Internship Training at

OCTAVO SOLUTIONS PVT. LTD.

By
HEMLATA VERMA

PGDHM
2012-2014

International Institute of Health Management Research
New Delhi

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GAP ANALYSIS OF DISTRICT JOINT HOSPITAL, SANJAY NAGAR, GHAZIABAD AS PER NABH STANDARDS

By
HEMLATA VERMA

Under the guidance of
Ms. Jhilam Mitra

Post Graduate Diploma in Hospital and Health Management
Year 2012 - 2014

International Institute of Health Management Research

Acknowledgment

The success of any assignment would be incomplete without the expression of appreciation of gratitude to the people who made it successful .Though words fall short to express the sincere gratitude towards everyone who helped directly or indirectly in my endeavour.

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The certificate is awarded to

Ms. HEMLATA VERMA

In recognition of having successfully completed her

Internship in OCTAVO SOLUTIONS PVT. LTD.

And has successfully completed her Project on

"GAP ANALYSIS OF DISTRICT JOINT HOSPITAL, SANJAY NAGAR, GAZIABAD AS PER NABH STANDARDS"

Date: 30th April, 2014

Organisation: OCTAVO SOLUTIONS PVT. LTD.

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

We wish her all the best for future endeavours.

Octavo Solutions Pvt. Ltd. New Delhi

Vice President

Octavo Solutions P Ltd.

A Private Limited Company, Regd. No. U72400DL2007PTC159745 2006-2007, Under Companies Registration Act

Corporate Office : B-4/167, Basement, Safdarjung Enclave, New Delhi - 110029

Phones : +91-11-64550707
40536561
Telefax : +91 11 41658335

Website : www.octavosolutions.com
E - mail :contactoctavo@gmail.com

TO WHOMSOEVER MAY CONCERN

This is to certify that **Hemlata Verma** student of Post Graduate Diploma in Hospital and Health Management (PGDHM) from International Institute of Health Management Research, New Delhi has undergone internship training at **Octavo Solutions Pvt. Ltd.** from **10/Feb./2014** to **30/April/2014** .

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

The Internship is in fulfillment of the course requirements.

I wish her success in all her future endeavors.

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

Name of mentor
Mrs. Preetha G.S.
IIHMR, New Delhi

Certificate Of Approval

The following dissertation titled "**Gap Analysis of District Joint Hospital, Sanjay Nagar, Ghaziabad as per NABH standards** at "**Octavo Solutions Pvt. Ltd.** is hereby approved as a certified study in management carried out and presented in a manner satisfactorily to warrant its acceptance as a prerequisite for the award of **Post Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation.

Name	Signature
Dr. V.K. Singh	
Dr. B.S. Singh	
Dr. Preetha G.S.	

Certificate from Dissertation Advisory Committee

This is to certify that **Dr. Hemlata Verma,** a graduate student of the **Post- Graduate Diploma in Health and Hospital Management** has worked under our guidance and supervision. He/ She is submitting this dissertation titled "**Gap Analysis of District Joint Hospital, Sanjay Nagar, Ghaziabad as per NABH standards**" at "**Octavo Solutions Pvt. Ltd**" in partial fulfillment of the requirements for the award of the **Post- Graduate Diploma in Health and Hospital Management.**

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

Mrs. Preetha G. S.,
Associate Professor,
IIHMR, New Delhi.

Jhilam Mitra
Ms. Jhilam Mitra
Assistant Consultant,
Octavo Solutions Pvt. Ltd

INTERNATIONAL INSTITUTE OF HEALTH MANAGEMENT RESEARCH, NEW DELHI

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled "GAP ANALYSIS OF DISTRICT HOSPITAL, SANJAY NAGAR, GHAZIABAD AS PER NABH STANDARDS" and submitted by (Name) Dr. HAMLATA VERMA ..... Enrollment No. PG/12/034 ..... under the supervision of MRS. PREETHA G. S. ..... for award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the period from 01/02/2014 to 30/09/2014 embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.

Hamlata

Signature

FEEDBACK FORM

Name of the Student: Hemlata Verma

Dissertation Organisation: Octavo Solutions P Ltd.

Area of Dissertation: Quality Accreditation & Certification

Attendance: Regular

Objectives achieved: Successfully completed the process of gap analysis & Preparation of reports

Deliverables: Preparation of tool for gap analysis, conducting gap analysis, formulation of report, scoring as per the self assessment toolkit

Strengths: Quick learner & smart working

Suggestions for Improvement: Need to focus more on communication & Presentation Skill

Jhilam Mitra

Organisation Mentor (Dissertation)

Date: 08/05/14

Place: New Delhi

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LIST OF ABBREVIATIONS

S.NO.	ABBREVIATED FORM	FULL FORM
1.	AAC	Access, assessment and continuity of care
2.	AC	Air conditioning
3.	ACHS	Australian Council On Healthcare Standards
4.	ACLS	Advanced cardiac life support
5.	AERB	Atomic Energy Regulatory Board
6.	AHU	Air handling unit
7.	AMC	Annual Maintenance Contract
8.	BARC	Bhabha Atomic Research Centre
9.	BLS	Basic life support
10.	BMW	Bio Medical Waste Management
11.	CCTV	Close Circuit Television
12.	CCU	Critical Care Unit
13.	COP	Care Of Patients
14.	CPR	Cardio Pulmonary Resuscitation
15.	CQI	Continuous Quality Improvement
16.	CSSD	Central Sterile and Supply Department
17.	EOQ	Economic Oder Quantity

18.	FMS	Facility Management System
19.	HDU	High Dependency Unit
20.	HIC	Hospital Infection Control
21.	HMIS	Hospital Management Information System
22.	HRM	Human Resource Management
23.	ICU	Intensive Care Unit
24.	IMS	Information Management System
25.	IPD	In Patient department
26.	LAMA	Leave against Medical Advice
27.	MOM	Management Of Medication
28.	MRD	Medical Records Department
29.	MRI	Magnetic Resonance Imaging
30.	NABH	National Accreditation Board for Hospitals and Healthcare Providers
31.	OPD	Out Patient Department
32.	OSPL	Octavo Solutions Pvt. Ltd.
33.	OT	Operation Theatre
34.	PM	Preventive Maintenance
35.	PPE	Personal Protective Equipment

36.	PRE	Patient Right and Education
37.	QA	Quality Assurance
38.	QCI	Quality Council of India
39.	ROM	Responsibilities Of Management
40.	SOP	Standard Operating Procedure
41.	TQM	Total Quality Management
42.	UTI	Urinary Tract Infection

LIST OF APPENDICES

Part 1

INTERNSHIP

1. OBJECTIVE OF INTERNSHIP

I have done internship from Octavo Solutions Pvt. Limited, New Delhi, for the period of three months from 10th February to 30th April 2014.

The objective of the internship at Octavo Solutions Pvt. Ltd. was to gain relevant knowledge, skills, and experience while establishing important connections in the field. I was able to gain valuable hands-on work experience on various dimensions of a Healthcare Consulting Organization like Planning, System Development and Operation, Quality Healthcare Certification etc. I was also able to test personal aptitudes, abilities, and interests in relation to my career choice and job demands as well as to improve interpersonal skills such as confidence, maturity, decision making.

As a Management Consultant, my roles and responsibilities included understanding the current ongoing Projects being handled by my Organization and understand the functioning of the unit. Octavo Solutions, with precise domain knowledge and understanding of industry dynamics, ensures that it creates and operates quality healthcare organizations and facilities, and help clients with best models of systems and policies to generate sustainable results. Management consultants help organisations to solve issues, create value, maximise growth and improve the business performance of their clients. They use their business skills to provide objective advice, expertise and specialist skills which the organisation may be lacking.

2. ORGANISATIONAL PROFILE

OSPL is a multidisciplinary health and hospital consulting firm founded in 2006. The organisation is managed by a board of health management experts from various sectors like Public Health, **Public Health Engineering, Biomedical Engineering, Clinical Experts, Quality, Project Management, Information Technology, Accreditation of Healthcare Institutions, Planning, Architecture, Skill Development Training, etc.,**

Octavo Solutions Pvt. Ltd. has successfully implemented more than 250 projects across 16 states in India today. It is the first consulting firm to be registered with Quality Council of India (National **Accreditation Board for Education and Training) for consulting services in the field of Healthcare (NC07 01).**

Consultants on board have also been involved in framing standards for various healthcare facilities across the Nation and have enabled visionaries from all over India to contribute to the healthcare sector by assisting them in planning and development of healthcare facilities and infrastructure projects ranging from small healthcare service providing institutions to large technical organisations, including large scale Public Health Projects with the Government of India and also Public Private Partnership enterprises.

Services Offered

- Planning
- System Development & Operation
- Quality Healthcare Certifications
- Public Private Partnership
- Capacity Building
- Information & Technology
- Public & Rural Health
- Knowledge Management

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

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

KEY STRENGTHS AND SALIENT FEATURES OF OSPL

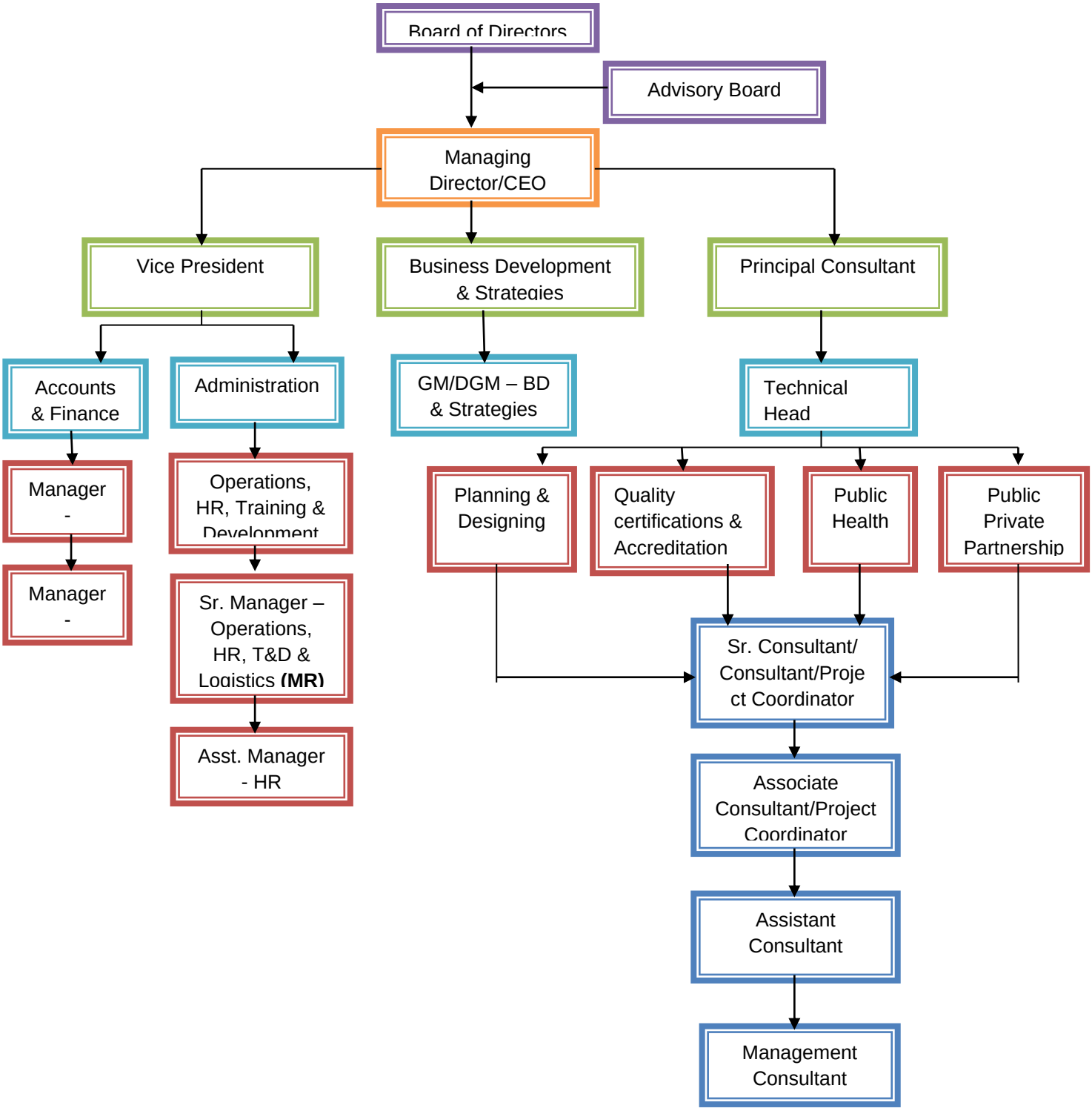
The primary **strength** of our company is to partner the client organization to optimize resources & implement the improvement strategies successfully. An assignment begins with an accurate assessment of people, processes, performance and strategies. Our consultants define competitive strengths, threats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

KEY STRENGTHS:

1. A **Private Limited Company**
2. Short listed firm with **NHSRC** (National Health Systems Resource Centre) under aegis of Ministry of Health & Family Welfare (Government of India)
3. **Talented Leadership** from leading institutes like
   - ❖ All India Institute of Medical Sciences (Delhi),
   - ❖ School of Planning and Architecture (Delhi),
   - ❖ Tata Institute of Social Sciences, (Mumbai)
   - ❖ Indian Institute of Health Management and Research (Jaipur & Delhi)
   - ❖ Symbiosis Institute of Health Sciences (Pune)
   - ❖ Jamia Hamdard University (Delhi)
4. Great Team with all essential skills
5. Dr. Bidhan Das- Member, Technical Committee of NABH for drafting standards
6. Dr T.Venkatesh- Member, Technical Committee of NABL for drafting standards
7. Dr Bidhan Das has Standards for Primary Healthcare (NABH) to his credit which is on its (likely) first test in State of Gujarat

8. Dr. Bidhan Das- First ACHS International Surveyor (Australian Council for Health Standards) in India
9. OSPL is **SE-Asia Partners for ACHSI**
10. OSPL has presence in **14 states (**including Union Territories)
11. OSPL has working offices at **7** different locations across India.
12. OSPL has three overseas **(International)** project to its credit.
13. In short span of just 4 years, OSPL has rendered its **consulting services to over 30,000 beds** within the healthcare sector
14. OSPL has provided consulting services to over 100 Hospitals (bed range 30-1500), 07 Teaching Hospital & Medical Colleges, 01 Rehabilitation Hospital, 02 Dental Hospital & Colleges, 02 AYUSH Hospitals.
15. Combined Years of Experience of OSPL's Technical Personnel is 68 Man-Years in ISO/ NABL/ NABH/ QMS and Hospital Planning assignments. Their key Personnel have rich experience of having conducted over 720 Audits/ Assessments and provided consulting services to 497 client organizations for establishing QMS.

3. ORGANOGRAM



Part 2

DISSERTATION

GAP ANALYSIS OF DISTRICT JOINT HOSPITAL, SANJAY NAGAR, GHAZIABAD AS PER NABH STANDARDS

2.1 EXECUTIVE SUMMARY

The Gap Analysis of District Joint Hospital, Sanjay nagar, Ghaziabad was done during the period of 20th March to 20th April 2014. A visit to hospital premises and personal interviews of all categories of hospital staff was organized during this period. The purpose was to assess the functional areas of hospital services with a view of analysing the gaps in the hospital for NABH Accreditation.

District hospital is a newly constructed 100 bedded hospital commissioned in 2008. For doing gap analysis the assessment of documentation and implementation with respect to Structure (Manpower, equipment, infrastructure and Statutory requirements),Processes (Clinical & Administrative)and Outcome against NABH Standard (3rd edition) was done.

There were many structural gaps observed. Though Hospital Signage system is observed inside the hospital, but signages are painted on walls and are not as per standards. Standard forms and formats, relevant licenses and statutory requirements viz - NOC fire safety, PCB; essential equipment's/accessories such as, defibrillator, Foot Operated, Bio medical waste buckets, Digital temperature device, etc. are not available in the hospital. There is shortage of manpower especially of paramedical and Class IV staff. Though separate OT complex is present but Zoning in the Operation Theatres is not done. Dedicated ICCU is present but it is not equipped and manned to treat emergency cases. ICU, Blood Bank, Medical record Department, are not present in the hospital. Security service is not available for the safety of hospital staff and patients. Proper fire fighting system is not installed in the hospital.

The procedural gaps included absence of system of allotting Unique ID numbers for patients at the time of Registration. The knowledge and practices about BMW management are rudimentary and need repeated training and monitoring. Sterilization & Infection Control practices inside the OT are found to be very poor. Queue management is missing in OPD. Patient's Records are not dated, timed, signed, and sealed uniformly. Proper consent forms are not present since consent is taken on BHT only which is written in Hindi.

There is no monitoring of various outcome indicators of quality in each department. Also hospital infection rates are not monitored which is mandatory for NABH.

The hospital needs to take actions for compliance with the Accreditation standards of NABH (3rd edition) to impact the delivery of healthcare services positively, ensuring quality services, efficient outcomes with economy, risk management with patients, staff and visitors safety and above all equity in healthcare services for all the citizens.

2.2 INTRODUCTION OF STUDY

National Accreditation Board for Hospitals & Healthcare Providers (NABH) is a constituent board of Quality Council of India, set up to establish and operate accreditation programme for healthcare organisations. The board is structured to cater to much desired needs of the consumers and to set benchmarks for progress of health industry. The board while being supported by all stakeholders including industry, consumers, government, have full functional autonomy in its operation.[1]

Organisations like the Quality Council of India (QCI) and its National Accreditation Board for Hospitals and Healthcare providers NABH have designed an exhaustive healthcare standard for hospitals and healthcare providers. This standard consists of stringent 600 plus objective elements for the hospital to achieve in order to get the NABH accreditation. These standards are divided between patient centred standards and organization centred standards.

To comply with these standard elements, the hospital will need to have a process-driven approach in all aspects of hospital activities – from registration, admission, pre-surgery, peri-surgery and post-surgery protocols, discharge from the hospital to follow-up with the hospital after discharge. Not only the clinical aspects but the governance aspects are to be process driven based on clear and transparent policies and protocols. In a nutshell NABH aims at streamlining the entire operations of a hospital.

NABH is equivalent to JCI and other International standards including HAS: Haute Authorite de Sante, Australian Council on Healthcare Standards, the Japan Council for Quality in Health Care, and the National Committee for Quality Assurance in the United States. Its standards have been accredited by ISQUA the apex body accrediting the accreditators hence making NABH accreditation at par with the world's most leading hospital accreditations.

GAP ANALYSIS

Gap Analysis is a process to analyse the degree of compliance to any standard. Gap analysis involves determining, documenting, and approving the difference between hospital's requirements and current capabilities.

OUTLINE OF NABH STANDARDS

PATIENT CENTERED STANDARDS

- Access, Assessment and Continuity of Care (AAC)
- Care of patients (COP)
- Management of Medication (MOM)
- Patient Right & Education (PRE)
- Hospital Infection & Control (HIC)

ORGANIZATION CENTERED STANDARDS

- Continuous Quality Improvement (CQI)
- Responsibility of management (ROM)
- Facility Management & Safety (FMS)
- Human Resource Management (HRM)
- Information Management System (IMS)

ASSESSMENT CRITERIA

A hospital willing to be accredited by NABH must ensure the implementation of NABH standards in its organization.

The assessment team will check the implementation of NABH Standards in organization. The Hospital shall be able to demonstrate to NABH assessment team that all NABH standards, as applicable, are followed.

NEED FOR HOSPITAL ACCREDITATION

- Public Recognition by a National Healthcare Accreditation Body
- Single most important approach for improving the quality of hospitals
- Promotes hospitals and ensures quality of care
- Ensures Transparent system of control

2.3 PROBLEM STATEMENT

Gap analysis is the comparison of actual performance with potential performance. Gap analysis naturally flows from benchmarking and other assessments. Once the general expectation of performance in the industry is understood, it is possible to compare that expectation with the company's current level of performance. This comparison becomes the gap analysis.

Recent spurt in Public Private Partnership (PPP) projects, and thrust on quality by the government sector and its demand (& mandate in some areas) on NABH and ISO, requires doing the gap analysis so as to implement the processes which are lacking in Government hospitals. With CGHS making NABH mandatory for care and hospitalisation cost reimbursements, there is hectic activity seen in hundreds of hospitals waking up to the long due need for quality healthcare and applying for the coveted quality mark.

The trend is on a steep rise, and it is just a matter of time when the government launches patient awareness on NABH quality in full swing. This would make the patient demand at least an ISO, QMS certified hospital if not NABH.

This present study intends to provide some information regarding the same. This research report will help U.P. government to know the present status of District hospital, Sanjay nagar, Ghaziabad so that they can take necessary actions to improve the quality of hospital services.

