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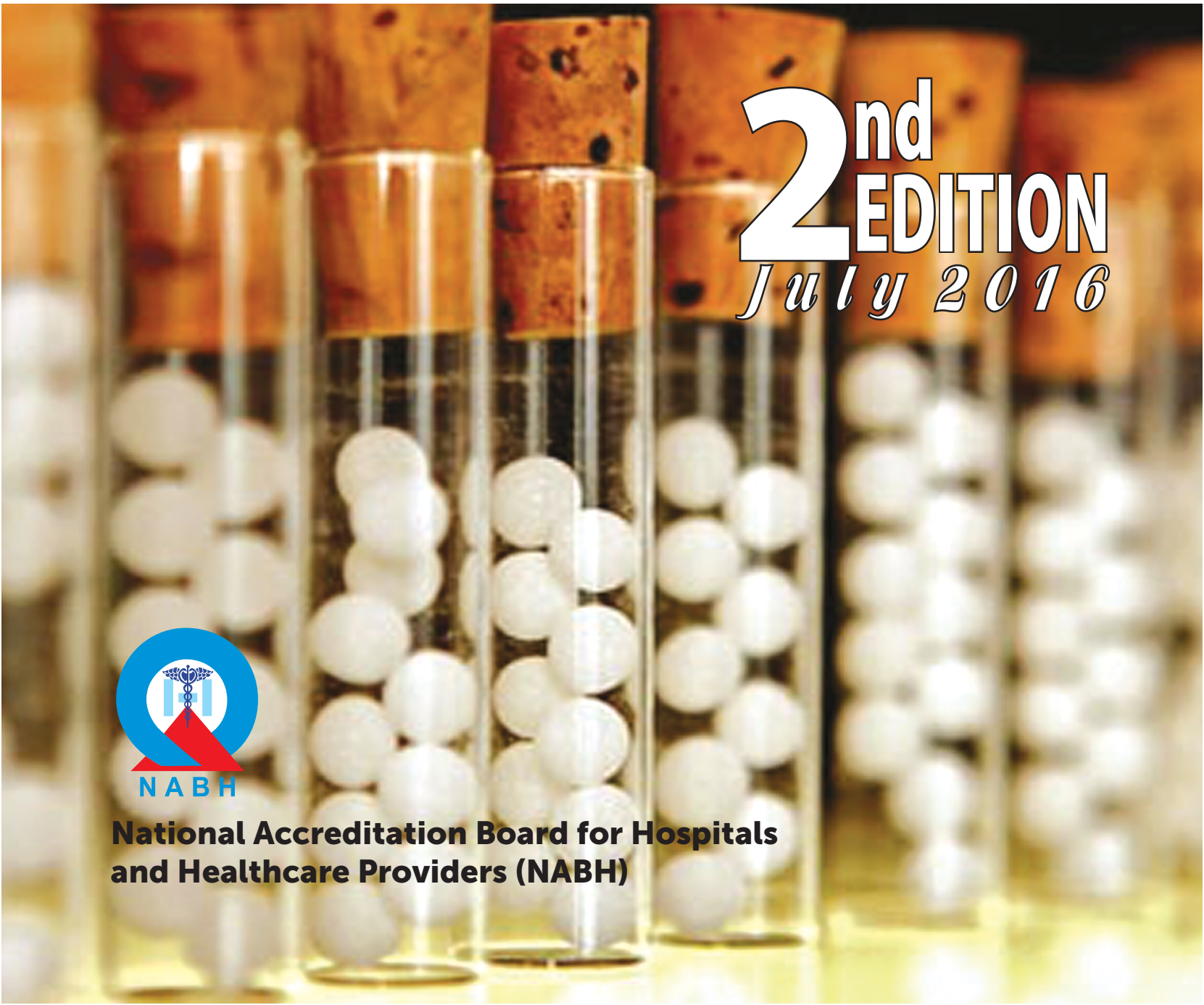

2nd EDITION

July 2016

NABH

National Accreditation Board for Hospitals and Healthcare Providers (NABH)

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15th August 2020

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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)lSQua) 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 form 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 Homoeopathy Hospitals

2nd Edition

July 2016

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सत्यमेव जयते

अजीत मोहन शरण
AJIT M. SHARAN

एक कदम स्वच्छता की ओर

सचिव
भारत सरकार
आयुर्वेद, योग व प्राकृतिक चिकित्सा
यूनानी, सिद्ध एवं होम्योपैथी (आयुष) मंत्रालय
आयुष भवन, 'बी' ब्लाक, जी.पी.ओ. कॉम्पलेक्स,
आई.एन.ए. नई दिल्ली-110023

SECRETARY
GOVERNMENT OF INDIA
MINISTRY OF AYURVEDA, YOGA & NATUROPATHY
UNANI, SIDDHA AND HOMOEOPATHY (AYUSH)
INA, NEW DELHI - 110023
Tel. : 011-24651950, Fax : 011-24651937
E-mail : secy-ayush@nic.in

FOREWORD

Historically, people have used homeopathy to maintain health and treat a wide range of long-term illnesses, such as allergies, eczema, sinusitis, asthma, migraine, rheumatoid arthritis, irritable bowel syndrome etc. They have also used it to treat minor injuries, such as scrapes and muscle strains or sprains. The therapy has inherent advantage of being safe, effective, acceptable and cost effective.

2. The system follows the same criteria for the diagnosis, approach and general management as any other system of medicine. Hence the clinical history, examination techniques, findings and interpretation, investigations, clinical management etc are similar with other systems. The approach to therapy, however, is distinctly different. In Homeopathic practice, it goes beyond clinical symptomatology in to the study of the constitution of the suffering individual.

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 Homeopathy system of Medicine.

4. Ministry of AYUSH is happy to endorse the second edition of NABH Accreditation Standards for Homeopathy 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 Director General, Central Council of Research in Homoeopathy (CCRH); President, Central Council for Homoeopathy (CCH) and Adviser-Homeopathy, Ministry of AYUSH.

Ajit Sharan

(Ajit M. Sharan)

NEW DELHI
28th July, 2016

INTRODUCTION

The first edition of NABH standard has been in practice for last six years 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 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 Homoeopathy healthcare organisation can comply with the requirement of the standards. Three books are being made available for use by the stakeholders i.e. 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 organisations 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 requirement, 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 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, comply with and monitoring the effective implementation of legal, statutory and regulatory requirements which effect 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 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 Homoeopathy hospital accreditation standard is divided into 10 chapters, which have been further divided into 104 standards (as compared to 87 in first edition). Put together there are 677 objective elements (as compared to 435 in first edition) incorporated within these standards. The increase in objective 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.

Homoeopathy is a unique therapeutic system in a way that Homoeopathic case management involves arriving at two types of diagnosis (i) clinical diagnosis (ii) diagnosing patient as a person from homoeopathic perspective. The fundamentals of homoeopathy demand individualization of patient and understanding the totality of phenomena of sickness.

In these guidelines, the various processes have also been elaborated such as Case taking from homoeopathic perspective, Case analysis and evaluation, Miasmatic analysis, Totality formation, Repertorisation, Remedy differentiation, Choice of remedy, Posology and Follow up assessment. 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 Standard 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 statement 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 organisation provides. This will facilitate in appropriately matching patients with the organisation's resources. Only those patients who can be cared for by the organisation are admitted to the organisation. Emergency patients receive first aid/ life-stabilising/ appropriate homoeopathic treatment and are then either admitted (if resources are available) or transferred appropriately to an organisation that has the resources to take care of such patients. Out-patients who do not match the organisation's resources are similarly referred to organisations that have the matching resources.

Patients that match the organisations resources are admitted using a defined process. Patients cared for by the organisation undergo an established initial assessment and periodic and regular reassessments.

Assessments include planning for utilisation of 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 healthcare 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 (in and out) or referral of patients.
AAC.4.	Patients cared for by the organisation undergo an established initial assessment.
AAC.5.	Patients cared for by the organisation undergo a regular reassessment.
AAC.6.	Laboratory services 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 are provided as per the scope of services of the organisation.
AAC.10.	There is an established quality assurance programme for imaging services.
AAC.11.	There is an established safety programme in the imaging services.
AAC.12.	Patient care is continuous and multidisciplinary in nature.
AAC.13.	The organisation has a documented discharge process.
AAC.14.	Organisation defines the content of the discharge summary.

*** This implies that this objective element requires documentation.**

Standards and Objective Elements

Standard

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

Objective Elements

a. The healthcare services being provided are clearly defined and are in consonance with the needs of the community.

b. Each defined service should have appropriate diagnostics and treatment facilities with suitably qualified personnel who provide out-patient, in-patient and emergency cover.

c. The defined healthcare services are prominently displayed.

d. The staff are oriented to these services.

