

ACCREDITATION STANDARDS FOR AYURVEDA HOSPITALS

NATIONAL ACCREDITATION BOARD FOR HOSPITALS AND HEALTHCARE PROVIDERS (NABH)

**2nd
EDITION**
April 2016



**National Accreditation Board for Hospitals
and Healthcare Providers (NABH)**





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NABH PLEDGES

Taking Quality to the Last Man in the Line

HAPPY INDEPENDENCE DAY
15th August 2020



PREFACE TO THE RE-PRINT

National Accreditation Board for Hospitals and Healthcare Providers (NABH), a constituent board of Quality Council of India, established in 2005, is in its 15th year of creating an ecosystem of quality in healthcare in India. NABH standards focus on patient safety and quality of the delivery of services by the hospitals in the changing healthcare environment. Without being prescriptive, the objective elements remain informative and guide the organisation in conducting its operations with a focus on patient safety.

All NABH standards have been developed in consultation with various stakeholders in the healthcare industry and if implemented help the healthcare organizations in stepwise progression to mature quality systems covering the entire spectrum of patient safety and healthcare delivery.

The NABH organization & the hospital accreditation standards are internationally recognized and benchmarked. NABH is an Institutional as well as a Board member of the International Society for Quality in Health Care (ISQua) and Asian Society for Quality in Health Care (ASQua) and a member of the Accreditation Council of International Society for Quality in Health Care (ISQua).

Over the years, successive NABH standards have brought about not only paradigm shifts in the hospitals' approach towards delivering the healthcare services to the patients but have equally sensitised the healthcare workers and patients towards their rights and responsibilities.

In celebration of our 74th Independence Day, on 15th of August, 2020, we are pleased to announce, that starting today, in an enhanced effort to connect with people, all NABH standards, across programmes, will be available free of charge as downloadable documents in PDF format on the NABH website www.nabh.co. (The Printed copies of Standards and Guidebooks will continue to remain available for purchase at a nominal price).

NABH also announces the enriched continuation of its **"NABH Quality Connect-Learning with NABH"** initiative, connecting free monthly training classes, webinars and seminars. The various topics that will be taken up will cover all aspects of patient safety, including: Key Performance Indicators, Hospital Infection Control, Management of Medication, Document Control etc.

Recently introduced communication initiatives like **Dynamic Website Resource Center** and **NABH Newsletter Quality Connect** (focusing on sharing the best quality practices, news and views) will also be bettered.

It is sincerely hoped that all stakeholders will certainly benefit from the collective efforts of the Board and practical suggestions of thousands of Quality Champions from India and abroad

NABH remains committed to ensuring healthy lives and promote wellbeing for all at all ages (SDG-3-Target 2030), creating a culture of quality in healthcare and taking Quality, Safety and Wellness to the Last Man in the Line.

Jai Hind

(Dr. Atul Mohan Kochhar)
CEO-NABH

15th August 2020

National Accreditation Board for Hospitals and Healthcare Providers (NABH)

Accreditation Standards for Ayurveda Hospitals

2nd Edition

April 2016

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2nd Edition April 2016



अजीत मोहन शरण
AJIT M. SHARAN



सचिव

भारत सरकार

आयुर्वेद, योग व प्राकृतिक चिकित्सा
यूनानी, सिद्ध एवं होम्योपैथी (आयुष) मंत्रालय
आयुष भवन, 'बी' ब्लॉक, जी.पी.ओ. कॉम्प्लेक्स,
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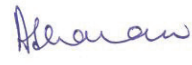
Foreword

There is a resurgence of interest in the holistic systems of health care, especially in the prevention and management of chronic lifestyle related non communicable diseases and systemic diseases. Health sector trends suggest that no single system of health care has the capacity to solve all of the society's medical needs. India can be a world leader in the era of integrative medicine because it has strong foundations in Western biomedical sciences and an immensely rich and mature indigenous medical heritage of its own. Ayurveda is one such stream.

2. Ayurveda, the science of life, the origin of most forms of natural and traditional medicine has its mention in one of the oldest philosophical texts of the world, the Atharva Veda. In its broader scope, Ayurveda in India has always sought to prepare mankind for the realization of the full potential of its self, through a psychosomatic integration. A comprehensive healthcare is what this natural and traditional medicine prescribes for the ultimate self-realization.

3. National Accreditation Board for Hospitals and Healthcare Providers (NABH), a constituent board of Quality Council of India (QCI) has put in sincere efforts to bring out the second edition of quality standards for patient care in Ayurveda system of Medicine.

4. Ministry of AYUSH is happy to endorse the second edition of NABH Accreditation Standards for Ayurveda Hospitals. I extend my hearty congratulations to NABH AYUSH Technical Committee Members and entire NABH team for their work. I also appreciate the huge effort towards review and guidance provided by Adviser-Ayurveda, Ministry of AYUSH.


(Ajit M. Sharan)

NEW DELHI
29th April, 2016

INTRODUCTION

The first edition of NABH standard has been in practice for last six years now (2009-15) and is revised and up-graded to 2nd edition. The guiding principles for revision of the standards have mainly been the experience of stake holders including assessors, hospitals, members of accreditation and technical committees and industry experts. Before finalization of these, public opinion was also sought. Secretariat of NABH did bulk of job by collating and assimilating the feedback information, linking with relevant chapters and presenting to the technical committee for deliberations. This was again discussed in detail by industry experts. It was finally and extensively reviewed by Committee appointed by Ministry of AYUSH, which went in to thought process and came out with the edition, which is now in your hands.

The accreditation standards are not expected to be prescriptive. They only lay down the requirements and it is up to the healthcare organizations to come out with the systems, processes and modes of measuring performance indicators, which can demonstrate compliance to the requirements as specified in the standard. NABH has tried its best to be as objective and pragmatic as possible.

There can be more than one way, by which an Ayurveda healthcare organisation can comply with the requirements of the standards. Three books are being made available for use by the stakeholders ie 2nd edition Standards book, a guidebook containing glossary and a compilation of various practices in the form of annexures, including matrix for calculating quality indicators and other relevant material.

Accreditation as we know is basically a framework which helps healthcare organizations to establish objective systems aimed at patient safety and quality of care. Documentation plays an important role in defining such systems. Wherever there are references to documented requirements, it needs to be clearly understood that such documentation needs to be established and understood at all levels, reviewed at regular intervals, and controlled and evidenced for their effective implementation by way of records.

The second edition of these standards has put more focus on clinical care aspects. Structural requirement which used to be a separate book in first edition, have been incorporated in second edition at appropriate places.

The requirements of the standards shall have to be identified; evidenced by data gathered, analysed and interpreted with the aim of improving the quality system of a hospital. Wherever the word shall/should is used, it is imperative that the organisation implement the same. Where the phrase can/could/preferable is used the organisation would use its discretion and implement it according to the practicability of the proposed guidance.

In general, the organisation will need to establish clear evidence backed by robust systems and data collection to prove that they are complying with the intent of the standards. These systems are as we say, defined, implemented, owned by the staff and finally provide objective evidence of compliance. Some of the key issues are as follows;

1. Patient related: monitoring safety, treatment standards and quality of care. This would mean to effectively meet the expectation of patients and their families and associates.
2. Employee related: monitoring competence, on-going training, awareness of patient requirements and monitoring employee satisfaction.
3. Regulatory related: identifying, complying with and monitoring the effective implementation of legal, statutory and regulatory requirements which affect patient safety.
4. Organisation policies related: defining, promoting awareness of and ensuring implementation of, the policies and procedures laid down by the organisation, amongst staffs, patients and interested parties including visiting medical consultants.
5. NABH Standards related: identification of how the organization meets the NABH standards and the objective elements. Where a part of an element, an element or a standard cannot be applied (for example, related to emergency, surgical procedures, laboratory services, radiological services, etc) in a particular organization, adequate explanation and justification must be provided to NABH and its team of assessors to enable exclusion of applicability. In particular, it must be ensured that the intent of each chapter of standards is understood and applied.