2.4 RATIONALE OF THE STUDY

Assessment of quality of services provided by the hospitals in these days has been a serious concern for the hospitals and health care organizations owing to the excessive demands imposed on them by the users, consumers, government and the society at large. As a result, many hospitals have resorted to such assessment not only for the reasons of compliance but for the improvement of the services to the satisfaction of the users. Nevertheless, such efforts have not been much strengthened by research perspective owing to the lack of adequate qualification on the part of the providers and also lack of time to scientifically carry out such assessments by the executives.

The present study represents some progress in this direction. This study would guide the U.P. State Government to understand the existing deficiencies/gaps in healthcare delivery services thereby enabling the policy makers to formulate a strategy to fulfil such deficiencies/gaps and strive towards further improvement.

2.5 REVIEW OF LITERATURE

2.5.1 PREPARING FOR NABH ACCREDITATION

Hospital management shall first decide about getting accreditation for its hospital from NABH. It is important for a hospital to make a definite plan of action for obtaining accreditation and nominate a responsible person to co-ordinate all activities related to seeking accreditation.

An official nominated should be familiar with existing hospital quality assurance system. Hospital shall procure a copy of standards from the NABH Secretariat against payment. Further clarification regarding standards can be got form NABH Secretariat in person, by post, by e-mail or on telephone. The hospital looking for accreditation shall understand the NABH assessment procedure. The hospitals shall ensure that the standards are implemented in the organization.

The hospitals can download the application form for NABH Accreditation from the web-site. The applicant hospital must have conducted self-assessment against NABH standards at least 3 months before submission of application and must ensure that it complies with NABH Standards.

2.5.2 NABH ACCREDITATION PROCEDURE [2]

APPLICATION FOR ACCREDITATION:

The hospital shall apply to NABH in the prescribed application form. The application shall be accompanied with the following:

- Prescribed application fee as detailed in the application form
- Signed copy of 'Terms and Conditions for Maintaining NABH Accreditation', available free on the web-site
- Filled in Self Assessment Toolkit, available free on the web-site.
- Quality/ hospital Manual (as per NABH standards) and other NABH relevant Documents i.e. different policies and procedures of the hospital

Self-Assessment toolkit is for self-assessing itself against NABH Standards.
The self assessment shall be done by the hospital in a stringent manner and if at the time of pre-assessment it is found that there is a significant difference between the self assessment and the pre-assessment report then the organization shall apply for final assessment not earlier than six months from the date of completion of pre-assessment. The applicant hospital must apply for all its facilities and services being rendered from the specific location. NABH accreditation is only considered for hospital's entire activities and not for a part of it.

SCRUTINY OF APPLICATION:

NABH Secretariat receives the application form and after scrutiny of application for its completeness in all respect, acknowledgement letter for the application shall be issued to the hospital with a unique reference number. The hospital shall be required to quote this reference number in all future correspondence with NABH.

PRE-ASSESSMENT:

NABH appoints a Principal Assessor/ Assessment Team who is responsible for pre assessment of healthcare organization. NABH forwards the application form, documents, procedures, Self assessment toolkit to the Principal Assessor/ Assessment Team.

OBJECTIVE OF PRE-ASSESSMENT:

• Check the preparedness of the hospital for final assessment
• Review the scope of accreditation and ascertain the requirement of the number of assessors and the duration of the accreditation
• Review of the documentation system of the hospital
• Explain the methodology to be adopted for assessment.
The Principal assessor shall submit a pre-assessment report in the format specified in the document 'Pre-Assessment Guidelines & Forms'. Copy of the report is handed over to the organization after the assessment and original sent to NABH secretariat. The hospital shall be required to pay the requisite Annual fee before the final assessment

FINAL ASSESSMENT:

The hospital is required to take necessary corrective action to the nonconformities pointed out during the pre-assessment. The final assessment involves comprehensive review of hospital functions and services. NABH shall appoint an assessment team. The team shall include Principal assessor (already appointed) and the assessors. The total number of assessors appointed shall depend on the number of beds and services provided. The date of final assessment shall be agreed upon by the hospital management and assessors. Assessment shall be conducted on hospital's department and services. Based on the assessment by the assessors, the assessment report is prepared by the Principal assessor in a format prescribed by NABH. The details of non-conformity (ies) observed during the assessment are handed over to the hospital by the Principal assessor and detailed assessment report is sent to NABH.

SCRUTINY OF ASSESSMENT REPORT

NABH shall examine the assessment report. The report is taken to the accreditation committee. Depending on the score and compliance to standard would decided the award of accreditation or otherwise as per details given below.

PRE-ACCREDITATION ENTRY LEVEL:

Conditions for qualifying to this award are as below

- All the regulatory legal requirements should be fully met.
- No individual standard should have more than two zeros.
- The average score for individual standard must not be less than 5.
- The average score for individual chapter must be more than 5.
- The overall average score for all standards must exceed 5.

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

PRE-ACCREDITATION PROGRESSIVE LEVEL:

Conditions for qualifying to this award are as below

- All the regulatory legal requirements should be fully met.
- No individual standard should have more than two zeros.
- The average score for individual standard must not be less than 5.
- The average score for individual chapter must be more than 6.
- The overall average score for all standards must exceed 6.

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

ACCREDITED:

Conditions for qualifying for accreditation are as below:
• All the regulatory legal requirements should be fully met.
• No individual standard should have more than one zero to qualify.
• The average score for individual standards must not be less than 5.
• The average score for individual chapter must not be less than 7.
• The overall average score for all standards must exceed 7.
The validity period for accreditation is 3 years subject to terms and conditions.

ISSUE OF ACCREDITATION CERTIFICATE

NABH shall issue an accreditation certificate to the hospital with a validity of three years. The certificate has a unique number and date of validity. The certificate is accompanied by scope of accreditation. The applicant hospital must make all payment due to NABH, before the issue of certificate. All decision taken by NABH regarding grant of accreditation shall be open to appeal by the hospitals, to chairman NABH.

SURVEILLANCE AND RE ASSESSMENT

Accreditation to a hospital shall be valid for a period of three years. NABH conducts one surveillance of the accredited hospitals in one accreditation cycle of three years. The surveillance visit will be planned during the 2nd year i.e. after 18 months of accreditation. The hospitals may apply for renewal of accreditation at least six months before the expiry of validity of accreditation for which reassessment shall be conducted. NABH may call for un-announced visit, based on any concern or any serious incident reported upon by an individual or organization or media.

2.5.3 BENEFITS OF ACCREDITATION:

BENEFITS FOR PATIENTS:

- High Quality of Care and Patient Safety
- Patients are serviced by Credential Medical staff
- Rights of patients are respected and protected
- Patients satisfaction is regularly evaluated
- Provides Boost to Medical Tourism

BENEFITS FOR HOSPITALS:

- Stimulates Continuous Improvement
- Enables in demonstrating commitment to Quality Care
- Raises Confidence in the services provided
- Provided opportunity to benchmark with the best

BENEFITS FOR HOSPITAL STAFF

- Staff are more satisfied
- Provides continuous learning, good working environment, leadership
- Ownership of all clinical processes
- Improves Overall Professional development of clinicians and paramedical staff
- Provides leadership for quality Improvement with medicine & Nursery

BENEFITS TO PAYING & REGULATORY BODIES

- Objective system of empanelment by Insurance & other third parties
- Provides access to reliable and certified information on facilities, infrastructure and level of care

1. "Gaps in quality of expected and perceived health services in public hospitals"

K. Francis Sudhakar, M. Kameshwar Rao, T.Rahul (1Jan 2012)[3]

The services gap analysis is done and presented in order to know, the quality service gaps existing in the study hospitals. The analysis for the gaps was made using the SERVQUAL approach as suggested by Parasuraman, Zeithanl and Berry (1988). Service gap is computed as the difference of the ideal and the actual services perceived by the patients. It was found that as regards tangibles in public hospitals services, there is a wide gap by 3 counts which were statistically significant. With regard to reliability, by 3 counts there is the gap. Such gap or difference in the quality scores is statistically significant. As regards responsiveness it is found that the gap found between them is by 3.0 units. Such gap is statistically significant. With regard to assurance, it is found that the gap is 3.0 units. Such gap is statistically significant. Lastly, with regard to empathy, it is found that the gap is found to be 3.0 units. Such gap is statistically significant.

2. Gap Analysis Report for Pondichery Institute of Medical Sciences [4]

Christian Medical Association of India (CMAI), 21st January 2010

The CMAI team visited the hospital for initial assessment against NABH Standards. This Gap Assessment was carried out for a period of 6 days starting from 14th January 2010 to 21st January 2010. It was found that infrastructurally hospital is really strong and has huge resources as far as space is concerned. But on the other hand the premises are in unkempt condition and harbours many areas having a potential for infestation of microorganism that could encourage Hospital Cross Infection. Hospital Signage, another important NABH Criteria, needs re-designing to follow uniformity for the standardization of design, color

coding, symbols, directional signs, etc as per the standard signage system. Bio-medical waste segregation and disposal is major area of concern for the hospital as nowhere in the organization, segregation is being followed. Biomedical engineering also needs re-modulation in the form of more documentation and in-house calibration and preventive maintenance of the equipments. One major area of concern for the hospital is the improper and unnecessary space occupying practice of storing of condemned articles.

3. **Gap analysis report GH-store, Panchkula [5]**

Dr. Harpreet Kaur, MO, HSHRC ,Sh. Satish Rohilla ,Sh. Rawat, Miss Uma Rani, 13 September 2012

This gap analysis is done by HSHRC Drug Unit team to identify the structural & procedural requirements for quality improvement. It is observed that the staff is not enough to maintain all the work in the store. Inner environment of the store is compact, cold and humid with appropriate arrangement of the medicine boxes. Books/copies like Stock register, Quotations for local purchase is present and made available. Indent book as such is not available. Requisition slips are collected but not properly tagged or filed. The debit and credit of items received or issued is written within the stock register itself. Storage conditions are not controlled in the store which may affect the efficacy of the stored drugs. No documented procedure is in place for the distribution of drugs from the store to various units. At present no adequate mechanism is in place and medicines are carried to units using trolleys or statures in open. Risk management is an issue of the safety and security of store personnel. There are many near miss incidents happening in the store which may be easily ignored. Though not so frequent but occupational health hazards may also likely to be occur in the store because of minute negligence.

2.6 OBJECTIVE OF THE STUDY

2.6.1 AIM:

To assess **District Joint Hospital, Sanjay Nagar, Ghaziabad** as per National Accreditation Board for Hospitals & Healthcare Providers (NABH) standards.

2.6.2 OBJECTIVES:

- To assess the hospital as per NABH standards on the grounds of structure, process and outcome.
- To do scoring of the hospital services as per "Self assessment toolkit" given by NABH
- To suggest alterations in Structural Designs of the facilities to meet the requirement.(if any)
- To recommend on other areas of improvement (if any)

2.7 METHODOLOGY

The data collection source for the study is primary data and secondary data source. The primary data will be collected through the use of observation and Gap analysis checklist which consists of the structural, procedural and outcome criteria for the assessment.

Study design: Descriptive cross-sectional study

Study area: **District Hospital, Sanjay Nagar, Ghaziabad**

Study duration: The study duration is of 1 month from 20th March to 20th April.

Data collection tool and technique: Observation, Checklist and interview of the staff for primary data and hospital records for secondary data.

- Collection of primary data and secondary data from the hospital for assessing the Structure (infrastructure, manpower, equipment, licenses), Process (Policies and procedures) and Outcome so that gaps can be identified.
- Structural works have been evaluated as per the minimum requirement of NABH.
- Manpower for the hospitals has been compared with the work load.
- Equipment gaps have been assessed on the basis of their utilization and available standards and guidelines.
- The system and processes are assessed through inspection, interviews, discussions and observations on ground using the NABH standards as a yardstick.
- Scoring is done according to the score sheet given by NABH at last on the basis of gaps identified.
- Regarding scoring following criteria is applied -
    - Compliance to the requirement: 10
    - Partial compliance to the requirement: 5
    - Non-compliance to the requirement: 0
    - Not Applicable: NA

2.8 HOSPITAL PROFILE

2.8.1 INTRODUCTION

The District hospital , Sanjay nagar, Ghaziabad is a new hospital established in 2008. The hospital has over 100 inpatient beds and state of art technology to cater for the local people.

2.8.2 SCOPE OF SERVICES

Sl. No.	Name of Services/ Department	Availability (Yes/No/NA)	Remarks
GROUP A – CLINICAL SERVICES			
01	General Medicine	Yes	
02	Obstetrics and Gynaecology	Yes	
03	Paediatrics	Yes	
04	Orthopaedics	Yes	
05	Ophthalmology	Yes	
06	Anaesthesiology	Yes	
07	General Surgery	Yes	
08	Dentistry	Yes	
09	ENT	No	
10	TB & Chest	No	
GROUP B: CLINICAL SUPPORT SERVICES			
11	Laboratory	Yes	
12	USG	Yes	
13	Blood Bank	No	
14	Physiotherapy	Yes	
GROUP C: SUPPORT SERVICES			
16	Medical Store	Yes	
17	Kitchen & Dietary	Yes	
18	Laundry	No	
19	CSSD/TSSU	Yes	TSSU present
20	Medical Records	No	
21	Ambulance & Transport	Yes	
22	Security Services	No	
23	Housekeeping Services	Yes	In house
24	Biomedical engineering	No	
25	Maintenance	No	
26	Mortuary services	Yes	
GROUP D: ADMINISTRATIVE SERVICES			
28	General Administration	Yes	
29	Account	Yes	

2.8.3 SIGNAGE SYSTEM

Signage's	Displayed (Yes / No / NA)	Bilingual (Yes / No / NA)	Pictorial (Yes / No / NA)	Remarks (if any)
Citizen Charter	Yes	No	NA	Painted on walls & not as per standards
Mission	No		NA	
Vision	No		NA	
Patients Charter	No		NA	
Scope of Services	Yes	No	NA	
Tariff List	NA		NA	
Doctors list along with their Specialities and Qualifications	Yes	No	NA	Qualifications not displayed
OPD Schedule of Doctors (Speciality, Timings and Day of Availability)	No		NA	
Biohazard Symbols	No		NA	
Fire Exit Plan	No		No	
Floor Directory	No		NA	
Wash Rooms (Differently Able)	No		No	
Toilets	Yes	No	No	
Ambulance Parking Area	Yes	No	No	
Drinking Water	No	-	No	
Health Education Related Signage (HIV & Immunization)	Yes	No	Yes	

2.8.4 STATUTORY REQUIREMENTS

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

2.8.5 BED DISTRIBUTION

Floor	Class/Department	Beds
Ground Floor	ICCU	10
First Floor	Gynaecology Ward	24
	Paediatric	06
	Medical Ward	30
	Surgical Male	15
	Surgical Female	15
	Isolation	06
TOTAL		**106**

2.8.6 STRUCTURAL DETAILS

A. Land	• Total land area- 28500 sq. m		
B. Building	• Hospital building-7235 sq. m • Total Residential area- 8750 sq. m • Total Garden Area and free space-12,515 sq. m		
C. HVAC	Availability of HVAC system		No
		Number	**Capacity**
D. Electricity	Transformer/Power station	1	250KVA
	DG set	1	110 KVA
	Invertors	10	1KWh
	Total Load Sanctioned		33 KVA

E. Water	Water Tanks R.O Plant Water Tanks (Overhead) Water tank (Sump)	01 1	5000 litres 1,00,000 litres 15HP

2.8.7 MANPOWER

Sl. No	Designations	Sanctioned	Actual	Vacant / Surplus (Sanction - Actual	NABH	Vacant (NABH)
DOCTORS						
1	CMS	1	1	0	-	
2	Physician	2	2	0	3	1
3	Surgeon	2	2	0	3	1
4	Paediatrician	2	1	1	2	1
5	Anaesthetist	1	1	0	2	1
6	Radiologist	2	1	1	2	1
6	Ophthalmologist	1	1	0	2	1
7	Orthopaedic	1	1	1`	1	0
8	E.N.T	1	1	0	2	1
	Eye Surgeon	1	1	0	-	-
9	Pathologist	1	1	0	2	1
10	Cardiologist	1	0	1	3	0
11	Skin	0	0	0	2	1

12	Obs &Gynae	4	4	0	2	2 surplus
13	MS	0	0	0	1	1
14	EMO	7	7	0	6	2
15	MO	5	5	0	11	6
16	Dental Surgeon	1	1	0	1	0
	Total	**33**	**30**	**3**	**45**	**20**
Class-III Staff						
1	Nursing Superintendent(Matron)	1	1	0	1	0
2	OT Supervisor(Asst. Matron)	1	0	1	-	-
3	Sister + Staff Nurse	19+38	12+22	23	68	09
4	Chief pharmacist + Pharmacist	1+4	1+4	0	9	4
5	X-ray Technician	2	2	0	3	1
6	X ray Assistant	2	2	0	-	-
7	Lab supervisor	0	0	0	1	0
8	Lab- Technician	2	1	1	6	5
9	Lab Assistant	2	2	0	-	-
10	Physiotherapist	1	1	0	1	1
11	Occupational Therapist	0	0	0	-	-
12	Dental hygienist	1	1	0	-	-
13	Optometrist	1	1	0	1	1
14	Electrician	1	0	1	1	1
15	E.C.G Technician	1	1	0	1	1
16	CSSD Technician	0	0	0	1	1

17	Driver	4	1	3	2	1 surplus
18	Office I/C/Superintendent	1	1	0	1	1
19	Senior assistant	1	0	1	-	-
20	Senior Clerk + Junior Clerk	2+4	2+4	1	4	2 surplus
21	Store keeper	1	0	1	2	2
22	Record room keeper	2	0	2	2	2
23	Dietician	0	0	0	1	1
	Total	**92**	**59**	**34**	**105**	**33**
Class IV staff						
1	Housekeeping Staff	4	0	4	6	6
2	Ward Boys /Aaya	28	1	27	13	12
3	Dhobi	5	0	0	-	-
4	Kahar/plumber	2	0	1	1	1
5	Cook assistant/ Bearer	7	4	3	8	4
6	Tailor	1	0	1	-	-
7	Chaprasi	1	1	0	-	-
8	Guard	5	3	2	6	1
9	Cook	2	2	0	10	8
	Total	**55**	**11**	**38**	**44**	**32**

2.9 GAP ANALYSIS

1. OPD

Part of the hospital with allotted physical &medical facilities in sufficient amount, with regularly scheduled hours to provide care to patients who are not registered as inpatients. It includes:

• General OPD

• Emergency OPD

• Referral / Specialty OPD

STRUCTURE

- Non availability of separate queue for Differently abled patients
- Non availability of separate and functional toilet for differently abled patients.
- Citizen charter and Patient charter are not displayed
- No provision of patient privacy in the consultation room
- Calibration of BP apparatus, weighing machine and thermometer not done
- Non availability of nurse to do Patient Care in specific OPDs

PROCESS

- UHID not generated for all patients
- Separate Registration not done for old and new OPD patients
- Patient privacy is not maintained during consultation time

OUTCOME

- Monitoring of waiting time is not being done
- OPD patient satisfaction survey is not being done

2. AMBULANCE SERVICES

Ambulance is an out reaching limb of hospital based medical services to transport the sick and injured as quickly and comfortable to the hospital to provide prompt emergency treatment. It is equipped with all necessary life saving equipments and trained staff.

STRUCTURE

- Adequate communication system is not present in ambulance
- Required equipments (Stetho, sphygmo, suction app, defib, monitor, oxygen cylinder) and medicines are not available in the ambulance.
- Vehicle license and driver licence are not available
- Maintenance of the medical Gas (oxygen) to 90% of the total capacity is not being done
- Calibration of Equipments is not being done

PROCESS

- Staff is not trained in BLS
- Medication and equipment checklist is not maintained
- Infection control practices are not being followed

3. EMERGENCY DEPARTMENT

The **Emergency Department (ED)** is a department that provides initial treatment to Patients with a broad spectrum of illnesses and injuries, some of which may be life-threatening and requiring immediate attention.

STRUCTURE

- Triage area is not marked separately
- Emergency signage is not visible from the road with proper lighting and signs
- Nurse is not available round the clock for emergency care of patients
- Number of trolleys and wheelchairs are not commensurate to the needs
- List of all staff that contains Name, Contact details, Designation is not available
- Doctor's name and contact number is not present at all times in the emergency room
- An appropriately qualified staff member is not scheduled to manage triage activities.
- Defibrillator, Cardiac Monitor, Oral Airways of various sizes,Laryngoscope with various blades, Laryngoscope replacement batteries and bulbs. Endotracheal tubes of various sizes are not available

PROCESS

- Security staffs are not immediately available when required in the emergency room.
- Electrical equipment (e.g. defibrillator) is not charged at all times.
- BMW is not segregated and handled properly.
- Staff is not trained in BLS/ACLS

OUTCOME

- Time for initial assessment of emergency patient is not being monitored.