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 procedures address out-patients, in-patients and emergency patients. *

c. A unique identification number is generated at the end of registration.

d. Patients are accepted only if the organisation can provide the required service.

e. The documented policies and procedures also address managing patients during non-availability of beds.

f. Access to the healthcare services in the organisation is prioritised according to the clinical needs of the patient.

g. The staff are aware of these processes.

Standard

AAC.3.	**There is an appropriate mechanism for transfer (in and out) or referral of patients.**

Objective Elements

a. Documented policies and procedures guide the transfer-in of patients to the organisation. *

b. Documented policies and procedures guide the transfer-out/referral of unstable patients to another facility in an appropriate manner. *

c. Documented policies and procedures guide the transfer- out/referral of stable patients to another facility in an appropriate manner. *

d. The documented procedures identify staff responsible during transfer/referral. *

e. The organisation gives a summary of patient's condition and the treatment given.*

Standard

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

Objective Elements

a. The organisation defines and documents the content of the initial assessment for the out–patients, in-patients and emergency patients. *

b. The organisation determines who can perform the initial assessment. *

c. The organisation defines the time frame within which the initial assessment is completed based on patient's needs. *

d. The initial assessment for in-patients is documented within 24 hours or earlier as per the patient's condition, as defined in the organisation's policy. *

e. Initial assessment of in-patients also includes nursing assessment which is done at the time of admission and documented. *

f. Initial assessment includes screening for nutritional needs.

g. The initial assessment results in a documented care plan. *

h. The care plan reflects desired results of the treatment, care or service.

i. The care plan is countersigned by the clinician in-charge of the patient within 24 hours.

Standard

AAC.5.	**Patients cared for by the organisation undergo a regular reassessment.**

Objective Elements

a. Patients are reassessed at appropriate intervals.

b. Out-patients are informed of their next follow-up, where appropriate.

c. For in-patients during reassessment the care plan is monitored and modified, where found necessary.

d. Staff involved in direct clinical care document reassessments. *

e. Patients are reassessed to determine their response to treatment and to plan further treatment or discharge.

f. The organisation lays down guidelines and implements processes to identify early warning signs of change or deterioration in clinical conditions for initiating prompt intervention.

Standard

AAC.6.	**Laboratory services are provided as per the scope of services of the organisation.**

Objective Elements

a. Scope of the laboratory services commensurate to the services provided by the organisation.

b. The infrastructure (physical and equipment) is adequate to provide the defined scope of services.

c. The manpower is adequate to provide the defined scope of services.

d. Qualified and trained personnel perform, supervise and interpret the investigations.

e. Documented procedures guide ordering of tests, collection, identification, handling, safe transportation, processing and disposal of specimens. *

f. Laboratory results are available within a defined time frame. *

g. Critical results are intimated immediately to the personnel concerned. *

h. Results are reported in a standardised manner.

i. There is a mechanism to address recall / amendment of reports whenever applicable.

j. Laboratory tests not available in the organisation are outsourced to organisation(s) based on their quality assurance system. *

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 are provided as per the scope of services of the organisation.**

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 equipment) and manpower is adequate to provide for its defined scope of services.

d. Adequately qualified and trained personnel perform, supervise and interpret the investigations.

e. Documented policies and procedures exist to ensure correct identification and safe and timely transportation of patients to and from the imaging services. *

f. Imaging results are available within a defined timeframe. *

g. Critical results are intimated immediately to the personnel concerned. *

h. Results are reported in a standardised manner.

i. There is a mechanism to address recall / amendment of reports whenever applicable.

j. Imaging tests not available in the organisation are outsourced to organisation(s) based on their quality assurance system. *

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 periodic internal / external peer review of imaging protocols and results using appropriate sampling.

c. The programme addresses surveillance of imaging results in collaboration with referring clinicians for follow up wherever applicable *

d. A system is in place to ensure the appropriateness of the investigations and procedures for the clinical indication.

e. The programme includes periodic calibration and maintenance of all equipment. *

f. The programme includes the documentation of corrective and preventive actions.*

Standard

AAC.11.	**There is an established safety programme in the imaging services.**

Objective Elements

a. The radiation-safety programme is documented. *

b. This programme is aligned with the organisation's safety programme.

c. Patients are appropriately screened for safety / risk prior to undergoing an imaging on a particular modality.

d. Handling, usage and disposal of radio-active and hazardous materials are as per statutory requirements.

e. Imaging personnel and patients are provided with appropriate radiation safety and monitoring devices where applicable.

f. Radiation-safety and monitoring devices are periodically tested and results are documented. *

g. Imaging and ancillary personnel are trained in imaging safety practices and radiation-safety measures.

h. Imaging signage are prominently displayed in all appropriate locations.

Standard

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

Objective Elements

a. During all phases of care, there is a qualified individual identified as responsible for the patient's care.

b. Care of patients is coordinated in all care settings within the organisation.

c. Information about the patient's care and response to treatment is shared among medical, nursing and other care-providers.

d. Information is exchanged and documented during each staffing shift, between shifts, and during transfers between units/departments.

e. Transfers between departments/units are done in a safe manner.

f. The patient's record(s) is available to the authorised care-providers to facilitate the exchange of information.

g. Documented procedures guide the referral of patients to other departments/ specialities. *

h. The organisation ensures continuity of care while adhering to defined timelines and informs the caregiver and/or the patient/family whenever there is a change in schedule.

i. The organisation has a mechanism in place to monitor whether adequate clinical intervention has taken place in response to a critical value alert.

Standard

AAC.13.	**The organisation 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 procedures exist for coordination of various departments and agencies involved in the discharge process (including medico-legal and absconded cases). *

c. Documented policies and procedures are in place for patients leaving against medical advice and patients being discharged on request. *

d. A discharge summary is given to all the patients leaving the organisation (including patients leaving against medical advice and on request).

e. The organisation defines the time taken for discharge and monitors the same.

Standard

AAC.14.	**Organisation 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, homoeopathic analysis and evaluation, medication(s) 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 chapter:

The organisation provides uniform care to all patients in different settings as per the scope of the services and ensures documented individualised patient-focused case management plan to achieve appropriate outcomes. The homoeopathic practice revolves around individualization and totality of the phenomena of sickness. Hence, the emphasis is laid on the sick rather than on sickness. Success in homoeopathic practice depends on translating these principles into practice. Accordingly, disease diagnosis (for appropriate management and prognosis) and patient diagnosis (for individualization) becomes imperative for the care of patient.

The different settings include care provided in outpatient units, various categories of wards, intensive care units, 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, use of blood and blood components, care of patients in the intensive care and high dependency units in homoeopathic hospitals wherever applicable

Policies, procedures, applicable laws and regulations also guide care of vulnerable patients (elderly, physically and/or mentally-challenged and children), high-risk obstetrical patients, paediatric patients, patients undergoing moderate sedation, administration of anaesthesia, patients undergoing surgical procedures, patients under restraints, research activities and end of life care.

Pain management, nutritional therapy and rehabilitative services are also addressed with a view to providing comprehensive health care.

The standards aim to guide and encourage patient safety as per the principles and scope of Homeopathy for providing care to patients.

Summary of Standards

COP 1:	Uniform care to patients is provided in all settings of the organisation and is guided by the applicable laws, regulations and guidelines.
COP 2:	Documented Policies and Procedures for Homoeopathic Case Management.
COP 3:	Emergency services are guided by documented policies, procedures applicable laws and regulations, if applicable.
COP 4:	The ambulance services are commensurate with the scope of the services provided by the organisation.
COP 5:	The organisation plans for handling community emergencies, epidemics and other disasters**.**
COP 6:	Documented policies and procedures guide the care of patients requiring cardio-pulmonary resuscitation.
COP 7:	Documented policies and procedures guide nursing care.
COP 8:	Documented procedures guide the performance of various procedures as per scope of services of the organization.
COP 9:	Documented policies and procedures define rational use of blood and blood components, if applicable.
COP 10:	Documented policies and procedures guide the care of patients in the intensive care and high dependency units, if applicable.
COP 11:	Documented policies and procedures guide the care of vulnerable patients.
COP 12:	Documented policies and procedures guide obstetric care as per the scope of services of the organization.
COP 13:	Documented policies and procedures guide paediatric services.
COP 14:	Documented policies and procedures guide the care of patients undergoing moderate sedation, if applicable.

