures exist to prevent adverse events like wrong site, wrong patient and wrong procedure.	0
d	Informed consent is taken by the personnel performing the procedure where applicable.	5
e	Adherence to standard precautions and asepsis is adhered to during the conduct of the procedure.	5
f	Patients are appropriately monitored during and after the procedure.	5
g	Procedures are documented accurately in the patient record.	0
		2.86
COP.7: Documented policies and procedures define rational use of blood and blood products.		
a	Documented policies and procedures are used to guide rational use of blood and blood products.	0
b	Documented procedures govern transfusion of blood and blood products.	0
c	The transfusion services are governed by the applicable laws and regulations.	0
d	Informed consent is obtained for donation and transfusion of blood and blood products.	0
e	Informed consent also includes patient and family education about donation.	0
f	The organization defines the process for availability and transfusion of blood/blood components for use in emergency.	0
g	Post transfusion form is collected; reactions if any identified and are analyzed for preventive and corrective actions.	0
h	Staffs are trained to implement the policies.	0
		0
COP.8: Documented policies and procedures guide the care of patients in the Intensive care and high dependency units.		
a	Documented policies and procedures are used to guide the care of patients in the Intensive care and high dependency units.	0
b	The organization has documented admission and discharge criteria for its intensive care and high dependency units.	0
c	Staffs are trained to apply these criteria.	0
d	Adequate staff and equipment are available.	0
e	Defined procedures for situation of bed shortages are followed.	0
f	Infection control practices are documented and followed.	0

	g	A quality assurance programme is documented and implemented.	0
			0
COP.9: Documented policies and procedures guide the care of vulnerable patients (elderly, children, physically and/or mentally challenged).			
	a	Policies and procedures are documented and are in accordance with the prevailing laws and the national and international guidelines.	0
	b	Care is organized and delivered in accordance with the policies and procedures.	0
	c	The organization provides for a safe and secure environment for this vulnerable group.	5
	d	A documented procedure exists for obtaining informed consent from the appropriate legal representative.	0
	e	Staff are trained to care for this vulnerable group.	0
			1
COP.10: Documented policies and procedures guide obstetric care.			
	a	There is a documented policy and procedure for obstetric services.	0
	b	The organization defines and displays whether high risk obstetric cases can be cared for or not.	0
	c	Persons caring for high risk obstetric cases are competent.	5
	d	Documented procedures guide provision of ante-natal services.	0
	e	Obstetric patient's assessment also includes maternal nutrition.	5
	f	Appropriate pre-natal, peri-natal and post-natal monitoring is performed and documented.	5
	g	The organization caring for high risk obstetric cases has the facilities to take care of neonates of such cases.	5
			2.86
COP.11: Documented policies and procedures guide paediatric services.			
	a	There is a documented policy and procedure for paediatric services.	0
	b	The organization defines and displays the scope of its paediatric services.	5
	c	The policy for care of neonatal patients is in consonance with the national/ international guidelines.	0

d	Those who care for children have age specific competency.	5
e	Provisions are made for special care of children.	0
f	Patient assessment includes detailed nutritional, growth, psychosocial and immunization assessment.	5
g	Documented policies and procedures prevent child/neonate abduction and abuse.	0
h	The children's family members are educated about nutrition, immunization and safe parenting and this is documented in the medical record.	5
		2.5
COP.12: Documented policies and procedures guide the care of patients undergoing moderate sedation.		
a	Documented procedures guide the administration of moderate sedation.	0
b	Informed consent for administration of moderate sedation is obtained.	0
c	Competent and trained persons perform sedation.	10
d	The person administering and monitoring sedation is different from the person performing the procedure.	10
e	Intra-procedure monitoring includes at a minimum the heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation, and level of sedation.	5
f	Patients are monitored after sedation and the same documented.	5
g	Criteria are used to determine appropriateness of discharge from the recovery area.	5
h	Equipment and manpower are available to manage patients who have gone intoa deeper level of sedation than initially intended.	5
		5
COP.13: Documented policies and procedures guide the administration of anesthesia.		
A	There is a documented policy and procedure for the administration of anaesthesia.	0
B	Patients for anesthesia have a pre-anesthesia assessment by a qualified anaesthesiologist.	5
C	The pre-anaesthesia assessment results in formulation of an anaesthesia plan which is documented	5
D	An immediate pre-operative re-evaluation is performed and documented.	5
E	Informed consent for administration of anaesthesia is obtained by the anaesthesiologist.	5

F	During anaesthesia monitoring includes regular recording of temperature, heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation and end tidal carbon dioxide.	5
G	Patient's post-anaesthesia status is monitored and documented.	5
H	The anaesthesiologist applies defined criteria to transfer the patient from the recovery area.	5
I	The type of anesthesia and anaesthetic medications used are documented in the patient record.	5
j	Procedures shall comply with infection control guidelines to prevent cross infection between patients.	0
k	Adverse anesthesia events are recorded and monitored.	0
		3.64
COP.14: Documented policies and procedures guide the care of patients undergoing surgical procedures.		
a	The policies and procedures are documented.	0
b	Surgical patients have a preoperative assessment and a provisional diagnosis documented prior to surgery.	5
c	An informed consent is obtained by a surgeon prior to the procedure.	5
d	Documented policies and procedures exist to prevent adverse events like wrong site, wrong patient and wrong surgery.	0
e	Persons qualified by law are permitted to perform the procedures that they are entitled to perform.	5
f	A brief operative note is documented prior to transfer out of patient from recovery area.	5
g	The operating surgeon documents the post-operative plan of care.	5
h	Patient, personnel and material flow conforms to infection control practices.	5
i	Appropriate facilities and equipment/appliances/instrumentation are available in the operating theatre.	5
j	A quality assurance programme is followed for the surgical services.	0
k	The quality assurance programme includes surveillance of the operation theatre environment.	0
		3.18
COP.15: Documented policies and procedures guide the care of patients under restraints (physical and / or chemical).		
a	Documented policies and procedures guide the care of patients under restraints.	0