4. LABORATORY

A medical laboratory or clinical laboratory is a laboratory where tests are done on clinical specimens in order to get information about the health of a patient as pertaining to the diagnosis, treatment, and prevention of disease.

STRUCTURE

- No provision for hand washing facility in this unit
- No separate area available for sample collection

PROCESS

- Scope of services not defined
- Laboratory equipments not calibrated
- Laboratory staff is not aware about the safety precautions while handling samples
- BMW segregation not done as per BMW guidelines

PROCESS

- Critical results are not defined, reported, and documented.
- Surveillance for lab test not being carried out
- EQAS not being monitored
- Turnaround time for lab reports is not being monitored
- MOU not available for outsourced tests
- Temperature monitoring of refrigerator is not being done

OUTCOME

- Following outcomes are not being monitored:
  - Number of reporting errors per 1000 investigations
  - % of redo's
  - % of adherence to safety precautions
  - % of reports having clinical correlation with provisional diagnosis

5. RADIOLOGY DEPARTMENT

The Radiology and Imaging Services is the branch of medicine that deals with the diagnostic and therapeutic applications of radiation. Diagnostic Radiology is the interpretation of images of the human body to aid in diagnosis of disease. Therapeutic Radiology utilizes radiation for treatment of diseases such as cancer. There is now separated sub specialty as radiation oncology.

STRUCTURE

- This unit lacks AERB (SITE/TYPE approval)
- Basic facilities for staff not available (toilet/drinking water/change room)
- No change room available for patients
- TLD badges and Gonad shield not available
- Critical results are not defined, reported, and documented.
- Radiation hazard symbol is not present

PROCESS

- Maintenance of radiology equipments not being done
- Radiology equipments are not calibrated
- Quality Assurance program is not being followed
- Turnaround time for reports not being monitored

OUTCOME

- Following outcomes are not being monitored :
  - Number of reporting errors per 1000 investigations
  - % of reports having clinical correlation with provisional diagnosis
  - % of adherence to safety precautions
  - % of redo's

6. WARDS

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

STRUCTURE

- Basic facilities for staffs not present (toilet/ drinking water)
- Emergency crash cart not present in the ward
- Number of nurses in each shift is not adequate
- Racks are not present to store linen
- Wash basin is not present in each ward.
- PPE are not provided in each ward

PROCESS

- Vitals of the patient not checked every day
- Indent of medicines and other items is not placed by nurses regularly
- PPE are not used by the nurses
- BMW is not segregated at the point of generation
- Nurse on duty does not record the details of the patient in the BHT on a daily basis
- Nurses not trained in BLS(CPR)

OUTCOME

- Infection control practices are not being followed
- Bio medical waste management practice not being followed
- Staff not aware about transfer IN/OUT system
- Discharge process is not defined and documented

7. ICCU

Area that specializes in the care of critically ill patients. Intensive care implies continuous monitoring, intensive nursing and rapid or intensive therapeutic intervention.

STRUCTURE

- Required equipments are not available
- Fowler's bed not available

PROCESS

- Following policies and procedures are not defined and documented
  - Admission and discharge of the patient
  - Procedure for situation of bed shortage
  - Initial assessment and reassessment
  - Referral of patients to other department
  - Procedure for LAMA patients
  - Quality assurance programe
  - Care of patients under restraints, reasons of restrains
  - Uniform use of resuscitation
  - Rational use of blood and blood products
  - Infection control practices
  - Monitoring of patients after medication administration
  - Patient's medication brought from outside the organisation
  - Use of narcotic drugs & psychotropic substances
  - Scope of paediatric services
  - Antibiotic policy
  - Care of vulnerable patients
  - Policy for obtaining consent

PROCESS

- Staff is not aware about the end of life care policy
- Initial assessment does not include screening for nutritional needs
- Staff is not trained on resuscitation
- Informed consent is not obtained before donation and transfusion of blood and blood products
- Patient and family are not educated about donation
- Post transfusion reaction are not monitored and analyzed for preventive and corrective actions
- Staff caring for children do not have age specific competency
- There is no written order for the diet
- Nutritional therapy is not planned and provided in a collaborative manner
- Emergency medications are not available all the time and replenished in a timely manner when used
- Medication orders are not written in a uniform location and are not clear, legible, dated, timed, named and signed
- There is no written order for high risk medication done
- Medication administration is not documented
- Knowledge to pick adverse drug events and reporting of the same is lacking in staff
- Narcotic drugs are not stored in a safe manner
- Proper records are not kept for the usage, administration and disposal of narcotic drugs
- Infection control data is not collected
- No availability of various HAI rates of that area and action taken report

PROCESS

- The layout of beds, its spacing, and visual privacy are not appropriate.
- All the equipments are not periodically inspected and calibrated
- Service labels on Equipment and calibration records are not present.
- The Information is not exchanged and documented during transfers between units/departments.
- The organization does not provide a safe and secure environment for the vulnerable patients
- The informed consent is not obtained by a surgeon prior to the procedure
- The instructions for proper hand washing are not displayed and not followed by the staff.
- Adequate PPE like gloves, masks are not available and used by the staff.
- Isolation /Barrier nursing facility is not available.
- Segregation of bio-medical waste is not done as per the guidelines.
- Procedure is not documented to describe who can give consent when patient is incapable of independent decision making.

OUTCOME

- Re intubation rate is not being monitored
- ICU utilization is not being monitored

8. OPERATION THEATRE

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

STRUCTURE

- Proper Zoning concept is not followed(Clean zone, protective zone, sterile zone, and disposal zone)
- Number of OT tables present in the hospital were not appropriate for the daily load
- OT did not have a crash cart and defibrillator
- Scrubbing area not present for the OT staff

PROCESS

- Consent for the surgery and anesthesia is not being taken from the patient
- OT list is not prepared and OT booking not being done
- Pre, intra, post operative notes are not documented
- Infection control practices not being followed in OT
- Pre operative checklist not being followed
- Bio medical waste management practices not being followed

OUTCOME

- Following outcome indicators are not being monitored:
  - % of anesthesia related adverse events
  - % of anesthesia related mortality
  - % of modification in plan of anesthesia
  - % of unplanned ventilation following anesthesia
  - % of Surgical site infection rate
  - Re Exploration rate
  - Re scheduling of surgeries

9. PHARMACY

Hospital pharmacies provide a huge quantity of medications per day which is allocated to the wards and to intensive care unit according to medication schedule.

STRUCTURE

- All items storage areas are not marked and labeled
- Refrigerator for storing medicines(2-8 degree C) not available
- Provision for storage of narcotic drugs(double lock and key system) not present

PROCESS

- Pest/rodent control measures are not regularly under taken
- Sound Inventory control practices not followed (ABC, VED, FSN,FIFO)
- General items required by the hospital are not purchased from vendors registered by management
- No Drugs and therapeutics committee in the hospital
- No hospital drug formulary available
- Adverse drug reactions are not analyzed

OUTCOME

- Following outcome indicators are not being monitored:
  - % of local purchase
  - % of stock outs
  - % of variation from the procurement process
  - % of goods rejected before GRN

10. BIOMEDICAL WASTE MANAGEMENT

Biomedical waste is generated from biological and medical sources and activities, such as the diagnosis, prevention, or treatment of diseases. Biomedical waste must be properly managed and disposed of to protect the environment, general public and workers, especially healthcare and sanitation workers who are at risk of exposure to biomedical waste as an occupational hazard. Steps in the management of biomedical waste include generation, accumulation, handling, storage, treatment, transport and disposal.

STRUCTURE

- Display of proper work instructions at the point of segregation is not present

PROCESS

- Segregation of BMW at point of generation, not being done
- Route for transportation of waste is not separate from the general traffic area
- No provision of regular health checkup for staff of this unit
- Usage of PPE by staff is not being practiced
- Annual report is not submitted to UP PCB
- Monitoring is not done for the amount of BMW generated

11. HOSPITAL INFECTION CONTROL

Infection control is the discipline concerned with preventing healthcare-associated infection. Infection control addresses factors related to the spread of infections within the health-care setting (whether patient-to-patient, from patients to staff and from staff to patients, or among-staff), including prevention (via hand hygiene, cleaning/disinfection/sterilization, vaccination, surveillance), monitoring/investigation of demonstrated or suspected spread of infection within a particular health-care setting (surveillance and outbreak investigation), and management (interruption of outbreaks). There is a hospital infection control committee which looks after these activities.

STRUCTURE

- A designated and qualified infection control nurse(s) is not present
- Adequate and appropriate facilities for hand hygiene, in all patient care areas, are not provided
- A designated infection control officer is not present

PROCESS

- No implementation of policies and/or procedures to prevent infection
- Organization does not adhere to standard precautions at all times
- Hospital does not adhere to laundry and linen management processes
- Hospital does not adhere to kitchen sanitation and food handling issues
- Hospital does not have appropriate engineering controls to prevent infections
- HIC surveillance data is not collected regularly
- Verification of data not done on a regular basis by the infection control team
- In cases of notifiable diseases, information (in relevant format) is not sent to appropriate authorities
- Tracking and analysis of infection risks, rates and trends is not done
- Surveillance activities does not include monitoring the effectiveness of housekeeping services
- Appropriate feedback regarding HAI rates are not provided on a regular basis to appropriate personnel

PROCESS

- Hospital infection control committee and team are not formed
- Personal protective equipment are not used correctly by the staff
- Compliance with hand hygiene guidelines is not monitored
- Documented procedure for identifying an outbreak is not present
- Implementation of laid down procedure not done
- Documented procedure does not exist to guide the cleaning, packing, disinfection and/or sterilization, storing and issue of items
- Isolation / barrier nursing facilities are not available
- Visit by the hospital authorities to the disposal site not being done and documented
- Organization doees not earmark adequate funds from its annual budget for infection control activities
- Appropriate “in-service” training sessions for all staff is not conducted
- Appropriate pre and post exposure prophylaxis not provided to all concerned staff members

OUTCOME

- Following indicators are not being monitored:
  - UTI rate
  - VAP rate
  - SSI rate
  - Central line associated blood stream infection rate

12. CSSD / TSSU

Central sterile supply department (CSSD) is a service unit in a hospital that processes, issues, and controls the sterile stores supply to all departments of the hospital. The purpose of such a CSSD is to provide all the departments of a hospital with guaranteed sterile equipment ready and available for immediate use in patient care – a step towards the prevention of hospital acquired infections (HAI).

STRUCTURE

- Sufficient space is not available(0.75sq mts/bed)
- Layout does not follow the functional flow: Receiving, Washing, decontamination, drying, notpacking, loading, unloading, storing and issuing
- Racks are not present in the department
- Technician is not present in CSSD
- Decontamination solution not present
- Transport trolley not present for items

PROCESS

- CSSD sterilization register not maintained (receipt/Issue)
- Labeling of drums in CSSD does not take place
- Chemical, biological and bowie-dick test not performed
- Recall system of items not followed
- Reuse policy for items not available

13. STORE

Hospital store is a department which handles materials in a hospital. It addresses various activities like Purchasing, Storage, Issue, and Inventory Control.

STRUCTURE

- There is water seepage/ damp in the store

PROCESS

- The items are not labeled & arranged at designated place.
- Items such as radiographic films, spirits etc (which are inflammable) are not stored in a separate location.
- Inventory recording system is not present either computerized or on register
- Frequently used items are not arranged and located in most easily accessible area.
- Pest/rodent control measures are not regularly under taken
- Lead time in issuing material to the department are not recorded
- Stock Turnover details are not calculated on a monthly basis.
- Sound inventory control practices are not followed (ABC/VED/FSN/FIFO)
- Condemnation policy not followed
- Purchase and condemnation committee not present in the hospital
- A comparative list of rates of potential suppliers is not maintained

OUTCOME

- Following indicators are not being monitored:
  - % of stock outs
  - % of goods rejected before preparation of GRN
  - % of variation from procurement process

14. KITCHEN/DIETARY

The Hospital Dietary Department provides meal services and clinical support for inpatients.

STRUCTURE

- Layout does not follow the functional flow: Receiving, storage, preparation, distribution and cleaning
- DG power supply is not given to this unit
- Dedicated food storage area does not exist
- Measures for fire detection/fire fighting are not installed in this unit
- The person responsible for this department is not a qualified dietician or has no supervision from a consultant dietician.

PROCESS

- Health check up of all staff is not done at least once a year.
- Nutritional Assessment not done for all the patients
- Diet Sheet is not prepared by Dietician as per the treating Doctors instruction on the patient's case sheet.
- Each patient's Case sheet is not checked by doctor and dietician and changes are not made in their diet depending on their condition
- Food distribution to patients do not occur in covered trolleys
- Infection control practices are not being followed

15. HOUSEKEEPING

The hospital housekeeping service comprises of activities related to cleanliness, maintenance of a healthy environment and good sanitation service keeping the hospital premises free from pollution.

PROCESS

- House keeping staff is not being trained in the infection control practices
- Staff is not using PPE
- Daily cleaning schedule not available
- Staff not aware about the preparation of cleaning solutions
- Pest control methods not being practiced
- Medical examination of staff not being done periodically

16. MORTUARY

All hospital death cases MLC, Non-MLC and all brought dead cases brought to Hospital are kept in hospital mortuary. It is the moral duty of authority to ensure proper respect and proper handling of the dead body after the death of the patient.

STRUCTURE

- Calibration and maintenance is not done regularly
- Measures for fire detection/firefighting not installed in this unit

PROCESS

- Temperature not being regularly monitored
- Process of infection control not followed

17. LABOUR DEPARTMENT

STRUCTURE

- Separate areas are not demarcated for septic and aseptic deliveries
- Labour room does not have a toilet facility
- Disposable Delivery Kits not present in required quantities
- ECG monitor not present

PROCESS

- Work Instructions not displayed prominently
- Labour Room Register does not have a record of referred cases
- Part preparation of the patient is not done before the operation
- APGAR SCORE not being used
- Standard Operating Procedures not being followed for Induction of Labour and progress of labour

OUTCOME

- Maternal mortality rate not being monitored
- Still birth rate not being monitored

2.10 SCORING OF HOSPITAL AS PER SELF ASSESSMENT TOOLKIT

Chapter 1: ACCESS, ASSESSMENT AND CONTINUITY OF CARE (AAC)

AAC.1: The organization defines and displays the services that it provides.	**5**
AAC.2: The organization has a well-defined registration and admission process.	**3.3**
AAC.3: There is an appropriate mechanism for transfer (in and out) or referral of patients.	**0**
AAC.4: Patients cared for by the organization undergo an established initial assessment.	**3.5**
AAC.5: Patients cared for by the organization undergo a regular reassessment	**5**
AAC.6: Laboratory services are provided as per the scope of services of the organization.	**5.6**
AAC.7: There is an established laboratory quality assurance programme	**0**
AAC.8: There is an established laboratory safety programme.	**2**
AAC.9: Imaging services are provided as per the scope of services of the organization.	**3.3**
AAC.10: There is an established Quality assurance programme for imaging services.	**0**
AAC.11: There is an established radiation safety programme.	**2.1**
AAC.12: Patient care is continuous and multidisciplinary in nature.	**5.7**
AAC.13: The organization has a documented discharge process.	**1.25**
AAC.14: Organization defines the content of the discharge summary.	**0**
Average score of the chapter	**2.6**

Table no. 1

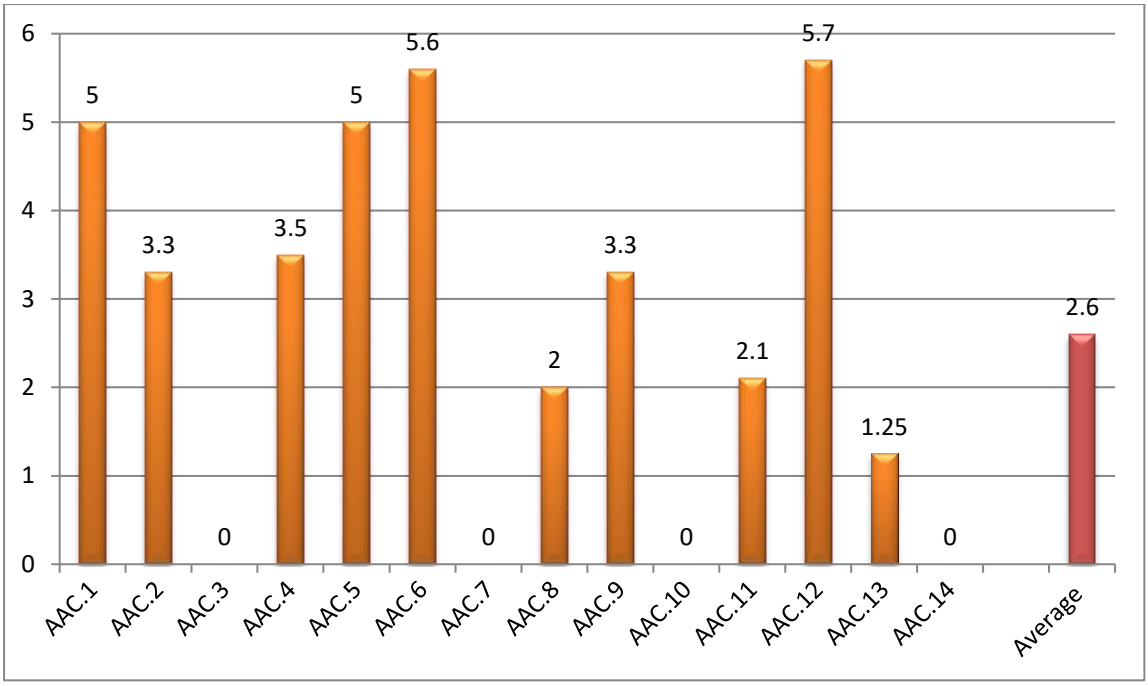


Fig. no. 1

INTERPRETATION

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

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

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

AAC 4. Policies are there to guide the initial assessment of patient but documentation and implementation is lacking. Initial assessment does not include nutritional assessment.

AAC 5.Patient are reassessed at regular intervals but documentation is not maintained as per norms.

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

disposal of specimens are not documented and implemented. The list for outsourced tests is not available.

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

AAC 8. Laboratory Safety programme has been documented, but not implemented. The staff are trained and provided with PPE.

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

AAC 10. The quality assurance programme is neither documented nor implemented. It does not address validation of imaging methods and surveillance of imaging results. It also does not address periodic calibration and maintenance of all equipments.

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

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

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

AAC 14. The hospital has not defined and documented the content of discharge summary.

Chapter 2: CARE OF PATIENTS (COP)

COP.1: Uniform care to patients is provided in all settings of the organization and is guided by the applicable laws, regulations and guidelines.	**1.25**
COP.2: Emergency services are guided by documented policies, procedures, applicable laws and regulations.	**0.7**
COP.3: The ambulance services are commensurate with the scope of the services provided by the organization.	**1.85**
COP.4: Documented policies and procedures guide the care of patients requiring cardio-pulmonary resuscitation.	**0**
COP.5: Documented policies and procedures guide nursing care.	**4.28**
COP.6: Documented procedures guide the performance of various procedures.	**2.85**
COP.7: Documented policies and procedures define rational use of blood and blood products.	**1.25**
COP.8: Documented policies and procedures guide the care of patients in the Intensive care and high dependency units.	**0.7**
COP.9: Documented policies and procedures guide the care of vulnerable patients (elderly, children, physically and/or mentally challenged).	**3**
COP.10: Documented policies and procedures guide obstetric care.	**1.4**
COP.11: Documented policies and procedures guide paediatric services.	**1.25**
COP.12: Documented policies and procedures guide the care of patients undergoing moderate sedation.	**3.1**
COP.13: Documented policies and procedures guide the administration of anaesthesia.	**3.1**
COP.14: Documented policies and procedures guide the care	**2.7**

of patients undergoing surgical procedures.	
COP.15: Documented policies and procedures guide the care of patients under restraints (physical and / or chemical).	**0**
COP.16: Documented policies and procedures guide appropriate pain management.	**2**
COP.17: Documented policies and procedures guide appropriate rehabilitative services.	**N.A**
COP.18: Documented policies and procedures guide all research activities.	**N.A**
COP.19: Documented policies and procedures guide nutritional therapy.	**0**
COP.20: Documented policies and procedures guide the end of life care.	**1**
Average	**1.7**

Table no. 2

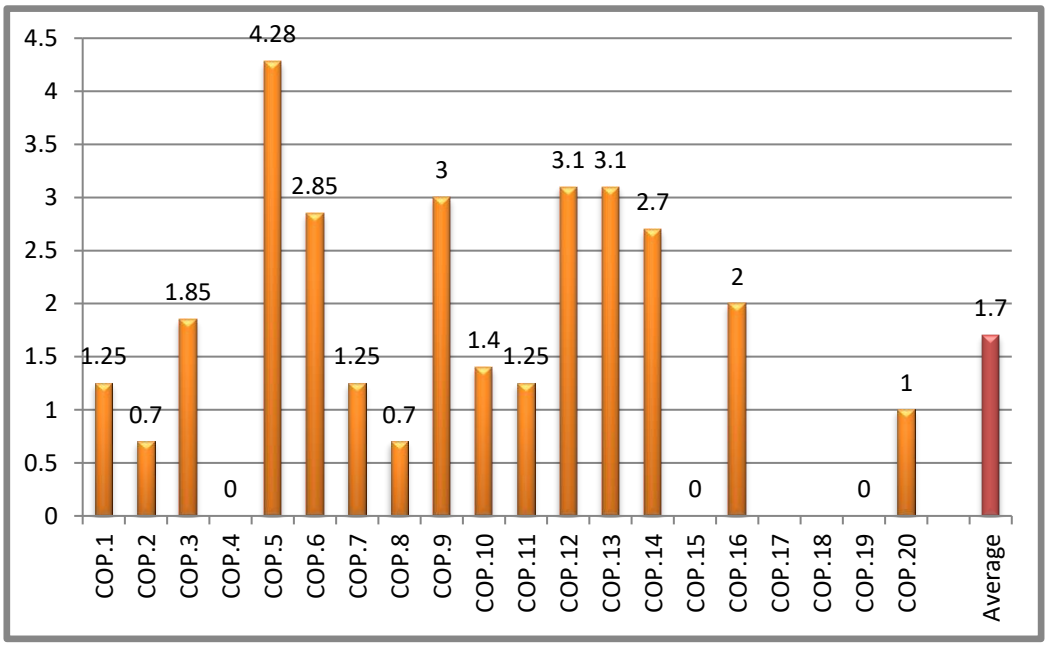


Fig. no. 2

INTERPRETATION

COP-1.Documentation of policy and procedures for uniform care of patients in all setting of the hospital is not done.