COP 15:	Documented policies and procedures guide the administration of anaesthesia, if applicable.
COP 16:	Documented policies and procedures guide the care of patients undergoing surgical procedures, if applicable.
COP.17:	Documented policies and procedures guide sensitization about organ transplant programme in the organisation.
COP 18:	Documented policies and procedures guide the care of patients under restraints (physical and/or chemical), if applicable.
COP 19:	Documented policies and procedures guide appropriate pain management as per homoeopathic principles.
COP 20:	Documented policies and procedures guide appropriate rehabilitative services, if applicable.
COP 21:	Documented policies and procedures guide all research activities.
COP 22:	Documented policies and procedures guide nutritional requirements as per the scope of services.
COP 23:	Documented policies and procedures guide the end of life care, if applicable.

*** This implies that this objective element requires documentation.**

Standards and Objective Elements

Standard

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

Objective Elements

a. Care delivery is uniform for a given health problem when similar care is provided in more than one setting. *

b. Uniform care is guided by documented policies and procedures**.**

c. These reflect applicable laws, regulations and guidelines.

d. The organisation adapts evidence-based medicine as applicable to Homoeopathy and clinical practice guidelines to guide uniform patient care.

Standard

COP.2.	**Documented Policies and Procedures for Homoeopathic Case Management.**

Objective Elements

a. There are documented policies and procedures for all activities pertaining to the case management.*

b. These reflect standards and principles of homoeopathic practice.

c. The case management is done as per current Good Clinical Practice guidelines.

d. Case management is aligned and integrated with overall patient care.

e. Case records are documented in the prescribed format. *****

f. Doctors are provided with adequate resources for efficient case management.

g. Doctors are empowered to take clinical and case management decisions to ensure the timely and effective care of patients.

Standard

COP.3.	**Emergency services are guided by documented policies, procedures, applicable laws and regulations, if applicable.**

Objective Elements

a. There shall be an identified area in the organisation which is easily accessible to receive and manage emergency patients.

b. Policies and procedures for emergency care are documented and are in consonance with statutory requirements. *

c. This also addresses the handling of medico-legal cases. *

d. The patients receive care in consonance with the policies**.**

e. Documented policies and procedures guide the triage of patients for initiation of appropriate care. *

f. Staff are familiar with the policies and trained on the procedures for care of emergency patients.

g. Admission or discharge to home or transfer to another organisation is also documented.

h. In case of discharge to home or transfer to another organisation, a discharge note shall be given to the patient.

i. Quality assurance programmes are documented and implemented. *

j. The documented policies and procedures guide management of patients found dead on arrival to the hospital. *

Standard

COP.4.	**The ambulance services are commensurate with the scope of the services provided by the organisation.**

Objective Elements

a. There is adequate access and space for the ambulance(s).

b. The ambulance adheres to statutory requirements.

c. The ambulance(s) is appropriately equipped**.**

d. The ambulance(s) is manned by trained personnel.

e. The ambulance(s) is checked on a daily basis.*

f. Equipment's are checked on a daily basis using a checklist. *

g. Emergency medications are checked daily and prior to dispatch using a checklist.

h. The ambulance(s) has a proper communication system.*

i. The emergency department identifies opportunities to initiate treatment at the earliest when the patient is in transit to the organisation**.**

Standard

COP.5	**The organisation plans for handling community emergencies, epidemics and other disasters.**

Objective Elements

a. The organisation identifies potential emergencies. *

b. The organisation has a documented disaster management plan. *

c. Provision is made for availability of medical supplies, equipment and materials during such emergencies.

d. Staff are trained in the hospital's disaster management plan.

e. The plan is tested at least twice a year.

Standard

COP.6.	**Documented policies and procedures guide the care of patients requiring cardio-pulmonary resuscitation.**

Objective Elements

a. Documented policies and procedures guide the uniform use of resuscitation throughout the organisation. *

b. Staff providing direct patient care are trained and periodically updated in cardio-pulmonary resuscitation

c. The events during a cardiopulmonary resuscitation are recorded.

d. A post-event analysis of all cardiopulmonary resuscitations is done by a multidisciplinary committee.

e. Corrective and preventive measures are taken based on the post-event analysis.

Standard

COP.7.	**Documented policies and procedures guide nursing care.**

Objective Elements

a. There are documented policies and procedures for all activities of the nursing services. *

b. These reflect current standards of nursing services and practice, relevant regulations and purposes of the services.

c. Assignment of patient care is done as per current good practice guidelines.

d. Nursing care is aligned and integrated with overall patient care.

e. Care provided by nurses is documented in the patient record. *****

f. Nurses are provided with adequate equipment for providing safe and efficient nursing services.

g. Nurses are empowered to take nursing-related decisions to ensure the timely care of patients.

Standard

COP.8.	**Documented procedures guide the performance of various procedures as per scope of services of the organization.**

Objective Elements

a. Documented procedures are used to guide the performance of various clinical procedures. *

b. Only qualified personnel order, plan, perform and assist in performing procedures**.**

c. Documented procedures exist to prevent adverse events like a wrong site, wrong patient and wrong procedure. *

d. Informed consent is taken by the personnel performing the procedure, where applicable.

e. Adherence to standard precautions and asepsis is adhered to during the conduct of the procedure as applicable.

f. Patients are appropriately monitored during and after the procedure wherever applicable.

g. Procedures are documented accurately in the patient record. *

Standard

COP.9.	**Documented policies and procedures define rational use of blood and blood components, if applicable.**

Objective Elements

a. Documented policies and procedures are used to guide the rational use of blood and blood components. *

b. Documented procedures govern transfusion of blood and blood components *

c. The transfusion services are governed by the applicable laws and regulations.

d. Informed consent is obtained for donation and transfusion of blood and blood components.

e. Informed consent also includes patient and family education about the donation.

f. The organisation defines the process for availability and transfusion of blood/blood components for use in emergency situations. *

g. Post-transfusion form is collected, reactions if any identified and are analysed for preventive and corrective actions.

h. Staff are trained to implement the policies**.**

Standard

COP.10.	**Documented policies and procedures guide the care of patients in the intensive care and high dependency units, if applicable.**

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 are trained to apply these criteria.

d. Adequate staff and equipment are available.

e. Defined procedures for the situation of bed shortages are followed. *

f. Infection control practices are documented and followed. *

g. A quality assurance programme is documented and implemented. *

h. Patients and families are counselled by the treating medical professional at periodic intervals and when there is a significant change in the condition of the patient, and same is documented. *

Standard

COP.11.	**Documented policies and procedures guide the care of vulnerable patients.**

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 organised and delivered in accordance with the policies and procedures.

c. The organisation provides for a safe and secure environment for the vulnerable group.

d. A documented procedure exists for obtaining informed consent from the appropriate legal representative. *

e. Staff are trained to care for the vulnerable group.

Standards

COP.12.	**Documented policies and procedures guide obstetric care as per the scope of services of the organization.**

Objective Elements

a. There is a documented policy and procedure for obstetric services. *

b. The organisation defines and displays whether high-risk obstetric cases can be cared for or not.

c. Persons caring for high-risk obstetric cases are competent.

d. Documented procedures guide the provision of ante-natal services. *

e. Obstetric patient's assessment also includes maternal nutrition.

f. Appropriate pre-natal, peri-natal and post-natal monitoring is performed and documented. *

g. The organisation caring for high-risk obstetric cases has the facilities to take care of neonates of such cases.

Standard

COP.13.	**Documented policies and procedures guide paediatric services.**

Objective Elements

a. There is a documented policy and procedure for paediatric services. *

b. The organisation defines and displays the scope of its paediatric services.

c. The policy for care of neonatal patients is in consonance with the national/ international guidelines. *

d. Provisions are made for special care of children.

e. Patient assessment includes detailed nutritional, growth, developmental and immunisation assessment along with homoeopathic intervention.

f. Documented policies and procedures prevent child/neonate abduction and abuse.*

g. The children's family members are educated about nutrition, immunisation, safe parenting, homoeopathic management and this is documented. *

Standard

COP.14.	**Documented policies and procedures guide the care of patients undergoing moderate sedation, if applicable.**

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 observation/recovery area. *

h. Equipment and manpower are available to manage patients who have gone into a deeper level of sedation than initially intended.