The 2nd edition of Ayurveda hospital accreditation standard is divided into 10 chapters, which have been further divided into 98 standards (as compared to 94 in first edition). Put together there are 590 objective elements (as compared to 492 in first edition) incorporated within these standards. The increase in objective elements is to put increased emphasis on patient safety and also to encourage healthcare organizations to pursue continuous quality improvements. Objective elements are required to be complied with in order to meet the

requirement of a particular Standard. Similarly, standards are required to be complied with, in order to meet the requirement of a particular Chapter. Finally, compliance with all chapters is equally important to establish compliance with the Accreditation Standard.

The Standards shall facilitate health care organizations to deliver safe high quality care.

In the beginning of each chapter, intent is given to highlight the summary of the chapter. The intent statement provides a brief explanation of a chapter's rationale, meaning, and significance. Intent statements may contain detailed expectations of the chapter that are evaluated in the on-site assessment process. For most of the objective elements, interpretation is provided in a separate book just to further elaborate on how that objective element can be met.

We are thankful to chairman & members of Technical Committee who have put great efforts to accomplish this task. These standards are equally applicable to government and private hospitals, and are applicable to whole organisation. Standards are dynamic and would be under constant review process. Comments and suggestions for improvement are appreciated. We seek your support in keeping these standards adequate to the need of the industry.

Dr. K.K. Kalra

CEO NABH

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Chapter 1

Access Assessment and Continuity of Care (AAC)

Intent of the chapter:

Patients are well informed of the services that an organization can and cannot provide. This will facilitate in appropriately matching patients with the organization's resources. Only those patients who can be cared for by the organization are admitted to the organization. Out-patients who do not match the organization's resources are similarly referred to organizations that have the matching resources.

Patients that match the organizations resources are admitted using a defined process that includes patient and family education.

Patients cared for by the organization undergo an established initial assessment and periodic and regular reassessments.

Assessments may include laboratory and imaging services. The laboratory and imaging services are provided by competent staff in a safe environment for both patients and staff.

These assessments result in formulation of a definite care plan.

Patient care is multidisciplinary in nature and encourages continuity of care through well defined transfer and discharge protocols. These protocols include transfer of adequate information with the patient.

Summary of Standards

AAC.1.	The organisation defines and displays the services that it provides.
AAC.2.	The organisation has a well-defined registration and admission process.
AAC.3.	There is an appropriate mechanism for transfer or referral of patients who do not match the organizational resources.
AAC.4.	Patients cared for by the organisation undergo an established initial assessment.
AAC.5.	All patients cared for by the organisation undergo a regular reassessment.
AAC.6.	Laboratory services, if applicable are provided as per the scope of services of the organisation.
AAC.7.	There is an established laboratory quality assurance programme.
AAC.8.	There is an established laboratory-safety programme.
AAC.9.	Imaging services, if applicable are provided as per the scope of services of the organization.
AAC.10.	There is an established quality assurance programme for imaging services.
AAC.11.	There is an established radiation safety programme.
AAC.12.	Patient care is continuous and multidisciplinary in nature.
AAC.13.	The organization has a documented discharge process.
AAC.14.	Organization defines the content of the discharge summary.

Standards and Objective Elements

Standard

AAC.1.	The organisation defines and displays the services that it provides.
---------------	---

Objective Elements

- a. The services being provided are clearly defined and are in consonance with the needs of the community.
- b. The defined services are prominently displayed.
- c. The staff is oriented to these services.

Standard

AAC.2.	The organisation has a well-defined registration and admission process.
---------------	--

Objective Elements

- a. Documented policies and procedures are used for registering and admitting patients.
- b. The Documented policies and 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. The staff is aware of these processes.
- g. Maintenance of separate daily record of bed occupancy with monthly conclusion of occupancy.

Standard

AAC.3.	There is an appropriate mechanism for transfer or referral of patients who do not match the organizational resources.
---------------	--

Objective Elements

- Documented policies and procedures guide the transfer of patients to another facility in an appropriate manner.
- Documented policies and procedures guide the transfer of stable/unstable patients to another facility in an appropriate manner.
- Procedures identify staff responsible during transfer/referral.
- The organisation gives a summary of patient's condition and the treatment given.

Standard

AAC.4.	Patients cared for by the organisation undergo an established initial assessment.
---------------	--

Objective Elements

- The organisation defines and documents the content of the initial assessment for the out-patients, in-patients and emergency patients.
- The organisation determines who can perform the initial assessment.
- The organisation defines the time frame within which the initial assessment is completed based on patient needs.
- The initial assessment for in-patients is documented within 24 hours or earlier as per the patient's condition or hospital policy. Initial assessment includes identification of medication that the in-patient is using of the relevant AYUSH system, of any other AYUSH system and of modern medicine.
- Initial assessment includes screening for nutritional needs.
- Care plan has to be documented and is monitored after the initial assessment.

- g. The care plan also includes preventive aspects of the care where appropriate.
- h. The care plan is countersigned by the doctor in-charge of the patient within 24 hours.
- i. The care plan includes desired results of the treatment, care or service.

Standard

AAC.5.	All patients cared for by the organisation undergo a regular reassessment.
---------------	---

Objective Elements

- a. All 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.

Standard

AAC.6.	Laboratory services, if applicable are provided as per the scope of services of the organisation.
---------------	--

Objective Elements

- a. Scope of the laboratory services are commensurate to the services provided by the organization.
- b. Adequately qualified and trained personnel perform and/or supervise the investigations.
- c. Documented policies and procedures guide collection, identification, handling, safe transportation, processing and disposal of specimens.

- d. Laboratory results are available within a defined time frame.
- e. Critical results are intimated immediately to the personnel concerned.
- f. Results are reported in a standardised manner.
- g. Laboratory tests not available in the organisation are outsourced to organisation(s) based on their quality assurance system.

Standard

AAC.7.	There is an established laboratory quality assurance programme.
---------------	--

Objective Elements

- 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.

Standard

AAC.8.	There is an established laboratory-safety programme.
---------------	---

Objective Elements

- 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.

Standard

AAC.9.	Imaging services, if applicable are provided as per the scope of services of the organization.
---------------	---

Objective Elements

- 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 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 guide identification and safe transportation of patients to imaging services.
- f. Imaging results are available within a defined time frame.
- g. Critical results are intimated immediately to the personnel concerned.
- h. Results are reported in a standardized manner.
- i. Imaging tests not available in the organization are outsourced to organization(s) based on their quality assurance system.

Standard

AAC.10.	There is an established quality assurance programme for imaging services.
----------------	--

Objective Elements

- a. The quality assurance programme for imaging services is documented.
- b. The programme addresses verification and/or validation of imaging methods.

- c. The programme addresses surveillance of imaging results.
- d. The programme includes periodic calibration and maintenance of all equipment.
- e. The programme includes the documentation of corrective and preventive actions.

Standard

AAC.11.	There is an established radiation safety programme.
----------------	--

Objective Elements

- a. The radiation-safety programme is documented.
- b. This programme is integrated with the organization's safety programme.
- c. Handling, usage and disposal of radio-active and hazardous materials are as per statutory requirements.
- d. Imaging personnel are provided with appropriate radiation safety devices.
- e. Radiation-safety devices are periodically tested and results documented.
- f. Imaging personnel are trained in radiation-safety measures.
- g. Imaging signage are prominently displayed in all appropriate locations.

Standard

AAC.12.	Patient care is continuous and multidisciplinary in nature.
----------------	--

Objective Elements

- a. During all phases of care, there is a qualified individual designated as responsible for the patient's care.
- b. Care of patients is coordinated in all care settings within the organization.
- 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. The patient's record(s) is available to the authorized care-providers to facilitate the exchange of information.
 - f. Documented policies and procedures guide the referral of patients to other departments/ specialties.