	b	These include both physical and chemical restraint measures.	0
	c	These include documentation of reasons for restraints.	0
	d	These patients are more frequently monitored.	0
	e	Staff receive training and periodic updating in control and restraint techniques.	0
			0
COP.16: Documented policies and procedures guide appropriate pain management.			
	a	Documented policies and procedures guide the management of pain.	0
	b	All patients are screened for pain.	0
	c	Patients with pain undergo detailed assessment and periodic re-assessment.	0
	d	The organization respects and supports management of pain for such patients.	0
	e	Patient and family are educated on various pain management techniques where appropriate.	0
			0
COP.17: Documented policies and procedures guide appropriate rehabilitative services.			
	a	Documented policies and procedures guide the provision of rehabilitative services.	0
	b	These services are commensurate with the organizational requirements.	5
	c	Care is guided by functional assessment and periodic re-assessment which is done and documented by qualified individual (s).	5
	d	Care is provided adhering to infection control and safe practices.	0
	e	Rehabilitative services are provided by a multidisciplinary team.	0
	f	There is adequate space and equipment to perform these activities.	5
			2.5
COP.18: Documented policies and procedures guide all research activities.			NA
	a	Documented policies and procedures guide all research activities in compliance with national and international guidelines.	

b	The organization has an ethics committee to oversee all research activities.	
c	The committee has the powers to discontinue a research trial when risks outweigh the potential benefits.	
d	Patient's informed consent is obtained before entering them in research protocols.	
e	Patients are informed of their right to withdraw from the research at any stage and also of the consequences (if any) of such withdrawal.	
f	Patients are assured that their refusal to participate or withdrawal from participation will not compromise their access to the organization's services.	
		NA
COP.19: Documented policies and procedures guide nutritional therapy.		
a	Documented policies and procedures guide nutritional assessment and reassessment.	0
b	Patients receive food according to their clinical needs.	5
c	There is a written order for the diet.	5
d	Nutritional therapy is planned and provided in a collaborative manner.	5
e	When families provide food, they are educated about the patient's diet limitations.	5
f	Food is prepared, handled, stored and distributed in a safe manner.	0
		3.33
COP.20: Documented policies and procedures guide the end of life care.		
a	Documented policies and procedures guide the end of life care.	0
b	These policies and procedures are in consonance with the legal requirements.	0
c	These also address the identification of the unique needs of such patient and family.	0
d	Symptomatic treatment is provided and where appropriate measures are taken for alleviation of pain.	5
e	Staff are educated and trained in end of life care.	0
		1
	SCORE OF CHAPTER – 02	**2.19**

Chapter 3: Management of Medication (MOM)			
MOM.1: Documented policies and procedures guide the organization of pharmacy services and usage of medication.			
	a	There is a documented policy and procedure for pharmacy services and medication usage.	0
	b	These comply with the applicable laws and regulations.	5
	c	A multidisciplinary committee guides the formulation and implementation of these policies and procedures.	0
	d	There is a procedure to obtain medication when the pharmacy is closed.*	5
			2.5
MOM.2. There is a hospital formulary.			
	a	A list of medications appropriate for the patients and as per the scope of the organization's clinical services is developed.	5
	b	The list is developed and updated collaboratively by the multidisciplinary committee.	5
	c	The formulary is available for clinicians to refer and adhere to.	0
	d	There is a defined process for acquisition of these medications	5
	e	e. There is a process to obtain medications not listed in the formulary.	5
			4
MOM.3: Documented policies and procedures guide the storage of medication			
	a	Documented policies and procedures exist for storage of medication	0
	b	Medications are stored in a clean; safe and secure environment; and incorporating manufacturer's recommendation (s).	5
	c	Sound inventory control practices guide storage of the medications.	5
	d	Sound alike and look alike medications are identified and stored separately.*	0
	e	The list of emergency medications is defined and is stored in a uniform manner	0
	f	Emergency medications are available all the time.	5
	g	Emergency medications are replenished in a timely manner when used.	5

			2.86
MOM.4: Documented policies and procedures guide the safe and rational prescription of medications			
	a	Documented policies and procedures exist for prescription of medications.	0
	b	These incorporate inclusion of good practices/guidelines for rational prescription of medications.	0
	c	The organization determines the minimum requirements of a prescription.	5
	d	Known drug allergies are ascertained before prescribing.	5
	e	The organization determines who can write orders.*	5
	f	Orders are written in a uniform location in the medical records.	5
	g	Medication orders are clear, legible, dated, timed, named and signed.	5
	h	Medication orders contain the name of the medicine, route of administration, dose to be administered and frequency/time of administration.	5
	i	Documented policy and procedure on verbal orders is implemented.	0
	j	The organization defines a list of high risk medication (s).	0
	k	Audit of medication orders/prescription is carried out to check for safe and rational prescription of medications.	0
	l	Corrective and/or preventive action (s) is taken based on the analysis where appropriate.	0
			2.5
MOM.5: Documented policies and procedures guide the safe dispensing of medications.			
	a	Documented policies and procedures guide the safe dispensing of medications	0
	b	The procedure addresses medication recall.	0
	c	Expiry dates are checked prior to dispensing.	5
	d	There is a procedure for near expiry medications.	5
	e	Labelling requirements are documented and implemented by the organization.	0
	f	High risk medication orders are verified prior to dispensing.	0