Standard

COP.15.	**Documented policies and procedures guide the administration of anaesthesia, if applicable.**

Objective Elements

a. There is a documented policy and procedure for the administration of anaesthesia.*

b. Patients for anaesthesia have a pre-anaesthesia assessment by a qualified anaesthesiologist.

c. The pre-anaesthesia assessment results in formulation of an anaesthesia plan which is documented.

d. An immediate preoperative re-evaluation is performed and documented**.**

e. Informed consent for administration of anaesthesia is obtained by the anesthesiologist.

f. During anaesthesia monitoring includes regular recording of temperature, heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation and end tidal carbon dioxide.

g. Patient's post-anaesthesia status is monitored and documented.

h. The anaesthesiologist applies defined criteria to transfer the patient from the recovery area. *

i. The type of anaesthesia and anaesthetic medications used are documented in the patient record. *

j. Procedures shall comply with infection control guidelines to prevent cross-infection between patients.

k. Adverse anaesthesia events are recorded and monitored**.**

Standard

COP.16.	**Documented policies and procedures guide the care of patients undergoing surgical procedures, if applicable.**

Objective Elements

a. The policies and procedures are documented. *

b. Surgical patients have a preoperative assessment and a provisional diagnosis documented prior to surgery.

c. An informed consent is obtained by a surgeon prior to the procedure.

d. Documented policies and procedures exist to prevent adverse events like wrong site, wrong patient and wrong surgery. *

e. Persons qualified by law are permitted to perform the procedures that they are entitled to perform.

f. A brief operative note is documented prior to transfer out of patient from recovery.

g. The operating surgeon documents the postoperative Care plan.

h. Patient, personnel and material flow conform to infection control practices.

i. Appropriate facilities and equipment/appliances/instrumentation are available in the operating theatre.

j. A quality assurance programme is followed for the surgical services. *

k. The quality assurance programme includes surveillance of the operation theatre environment. *

Standard

COP.17.	**Documented policies and procedures guide sensitization about organ transplant programme in the organisation.**

a. The organisation ensures education and counselling about organ transplantation.

b. The organisation shall take measures to create awareness regarding organ donation.*

Standard

COP. 18.	**Documented policies and procedures guide the care of patients under restraints (physical and/or chemical) if applicable.**

Objective Elements

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

b. The policies and procedures include both physical and chemical restraint measures.

c. The reasons for restraints are documented.

d. Patients on restraints are more frequently monitored.

e. Staff receives training and periodic updating in control and restraint techniques.

Standard

COP.19.	**Documented policies and procedures guide appropriate pain management as per homoeopathic principles.**

Objective Elements

a. Documented policies and procedures guide the management of pain. *

b. All patients are screened for pain.

c. Patients with pain undergo detailed assessment and periodic reassessment.

d. Pain alleviation measures or medications are initiated and titrated according to patient's need and response.

e. The organisation respects and supports management of pain for such patients.

f. Patient and family are educated on various pain management techniques, where appropriate.

Standard

COP.20.	**Documented policies and procedures guide appropriate rehabilitative services, if applicable.**

Objective Elements

a. Documented policies and procedures guide the provision of rehabilitative services.*

b. These services are commensurate with the organisational requirements.

c. Care is guided by functional assessment and periodic re-assessment which is done and documented by qualified individual(s).

d. Care is provided adhering to infection control and safe practices.

e. Rehabilitative services are provided by a multidisciplinary team.

f. There is adequate space and equipment to perform these activities.

Standard

COP.21.	**Documented policies and procedures guide all research activities.**

Objective Elements

a. Documented policies and procedures guide all research activities in compliance with regulatory, national and international guidelines. *

b. The organisation has an ethics committee to oversee all research activities.

c. The committee has the powers to discontinue a research trial when risks outweigh the potential benefits.

d. Patient's informed consent is obtained before entering them in research protocols.

e. Patients are informed of their right to withdraw from the research at any stage and also of the consequences (if any) of such withdrawal.

f. Patients are assured that their refusal to participate or withdrawal from participation will not compromise their access to the organisation's services.

Standard

COP.22.	**Documented policies and procedures guide nutritional requirements as per scope of services.**

Objective Elements

a. Documented policies and procedures guide nutritional requirements including assessment and reassessment. *

b. Nutritional therapy is planned and provided in a collaborative manner.

c. There is a written order for the diet.

d. Patients receive food according to their clinical needs.

e. Food is prepared, handled, stored and distributed in a safe manner.

f. When families provide food, they are educated about the patient's diet limitations.

Standard

COP.23.	**Documented policies and procedures guide the end of life care, if applicable.**

Objective Elements

a. Documented policies and procedures guide the end of life care. *

b. These policies and procedures are in consonance with the legal requirements.

c. These also address the identification of the unique needs of such patient and family.

d. Symptomatic homoeopathic treatment is provided and where appropriate measures are taken for the alleviation of pain.

e. Staff are educated and trained in end of life care.

Chapter 3

Management of Medication (MOM)

Intent of the chapter:

The organisation has a safe and organised medication process. The process includes policies and procedures that guide the availability (as per hospital formulary), 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 guide and audit medication processes. The pharmacy should have oversight of all medications stocked out of the pharmacy. The pharmacy should ensure correct storage (as regards to temperature, light, look-alike, sound-alike etc.), expiry dates where applicable and maintenance of documentation.

The availability of emergency medication is stressed upon. The organisation should have a mechanism to ensure that the emergency medications are standardised throughout the organisation, readily available and replenished in a timely manner. There should be a monitoring mechanism to ensure that the required medications are always stocked and well within expiry dates.

Every high-risk medication order should be verified by an appropriate person so as to ensure accuracy of the dose, frequency and route of administration. The “appropriate person” could be another doctor, registered nurse or, a clinical pharmacist. Safe use of high-risk medication like narcotics, chemotherapeutic agents and radioactive isotopes are guided by policies and procedures. Storage of dilutions, mother tinctures and vehicles including their safe use are to be guided by policies & laws

The process also includes monitoring of patients after administration and procedures for reporting and analysing medication errors.

Patients and family members are educated about safe medication and food-drug interactions.

Summary of Standards

MOM 1:	Documented policies and procedures guide the organisation of pharmacy services and usage of medication.
MOM 2:	There is a hospital formulary.
MOM 3:	Documented policies and procedures guide the storage of medication.
MOM 4:	Documented policies and procedures guide the safe and rational prescription of medications.
MOM 5:	Documented policies and procedures guide the safe dispensing of medications.
MOM 6:	There are documented policies and procedures for medication administration.
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 procedures guide the use of narcotic drugs and psychotropic substances.
MOM 10:	Documented policies and procedures guide the usage of chemotherapeutic agents.
MOM 11:	Documented policies and procedures govern usage of radioactive drugs.

*** This implies that this objective element requires documentation.**

Standards and Objective Elements

Standard

MOM.1.	**Documented policies and procedures guide the organisation of pharmacy services and usage of medication.**

Objective Elements

a. There is a documented policy and procedure for pharmacy services and medication usage. *

b. Policies and procedures comply with the applicable laws and regulations. *

c. A multidisciplinary committee guides the formulation and implementation of these policies and procedures. *

d. There is a procedure to obtain medication when the pharmacy is closed. *

Standard

MOM.2.	**There is a hospital formulary.**

Objective Elements

a. A list of medications appropriate for the patients and as per the scope of the organisation's clinical services is developed collaboratively by the multidisciplinary committee.

b. The list is reviewed and updated collaboratively by the multidisciplinary committee at least annually.

c. The formulary is available for clinicians to refer and adhere to.

d. There is a defined process for acquisition of these medications. *

e. There is a process to obtain medications not listed in the formulary. *

Standard

MOM.3.	**Documented policies and procedures guide the storage of medication.**

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 in all areas throughout the organisation.

d. Look-alike and Sound-alike medications are identified and stored appropriately. *

e. The list of emergency medications is defined and is stored in a uniform manner. *

f. Emergency medications are available all the time.

g. Emergency medications are replenished in a timely manner when used.

Standard

MOM.4.	**Documented policies and procedures guide the safe and rational prescription of medications.**

Objective Elements

a. Documented policies and procedures exist for prescription of medications. *

b. These incorporate inclusion of good practices/guidelines for rational prescription of medications.

c. The organisation determines the minimum requirements of a prescription. *

d. Known drug allergies and idiosyncrasies are ascertained before prescribing.

e. The organisation determines who can write orders. *

f. Orders are written in a uniform location in the medical records which also reflects patient's name and unique identification number.

g. Medication orders are clear, legible, dated, timed**,** named and signed.

h. Medication orders contain the name of the medicine, potency, route of administration, dose to be administered and frequency/time of administration.

i. Documented policy and procedure on verbal orders is implemented. *

j. The organisation defines a list of high-risk medication(s) for conventional medicines. *

k. Audit of medication orders/prescription is carried out to check for safe and rational prescription of medications.

l. Reconciliation of medications occur at transition points of patient care

m. Corrective and/or preventive action(s) is taken based on the analysis, where appropriate.