Standard

AAC.13.	The organization has a documented discharge process.
----------------	---

Objective Elements

- a. The patient's discharge process is planned in consultation with the patient and/or family.
- b. Documented policies and 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 (LAMA) and patients being discharged on request.
- d. A discharge summary is given to all the patients leaving the organization (including patients leaving against medical advice and on request).

Standard

AAC.14.	Organization defines the content of the discharge summary.
----------------	---

Objective Elements

- 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)

Intent of the standards

The organization provides uniform care of patients in different settings. The different settings include care provided in outpatient units, various categories of wards, procedure rooms and operation theatre. When similar care is provided in these different settings, care delivery is uniform. Policies, procedures, applicable laws and regulations guide emergency and ambulance services, cardio-pulmonary resuscitation.

Policies, procedures, applicable laws and regulations also guide care of vulnerable patients (elderly, physically and/or mentally challenged and children), obstetrical patients, pediatric patients, patients undergoing parasurgical procedures, patients undergoing Panchakarma Therapy, patients under restraints and research activities.

Pain management , Poshna karma and rehabilitative services are also addressed with a view to provide comprehensive health care.

The standards aim to guide and encourage patient safety as the overall principle for providing care to patients.

Summary of Standards

COP.1.	Uniform care of patients is provided in all settings of the organization and is guided by the applicable laws, regulations and guidelines.
COP.2.	Emergency services are guided by policies, procedures and applicable laws and regulations.
COP.3.	The ambulance services are commensurate with the scope of the services provided by the organization.
COP.4.	Documented policies and procedures guide the care of vulnerable patients (elderly, physically and/or mentally challenged and children).
COP.5.	Documented policies and procedures guide obstetric (Ante Natal & Post Natal) care.
COP.6.	Documented policies and procedures guide obstetric (Normal Labour and Caesarean Section) care
COP.7.	Documented policies and procedures guide Neonatal care.
COP.8.	Documented policies and procedures guide the care of Pediatric patients.
COP.9.	Documented policies and procedures guide the care of patients undergoing surgical, parasurgical, panchakarma and other treatment procedures
COP.10.	Documented policies and procedures guide the care of patients undergoing moderate sedation.
COP.11.	Documented policies and procedures guide the administration of anaesthesia.
COP.12.	Documented policies and procedures define rational use of blood and blood products.
COP.13.	Documented policies and procedures guide the care of patients in the intensive care and high dependency units.
COP.14.	Documented policies and procedures guide the care of patients under restraints.
COP.15.	Documented policies and procedures guide appropriate pain management.

COP.16.	Documented policies and procedures guide appropriate rehabilitative services.
COP.17.	Documented policies and procedures guide all research activities.
COP.18.	Documented policies and procedures guide Therapeutic diet.

Standards and Objective Elements

Standard

COP.1.	Uniform care of patients is provided in all settings of the organization and is guided by the applicable laws, regulations and guidelines.
---------------	---

Objective Elements

- a. Care delivery is uniform when similar care is provided in more than one setting.
- b. Uniform care reflects applicable laws, regulations and guidelines.
- c. Standard guidelines are adopted to guide uniform patient care whenever possible.

Standard

COP.2.	Emergency services are guided by policies, procedures and applicable laws and regulations.
---------------	---

Objective Elements

- a. Policies and procedure for emergency care are documented
- b. Policies also address handling of medico-legal cases.
- c. The patients receive care in consonance with the policies.
- d. Documented policies and procedures guide the triage of patients for initiation of appropriate care.
- e. Staff is familiar with the policies and trained on the procedures for care of emergency patients.
- f. Admission or discharge to home or transfer to another organization is also documented.
- g. In case of discharge to home or transfer to another organization a discharge note shall be given to the patient.

Standard

COP.3.	The ambulance services inhouse or outsourced are commensurate with the scope of the services provided by the organization.
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Objective Elements

- a. There is adequate access and space for the ambulance(s).
- b. The ambulance adheres to statutory requirements.
- c. Ambulance(s) is appropriately equipped.
- d. Ambulance(s) is manned by trained personnel.
- e. Ambulance is checked on a daily basis.
- f. Equipment are checked on a daily basis.
- g. Emergency medications are checked daily and prior to dispatch.
- h. The ambulance(s) has a proper communication system.

Standard

COP.4.	Documented policies and procedures guide the care of vulnerable patients (elderly, physically and/or mentally challenged and children).
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Objective Elements

- a. Policies and procedures are documented and are in accordance with the prevailing laws and the national and international guidelines.
- b. Care is organized and delivered in accordance with the policies and procedures.
- c. The organisation provides for a safe and secure environment for this vulnerable group.
- d. A documented procedure exists for obtaining informed consent from the appropriate legal representative.

- e. Staff is trained to care for this vulnerable group.

Standard

COP.5.	Documented policies and procedures guide obstetric (Antenatal and Post Natal) Care.
---------------	--

Objective Elements

- a. There is a documented policy and procedure for Obstetric services.
- b. The organization defines and displays whether Obstetric cases can be cared or not.
- c. Documented procedures guide provision of Ante-natal services.
- d. Obstetric patient's assessment also includes maternal nutrition.
- e. Appropriate Ante-natal and Post-natal monitoring is performed and documented.

Standard

COP.6.	Documented policies and procedures guide obstetric (Normal Labour and Caesarean Section) care.
---------------	---

Objective Elements

- a. There is a documented policy and procedure for obstetric (Normal Labour and Caesarean Section) services.
- b. Persons caring for high-risk obstetric cases are competent.
- c. Appropriate peri-natal monitoring is performed and documented.
- d. The organisation caring for high-risk obstetric cases has the facilities to take care of neonates of such cases.

Standard

COP.7.	Documented policies and procedures guide Neonatal care.
---------------	--

Objective Elements

- There is a documented policy and procedure for Neonatal services.
- The policy for care of neonatal patients is in consonance with the national/ international guidelines.
- Those who care for children have age specific competency.
- Provisions as permitted by state law are made for special care of neonates.
- Patient assessment includes detailed nutritional, growth, and immunization assessment.
- Documented policies and procedures prevent neonate abduction and abuse.
- The children's family members are educated about nutrition, immunization and safe parenting and this is documented in the medical record.

Standard

COP.8.	Documented policies and procedures guide the care of Pediatric patients.
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Objective Elements

- There is a documented policy and procedure for Paediatric services.
- The organization defines and displays the scope of its pediatric services.
- Provisions are made for special care of children.
- Patient assessment includes detailed nutritional, growth and psychosocial assessment.
- Documented policies and procedures prevent child abduction and abuse.

- f. The family members of the child are educated about nutrition, immunization and safe parenting and this is documented in the medical record.

Standard

COP.9.	Policies and procedures guide the care of patients undergoing Surgical, parasurgical, panchakarma and other treatment procedures
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Objective Elements

- a. The policies and procedures are documented.
- b. An informed consent is obtained by a Physician/Surgeon prior to the procedure.
- c. Patients shall have a preoperative (parasurgical), preprocedure (panchakarma) assessment and a provisional diagnosis documented prior to surgery/procedures
- d. Documented policies and procedures exist to prevent adverse events like wrong site, wrong patient and wrong surgery/procedures.
- e. Persons qualified by law are permitted to perform the procedures that they are entitled to perform.
- f. A brief operative note / note regarding the procedure is documented prior to transfer of patient from recovery area.
- g. The operating surgeon/physician document the post-operative/post-procedure care plan.
- h. Adequate area, appropriate facilities and equipment/instruments are available in the OT / Panchakarma therapy and Treatment procedure room
- i. Patient, personnel and material flow conforms to infection control practices.
- j. Guidelines for various Parasurgical procedures / Panchakarma therapy and other Treatment procedures are prepared separately and adhered.
- k. Standard precautions and asepsis is adhered to during the conduct of therapies.
- l. A quality assurance program is followed for the Parasurgical / panchakarma therapy and other treatment services.

- m. The quality assurance program includes surveillance of the OT / panchakarma or treatment procedure room.