			1.67
MOM.6: There are documented policies and procedures for medication management.			
	a	Medications are administered by those who are permitted by law to do so.	5
	b	Prepared medication is labeled prior to preparation of a second drug.	5
	c	Patient is identified prior to administration.	5
	d	Medication is verified from the order prior to administration.	5
	e	Dosage is verified from the order prior to administration.	5
	f	Route is verified from the order prior to administration.	5
	g	Timing is verified from the order prior to administration.	5
	h	Medication administration is documented.	5
	i	Documented policies and procedures govern patient's self- administration of medications.	0
	j	Documented policies and procedures govern patient's medications brought from outside the organization.*	0
			4
MOM.7: Patients are monitored after medication administration.			
	a	Documented policies and procedures guide the monitoring of patients after medication administration.	0
	b	The organization defines those situations where close monitoring is required.	0
	c	Monitoring is done in a collaborative manner.	5
	d	Medications are changed where appropriate based on the monitoring.	5
			2.5
MOM.8: Near misses, medication errors and adverse drug events are reported and analysed.			
	a	Documented procedure exists to capture near miss, medication error and adverse drug event.	0
	b	Near miss, medication error and adverse drug event are defined.	0

c	These are reported within a specified time frame.	0
d	They are collected and analysed.	0
e	Corrective and/or preventive action (s) is taken based on the analysis where appropriate.	0
		0
MOM.9: Documented procedures guide the use of narcotic drugs and psychotropic substances.		
a	Documented procedures guide the use of narcotic drugs and psychotropic substances which are in consonance with local and national regulations.	0
b	These drugs are stored in a secure manner.	0
c	A proper record is kept of the usage, administration and disposal of these drugs.	0
d	These drugs are handled by appropriate personnel in accordance with the documented procedure.	0
		0
MOM.10: Documented policies and procedures guide the usage of chemotherapeutic agents.		NA
a	Documented policies and procedures guide the usage of chemotherapeutic agents.	
b	Chemotherapy is prescribed by those who have the knowledge to monitor and treat the adverse effect of chemotherapy.	
c	Chemotherapy is prepared in a proper and safe manner and administered by qualified personnel.	
d	Chemotherapy drugs are disposed off in accordance with legal requirements.	
		NA
MOM.11: Documented policies and procedures govern usage of radioactive drugs.		NA
a	Documented policies and procedures govern usage of radioactive drugs.	
b	These policies and procedures are in consonance with laws and regulations.	
c	The policies and procedures include the safe storage, preparation, handling, distribution and disposal of radioactive drugs.	
d	Staff, patients and visitors are educated on safety precautions.	
		NA

MOM.12: Documented policies and procedures guide the use of implantable prosthesis and medical devices.			
	a	Usage of implantable prosthesis and medical devices is guided by scientific criteria for each individual item and national / international recognized guidelines / approvals for such specific item(s).	0
	b	Documented policies and procedures govern procurement, storage / stocking, issuance and usage of implantable prosthesis and medical devices incorporating manufacturer's recommendation(s).*	0
	c	Patient and his / her family are counselled for the usage of implantable prosthesis and medical device including precautions, if any.	5
	d	The batch and serial number of the implantable prosthesis and medical devices are recorded in the patient's medical record and the master logbook.	10
			3.75
MOM.13: Documented policies and procedures guide the use of medical supplies and consumables			5
	a	There is a defined process for acquisition of medical supplies and consumables.	5
	b	Medical supplies and consumables are used in a safe manner where appropriate.	5
	c	Medical supplies and consumables are stored in a clean; safe and secure environment; and incorporating manufacturer's recommendation (s).	5
	d	Sound inventory control practices guide storage of medical supplies and consumables.	5
			5
		SCORE OF CHAPTER – 03	**2.62**
Chapter 4: Patient Rights and Education (PRE)			
PRE.1. The organization protects patient and family rights and informs them about their responsibilities during care.			
	a	Patient and family rights and responsibilities are documented and displayed.	0
	b	Patients and families are informed of their rights and responsibilities in a format and language that they can understand.	5
	c	The organization's leaders protect patient and family rights.	5
	d	Staff is aware of their responsibility in protecting patient and family rights.	0
	e	Violation of patient and family rights is recorded, reviewed and corrective / preventive measures taken.	0
			2
PRE.2: Patient and family rights support individual beliefs, values and involve the patient and family in decision making processes.			

a	Patients and family rights include respecting any special preferences, spiritual and cultural needs.	0
b	Patient and family rights include respect for personal dignity and privacy during examination, procedures and treatment.	5
c	Patient and family rights include protection from physical abuse or neglect.	0
d	Patient and family rights include treating patient information as confidential.	5
e	Patient and family rights include refusal of treatment.	5
f	Patient and family rights include informed consent before transfusion of blood and blood products, anaesthesia, surgery, initiation of any research protocol and any other invasive / high risk procedures / treatment.	5
g	Patient and family rights include right to complain and information on how to voice a complaint.	5
h	Patient and family rights include information on the expected cost of the treatment.	5
i	Patient and family rights include access to his / her clinical records.	0
j	Patient and family rights include information on plan of care, progress and information on their health care needs.	5
		3.5
PRE.3: The patient and/ or family members are educated to make informed decisions and are involved in the care planning and delivery process.		
a	The patient and/or family members are explained about the proposed care including the risks, alternatives and benefits.	5
b	The patient and/or family members are explained about the expected results.	5
c	The patient and / or family members are explained about the possible complications.	5
d	The care plan is prepared and modified in consultation with patient and/or family members.	5
e	The care plan respects and where possible incorporates patient and/or family concerns and requests.	5
f	The patient and/or family members are informed about the results of diagnostic tests and the diagnosis	5
g	g. The patient and/or family members are explained about any change in the patient's condition.	5
		5.00
PRE.4: A documented procedure for obtaining patient and / or family's consent exists for informed decision making about their care.		
a	Documented procedure incorporates the list of situations where informed consent is required and the process for taking informed consent.	0

