Poonam Report

by Poonam M

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DESSERTATION

In

METRO HEART INSTITUTE WITH MULTISPECIALITY

A TERTIARY CARE HOSPITAL, FARIDABAD

On

GAP ANALYSIS AS PER NABH STANDARDS (2015)

SUBMITTED BY

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PG/16/035

UNDER THE GUIDANCE OF

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LIST OF ABBRIVIATION

1. ACLS – Advanced Cardiovascular Life Support
2. AHU – Air Handling Unit
3. BLS – Basic Life Support
4. BME – Bio Medical Engineer
5. BMW –Bio Medical Waste
6. CAO- Chief Administrative Officer
7. CCU – Critical Cardiac Unit
8. CCTV- Closed Circuit Unit
9. CSSD – Central Sterile and Supply Department
10. CTVS- Cardio Thoracic Vascular Surgery
11. CT – Computer Tomography
12. DOR- Discharge on Request
13. ENT – Ear Nose and Throat
14. GDA- General Duty Assistance
15. HAZMAT – Hazardous Material
16. HDU – High Dependency Unit
17. HRD – Human Resource Department
18. ICU- Intensive Care Unit
19. IPD- In Patient Department
20. I.T. – Information Technology
21. IVF – Intra Vitro Fertility
22. LDR- Labour Delivery Room
23. LAMA – Leave Against Medical Advice
24. LASA – Look Alike Sound Alike
25. MLC- Medico Legal Case
26. MOU – Memorandum of Understanding
27. MRD- Medical Record Department
28. MRI – Magnetic Resonance Imaging
29. MS – Medical Superintendent
30. MSDS –Material Safety Data Sheet
31. NABH – National Board Of Hospital and Health Care Provider
32. NICU- Neonatal Intensive Care Unit

33. OPD- Out Patient Department
34. OT-Operation Theatre
35. QCI- Quality Council Of India
36. TPA – Third Part Administration
37. USG- Ultra Sonography
38. UPS – Uninterruptible Power Supply

Organization Overview

Metro Heart Institute with Multi strength Hospital is one of the greatest tertiary care focus claimed and worked by Metro Specialty Private Limited. what's more, has been positioned among the best multi strength healing facility in Delhi-NCR. This is the principal clinic in Haryana, has been licensed with NABH and NABL accreditation and is outfitted with cutting edge innovation. The doctor's facility conveys all administrations under one rooftop preventive, indicative, restorative, rehabilitative, and palliative.

The clinic is situated at segment 16A, Faridabad and effortlessly opens in Delhi-NCR. It spreads 8 acres of land, in the core of the city. The healing center has 400 beds, which will be expanded further in not so distant future.

The sum total of what administrations have been arranged with expectation to make committed guides for the specialities, with interventional benefits in close territory to OTS and ICUs to guarantee convenient and productive administrations. Healing center has modular OTs with Hepa channels and AHU, to guarantee patient's safety and security. All OTs have best in class pendants, working lights, anaesthesia work stations and propelled data framework.

The doctor's facility has extraordinary compared to other basic care offices in the district with 72 beds devoted to ICUs in various territories like Cardiac, Medical, Surgical, CTVS and NICUs. All basic care units are outfitted with top of the line checking gadgets, ventilators, syringe pumps and so on. In ICUs, 24*7 bed side offices accessible for Haemodialysis, Endoscopy and Bronchoscopy. Every single electrical point are on UPS framework so control in life sparing hardware never goes off and run continuous in ICUs. The healing center has propelled assembling administration framework for multi-layered control, electronic security framework with coordinated CCTVs, spreading over the office and a propelled terminate security framework to make doctor's facility altogether ok for patients and representatives.

Scope of Services: -

The medicinal services association gives following clinical and strong administrations.

METRO HEART COMMAND:

- Non Invasive Cardiology

- Invasive Cardiology
- Cardiac surgery
- Vascular Surgery
- Thoracic Surgery

METRO GASTRO SCIENCE CENTRE:

- Gastroenterology
- Gastrointestinal Surgery
- Endoscopic Colonoscopy

SUPER SPECIALITY SERVICES:

- Nephrology
- Kidney Transplant
- Neurology
- Neurosurgery
- Plastic, Cosmetic Surgery and Reconstructive Surgery
- Urology
- Bronchoscopy
- Pulmonology
- Endocrine and Metabolic Diseases
- Paediatric Surgery

OTHER SPECVIALITY SERVICES:

- Gynaecology, obstetric and infertility
- Paediatric
- Internal Medicine
- Critical care Medicine
- General Surgery and Minimal access surgery (Laparoscopic Surgery)
- Ophthalmology
- ENT
- Dermatology
- Orthopaedic and Join replacement
- Dentistry
- Physiotherapy

- Dietetics
- Psychiatry, clinical psychology and Psychotherapy
- Pathology
- Blood Bank

SPECIAL CLINICS:

- Comprehensive Health Check-up
- Sleep Lab
- Migraine Clinic
- Epilepsy Clinic

ROUND THE CLOCK (24hrs) SERVICES:

- Radiology services like CT, MRI
- Ambulance, Emergency and Trauma
- Lab and Blood Bank Services
- Pharmacy Services (IPD and OPD)

Services Not Available at MHIM:

- Liver Transplant
- Stem cell Transplant
- Heart Transplant

VISION

"ALL HEALTH CARE SERVICES UNDER ONE ROOF"

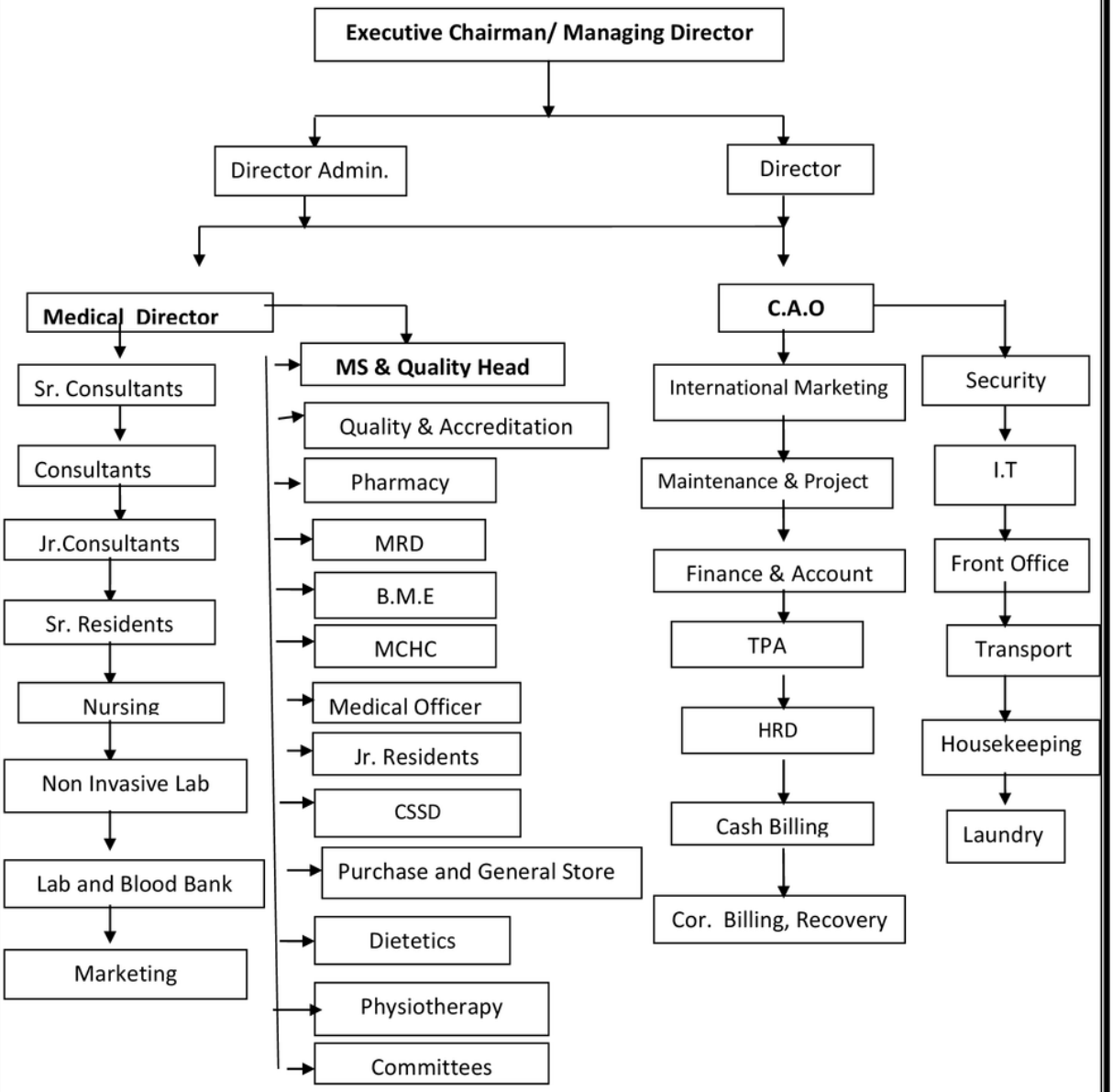
MISSION

"WORLD CLASS HEALTH CARE SERVICES AT THE MOST AFFORDABLE COST"

VALUES

- Service to others
- Teamwork
- Accountability
- Respect
- Inclusion and Diversity
- Quest for Excellence