Standard

COP.10.	Documented policies and procedures guide the care of patients undergoing moderate sedation.
----------------	--

Objective Elements

- 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 recovery area.
- h. Equipment and manpower are available to rescue patients from a deeper level of sedation than that intended.

Standard

COP.11.	Documented policies and procedures guide the administration of anaesthesia.
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Objective Elements

- a. There is a documented policy and procedure for the administration of anaesthesia.
- b. All 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 pre-operative 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. All adverse anaesthesia events are recorded and monitored.

Standard

COP.12.	Documented policies and procedures define rational use of blood and blood products.
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Objective Elements

- a. Documented policies and procedures are used to guide rational use of blood and blood products.
- b. Documented procedures govern transfusion of blood and blood products.
- 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 products.

- e. Informed consent also includes patient and family education about donation.
- f. The organisation defines the process for availability and transfusion of blood / blood components for use in emergency.
- 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.

Standard

COP.13.	Documented policies and procedures guide the care of patients in the intensive care and high dependency units.
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Objective Elements

- 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 is trained to apply these criteria.
- d. Adequate staff and equipment are available.
- e. Defined procedures for situation of bed shortages are followed.
- f. Infection control practices are documented and followed.
- g. A quality-assurance programme is documented and implemented.

Standard

COP.14.	Documented policies and procedures guide the care of patients under restraints.
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Objective Elements

- a. Documented policies and procedures guide the care of patients under restraints.

- b. These include physical restraint measures.
- c. These include documentation of reasons for restraints.
- d. These patients are more frequently monitored.
- e. Staff receives training and periodic updating in control and restraint techniques.

Standard

COP.15.	Documented policies and procedures guide appropriate pain management.
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Objective Elements

- a. Documented policies and procedures guide the management of pain.
- b. Patients with pain undergo detailed assessment and periodic re-assessment.
- c. The organization respects and supports the management of pain for all patients.
- d. Patient and family are educated on various pain management techniques, where appropriate.

Standard

COP.16.	Documented policies and procedures guide appropriate rehabilitative services.
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Objective Elements

- a. Documented policies and procedures guide the provision of rehabilitative services.
- b. The scope of rehabilitative services are commensurate with the organization's requirements.
- c. Care is guided by functional assessment and periodic re-assessment which is done and documented by qualified individual(s).
- d. Rehabilitative services are provided by a multidisciplinary team.
- e. There is adequate space and equipment to perform these activities.

Standard

COP.17.	Documented policies and procedures guide all research activities.
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Objective Elements

- a. Documented policies and procedures guide all research activities in compliance with national and international guidelines.
- b. The organization has an ethics committee to oversee all research activities.
- c. The committee has the powers to discontinue a research trial when risks outweigh the potential benefits.
- d. Patient's informed consent is obtained before entering them in research protocols.
- e. Patients are informed of their right to withdraw from the research at any stage and also of the consequences (if any) of such withdrawal.
- f. Patients are assured that their refusal to participate or withdrawal from participation will not compromise their access to the organization's services.

Standard

COP.18.	Documented policies and procedures guide Therapeutic diet (Poshana Karma)
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Objective Elements

- a. Documented policies and procedures guide implementation of therapeutic diet (poshana karma) after assessment and reassessment of patient needs.
- b. Patients receive food according to their clinical needs.
- c. There is a written order for the pathyahara.
- d. When families provide food, they are educated about the patient's pathya and apathya.
- e. Food is prepared, handled, stored and distributed in a safe manner.

Chapter 3

Management of Medication (MOM)

Intent of the standards

The organization has a safe and organized medication process. The process includes documented policies and procedures that guide the availability, safe storage, prescription, dispensing and administration of medications.

The standards encourage integration of the pharmacy into everyday functioning of hospitals and patient care. The pharmacy should have oversight of all medications stocked out of the pharmacy. The pharmacy should ensure correct storage (as regards to temperature, look-alike, sound-alike etc), expiry dates and maintenance of documentation.

Every high alert medication order should be verified by an appropriate person so as to ensure accuracy of the dose, frequency and route of administration.

The process also includes monitoring of patients after administration and procedures for reporting and analyzing medication errors & adverse drug events.

Policies and procedures guiding the use of formulations containing toxic/narcotic drugs.

Safe use of high alert medication is guided by documented policies and procedures. Patients and family members are educated about safe medication. Policies and procedures guide the use of medical supplies and consumables.

Summary of Standards

MOM.1.	Documented policies and procedures guide the organization of pharmacy services and usage of medication.
MOM.2.	There is a hospital formulary.
MOM.3.	Documented policies and procedures exist for storage of medication.
MOM.4.	Documented policies and procedures exist for prescription of medications.
MOM.5.	Documented policies and procedures guide the safe dispensing of medications.
MOM.6.	There are defined procedures for medication management.
MOM.7.	Patients are monitored after medication administration.
MOM.8.	Near misses, medication errors and adverse drug events are reported and analysed.
MOM.9.	Documented policies and procedures guide the use of medical supplies and consumables.
MOM.10.	Documented policies and procedures guide the use of formulations containing toxic/narcotic drugs.

Standards and Objective Elements

Standard

MOM.1.	Documented policies and procedures guide the organization of pharmacy services and usage of medication.
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Objective Elements

- a. There is a documented policy and procedure for pharmacy services and medication usage.
- b. These comply with the applicable laws and regulations.
- c. A multidisciplinary committee guides the formation and implementation of these policies and procedures.
- d. There is a procedure to obtain medication when the pharmacy is closed.

Standard

MOM.2.	There exists a hospital formulary.
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Objective Elements

- a. A list of medication appropriate for the patients and organization's resources is developed.
- b. The list is developed collaboratively by the multidisciplinary committee.
- 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 defined process for preparation of these medications.
- f. There is a process to obtain medications not listed in the formulary.

Standard

MOM.3.	Documented policies and procedures exist for storage of medication.
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Objective Elements

- 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.
- d. Sound alike and look alike medications are identified and stored separately.

Standard

MOM.4.	Documented policies and procedures exist for prescription of medications.
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Objective Elements

- a. Documented policies and procedures exist for prescription of medications.
- b. The organisation determines the minimum requirements of a prescription.
- c. The organization determines who can write orders.
- d. Orders are written in a uniform location in the medical records.
- e. Medication orders are clear, legible, dated, timed, named and signed.
- f. Medication orders contain the name of the medicine, route of administration, dose to be administered and frequency/time of administration.
- g. Policy on verbal orders is documented and implemented.
- h. The organization defines a list of high alert medication.
- i. High Alert medication orders are verified prior to dispensing.

Standard

MOM.5.	Documented policies and procedures guide the safe dispensing of medications.
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Objective Elements

- a. Documented policies and procedures guide the safe dispensing of medications.
- b. The policies include a procedure for medication recall.
- c. Expiry dates are checked prior to dispensing, wherever applicable.
- d. Labeling requirements are documented and implemented by the organization.

Standard

MOM.6.	There are documented policies and procedures for medication management.
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Objective Elements

- a. Medications are administered by those who are permitted to do so.
- b. Prepared medication is labeled prior to preparation of a second drug.
- c. Patient is identified prior to administration.
- d. Medication is verified from the order 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. Policies and procedures govern patient's self administration of medications.
- j. Documented policies and procedures govern patient's medications brought from outside the organization.

Standard

MOM.7.	Patients are monitored after medication administration.
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Objective Elements

- 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.

Standard

MOM.8.	Near misses, medication errors and adverse drug events are reported and analysed.
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Objective Elements

- 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.

Standard

MOM.9.	Documented policies and procedures guide the use of medical supplies and consumables.
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Objective Elements

- 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.

Standard

MOM.10.	Documented policies and procedures guide the use of formulations containing toxic/narcotic drugs.
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Objective Elements

- a. Documented procedures guide the use of formulations containing toxic/narcotic drugs.
- b. These procedures are in consonance with local and national regulations.
- c. These drugs are stored in a secure manner.
- d. A proper record is kept of the usage, administration and disposal of these drugs.
- e. These drugs are handled by appropriate personnel in accordance with the documented procedure.