b	General consent for treatment is obtained when the patient enters the organization.	0
c	Patient and/or his family members are informed of the scope of such general consent.	0
d	Informed consent includes information regarding the procedure, risks, benefits, alternatives and as to who will perform the requisite procedure in a language that they can understand.	0
e	The procedure describes who can give consent when patient is incapable of independent decision making.	0
f	Informed consent is taken by the person performing the procedure.	0
g	Informed consent process adheres to statutory norms.	0
h	Staffs are aware of the informed consent procedure.	0
		0
PRE.5: Patient and families have a right to information and education about their healthcare needs.		
a	Patient and/or family are educated about the safe and effective use of medication and the potential side effects of the medication, when appropriate.	5
b	Patient and/or family are educated about food-drug interactions.	5
c	Patient and/or family are educated about diet and nutrition.	5
d	Patient and/or family are educated about immunizations.	10
e	Patient and/or family are educated about organ donation, when appropriate.	0
f	Patient and/or family are educated about their specific disease process, complications and prevention strategies.	5
g	Patient and/or family are educated about preventing healthcare associated infections.	0
h	Patient and/or family are educated in a language and format that they can understand.	5
		4.38
PRE.6: Patient and families have a right to information on expected costs.		
a	There is uniform pricing policy in a given setting (out-patient and ward category).	5
b	The tariff list is available to patients.	5
c	The patient and/or family members are explained about the expected costs.	0
d	Patient and/or family are informed about the financial implications when there is a change in the patient condition or treatment setting.	5
		3.75

PRE.7: Organization has a complaint redressal procedure.			
	a	The organization has a documented complaint redressal procedure.	5
	b	Patient and/or family members are made aware of the procedure for lodging complaints.	5
	c	All complaints are analysed.	5
	d	Corrective and/or preventive action (s) is taken based on the analysis where appropriate.	5
			5
		SCORE OF CHAPTER – 04	**3.38**
Chapter 5: Hospital Infection Control (HIC)			
HIC.1: The organization has a well-designed, comprehensive and coordinated Hospital Infection Prevention and Control (HIC) programme aimed at reducing/ eliminating risks to patients, visitors and providers of care.			
	a	The hospital infection prevention and control programme is documented which aims at preventing and reducing risk of healthcare associated infections.	0
	b	The infection prevention and control programme is a continuous process and updated at least once in a year.	0
	c	The hospital has a multi-disciplinary infection control committee which co-ordinates all infection prevention and control activities.	0
	d	The hospital has an infection control team which co-ordinates implementation of all infection prevention and control activities.	0
	e	The hospital has designated infection control officer as part of the infection control team.	0
	f	The hospital has designated infection control nurse(s) as part of the infection control team.	0
			0
HIC.2: The organization implements the policies and procedures laid down in the Infection Control Manual.			
	a	The organization identifies the various high-risk areas and procedures and implements policies and/or procedures to prevent infection in these areas	0
	b	The organization adheres to standard precautions at all times.	0
	c	The organization adheres to hand hygiene guidelines.	0
	d	The organization adheres to safe injection and infusion practices.	0
	e	The organization adheres to transmission based precautions at all times.	0
	f	The organization adheres to cleaning, disinfection and sterilization practices	0
	g	An appropriate antibiotic policy is established and implemented.	0

	h	The organization adheres to laundry and linen management processes.	0
	i	The organization adheres to kitchen sanitation and food handling issues.	0
	j	The organization has appropriate engineering controls to prevent infections.	0
	k	The organization adheres to housekeeping procedures.	0
			0
HIC.3: The organization performs surveillance activities to capture and monitor infection prevention and control data.			
	a	Surveillance activities are appropriately directed towards the identified high-risk areas and procedures.	0
	b	Collection of surveillance data is an on-going process.	0
	c	Verification of data is done on a regular basis by the infection control team.	0
	d	Scope of surveillance activities incorporates tracking and analysing of infection risks, rates and trends.	0
	e	Surveillance activities include monitoring the compliance with hand hygiene guidelines.	0
	f	Surveillance activities include monitoring the effectiveness of housekeeping services.	0
	g	Appropriate feedback regarding HAI rates are provided on a regular basis to appropriate personnel.	
	h	In cases of notifiable diseases, information (in relevant format) is sent to appropriate authorities.	0
			0
HIC.4: The organization takes actions to prevent and control Healthcare Associated Infections (HAI) in patients.			
	a	The organization takes action to prevent urinary tract infections.	0
	b	The organization takes action to prevent respiratory tract infections.	0
	c	The organization takes action to prevent intra-vascular device infections.	0
	d	The organization takes action to prevent surgical site infections.	0
			0
HIC.5: The organization provides adequate and appropriate resources for prevention and control of Healthcare Associated Infections (HAI).			
	a	Adequate and appropriate personal protective equipment, soaps, and disinfectants are available and used correctly.	5
	b	Adequate and appropriate facilities for hand hygiene in all patient care areas are accessible to health care providers.	5