Organization Organogram



Organization Layout

New Wing Unit –B		
Building/Block	**Level**	**Area/Activity**
Two	Basement (-3)	Bio Medical Engineer, MRD
Two	Basement (-2)	HR, Finance and Account, Marketing, Library, Legal department
Two	Basement (-1)	Dialysis , Purchase department, Maintenance
Two	Ground Floor	OPD(Orthopaedic, Pulmonology, Gynaec & Obs., Cardiac, Eye).,Treatment Room-2,Cardiac Lab, Front Office, Master health check-up, Admission counter, Coffee cafeteria, Pharmacy, Food street, Perfect Bake, International waiting Lounge, TPA, Information Counter
Two	1st Floor	New OT
Two	2nd Floor	Board Room, Administrative department, CSSD,
Two	3rd Floor	Paediatric ward,NICU, PICU, LDR, Gynaec ward
Two	4th floor	IVF, Deluxe Room
Two	5th Floor	International ward, Presidential Suit, Suit Room
OLD WING UNIT- A		
One	Basement (-1)	Physiotherapy, Lab and Blood Bank, Laundry, General Store, Mortuary, Control Room, IT,IPD Billing
One	Ground Floor	Information counter, OPD, Front Office, Treatment Room-1, Patient Counselling Room, Sample Collection Room, Radiology Department(X-RAY, Ultrasound, Memography, CT Scan, MRI) ,Neuroscience Lab., Dental Department, Emergency, Emergency Admission Counter,

One	1st Floor	CCU, Cath. Lab, CTVS Post OP, Old OT ,Endoscopy, Bronchoscopy, SICU, Transplant ICU
One	2nd Floor	MICU,HDU,2nd Deluxe Ward, IPD Pharmacy, Discharge Lounge, General ward,
One	3rd Floor	Medical Ward, Cardiac Ward
One	4th Floor	Deluxe Ward, Surgical Ward
One	5th Floor	Kitchen

ABSTRACTS

Doctor's facility and medicinal services offices are vital component of human culture. The healing facilities should fill in as spots of wellbeing, for patients as well as for the overall population. In this way the nature of administrations gave in different divisions is prime worry for any healing facility. An examination was directed to comprehend the part of NABH models and its effect on nature of human services of a healing centre.

Gap assessment is the underlying advance in the survey of the accessible administration conveyance framework. It is a proficient base to actualize a cutting edge administration framework. It uncovers the zones of change in the current administration framework. It centers around the parts of the administration and how viable they are.

The investigation gave the information which demonstrates the gap between the current administrations and the Standards of NABH in various branches of the doctor's facility. Essential information was gathered through perception, talk with staff and patients of staff and optional information was gathered from healing facility records in the frame manuals, strategies and strategy rules. Clearly a self appraisal toolbox i.e. an agenda is utilized and restorative, preventive activities are prescribed to decrease the gaps.

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INTRODUCTION OF NABH

National Accreditation Board for Hospitals and Healthcare Providers (NABH) is a constituent leading body of Quality Council of India (QCI), set up to set up and work accreditation program for social insurance associations. NABH was set up in year 2006 and after that the norms has been re-examined like clockwork. Presently the fourth version of NABH norms discharged in December 2015 is being used. The board is organized to provide food much wanted needs of the customers and to set benchmarks for advance of wellbeing Industry. The board while being upheld by all partners including industry, customers, government, have full useful independence in its activity.

.International Linkage:

- NABH is an Institutional Member and additionally a Board individual from the International Society for Quality in Health Care (ISQua).
- NABH is an individual from the Accreditation Council of International Society for Quality in Health Care.(ISQua).
- NABH is ready of Asian Society for Quality in Healthcare.(ASQua)

Vision, Mission and Scope:

To be pinnacle national medicinal services accreditation and quality change body, functioning at standard with worldwide benchmarks.

To work accreditation and unified projects in a joint effort with partners concentrating on tolerant security and nature of medicinal services in light of national/universal guidelines, through procedure of self and outside assessment

Scope of NABH/Objectives:-

- Accreditation of medicinal services offices.
- Quality advancement, activity like Safe-1, Nursing Excellence, Laboratory accreditation programs (not restricted to these).
- IEC exercises: open address, promotion, workshops/classes.

- Educational and Training for Quality & Patient Safety.
- Recognition: Endorsement of different healthcare quality courses/workshops.

Accreditation is An open acknowledgment of the accomplishment of accreditation guidelines by social insurance association, showed through an autonomous outside companion appraisal of that association's level of execution in connection to the gauges,

Advantages of Accreditation: -

- Accreditation gives high calibre of care and patient wellbeing.
- The staff in a certify healing center are fulfilled.
- Accreditation to a clinic fortifies persistent Improvement.
- Accreditation gives a target arrangement of empanelment by protection and other outsiders.

NABH ACCREDITATION PROCESS

Application for Accreditation (By HealthCare Organizations)

⇩

Acknowledgement & Scrutiny of the Application (By NABH Secretarist)

⇩

Self assessments by Healthcare organizations (Toolkits provided by NABH)

⇩

Pre- Assessments visits (By Assessment Team)

⇩

Final Assessment of Hospital (By Assessment Team)

⇩

Review of Assessments Reports (By NABH Secretarist)

⇩

Recommendation for Accreditation (BY Accreditation Committee)

⇩

Approval for Accreditation (BY chairman, NABH)

⇩

Issue of Accreditation Certificates (By NABH Secretarist)

NABH Standards has 10 chapters, 105 Standards & 683 Objective Elements. And 70 Quality Indicators.

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Outline of NABH Standards:-

Patient Cantered Standards Chapters	**Std.**
1. Access, Assessment & Continuity of Care (AAC)	14
2. Care of Patient (COP)	20
3. Management of Medication (MOM)	13
4. Patient Right and Education (PRE)	07
5. Hospital Infection Control (HIC)	09

Organization Cantered Standards Chapters	**Std.**
6. Continuous Quality Improvement(CQI)	08
7. Responsibility of Management (ROM)	06
8. Facility Management and Safety (FMS)	06
9. Human Resource Management (HRM)	10
10. Information Management System (IMS)	07

REVIEW OF LITERATURE

Quality Management Systems and Accreditation are flexible apparatuses to guarantee value in medicinal services administrations and the gathering the expanding yearnings of individuals. Ideal/perfect territory of Patient care can be accomplished by the social insurance establishment that spotlights on consistence with accreditation norms of NABH and like bodies. Hole investigation is a device that causes an association to contrast its real execution and expected/set down benchmarks. Hole examination alludes to an investigation where healing center think about the present approach, methodology, SOP's, foundation with characterized set down principles of accreditation body, NABH. Neuro Surgery is that specific office of the doctor's facility where lifesaving or life enhancing methodology are done on the human body by obtrusive strategies under strict aseptic conditions in controlled condition by exceptionally prepared staff to advance recuperating and cure with most extreme wellbeing, solace and economy .A professionally supported program that invigorates a high caliber of patient care in75 had relations with Neuro mind Tertiary Hospital in the present time of proof based medication, it winds up Imperative togive greatest significance to arranging/working specialities unpredictable, subject to the impediment of fund and space, The investigation will push us to recommend the fundamental changes for Improving the patient care and use of offices of expert clinic to ideal attractive execution models.

The thought of authorizing quality care in therapeutic calling can be followed back to mid 1900s as 'Medicinal Audit" in the United States of America (USA). The Medical Audit step by step moved to "Clinic Standardization Program" in 1918 lastly appeared as "Quality Assurance exercises". (i.e., conveyance of significant and viable medicinal care as per the benchmarks) with the arrangement of "Joint Commission on Accreditation of Hospitals" later named as "Joint Commission on Accreditation of Health Care Organizations" in 1960. The Geneva – Based International Organization for Standardization (ISO) 9000 arrangement of principles produced intrigue around the world. In India, National Accreditation Board for Hospital and Health Care Providers (NABH), a constituent leading group of Quality Council of India (QCI), has been set up to build up and work accreditation program for social insurance associations.

An examination done by the World Health Care Organization (WHO) portrays the structure and exercises at the national and global level to advance quality in medicinal services , quality devices utilized as a part of different nations, and activities in wellbeing administrations' accreditation. The abridge expressed the status of accreditation in different nations at introduce. The information helped in knowing the characteristic history of accreditation in different nations. The overall investigation attempted by the WHO demonstrated the need and significance of accreditation in today.

Gopinath led an investigation over the time of a month in 2010. The outcome demonstrated that healing facilities just fulfil three measures access, evaluation and coherence of doctor's facility mind (AAC)- and two principles of care of patients. The examination reported the hole between genuine models of the NABH and existing benchmarks in the healing center.

The gap assessment on foundation of Rajasthan Hospital, Ahmadabad was led in December 2012, distinct investigation was done, It uncovers that the healing center is extremely solid and colossal assets anyway some specific zones were in unkempt condition and could support Hospital Cross Infection. The biomedical waste isolation region was one of the real concerns. Doctor's facility signage, other critical NABH criteria, didn't welcome upgrading to take after consistency for the institutionalization of configuration, shading coding, images, directional signs, and so on according to the standard signage framework. Biomedical building was additionally distinguished for re-balance as more documentation and in-house adjustment and preventive support of the hardware.

AIM

- To improve quality of healthcare services in the hospital.
- To increase patient satisfaction level in the hospital.
- To achieve international Patient Safety goals in the hospital.

OBJECTIVE

- To evaluate the current service delivery of a Multispecialty Hospital.
- To distinguish gaps in tertiary care healing facility.
- To prescribe Corrective and preventive activities for crossing over the gaps in department in view of redid prerequisites for the clinic.

METHODOLOGY

Study Design: Descriptive study

Study Area: Metro Heart Institute with Multispecialty Hospital

Study Location: All Clinical and Non-Clinical Departments.

Study Period: 2 Month (1st March 2018 to 30th April 2018)

Study Tool: Checklist of NABH Self Assessment Tool Kit.

Scoring Criteria would be applicable

- Partial Compliance required- 5
- Full compliance required-10
- Non compliance required- 0
- Not Applicable=NA

Evaluation Criteria during final assessment:

- No individual standard should have more than one zero to qualify.
- The average score for individual standard 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

Data collection Technique:

- **Primary data-**
  1. Direct Observation
  2. Discussion with the hospital Staff
- **Secondary data-**
- 1. Hospital Manuals, Policies
  3. Records from registers of respective departments.