Chapter 4

Patient Rights and Education (PRE)

Intent of the standards

The organization defines the patient and family rights and responsibilities. The staff is aware of these and is trained to protect patient rights. Patients are informed of their rights and educated about their responsibilities at the time of admission. The patients are educated about the mechanisms available for addressing grievances.

Patients and family members are educated about pathya & apathya ahara.

A documented process for obtaining patient and/or families consent exists for informed decision making about their care as per prevailing law.

Patient and families have a right to information and education about their healthcare needs in a language and manner that is understood by them.

Summary of Standards

PRE.1.	The organization protects patient and family rights and informs them about their responsibilities during care.
PRE.2.	Patient and family rights support individual beliefs, values and involve the patient and family in decision making processes.
PRE.3.	The patient and/or family members are educated to make informed decisions and are involved in the care planning and delivery process.
PRE.4.	A documented process for obtaining patient and/or family's consent exists for informed decision making about their care.
PRE.5.	Patient and families have a right to information and education about their healthcare needs.
PRE.6.	Patient and families have a right to information on expected costs.
PRE.7.	Organisation has a complaint redressal procedure.

Standards and Objective Elements

Standard

PRE.1.	The organization protects patient and family rights informs them about their responsibilities during care
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Objective Elements

- 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 organization's leaders protect patient's and family rights.
- d. Staff is aware of their responsibility in protecting patients and family rights.
- e. Violation of patient and family rights is recorded, reviewed and corrective/preventive measures taken.

Standard

PRE.2.	Patient and family rights support individual beliefs, values and involve the patient and family in decision making processes.
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Objective Elements

- a. Patient and family rights address 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 physical abuse or neglect.
- d. Patient and family rights include treating patient information as confidential.
- e. Patient and family rights include refusal of treatment.
- f. Patient and family rights include informed consent before panchakarma therapy,

prasuti tantra and streeroga procedures, shalakya procedures, anesthesia, parasurgical procedure, and surgery, initiation of any research protocol and any invasive/high risk procedures/treatment.

- g. Patient and family rights include information on how to voice a complaint.
- h. Patient and family rights include information on the expected cost of the treatment.
- i. Patient and family have a right to have an access to his/her clinical records.
- j. Patient and family rights include information on care plan, progress and information on their health care needs.

Standard

PRE.3.	The patient and/or family members are educated to make informed decisions and are involved in the care planning and delivery process
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Objective Elements

- 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.

Standard

PRE.4.	A documented procedure for obtaining patient and/ or family's consent exists for informed decision making about their care.
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Objective Elements

- a. General consent for treatment is obtained when the patient enters the organisation.
- b. Patient and/or his family members are informed of the scope of such general consent.
- c. Documented procedure incorporates the list of situations where informed consent is required and the process for taking informed consent.
- d. Informed consent includes information regarding the procedure, risks, benefits, alternatives and as to who will perform the requisite procedure in a language that they can understand.
- 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.

Standard

PRE.5.	Patient and families have a right to information and education about their Healthcare needs.
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Objective Elements

- a. When appropriate, patient and/or family are educated about the safe and effective use of medication and the potential side effects of the medication.
- b. Patient and/or family are educated about food-medicine interactions.
- c. Patient and/or family are educated about pathyahara and poshana

- d. Patient and/or family are educated about their specific disease process, complications and prevention strategies.
- e. Patient and/or family are educated about preventing infections.
- f. Patient and/or family are educated in a language and format that they can understand.

Standard

PRE.6.	Patient and families have a right to information on expected costs.
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Objective elements

- a. There is uniform pricing policy in a given setting (out-patient and inpatient category).
- b. The tariff list is available to patients.
- c. Patients and family are educated about the estimated costs of treatment.
- d. Patients and family are informed about the financial implications when there is a change in the patient condition or treatment setting.

Standard

PRE.7.	Organisation has a complaint redressal procedure.
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Objective elements

- a. The organisation has a documented complaint redressal procedure.
- b. Patient and/or family members are made aware of the procedure for lodging complaints.
- c. All complaints are analysed.
- d. Corrective and/or preventive action(s) are taken based on the analysis where appropriate.

Chapter 5

Hospital Infection Control (HIC)

Intent of the standards

The standards guide the provision of an effective infection control program in the organization. The program is documented and aims at reducing/eliminating infection risks to patients, visitors and providers of care.

The organization measures and takes action to prevent or reduce the risk of Hospital Associated Infection (HAI) in patients and employees.

The organization provides proper facilities and adequate resources to support the Infection Control Program.

The program includes an action plan to control outbreaks of infection, disinfection/sterilization activities, Bio-medical Waste (BMW) management, training of staff and employee health.

Summary of Standards

HIC.1.	The organization has a well-designed, comprehensive and coordinated Hospital Infection Prevention & Control (HIC) programme aimed at reducing/ eliminating risks to patients, visitors and providers of care.
HIC.2.	The organization implements the policies and procedures laid down in the Infection Control Manual.
HIC.3.	The organization performs surveillance activities to capture and monitor infection prevention and control data.
HIC.4.	The organization takes actions to prevent or reduce the risk of Hospital Associated Infections (HAI) in patients and employees.
HIC.5.	The organization provides adequate and appropriate resources for prevention and control of Healthcare Associated Infections (HAI).
HIC.6.	Biomedical waste (BMW) is handled in an appropriate and safe manner.
HIC.7.	The infection control programme is supported by the organization's management and includes training of staff.
HIC.8.	There are documented policies and procedures for sterilization activities in the organization.

Standards and Objective Elements

Standard

HIC.1.	The organization has a well-designed, comprehensive and coordinated Hospital Infection Prevention & Control (HIC) programme aimed at reducing/ eliminating risks to patients, visitors and providers of care
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Objective Elements

- The hospital infection prevention and control programme is documented which aims at preventing and reducing risk of healthcare associated infections.
- The infection prevention and control programme is a continuous process and updated at least once in a year.
- The hospital has a multi-disciplinary infection control committee which coordinates all infection prevention and control activities
- The hospital has an infection control team, which coordinates implementation of all infection prevention and control activities.
- The hospital has designated infection control officer as part of the infection control team.

Standard

HIC.2.	The organization implements the policies and procedures laid down in the Infection Control Manual.
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Objective Elements

- The organization identifies the various high-risk areas and procedures and implements policies and/or procedures to prevent infection in these areas.
- The organization adheres to standard precautions at all times.
- The organization adheres to hand-hygiene guidelines.
- The organization adheres to cleaning, disinfection and sterilization practices.

- e. An appropriate antibiotic policy for organisations providing integrated services with allopathy is established and implemented.
- f. Laundry and linen management processes are also included
- g. Kitchen sanitation and food handling issues are included in the manual.
- h. Engineering controls to prevent infections are included.
- i. The organisation adheres to housekeeping procedures.
- j. Mortuary practices and procedures are included as appropriate to the organization.

Standard

HIC.3.	The organization performs surveillance activities to capture and monitor infection prevention and control data.
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Objective Elements

- a. Surveillance activities are appropriately directed towards the identified high-risk areas and procedures.
- b. Collection of surveillance data is an ongoing process.
- c. Verification of data is done on regular basis by the infection control team.
- d. Scope of surveillance activities incorporates tracking and analyzing of infection risks, rates and trends.
- e. Surveillance activities include monitoring the effectiveness of housekeeping services.
- f. Surveillance activities include monitoring the compliance with hand-hygiene guidelines.
- g. Appropriate feedback regarding HAI rates are provided on a regular basis to appropriate personnel.
- h. In cases of notifiable diseases, information (in relevant format) is sent to appropriate authorities.