Standard

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

Objective Elements

a. Documented policies and procedures guide the safe dispensing of medications. *

b. The procedure addresses medication recall. *

c. Expiry dates are checked prior to dispensing.

d. There is a procedure for near expiry medications. *

e. Labelling requirements are documented and implemented by the organisation. *

f. High-risk medication orders are verified prior to dispensing for conventional medicines.

Standard

MOM.6.	**There are documented policies and procedures for medication administration.**

Objective Elements

a. Medications are administered by those who are permitted by law to do so.

b. Prepared medication is labelled prior to preparation of a second drug if applicable.

c. Patient is identified prior to administration.

d. Medication is verified from the order and physically inspected prior to administration.

e. Dosage is verified from the order prior to administration.

f. Route is verified from the order prior to administration.

g. Timing is verified from the order prior to administration.

h. Medication administration is documented.

i. Documented policies and procedures govern patient's self-administration of medications. *

j. Documented policies and procedures govern patient's own medications brought from outside the organisation. *

Standard

MOM.7.	**Patients are monitored after medication administration.**

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.**

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 procedures guide the use of narcotic drugs and psychotropic substances, if applicable.**

Objective Elements

a. Documented procedures guide the use of narcotic drugs and psychotropic substances which are in consonance with local and national regulations. *

b. These drugs are stored in a secure manner.

c. A proper record is kept of the usage, administration and disposal of these drugs.

d. These drugs are handled by appropriate personnel in accordance with the documented procedure.

Standard

MOM.10.	**Documented policies and procedures guide the usage of chemotherapeutic agents, if applicable.**

Objective Elements

a. Documented policies and procedures guide the usage of chemotherapeutic agents. *

b. Chemotherapy is prescribed by those who have the knowledge to monitor and treat the adverse effect of chemotherapy.

c. Chemotherapy is prepared in a proper and safe manner and administered by qualified personnel.

d. Chemotherapy drugs are disposed in accordance with legal requirements.

e. Patient and family are educated regarding benefits/risks of chemotherapy, precautions to be taken and possible adverse reactions.

Standard

MOM.11.	**Documented policies and procedures guide the use of medical supplies and consumables.**

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

e. There is a mechanism in place to verify the condition of medical supplies and consumables.

Chapter 4

Patient Rights and Education (PRE)

Intent of the chapter:

The organisation defines the patient and family's rights and responsibilities. The staff is aware of these rights and is trained to protect them. Patients are informed of their rights and educated about their responsibilities at the time of admission. They are informed about the disease, the possible outcomes and are involved in decision making. The costs are explained in a clear manner to patient and/or family. Patients are educated about the mechanisms available for addressing grievances.

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

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

Summary of Standards

PRE 1:	The organisation protects patient and family rights and informs them about their responsibilities during care.
PRE2:	Patient and family rights support individual beliefs, values and involve the patient and family in decision making processes.
PRE3:	The patient and/or family members are educated to make informed decisions and are involved in the care planning and delivery process.
PRE4:	A documented procedure for obtaining patient and/or family's consent exists for informed decision making about their care.
PRE5:	Patient and families have a right to information and education about their healthcare needs.
PRE6:	Patients and families have a right to information on expected costs.
PRE7:	The organisation has a mechanism to capture patient's feedback and redressal of complaints.
PRE8:	The organisation has a system for effective communication with patients and / or families.

*** This implies that this objective element requires documentation.**

Standards and Objective Elements

Standard

PRE.1.	**The organisation protects patient and family rights and informs them about their responsibilities during care.**

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 organisation's leaders protect patient and family rights.

d. Staff are aware of their responsibility in protecting patient and family rights.

e. Violation of patient and family rights is recorded, reviewed and corrective / preventive measures taken.

Standard

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

Objective Elements

a. Patients and family rights include respecting any special preferences, spiritual and cultural needs.

b. Patient and family rights include respect for personal dignity and privacy during examination, procedures and treatment.

c. Patient and family rights include protection from neglect or abuse.

d. Patient and family rights include treating patient information as confidential.

e. Patient and family rights include refusal of treatment.

f. Patient and family have a right to seek an additional opinion regarding clinical care.

g. Patient and family rights include informed consent before transfusion of blood and blood components, anaesthesia, surgery, initiation of any research protocol and any other invasive / high risk procedures / treatment wherever applicable.

h. Patient and family rights include right to complain and information on how to voice a complaint.

i. Patient and family rights include information on the expected cost of the treatment.

j. Patient and family rights include access to his / her clinical records.

k. Patient and family rights include information on Care plan, progress and information on their health care needs.

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.**

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 in a timely manner.

Standard

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

Objective Elements

a. Documented procedure incorporates the list of situations where informed consent is required and the process for taking informed consent. *

b. General consent for treatment is obtained when the patient enters the organisation.

c. Patient and/or his family members are informed of the scope of such general consent.

d. Informed consent includes information regarding the procedure, its risks, benefits, alternatives and as to who will perform the procedure in a language that they can understand.

e. The procedure describes who can give consent when patient is incapable of independent decision making. *

f. Informed consent is taken by the person performing the procedure.

g. Informed consent process adheres to statutory norms.

h. Staff are aware of the informed consent procedure.

Standard

PRE.5.	**Patient and families have a right to information and education about their healthcare needs.**

Objective Elements

a. Patient and/or family are educated about the safe and effective use of medication and the potential side effects of the medication, when appropriate.

b. Patient and/or family are educated about food-drug interaction if applicable.

c. Patient and/or family are educated about diet and nutrition.

d. Patient and/or family are educated about immunisations and probable homoeopathic prophylaxis.

e. Patient and/or family are educated about their specific disease process, complications and prevention strategies.

f. Patient and/or family are educated about preventing healthcare associated infections.

g. The patients and/or family members' special educational needs are identified and addressed.

h. Patient and/or family are educated in a language and format that they can understand.

Standard

PRE.6.	**Patients and families have a right to information on expected costs.**

Objective elements

a. There is a uniform pricing policy in a given setting (out-patient and ward category).

b. The relevant tariff list is available to patients.

c. The patient and/or family members are explained about the expected costs.

d. Patient and/or family are informed about the financial implications when there is a change in the patient condition or treatment setting.

Standard

PRE.7.	**The organisation has a mechanism to capture patient's feedback and redressal of complaints.**

Objective elements

a. The organisation has a mechanism to capture feedbacks from patients which includes patient satisfaction and patient experience

b. The organisation has a documented complaint redressal procedure. *

c. Patient and/or family members are made aware of the procedure for giving feedback and /or lodging complaints.

d. All feedback and complaints are reviewed and/or analysed within a defined time frame.

e. Corrective and/or preventive action(s) are taken based on the analysis where appropriate.

Standard

PRE.8.	**The organisation has a system for effective communication with patients and /or families.**

Objective elements

a. Documented policies and procedures guide the effective communication with the patients and/or families. *

b. The organisation shall identify special situations where enhanced communication would be required. *

c. The organisation lays down an approach for effective communication in these identified situations.

d. The organisation also defines what constitutes an unacceptable communication and sensitizes the staff about the same. *

e. The organisation has a system to monitor and review the implementation of effective communication.

f. The staff are trained in healthcare communication techniques periodically.

Chapter 5

Hospital Infection Control (HIC)

Intent of the chapter:

The standards guide the provision of an effective healthcare-associated infection prevention and control programme in the organisation. The programme is documented and aims at reducing/eliminating infection risks to patients, visitors and providers of care.

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

The organisation provides proper facilities and adequate resources to support the Infection Control Programme.

The organisation has effective antimicrobial management program through regularly updated antibiotic policy based on local data and monitors its implementation. Program also includes monitoring of antimicrobials usage in the organisation.

The programme includes an action plan to control outbreaks of infection, disinfection/ sterilization activities, biomedical waste (BMW) management, training of staff and employee health.

Summary of Standards

HIC 1:	The organisation has a well-designed, comprehensive and coordinated Hospital Infection Prevention and Control (HIC) programme aimed at reducing/eliminating risks to patients, visitors and providers of care.
HIC 2:	The organisation implements the policies and procedures laid down in the Infection Control Manual in all areas of the hospital.
HIC 3:	The organisation performs surveillance activities to capture and monitor infection prevention and control data.
HIC 4:	The organisation takes actions to prevent and control Healthcare Associated Infections (HAI) in patients.
HIC 5:	The organisation provides adequate and appropriate resources for prevention and control of Healthcare Associated Infections (HAI).
HIC 6:	The organisation identifies and takes appropriate action to control outbreaks of infections.
HIC 7:	There are documented policies and procedures for sterilization activities in the organisation.
HIC 8:	Biomedical waste (BMW) is handled in an appropriate and safe manner.
HIC 9:	The infection control programme is supported by the management and includes training of staff.