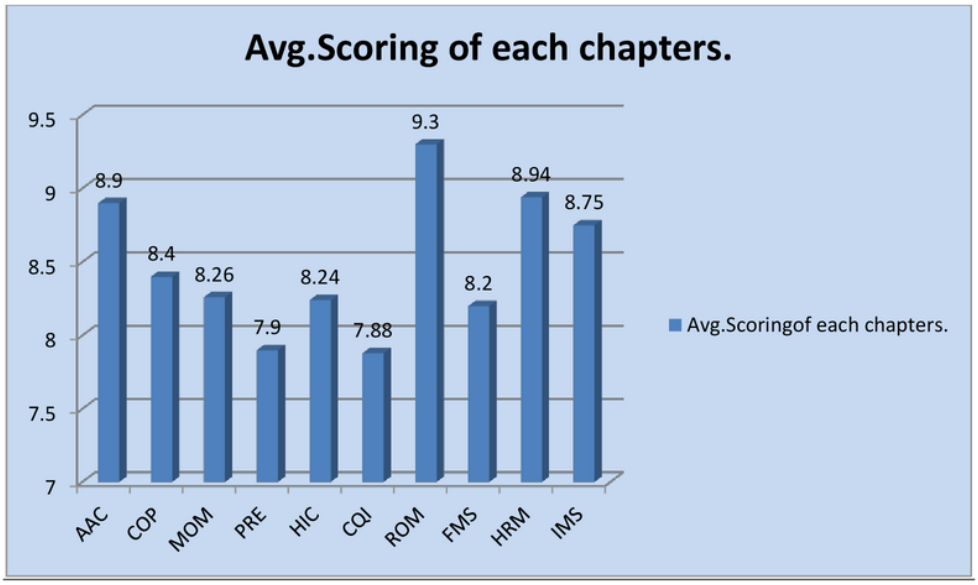
FINDING GAPS

Sr. No	Observation	NABH Std
1.	The defined health care services not proper displayed in OPD	AAC 1.c.
2	Front office staff is not oriented about services	AAC 1.d.
3	Initial assessment of inpatient form is not documented with in 24hrs. In ward	AAC4. d.
4	The initial assessment of care plan is not proper documented and countersigned by Clinician In charge of patient with in 24hrs. In ward	AAC4. g.i
5	Critical results of Imagine is informed to doctor but not documented	AAC 9.g
6	Recall register is not maintained in radiology department	AAC.9.I
7	Out sourced services are available for imagine services but there is no MOU	AAC.9.J
8	Internal peer review for imagine services is not proper documented.	AAC10. b
9	Lead apron is checked and documented but thyroid and ganoids shield is not checked and documented.	AAC11.a
10	RMOs handover form is not documented in the ward during each shift and during transfer between units/ department	AAC12. b
11	LAMA consent/ DOR consent is not proper documented.	AAC.13.c
12	ACLS ambulance is equipped but BLS ambulance is not proper equipped there is no emergency drugs.	COP3 c
13	Disaster plan is not tested at least twice in a year	COP 4. e
14	Inform consent for transfusion of Blood is not proper signed by doctors .and as well as patients.(in dialysis)	COP 7. d
15.	Admission and discharge criteria in ICU. Is documented but staff is not aware about this criteria.	COP 9..c

16	Inform consent of moderate sedation is not signed by Anaesthetics and also risk is not mentioned in the consent form.	COP 13.b
17	Surgical safety checklist is not proper filled by surgeons. Site marking is not done in surgical safety checklist.	COP 15.d
18	Nursing staff in the ward is not proper trained for "End of life care policy."	COP 22.e
19	LASA drugs are identified and stored physically each other in OT	MOM 3. d
20	Medication orders are written in illegible hand writing. Medication chart is not signed by doctors. In ward and proper drug, dose, route and frequency of administration is not proper mentioned. While discontinue of drugs there is no signed by doctors.	MOM 4.g,h
21	Prescription Audit is not done in proper way.	MOM 4.k
22	Medication error is not collected and analyzed in proper way in the ward and ICUs	MOM 8. d
23	Near about expiry drugs inj. Adrenalin is found in Crash Cart Trolley.	MOM 5.d
24	The batch and serial no. of Ortho implant or medical devices are not recorded in Patients Medical record or any master log book	MOM 12 d
25	Patients rights and responsibilities are not displayed prominently in OPD.	PRE 1.b
26	A patient's rights identified and displayed do not include right to complain and information on how to voice a complaint.	PRE2. h
27	Informed consent is not taken by the person Who performs the procedure. (dialysis, Cath. lab.)	PRE 4.f
28	Hand hygiene facilities are not available for HCW especially 3rd floor and 4th floor of ward. And Hand Hygiene posters are not available in hand hygiene area- Deluxe ward, Kitchen, In minor OT of Emergency Room	HIC 5. b

29	BMW segregation is not done as per BMW rules in OLD OT Complex	HIC 8.b
30	Personnel protective measures are not used by housekeeping staff while handling Bio Medical Waste.	HIC 8. e
31	Audits are not conducted at regular intervals for continuous monitoring	HIC 1.h
32	In patient safety programme there is no evidence of any risk measures like HIRA (Hazard Identification and Risk Analysis)	CQI 2. C FMS 1.a ROM 6,
33	The organization has not proper incident report system	CQI 8.a
34	Scope of services are not identified in OPD specially for Oncology, Neuroscience	ROM 4.a
35	Internal sign posting and signages are not displayed in bilingual language especially OPD name, Doctors availability time	FMS 2.c
36	There is no documentation for maintenance plan for facilities and furniture.	FMS2.k
37	List of Hazardous material MSDS sheet is not in bilingual and few staffs are not trained about MSDS sheet. and HAZMAT	FMS 7.b,e
38	Job specification and job description is not well defined by Human Resource Department.	HRM1.c
39	Patient's rights and responsibilities are not included in induction training.	HRM 2.f
40	Few staffs are not aware about organization's wide policies and procedure	HRM 2.h
41	There is no system to address security and integrity of information when patient's records are issued to the Clinicians, hospital staff.	IMS 5. c
42	Medical records are not reviewed periodically	IMS 7.e

Gap Analysis as Per NABH Standards (2015)



The assessment and gap analysis provided effective insight into the systems and processes of the hospital. A chapter wise list of findings has been presented. All the chapters had scores more than 8 except Patient Right and Education (PRE) and Continuous Quality Improvement (CQI). There are 3 chapters- Management of Medication (MOM), Hospital Infection control (HIC) and Facility Management and Safety (FMS) got equal scoring 8.2 and Human Resource Management (HRM) and Access Assessment and Continuity of Care (AAC) got equal scoring 8.9 and The chapter Responsibility of Management (ROM) got highest score was 9.3.

RECOMMENDATION:

- Training should be given to all Housekeeping Staff and also GDAs. For use of PPE while handling of BMW and also about Hand hygiene practice.
- Random Audit should be done by Quality team in each and every department.
- There is a requirement of Clinical Pharmacologist for prescription audit and for capturing the data of medication error.
- HIC team needs to be more active to prevent Healthcare Associated Infection (HAI) or Nosocomial Infection.
- Training for communication skill is required for all front office staff.

- ❖ Annual manpower planning should be done by Human Resource Department.
- ❖ Signage must be displayed in bilingual language.

CONCLUSION

The investigation demonstrates that there are a few holes in the healing facility according to NABH standards. The healing facility had Score 8.47 and was fit for accreditation. Scarcely any holes were distinguished if satisfied, will help in enhancing proficiency of the Hospital and furthermore help to expand persistent fulfilment level.

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SELF ASSESSMENT TOOLKIT

		Elements	Scores (0/ 5/ 10)
Chapter 1: ACCESS, ASSESSMENT AND CONTINUITY OF CARE (AAC)			
AAC.1: The organisation defines and displays the healthcare services that it provides.			
	a	The healthcare services being provided are clearly defined and are in consonance with the needs of the community.	
	b	Each defined service should have appropriate diagnostics and treatment facilities with suitably qualified personnel who provide out-patient, in-patient and emergency cover.	
	c	The defined healthcare services are prominently displayed.	
	d	The staff are oriented to these services.	
AAC.2: The organisation has a well-defined registration and admission process.			
	a	Documented policies and procedures are used for registering and admitting patients. *	
	b	The documented procedures address out-patients, in-patients and emergency patients. *	
	c	A unique identification number is generated at the end of registration.	
	d	Patients are accepted only if the organisation can provide the required service.	
	e	The documented policies and procedures also address managing patients during non-availability of beds. *	
	f	Access to the healthcare services in the organisation is prioritised according to the clinical needs of the patient.	
	g	The staff are aware of these processes.	
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 organisation. *	
	b	Documented policies and procedures guide the transfer-out/referral of unstable patients to another facility in an appropriate manner. *	
	c	Documented policies and procedures guide the transfer- out/referral of stable patients to another facility in an appropriate manner. *	
	d	The documented procedures identify staff responsible during transfer/referral.*	
	e	The organisation gives a summary of patient's condition and the treatment given.	
AAC.4: Patients cared for by the organisation undergo an established initial assessment.			
	a	The organisation defines and documents the content of the initial assessment for the out–patients, in-patients and emergency patients. *	
	b	The organisation determines who can perform the initial assessment. *	
	c	The organisation defines the time frame within which the initial assessment is completed based on patient's needs. *	
	d	The initial assessment for in-patients is documented within 24 hours or earlier as per the patient's condition, as defined in the organisation's policy. *	

	e	Initial assessment of in-patients includes nursing assessment which is done at the time of admission and documented.	
	f	Initial assessment includes screening for nutritional needs.	
	g	The initial assessment results in a documented care plan .	
	h	The care plan reflects desired results of the treatment, care or service.	
	i	The care plan is countersigned by the clinician in-charge of the patient within 24 hours.	
AAC.5: Patients cared for by the organisation undergo a regular reassessment.			
	a	Patients are reassessed at appropriate intervals.	
	b	Out-patients are informed of their next follow-up, where appropriate.	
	c	For in-patients during reassessment the care plan is monitored and modified, where found necessary.	
	d	Staff involved in direct clinical care document reassessments.*	
	e	Patients are reassessed to determine their response to treatment and to plan further treatment or discharge.	
	f	The organisation lays down guidelines and implements processes to identify early warning signs of change or deterioration in clinical conditions for initiating prompt intervention.	
AAC.6: Laboratory services are provided as per the scope of services of the organisation.			
	a	Scope of the laboratory services commensurate to the services provided by the organisation.	
	b	The infrastructure (physical and equipment) is adequate to provide the defined scope of services.	
	c	The manpower is adequate to provide the defined scope of services.	
	d	Qualified and trained personnel perform, supervise and interpret the investigations.	
	e	Documented procedures guide ordering of tests, collection, identification, handling, safe transportation, processing and disposal of specimens. *	
	f	Laboratory results are available within a defined time frame. *	
	g	Critical results are intimated immediately to the personnel concerned. *	
	h	Results are reported in a standardised manner.	
	i	There is a mechanism to address recall / amendment of reports whenever applicable.	
	j	Laboratory tests not available in the organisation are outsourced to organisation(s) based on their quality assurance system.*	
AAC.7:There is an established laboratory quality assurance programme.			
	a	The laboratory quality assurance programme is documented. *	
	b	The programme addresses verification and / or validation of test methods. *	
	c	The programme addresses surveillance of test results. *	
	d	The programme includes periodic calibration and maintenance of all equipment.*	
	e	The programme includes the documentation of corrective and preventive actions.*	
AAC.8:There is an established laboratory safety programme.			
	a	The laboratory safety programme is documented. *	
	b	This programme is aligned with the organisation's safety programme.	
	c	Written procedures guide the handling and disposal of infectious and hazardous materials. *	
	d	Laboratory personnel are appropriately trained in safe practices.	