Standard

HIC.4.	The organization takes actions to prevent or reduce the risk of Hospital Associated Infections (HAI) in patients and employees.
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Objective Elements

- a. The organization takes action to prevent urinary tract infections.
- b. The organization takes action to prevent respiratory tract infections.
- c. The organization takes action to prevent Parasurgical site infections and other HAI.
- d. The organization takes action to prevent skin infections.
- e. The organization takes action to prevent surgical site infections and other HAI.
- f. Appropriate pre- and post-exposure prophylaxis is provided to all staff members concerned.

Standard

HIC.5.	The organization provides adequate and appropriate resources for prevention and control of Healthcare Associated Infections (HAI).
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Objective Elements

- 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.

Standard

HIC.6.	Biomedical waste (BMW) is handled in an appropriate and safe manner.
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Objective Elements

- The organization adheres to statutory provisions with regard to biomedical waste.
- Proper segregation and collection of biomedical waste from all patient-care areas of the hospital is implemented and monitored.
- The organization ensures that biomedical waste is stored and transported to the site of treatment and disposal in proper covered vehicles within stipulated time limits in a secure manner.
- Biomedical waste treatment facility is managed as per statutory provisions (if in-house) or outsourced to authorized contractor(s).
- Appropriate personal protective measures are used by all categories of staff handling biomedical waste.

Standard

HIC.7.	The infection control programme is supported by the organization's management and includes training of staff.
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Objective Elements

- Hospital management makes available resources required for the infection control programme.
- The hospital earmarks adequate funds from its annual budget in this regard.
- The organisation conducts induction training for all staff.
- The organisation conducts appropriate "in-service" training sessions for all staff at least once in a year.

Standard

HIC.8.	There are documented policies and procedures for sterilization activities in the organization.
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Objective Elements

- a. There is adequate space available for sterilization activities
- b. Documented procedure guides the cleaning, packing, disinfection and/or sterilisation, storing and issue of items.
- c. Regular validation tests for sterilisation are carried out and documented.
- d. There is an established recall procedure when breakdown in the sterilisation system is identified.

Chapter 6

Continuous Quality Improvement (CQI)

Intent of the standards

The standards encourage an environment of continuous quality improvement. The quality program should be documented and involve all areas of the organization and all staff members. The organization should collect data on structures, processes and outcomes, especially in areas of high risk situations. The collected data should be collated, analyzed and used for further improvements. The improvements should be sustained. Infection control and patient safety plans should also be integrated into the organization's quality plan.

The organization should define its sentinel events and intensively investigate when such events occur.

The quality programme should be supported by the management.

Summary of Standards

CQI.1.	There is a structured quality improvement and continuous monitoring programme in the organization.
CQI.2.	There is a structured patient-safety programme in the organisation.
CQI.3.	The organization identifies key indicators to monitor the clinical structures, processes and outcomes which are used as tools for continual improvement.
CQI.4.	The organization identifies key indicators to monitor the managerial structures, processes and outcomes which are used as tools for continual improvement.
CQI.5.	The quality improvement programme is supported by the management.
CQI.6.	There is an established system for clinical audit.
CQI.7.	Incidents, complaints and feedback are collected and analysed to ensure continual quality improvement.
CQI.8.	Sentinel events are intensively analyzed.

Standards and Objective Elements

Standard

CQI.1.	There is a structured quality improvement and continuous monitoring programme in the organization.
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Objective Elements

- a. The quality improvement programme is developed, implemented and maintained by a multi-disciplinary committee.
- b. The quality improvement programme is documented.
- c. There is a designated individual for coordinating and implementing the quality improvement programme.
- d. The quality improvement programme is comprehensive and covers all the major elements related to quality improvement and risk management.
- e. The designated programme is communicated and coordinated amongst all the employees of the organization through proper training mechanism.
- f. The quality improvement programme is reviewed at predefined intervals and opportunities for improvement are identified.
- 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.

Standard

CQI.2.	There is a structured patient-safety programme in the organisation.
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Objective Elements

- 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 organization 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 organization adopts and implements national/international patient-safety goals/solutions.
- j. The organization uses at least two identifiers to identify patients across the organization.

Standard

CQI.3.	The organization identifies key indicators to monitor the clinical structures, processes and outcomes which are used as tools for continual improvement.
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Objective Elements

- a. Monitoring includes appropriate patient assessment.
- b. Monitoring includes safety and quality control programmes of the diagnostics services.
- c. Monitoring includes medication management.
- d. Monitoring includes availability and content of medical records.
- e. Monitoring includes infection control activities.

- f. Monitoring includes Parasurgical services.
- g. Monitoring includes Panchakarma therapies and Treatment procedures
- h. Monitoring includes clinical research.
- i. Monitoring includes data collection to support further improvements.
- j. Monitoring includes data collection to support evaluation of these improvements.
- k. Monitoring includes use of anaesthesia.
- l. Monitoring includes surgical services.
- m. Monitoring includes use of blood and blood products.

Standard

CQI.4.	The organization identifies key indicators to monitor the managerial structures, processes and outcomes which are used as tools for continual improvement.
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Objective Elements

- a. Monitoring includes procurement of medication essential to meet patient needs.
- b. Monitoring includes reporting of activities as required by laws and regulations.
- c. Monitoring includes risk management.
- d. Monitoring includes utilization of space, manpower and equipment.
- e. Monitoring includes patient satisfaction which also incorporates waiting time for services.
- f. Monitoring includes employee satisfaction.
- g. Monitoring includes adverse events and near misses.
- h. Monitoring includes availability and content of medical records.
- i. Monitoring includes data collection to support further improvements.

- j. Monitoring includes data collection to support evaluation of these improvements.

Standard

CQI.5.	The quality improvement programme is supported by the management.
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Objective Elements

- a. Hospital Management makes available adequate resources required for quality improvement programme.
- b. Hospital earmarks adequate funds from its annual budget in this regard.
- c. The management identifies organizational performance improvement targets.
- d. Appropriate statistical and management tools are applied whenever required

Standard

CQI.6.	There is an established system for clinical audit.
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Objective Elements

- a. Medical and nursing staff participates in this system.
- b. The parameters to be audited are defined by the organization.
- c. Patient and staff anonymity is maintained.
- d. All audits are documented.
- e. Remedial measures are implemented.

Standard

CQI.7.	Incidents, complaints and feedback are collected and analysed to ensure continual quality improvement.
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Objective Elements

- a. The organization has an incident reporting system.
- b. The organization has a process to collect feedback and receive complaints.
- c. The organization has established processes for analysis of incidents, feedbacks and complaints.
- d. Corrective and preventive actions are taken based on the findings of such analysis.
- e. Feedback about care and service is communicated to staff.

Standard

CQI.8.	Sentinel events are intensively analyzed.
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Objective Elements

- a. The organisation has defined sentinel events.
- b. The organization has established processes for intense analysis of such events.
- c. Sentinel events are intensively analyzed when they occur.
- d. Corrective and Preventive Actions are taken based on the findings of such analysis.

Chapter 7

Responsibilities of Management (ROM)

Intent of the standards

The standards encourage the governance of the organization in a professional and ethical manner. The organization complies with the laid down and applicable legislations and regulations. The responsibilities of the leaders at all levels are defined. The services provided by each department are documented.

Leaders ensure that patient safety and risk management issues are an integral part of patient care and hospital management.

Summary of Standards

ROM.1.	The responsibilities of the management are defined.
ROM.2.	The organization complies with the laid-down and applicable legislations and regulations.
ROM.3.	The services provided by each department are documented.
ROM.4.	The organization is managed by the leaders in an ethical manner.
ROM.5.	The organisation displays professionalism in management of affairs.
ROM.6.	Management ensure that patient safety aspects and risk management issues are an integral part of patient care and hospital management.

Standards and Objective Elements

Standard

ROM.1.	The responsibilities of the management are defined.
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Objective Elements

- a. Those responsible for governance lay down the organization's vision and mission statement.
- b. Those responsible for governance approve the strategic and operational plans and organization's budget.
- c. Those responsible for governance approve the organization's budget and allocate the resources required to meet the organization's mission.
- d. Those responsible for governance monitor and measure the performance of the organization against the stated mission.
- e. Those responsible for governance establish the organization's organogram.
- f. Those responsible for governance appoint the senior leaders in the organization.
- g. Those responsible for governance support safety initiatives and quality-improvement plans.
- h. Those responsible for governance support research activities
- i. Those responsible for governance address the organization's social responsibility.