COP-2.Emergency services provided by the organisation are not well documented and implemented.

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

COP- 4. Policies and procedures to guide the care of patients requiring cardio-pulmonary resuscitation are not available. Staffs are not trained uniformly and periodically updated in CPR. The events during a CPR are not recorded and hence post event analysis is not carried out by multidisciplinary committee.

COP-5.The policy and procedure to guide nursing care has neither been documented nor implemented.

COP-6. Policies to guide the performance of various procedures is not available

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

COP- 8. The organization has no documented admission and discharge criteria for intensive care unit. For Intensive Care Unit and High Dependency Unit adequate staff and equipments are not there. Staff is not trained to apply these criteria. Infection control practices are not followed uniformly. Quality assurance programme for the ICCU is not implemented.

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

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

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

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

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

COP- 14 Policies and procedures are not documented for the care of patients undergoing surgical procedures and are not implemented also. Quality assurance programme is not followed for surgical procedures.

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

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

COP- 17 The hospital does not provide rehabilitative services so this standard is not applicable.

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

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

COP- 20. Policies for End of Life Care have not been documented and the staffs are not trained on the same.

Chapter 3: Management of Medication (MOM)

MOM.1: Documented policies and procedures guide the organization of pharmacy services and usage of medication.	**0**
MOM.2. There is a hospital formulary.	**4**
MOM.3: Documented policies and procedures guide the storage of medication	**1.42**
MOM.4: Documented policies and procedures guide the safe and rational prescription of medications	**1.25**
MOM.5: Documented policies and procedures guide the safe dispensing of medications.	**1.6**
MOM.6:There are documented policies and procedures for medication management.	**4**
MOM.7: Patients are monitored after medication administration.	**2.5**
MOM.8: Near misses, medication errors and adverse drug events are reported and analysed.	**0**
MOM.9: Documented procedures guide the use of narcotic drugs and psychotropic substances.	**0**
MOM.10: Documented policies and procedures guide the usage of chemotherapeutic agents.	**NA**
MOM.11: Documented policies and procedures govern usage of radioactive drugs.	**NA**
MOM.12: Documented policies and procedures guide the use of implantable prosthesis and medical devices.	**0**
MOM.13: Documented policies and procedures guide the use of medical supplies and consumables	**3.75**
Average	**1.7**

Table no. 3

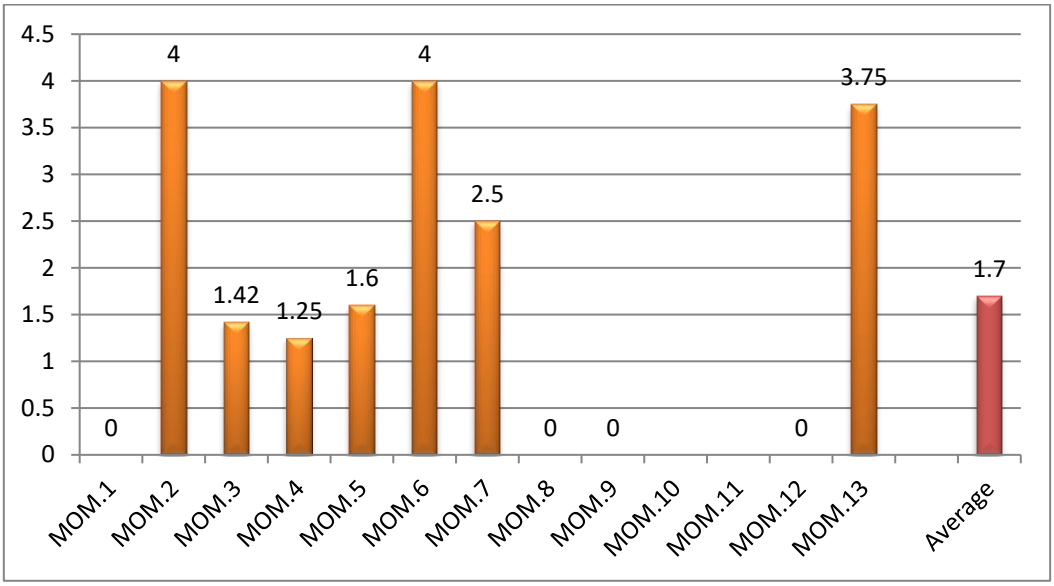


Fig. no. 3

INTERPRETATION

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

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

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

MOM-4. The organisation does not have documented policies and procedures for prescription of medications and for high risk medications but organisation determine who can write the prescription.

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

MOM-6. Documentation has not been done for medication administration. Medications are administered by those who are permitted by law to do so.

MOM-7. Documentation policies and procedure to guide the monitoring of patients after medication administration has been done now but other polices require to be implemented. Organisation also defines those situations where close monitoring is required.

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

MOM-9. Documented procedures does not exist to guide the use of narcotic drugs and psychotropic substances which are in consonance with local and national regulations. The drugs are not stored properly and records are not maintained.

MOM-10: Chemotherapeutic agents are not used in the hospital.

MOM- 11: Radioactive drugs are not used in the hospital.

MOM-12: Documented policies and procedures does not govern procurement, storage / stocking, issuance and usage of implantable prosthesis and medical devices.

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

Chapter 4: Patient Rights and Education (PRE)

PRE.1. The organization protects patient and family rights and informs them about their responsibilities during care.	**1**
PRE.2: Patient and family rights support individual beliefs, values and involve the patient and family in decision making processes.	**0**
PRE.3: The patient and/ or family members are educated to make informed decisions and are involved in the care planning and delivery process.	**3.5**
PRE.4: A documented procedure for obtaining patient and / or family's consent exists for informed decision making about their care.	**1.25**
PRE.5: Patient and families have a right to information and education about their healthcare needs.	**1.8**
PRE.6: Patient and families have a right to information on expected costs.	**10**
PRE.7: Organization has a complaint redressal procedure.	**5**
Average	**3.2**

Table no. 4

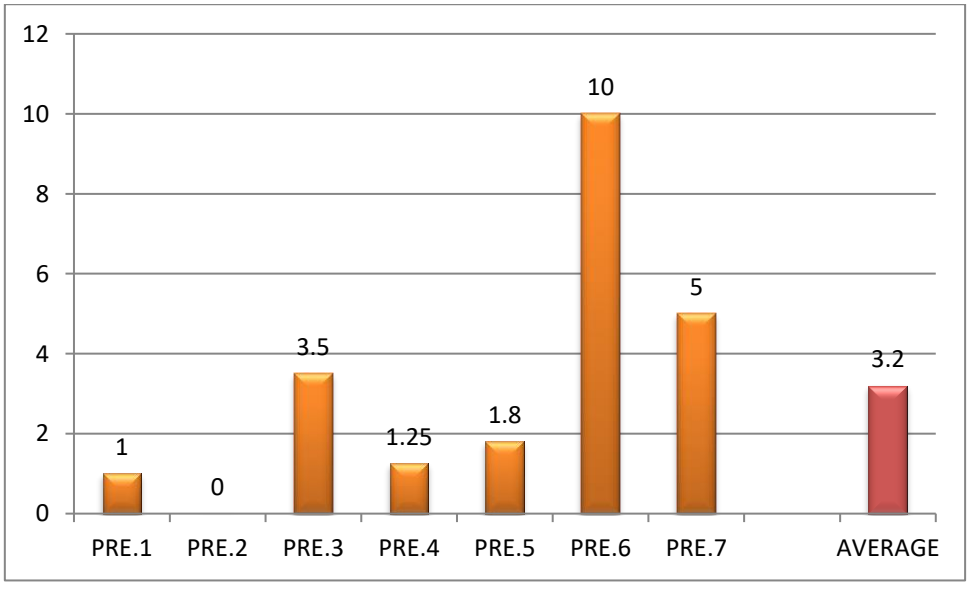


Fig. no. 4

INTERPRETATION

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

PRI-2 There is no policy in which patients rights and responsibility has been described and many other policies which are documented need to be implemented.

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

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

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

PRI-6. The patient and their family members are educated uniformly about the estimated costs of treatment and this policy is implemented.

PRI-7. The documentation of organization redressed procedure has been done but not implemented. All complaints should be analysed according to the documentation but this is not implemented.

Chapter 5: Hospital Infection Control (HIC)

HIC.1: The organization has a well-designed, comprehensive and coordinated Hospital Infection Prevention and Control (HIC) programme aimed at reducing/ eliminating risks to patients, visitors and providers of care.	**0**
HIC.2: The organization implements the policies and procedures laid down in the Infection Control Manual.	**1.36**
HIC.3: The organization performs surveillance activities to capture and monitor infection prevention and control data.	**0**
HIC.4: The organization takes actions to prevent and control Healthcare Associated Infections (HAI) in patients.	**0**
HIC.5: The organization provides adequate and appropriate resources for prevention and control of Healthcare Associated Infections (HAI).	**2.5**
HIC.6: The organization identifies and takes appropriate action to control outbreaks of infections.	**0**
HIC.7: There are documented policies and procedures for sterilization activities in the organization.	**0**
HIC.8: Biomedical iste (BMW) is handled in an appropriate and safe manner.	**3**
HIC.9: The infection control programme is supported by the management and includes training of staff.	**0**
Average	**0.76**

Table no. 5

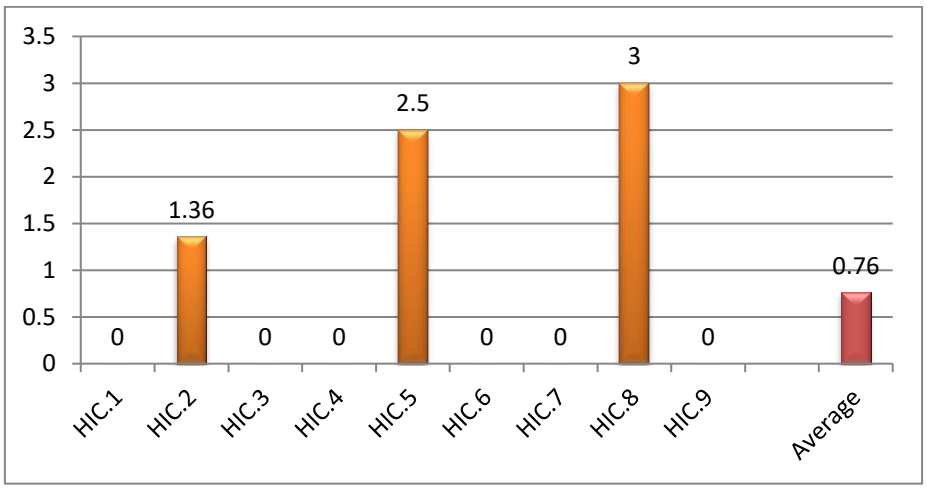


Fig no. 5

INTERPRETATION

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

HIC-2.Infection Control manual has not been documented. Linen and laundry management & kitchen management is improper and antibiotic policy need to be implemented.

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

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

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

HIC-6. Outbreaks of infections are not documented properly and not implemented yet

HIC-7. Documentation has not been done for procedures for sterilisation activities in the organisation. There is no adequate space for sterilization activities. Regular validation tests for sterilization (bowie dick tape test and leak rate test) are not carried out. No established recall procedure for sterile and non sterile items.

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

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

Chapter 6: Continual Quality Improvement (CQI)

CQI.1: There is a structured quality improvement and continuous monitoring programme in the organization.	**0**
CQI.2: There is a structured patient safety programme in the organization.	**0**
CQI.3: The organization identifies key indicators to monitor the clinical structures, processes and outcomes which are used as tools for continual improvement.	**2.27**
CQI.4: The organization identifies key indicators to monitor the managerial structures, processes and outcomes which are used as tools for continual improvement.	**0**
CQI.5: The quality improvement programme is supported by the management.	**0**
CQI.6: There is an established system for clinical audit.	**0**
CQI.7: Incidents, complaints and feedback are collected and analysed to ensure continual quality improvement.	**0**
CQI.8: Sentinel events are intensively analysed.	**0**
AVERAGE	**0.28**

Table no. 6

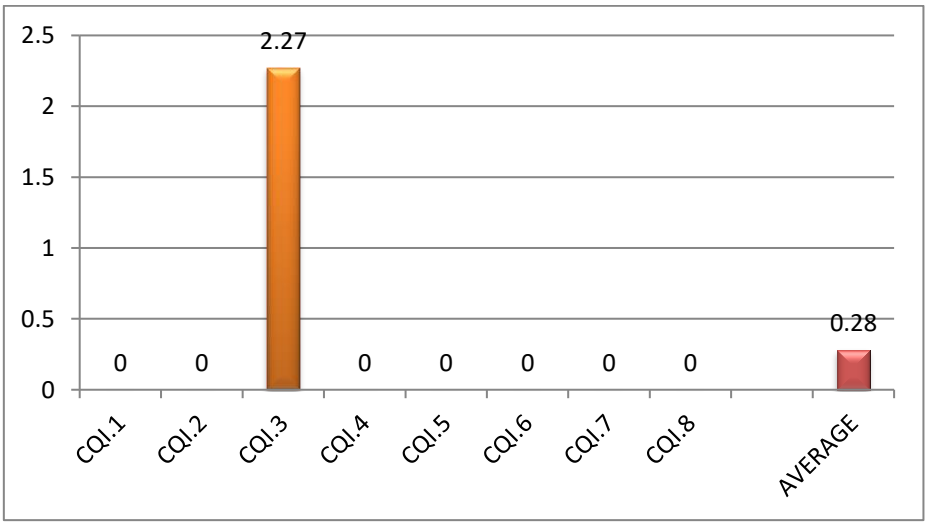


Fig. no. 6

INTERPRETATION

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

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

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

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

CQI-5. Although management supports and implements use of appropriate quality improvement, statistical and management tools in its quality improvement program but organisational performance and improvements are not monitored.

CQI-6. System for audit of patient care services has not been documented and need to be implemented. Remedial measures are not implemented and documented.

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

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

Chapter 7: Responsibilities of Management (ROM)

ROM.1: The responsibilities of those responsible for governance are defined.	**1.66**
ROM.2: The organization complies with the laid down and applicable legislations and regulations.	**0**
ROM.3: The services provided by each department are documented.	**3.75**
ROM.4: The organization is managed by the leaders in an ethical manner.	**6.66**
ROM.5: The organization displays professionalism in management of affairs.	**2.72**
ROM.6: Management ensures that patient safety aspects and risk management issues are an integral part of patient care and hospital management.	**0**
AVERAGE	**2.46**

Table no. 7

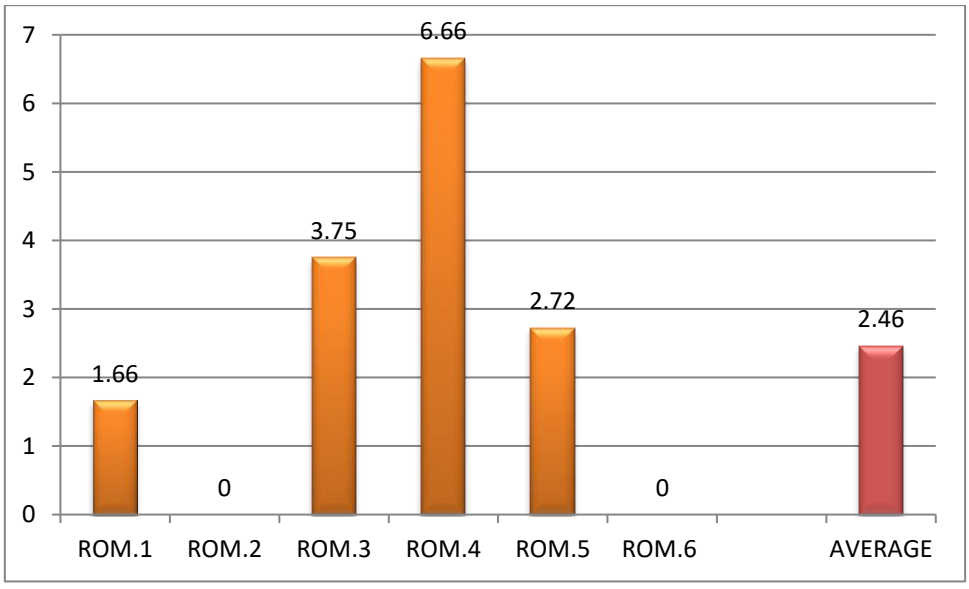


Fig. no. 7

INTERPRETATION

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

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

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

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

ROM-5. The person heading the organization has requisite and appropriate administrative qualifications. The organization does not document employee rights and responsibilities.

ROM-6. Management does not ensure proactive risk management across the organization. The leaders are not aware of the risk management procedures followed in the hospital. There is no safety and risk management committee in the hospital to oversee the hospital wide safety programme. There is no system for reporting of internal and external process failures.

Chapter 8: Facility Management and Safety (FMS)

FMS.1: The organization has a system in place to provide a safe and secure environment.	**0.83**
FMS.2: The organization's environment and facilities operate to ensure safety of patients, their families, staff and visitors.	**4.09**
FMS.3: The organization has a programme for engineering support services.	**4.4**
FMS.4: The organization has a programme for bio-medical equipment management.	**4.2**
FMS.5: The organization has a programme for medical gases, vacuum and compressed air.	**5**
FMS.6: The organization has plans for fire and non-fire emergencies within the facilities.	**2**
FMS.7: The organization plans for handling community emergencies, epidemics and other disasters.	**4**
FMS.8: The organization has a plan for management of hazardous materials.	**0**
AVERAGE	**3.08**

Table no. 8

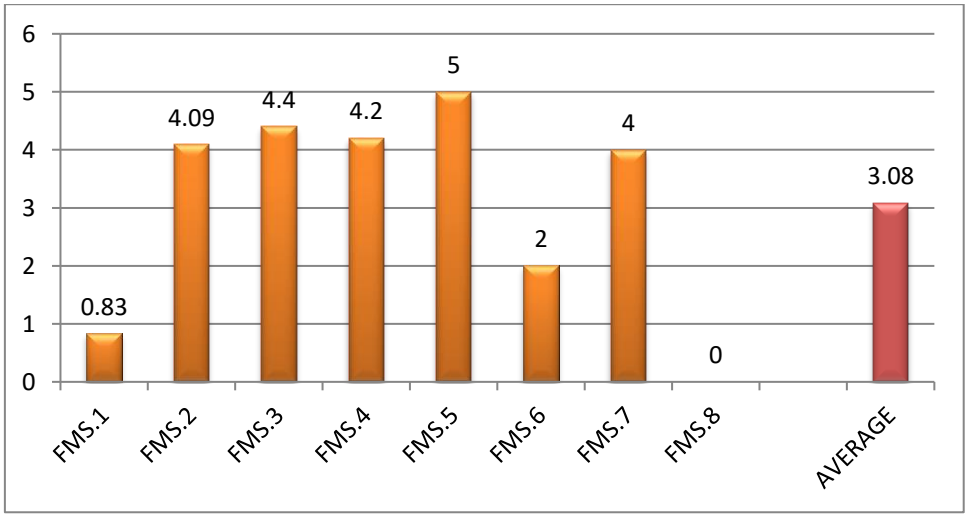


Fig. no. 8

INTERPRETATION

FMS-1. The organization has no system in place to provide a safe and secure environment.