	c	Isolation / barrier nursing facilities are available.	0
	d	Appropriate pre and post exposure prophylaxis is provided to all concerned staff members.	0
			2.5
HIC.6: The organization identifies and takes appropriate action to control outbreaks of infections.			
	a	Organization has a documented procedure for identifying an outbreak.	0
	b	Organization has a documented procedure for handling such outbreaks.	0
	c	This procedure is implemented during outbreaks.	0
	d	After the outbreak is over appropriate corrective actions are taken to prevent recurrence.	0
			0
HIC.7: There are documented policies and procedures for sterilization activities in the organization.			
	a	The organization provides adequate space and appropriate zoning for sterilization activities.	0
	b	Documented procedure guides the cleaning, packing, disinfection and/or sterilization, storing and issue of items.	0
	c	Reprocessing of instruments and equipment are covered.	0
	d	Regular validation tests for sterilizationare carried out and documented.	0
	e	There is an established recall procedure when breakdown in the sterilization system is identified.	0
			0
HIC.8: Biomedical waste (BMW) is handled in an appropriate and safe manner.			
	a	The organization adheres to statutory provisions with regard to biomedical waste.	5
	b	Proper segregation and collection of biomedical waste from all patient care areas of the hospital is implemented and monitored.	5
	c	The organization ensures that biomedical waste is stored and transported to the site of treatment and disposal in proper covered vehicles within stipulated time limits in a secure manner.	5
	d	Biomedical waste treatment facility is managed as per statutory provisions (if in-house) or outsourced to authorised contractor(s).	5
	e	Appropriate personal protective measures are used by all categories of staff handling biomedical waste.	5
			5

HIC.9: The infection control programme is supported by the management and includes training of staff.			
	a	The management makes available resources required for the infection control programme.	5
	b	The organization earmarks adequate funds from its annual budget in this regard.	0
	c	The organization conducts induction training for all staff.	5
	d	The organization conducts appropriate “in-service” training sessions for all staff at least once in a year.	0
			2.5
	SCORE OF CHAPTER – 05		**1.11**
Chapter 6: Continual Quality Improvement (CQI)			
CQI.1: There is a structured quality improvement and continuous monitoring programme in the organization.			
	a	The quality improvement programme is developed, implemented and maintained by a multi-disciplinary committee.	0
	b	The quality improvement programme is documented.	0
	c	There is a designated individual for coordinating and implementing the quality improvement programme.	0
	d	The quality improvement programme is comprehensive and covers all the major elements related to quality assurance and supports innovation.	0
	e	The designated programme is communicated and coordinated amongst all the staff of the organization through appropriate training mechanism.	0
	f	The quality improvement programme identifies opportunities for improvement based on review at pre-defined intervals.	0
	g	The quality improvement programme is a continuous process and updated at least once in a year.	0
	h	Audits are conducted at regular intervals as a means of continuous monitoring.	0
	i	There is an established process in the organization to monitor and improve quality of nursing and complete patient care.	0
			0
CQI.2: There is a structured patient safety programme in the organization.			
	a	The patient safety programme is developed, implemented and maintained by a multi-disciplinary committee.	0
	b	The patient safety programme is documented.	0
	c	The patient safety programme is comprehensive and covers all the major elements related to patient safety and risk management.	0
	d	The scope of the programme is defined to include adverse events ranging from “no harm” to “sentinel events”.	0
	e	There is a designated individual for coordinating and implementing the patient safety programme.	0

f	The designated programme is communicated and coordinated amongst all the staff of the organization through appropriate training mechanism.	0
g	The patient safety programme identifies opportunities for improvement based on review at pre-defined intervals.	0
h	The patient safety programme is a continuous process and updated at least once in a year.	0
i	The organization adapts and implements national/international patient safety goals/solutions.	0
j	The organization uses at least two identifiers to identify patients across the organization.	0
		0
CQI.3: The organization identifies key indicators to monitor the clinical structures, processes and outcomes which are used as tools for continual improvement.		
a	Monitoring includes appropriate patient assessment.	0
b	Monitoring includes safety and quality control programmes of all the diagnostic services.	0
c	Monitoring includes medication management.	0
d	Monitoring includes use of anaesthesia.	0
e	Monitoring includes surgical services.	0
f	Monitoring includes use of blood and blood products.	0
g	Monitoring includes infection control activities.	0
h	Monitoring includes review of mortality and morbidity indicators.	0
i	Monitoring includes clinical research.	NA
j	Monitoring includes data collection to support further improvements.	0
k	Monitoring includes data collection to support evaluation of these improvements.	0
		0
CQI.4: The organization identifies key indicators to monitor the managerial structures, processes and outcomes which are used as tools for continual improvement.		
a	Monitoring includes procurement of medication essential to meet patient needs.	0

b	Monitoring includes risk management.	0
c	Monitoring includes utilization of space, manpower and equipment.	0
d	Monitoring includes patient satisfaction which also incorporates waiting time for services.	0
e	Monitoring includes employee satisfaction.	0
f	Monitoring includes adverse events and near misses.	0
g	Monitoring includes availability and content of medical records.	0
h	Monitoring includes data collection to support further improvements.	0
i	Monitoring includes data collection to support evaluation of these improvements.	0
		0
CQI.5: The quality improvement programme is supported by the management.		
a	The management makes available adequate resources required for quality improvement programme.	0
b	Organization earmarks adequate funds from its annual budget in this regard.	0
c	The management identifies organizational performance improvement targets.	0
d	The management supports and implements use of appropriate quality improvement, statistical and management tools in its quality improvement programme.	0
		0
CQI.6: There is an established system for clinical audit.		
a	Medical and nursing staff participates in this system.	0
b	The parameters to be audited are defined by the organization.	0
c	Patient and staff anonymity is maintained.	0
d	All audits are documented.	0
e	Remedial measures are implemented.	0
		0
CQI.7: Incidents, complaints and feedback are collected and analysed to ensure continual quality improvement.		