*** This implies that this objective element requires documentation.**

Standards and Objective Elements

Standard

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

Objective Elements

a. The hospital infection prevention and control programme is documented which aims at preventing and reducing risk of healthcare associated infections in all areas of the hospital. *

b. The infection prevention and control programme is a continuous process and updated at least once in a year.

c. The hospital has a multi-disciplinary infection control committee, which co-ordinates all infection prevention and control activities. *

d. The hospital has an infection control team, which coordinates implementation of all infection prevention and control activities. *

e. The hospital has designated infection control officer as part of the infection control team. *

f. The hospital has designated infection control nurse(s) as part of the infection control team. *

Standard

HIC.2.	**The organisation implements the policies and procedures laid down in the Infection Control Manual in all areas of the hospital.**

Objective Elements

a. The organisation identifies the various high-risk areas and procedures and implements policies and/or procedures to prevent infection in these areas. *

b. The organisation adheres to standard precautions at all times. *

c. The organisation adheres to hand-hygiene guidelines. *

d. The organisation adheres to transmission-based precautions at all times. *

e. The organisation adheres to safe injection and infusion practices. *

f. The organisation adheres to cleaning, disinfection and sterilization practices. *

g. The organisation implements the antibiotic policy and monitors rational use of antimicrobial agents, if applicable. *

h. The organisation adheres to laundry and linen management processes. *

i. The organisation adheres to kitchen sanitation and food-handling issues. *

j. The organisation has appropriate engineering controls to prevent infections. *

k. The organisation adheres to housekeeping procedures. *

Standard

HIC.3.	**The organisation performs surveillance activities to capture and monitor infection prevention and control data.**

Objective Elements

a. Surveillance activities are appropriately directed towards the identified high-risk areas and procedures.

b. A collection of surveillance data is an on-going process.

c. Verification of data is done on a regular basis by the infection control team.

d. The scope of surveillance activities incorporates tracking and analyzing of infection risks, rates and trends.

e. Surveillance activities include monitoring the compliance with hand-hygiene guidelines.

f. Surveillance activities include mechanisms to capture the occurrence of epidemiological significant diseases, multi-drug-resistant organisms and highly virulent infections, wherever applicable.

g. Surveillance activities include monitoring the effectiveness of housekeeping services.

h. Appropriate feedback regarding Healthcare Associated Infection (HAI) rates is provided on a regular basis to appropriate personnel.

i. In cases of notifiable diseases, information (in relevant format) is sent to appropriate authorities.

Standard

HIC.4.	**The organisation takes actions to prevent and control Healthcare Associated Infections (HAI) in patients, if applicable.**

Objective Elements

a. The organisation takes action to prevent catheter associated urinary tract Infections.

b. The organisation takes action to prevent Ventilator Associated Pneumonia.

c. The organisation takes action to prevent catheter linked blood stream infections.

d. The organisation takes action to prevent surgical site infections.

Standard

HIC.5.	**The organisation provides adequate and appropriate resources for prevention and control of Healthcare Associated Infections (HAI).**

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.

c. Isolation/barrier nursing facilities are available.

d. Appropriate pre- and post-exposure prophylaxis is provided to all staff members concerned. *

Standard

HIC.6.	**The organisation identifies and takes appropriate action to control outbreaks of infections.**

Objective Elements

a. Organisation has a documented procedure for identifying an outbreak. *

b. Organisation has a documented procedure for handling such outbreaks. *

c. This procedure is implemented during outbreaks.

d. After the outbreak is over appropriate corrective actions are taken to prevent recurrence.

Standard

HIC.7.	**There are documented policies and procedures for sterilization activities in the organisation.**

Objective Elements

a. The organisation provides adequate space and appropriate zoning for sterilization activities.

b. Documented procedure guides the cleaning, packing, disinfection and/or sterilization, storing and issue of items. *

c. Reprocessing of instruments and equipment are covered**. ***

d. The organisation shall have a documented policy and procedure for reprocessing of devices whenever applicable. *

e. Regular validation tests for sterilization are carried out and documented. *

f. There is an established recall procedure when breakdown in the sterilization system is identified. *

Standard

HIC.8.	**Biomedical waste (BMW) is handled in an appropriate and safe manner.**

Objective Elements

a. The organisation adheres to statutory provisions with regard to biomedical waste.

b. Proper segregation and collection of biomedical waste from all patient-care areas of the hospital is implemented and monitored.

c. The organisation ensures that biomedical waste is stored and transported to the site of treatment and disposal in properly covered vehicles within stipulated time limits in a secure manner.

d. The biomedical waste treatment facility is managed as per statutory provisions (if in- house) or outsourced to authorized contractor(s).

e. Appropriate personal protective measures are used by all categories of staff handling biomedical waste.

Standard

HIC.9.	**The infection control programme is supported by the management and includes training of staff.**

Objective Elements

a. The management makes available resources required for the infection control programme.

b. The organisation earmarks adequate funds from its annual budget in this regard.

c. The organisation conducts induction training for all staff.

d. The organisation conducts appropriate “in-service” training sessions for all staff at least once in a year.

Chapter 6

Continual Quality Improvement (CQI)

Intent of the chapter:

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

The organisation 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 organisation.
CQI 2:	There is a structured patient-safety programme in the organisation.
CQI 3:	The organisation identifies key indicators to monitor the clinical structures, processes and outcomes, which are used as tools for continual improvement**.**
CQI 4:	The organisation identifies key indicators to monitor the managerial structures, processes and outcomes, which are used as tools for continual improvement**.**
CQI 5:	There is a mechanism for validation and analysis of quality indicators to facilitate quality improvement.
CQI 6:	The quality improvement programme is supported by the management.
CQI 7:	There is an established system for clinical audit.
CQI 8:	Incidents are collected and analysed to ensure continual quality improvement.
CQI 9:	Sentinel events are intensively analysed.

*** This implies that this objective element requires documentation.**

Standards and Objective Elements

Standard

CQI.1.	**There is a structured quality improvement and continuous monitoring programme in the organisation.**

Objective Elements

a. The quality improvement programme is developed, implemented and maintained by a multi-disciplinary committee.*

b. The quality improvement programme is documented which is comprehensive and covers all the major elements related to quality assurance.*

c. There is a designated individual for coordinating and implementing the quality improvement programme.*

d. The quality improvement programme promotes and demonstrates use of innovations to improve process efficiency and effectiveness.

e. The designated programme is communicated and coordinated amongst all the staff of the organisation through appropriate training mechanism.

f. The quality improvement programme identifies opportunities for improvement based on review at pre-defined intervals.*

g. The quality improvement programme is a continuous process and updated at least once in a year.

h. Audits are conducted at regular intervals as a means of continuous monitoring.*

i. There is an established process in the organisation to monitor and improve quality of nursing care.*

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

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 organisation through appropriate training mechanism.

g. The patient-safety programme identifies opportunities for improvement based on review at pre-defined intervals.

h. The patient-safety programme is a continuous process and updated at least once in a year.

i. The organisation adapts and implements national/international patient-safety goals/solutions.

Standard

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

Objective Elements

a. Monitoring includes appropriate patient assessment.

b. Monitoring includes safety and quality-control programmes of all the diagnostic services.

c. Monitoring includes medication management.

d. Monitoring includes use of anaesthesia, if applicable.

e. Monitoring includes surgical services, if applicable.

f. Monitoring includes use of blood and blood components, if applicable.

g. Monitoring includes infection control activities.

h. Monitoring includes review of mortality and morbidity indicators.

i. Monitoring includes clinical research

j. Monitoring includes patient safety goals.

k. The organisation identifies and monitors priority aspects of patient care.

Standard

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

Objective Elements

a. Monitoring includes procurement of medication essential to meet patient needs.

b. Monitoring includes risk management.

c. Monitoring includes utilisation of space, manpower and equipment.

d. Monitoring includes patient satisfaction which also incorporates waiting time for services.

e. Monitoring includes employee satisfaction.

f. Monitoring includes adverse events and near misses.

g. Monitoring includes availability and content of medical records.

h. The organisation identifies and monitors priority managerial activities in the organisation.

Standard

CQI.5.	**There is a mechanism for validation and analysis of quality indicators to facilitate quality improvement.**

Objective Elements

a. There is a mechanism for validation of data.

b. There is a mechanism for analysis of data which results in identifying opportunities for improvement.

c. The opportunities for improvement are implemented and evaluated.

d. The organisation uses appropriate quality improvement, statistical and management tools in its quality improvement programme.

e. Feedback about care and service is communicated to staff.