FMS-2. Facilities are appropriate to the scope of services of the organization. Potable water and electricity are available round the clock but quality check is not done.

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

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

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

FMS-6. The organization has no plans for fire and for non-fire emergencies within the facilities. Fire safety plan needs a lot of changes. Staffs are not trained for their role in management of such emergencies and mock drills are not conducted.

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

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

Chapter 9: Human Resource Management (HRM)

HRM.1. The organization has a documented system of human resource planning.	**3.75**
HRM.2. The organization has a documented procedure for recruiting staff and orienting them to the organization's environment.	**5**
HRM.3. There is an on-going programme for professional training and development of the staff.	**0**
HRM.4. Staff are adequately trained on various safety related aspects.	**2.5**
HRM.5. An appraisal system for evaluating the performance of an employee exists as an integral part of the human resource management process.	**5**
HRM.6. The organization has documented disciplinary and grievance handling policies and procedures.	**5**
HRM.7. The organization addresses the health needs of the employees.	**2.5**
HRM.8. There is documented personal information for each staff member.	**5**
HRM.9. There is a process for credentialing and privileging of medical professionals, permitted to provide patient care without supervision.	**4.1**
HRM.10. There is a process for credentialing and privileging of nursing professionals, permitted to provide patient care without supervision.	**3.3**
AVERAGE	**3.6**

Table no. 9

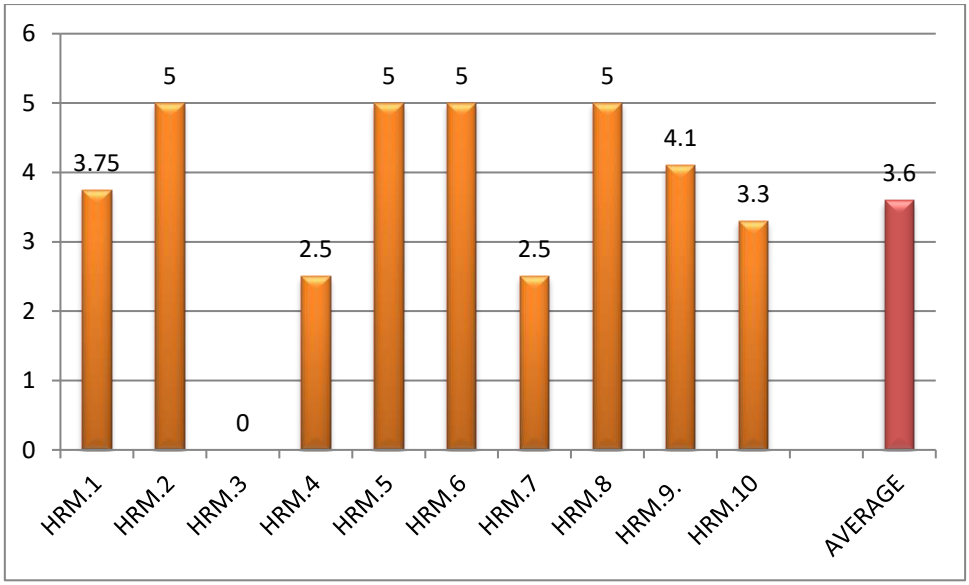


Fig. no. 9

INTERPRETATION

HRM-1 The organization has no documented system of human resource planning and the required job specification and job description are not well defined for each category of staff.

HRM-2. Employee rights and responsibilities are not defined and implemented . Staffs are not made aware of his/her rights and responsibilities. Patient rights and responsibilities are not defined to the employees..

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

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

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

HRM-6. The organization has documented disciplinary and grievance handling policies and procedures but not properly implemented.

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

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

HRM-9. There is a process for collecting, verifying and evaluating the credentials (education, registration, training and experience) of medical professionals permitted to provide patient care without supervision. Documentation has been done for the process for authorising all medical professionals to admit and treat patients and provide other clinical services commensurate with their qualifications but implementation is still required.

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

Chapter 10: Information Management System (IMS)

IMS.1. Documented policies and procedures exist to meet the information needs of the care providers, management of the organization as well as other agencies that require data and information from the organization.	**1**
IMS.2. The organization has processes in place for effective management of data.	**3**
IMS.3. The organization has a complete and accurate medical record for every patient.	**5**
IMS.4. The medical record reflects continuity of care.	**3.75**
IMS.5. Documented policies and procedures are in place for maintaining confidentiality, integrity and security of records, data and information.	**0**
IMS.6. Documented policies and procedures exist for retention time of records, data and information.	**0**
IMS.7. The organization regularly carries out review of medical records.	**0**
AVERAGE	**1.8**

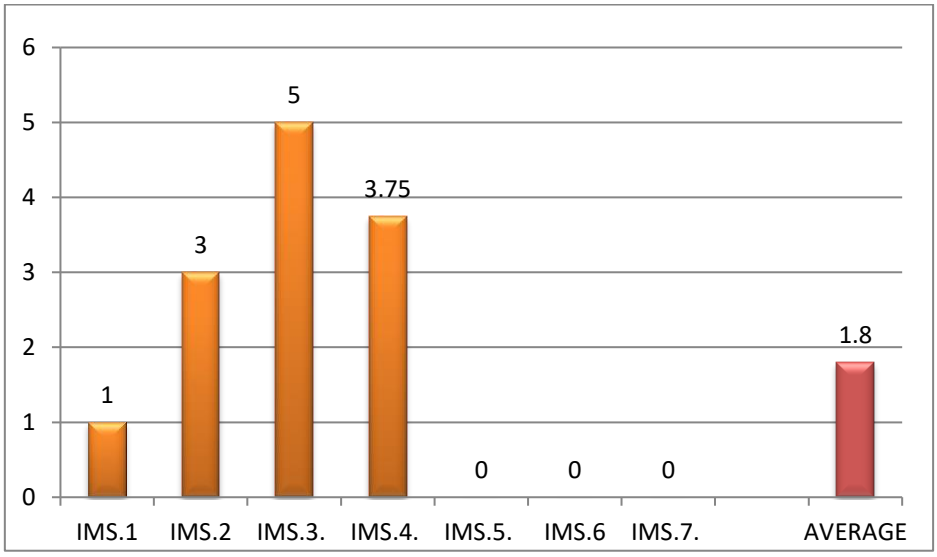


Fig. no. 10

INTERPRETATION

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

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

IMS-3. The hospital has no complete document of accurate medical record for every patient. There is no unique identifier. Entry in the medical record is named, signed, dated and timed. Provision for 24 hours availability of patient record is not maintained.

IMS-4. The medical record contains a copy of the discharge summary duly signed by appropriate and qualified personnel and the medical record reflects continuity of care

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

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

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

OVERALL SCORE OF ALL CHAPTERS

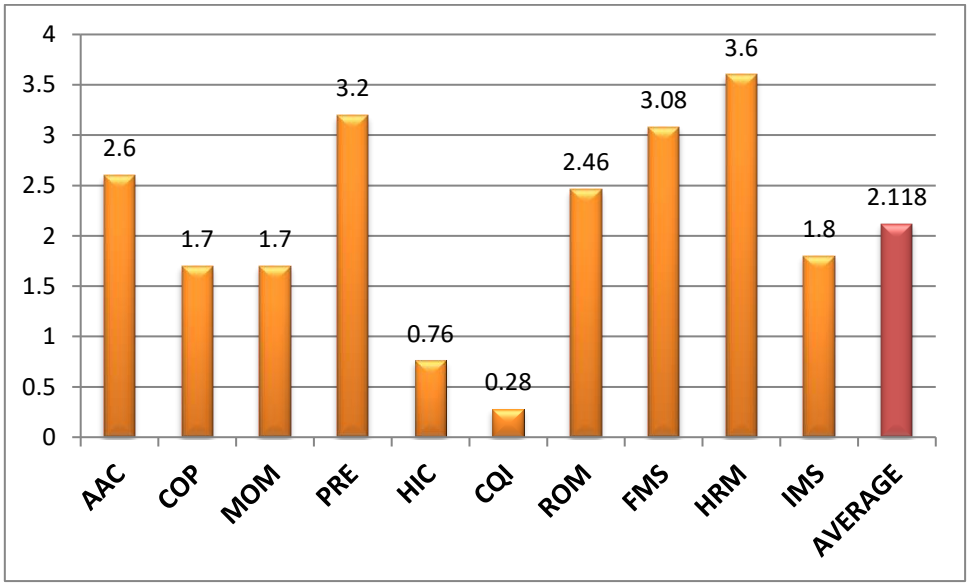


Fig. no. 11

2.11 DISCUSSION

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

1) There are many individual standard**s** with more than two zeros.
2) Average score for individual standard is less than 5.
3) All individual chapters are having average score less than 5.
4) The overall average of all the chapters is less than 5.
5) All the regulatory legal requirements are not fully met.

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

2.12 RECOMMENDATIONS

OPD

- Separate queue and functional toilet for Differently abled persons should be made.
- Citizen charter and Patient charter needs to be displayed.
- Provision of patient privacy in the consultation room should be there.
- Calibration of BP apparatus, weighing machine and thermometer needs to be done .
- Nurses should be appointed to do Patient Care in specific OPDs.
- UHID should be generated for all patients.
- Separate Registration should be done for old and new OPD patients.
- Outcome indicators should be captured and monitored.

AMBULANCE

- Adequate communication system should be installed in ambulance
- Required equipments (Stethoscope, sphygmomanometer, suction app, defibrillator, monitor, oxygen cylinder) and medicines should be available in the ambulance.
- Vehicle license and driver license are to be obtained.
- Maintenance of the medical Gas (oxygen) to 90% of the total capacity needs to be done
- Calibration of Equipments needs to be done
- Staff needs to be trained in BLS
- Medication and equipment checklist should be maintained
- Infection control practices needs to be followed

EMERGENCY DEPARTMENT

- Triage area needs to be marked separately
- Emergency signage should be visible from the road with proper lighting and signs
- Nurse should be available round the clock for emergency care of patients
- Number of trolleys and wheelchairs should be commensurate to the needs
- List of all staff that contains Name, Contact details, Designation should be displayed
- An appropriately qualified staff member should be scheduled to manage triage activities.
- Defibrillator, Cardiac Monitor, Oral Airways of various sizes, Laryngoscope with various blades, Laryngoscope replacement batteries and bulbs. Endotracheal tubes of various sizes should be present
- Security staffs should be immediately available when required in the emergency room.
- Electrical equipment (e.g. defibrillator) should be charged at all times.
- BMW should be segregated and handled properly.
- Staff needs to be trained in BLS/ACLS
- Time for initial assessment of emergency patient should be monitored.

LABORATORY

- Hand washing facility should be provided in this unit.
- There should be a separate area available for sample collection
- Scope of services needs to be defined
- Laboratory equipments needs to be calibrated
- Laboratory staff should be made aware about the safety precautions while handling samples
- Critical results needs to be defined, reported, and documented.

- Surveillance for lab test should be carried out
- EQAS needs to be monitored
- Turnaround time for lab reports needs to be monitored
- Temperature monitoring of refrigerator should be done
- Outcome indicators need to be captured and monitored.

RADIOLOGY DEPARTMENT

- AERB (SITE/TYPE approval) needs to be obtained
- Basic facilities for staff should be available (toilet/drinking water/change room)
- Provision of change room should be there for patients.
- TLD badges and Gonad shield should be provided to the technicians.
- Critical results needs to be defined, reported, and documented.
- Radiation hazard symbol should be displayed.
- Maintenance and calibration of radiology equipments needs to be done
- Quality Assurance program should be followed.
- Outcome indicators need to be captured and monitored.

WARDS

- Basic facilities for staffs should be provided (toilet/ drinking water)
- Emergency crash cart should be present in the ward
- Adequate number of nurses should be present in each shift
- Racks, wash basin, PPE need to be provided by the management.
- Vitals of the patient should be checked every day
- Nurses needs to be trained in BLS(CPR)
- Infection control practices and Bio medical waste management practice need to be followed
- Staff should be aware about transfer IN/OUT system

- Discharge process needs to be defined and documented

ICCU

- Required equipments and Fowler's bed should be present
- Following policies and procedures needs to be defined and documented :
    - Admission and discharge of the patient
    - Procedure for situation of bed shortage
    - Initial assessment and reassessment
    - Referral of patients to other department
    - Procedure for LAMA patients
    - Quality assurance programme
    - Care of patients under restraints, reasons of restrains
    - Uniform use of resuscitation
    - Rational use of blood and blood products
    - Infection control practices
    - Monitoring of patients after medication administration
    - Patient's medication brought from outside the organisation
    - Use of narcotic drugs & psychotropic substances
    - Scope of paediatric services
    - Antibiotic policy
    - Care of vulnerable patients
    - Policy for obtaining consent Staff is not aware about the end of life care policy
    - Initial assessment does not include screening for nutritional needs
- Staff needs to be trained on resuscitation
- Informed consent should be obtained before donation and transfusion of blood and blood products

- Post transfusion reaction should be monitored and analyzed for preventive and corrective actions
- Competent staff needs to be recruited for pediatric care
- Nutritional therapy should be planned and provided in a collaborative manner
- Emergency medications should be available all the time and replenished in a timely manner when used
- Medication orders should be written in a uniform location and should be clear, legible, dated, timed, named and signed .
- There should be written order for high risk medication done
- Medication administration should be documented
- Narcotic drugs should be stored in a safe manner and proper records should be kept for the usage, administration and disposal of narcotic drugs
- Infection control data should be collected
- The layout of beds, its spacing, and visual privacy should be according to the standards.
- All the equipments needs to be periodically inspected and calibrated
- The organization should provide a safe and secure environment for the vulnerable patients
- The instructions for proper hand washing should be displayed and followed by the staff.
- Adequate PPE like gloves, masks should be available and used by the staff.
- Isolation /Barrier nursing facility should be available.
- Procedure needs to be documented to describe who can give consent when patient is incapable of independent decision making.
- Outcome indicators need to be captured and monitored.

OPERATION THEATRE

- Proper Zoning concept needs to be followed(Clean zone, protective zone, sterile zone, and disposal zone)
- Number of OT tables present in the hospital should be according to the daily load

- OT should have a crash cart and defibrillator
- Scrubbing area should be present for the OT staff
- Consent for the surgery and anesthesia should be taken from the patient
- OT list should be prepared, OT booking needs to be done and pre, intra, post operative notes needs to be documented.
- Infection control practices should be followed in OT
- Pre operative checklist should be followed
- Outcome indicators need to be monitored.

PHARMACY

- All items storage areas should be marked and labeled
- Refrigerator for storing medicines(2-8 degree C) should be available
- Provision for storage of narcotic drugs(double lock and key system) should be there
- Pest/rodent control measures should be regularly under taken
- Sound Inventory control practices needs to be followed (ABC, VED, FSN,FIFO)
- General items required by the hospital should be purchased from vendors registered by management
- Drugs and therapeutics committee should be made.
- Hospital drug formulary needs to be made
- Adverse drug reactions needs to be analyzed
- Outcome indicators should be monitored.

BIOMEDICAL WASTE MANAGEMENT

- Proper work instructions at the point of segregation need to be displayed.
- Segregation of BMW at point of generation, needs to be done
- Route for transportation of waste should be separate from the general traffic area
- Regular health checkup for staff of this unit should be done.
- Usage of PPE by staff should be encouraged.
- Annual report should be submitted to UP PCB

- Monitoring needs to be done for the amount of BMW generated

HOSPITAL INFECTION CONTROL

- A designated and qualified infection control nurse(s) and infection control officer should be present
- Adequate and appropriate facilities for hand hygiene, in all patient care areas, must be provided
- Implementation of policies and/or procedures to prevent infection should be done.
- Hospital should adhere to laundry and linen management and kitchen sanitation and food handling processes
- Hospital should have appropriate engineering controls to prevent infections
- HIC surveillance data should be collected regularly and verification should be done.
- In cases of notifiable diseases, information (in relevant format) should be sent to appropriate authorities
- Surveillance activities should include monitoring of the effectiveness of housekeeping services
- Hospital infection control committee and team must be formed
- Compliance with hand hygiene guidelines needs to be monitored
- Documented procedure for identifying an outbreak should be present
- Documented procedure should exist to guide the cleaning, packing, disinfection and/or sterilization, storing and issue of items
- Visit by the hospital authorities to the disposal site should be done and documented
- Organization should earmark adequate funds from its annual budget for infection control activities
- Appropriate “in-service” training sessions for all staff should be conducted
- Appropriate pre and post exposure prophylaxis should be provided to all concerned staff members
- Outcome indicators need to be monitored.

CSSD / TSSU

- Sufficient space should be made available(0.75sq mts/bed)
- Layout should follow the functional flow: Receiving, washing, decontamination, drying, packing, loading, unloading, storing and issuing
- Racks, Decontamination solution , Transport trolley , Technician should be present in the department
- CSSD sterilization register needs to be maintained (receipt/Issue)
- Labeling of drums in CSSD should be done
- Chemical, biological and bowie-dick test must be performed
- Recall system of items must be followed
- Reuse policy for items should be available

STORE

- There should not be any water seepage/ damp in the store
- The items need to be labeled & arranged at designated place.
- Items such as radiographic films, spirits etc (which are inflammable) must be stored in a separate location.
- Inventory recording system should be present either computerized or on register
- Frequently used items should be arranged and located in most easily accessible area.
- Pest/rodent control measures should be regularly under taken
- Lead time in issuing material to the department should be recorded
- Stock Turnover details needs to be calculated on a monthly basis.
- Sound inventory control practices must be followed (ABC/VED/FSN/FIFO)
- Condemnation policy must be followed
- Purchase and condemnation committee needs to be made
- A comparative list of rates of potential suppliers should be maintained
- Outcome indicators should be monitored.

KITCHEN/DIETARY

- Layout must follow the functional flow: Receiving, storage, preparation, distribution and cleaning
- DG power supply should be given to this unit
- Dedicated food storage area should be present
- Measures for fire detection/fire fighting must be installed in this unit
- The person responsible for this department must be a qualified dietician or should take supervision from a consultant dietician.
- Health check up of all staff should be done at least once a year.
- Nutritional Assessment should be done for all the patients
- Diet Sheet needs to be prepared by Dietician as per the treating Doctors instruction on the patient's case sheet.
- Each patient's Case sheet should be checked by doctor and dietician and changes are not made in their diet depending on their condition
- Food distribution to patients should occur in covered trolleys

HOUSEKEEPING

- Housekeeping staff needs to be trained in the infection control practices
- Daily cleaning schedule should be available
- Staff should be aware about the preparation of cleaning solutions
- Pest control methods must be practiced
- Medical examination of staff should be done periodically

MORTUARY

- Calibration and maintenance needs to be done regularly
- Measures for fire detection/firefighting needs to be installed in this unit

- Temperature should be regularly monitored
- Process of infection control should be followed

LABOUR DEPARTMENT

- Separate areas should be demarcated for septic and aseptic deliveries
- Labour room needs to have a toilet facility
- Disposable Delivery Kits should be present in required quantities
- ECG monitor should be purchased
- Labour Room Register should have a record of referred cases
- Part preparation of the patient should be done before the operation
- APGAR SCORE must be used and Standard Operating Procedures must be followed for induction of Labour and progress of labour

2.13 CONCLUSION

Accredited hospitals offer higher quality of care to their patients. Accreditation also provides a competitive advantage in the healthcare industry and strengthens community confidence in the quality and safety of care, treatment and services. Overall it improves risk management and risk reduction and helps organise and strengthen patient safety efforts and creates a culture of patient safety.

After doing gap analysis of District hospital, Sanjay nagar, Ghaziabad, it is realised that the hospital is not able to fulfil the criteria for pre – accreditation entry level. The hospital authorities need to realise the existing gaps in the structure and processes of the hospital and they must take necessary actions to improve the condition in order to get the accreditation.

With the help of accreditation a hospital can achieve the optimum quality that is needed for bringing patient safety and satisfaction. The step to analyse the gaps is a stepping stone towards achieving NABH accreditation and if the improvement is done as per requirement, the hospital will be able to fulfil the criteria for NABH accreditation which will help the hospital to have competitive edge over other private and government hospitals.

2.14 LIMITATIONS OF THE STUDY

- There was difficulty in data retrieval for the study because of unorganised medical record system.
- The secondary data collected was not updated periodically which may affect the overall result.
- There was difficulty in collecting data about some of the structural elements as the detailed layout of the hospital is not available.
- Due to huge workload and lack of time the staff was not able to share the data in a proper manner.