a	The organization has an incident reporting system.	5
b	The organization has a process to collect feedback and receive complaints.	5
c	The organization has established processes for analysis of incidents, feedbacks and complaints.	5
d	Corrective and preventive actions are taken based on the findings of such analysis.	5
e	Feedback about care and service is communicated to staff.	5
		5
CQI.8: Sentinel events are intensively analysed.		
a	The organization has defined sentinel events.	0
b	The organization has established processes for intense analysis of such events.	0
c	Sentinel events are intensively analysed when they occur.	0
d	Corrective and Preventive Actions are taken based on the findings of such analysis.	0
		0
	SCORE OF CHAPTER – 06	**0.63**
Chapter 7: Responsibilities of Management (ROM)		
ROM.1: The responsibilities of those responsible for governance are defined.		
a	Those responsible for governance lay down the organization's vision, mission and values.	0
b	Those responsible for governance approve the strategic and operational plans and organization's budget.	5
c	Those responsible for governance monitor and measure the performance of the organization against the stated mission.	0
d	Those responsible for governance establish the organization's organogram.	5
e	Those responsible for governance appoint the senior leaders in the organization.	5
f	Those responsible for governance support safety initiatives and quality improvement plans.	0
g	Those responsible for governance support research activities.	0
h	Those responsible for governance address the organization's social responsibility.	5
i	Those responsible for governance inform the public of the quality and performance of services.	5

			2.78
ROM.2: The organization complies with the laid down and applicable legislations and regulations.			
	a	The management is conversant with the laws and regulations and knows their applicability to the organization.	5
	b	The management ensures implementation of these requirements.	0
	c	Management regularly updates any amendments in the prevailing laws of the land.	0
	d	There is a mechanism to regularly update licenses/ registrations/certifications.	0
			1.25
ROM.3: The services provided by each department are documented.			
	a	Scope of services of each department is defined	5
	b	Administrative policies and procedures for each department are maintained.	0
	c	Each organizational programme, service, site or department has effective leadership.	0
	d	Departmental leaders are involved in quality improvement.	0
			1.25
ROM.4: The organization is managed by the leaders in an ethical manner.			
	a	The leaders make public the vision, mission and values of the organization.	0
	b	The leaders establish the organization's ethical management.	5
	c	The organization discloses its ownership.	10
	d	The organization honestly portrays the services which it can and cannot provide.	5
	e	The organization honestly portrays its affiliations and accreditations.	5
	f	The organization accurately bills for its services based upon a standard billing tariff.	10
			5.83
ROM.5: The organization displays professionalism in management of affairs.			
	a	The person heading the organization has requisite and appropriate administrative qualifications.	5
	b	The person heading the organization has requisite and appropriate administrative experience.	5
	c	The organization prepares the strategic and operational plans including long term and short term goals commensurate to the organization's vision, mission and values in consultation with the various stake holders.	0

d	d. The organization coordinates the functioning with departments and external agencies, and monitors the progress in achieving the defined goals and objectives.	0
e	The organization plans and budgets for its activities annually.	5
f	The performance of the senior leaders is reviewed for their effectiveness.	0
g	The functioning of committees is reviewed for their effectiveness.	0
h	The organization documents employee rights and responsibilities.	0
i	The organization documents the service standards.	0
j	The organization has a formal documented agreement for all outsourced services.	0
k	The organization monitors the quality of the outsourced services.	0
		1.36
ROM.6: Management ensures that patient safety aspects and risk management issues are an integral part of patient care and hospital management.		
a	Management ensures proactive risk management across the organization.	0
b	Management provides resources for proactive risk assessment and risk reduction activities.	0
c	Management ensures implementation of systems for internal and external reporting of system and process failures.	5
d	Management ensures that appropriate corrective and preventive action is taken to address safety related incidents.	5
		2.5
	SCORE OF CHAPTER – 07	**2.50**
Chapter 8: Facility Management and Safety (FMS)		
FMS.1: The organization has a system in place to provide a safe and secure environment.		
a	Safety committee coordinates development, implementation, and monitoring of the safety plan and policies	0
b	Patient safety devices are installed across the organization and inspected periodically.	5
c	The organization is a non-smoking area.	10
d	Facility inspection rounds to ensure safety are conducted at least twice in a year in patient care areas and at least once in a year in non-patient care areas.	0
e	Inspection reports are documented and corrective and preventive measures are undertaken.	0

	f	There is a safety education programme for staff.	0
			2.5
FMS.2: The organization's environment and facilities operate to ensure safety of patients, their families, staff and visitors.			
	a	Facilities are appropriate to the scope of services of the organization.	5
	b	Up-to-date drawings are maintained which detail the site layout, floor plans and fire escape routes.	0
	c	There is internal and external sign posting in the organization in a language understood by patient, families and community.	5
	d	The provision of space shall be in accordance with the available literature on good practices (Indian or International Standards) and directives from government agencies.	5
	e	Potable water and electricity are available round the clock.	10
	f	Alternate sources for electricity and water are provided as backup for any failure / shortage.	10
	g	The organization regularly tests these alternate sources.	0
	h	There are designated individuals responsible for the maintenance of all the facilities.	0
	i	iThere is a documented operational and maintenance (preventive and breakdown) plan.	0
	j	Maintenance staff is contactable round the clock for emergency repairs.	0
	k	Response times are monitored from reporting to inspection and implementation of corrective actions.	0
			3.18
FMS.3: The organization has a programme for engineering support services.			
	a	The organization plans for equipment in accordance with its services and strategic plan.	5
	b	Equipment are selected, rented, updated or upgraded by a collaborative process.	5
	c	Equipment are inventoried and proper logs are maintained as required.	0
	d	Qualified and trained personnel operate and maintain equipment and utility systems.	5
	e	There is a documented operational and maintenance (preventive and breakdown) plan.	0
	f	There is a maintenance plan for water management.	0
	g	There is a maintenance plan for electrical systems.	0