Standard

CQI.6.	**The quality improvement programme is supported by the management.**

Objective Elements

a. The leaders at all levels in the organisation are aware of the intent of the quality improvement program and the approach to its implementation.

b. The management makes available adequate resources required for quality improvement programme.

c. Organisation earmarks adequate funds from its annual budget in this regard.

d. The management identifies organisational performance improvement targets.

Standard

CQI.7.	**There is an established system for clinical audit.**

Objective Elements

a. Medical and nursing staff participates in this system.

b. The parameters to be audited are defined by the organisation.

c. Patient and staff anonymity is maintained.

d. All audits are documented.

e. Remedial measures are implemented.

Standard

CQI.8.	**Incidents are collected and analysed to ensure continual quality improvement.**

Objective Elements

a. The organisation has an incident reporting system. *

b. The organisation has established processes for analysis of incidents.

c. Corrective and preventive actions are taken based on the findings of such analysis.

d. The organisation shall have a process for informing various stakeholders in case of a near miss / adverse event.

Standard

CQI.9.	**Sentinel events are intensively analysed.**

Objective Elements

a. The organisation has defined sentinel events. *

b. The organisation has established processes for intense analysis of such events.

c. Sentinel events are intensively analysed when they occur.

d. Corrective and preventive actions are taken based on the findings of such analysis.

Chapter 7

Responsibilities of Management (ROM)

Intent of the chapter:

The standards encourage the governance of the organisation in a professional and ethical manner. The responsibilities of the management are defined. The organisation complies with all applicable regulations. The organisation is led by a suitably qualified and experienced individual .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 those responsible for governance are defined.
ROM 2:	The organisation is responsible for and complies with the laid-down and applicable legislations, regulations and notifications.
ROM 3:	The services provided by each department are documented.
ROM 4:	The organisation is managed by the leaders in an ethical manner.
ROM 5:	The organisation displays professionalism in management of affairs.
ROM 6:	Management ensures that patient-safety aspects and risk-management issues are an integral part of patient care and hospital management.

*** This implies that this objective element requires documentation.**

Standards and Objective Elements

Standard

ROM.1.	**The responsibilities of those responsible for governance are defined.**

Objective Elements

a. Those responsible for governance lay down the organisation's vision, mission and values. *

b. Those responsible for governance approve the strategic and operational plans and organisation's annual budget

c. Those responsible for governance monitor and measure the performance of the organisation against the stated mission.

d. Those responsible for governance establish the organisation's organogram. *

e. Those responsible for governance appoint the senior leaders in the organisation.

f. Those responsible for governance support safety initiatives and quality-improvement plans.

g. Those responsible for governance support research activities.

h. Those responsible for governance address the organisation's social responsibility.

i. Those responsible for governance inform the public of the quality and performance of services.

Standard

ROM.2.	**The organisation is responsible for and complies with the laid-down and applicable legislations, regulations and notifications.**

Objective Elements

a. The management is conversant with the applicable laws and regulations and undertakes the responsibility to adhere to the same.

b. The management ensures that the policies and procedures pertaining to patient care are in compliance with the prevailing laws, regulations and notifications.

c. The management has a mechanism which ensures implementation of these requirements.

d. Management has a mechanism which regularly updates any amendments in the prevailing laws of the land.

e. There is a mechanism to regularly update licenses/registrations/certifications.

Standard

ROM.3.	**The services provided by each department are documented.**

Objective Elements

a. Scope of services of each department is defined. *

b. Administrative policies and procedures for each department are maintained. *

c. Each organisational programme, service, site or department has effective leadership.

d. Departmental leaders are involved in quality improvement.

Standard

ROM.4.	**The organisation is managed by the leaders in an ethical manner.**

Objective Elements

a. The leaders make public the vision, mission and values of the organisation.

b. The leaders establish the organisation’s ethical management. *

c. The organisation discloses its ownership.

d. The organisation honestly portrays the services which it can and cannot provide.

e. The organisation honestly portrays its affiliations and accreditations.

f. The organisation accurately bills for its services based upon a standard billing tariff.

Standard

ROM.5.	**The organisation displays professionalism in management of affairs.**

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 performance of the senior leaders is reviewed for their effectiveness.

g. The functioning of committees is reviewed for their effectiveness.

h. The organisation documents employee rights and responsibilities. *

i. The organisation documents the service standards. *

j. The organisation has a formal documented agreement for all outsourced services.

k. The organisation monitors the quality of the outsourced services.

Standard

ROM.6.	**Management ensures that patient-safety aspects and risk-management issues are an integral part of patient care and hospital management.**

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 chapter:

The standards guide the provision of a safe and secure environment for patients, their families, staff and visitors. The organisation shall take steps to ensure this, including proactive risk mitigations.

To ensure this, the organisation conducts regular facility inspection rounds and takes the appropriate action to ensure safety.

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

The organisation has a programme for medical and utility equipment management.

The organisation plans for emergencies within the facilities.

The organisation is a no-smoking area and manages hazardous materials in a safe manner.

The organisation works towards measures on being energy efficient.

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 in a planned manner to ensure safety of patients, their families, staff and visitors and promotes environment friendly measures.
FMS 3:	The organisation has a programme for engineering support services and utility system.
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.
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.

*** This implies that this objective element requires documentation.**

Standards and Objective Elements

Standard

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

Objective Elements

a. Safety committee coordinates development, implementation and monitoring of the safety plan and policies.

b. Patient-safety devices & infrastructure are installed across the organisation and inspected periodically.

c. The organisation is a non-smoking area.

d. There is a procedure which addresses the identification and disposal of material(s) not in use in the organisation. *

e. Facility inspection rounds to ensure safety are conducted at least twice in a year in patient-care areas and at least once in a year in non-patient-care areas.

f. Inspection reports are documented and corrective and preventive measures are undertaken.

g. There is a safety education programme for staff.

Standard

FMS.2.	**The organisation's environment and facilities operate in a planned manner to ensure safety of patients, their families, staff and visitors and promotes environment friendly measures.**

Objective Elements

a. Facilities are appropriate to the scope of services of the organisation.

b. Up-to-date drawings are maintained which detail the site layout, floor plans and fire-escape routes.

c. There is internal and external sign postings in the organisation in a language understood by the patient, families and community.

d. The provision of space shall be in accordance with the available literature on good practices (Indian or international standards) and directives from government agencies.

e. Operational planning describes access to different areas in the hospital by staff, patients, visitors and vendors.

f. Potable water and electricity are available round the clock.

g. Alternate sources for electricity and water are provided as backup for any failure/shortage.

h. The organisation regularly tests these alternate sources.

i. There are designated individuals (with appropriate equipment) responsible for the maintenance of all the facilities.

j. Maintenance staff is contactable round the clock for emergency repairs.

k. There is a maintenance plan for facility and furniture. *

l. Response times are monitored from reporting to inspection and implementation of corrective actions.

m. The organisation takes initiatives towards an energy efficient and environmental friendly hospital. *

Standard

FMS.3.	**The organisation has a programme for engineering support services and utility system.**

Objective Elements

a. The organisation plans for equipment in accordance with its services and strategic plan.

b. Equipment are selected, rented, updated or upgraded by a collaborative process.

c. Equipment are inventoried and proper logs are maintained as required.

d. Qualified and trained personnel operate, inspect, test and maintain equipment and utility systems.

e. Utility equipment are periodically inspected and calibrated (wherever applicable) for their proper functioning.

f. There is a documented operational and maintenance (preventive and breakdown) plan. *

g. There is a maintenance plan for water management. *

h. There is a maintenance plan for electrical systems. *

i. There is a maintenance plan for heating, ventilation and air-conditioning. *

j. There is a maintenance plan for Information technology & communication network *

k. There is a documented procedure for equipment replacement and disposal. *

Standard

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

Objective Elements

a. The organisation plans for equipment in accordance with its services and strategic plan.

b. Equipment are selected, rented, updated or upgraded by a collaborative process.

c. Equipment are inventoried and proper logs are maintained as required.

d. Qualified and trained personnel operate and maintain the medical equipment.

e. Equipment are periodically inspected and calibrated for their proper functioning.

f. There is a documented operational and maintenance (preventive and breakdown) plan for equipment. *

g. There is a documented procedure for equipment replacement and disposal. *

h. The procedure addresses medical equipment recalls.

i. Response times are monitored from reporting to inspection and implementation of corrective actions.

Standard

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

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, inspection, testing 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.**

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 & infrastructure *

Standard

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

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 are educated and trained for handling such materials.