2.15 REFERENCES

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APPENDICES

1. SELF ASSESSMENT TOOLKIT

		Elements	Scores
Chapter 1: ACCESS, ASSESSMENT AND CONTINUITY OF CARE (AAC)			
AAC.1: The organization defines and displays the services that it provides.			
	a	The services being provided are clearly defined and are in consonance with the needs of the community.	5
	b	The defined services are prominently displayed.	5
	c	The staff is oriented to these services.	5
			5
AAC.2: The organization has a well-defined registration and admission process.			
	a	Documented policies and procedures are used for registering and admitting patients.	0
	b	The documented procedures address out- patients, in-patients and emergency patients.	0
	c	A unique identification number is generated at the end of registration.	0
	d	Patients are accepted only if the organization can provide the required service.	10
	e	The documented policies and procedures also address managing patients during non-availability of beds.	0
	f	The staff is aware of these processes.	10
			3.33
AAC.3: There is an appropriate mechanism for transfer (in and out) or referral of patients.			
	a	Documented policies and procedures guide the transfer-in of patients to the organization.	0
	b	Documented policies and procedures guide the transfer-out/ referral of unstable patients to another facility in an appropriate manner.	0
	c	Documented policies and procedures guide the transfer-out/ referral of stable patients to another facility in an appropriate manner.	0
	d	The documented procedures identify staff responsible during transfer/referral	0

	e	The organization gives a summary of patient's condition and the treatment given	5
			0
AAC.4: Patients cared for by the organization undergo an established initial assessment.			
	a	The organization defines and documents the content of the initial assessment for the out–patients, in-patients and emergency patients	5
	b	The organization determines who can perform the initial assessment.	10
	c	The organization defines the time frame within which the initial assessment is completed based on patient's needs	5
	d	The initial assessment for in-patients is documented within 24 hours or earlier as per the patient's condition as defined in the organization's policy	5
	e	Initial assessment of in-patients includes nursing assessment which is done at the time of admission and documented.	5
	f	Initial assessment includes screening for nutritional needs	0
	g	The initial assessment results in a documented plan of care	0
	h	The plan of care also includes preventive aspects of the care where appropriate	0
	i	The plan of care is countersigned by the clinician in-charge of the patient within 24 hours.	5
	j	The plan of care includes goals or desired results of the treatment, care or service	0
			3.5
AAC.5: Patients cared for by the organization undergo a regular reassessment			
	a	Patients are reassessed at appropriate intervals.	5
	b	Out-patients are informed of their next follow up where appropriate.	5
	c	For in-patients during reassessment the plan of care is monitored and modified where found necessary.	5
	d	Staff involved in direct clinical care document reassessments.	5
	e	Patients are reassessed to determine their response to treatment and to plan further treatment or discharge.	5
			5
AAC.6:Laboratory services are provided as per the scope of services of the organization.			
	a	Scope of the laboratory services are commensurate to the services provided by the organization.	5
	b	The infrastructure (physical and manpower) is adequate to provide for its defined scope of services.	10

	c	Adequately qualified and trained personnel perform, supervise and interpret the investigations.	10
	d	Documented procedures guide ordering of tests, collection, identification, handling, safe transportation, processing and disposal of specimens.	0
	e	Laboratory results are available within a defined time frame.	10
	f	Critical results are intimated immediately to the concerned personnel.	5
	g	Results are reported in a standardized manner.	5
	h	Laboratory tests not available in the organization are outsourced to organization(s) based on their quality assurance system.	0
			5.625
AAC.7:There is an established laboratory quality assurance programme			
	a	The laboratory quality assurance programme is documented.	0
	b	The programme addresses verification and/or validation of test methods.	0
	c	The programme addresses surveillance of test results.	0
	d	The programme includes periodic calibration and maintenance of all equipment.	0
	e	The programme includes the documentation of corrective and preventive actions.	0
			0
AAC.8:There is an established laboratory safety programme.			
	a	The laboratory safety programme is documented.	0
	b	This programme is aligned with the organization's safety programme.	0
	c	Written procedures guide the handling and disposal of infectious and hazardous materials.	0
	d	Laboratory personnel are appropriately trained in safe practices.	5
	e	Laboratory personnel are provided with appropriate safety equipment / devices.	5
			2
AAC.9: Imaging services are provided as per the scope of services of the organization.			
	a	Imaging services comply with legal and other requirements.	5
	b	Scope of the imaging services are commensurate to the services provided by the organization.	10

c	The infrastructure (physical and manpower) is adequate to provide for its defined scope of services.	10
d	Adequately qualified and trained personnel perform, supervise and interpret the investigations.	5
e	Documented policies and procedures guide identification and safe transportation of patients to imaging services.	0
f	Imaging results are available within a defined time frame.	0
g	Critical results are intimated immediately to the concerned personnel.	0
h	Results are reported in a standardized manner.	0
i	Imaging tests not available in the organization are outsourced to organization(s) based on their quality assurance system.	0
		3.33
AAC.10:There is an established Quality assurance programme for imaging services.		
a	The quality assurance programme for imaging services is documented.	0
b	The programme addresses verification and/or validation of imaging methods.	0
c	The programme addresses surveillance of imaging results.	0
d	The programme includes periodic calibration and maintenance of all equipment.	0
e	The programme includes the documentation of corrective and preventive actions.	0
		0
AAC.11:There is an established radiation safety programme.		
a	The radiation safety programme is documented.	0
b	This programme is aligned with the organization's safety programme.	0
c	Handling, usage and disposal of radio-active and hazardous materials is as per statutory requirements.	0
d	Imaging personnel are provided with appropriate radiation safety devices.	5
e	Radiation safety devices are periodically tested and results documented.	0
f	Imaging personnel are trained in radiation safety measures.	5
g	Imaging signage are prominently displayed in all appropriate locations.	5
		2.142
AAC.12:Patient care is continuous and multidisciplinary in nature.		

a	During all phases of care, there is a qualified individual identified as responsible for the patient's care.	10
b	Care of patients is coordinated in all care settings within the organization.	10
c	Information about the patient's care and response to treatment is shared among medical, nursing and other care providers.	5
d	Information is exchanged and documented during each staffing shift, between shifts, and during transfers between units/departments.	5
e	Transfers between departments/units are done in a safe manner.	5
f	The patient's record (s) is available to the authorized care providers to facilitate the exchange of information.	5
g	Documented procedures guide the referral of patients to other departments/ specialities.	0
		5.714
AAC.13: The organization has a documented discharge process.		
a	The patient's discharge process is planned in consultation with the patient and/or family.	5
b	Documented procedures exist for coordination of various departments and agencies involved in the discharge process (including medico-legal and absconded cases).	0
c	Documented policies and procedures are in place for patients leaving against medical advice and patients being discharged on request	0
d	A discharge summary is given to all the patients leaving the organization (including patients leaving against medical advice and on request).	0
		1.25
AAC.14: Organization defines the content of the discharge summary.		
a	Discharge summary is provided to the patients at the time of discharge.	0
b	Discharge summary contains the patient's name, unique identification number, date of admission and date of discharge.	0
c	Discharge summary contains the reasons for admission, significant findings and diagnosis and the patient's condition at the time of discharge.	0
d	Discharge summary contains information regarding investigation results, any procedure performed, medication administered and other treatment given.	0
e	Discharge summary contains follow up advice, medication and other instructions in an understandable manner.	0
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.	0
		0

	SCORE OF CHAPTER - 01		2.635
Chapter 2: CARE OF PATIENTS (COP)			
COP.1: Uniform care to patients is provided in all settings of the organization and is guided by the applicable laws, regulations and guidelines.			
	a	Care delivery is uniform for a given health problem when similar care is provided in more than one setting.	5
	b	Uniform care is guided by documented policies and procedures	0
	c	These reflect applicable laws, regulations and guidelines	0
	d	The organization adapts evidence based medicine and clinical practice guidelines to guide uniform patient care.	0
			1.25
COP.2: Emergency services are guided by documented policies, procedures, applicable laws and regulations.			
	a	Policies and procedures for emergency care are documented and are in consonance with statutory requirements.	0
	b	This also addresses handling of medico-legal cases.	5
	c	The patients receive care in consonance with the policies.	0
	d	Documented policies and procedures guide the triage of patients for initiation of appropriate care	0
	e	Staff are familiar with the policies and trained on the procedures for care of emergency patients.	0
	f	Admission or discharge to home or transfer to another organization is also documented.	0
	g	In case of discharge to home or transfer to another organization a discharge note shall be given to the patient.	0
			0.714
COP.3: The ambulance services are commensurate with the scope of the services provided by the organization.			
	a	There is adequate access and space for the ambulance(s).	0
	b	The ambulance adheres to statutory requirements.	10
	c	Ambulance(s) is appropriately equipped.	0
	d	Ambulance(s) is manned by trained personnel.	0

	e	Ambulance (s) is checked on a daily basis.	0
	f	Equipment are checked on a daily basis using a checklist.	0
	g	Emergency medications are checked daily and prior to dispatch using a checklist.	5
	h	The ambulance(s) has a proper communication system.	0
			1.875
COP.4: Documented policies and procedures guide the care of patients requiring cardio-pulmonary resuscitation.			
	a	Documented policies and procedures guide the uniform use of resuscitation throughout the organization	0
	b	Staff providing direct patient care are trained and periodically updated in cardio pulmonary resuscitation.	0
	c	The events during a cardio-pulmonary resuscitation are recorded.	0
	d	A post-event analysis of all cardio-pulmonary resuscitations is done by a multidisciplinary committee.	0
	e	Corrective and preventive measures are taken based on the post-event analysis.	0
			0
COP.5: Documented policies and procedures guide nursing care.			
	a	There are documented policies and procedures for all activities of the Nursing Services.	0
	b	These reflect current standards of nursing services and practice, relevant regulations and the purposes of the services.	0
	c	Assignment of patient care is done as per current good practice guidelines.	5
	d	Nursing care is aligned and integrated with overall patient care.	10
	e	Care provided by nurses is documented in the patient record.	5
	f	Nurses are provided with adequate equipment for providing safe and efficient nursing services.	5
	g	Nurses are empowered to take nursing related decisions to ensure timely care of patients.	5
			4.285
COP.6: Documented procedures guide the performance of various procedures.			
	a	Documented procedures are used to guide the performance of various clinical procedures.	0
	b	Only qualified personnel order, plan, perform and assist in performing procedures.	5

c	Documented procedures exist to prevent adverse events like wrong site, wrong patient and wrong procedure.	0
d	Informed consent is taken by the personnel performing the procedure where applicable.	5
e	Adherence to standard precautions and asepsis is adhered to during the conduct of the procedure.	0
f	Patients are appropriately monitored during and after the procedure.	5
g	Procedures are documented accurately in the patient record.	5
		2.857
COP.7: Documented policies and procedures define rational use of blood and blood products.		
a	Documented policies and procedures are used to guide rational use of blood and blood products.	0
b	Documented procedures govern transfusion of blood and blood products.	0
c	The transfusion services are governed by the applicable laws and regulations.	5
d	Informed consent is obtained for donation and transfusion of blood and blood products.	5
e	Informed consent also includes patient and family education about donation.	0
f	The organization defines the process for availability and transfusion of blood/blood components for use in emergency.	0
g	Post transfusion form is collected; reactions if any identified and are analysed for preventive and corrective actions.	0
h	Staff are trained to implement the policies.	0
		1.25
COP.8: Documented policies and procedures guide the care of patients in the Intensive care and high dependency units.		
a	Documented policies and procedures are used to guide the care of patients in the Intensive care and high dependency units.	0
b	The organization has documented admission and discharge criteria for its intensive care and high dependency units.	0
c	Staff are trained to apply these criteria.	0
d	Adequate staff and equipment are available.	5
e	Defined procedures for situation of bed shortages are followed.	0
f	Infection control practices are documented and followed.	0

	g	A quality assurance programme is documented and implemented.	0
			0.714
COP.9: Documented policies and procedures guide the care of vulnerable patients (elderly, children, physically and/or mentally challenged).			
	a	Policies and procedures are documented and are in accordance with the prevailing laws and the national and international guidelines.	0
	b	Care is organized and delivered in accordance with the policies and procedures.	5
	c	The organization provides for a safe and secure environment for this vulnerable group.	0
	d	A documented procedure exists for obtaining informed consent from the appropriate legal representative.	5
	e	Staff are trained to care for this vulnerable group.	5
			3
COP.10: Documented policies and procedures guide obstetric care.			
	a	There is a documented policy and procedure for obstetric services.	0
	b	The organization defines and displays whether high risk obstetric cases can be cared for or not.	0
	c	Persons caring for high risk obstetric cases are competent.	10
	d	Documented procedures guide provision of ante-natal services.	0
	e	Obstetric patient's assessment also includes maternal nutrition.	0
	f	Appropriate pre-natal, peri-natal and post-natal monitoring is performed and documented.	0
	g	The organization caring for high risk obstetric cases has the facilities to take care of neonates of such cases.	0
			1.428
COP.11: Documented policies and procedures guide paediatric services.			
	a	There is a documented policy and procedure for paediatric services.	0
	b	The organization defines and displays the scope of its paediatric services.	0

c	The policy for care of neonatal patients is in consonance with the national/ international guidelines.	0
d	Those who care for children have age specific competency.	5
e	Provisions are made for special care of children.	0
f	Patient assessment includes detailed nutritional, growth, psychosocial and immunization assessment.	0
g	Documented policies and procedures prevent child/neonate abduction and abuse.	0
h	The children's family members are educated about nutrition, immunization and safe parenting and this is documented in the medical record.	5
		1.25
COP.12: Documented policies and procedures guide the care of patients undergoing moderate sedation.		
a	Documented procedures guide the administration of moderate sedation.	0
b	Informed consent for administration of moderate sedation is obtained.	0
c	Competent and trained persons perform sedation.	10
d	The person administering and monitoring sedation is different from the person performing the procedure.	10
e	Intra-procedure monitoring includes at a minimum the heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation, and level of sedation.	0
f	Patients are monitored after sedation and the same documented.	0
g	Criteria are used to determine appropriateness of discharge from the recovery area.	0
h	Equipment and manpower are available to manage patients who have gone into a deeper level of sedation than initially intended.	5
		3.125
COP.13: Documented policies and procedures guide the administration of anaesthesia.		
a	There is a documented policy and procedure for the administration of anaesthesia.	0
b	Patients for anaesthesia have a pre-anaesthesia assessment by a qualified anaesthesiologist.	5
c	The pre-anaesthesia assessment results in formulation of an anaesthesia plan which is documented	5

d	An immediate pre-operative re-evaluation is performed and documented.	5
e	Informed consent for administration of anaesthesia is obtained by the anaesthesiologist.	10
f	During anaesthesia monitoring includes regular recording of temperature, heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation and end tidal carbon dioxide.	5
g	Patient's post-anaesthesia status is monitored and documented.	5
h	The anaesthesiologist applies defined criteria to transfer the patient from the recovery area.	0
i	The type of anaesthesia and anaesthetic medications used are documented in the patient record.	0
j	Procedures shall comply with infection control guidelines to prevent cross infection between patients.	0
k	Adverse anaesthesia events are recorded and monitored.	0
		3.18
COP.14: Documented policies and procedures guide the care of patients undergoing surgical procedures.		
a	The policies and procedures are documented.	0
b	Surgical patients have a preoperative assessment and a provisional diagnosis documented prior to surgery.	5
c	An informed consent is obtained by a surgeon prior to the procedure.	5
d	Documented policies and procedures exist to prevent adverse events like wrong site, wrong patient and wrong surgery.	0
e	Persons qualified by law are permitted to perform the procedures that they are entitled to perform.	10
f	A brief operative note is documented prior to transfer out of patient from recovery area.	5
g	The operating surgeon documents the post-operative plan of care.	0
h	Patient, personnel and material flow conforms to infection control practices.	0
i	Appropriate facilities and equipment/appliances/instrumentation are available in the operating theatre.	5
j	A quality assurance programme is followed for the surgical services.	0
k	The quality assurance programme includes surveillance of the operation theatre environment.	0

			2.72
COP.15: Documented policies and procedures guide the care of patients under restraints (physical and / or chemical).			
	a	Documented policies and procedures guide the care of patients under restraints.	0
	b	These include both physical and chemical restraint measures.	0
	c	These include documentation of reasons for restraints.	0
	d	These patients are more frequently monitored.	0
	e	Staff receive training and periodic updating in control and restraint techniques.	0
			0
COP.16: Documented policies and procedures guide appropriate pain management.			
	a	Documented policies and procedures guide the management of pain.	0
	b	All patients are screened for pain.	5
	c	Patients with pain undergo detailed assessment and periodic re-assessment.	0
	d	The organization respects and supports management of pain for such patients.	5
	e	Patient and family are educated on various pain management techniques where appropriate.	0
			2
COP.17: Documented policies and procedures guide appropriate rehabilitative services.			
	a	Documented policies and procedures guide the provision of rehabilitative services.	N.A
	b	These services are commensurate with the organizational requirements.	N.A
	c	Care is guided by functional assessment and periodic re-assessment which is done and documented by qualified individual (s).	N.A
	d	Care is provided adhering to infection control and safe practices.	N.A
	e	Rehabilitative services are provided by a multidisciplinary team.	N.A

	f	There is adequate space and equipment to perform these activities.	N.A
			N.A
COP.18: Documented policies and procedures guide all research activities.			N.A
	a	Documented policies and procedures guide all research activities in compliance with national and international guidelines.	N.A
	b	The organization has an ethics committee to oversee all research activities.	N.A
	c	The committee has the powers to discontinue a research trial when risks outweigh the potential benefits.	N.A
	d	Patient's informed consent is obtained before entering them in research protocols.	N.A
	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.	N.A
	f	Patients are assured that their refusal to participate or withdrawal from participation will not compromise their access to the organization's services.	N.A
			N.A
COP.19: Documented policies and procedures guide nutritional therapy.			
	a	Documented policies and procedures guide nutritional assessment and reassessment.	0
	b	Patients receive food according to their clinical needs.	0
	c	There is a written order for the diet.	0
	d	Nutritional therapy is planned and provided in a collaborative manner.	0
	e	When families provide food, they are educated about the patient's diet limitations.	0
	f	Food is prepared, handled, stored and distributed in a safe manner.	
			0
COP.20: Documented policies and procedures guide the end of life care.			
	a	Documented policies and procedures guide the end of life care.	0
	b	These policies and procedures are in consonance with the legal requirements.	0

	c	These also address the identification of the unique needs of such patient and family.	0
	d	Symptomatic treatment is provided and where appropriate measures are taken for alleviation of pain.	5
	e	Staff are educated and trained in end of life care.	0
			1
		SCORE OF CHAPTER - 02	1.719
Chapter 3: Management of Medication (MOM)			
MOM.1: Documented policies and procedures guide the organization of pharmacy services and usage of medication.			
	a	There is a documented policy and procedure for pharmacy services and medication usage.	0
	b	These comply with the applicable laws and regulations.	0
	c	A multidisciplinary committee guides the formulation and implementation of these policies and procedures.	0
	d	There is a procedure to obtain medication when the pharmacy is closed.*	0
			0
MOM.2. There is a hospital formulary.			
	a	A list of medications appropriate for the patients and as per the scope of the organization's clinical services is developed.	5
	b	The list is developed and updated collaboratively by the multidisciplinary committee.	5
	c	The formulary is available for clinicians to refer and adhere to.	0
	d	There is a defined process for acquisition of these medications	5
	e	There is a process to obtain medications not listed in the formulary.	5
			4
MOM.3: Documented policies and procedures guide the storage of medication			
	a	Documented policies and procedures exist for storage of medication	0

b	Medications are stored in a clean; safe and secure environment; and incorporating manufacturer's recommendation (s).	5
c	Sound inventory control practices guide storage of the medications.	0
d	Sound alike and look alike medications are identified and stored separately.*	0
e	The list of emergency medications is defined and is stored in a uniform manner	0
f	Emergency medications are available all the time.	5
g	Emergency medications are replenished in a timely manner when used.	0
		1.428
MOM.4: Documented policies and procedures guide the safe and rational prescription of medications		
a	Documented policies and procedures exist for prescription of medications.	0
b	These incorporate inclusion of good practices/guidelines for rational prescription of medications.	0
c	The organization determines the minimum requirements of a prescription.	0
d	Known drug allergies are ascertained before prescribing.	0
e	The organization determines who can write orders.*	10
f	Orders are written in a uniform location in the medical records.	5
g	Medication orders are clear, legible, dated, timed, named and signed.	0
h	Medication orders contain the name of the medicine, route of administration, dose to be administered and frequency/time of administration.	0
i	Documented policy and procedure on verbal orders is implemented.	0
j	The organization defines a list of high risk medication (s).	0
k	Audit of medication orders/prescription is carried out to check for safe and rational prescription of medications.	0
l	Corrective and/or preventive action (s) is taken based on the analysis where appropriate.	0
		1.25