	e	Laboratory personnel are provided with appropriate safety equipment / devices.	
AAC.9: Imaging services are provided as per the scope of services of the organisation.			
	a	Imaging services comply with legal and other requirements.	
	b	Scope of the imaging services is commensurate to the services provided by the organisation.	
	c	The infrastructure (physical and equipment) and manpower is adequate to provide for its defined scope of services.	
	d	Adequately qualified and trained personnel perform, supervise and interpret the investigations.	
	e	Documented policies and procedures exist to ensure correct identification and safe and timely transportation of patients to and from the imaging services. *	
	f	Imaging results are available within a defined timeframe. *	
	g	Critical results are intimated immediately to the personnel concerned.*	
	h	Results are reported in a standardised manner.	
	i	There is a mechanism to address recall / amendment of reports whenever applicable.	
	j	Imaging tests not available in the organisation are outsourced to organisation(s) based on their quality assurance system.*	
AAC.10: There is an established quality assurance programme for imaging services.			
	a	The quality assurance programme for imaging services is documented. *	
	b	The programme addresses periodic internal / external peer review of imaging protocols and results using appropriate sampling.	
	c	The programme addresses surveillance of imaging results in collaboration with referring clinicians for follow up wherever applicable *	
	d	A system is in place to ensure the appropriateness of the investigations and procedures for the clinical indication.	
		The programme includes periodic calibration and maintenance of all equipment.*	
	e	The programme includes the documentation of corrective and preventive actions.*	
AAC.11:There is an established safety programme in the Imaging services.			
	a	The radiation-safety programme is documented. *	
	b	This programme is aligned with the organisation's safety programme.	
	c	Patients are appropriately screened for safety / risk prior to undergoing an imaging on a particular modality.	
	d	Handling, usage and disposal of radio-active and hazardous materials are as per statutory requirements.	
	e	Imaging personnel and patients are provided with appropriate radiation safety and monitoring devices where applicable.	
	f	Radiation-safety and monitoring devices and are periodically tested and results are documented.*	
	g	Imaging and ancillary personnel are trained in imaging safety practices and radiation-safety measures.	
	h	Imaging signage are prominently displayed in all appropriate locations.	
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.	
	b	Care of patients is coordinated in all care settings within the organisation.	
	c	Information about the patient's care and response to treatment is shared among medical, nursing and other care-providers.	
	d	Information is exchanged and documented during each staffing shift, between shifts, and during transfers between units/departments.	
	e	Transfers between departments/units are done in a safe manner.	
	f	The patient's record(s) is available to the authorised care-providers to facilitate the exchange of information.	
	g	Documented procedures guide the referral of patients to other departments/ specialities. *	
	h	The organisation ensures continuity of care while adhering to defined timelines and informs the caregiver and/or the patient/family whenever there is a change in schedule.	
	i	The organisation has a mechanism in place to monitor whether adequate clinical intervention has taken place in response to a critical value alert.	
AAC.13: The organisation has a documented discharge process.			
	a	The patient's discharge process is planned in consultation with the patient and/or family.	
	b	Documented procedures exist for coordination of various departments and agencies involved in the discharge process (including medico-legal and absconded cases). *	
	c	Documented policies and procedures are in place for patients leaving against medical advice and patients being discharged on request. *	
	d	A discharge summary is given to all the patients leaving the organisation (including patients leaving against medical advice and on request).	
	e	The organisation defines the time taken for discharge and monitors the same.	
AAC.14: Organisation defines the content of the discharge summary.			
	a	Discharge summary is provided to the patients at the time of discharge.	
	b	Discharge summary contains the patient's name, unique identification number, date of admission and date of discharge.	
	c	Discharge summary contains the reasons for admission, significant findings and diagnosis and the patient's condition at the time of discharge.	
	d	Discharge summary contains information regarding investigation results, any procedure performed, medication administered and other treatment given.	
	e	Discharge summary contains follow-up advice, medication and other instructions in an understandable manner.	
	f	Discharge summary incorporates instructions about when and how to obtain urgent care.	
	g	In case of death, the summary of the case also includes the cause of death.	
Chapter 2: CARE OF PATIENTS (COP)			
COP.1: Uniform care to patients is provided in all settings of the organisation 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. *	

	b	Uniform care is guided by documented policies and procedures.	
	c	These reflect applicable laws, regulations and guidelines.	
	d	The organisation adapts evidence-based medicine and clinical practice guidelines to guide uniform patient care.	
COP.2: Emergency services are guided by documented policies, procedures, applicable laws and regulations.			
	a	There shall be an identified area in the organisation which is easily accessible to receive and manage emergency patients.	
	b	Policies and procedures for emergency care are documented and are in consonance with statutory requirements. *	
	c	This also addresses handling of medico-legal cases. *	
	d	The patients receive care in consonance with the policies.	
	e	Documented policies and procedures guide the triage of patients for initiation of appropriate care. *	
	f	Staff are familiar with the policies and trained on the procedures for care of emergency patients.	
	g	Admission or discharge to home or transfer to another organisation is also documented.	
	h	In case of discharge to home or transfer to another organisation, a discharge note shall be given to the patient.	
	i	Quality assurance programmes are documented and implemented.	
	j	The documented policies and procedures guide management of patients found dead on arrival to the hospital.*	
COP.3: The ambulance services are commensurate with the scope of the services provided by the organisation.			
	a	There is adequate access and space for the ambulance(s).	
	b	The ambulance adheres to statutory requirements.	
	c	The ambulance(s) is appropriately equipped.	
	d	The ambulance(s) is manned by trained personnel.	
	e	The ambulance(s) is checked on a daily basis.	
	f	Equipments are checked on a daily basis using a checklist.*	
	g	Emergency medications are checked daily and prior to dispatch using a checklist.	
	h	The ambulance(s) has a proper communication system.	
	i	The emergency department identifies opportunities to initiate treatment at the earliest when the patient is in transit to the organisation.	
COP.4: The organisation plans for handling community emergencies, epidemics and other disasters.			
	a	The organisation identifies potential emergencies. *	
	b	The organisation has a documented disaster management plan. *	
	c	Provision is made for availability of medical supplies, equipment and materials during such emergencies.	
	d	Staff are trained in the hospital's disaster management plan.	
	e	The plan is tested at least twice a year.	

COP.5: 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 organisation. *	
	b	Staff providing direct patient care are trained and periodically updated in cardio-pulmonary resuscitation.	
	c	The events during a cardiopulmonary resuscitation are recorded.	
	d	A post-event analysis of all cardiopulmonary resuscitations is done by a multidisciplinary committee.	
	e	Corrective and preventive measures are taken based on the post-event analysis.	
COP.6: Documented policies and procedures guide nursing care.			
	a	There are documented policies and procedures for all activities of the nursing services. *	
	b	These reflect current standards of nursing services and practice, relevant regulations and purposes of the services.	
	c	Assignment of patient care is done as per current good practice guidelines.	
	d	Nursing care is aligned and integrated with overall patient care.	
	e	Care provided by nurses is documented in the patient record.*	
	f	Nurses are provided with adequate equipment for providing safe and efficient nursing services.	
	g	Nurses are empowered to take nursing-related decisions to ensure the timely care of patients.	
COP.7: Documented procedures guide the performance of various procedures.			
	a	Documented procedures are used to guide the performance of various clinical procedures. *	
	b	Only qualified personnel order, plan, perform and assist in performing procedures.	
	c	Documented procedures exist to prevent adverse events like a wrong site, wrong patient and wrong procedure. *	
	d	Informed consent is taken by the personnel performing the procedure, where applicable.	
	e	Adherence to standard precautions and asepsis is adhered to during the conduct of the procedure.	
	f	Patients are appropriately monitored during and after the procedure.	
	g	Procedures are documented accurately in the patient record.*	
COP.8: Documented policies and procedures define rational use of blood and blood components.			
	a	Documented policies and procedures are used to guide the rational use of blood and blood components. *	
	b	Documented procedures govern transfusion of blood and blood components. *	
	c	The transfusion services are governed by the applicable laws and regulations.	