Standard

ROM.2.	The organisation complies with the laid-down and applicable legislations and regulations.
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Objective Elements

- a. The management is conversant with the laws and regulations and knows their applicability to the organisation.

- b. The management ensures implementation of these requirements.
- c. Management regularly updates any amendments in the prevailing laws of the land.
- d. There is a mechanism to regularly update licenses/registrations/certifications.

Standard

ROM.3.	The services provided by each department are documented.
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Objective Elements

- a. Scope of services of each department is defined.
- b. Administrative policies and procedures for each department are maintained.
- c. Each organizational program, service, site or department has effective leadership.
- d. Departmental leaders are involved in quality improvement.

Standard

ROM.4.	The organization is managed by the leaders in an ethical manner.
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Objective Elements

- a. The leaders make public the mission statement of the organization.
- b. The leaders establish the organization's ethical management.
- c. The organisation's established ethical management shall be documented.
- d. The organization discloses its ownership.
- e. The organization honestly portrays the services which it can and cannot provide.
- f. The organization honestly portrays its affiliations and accreditations.
- g. The organization accurately bills for it's services based upon a standard billing tariff.

Standard

ROM.5.	The organisation displays professionalism in management of affairs.
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Objective elements

- 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 functioning of committees is reviewed for their effectiveness.
- g. The organisation documents employee rights and responsibilities.
- h. The organisation has a formal documented agreement for all outsourced services.
- i. The organisation monitors the quality of the outsourced services.

Standard

ROM.6.	Management ensure that patient safety aspects and risk management issues are an integral part of patient care and hospital management.
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Objective elements

- 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)

Intent of the standards

The standards guide the provision of a safe and secure environment for patients, their families, staff and visitors. To ensure this, the organization complies with the relevant rules and regulations, laws and byelaws and requisite facility inspection requirements. The organization plans for emergencies within the facilities and the community.

The organization plans for eliminating smoking within the facility and safe management of hazardous materials.

The organization provides for safe water, electricity, medical gases and vacuum systems.

The organization has a program for clinical and support service equipment management.

Summary of Standards

FMS.1.	The organisation has a system in place to provide a safe and secure environment.
FMS.2.	The organisation's environment and facilities operate to ensure safety of patients, their families, staff and visitors.
FMS.3.	The organisation has a programme for engineering support services.
FMS.4.	The organisation has a programme for bio-medical equipment management.
FMS.5.	The organisation has a programme for medical gases, vacuum and compressed air if applicable.
FMS.6.	The organisation has plans for fire and non-fire emergencies within the facilities.
FMS.7.	The organisation has a plan for management of hazardous materials.
FMS.8.	The organisation has herbal plantation

Standards and Objective Elements

Standard

FMS.1.	The organisation has a system in place to provide a safe and secure environment.
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Objective Elements

- Safety committee coordinates development, implementation and monitoring of the safety plan and policies.
- Patient-safety devices are installed across the organisation and inspected periodically.
- The organisation is a non-smoking area.
- 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.
- Inspection reports are documented and corrective and preventive measures are undertaken.
- There is a safety education programme for staff.

Standard

FMS.2.	The organisation's environment and facilities operate to ensure safety of patients, their families, staff and visitors
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Objective Elements

- Facilities are appropriate to the scope of services of the organisation.
- Up-to-date drawings are maintained which detail the site layout, floor plans and fire-escape routes.
- There is internal and external sign postings in the organisation in a language understood by the patient, families and community.
- 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. Potable water and electricity are available round the clock.
 - f. Alternate sources for electricity and water are provided as backup for any failure/shortage.
 - g. The organisation regularly tests these alternate sources.
 - h. There are designated individuals responsible for the maintenance of all the facilities.
 - i. There is a documented operational and maintenance (preventive and breakdown) plan.
 - j. Maintenance staff is contactable round the clock for emergency repairs.
 - k. Response times are monitored from reporting to inspection and implementation of corrective actions.

Standard

FMS.3.	The organisation has a programme for engineering support services.
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Objective Elements

- a. The organisation plans for equipment in accordance with its services and strategic plan.
- b. Equipment are selected, 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 equipment and utility systems.
- e. There is a documented operational and maintenance (preventive and breakdown) plan.
- f. There is a maintenance plan for water management.

- g. There is a maintenance plan for electrical systems.
- h. There is a maintenance plan for heating, ventilation and air-conditioning.
- i. There is a documented procedure for equipment replacement and disposal.

Standard

FMS.4.	The organisation has a programme for bio-medical equipment management.
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Objective Elements

- a. The organisation plans for equipment in accordance with its services and strategic plan.
- b. Equipment are selected, updated or upgraded by a collaborative process.
- c. All 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.
- g. There is a documented procedure for equipment replacement and disposal.

Standard

FMS.5.	The organisation has a programme for medical gases, vacuum and compressed air if applicable.
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Objective Elements

- 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 and maintenance plan for piped medical gas, compressed air and vacuum installation.

Standard

FMS.6.	The organisation has plans for fire and non-fire emergencies within the facilities
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Objective Elements

- 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 its role in case of such emergencies.
- d. Mock drills are held at least twice a year.
- e. There is a maintenance plan for fire-related equipment.

Standard

FMS.7.	The organisation has a plan for management of hazardous materials
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Objective Elements

- 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. There is a plan for managing spills of hazardous materials.
- d. Staff is educated and trained for handling such materials.

Standard

FMS.8.	The organisation has herbal plantation
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Objective Elements

- a. The organisation has herbal plantation within the organisation.

Chapter 9

Human Resource Management (HRM)

Intent of the standards

The most important resource of a hospital and health care system is the human resource. Human resources are an asset for effective and efficient functioning of a hospital. Without an equally effective human resource management system, all other inputs like technology, infrastructure and finances come to naught. Human resource management is concerned with the “people” dimension in management.

The goal of human resource management is to acquire, provide, retain and maintain competent people in right numbers to meet the needs of the patients and community served by the organization. This is based on the organization’s mission, objectives, goals and scope of services.

Effective Human Resource Management involves the following processes and activities:

- a. Acquisition of Human Resources which involves human resource planning, recruiting and socialization of the new employees.
- b. Training and development relates to the performance in the present and future anticipated jobs. The employees are provided with opportunities to advance personally as well as professionally.
- c. Motivation relates to job design, performance appraisal and discipline.
- d. Maintenance relates to safety and health of the employees.

The term “staff/ employee” refers to all salaried personnel working in the organization as well as contractual personnel. It does not refer to “fee for service” medical professionals.

The term “Paricharaka ” refers to Class XII/PUC with training for 6 months or Class X with 3 years’ relevant experience either in nursing, pharmacy or therapy or personnel having educational qualification less than class X provided he/she is certified by the Head of the Organisation for their competence & skill.

The term “Panchakarma Therapists” refers to person with qualification of Panchakarma Therapist or paricharaka therapist.

Summary of Standards

HRM.1.	The organization has a documented system of human resource planning.
HRM.2.	The organisation has a documented procedure for recruiting staff and orienting them to the organisation's environment.
HRM.3.	There is an ongoing programme for professional training and development of the staff.
HRM.4.	Staff, students and volunteers are adequately trained on specific job duties or responsibilities related to safety.
HRM.5.	An appraisal system for evaluating the performance of an employee exists as an integral part of the human resource management process.
HRM.6.	The organization has a well-documented disciplinary procedure.
HRM.7.	A grievance handling mechanism exists in the organization.
HRM.8.	The organization addresses the health needs of the employees.
HRM.9.	There is a documented personal record for each staff member.
HRM.10.	There is a process for credentialing and privileging of medical professionals, permitted to provide patient care without supervision.
HRM.11.	There is a process for credentialing and privileging of nursing professionals, permitted to provide patient care without supervision.
HRM.12.	There is a process for collecting, verifying and evaluating the credentials (education, training and experience) of Panchakarma Therapist, Paricharaka.