Chapter 9

Human Resource Management (HRM)

Intent of the chapter:

The most important resource of a hospital and healthcare 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 organisation. This is based on the organisation'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 socialisation 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 "employee" refers to all salaried personnel working in the organisation. The term "staff" refers to all personnel working in the organisation including employees, "fee for service" medical professionals, part-time workers, contractual personnel and volunteers.

Summary of Standards

HRM 1:	The organisation 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 are adequately trained on various safety-related aspects.
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 organisation has documented disciplinary and grievance handling policies and procedures.
HRM 7:	The organisation addresses the health needs of the employees.
HRM 8:	There is documented personal information for each staff member.
HRM 9:	There is a process for credentialing and privileging of medical professionals, permitted to provide patient care without supervision.
HRM 10:	There is a process for credentialing and privileging of nursing professionals, permitted to provide patient care without supervision.

*** This implies that this objective element requires documentation.**

Standards and Objective Elements

Standard

HRM.1.	**The organisation has a documented system of human resource planning.**

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 specification and job description are well defined for each category of staff. *

d. The organisation verifies the antecedents of the potential employee with regards to criminal/negligence background.

Standard

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

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

Standard

HRM.3.	**There is an on-going programme for professional training and development of the staff.**

Objective Elements

a. A documented training and development policy exists for the staff. *

b. The organisation maintains the training record.

c. Training also occurs when job responsibilities change/new equipment is introduced.

d. Evaluation of training effectiveness is done by the organisation

e. Feedback mechanisms are in place for improvement of training and development programme.

HRM.4.	**Staff are adequately trained on various safety-related aspects.**

Objective Elements

a. Staff are trained on the risks within the organisation's environment.

b. Staff members can demonstrate and take actions to report, eliminate, or minimise risks.

c. Staff members are made aware of procedures to follow in the event of an incident.

d. Staff are trained on occupational safety aspects.

Standard

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

Objective Elements

a. A documented performance appraisal system exists in the organisation. *

b. The employees are made aware of the system of appraisal at the time of induction.

c. Performance is evaluated based on the pre-determined criteria.

d. The appraisal system is used as a tool for further development.

e. Performance appraisal is carried out at pre-defined intervals and is documented.

Standard

HRM.6.	**The organisation has documented disciplinary and grievance handling policies and procedures.**

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 disciplinary policy and procedure is based on the principles of natural justice.

d. The disciplinary and grievance procedure is in consonance with the prevailing laws.

e. There is a provision for appeals in all disciplinary cases.

f. The redress procedure addresses the grievance.

g. Actions are taken to redress the grievance.

Standard

HRM.7.	**The organisation addresses the health needs of the employees.**

Objective Elements

a. A pre-employment medical examination is conducted on all the staff.

b. Health problems of the employees are taken care of in accordance with the organisation's policy.

c. Regular health checks of staff dealing with direct patient care are done at least once a year and the findings/results are documented.

d. Occupational health hazards are adequately addressed.

Standard

HRM.8.	**There is documented personal information for each staff member.**

Objective Elements

a. Personal files are maintained with respect to all staff.

b. The personal files contain personal information regarding the staff's qualification, disciplinary background and health status.

c. All records of in-service training and education are contained in the personal files.

d. Personal files contain results of all evaluations.

Standard

HRM.9.	**There is a process for credentialing and privileging of medical professionals, permitted to provide patient care without supervision.**

Objective Elements

a. Medical professionals permitted by law, regulation and the organisation to provide patient care without supervision are identified.

b. The education, registration, training and experience of the identified medical professionals is documented and updated periodically.

c. All such information pertaining to the medical professionals is appropriately verified when possible.

d. Medical professionals are granted privileges to admit and care for patients in consonance with their qualification, training, experience and registration

e. The requisite services to be provided by the medical professionals are known to them as well as the various departments/units of the organisation.

f. Medical professionals admit and care for patients as per their privileging.

Standard

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

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.

Chapter 10

Information Management System (IMS)

Intent of chapter:

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 utilised appropriately by the organisations. One of the major intent of this chapter is to ensure data and information meet the organisation's needs and support the delivery of quality care and service.

Provision of patient care is a complex activity that is highly dependent on communication of information. This communication is to and from the community, patients and their families, and other health professionals. Failures in communication are one of the most common root causes of patient safety incidents. The goal of Information management in a hospital is to ensure that the right information is made available to the right person. This is provided in an authenticated, secure and accurate manner at the right time and place. This helps achieve the ultimate organisational goal of a satisfied and improved provider and recipient of any health care setting.

An effective Information management system is based on the information needs of the organisation. The system is able to capture, transmit, store, analyse, utilise and retrieve information as and when required for improving clinical outcomes as well as individual and overall organisational 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. These standards are designed to be equally compatible with non-computerised systems and future technologies.

Summary of Standards

IMS 1:	Documented policies and procedures exist to meet the information needs of the care providers, management of the organisation as well as other agencies that require data and information from the organisation.
IMS 2:	The organisation has processes in place for effective control and management of data.
IMS 3:	The organisation 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 records, data and information.
IMS 6:	Documented policies and procedures exist for retention time of records, data and information.
IMS 7:	The organisation regularly carries out review of medical records.

*** This implies that this objective element requires documentation.**

Standards and Objective Elements

Standard

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

Objective Elements

a. The information needs of the organisation are identified and are appropriate to the scope of the services being provided by the organisation. *

b. Documented policies and procedures to meet the information needs exist. *

c. All information management and technology acquisitions are in accordance with the documented policies and procedures.

d. Documented policies and procedures guide the use of Telemedicine facility in a safe and secure manner

e. The organisation contributes to external databases in accordance with the law and regulations.

Standard

IMS.2.	**The organisation has processes in place for effective control and management of data.**

Objective Elements

a. The organisation has an effective process for document control. *

b. Formats for data collection are standardized.

c. Necessary resources are available for analyzing data.

d. Documented procedures are laid down for timely and accurate dissemination of data. *

e. Documented procedures exist for storing and retrieving data. *

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

Standard

IMS.3.	**The organisation has a complete and accurate medical record for every patient.**

Objective Elements

a. Every medical record has a unique identifier.

b. Organisation policy identifies those authorized to make entries in medical record.

c. Entry in the medical record is named, signed, dated and timed.

d. The author of the entry can be identified.

e. The contents of medical record are identified and documented. *

f. The organisation has a documented policy for usage of abbreviations and develops a list based on accepted practices.

g. The record provides a complete, up-to-date and chronological account of patient care.

h. Provision is made for 24-hour availability of the patient's record to healthcare providers to ensure continuity of care.

Standard

IMS.4.	**The medical record reflects continuity of care.**

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 summary duly signed by appropriate and qualified personnel.

f. In case of death, the medical record contains a copy of the cause of death certificate.

g. Whenever a clinical autopsy is carried out, the medical record contains a copy of the report of the same.

h. Care providers have access to current and past medical record.

Standard

IMS.5.	**Documented policies and procedures are in place for maintaining confidentiality, integrity and security of records, data and information.**

Objective Elements

a. Documented policies and procedures exist for maintaining confidentiality, security and integrity of records, data and information. *

b. Documented policies and procedures are in consonance with the applicable laws.

c. The policies and procedure(s) incorporate safeguarding of data/record against loss, destruction and tampering.

d. The organisation has an effective process of monitoring compliance of the laid down policy and procedure.

e. The organisation uses developments in appropriate technology for improving confidentiality, integrity and security.

f. Privileged health information is used for the purposes identified or as required by law and not disclosed without the patient's authorisation.

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.**

Objective Elements

a. Documented policies and procedures are in place on retaining the patient's clinical records, data and information. *

b. The policies and procedures are in consonance with the local and national laws and regulations.

c. The retention process provides expected confidentiality and security.

d. The destruction of medical records, data and information is in accordance with the laid-down policy.

Standard

IMS.7.	**The organisation regularly carries out review of medical records.**

Objective Elements

a. The medical records are reviewed periodically.

b. The review uses a representative sample based on statistical principles.

c. The review is conducted by identified individuals.

d. The review focuses on the timeliness, legibility and completeness of the medical records.

e. The review process includes records of both active and discharged patients.

f. The review points out and documents any deficiencies in records.

g. Appropriate corrective and preventive measures are undertaken within a defined period of time and are documented

National Accreditation Board for Hospitals
and Healthcare Providers (NABH)

5th Floor, ITPI Building 4A, Ring Road, IP Estate,
New Delhi - 110 002
Ph.: +91 11 23323516, 23323517,
23323518, 23323519, 23323520
Fax: +91 11 23323415
E-mail: helpdesk@nabh.co Website: www.nabh.co

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