	d	Informed consent is obtained for donation and transfusion of blood and blood components.	
	e	Informed consent also includes patient and family education about the donation.	
	f	The organisation defines the process for availability and transfusion of blood/blood components for use in emergency situations.*	
	g	Post-transfusion form is collected, reactions if any identified and are analysed for preventive and corrective actions.	
	h	Staff is trained to implement the policies.	
COP.9: 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. *	
	b	The organisation has documented admission and discharge criteria for its intensive care and high dependency units. *	
	c	Staff are trained to apply these criteria.	
	d	Adequate staff and equipment are available.	
	e	Defined procedures for the situation of bed shortages are followed. *	
	f	Infection control practices are documented and followed. *	
	g	A quality assurance programme is documented and implemented.*	
	h	Patients and families are counselled by the treating medical professional at periodic intervals and when there is a significant change in the condition of the patient, and same is documented.*	
COP.10: Documented policies and procedures guide the care of vulnerable patients.			
	a	Policies and procedures are documented and are in accordance with the prevailing laws and the national and international guidelines. *	
	b	Care is organised and delivered in accordance with the policies and procedures.	
	c	The organisation provides for a safe and secure environment for the vulnerable group.	
	d	A documented procedure exists for obtaining informed consent from the appropriate legal representative. *	
	e	Staff are trained to care for this vulnerable group.	
COP.11: Documented policies and procedures guide obstetric care.			
	a	There is a documented policy and procedure for obstetric services. *	
	b	The organisation defines and displays whether high-risk obstetric cases can be cared for or not.	
	c	Persons caring for high-risk obstetric cases are competent.	
	d	Documented procedures guide the provision of ante-natal services. *	
	e	Obstetric patient's assessment also includes maternal nutrition.	
	f	Appropriate pre-natal, peri-natal and post-natal monitoring is performed and documented.*	
	g	The organisation caring for high-risk obstetric cases has the facilities to take care of	

		neonates of such cases.	
COP.12: Documented policies and procedures guide paediatric services.			
	a	There is a documented policy and procedure for paediatric services. *	
	b	The organisation defines and displays the scope of its paediatric services.	
	c	The policy for care of neonatal patients is in consonance with the national/ international guidelines. *	
	d	Those who care for children have age-specific competency.	
	e	Provisions are made for special care of children.	
	f	Patient assessment includes detailed nutritional, growth, developmental and immunisation assessment.	
	g	Documented policies and procedures prevent child/neonate abduction and abuse. *	
	h	The children's family members are educated about nutrition, immunisation and safe parenting and this is documented.*	
COP.13: Documented policies and procedures guide the care of patients undergoing moderate sedation.			
	a	Documented procedures guide the administration of moderate sedation. *	
	b	Informed consent for administration of moderate sedation is obtained.	
	c	Competent and trained persons perform sedation.	
	d	The person administering and monitoring sedation is different from the person performing the procedure.	
	e	Intra-procedure monitoring includes at a minimum the heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation, and level of sedation.	
	f	Patients are monitored after sedation and the same documented.*	
	g	Criteria are used to determine appropriateness of discharge from the observation/recovery area. *	
	h	Equipment and manpower are available to manage patients who have gone into a deeper level of sedation than initially intended.	
COP.14: Documented policies and procedures guide the administration of anaesthesia.			
	a	There is a documented policy and procedure for the administration of anaesthesia. *	
	b	Patients for anaesthesia have a pre-anaesthesia assessment by a qualified anaesthesiologist.	
	c	The pre-anaesthesia assessment results in formulation of an anaesthesia plan which is documented.	
	d	An immediate preoperative re-evaluation is performed and documented.	
	e	Informed consent for administration of anaesthesia is obtained by the anaesthesiologist.	
	f	During anaesthesia monitoring includes regular recording of temperature, heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation and end tidal carbon dioxide.	
	g	Patient's post-anaesthesia status is monitored and documented.	

	h	The anaesthesiologist applies defined criteria to transfer the patient from the recovery area. *	
	i	The type of anaesthesia and anaesthetic medications used are documented in the patient record.*	
	j	Procedures shall comply with infection control guidelines to prevent cross-infection between patients.	
	k	Adverse anaesthesia events are recorded and monitored.	
COP.15: Documented policies and procedures guide the care of patients undergoing surgical procedures.			
	a	The policies and procedures are documented. *	
	b	Surgical patients have a preoperative assessment and a provisional diagnosis documented prior to surgery.	
	c	An informed consent is obtained by a surgeon prior to the procedure.	
	d	Documented policies and procedures exist to prevent adverse events like wrong site, wrong patient and wrong surgery. *	
	e	Persons qualified by law are permitted to perform the procedures that they are entitled to perform.	
	f	A brief operative note is documented prior to transfer out of patient from recovery area.	
	g	The operating surgeon documents the postoperative care plan.	
	h	Patient, personnel and material flow conform to infection control practices.	
	i	Appropriate facilities and equipment/appliances/instrumentation are available in the operating theatre.	
	j	A quality assurance programme is followed for the surgical services. *	
	k	The quality assurance programme includes surveillance of the operation theatre environment. *	
COP.16: Documented policies and procedures guide organ transplant programme in the organisation.			
	a	The organ transplant program shall be in consonance with the legal requirements and shall be conducted in an ethical manner.	
	b	Documented policies and procedures guide the organ transplant program.*	
	c	The organisation ensures education and counselling of recipient and donor through trained / qualified counsellors before organ transplantation.	
	d	The organisation shall take measures to create awareness regarding organ donation.	
COP.17: 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. *	
	b	The policies and procedures include both physical and chemical restraint measures.	
	c	The reasons for restraints are documented.	
	d	Patients on restraints are more frequently monitored.	
	e	Staff receives training and periodic updating in control and restraint techniques.	

COP.18: Documented policies and procedures guide appropriate pain management.			
	a	Documented policies and procedures guide the management of pain. *	
	b	All patients are screened for pain.	
	c	Patients with pain undergo detailed assessment and periodic reassessment.	
	d	Pain alleviation measures or medications are initiated and titrated according to patient's need and response.	
	e	The organisation respects and supports management of pain for such patients.	
	f	Patient and family are educated on various pain management techniques, where appropriate.	
COP.19: Documented policies and procedures guide appropriate rehabilitative services.			
	a	Documented policies and procedures guide the provision of rehabilitative services. *	
	b	These services are commensurate with the organisational requirements.	
	c	Care is guided by functional assessment and periodic re-assessment which is done and documented by qualified individual(s).	
	d	Care is provided adhering to infection control and safe practices.	
	e	Rehabilitative services are provided by a multidisciplinary team.	
	f	There is adequate space and equipment to perform these activities.	
COP.20: Documented policies and procedures guide all research activities.			
	a	Documented policies and procedures guide all research activities in compliance with regulatory, national and international guidelines. *	
	b	The organisation 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 organisation's services.	
COP.21: Documented policies and procedures guide nutritional therapy.			
	a	Documented policies and procedures guide nutritional therapy including assessment and reassessment. *	
	b	Nutritional therapy is planned and provided in a collaborative manner.	
	c	There is a written order for the diet.	
	d	Patients receive food according to their clinical needs.	
	e	Food is prepared, handled, stored and distributed in a safe manner.	
	f	When families provide food, they are educated about the patient's diet limitations.	
COP.22: Documented policies and procedures guide the end of life care.			
	a	Documented policies and procedures guide the end of life care. *	

	b	These policies and procedures are in consonance with the legal requirements.	
	c	These also address the identification of the unique needs of such patient and family.	
	d	Symptomatic treatment is provided and where appropriate measures are taken for the alleviation of pain.	
	e	Staff are educated and trained in end of life care.	
Chapter 3: Management of Medication (MOM)			
MOM.1: Documented policies and procedures guide the organisation of pharmacy services and usage of medication.			
	a	There is a documented policy and procedure for pharmacy services and medication usage.*	
	b	Policies and procedures comply with the applicable laws and regulations.	
	c	A multidisciplinary committee guides the formulation and implementation of these policies and procedures.*	
	d	There is a procedure to obtain medication when the pharmacy is closed.*	
MOM.2. There is a hospital formulary.			
	a	A list of medications appropriate for the patients and as per the scope of the organisation's clinical services is developed collaboratively by the multidisciplinary committee.	
	b	The list is reviewed and updated collaboratively by the multidisciplinary committee at least annually.	
	c	The formulary is available for clinicians to refer and adhere to.	
	d	There is a defined process for acquisition of these medications*	
	e	There is a process to obtain medications not listed in the formulary. *	
MOM.3: Documented policies and procedures guide the storage of medication.			
	a	Documented policies and procedures exist for storage of medication. *	
	b	Medications are stored in a clean, safe and secure environment; and incorporating manufacturer's recommendation(s).	
	c	Sound inventory control practices guide storage of the medications in all areas throughout the organisation.	
	d	Look-alike and Sound-alike medications are identified and stored physically apart from each other.*	
	e	The list of emergency medications is defined and is stored in a uniform manner.*	
	f	Emergency medications are available all the time.	
	g	Emergency medications are replenished in a timely manner when used.	
MOM.4: Documented policies and procedures guide the safe and rational prescription of medications.			
	a	Documented policies and procedures exist for prescription of medications.*	
	b	These incorporate inclusion of good practices/guidelines for rational prescription of medications.	
	c	The organisation determines the minimum requirements of a prescription.*	
	d	Known drug allergies are ascertained before prescribing.	