MOM.5: Documented policies and procedures guide the safe dispensing of medications.			
	a	Documented policies and procedures guide the safe dispensing of medications	0
	b	The procedure addresses medication recall.	0
	c	Expiry dates are checked prior to dispensing.	5
	d	There is a procedure for near expiry medications.	0
	e	Labelling requirements are documented and implemented by the organization.	0
	f	High risk medication orders are verified prior to dispensing.	5
			1.66
MOM.6:There are documented policies and procedures for medication management.			
	a	Medications are administered by those who are permitted by law to do so.	10
	b	Prepared medication is labelled prior to preparation of a second drug.	5
	c	Patient is identified prior to administration.	5
	d	Medication is verified from the order prior to administration.	5
	e	Dosage is verified from the order prior to administration.	5
	f	Route is verified from the order prior to administration.	5
	g	Timing is verified from the order prior to administration.	0
	h	Medication administration is documented.	5
	i	Documented policies and procedures govern patient's self- administration of medications.	0
	j	Documented policies and procedures govern patient's medications brought from outside the organization.*	0
			4
MOM.7: Patients are monitored after medication administration.			

	a	Documented policies and procedures guide the monitoring of patients after medication administration.	0
	b	The organization defines those situations where close monitoring is required.	5
	c	Monitoring is done in a collaborative manner.	0
	d	Medications are changed where appropriate based on the monitoring.	5
			2.5
MOM.8: Near misses, medication errors and adverse drug events are reported and analysed.			
	a	Documented procedure exists to capture near miss, medication error and adverse drug event.	0
	b	Near miss, medication error and adverse drug event are defined.	0
	c	These are reported within a specified time frame.	0
	d	They are collected and analysed.	0
	e	Corrective and/or preventive action (s) is taken based on the analysis where appropriate.	0
			0
MOM.9: Documented procedures guide the use of narcotic drugs and psychotropic substances.			
	a	Documented procedures guide the use of narcotic drugs and psychotropic substances which are in consonance with local and national regulations.	0
	b	These drugs are stored in a secure manner.	0
	c	A proper record is kept of the usage, administration and disposal of these drugs.	0
	d	These drugs are handled by appropriate personnel in accordance with the documented procedure.	0
			0
MOM.10: Documented policies and procedures guide the usage of chemotherapeutic agents.			N.A
	a	Documented policies and procedures guide the usage of chemotherapeutic agents.	N.A
	b	Chemotherapy is prescribed by those who have the knowledge to monitor and treat the adverse effect of chemotherapy.	N.A

	c	Chemotherapy is prepared in a proper and safe manner and administered by qualified personnel.	N.A
	d	Chemotherapy drugs are disposed off in accordance with legal requirements.	N.A
MOM.11: Documented policies and procedures govern usage of radioactive drugs.			N.A
	a	Documented policies and procedures govern usage of radioactive drugs.	N.A
	b	These policies and procedures are in consonance with laws and regulations.	N.A
	c	The policies and procedures include the safe storage, preparation, handling, distribution and disposal of radioactive drugs.	N.A
	d	Staff, patients and visitors are educated on safety precautions.	N.A
MOM.12: Documented policies and procedures guide the use of implantable prosthesis and medical devices.			
	a	Usage of implantable prosthesis and medical devices is guided by scientific criteria for each individual item and national / international recognized guidelines / approvals for such specific item(s).	0
	b	Documented policies and procedures govern procurement, storage / stocking, issuance and usage of implantable prosthesis and medical devices incorporating manufacturer's recommendation(s).*	0
	c	Patient and his / her family are counselled for the usage of implantable prosthesis and medical device including precautions, if any.	0
	d	The batch and serial number of the implantable prosthesis and medical devices are recorded in the patient's medical record and the master logbook.	0
			0
MOM.13: Documented policies and procedures guide the use of medical supplies and consumables			
	a	There is a defined process for acquisition of medical supplies and consumables.	10
	b	Medical supplies and consumables are used in a safe manner where appropriate.	5
	c	Medical supplies and consumables are stored in a clean; safe and secure environment; and incorporating manufacturer's recommendation (s).	0
	d	Sound inventory control practices guide storage of medical supplies and consumables.	0
			3.75
	SCORE OF CHAPTER - 03		1.69

Chapter 4: Patient Rights and Education (PRE)			
PRE.1. The organization protects patient and family rights and informs them about their responsibilities during care.			
	a	Patient and family rights and responsibilities are documented and displayed.	0
	b	Patients and families are informed of their rights and responsibilities in a format and language that they can understand.	0
	c	The organization's leaders protect patient and family rights.	5
	d	Staff is aware of their responsibility in protecting patient and family rights.	0
	e	Violation of patient and family rights is recorded, reviewed and corrective / preventive measures taken.	0
			1
PRE.2: Patient and family rights support individual beliefs, values and involve the patient and family in decision making processes.			
	a	Patients and family rights include respecting any special preferences, spiritual and cultural needs.	0
	b	Patient and family rights include respect for personal dignity and privacy during examination, procedures and treatment.	0
	c	Patient and family rights include protection from physical abuse or neglect.	0
	d	Patient and family rights include treating patient information as confidential.	0
	e	Patient and family rights include refusal of treatment.	0
	f	Patient and family rights include informed consent before transfusion of blood and blood products, anaesthesia, surgery, initiation of any research protocol and any other invasive / high risk procedures / treatment.	0
	g	Patient and family rights include right to complain and information on how to voice a complaint.	0
	h	Patient and family rights include information on the expected cost of the treatment.	0
	i	Patient and family rights include access to his / her clinical records.	0
	j	Patient and family rights include information on plan of care, progress and information on their health care needs.	0
			0
PRE.3: The patient and/ or family members are educated to make informed decisions and are involved in the care planning and delivery process.			

a	The patient and/or family members are explained about the proposed care including the risks, alternatives and benefits.	5
b	The patient and/or family members are explained about the expected results.	5
c	The patient and / or family members are explained about the possible complications.	5
d	The care plan is prepared and modified in consultation with patient and/or family members.	0
e	The care plan respects and where possible incorporates patient and/or family concerns and requests.	0
f	The patient and/or family members are informed about the results of diagnostic tests and the diagnosis	5
g	The patient and/or family members are explained about any change in the patient's condition.	5
		3.57
PRE.4: A documented procedure for obtaining patient and / or family's consent exists for informed decision making about their care.		
a	Documented procedure incorporates the list of situations where informed consent is required and the process for taking informed consent.	0
b	General consent for treatment is obtained when the patient enters the organization.	0
c	Patient and/or his family members are informed of the scope of such general consent.	0
d	Informed consent includes information regarding the procedure, risks, benefits, alternatives and as to who will perform the requisite procedure in a language that they can understand.	5
e	The procedure describes who can give consent when patient is incapable of independent decision making.	0
f	Informed consent is taken by the person performing the procedure.	0
g	Informed consent process adheres to statutory norms.	0
h	Staff are aware of the informed consent procedure.	5
		1.25
PRE.5: Patient and families have a right to information and education about their healthcare needs.		
a	Patient and/or family are educated about the safe and effective use of medication and the potential side effects of the medication, when appropriate.	0
b	Patient and/or family are educated about food-drug interactions.	0
c	Patient and/or family are educated about diet and nutrition.	0

	d	Patient and/or family are educated about immunizations.	5
	e	Patient and/or family are educated about organ donation, when appropriate.	0
	f	Patient and/or family are educated about their specific disease process, complications and prevention strategies.	5
	g	Patient and/or family are educated about preventing healthcare associated infections.	0
	h	Patient and/or family are educated in a language and format that they can understand.	5
			1.875
PRE.6: Patient and families have a right to information on expected costs.			
	a	There is uniform pricing policy in a given setting (out-patient and ward category).	10
	b	The tariff list is available to patients.	10
	c	The patient and/or family members are explained about the expected costs.	10
	d	Patient and/or family are informed about the financial implications when there is a change in the patient condition or treatment setting.	10
			10
PRE.7: Organization has a complaint redressal procedure.			
	a	The organization has a documented complaint redressal procedure.	5
	b	Patient and/or family members are made aware of the procedure for lodging complaints.	5
	c	All complaints are analysed.	5
	d	Corrective and/or preventive action (s) is taken based on the analysis where appropriate.	5
			5
		SCORE OF CHAPTER - 04	3.24
Chapter 5: Hospital Infection Control (HIC)			
HIC.1: The organization has a well-designed, comprehensive and coordinated Hospital Infection Prevention and Control (HIC) programme aimed at reducing/ eliminating risks to patients, visitors and providers of care.			
	a	The hospital infection prevention and control programme is documented which aims at preventing and reducing risk of healthcare associated infections.	0

	b	The infection prevention and control programme is a continuous process and updated at least once in a year.	0
	c	The hospital has a multi-disciplinary infection control committee which co-ordinates all infection prevention and control activities.	0
	d	The hospital has an infection control team which co-ordinates implementation of all infection prevention and control activities.	0
	e	The hospital has designated infection control officer as part of the infection control team.	0
	f	The hospital has designated infection control nurse(s) as part of the infection control team.	0
			0
HIC.2: The organization implements the policies and procedures laid down in the Infection Control Manual.			
	a	The organization identifies the various high-risk areas and procedures and implements policies and/or procedures to prevent infection in these areas	0
	b	The organization adheres to standard precautions at all times.	0
	c	The organization adheres to hand hygiene guidelines.	5
	d	The organization adheres to safe injection and infusion practices.	0
	e	The organization adheres to transmission based precautions at all times.	0
	f	The organization adheres to cleaning, disinfection and sterilization practices	5
	g	An appropriate antibiotic policy is established and implemented.	0
	h	The organization adheres to laundry and linen management processes.	0
	i	The organization adheres to kitchen sanitation and food handling issues.	0
	j	The organization has appropriate engineering controls to prevent infections.	5
	k	The organization adheres to housekeeping procedures.	0
			1.363
HIC.3: The organization performs surveillance activities to capture and monitor infection prevention and control data.			
	a	Surveillance activities are appropriately directed towards the identified high-risk areas and procedures.	0
	b	Collection of surveillance data is an on-going process.	0
	c	Verification of data is done on a regular basis by the infection control team.	0
	d	Scope of surveillance activities incorporates tracking and analysing of infection risks, rates and trends.	0
	e	Surveillance activities include monitoring the compliance with hand hygiene guidelines.	0

	f	Surveillance activities include monitoring the effectiveness of housekeeping services.	0
	g	Appropriate feedback regarding HAI rates are provided on a regular basis to appropriate personnel.	0
	h	In cases of notifiable diseases, information (in relevant format) is sent to appropriate authorities.	0
			0
HIC.4: The organization takes actions to prevent and control Healthcare Associated Infections (HAI) in patients.			
	a	The organization takes action to prevent urinary tract infections.	0
	b	The organization takes action to prevent respiratory tract infections.	0
	c	The organization takes action to prevent intra-vascular device infections.	0
	d	The organization takes action to prevent surgical site infections.	0
			0
HIC.5: The organization provides adequate and appropriate resources for prevention and control of Healthcare Associated Infections (HAI).			
	a	Adequate and appropriate personal protective equipment, soaps, and disinfectants are available and used correctly.	5
	b	Adequate and appropriate facilities for hand hygiene in all patient care areas are accessible to health care providers.	0
	c	Isolation / barrier nursing facilities are available.	0
	d	Appropriate pre and post exposure prophylaxis is provided to all concerned staff members.	5
			2.5
HIC.6: The organization identifies and takes appropriate action to control outbreaks of infections.			
	a	Organization has a documented procedure for identifying an outbreak.	0
	b	Organization has a documented procedure for handling such outbreaks.	0
	c	This procedure is implemented during outbreaks.	0
	d	After the outbreak is over appropriate corrective actions are taken to prevent recurrence.	0
			0

HIC.7: There are documented policies and procedures for sterilization activities in the organization.			
	a	The organization provides adequate space and appropriate zoning for sterilization activities.	0
	b	Documented procedure guides the cleaning, packing, disinfection and/or sterilization, storing and issue of items.	0
	c	Reprocessing of instruments and equipment are covered.	0
	d	Regular validation tests for sterilizationare carried out and documented.	0
	e	There is an established recall procedure when breakdown in the sterilization system is identified.	0
			0
HIC.8: Biomedical waste (BMW) is handled in an appropriate and safe manner.			
	a	The organization adheres to statutory provisions with regard to biomedical waste.	0
	b	Proper segregation and collection of biomedical waste from all patient care areas of the hospital is implemented and monitored.	0
	c	The organization ensures that biomedical waste is stored and transported to the site of treatment and disposal in proper covered vehicles within stipulated time limits in a secure manner.	5
	d	Biomedical waste treatment facility is managed as per statutory provisions (if in-house) or outsourced to authorised contractor(s).	5
	e	Appropriate personal protective measures are used by all categories of staff handling biomedical waste.	5
			3
HIC.9: The infection control programme is supported by the management and includes training of staff.			
	a	The management makes available resources required for the infection control programme.	5
	b	The organization earmarks adequate funds from its annual budget in this regard.	0
	c	The organization conducts induction training for all staff.	0
	d	The organization conducts appropriate “in-service” training sessions for all staff at least once in a year.	0
			0
	SCORE OF CHAPTER - 05		0.76
Chapter 6: Continual Quality Improvement (CQI)			

CQI.1: There is a structured quality improvement and continuous monitoring programme in the organization.			
	a	The quality improvement programme is developed, implemented and maintained by a multi-disciplinary committee.	0
	b	The quality improvement programme is documented.	0
	c	There is a designated individual for coordinating and implementing the quality improvement programme.	0
	d	The quality improvement programme is comprehensive and covers all the major elements related to quality assurance and supports innovation.	0
	e	The designated programme is communicated and coordinated amongst all the staff of the organization through appropriate training mechanism.	0
	f	The quality improvement programme identifies opportunities for improvement based on review at pre-defined intervals.	0
	g	The quality improvement programme is a continuous process and updated at least once in a year.	0
	h	Audits are conducted at regular intervals as a means of continuous monitoring.	0
	i	There is an established process in the organization to monitor and improve quality of nursing and complete patient care.	0
			0
CQI.2: There is a structured patient safety programme in the organization.			
	a	The patient safety programme is developed, implemented and maintained by a multi-disciplinary committee.	0
	b	The patient safety programme is documented.	0
	c	The patient safety programme is comprehensive and covers all the major elements related to patient safety and risk management.	0
	d	The scope of the programme is defined to include adverse events ranging from “no harm” to “sentinel events”.	0
	e	There is a designated individual for coordinating and implementing the patient safety programme.	0
	f	The designated programme is communicated and coordinated amongst all the staff of the organization through appropriate training mechanism.	0
	g	The patient safety programme identifies opportunities for improvement based on review at pre-defined intervals.	0
	h	The patient safety programme is a continuous process and updated at least once in a year.	0
	i	The organization adapts and implements national/international patient safety goals/solutions.	0
	j	The organization uses at least two identifiers to identify patients across the organization.	0

			0
CQI.3: The organization identifies key indicators to monitor the clinical structures, processes and outcomes which are used as tools for continual improvement.			
	a	Monitoring includes appropriate patient assessment.	5
	b	Monitoring includes safety and quality control programmes of all the diagnostic services.	0
	c	Monitoring includes medication management.	5
	d	Monitoring includes use of anaesthesia.	5
	e	Monitoring includes surgical services.	5
	f	Monitoring includes use of blood and blood products.	5
	g	Monitoring includes infection control activities.	0
	h	Monitoring includes review of mortality and morbidity indicators.	0
	i	Monitoring includes clinical research.	0
	j	Monitoring includes data collection to support further improvements.	0
	k	Monitoring includes data collection to support evaluation of these improvements.	0
			2.27
CQI.4: The organization identifies key indicators to monitor the managerial structures, processes and outcomes which are used as tools for continual improvement.			
	a	Monitoring includes procurement of medication essential to meet patient needs.	0
	b	Monitoring includes risk management.	0
	c	Monitoring includes utilisation of space, manpower and equipment.	0
	d	Monitoring includes patient satisfaction which also incorporates waiting time for services.	0
	e	Monitoring includes employee satisfaction.	0
	f	Monitoring includes adverse events and near misses.	0

	g	Monitoring includes availability and content of medical records.	0
	h	Monitoring includes data collection to support further improvements.	0
	i	Monitoring includes data collection to support evaluation of these improvements.	0
			0
CQI.5: The quality improvement programme is supported by the management.			
	a	The management makes available adequate resources required for quality improvement programme.	0
	b	Organization earmarks adequate funds from its annual budget in this regard.	0
	c	The management identifies organizational performance improvement targets.	0
	d	The management supports and implements use of appropriate quality improvement, statistical and management tools in its quality improvement programme.	0
			0
CQI.6: There is an established system for clinical audit.			
	a	Medical and nursing staff participates in this system.	0
	b	The parameters to be audited are defined by the organization.	0
	c	Patient and staff anonymity is maintained.	0
	d	All audits are documented.	0
	e	Remedial measures are implemented.	0
			0
CQI.7: Incidents, complaints and feedback are collected and analysed to ensure continual quality improvement.			
	a	The organization has an incident reporting system.	0
	b	The organization has a process to collect feedback and receive complaints.	0
	c	The organization has established processes for analysis of incidents, feedbacks and complaints.	0
	d	Corrective and preventive actions are taken based on the findings of such analysis.	0

	e	Feedback about care and service is communicated to staff.	0
			0
CQI.8: Sentinel events are intensively analysed.			
	a	The organization has defined sentinel events.	0
	b	The organization has established processes for intense analysis of such events.	0
	c	Sentinel events are intensively analysed when they occur.	0
	d	Corrective and Preventive Actions are taken based on the findings of such analysis.	0
			0
		SCORE OF CHAPTER - 06	0.28
Chapter 7: Responsibilities of Management (ROM)			
ROM.1: The responsibilities of those responsible for governance are defined.			
	a	Those responsible for governance lay down the organization's vision, mission and values.	0
	b	Those responsible for governance approve the strategic and operational plans and organization's budget.	5
	c	Those responsible for governance monitor and measure the performance of the organization against the stated mission.	0
	d	Those responsible for governance establish the organization's organogram.	0
	e	Those responsible for governance appoint the senior leaders in the organization.	5
	f	Those responsible for governance support safety initiatives and quality improvement plans.	0
	g	Those responsible for governance support research activities.	0
	h	Those responsible for governance address the organization's social responsibility.	5
	i	Those responsible for governance inform the public of the quality and performance of services.	0
			1.66
ROM.2: The organization complies with the laid down and applicable legislations and regulations.			
	a	The management is conversant with the laws and regulations and knows their applicability to the organization.	0
	b	The management ensures implementation of these requirements.	0

	c	Management regularly updates any amendments in the prevailing laws of the land.	0
	d	There is a mechanism to regularly update licenses/ registrations/certifications.	0
			0
ROM.3: The services provided by each department are documented.			
	a	Scope of services of each department is defined	5
	b	Administrative policies and procedures for each department are maintained.	5
	c	Each organizational programme, service, site or department has effective leadership.	5
	d	Departmental leaders are involved in quality improvement.	0
			3.75
ROM.4: The organization is managed by the leaders in an ethical manner.			
	a	The leaders make public the vision, mission and values of the organization.	0
	b	The leaders establish the organization's ethical management.	10
	c	The organization discloses its ownership.	10
	d	The organization honestly portrays the services which it can and cannot provide.	5
	e	The organization honestly portrays its affiliations and accreditations.	5
	f	The organization accurately bills for its services based upon a standard billing tariff.	10
			6.66
ROM.5: The organization displays professionalism in management of affairs.			
	a	The person heading the organization has requisite and appropriate administrative qualifications.	10
	b	The person heading the organization has requisite and appropriate administrative experience.	10
	c	The organization prepares the strategic and operational plans including long term and short term goals commensurate to the organization's vision, mission and values in consultation with the various stake holders.	0
	d	d. The organization coordinates the functioning with departments and external agencies, and monitors the progress in achieving the defined goals and objectives.	0
	e	The organization plans and budgets for its activities annually.	10

	f	The performance of the senior leaders is reviewed for their effectiveness.	0
	g	The functioning of committees is reviewed for their effectiveness.	0
	h	The organization documents employee rights and responsibilities.	0
	i	The organization documents the service standards.	0
	j	The organization has a formal documented agreement for all outsourced services.	0
	k	The organization monitors the quality of the outsourced services.	0
			2.72
ROM.6: Management ensures that patient safety aspects and risk management issues are an integral part of patient care and hospital management.			
	a	Management ensures proactive risk management across the organization.	0
	b	Management provides resources for proactive risk assessment and risk reduction activities.	0
	c	Management ensures implementation of systems for internal and external reporting of system and process failures.	0
	d	Management ensures that appropriate corrective and preventive action is taken to address safety related incidents.	0
			0
	SCORE OF CHAPTER - 07		2.46
Chapter 8:Facility Management and Safety (FMS)			
FMS.1: The organization has a system in place to provide a safe and secure environment.			
	a	Safety committee coordinates development, implementation, and monitoring of the safety plan and policies	0
	b	Patient safety devices are installed across the organization and inspected periodically.	0
	c	The organization is a non-smoking area.	5
	d	Facility inspection rounds to ensure safety are conducted at least twice in a year in patient care areas and at least once in a year in non-patient care areas.	0
	e	Inspection reports are documented and corrective and preventive measures are undertaken.	0
	f	There is a safety education programme for staff.	0
			0.83