Standards and Objective Elements

Standard

HRM.1.	The organization has a documented system of human resource planning.
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Objective Elements

- 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 specifications and job description are well defined for each category of staff.
- d. The organization verifies the antecedents of the potential employee with regards to criminal/negligence background.

Standard

HRM.2.	The organisation has a documented procedure for recruiting staff and orienting them to the organisation's environment.
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Objective Elements

- 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 Documented policies and procedures as well as relevant department/unit/service/programme's documented policies and procedures.

Standard

HRM.3.	There is an ongoing programme for professional training and development of the staff.
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Objective Elements

- a. A documented training and development policy exists for the staff.
- b. The organisation maintains the training record.
- c. Staff should be given appropriate orientation/training to respective system of medicine.
- d. Training also occurs when job responsibilities change/new equipment is introduced.
- e. Feedback mechanisms for assessment of training and development programme exist.

Standard

HRM.4.	Staff, students and volunteers are adequately trained on specific job duties or responsibilities related to safety.
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Objective Elements

- a. All staff is trained on the risks within the hospital environment.
- b. Staff can demonstrate and take actions to report, eliminate/minimize risks.
- c. Staff are made aware of procedures to follow in the event of an incident.
- d. Reporting procedures for common problems, failures and user errors exist.

- e. Staff is trained on occupational safety aspects.

Standard

HRM.5.	An appraisal system for evaluating the performance of an employee exists as an integral part of the human resource management process.
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Objective Elements

- a. A documented performance appraisal system exists in the organization.
- 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.

Standard

HRM. 6.	The organization has a well-documented disciplinary policies and procedure.
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Objective Elements

- a. Documented policies and procedures exist
- b. The disciplinary policy and procedure is based on the principles of natural justice.
- c. The policy and procedure is known to all categories of employees of the organization.
- d. The disciplinary procedure is in consonance with the prevailing laws.
- e. There is a provision for appeals in all disciplinary cases.

Standard

HRM.7.	A grievance handling mechanism exists in the organization.
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Objective Elements

- a. Documented policies and procedures exist.
- b. The policies and procedures are known to all categories of staff of the organisation.
- c. The redress procedure addresses the grievance.
- d. Actions are taken to redress the grievance.

Standard

HRM.8.	The organization addresses the health needs of the employees.
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Objective Elements

- a. A pre-employment medical examination is conducted on all the employees.
- b. Health problems of the employees are taken care of in accordance with the organization'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.

Standard

HRM.9.	There is a documented personal record for each staff member.
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Objective Elements

- a. Personal files are maintained in respect of all staff.
- b. The personal files contain personal information regarding the staff 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.

Standard

HRM.10.	There is a process for credentialing and privileging of medical professionals, permitted to provide patient care without supervision.
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Objective Elements

- a. Medical professionals permitted by law, regulation and the hospital 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.

Standard

HRM.11.	There is a process for credentialing and privileging of nursing professionals, permitted to provide patient care without supervision.
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Objective Elements

- 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.

Standard

HRM.12.	There is a process for collecting, verifying and evaluating the credentials (education, training and experience) of Panchakarma Therapist & Paricharaka.
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Objective Element

- a. The education, training and experience of Panchakarma Therapist, Paricharaka are documented and updated periodically.
- b. All such information is appropriately verified when possible.
- c. Panchakarma Therapist and Paricharaka are granted privileges in consonance with their qualification, training, experience and registration.
- d. Panchakarma Therapist and Paricharaka care for patients as per their privileging.

Chapter 10

Information Management System (IMS)

Intent of Standards

Information is an important resource for effective and efficient delivery of health care. Provision of health care and its continued improvement is dependent to a large extent on the information generated, stored and utilized appropriately by the organizations.

The goal of Information Management in a hospital is to ensure that the required inputs are available to the right personnel. This is provided in an authenticated, secure and accurate manner at the right time and place. This helps to achieve the ultimate organizational goal of a satisfied and improved provider and recipient of health care.

An effective Information Management system is based on the information needs of the organization. The system is able to capture, transmit, store, analyze, utilize and retrieve information as and when required for improving clinical outcomes as well as individual and overall organizational performance.

Although a digital based information system improves efficiency, the basic principles of a good information management system apply equally to a manual/paper based system.

Summary of Standards

IMS.1.	Documented policies and procedures exist to meet the information needs of the care providers, management of the organization as well as other agencies that require data and information from the organization.
IMS.2.	The organization has processes in place for effective management of data.
IMS.3.	The organization has a complete and accurate medical record for every patient.
IMS.4.	The medical record reflects continuity of care.
IMS.5.	Documented policies and procedures are in place for maintaining confidentiality, integrity and security of information.
IMS.6.	Documented policies and procedures exist for retention time of records, data and information.
IMS.7.	The organization regularly carries out review of medical records.

Standards and Objective Elements

Standard

IMS.1.	Documented policies and procedures exist to meet the information needs of the care providers, management of the organization as well as other agencies that require data and information from the organization.
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Objective Elements

- a. The information needs of the organization are identified and are appropriate to the scope of the services being provided by the organization.
- b. Policies and procedures to meet the information needs are documented.
- c. These policies and procedures are in compliance with the prevailing laws and regulations.
- d. All information management and technology acquisitions are in accordance with the Documented policies and procedures.
- e. The organization contributes to external databases in accordance with the law and regulations.

Standard

IMS.2.	The organization has processes in place for effective management of data.
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Objective Elements

- a. Formats for data collection are standardized.
- b. Necessary resources are available for analyzing data.
- c. Documented procedures are laid down for timely and accurate dissemination of data.
- d. Documented procedures exist for storing and retrieving data.

- e. Appropriate clinical and managerial staff participates in selecting, integrating and using data.

Standard

IMS.3.	The organization has a complete and accurate medical record for every patient.
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Objective Elements

- a. Every medical record has a unique identifier.
- b. Organisation policy identifies those authorized to make entries in medical record.
- c. Every medical record entry is dated and timed.
- d. The author of the entry can be identified.
- e. The contents of medical record are identified and documented.
- f. The record provides an up-to-date and chronological account of patient care.
- g. Provision is made for 24-hour availability of the patient's record to healthcare providers to ensure continuity of care.

Standard

IMS.4.	The medical record reflects continuity of care.
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Objective Elements

- 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 note duly signed by appropriate and qualified personnel.
- f. In case of death, the medical record contains a copy of the death certificate indicating the cause, date and time of death.
- g. Care providers have access to current and past medical record.

Standard

IMS.5.	Documented policies and procedures are in place for maintaining confidentiality, integrity and security of information.
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Objective Elements

- a. Documented policies and procedures exist for maintaining confidentiality, security and integrity of information.
- b. Documented policies and procedures are in consonance with the applicable laws.
- c. The policies and procedures incorporate safeguarding of data/record against loss, destruction and tampering.
- d. The hospital has an effective process of monitoring compliance of the laid down policy.
- 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.

Standard

IMS.6.	Documented policies and procedures exist for retention time of records, data and information.
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Objective Elements

- Documented policies and procedures are in place on retaining the patient's clinical records, data and information.
- The Documented policies and procedures are in consonance with the local and national laws and regulations.
- The retention process provides expected confidentiality and security.
- The destruction of medical records, data and information is in accordance with the laid down policy.

Standard

IMS. 7.	The organization regularly carries out review of medical records.
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Objective Elements

- The medical records are reviewed periodically.
- The review uses a representative sample based on statistical principles.
- The review is conducted by identified care providers.
- The review focuses on the timeliness, legibility and completeness of the medical records.
- The review process includes records of both active and discharged patients.
- The review points out and documents any deficiencies in records.
- Appropriate corrective and preventive measures undertaken are documented.



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