	e	The organisation determines who can write orders.*	
	f	Orders are written in a uniform location in the medical records which also reflects patient's name and unique identification number.	
	g	Medication orders are clear, legible, dated, timed, named and signed.	
	h	Medication orders contain the name of the medicine, route of administration, dose to be administered and frequency/time of administration.	
	i	Documented policy and procedure on verbal orders is implemented.*	
	j	The organisation defines a list of high-risk medication(s).*	
	k	Audit of medication orders/prescription is carried out to check for safe and rational prescription of medications.	
	l	Reconciliation of medications occur at transition points of patient care.	
	m	Corrective and/or preventive action(s) is taken based on the analysis, where appropriate.	
MOM.5: Documented policies and procedures guide the safe dispensing of medications.			
	a	Documented policies and procedures guide the safe dispensing of medications.*	
	b	The procedure addresses medication recall.*	
	c	Expiry dates are checked prior to dispensing.	
	d	There is a procedure for near expiry medications.*	
	e	Labelling requirements are documented and implemented by the organisation.*	
	f	High-risk medication orders are verified prior to dispensing.	
MOM.6: There are documented policies and procedures for medication administration.			
	a	Medications are administered by those who are permitted by law to do so.	
	b	Prepared medication is labelled prior to preparation of a second drug.	
	c	Patient is identified prior to administration.	
	d	Medication is verified from the order and physically inspected prior to administration.	
	e	Dosage is verified from the order prior to administration.	
	f	Route is verified from the order prior to administration.	
	g	Timing is verified from the order prior to administration.	
	h	Medication administration is documented.	
	i	Documented policies and procedures govern patient's self-administration of medications. *	
	j	Documented policies and procedures govern patient's own medications brought from outside the organisation.*	
MOM.7: Patients are monitored after medication administration.			
	a	Documented policies and procedures guide the monitoring of patients after medication administration.*	
	b	The organisation defines those situations where close monitoring is required.*	

	c	Monitoring is done in a collaborative manner.	
	d	Medications are changed where appropriate based on the monitoring.	
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.*	
	b	Near miss, medication error and adverse drug event are defined.*	
	c	These are reported within a specified time frame. *	
	d	They are collected and analysed.	
	e	Corrective and/or preventive action(s) are taken based on the analysis where appropriate.	
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.*	
	b	These drugs are stored in a secure manner.	
	c	A proper record is kept of the usage, administration and disposal of these drugs.	
	d	These drugs are handled by appropriate personnel in accordance with the documented procedure.	
MOM.10: Documented policies and procedures guide the usage of chemotherapeutic agents.			
	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 in accordance with legal requirements.	
	e	Patient and family are educated regarding benefits/risks of chemotherapy, precautions to be taken and possible adverse reactions.	
MOM.11: Documented policies and procedures govern usage of radioactive drugs.			
	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.	
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 recognised guidelines/ approvals for such specific item(s).	
	b	Documented policies and procedures govern procurement, storage/stocking, issuance and usage of implantable prosthesis and medical devices incorporating manufacturer's recommendation(s).*	
	c	Patient and his/her family are counselled for the usage of implantable prosthesis and medical device including precautions, if any.	

	d	The batch and serial number of the implantable prosthesis and medical devices are recorded in the patient's medical record, the master logbook and the discharge summary.	
MOM.13: Documented policies and procedures guide the use of medical supplies and consumables.			
	a	There is a defined process for acquisition of medical supplies and consumables.*	
	b	Medical supplies and consumables are used in a safe manner, where appropriate.	
	c	Medical supplies and consumables are stored in a clean, safe and secure environment; and incorporating manufacturer's recommendation(s).	
	d	Sound inventory control practices guide storage of medical supplies and consumables.	
	e	There is a mechanism in place to verify the condition of medical supplies and consumables.	
Chapter 4: Patient Rights and Education (PRE)			
PRE.1. The organisation protects patient and family rights and informs them about their responsibilities during care.			
	a	Patient and family rights and responsibilities are documented and displayed.*	
	b	Patients and families are informed of their rights and responsibilities in a format and language that they can understand.	
	c	The organisation's leaders protect patient and family rights.	
	d	Staff are aware of their responsibility in protecting patient and family rights.	
	e	Violation of patient and family rights is recorded, reviewed and corrective/preventive measures taken.	
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.	
	b	Patient and family rights include respect for personal dignity and privacy during examination, procedures and treatment.	
	c	Patient and family rights include protection from neglect or abuse.	
	d	Patient and family rights include treating patient information as confidential.	
	e	Patient and family rights include refusal of treatment.	
	f	Patient and family have a right to seek an additional opinion regarding clinical care.	
	g	Patient and family rights include informed consent before transfusion of blood and blood components, anaesthesia, surgery, initiation of any research protocol and any other invasive / high risk procedures / treatment.	
	h	Patient and family rights include right to complain and information on how to voice a complaint	
	i	Patient and family rights include information on the expected cost of the treatment.	
	j	Patient and family rights include access to his / her clinical records.	
	k	Patient and family rights include information on Care plan, progress and information on their health care needs.	
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.	
	b	The patient and/or family members are explained about the expected results.	

	c	The patient and/or family members are explained about the possible complications.	
	d	The care plan is prepared and modified in consultation with patient and/or family members.	
	e	The care plan respects and where possible incorporates patient and/or family concerns and requests.	
	f	The patient and/or family members are informed about the results of diagnostic tests and the diagnosis.	
	g	The patient and/or family members are explained about any change in the patient's condition in a timely manner.	
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.*	
	b	General consent for treatment is obtained when the patient enters the organisation.	
	c	Patient and/or his family members are informed of the scope of such general consent.	
	d	Informed consent includes information regarding the procedure, it's risks, benefits, alternatives and as to who will perform the procedure in a language that they can understand.	
	e	The procedure describes who can give consent when patient is incapable of independent decision making.*	
	f	Informed consent is taken by the person performing the procedure.	
	g	Informed consent process adheres to statutory norms.	
	h	Staff are aware of the informed consent procedure.	
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.	
	b	Patient and/or family are educated about food-drug interaction	
	c	Patient and/or family are educated about diet and nutrition.	
	d	Patient and/or family are educated about immunisations.	
	e	Patient and/or family are educated about their specific disease process, complications and prevention strategies.	
	f	Patient and/or family are educated about preventing healthcare associated infections	
	g	The patients and/or family members' special educational needs are identified and addressed	
	h	Patient and/or family are educated in a language and format that they can understand.	
PRE.6: Patients and families have a right to information on expected costs.			
	a	There is a uniform pricing policy in a given setting (out-patient and ward category).	
	b	The relevant tariff list is available to patients.	
	c	The patient and/or family members are explained about the expected costs.	
	d	Patient and/or family are informed about the financial implications when there is a change in the patient condition or treatment setting.	
PRE.7: The organisation has a mechanism to capture patient's feedback and redressal of complaints.			
	a	The organisation has a mechanism to capture feedbacks from patients which includes patient satisfaction and patient's experience.	

	b	The organisation has a documented complaint redressal procedure.*	
	c	Patient and/or family members are made aware of the procedure for giving feedback and /or lodging complaints.	
	d	All feedback and complaints are reviewed and/or analysed within a defined time frame.	
	e	Corrective and/or preventive action(s) are taken based on the analysis where appropriate.	
PRE.8: The organisation has a system for effective communication with patients and /or families.			
	a	Documented policies and procedures guide the effective communication with the patients and/or families.*	
	b	The organisation shall identify special situations where enhanced communication would be required.*	
	c	The organisation lays down an approach for effective communication in these identified situations.	
	d	The organisation also defines what constitutes an unacceptable communication and sensitizes the staff about the same.*	
	e	The organisation has a system to monitor and review the implementation of effective communication	
	f	The staff are trained in healthcare communication techniques periodically.	
Chapter 5: Hospital Infection Control (HIC)			
HIC.1: The organisation 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 the risk of healthcare associated infections in all areas of the hospital.*	
	b	The infection prevention and control programme is a continuous process and updated at least once in a year.	
	c	The hospital has a multi-disciplinary infection control committee, which co-ordinates all infection prevention and control activities.*	
	d	The hospital has an infection control team, which coordinates implementation of all infection prevention and control activities.*	
	e	The hospital has designated infection control officer as part of the infection control team.*	
	f	The hospital has designated infection control nurse(s) as part of the infection control team.*	
HIC.2: The organisation implements the policies and procedures laid down in the Infection Control Manual in all areas of the hospital.			
	a	The organisation identifies the various high-risk areas and procedures and implements policies and/or procedures to prevent infection in these areas. *	
	b	The organisation adheres to standard precautions at all times.*	
	c	The organisation adheres to hand-hygiene guidelines. *	
	d	The organisation adheres to transmission-based precautions at all times.*	
	e	The organisation adheres to safe injection and infusion practices.*	
	f	The organisation adheres to cleaning, disinfection and sterilization practices.*	
	g	An appropriate antibiotic policy is established and documented *	

	h	The organisation implements the antibiotic policy and monitors rational use of antimicrobial agents.	
	i	The organisation adheres to laundry and linen management processes.*	
	j	The organisation adheres to kitchen sanitation and food-handling issues.*	
	k	The organisation has appropriate engineering controls to prevent infections. *	
	l	The organisation adheres to housekeeping procedures.*	
HIC.3: The organisation 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.	
	b	A collection of surveillance data is an on-going process.	
	c	Verification of data is done on a regular basis by the infection control team.	
	d	The scope of surveillance activities incorporates tracking and analyzing of infection risks, rates and trends.	
	e	Surveillance activities include monitoring the compliance with hand-hygiene guidelines.	
	f	Surveillance activities include mechanisms to capture the occurrence of epidemiological significant diseases and multi-drug-resistant organisms, and highly virulent infections.	
	g	Surveillance activities include monitoring the effectiveness of housekeeping services.	
	h	Appropriate feedback regarding healthcare associated infection(HAIs) rates is provided on a regular basis to appropriate personnel.	
	i	In cases of notifiable diseases, information (in relevant format) is sent to appropriate authorities.	
HIC.4: The organisation takes actions to prevent and control Healthcare Associated Infections (HAI) in patients.			
	a	The organisation takes action to prevent catheter associated urinary tract Infections.	
	b	The organisation takes action to prevent Ventilator Associated Pneumonia.	
	c	The organisation takes action to prevent catheter linked blood stream infections.	
	d	The organisation takes action to prevent surgical site infections.	
HIC.5: The organisation 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.	
	b	Adequate and appropriate facilities for hand hygiene in all patient-care areas are accessible to healthcare providers.	
	c	Isolation/barrier nursing facilities are available.	
	d	Appropriate pre- and post-exposure prophylaxis is provided to all staff members concerned.*	
HIC.6: The organisation identifies and takes appropriate action to control outbreaks of infections.			
	a	Organisation has a documented procedure for identifying an outbreak.*	
	b	Organisation has a documented procedure for handling such outbreaks.*	
	c	This procedure is implemented during outbreaks.	
	d	After the outbreak is over appropriate corrective actions are taken to prevent recurrence.	