	h	There is a maintenance plan for heating, ventilation and air-conditioning.	0
	i	There is a documented procedure for equipment replacement and disposal.	0
			1.67
FMS.4: The organization has a programme for bio-medical equipment management.			
	a	The organization plans for equipment in accordance with its services and strategic plan.	0
	b	Equipment are selected, rented, updated or upgraded by a collaborative process.	5
	c	Equipment are inventoried and proper logs are maintained as required.	0
	d	Qualified and trained personnel operate and maintain the medical equipment.	5
	e	Equipment are periodically inspected and calibrated for their proper functioning.	0
	f	There is a documented operational and maintenance (preventive and breakdown) plan.	0
	g	There is a documented procedure for equipment replacement and disposal.*	0
			1.43
FMS.5: The organization has a programme for medical gases, vacuum and compressed air.			
	a	Documented procedures govern procurement, handling, storage, distribution, usage and replenishment of medical gases.	0
	b	Medical gases are handled, stored, distributed and used in a safe manner.	5
	c	The procedures for medical gases address the safety issues at all levels.	0
	d	Alternate sources for medical gases, vacuum and compressed air are provided for, in case of failure.	5
	e	The organization regularly tests these alternate sources.	0
	f	There is an operational and maintenance plan for piped medical gas, compressed air and vacuum installation.*	0
			1.67
FMS.6: The organization has plans for fire and non-fire emergencies within the facilities.			
	a	The organization has plans and provisions for early detection, abatement and containment of fire and non-fire emergencies.	0
	b	The organization has a documented safe exit plan in case of fire and non-fire emergencies.	0
	c	Staff are trained for their role in case of such emergencies	0

	d	Mock drills are held at least twice in a year.	0
	e	There is a maintenance plan for fire related equipment.	0
			0
FMS.7: The organization plans for handling community emergencies, epidemics and other disasters.			
	a	The organization identifies potential emergencies.	0
	b	The organization has a documented disaster management plan.	0
	c	Provision is made for availability of medical supplies, equipment and materials during such emergencies.	0
	d	Staffs are trained in the hospital's disaster management plan.	0
	e	The plan is tested at least twice in a year.	0
			0
FMS.8: The organization has a plan for management of hazardous materials.			
	a	Hazardous materials are identified within the organization.	0
	b	The organization implements processes for sorting, labeling, handling, storage, transporting and disposal of hazardous material.	0
	c	Requisite regulatory requirements are met in respect of radioactive materials.	0
	d	There is a plan for managing spills of hazardous materials.	0
	e	Staff are educated and trained for handling such materials.	0
			0
	SCORE OF CHAPTER – 08		**1.31**
Chapter 9: Human Resource Management (HRM)			
HRM.1. The organization has a documented system of human resource planning.			
	a	Human resource planning supports the organization's current and future ability to meet the care, treatment and service needs of the patient.	5
	b	The organization maintains an adequate number and mix of staff to meet the care, treatment and service needs of the patient.	5
	c	The required job specification and job description are well defined for each category of staff.	0

	d	The organization verifies the antecedents of the potential employee with regards to criminal/negligence background.	0
			2.5
HRM.2. The organization has a documented procedure for recruiting staff and orienting them to the organization's environment.			
	a	There is a documented procedure for recruitment.	0
	b	Recruitment is based on pre-defined criteria	0
	c	Every staff member entering the organization is provided induction training	0
	d	The induction training includes orientation to the organization's vision, mission and values.	0
	e	The induction training includes awareness on employee rights and responsibilities.	0
	f	The induction training includes awareness on patient's rights and responsibilities.	0
	g	The induction training includes orientation to the service standards of the organization.	0
	h	Every staff member is made aware of organization wide policies and procedures as well as relevant department / unit / service / programme's policies and procedures.	0
			0
HRM.3. There is an on-going programme for professional training and development of the staff.			
	a	A documented training and development policy exists for the staff.	0
	b	The organization maintains the training record.	5
	c	Training also occurs when job responsibilities change/ new equipment is introduced.	5
	d	Feedback mechanisms for assessment of training and development programme exist and the feedback is used to improve the training programme.	0
			2.5
HRM.4. Staff are adequately trained on various safety related aspects.			
	a	Staff are trained on the risks within the organization's environment.	0
	b	Staff members can demonstrate and take actions to report, eliminate / minimize risks.	0
	c	Staff members are made aware of procedures to follow in the event of an incident.	0

	d	Staff are trained on occupational safety aspects.	0
			0
HRM.5. An appraisal system for evaluating the performance of an employee exists as an integral part of the human resource management process.			
	a	A documented performance appraisal system exists in the organization.*	5
	b	The employees are made aware of the system of appraisal at the time of induction.	5
	c	Performance is evaluated based on the pre-determined criteria.	5
	d	The appraisal system is used as a tool for further development.	5
	e	Performance appraisal is carried out at pre-defined intervals and is documented.	5
			5
HRM.6. The organization has documented disciplinary and grievance handling policies and procedures.			
	a	Documented policies and procedures exist.	0
	b	The policies and procedures are known to all categories of staff of the organization.	0
	c	The disciplinary policy and procedure is based on the principles of natural justice.	0
	d	The disciplinary procedure is in consonance with the prevailing laws.	5
	e	There is a provision for appeals in all disciplinary cases.	5
	f	The redress procedure addresses the grievance.	5
	g	Actions are taken to redress the grievance.	5
			2.86
HRM.7. The organization addresses the health needs of the employees.			
	a	A pre-employment medical examination is conducted on all the employees.	10
	b	Health problems of the employees are taken care of in accordance with the organization's policy.	0
	c	Regular health checks of staff dealing with direct patient care are done at-least once a year and the findings/ results are documented.	0