HIC.7: There are documented policies and procedures for sterilization activities in the organisation.			
	a	The organisation provides adequate space and appropriate zoning for sterilization activities.	
	b	Documented procedure guides the cleaning, packing, disinfection and/or sterilization, storing and issue of items.*	
	c	Reprocessing of instruments and equipment are covered.*	
	d	The organisation shall have a documented policy and procedure for reprocessing of devices whenever applicable.*	
	e	Regular validation tests for sterilization are carried out and documented.*	
	f	There is an established recall procedure when breakdown in the sterilization system is identified.*	
HIC.8: Biomedical waste (BMW) is handled in an appropriate and safe manner.			
	a	The organisation adheres to statutory provisions with regard to biomedical waste.	
	b	Proper segregation and collection of biomedical waste from all patient-care areas of the hospital is implemented and monitored.	
	c	The organisation ensures that biomedical waste is stored and transported to the site of treatment and disposal in properly covered vehicles within stipulated time limits in a secure manner.	
	d	The biomedical waste treatment facility is managed as per statutory provisions (if in-house) or outsourced to authorized contractor(s).	
	e	Appropriate personal protective measures are used by all categories of staff handling biomedical waste.	
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.	
	b	The organisation earmarks adequate funds from its annual budget in this regard.	
	c	The organisation conducts induction training for all staff.	
	d	The organisation conducts appropriate "in-service" training sessions for all staff at least once in a year.	
Chapter 6: Continual Quality Improvement (CQI)			
CQI.1: There is a structured quality improvement and continuous monitoring programme in the organisation.			
	a	The quality improvement programme is developed, implemented and maintained by a multi-disciplinary committee.*	
	b	The quality improvement programme is documented which is comprehensive and covers all the major elements related to quality assurance.*	
	c	There is a designated individual for coordinating and implementing the qualityimprovement programme.*	
	d	The quality improvement programme promotes and demonstrates use of innovations to improve process efficiency and effectiveness.	
	e	The designated programme is communicated and coordinated amongst all the staff of the organisation through appropriate training mechanism.	
	f	The quality improvement programme identifies opportunities for improvement based on review at pre-defined intervals.*	
	g	The quality improvement programme is a continuous process and updated at least	

		once in a year.	
	h	Audits are conducted at regular intervals as a means of continuous monitoring.*	
	i	There is an established process in the organisation to monitor and improve quality of nursing care.*	
CQI.2: There is a structured patient-safety programme in the organisation.			
	a	The patient-safety programme is developed, implemented and maintained by a multi-disciplinary committee.	
	b	The patient safety programme is documented.*	
	c	The patient safety programme is comprehensive and covers all the major elements related to patient safety and risk management.	
	d	The scope of the programme is defined to include adverse events ranging from "no harm" to "sentinel events".	
	e	There is a designated individual for coordinating and implementing the patient-safety programme.	
	f	The designated programme is communicated and coordinated amongst all the staff of the organisation through appropriate training mechanism.	
	g	The patient-safety programme identifies opportunities for improvement based on review at pre-defined intervals.	
	h	The patient-safety programme is a continuous process and updated at least once in a year.	
	i	The organisation adapts and implements national/international patient-safety goals/solutions.	
CQI.3: The organisation 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.	
	b	Monitoring includes safety and quality-control programmes of all the diagnostic services.	
	c	Monitoring includes medication management.	
	d	Monitoring includes use of anaesthesia.	
	e	Monitoring includes surgical services.	
	f	Monitoring includes use of blood and blood components.	
	g	Monitoring includes infection control activities.*	
	h	Monitoring includes review of mortality and morbidity indicators.*	
	i	Monitoring includes clinical research.*	
	j	Monitoring includes patient safety goals.*	
	k	The organisation identifies and monitors priority aspects of patient care.	
CQI.4: The organisation 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.	
	b	Monitoring includes risk management.	
	c	Monitoring includes utilisation of space, manpower and equipment.	
	d	Monitoring includes patient satisfaction which also incorporates waiting time for services.	
	e	Monitoring includes employee satisfaction.	
	f	Monitoring includes adverse events and near misses.	
	g	Monitoring includes availability and content of medical records.	
	h	The organisation identifies and monitors priority managerial activities in the organisation.	

CQI.5: There is a mechanism for validation and analysis of quality indicators to facilitate quality improvement.			
	a	There is a mechanism for validation of data	
	b	There is a mechanism for analysis of data which results in identifying opportunities for improvement.	
	c	The opportunities for improvement are implemented and evaluated	
	d	The organisation uses appropriate quality improvement, statistical and management tools in its quality improvement programme	
	e	Feedback about care and service is communicated to staff	
CQI.6: The quality improvement programme is supported by the management			
	a	The leaders at all levels in the organisation are aware of the intent of the quality improvement program and the approach to its implementation.	
	b	The management makes available adequate resources required for quality improvement programme.	
	c	Organisation earmarks adequate funds from its annual budget in this regard.	
	d	The management identifies organisational performance improvement targets.	
CQI.7: There is an established system for clinical audit.			
	a	Medical and nursing staff participates in this system.	
	b	The parameters to be audited are defined by the organisation.	
	c	Patient and staff anonymity is maintained.	
	d	All audits are documented.	
	e	Remedial measures are implemented.	
CQI.8: Incidents are collected and analysed to ensure continual quality improvement.			
	a	The organisation has an incident reporting system.*	
	b	The organisation has established processes for analysis of incidents	
	c	Corrective and preventive actions are taken based on the findings of such analysis.	
	d	The organisation shall have a process for informing various stakeholders in case of a near miss / adverse event.	
CQI .9 Sentinel events are intensively analysed.			
	a	The organisation has defined sentinel events.*	
	b	The organisation has established processes for intense analysis of such events.	
	c	Sentinel events are intensively analysed when they occur.	
	d	Corrective and preventive actions are taken based on the findings of such analysis.	
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 organisation's vision, mission and values.*	
	b	Those responsible for governance approve the strategic and operational plans and organisation's annual budget.	
	c	Those responsible for governance monitor and measure the performance of the organisation against the stated mission.	
	d	Those responsible for governance establish the organisation's organogram.*	
	e	Those responsible for governance appoint the senior leaders in the organisation.	
	f	Those responsible for governance support safety initiatives and quality improvement plans.	
	g	Those responsible for governance support research activities.	
	h	Those responsible for governance address the organisation's social responsibility.	

	i	Those responsible for governance inform the public of the quality and performance of services.	
ROM.2: The organisation is responsible for and complies with the laid down and applicable legislations, regulations and notifications.			
	a	The management is conversant with the applicable laws and regulations and undertakes the responsibility to adhere to the same.	
	b	b. The management ensures that the policies and procedures pertaining to patient care are in compliance with the prevailing laws, regulations and notifications.	
	c	The management has a mechanism which ensures implementation of these requirements.	
	d	Management has a mechanism which regularly updates any amendments in the prevailing laws of the land.	
	e	There is a mechanism to regularly update licenses/registrations/certifications.	
ROM.3: The services provided by each department are documented.			
	a	Scope of services of each department is defined.*	
	b	Administrative policies and procedures for each department are maintained.*	
	c	Each organisational programme, service, site or department has effective leadership.	
	d	Departmental leaders are involved in quality improvement.	
ROM.4: The organisation is managed by the leaders in an ethical manner.			
	a	The leaders make public the vision, mission and values of the organisation.	
	b	The leaders establish the organisation's ethical management.*	
	c	The organisation discloses its ownership.	
	d	The organisation honestly portrays the services which it can and cannot provide.	
	e	The organisation honestly portrays its affiliations and accreditations.	
	f	The organisation accurately bills for its services based upon a standard billing tariff.	
ROM.5: The organisation displays professionalism in management of affairs.			
	a	The person heading the organisation has requisite and appropriate administrative qualifications.	
	b	The person heading the organisation has requisite and appropriate administrative experience.	
	c	The organisation prepares the strategic and operational plans including long-term and short-term goals commensurate to the organisation's vision, mission and values in consultation with the various stakeholders.	
	d	The organisation coordinates the functioning with departments and external agencies, and monitors the progress in achieving the defined goals and objectives.	
	e	The organisation plans and budgets for its activities annually.	
	f	The performance of the senior leaders is reviewed for their effectiveness.	
	g	The functioning of committees is reviewed for their effectiveness.	
	h	The organisation documents employee rights and responsibilities.*	
	i	The organisation documents the service standards.*	
	j	The organisation has a formal documented agreement for all outsourced services.	
	k	The organisation monitors the quality of the outsourced services.	
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 organisation.	

	b	Management provides resources for proactive risk assessment and risk-reduction activities.	
	c	Management ensures implementation of systems for internal and external reporting of system and process failures.*	
	d	Management ensures that appropriate corrective and preventive actions are taken to address safety-related incidents.	
Chapter 8:Facility Management and Safety (FMS)			
FMS.1: The organisation 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.	
	b	Patient-safety devices & infrastructure are installed across the organisation and inspected periodically.	
	c	The organisation is a non-smoking area.	
	d	There is a procedure which addresses the identification and disposal of material(s) not in use in the organisation.*	
	e	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.	
	f	Inspection reports are documented and corrective and preventive measures are undertaken.	
	g	There is a safety education programme for staff.	
FMS.2: The organisation's environment and facilities operate in a planned manner to ensure safety of patients, their families, staff and visitors and promotes environment friendly measures.			
	a	Facilities are appropriate to the scope of services of the organisation.	
	b	Up-to-date drawings are maintained which detail the site layout, floor plans and fire-escape routes.	
	c	There is internal and external sign postings in the organisation in a language understood by patient, families and community.	
	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.	
	e	Operational planning describes access to different areas in the hospital by staff, patients, visitors and vendors.	
	f	Potable water and electricity are available round the clock.	
	g	Alternate sources for electricity and water are provided as backup for any failure / shortage.	
	h	The organisation regularly tests these alternate sources.	
	i	There are designated individuals (with appropriate equipment) responsible for the maintenance of all the facilities.	
	j	Maintenance staff is contactable round the clock for emergency repairs.	
	k	There is a maintenance plan for facility and furniture.*	
	l	Response times are monitored from reporting to inspection and implementation of corrective actions.	
	m	The organisation takes initiatives towards an energy efficient and environmental friendly hospital.*	
FMS.3: The organisation has a programme for engineering support services and utility system.			

	a	The organisation plans for equipment in accordance with its services and strategic plan.	
	b	Equipment are selected, rented, updated or upgraded by a collaborative process.	
	c	Equipment are inventoried and proper logs are maintained as required.	
	d	Qualified and trained personnel operate, inspect, test and maintain equipment and utility systems.	
	e	Utility equipment are periodically inspected and calibrated (wherever applicable) for their proper functioning.	
	f	There is a documented operational and maintenance (preventive and breakdown) plan.*	
	g	There is a maintenance plan for water management.*	
	h	There is a maintenance plan for electrical systems.*	
	i	There is a maintenance plan for heating, ventilation and air-conditioning.*	
	j	There is a maintenance plan for Information technology & communication network.*	
	k	There is a documented procedure for equipment replacement and disposal.*	
FMS.4: The organisation has a programme for bio-medical equipment management.			
	a	The organisation plans for equipment in accordance with its services and strategic plan.	
	b	Equipment are selected, rented, updated or upgraded by a collaborative process.	
	c	Equipment are inventoried and proper logs are maintained as required.	
	d	Qualified and trained personnel operate and maintain the medical equipment.	
	e	Equipment are periodically inspected and calibrated for their proper functioning.	
	f	There is a documented operational and maintenance (preventive and breakdown) plan for equipment.*	
	g	There is a documented procedure for equipment replacement and disposal.*	
	h	The procedures addresses medical equipment recalls.*	
	i	Response times are monitored from reporting to inspection and implementation of corrective actions.	
FMS.5: The organisation has a programme for medical gases, vacuum and compressed air.			
	a	Documented procedures govern procurement, handling, storage, distribution, usage and replenishment of medical gases.*	
	b	Medical gases are handled, stored, distributed and used in a safe manner.	
	c	The procedures for medical gases address the safety issues at all levels.	
	d	Alternate sources for medical gases, vacuum and compressed air are provided for, in case of failure.	
	e	The organisation regularly tests these alternate sources.	
	f	There is an operational, inspection, testing and maintenance plan for, piped medical gas, compressed air and vacuum installation.*	
FMS.6: The organisation has plans for fire and non-fire emergencies within the facilities.			
	a	The organisation has plans and provisions for early detection, abatement and containment of fire, and non-fire emergencies.*	
	b	The organisation has a documented safe-exit plan in case of fire and non-fire emergencies.	

	c	Staff is trained for their role in case of such emergencies.	
	d	Mock drills are held at least twice in a year.	
	e	There is a maintenance plan for fire-related equipment & infrastructure.*	
FMS.7: The organisation has a plan for management of hazardous materials.			
	a	Hazardous materials are identified within the organisation.*	
	b	The organisation implements processes for sorting, labelling, handling, storage, transporting and disposal of hazardous material.*	
	c	Requisite regulatory requirements are met in respect of radioactive materials.	
	d	There is a plan for managing spills of hazardous materials.*	
	e	Staff are educated and trained for handling such materials.	
Chapter 9: Human Resource Management (HRM)			
HRM.1. The organisation has a documented system of human resource planning.			
	a	Human resource planning supports the organisation's current and future ability to meet the care, treatment and service needs of the patient.*	
	b	The organisation maintains an adequate number and mix of staff to meet the care, treatment and service needs of the patient.	
	c	The required job specification and job description are well defined for each category of staff.*	
	d	The organisation verifies the antecedents of the potential employee with regards to criminal/negligence background.	
HRM.2. The organisation has a documented procedure for recruiting staff and orienting them to the organisation's environment.			
	a	There is a documented procedure for recruitment.*	
	b	Recruitment is based on pre-defined criteria	
	c	Every staff member entering the organisation is provided induction training	
	d	The induction training includes orientation to the organisation's vision, mission and values.	
	e	The induction training includes awareness on employee rights and responsibilities.	
	f	The induction training includes awareness on patient's rights and responsibilities.	
	g	The induction training includes orientation to the service standards of the organisation.	
	h	Every staff member is made aware of organisation's wide policies and procedures as well as relevant department / unit / service / programme's policies and procedures.	
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.*	
	b	The organisation maintains the training record.	
	c	Training also occurs when job responsibilities change/ new equipment is introduced.	
	d	Evaluation of training effectiveness is done by the organisation	
	e	Feedback mechanisms are in place for improvement of training and development programme.	
HRM.4. Staff are adequately trained on various safety-related aspects.			
	a	Staff are trained on the risks within the organisation's environment.	
	b	Staff members can demonstrate and take actions to report, eliminate, or minimize risks.	

	c	Staff members are made aware of procedures to follow in the event of an incident.	
	d	Staff are trained on occupational safety aspects.	
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 organisation.*	
	b	The employees are made aware of the system of appraisal at the time of induction.	
	c	Performance is evaluated based on the pre-determined criteria.	
	d	The appraisal system is used as a tool for further development.	
	e	Performance appraisal is carried out at pre-defined intervals and is documented.	
HRM.6. The organisation has documented disciplinary and grievance handling policies and procedures.			
	a	Documented policies and procedures exist.*	
	b	The policies and procedures are known to all categories of staff of the organisation.	
	c	The disciplinary policy and procedure is based on the principles of natural justice.	
	d	The disciplinary and grievance procedure is in consonance with the prevailing laws.	
	e	There is a provision for appeals in all disciplinary cases.	
	f	The redress procedure addresses the grievance.	
	g	Actions are taken to redress the grievance.	
HRM.7. The organisation addresses the health needs of the employees.			
	a	A pre-employment medical examination is conducted on all the staff.	
	b	Health problems of the employees are taken care of in accordance with the organisation's policy.	
	c	Regular health checks of staff dealing with direct patient care are done at least once a year and the findings/ results are documented.	
	d	Occupational health hazards are adequately addressed.	
HRM.8. There is documented personal information for each staff member.			
	a	Personal files are maintained with respect to all staff.	
	b	The personal files contain personal information regarding the staff's qualification, disciplinary background and health status.	
	c	All records of in-service training and education are contained in the personal files.	
	d	Personal files contain results of all evaluations.	
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 organisation to provide patient care without supervision are identified.	
	b	The education, registration, training and experience of the identified medical professionals is documented and updated periodically.	
	c	All such information pertaining to the medical professionals is appropriately verified when possible.	
	d	Medical professionals are granted privileges to admit and care for patients in consonance with their qualification, training, experience and registration.	
	e	The requisite services to be provided by the medical professionals are known to them as well as the various departments / units of the organisation.	
	f	Medical professionals admit and care for patients as per their privileging.	
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 organisation to provide patient care without supervision are identified.	
	b	The education, registration, training and experience of nursing staff is documented and updated periodically.	
	c	All such information pertaining to the nursing staff is appropriately verified when possible.	
	d	Nursing staff are granted privileges in consonance with their qualification, training, experience and registration.	
	e	The requisite services to be provided by the nursing staff are known to them as well as the various departments / units of the organisation.	
	f	Nursing professionals care for patients as per their privileging.	
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 organisation as well as other agencies that require data and information from the organisation.			
	a	The information needs of the organisation are identified and are appropriate to the scope of the services being provided by the organisation.*	
	b	Documented policies and procedures to meet the information needs exist.*	
	c	All information management and technology acquisitions are in accordance with the documented policies and procedures.	
	d	Documented policies and procedures guide the use of Telemedicine facility in a safe and secure manner.	
	e	The organisation contributes to external databases in accordance with the law and regulations.	
IMS.2. The organisation has processes in place for effective control and management of data.			
	a	The organisation has an effective process for document control.*	
	b	Formats for data collection are standardized.	
	c	Necessary resources are available for analysing data.	
	d	Documented procedures are laid down for timely and accurate dissemination of data.*	
	e	Documented procedures exist for storing and retrieving data.*	
	f	Appropriate clinical and managerial staff participates in selecting, integrating and using data.	
IMS.3. The organisation has a complete and accurate medical record for every patient.			
	a	Every medical record has a unique identifier.	
	b	Organisation policy identifies those authorized to make entries in medical record.	
	c	Entry in the medical record is named, signed, dated and timed.	
	d	The author of the entry can be identified.	
	e	The contents of medical record are identified and documented.*	
	f	The organisation has a documented policy for usage of abbreviations and develops a list based on accepted practices.	
	g	The record provides a complete, up-to-date and chronological account of patient care.	
	h	Provision is made for 24-hour availability of the patient's record to healthcare providers to ensure continuity of care.	
IMS.4. The medical record reflects continuity of care.			
	A	The medical record contains information regarding reasons for admission, diagnosis	

		and care plan.	
	b	The medical record contains the results of tests carried out and the care provided.	
	c	Operative and other procedures performed are incorporated in the medical record.	
	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.	
	e	The medical record contains a copy of the discharge summary duly signed by appropriate and qualified personnel.	
	f	In case of death, the medical record contains a copy of the cause of death certificate.	
	g	Whenever a clinical autopsy is carried out, the medical record contains a copy of the report of the same.	
	h	Care providers have access to current and past medical record.	
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.*	
	b	Documented policies and procedures are in consonance with the applicable laws.	
	c	The policies and procedure (s) incorporate safeguarding of data/ record against loss, destruction and tampering.	
	d	The organisation has an effective process of monitoring compliance of the laid down policy and procedure.	
	e	The organisation uses developments in appropriate technology for improving confidentiality, integrity and security.	
	f	Privileged health information is used for the purposes identified or as required by law and not disclosed without the patient's authorization.	
	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.*	
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.*	
	b	The policies and procedures are in consonance with the local and national laws and regulations.	
	c	The retention process provides expected confidentiality and security.	
	d	The destruction of medical records, data and information is in accordance with the laid-down policy.	
IMS.7. The organisation regularly carries out review of medical records.			
	a	The medical records are reviewed periodically.	
	b	The review uses a representative sample based on statistical principles.	
	c	The review is conducted by identified individuals.	
	d	The review focuses on the timeliness, legibility and completeness of the medical records.	
	e	The review process includes records of both active and discharged patients.	
	f	The review points out and documents any deficiencies in records.	
	g	Appropriate corrective and preventive measures are undertaken within a defined period of time and are documented.	

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