	d	Occupational health hazards are adequately addressed.	0
			2.5
HRM.8. There is documented personal information for each staff member.			
	a	Personal files are maintained in respect of all staff.	5
	b	The personal files contain personal information regarding the staff's qualification, disciplinary background and health status.	5
	c	All records of in-service training and education are contained in the personal files.	0
	d	Personal files contain results of all evaluations.	0
			2.5
HRM.9. There is a process for credentialing and privileging of medical professionals, permitted to provide patient care without supervision.			
	a	Medical professionals permitted by law, regulation and the organization to provide patient care without supervision is identified.	10
	b	The education, registration, training and experience of the identified medical professionals is documented and updated periodically.	5
	c	All such information pertaining to the medical professionals is appropriately verified when possible.	5
	d	Medical professionals are granted privileges to admit and care for patients in consonance with their qualification, training, experience and registration.	5
	e	The requisite services to be provided by the medical professionals are known to them as well as the various departments / units of the organization.	5
	f	Medical professionals admit and care for patients as per their privileging.	5
			5.83
HRM.10. There is a process for credentialing and privileging of nursing professionals, permitted to provide patient care without supervision.			
	a	Nursing staff permitted by law, regulation and the organization to provide patient care without supervision are identified.	10
	b	The education, registration, training and experience of nursing staff is documented and updated periodically.	5
	c	All such information pertaining to the nursing staff is appropriately verified when possible.	5
	d	Nursing staff are granted privileges in consonance with their qualification, training, experience and registration.	5
	e	The requisite services to be provided by the nursing staff are known to them as well as the various departments / units of the organization.	5
	f	Nursing professionals care for patients as per their privileging.	5

			5.83
	SCORE OF CHAPTER – 09		**2.95**
Chapter 10: Information Management System (IMS)			
IMS.1. Documented policies and procedures exist to meet the information needs of the care providers, management of the organization as well as other agencies that require data and information from the organization.			
	a	The information needs of the organization are identified and are appropriate to the scope of the services being provided by the organization.	5
	b	Documented policies and procedures to meet the information needs exist.	0
	c	These policies and procedures are in compliance with the prevailing laws and regulations.	0
	d	All information management and technology acquisitions are in accordance with the documented policies and procedures.	0
	e	The organization contributes to external databases in accordance with the law and regulations.	0
			1
IMS.2. The organization has processes in place for effective management of data.			
	a	Formats for data collection are standardized.	5
	b	Necessary resources are available for analysing data.	5
	c	Documented procedures are laid down for timely and accurate dissemination of data.	0
	d	Documented procedures exist for storing and retrieving data.	0
	e	Appropriate clinical and managerial staff participates in selecting, integrating and using data.	5
			3
IMS.3. The organization has a complete and accurate medical record for every patient.			
	a	Every medical record has a unique identifier.	0
	b	Organization policy identifies those authorized to make entries in medical record.	5
	c	Entry in the medical record is named, signed, dated and timed.	5
	d	The author of the entry can be identified.	5
	e	The contents of medical record are identified and documented.	0

	f	The record provides a complete, up-to-date and chronological account of patient care.	0
	g	Provision is made for 24-hour availability of the patient's record to healthcare providers to ensure continuity of care.	0
			2.14
IMS.4. The medical record reflects continuity of care.			
	a	The medical record contains information regarding reasons for admission, diagnosis and plan of care.	5
	b	The medical record contains the results of tests carried out and the care provided.	5
	c	Operative and other procedures performed are incorporated in the medical record.	5
	d	When patient is transferred to another hospital, the medical record contains the date of transfer, the reason for the transfer and the name of the receiving hospital.	5
	e	The medical record contains a copy of the discharge summary duly signed by appropriate and qualified personnel.	5
	f	In case of death, the medical record contains a copy of the cause of death certificate.	0
	g	Whenever a clinical autopsy is carried out, the medical record contains a copy of the report of the same.	5
	h	Care providers have access to current and past medical record.	0
			3.75
IMS.5. Documented policies and procedures are in place for maintaining confidentiality, integrity and security of records, data and information.			
	a	Documented policies and procedures exist for maintaining confidentiality, security and integrity of records, data and information.	0
	b	Documented policies and procedures are in consonance with the applicable laws.	0
	c	The policies and procedure (s) incorporate safeguarding of data/ record against loss, destruction and tampering.	0
	d	The organization has an effective process of monitoring compliance of the laid down policy and procedure.	0
	e	The organization uses developments in appropriate technology for improving confidentiality, integrity and security.	0
	f	Privileged health information is used for the purposes identified or as required by law and not disclosed without the patient's authorization.	0
	g	A documented procedure exists on how to respond to patients / physicians and other public agencies requests for access to information in the medical record in accordance with the local and national law.*	0
			0

IMS.6. Documented policies and procedures exist for retention time of records, data and information.			
	a	Documented policies and procedures are in place on retaining the patient's clinical records, data and information.	0
	b	The policies and procedures are in consonance with the local and national laws and regulations.	0
	c	The retention process provides expected confidentiality and security.	0
	d	The destruction of medical records, data and information is in accordance with the laid down policy.	0
			0
IMS.7. The organization regularly carries out review of medical records.			
	a	The medical records are reviewed periodically.	0
	b	The review uses a representative sample based on statistical principles.	0
	c	The review is conducted by identified care providers.	0
	d	The review focuses on the timeliness, legibility and completeness of the medical records.	0
	e	The review process includes records of both active and discharged patients.	0
	f	The review points out and documents any deficiencies in records.	0
	g	Appropriate corrective and preventive measures are undertaken within a defined period of time and are documented.	0
			0
		SCORE OF CHAPTER – 10	**1.41**
		TOTAL SCORE OF ALL CHAPTERS	**2.12**