FMS.2: The organization's environment and facilities operate to ensure safety of patients, their families, staff and visitors.			
	a	Facilities are appropriate to the scope of services of the organization.	5
	b	Up-to-date drawings are maintained which detail the site layout, floor plans and fire escape routes.	0
	c	There is internal and external sign posting in the organization in a language understood by patient, families and community.	0
	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.	0
	e	Potable water and electricity are available round the clock.	10
	f	Alternate sources for electricity and water are provided as backup for any failure / shortage.	10
	g	The organization regularly tests these alternate sources.	5
	h	There are designated individuals responsible for the maintenance of all the facilities.	5
	i	There is a documented operational and maintenance (preventive and breakdown) plan.	5
	j	Maintenance staff is contactable round the clock for emergency repairs.	5
	k	Response times are monitored from reporting to inspection and implementation of corrective actions.	0
			4.09
FMS.3: The organization has a programme for engineering support services.			
	a	The organization plans for equipment in accordance with its services and strategic plan.	5
	b	Equipment are selected, rented, updated or upgraded by a collaborative process.	5
	c	Equipment are inventoried and proper logs are maintained as required.	5
	d	Qualified and trained personnel operate and maintain equipment and utility systems.	5
	e	There is a documented operational and maintenance (preventive and breakdown) plan.	5
	f	There is a maintenance plan for water management.	5
	g	There is a maintenance plan for electrical systems.	5
	h	There is a maintenance plan for heating, ventilation and air-conditioning.	0

	i	There is a documented procedure for equipment replacement and disposal.	5
			4.44
FMS.4: The organization has a programme for bio-medical equipment management.			
	a	The organization plans for equipment in accordance with its services and strategic plan.	10
	b	Equipment are selected, rented, updated or upgraded by a collaborative process.	5
	c	Equipment are inventoried and proper logs are maintained as required.	5
	d	Qualified and trained personnel operate and maintain the medical equipment.	5
	e	Equipment are periodically inspected and calibrated for their proper functioning.	0
	f	There is a documented operational and maintenance (preventive and breakdown) plan.	0
	g	There is a documented procedure for equipment replacement and disposal.*	5
			4.28
FMS.5: The organization has a programme for medical gases, vacuum and compressed air.			
	a	Documented procedures govern procurement, handling, storage, distribution, usage and replenishment of medical gases.	0
	b	Medical gases are handled, stored, distributed and used in a safe manner.	10
	c	The procedures for medical gases address the safety issues at all levels.	0
	d	Alternate sources for medical gases, vacuum and compressed air are provided for, in case of failure.	5
	e	The organization regularly tests these alternate sources.	5
	f	There is an operational and maintenance plan for piped medical gas, compressed air and vacuum installation.*	10
			5
FMS.6: The organization has plans for fire and non-fire emergencies within the facilities.			
	a	The organization has plans and provisions for early detection, abatement and containment of fire and non-fire emergencies.	5
	b	The organization has a documented safe exit plan in case of fire and non-fire emergencies.	0
	c	Staff are trained for their role in case of such emergencies	0

	d	Mock drills are held at least twice in a year.	0
	e	There is a maintenance plan for fire related equipment.	5
			2
FMS.7: The organization plans for handling community emergencies, epidemics and other disasters.			
	a	The organization identifies potential emergencies.	5
	b	The organization has a documented disaster management plan.	5
	c	Provision is made for availability of medical supplies, equipment and materials during such emergencies.	5
	d	Staff are trained in the hospital's disaster management plan.	5
	e	The plan is tested at least twice in a year.	0
			4
FMS.8: The organization has a plan for management of hazardous materials.			
	a	Hazardous materials are identified within the organization.	0
	b	The organization implements processes for sorting, labelling, handling, storage, transporting and disposal of hazardous material.	0
	c	Requisite regulatory requirements are met in respect of radioactive materials.	0
	d	There is a plan for managing spills of hazardous materials.	0
	e	Staff are educated and trained for handling such materials.	0
			0
	SCORE OF CHAPTER - 08		3.081
Chapter 9: Human Resource Management (HRM)			
HRM.1. The organization has a documented system of human resource planning.			
	a	Human resource planning supports the organization's current and future ability to meet the care, treatment and service needs of the patient.	0
	b	The organization maintains an adequate number and mix of staff to meet the care, treatment and service needs of the patient.	5
	c	The required job specification and job description are well defined for each category of staff.	0

	d	The organization verifies the antecedents of the potential employee with regards to criminal/negligence background.	10
			3.75
HRM.2. The organization has a documented procedure for recruiting staff and orienting them to the organization's environment.			
	a	There is a documented procedure for recruitment.	10
	b	Recruitment is based on pre-defined criteria	10
	c	Every staff member entering the organization is provided induction training	5
	d	The induction training includes orientation to the organization's vision, mission and values.	5
	e	The induction training includes awareness on employee rights and responsibilities.	5
	f	The induction training includes awareness on patient's rights and responsibilities.	0
	g	The induction training includes orientation to the service standards of the organization.	0
	h	Every staff member is made aware of organization wide policies and procedures as well as relevant department / unit / service / programme's policies and procedures.	5
			5
HRM.3. There is an on-going programme for professional training and development of the staff.			
	a	A documented training and development policy exists for the staff.	0
	b	The organization maintains the training record.	0
	c	Training also occurs when job responsibilities change/ new equipment is introduced.	0
	d	Feedback mechanisms for assessment of training and development programme exist and the feedback is used to improve the training programme.	0
			0
HRM.4. Staff are adequately trained on various safety related aspects.			
	a	Staff are trained on the risks within the organization's environment.	0
	b	Staff members can demonstrate and take actions to report, eliminate / minimize risks.	0

	c	Staff members are made aware of procedures to follow in the event of an incident.	5
	d	Staff are trained on occupational safety aspects.	5
			2.5
HRM.5. An appraisal system for evaluating the performance of an employee exists as an integral part of the human resource management process.			
5	a	A documented performance appraisal system exists in the organization.*	5
	b	The employees are made aware of the system of appraisal at the time of induction.	5
	c	Performance is evaluated based on the pre-determined criteria.	5
	d	The appraisal system is used as a tool for further development.	5
	e	Performance appraisal is carried out at pre-defined intervals and is documented.	5
			5
HRM.6. The organization has documented disciplinary and grievance handling policies and procedures.			
	a	Documented policies and procedures exist.	5
	b	The policies and procedures are known to all categories of staff of the organization.	5
	c	The disciplinary policy and procedure is based on the principles of natural justice.	5
	d	The disciplinary procedure is in consonance with the prevailing laws.	5
	e	There is a provision for appeals in all disciplinary cases.	5
	f	The redress procedure addresses the grievance.	5
	g	Actions are taken to redress the grievance.	5
			5
HRM.7. The organization addresses the health needs of the employees.			
	a	A pre-employment medical examination is conducted on all the employees.	0

	b	Health problems of the employees are taken care of in accordance with the organization's policy.	5
	c	Regular health checks of staff dealing with direct patient care are done at-least once a year and the findings/ results are documented.	0
	d	Occupational health hazards are adequately addressed.	5
			2.5
HRM.8. There is documented personal information for each staff member.			
	a	Personal files are maintained in respect of all staff.	10
	b	The personal files contain personal information regarding the staff's qualification, disciplinary background and health status.	10
	c	All records of in-service training and education are contained in the personal files.	0
	d	Personal files contain results of all evaluations.	0
			5
HRM.9. There is a process for credentialing and privileging of medical professionals, permitted to provide patient care without supervision.			
	a	Medical professionals permitted by law, regulation and the organization to provide patient care without supervision are identified.	10
	b	The education, registration, training and experience of the identified medical professionals is documented and updated periodically.	5
	c	All such information pertaining to the medical professionals is appropriately verified when possible.	10
	d	Medical professionals are granted privileges to admit and care for patients in consonance with their qualification, training, experience and registration.	0
	e	The requisite services to be provided by the medical professionals are known to them as well as the various departments / units of the organization.	0
	f	Medical professionals admit and care for patients as per their privileging.	0
			4.16
HRM.10. There is a process for credentialing and privileging of nursing professionals, permitted to provide patient care without supervision.			
	a	Nursing staff permitted by law, regulation and the organization to provide patient care without supervision are identified.	10
	b	The education, registration, training and experience of nursing staff is documented and updated periodically.	0
	c	All such information pertaining to the nursing staff is appropriately verified when possible.	10

	d	Nursing staff are granted privileges in consonance with their qualification, training, experience and registration.	0
	e	The requisite services to be provided by the nursing staff are known to them as well as the various departments / units of the organization.	0
	f	Nursing professionals care for patients as per their privileging.	0
			3.33
		SCORE OF CHAPTER - 09	3.625
Chapter 10: Information Management System (IMS)			
IMS.1. Documented policies and procedures exist to meet the information needs of the care providers, management of the organization as well as other agencies that require data and information from the organization.			
	a	The information needs of the organization are identified and are appropriate to the scope of the services being provided by the organization.	5
	b	Documented policies and procedures to meet the information needs exist.	0
	c	These policies and procedures are in compliance with the prevailing laws and regulations.	0
	d	All information management and technology acquisitions are in accordance with the documented policies and procedures.	0
	e	The organization contributes to external databases in accordance with the law and regulations.	0
			1
IMS.2. The organization has processes in place for effective management of data.			
	a	Formats for data collection are standardized.	5
	b	Necessary resources are available for analysing data.	5
	c	Documented procedures are laid down for timely and accurate dissemination of data.	0
	d	Documented procedures exist for storing and retrieving data.	0
	e	Appropriate clinical and managerial staff participates in selecting, integrating and using data.	5
			3
IMS.3. The organization has a complete and accurate medical record for every patient.			
	a	Every medical record has a unique identifier.	5

	b	Organization policy identifies those authorized to make entries in medical record.	5
	c	Entry in the medical record is named, signed, dated and timed.	5
	d	The author of the entry can be identified.	5
	e	The contents of medical record are identified and documented.	5
	f	The record provides a complete, up-to-date and chronological account of patient care.	5
	g	Provision is made for 24-hour availability of the patient's record to healthcare providers to ensure continuity of care.	5
			5
IMS.4. The medical record reflects continuity of care.			
	a	The medical record contains information regarding reasons for admission, diagnosis and plan of care.	5
	b	The medical record contains the results of tests carried out and the care provided.	5
	c	Operative and other procedures performed are incorporated in the medical record.	5
	d	When patient is transferred to another hospital, the medical record contains the date of transfer, the reason for the transfer and the name of the receiving hospital.	0
	e	The medical record contains a copy of the discharge summary duly signed by appropriate and qualified personnel.	0
	f	In case of death, the medical record contains a copy of the cause of death certificate.	5
	g	Whenever a clinical autopsy is carried out, the medical record contains a copy of the report of the same.	5
	h	Care providers have access to current and past medical record.	5
			3.75
IMS.5. Documented policies and procedures are in place for maintaining confidentiality, integrity and security of records, data and information.			
	a	Documented policies and procedures exist for maintaining confidentiality, security and integrity of records, data and information.	0
	b	Documented policies and procedures are in consonance with the applicable laws.	0
	c	The policies and procedure (s) incorporate safeguarding of data/ record against loss, destruction and tampering.	0
	d	The organization has an effective process of monitoring compliance of the laid down policy and procedure.	0

	e	The organization uses developments in appropriate technology for improving confidentiality, integrity and security.	0
	f	Privileged health information is used for the purposes identified or as required by law and not disclosed without the patient's authorization.	0
	g	A documented procedure exists on how to respond to patients / physicians and other public agencies requests for access to information in the medical record in accordance with the local and national law.*	0
			0
IMS.6. Documented policies and procedures exist for retention time of records, data and information.			
	a	Documented policies and procedures are in place on retaining the patient's clinical records, data and information.	0
	b	The policies and procedures are in consonance with the local and national laws and regulations.	0
	c	The retention process provides expected confidentiality and security.	0
	d	The destruction of medical records, data and information is in accordance with the laid down policy.	0
			0
IMS.7. The organization regularly carries out review of medical records.			
	a	The medical records are reviewed periodically.	0
	b	The review uses a representative sample based on statistical principles.	0
	c	The review is conducted by identified care providers.	0
	d	The review focuses on the timeliness, legibility and completeness of the medical records.	0
	e	The review process includes records of both active and discharged patients.	0
	f	The review points out and documents any deficiencies in records.	0
	g	Appropriate corrective and preventive measures are undertaken within a defined period of time and are documented.	0

		0
	SCORE OF CHAPTER - 10	1.82
	TOTAL SCORE OF ALL CHAPTERS	2.13

2. GAP ANALYSIS CHECKLIST

11.1 EMERGENCY

Checklist for Emergency				
S. No.		Yes	No	Remarks
STRUCTURE				
1.	Whether the triage area is marked Separately		√	Dedicated area for Triaging of patient is not available
2.	Does the Emergency department have a separate entrance?	√		
3.	Is the Emergency signage visible from the road with proper lighting and signs?		√	
4.	Is the doctor available round the clock for emergency care of patients?	√		
5.	Is there a nurse available round the clock for emergency care of patients?		√	
6.	Does the number of trolleys and wheelchairs commensurate to the needs?		√	
7.	Does the emergency room retain a list of all staff that contains Name, Contact details, Designation?		√	
8.	Is Doctor's name and contact number kept posted at all times in the emergency room?		√	
9.	Is there an appropriate waiting area for the relatives of the patient?	√		
10.	An appropriately qualified staff member is scheduled to manage triage activities.		√	
11.	Is Emergency Crash Cart available?	√		
12.	Defibrillator		√	

13.	Cardiac Monitor		√	
14.	Emergency drugs	√		
15.	Resuscitation bags (i.e. AMBU) of various sizes	√		
16.	Oral Airways of various sizes		√	
17.	Laryngoscope with various blades		√	
18.	Laryngoscope replacement batteries and bulbs.		√	
19.	Endotracheal tubes of various sizes.		√	
PROCESS				
20.	Is there a system to review all imaging by a radiologist within 24 hours	√		
21.	Ability to perform acute blood test and receive results within one hour for Arterial blood gases, Full blood picture, urea and electrolytes, plasma, glucose, Blood levels for common overdose medication/agents, Coagulation studies.		√	
22.	Security staffs are immediately available when required in the emergency room.		√	
23.	Electrical equipment (e.g. defibrillator) is charged at all times.		√	No Defibrillator available
24.	Is Crash cart checked daily regarding regular testing?	√		
25.	The documentation from a medico-legal and treatment view point is detailed, professional and accurate.	√		
26.	Are the separate registers maintained for medico legal cases, discharge, admissions to ward?	√		
27.	Is BMW segregated and handled properly.		√	

28.	Is Triaging of the patients done?		√	
29.	Does the initial assessment of the patient take place?	√		However proper assessment criteria not followed
30.	Are the patients attended by attendants when they come or when they are transferred to wards?		√	.
31.	Is staff trained in BLS/ACLS		√	No evidence of training records. Staff are not able to demonstrate BLS/ACLS
OUTCOME				
32.	Time for initial assessment of emergency patient		√	

11.2 AMBULANCE

Checklist for Ambulance				
Sl.no	**Check points**	**Yes**	**No**	**Remarks**
STRUCTURE				
1	Adequate communication system exists in ambulance		√	
2	Required equipments (Stetho, sphygno, suction app, defib, monitor, oxygen cylinder) are available in the ambulance.		√	
3	Required medicines are available in the ambulance.		√	
4	Is Vehicle license available?		√	
5	Is driver license present?			

6	Maintenance of the medical Gas (oxygen) to 90% of the total capacity.		√	
7	Calibration of Equipments present		√	
PROCESS				
8	Is staff trained in BLS		√	
9	Is Medication and equipment checklist maintained		√	
10	Is infection control practices followed		√	

11.3 OPD

Checklist for OPD				
Sl. No.	**Check Points**	**Yes**	**No**	**Remarks**
STRUCTURE				
1	Availability of enquiry counter	√		
2	Availability of registration counter	√		Separate for male, female,
3	Availability of separate queue for Differently able.		√	
4	Availability of designated waiting area with adequate sitting arrangement	√		
5	Availability of drinking water facility	√		
6	Availability of separate and functional toilet for differently able.		√	
7	Availability of fan & lights in waiting area	√		

8	Is the Scope of services displayed?	√		Not bilingual
9	Is citizen charter and Patient charter displayed		√	Citizen Charter not appropriate and patient charter not available
10	Is list of doctors along with OPD Timings displayed	√		
11	Are the different OPD rooms numbered	√		
12	Is there provision of patient privacy in the consultation room		√	
13	Is BP apparatus with stethoscope present	√		
14	Is weighing machine present	√		
15	Is thermometer present	√		
16	Is calibration of BP apparatus, weighing machine and thermometer		√	
MANPOWER				
17	Availability of dedicated registration clerk	√		
18	Availability of nurse to do Patient Care in specific OPDs		√	
PROCESS				
19	Is UHID generated for all patients		√	
20	Is Separate Registration done for old and new OPD patients		√	
21	Is the tariff rates defined and made aware to the patients/ attendant	√		
22	Is patient privacy maintained during consultation time		√	

23	Is the staff aware of all the information like Doctors OPD timings, charges etc	√		
OUTCOME				
24	Monitoring of waiting time		√	
25	OPD patient satisfaction survey		√	

11.4 LABORATORY

Checklist for Laboratory				
Sl. NO	**Check points**	**Yes**	**No**	**Remarks**
STRUCTURE				
1	Is laboratory present in hospital? (In house/ outsourced)	√		**In house**
2	Is the various functional units of laboratories present in the hospital	√		
3	Is there continuous water supply to this unit?	√		
4	Is adequate drainage system present in this unit?	√		
5	Is there provision for hand washing facility in this unit?		√	Elbow Tap and Single use towel/tissue not available
6	Is there provision of personal protective devices for staff?(if yes mention the name)	√		Only Gloves available, No eye

				washer, No Goggles, available
7	Is the staff licensed and competent in knowledge and skill?	√		Staff is qualified but not trained
8	Is there separate area available for sample collection?		√	No Privacy Arrangement
9	Is pathologist available?	√		
10	Are BMW bins are present in the department?	√		
11	Is there power back up facility available	√		
PROCESS				
12	Is the scope of services defined		√	
13	Is maintenance of laboratory equipment done?	√		
14	Are laboratory equipment calibrated?		√	
15	Is laboratory staff aware about the safety precautions while handling samples?		√	
16	Is laboratory staff taking necessary precautions while handling samples?		√	All Safety devices not worn, Samples are not stored in a Proper area to avoid spillage, incidence
17	Is BMW segregation done as per BMW guidelines?		√	

18	Is critical results defined, reported, and documented.		√	
19	Is surveillance for lab test being carried out		√	
20	Is EQAS being monitored		√	
21	Laboratory reports are signed by Pathologist.	√		
22	Is labeling of sample done?	√		
23	Is time frame defined for dispatching lab reports?	√		
24	Is turnaround time for lab reports monitored?		√	
25	Is MOU available for outsourced tests		√	
26	Is temperature monitoring of refrigerator is done?		√	
OUTCOME				
27	Number of reporting errors per 1000 investigations		√	
28	% of reports having clinical correlation with provisional diagnosis		√	
29	% of adherence to safety precautions		√	
30	% of redo's		√	

11.5 RADIOLOGY & IMAGING

Checklist for Radiology & Imaging

S. No.	Check points	Yes	No	Remarks
	STRUCTURE			
1	Is this unit has AERB (SITE/TYPE approval)		√	
2	Are basic facilities for staff present? (toilet/drinking water/change room)		√	Change room not available for staff
3	Is the staff licensed and competent in knowledge and skill?	√		
4	Is there a change room available for patients?		√	
5	TLD badges available (Are they sufficient in number)		√	
6	Lead glass/Door available (Are they sufficient in number)	√		
7	Lead apron available (Are they sufficient in number)	√		
8	Gonad shield available (Are they sufficient in number)		√	
9	Thyroid shield available (Are they sufficient in number)		√	
10	Is radiologist available?	√		
11	Is critical results defined, reported, and documented.		√	
12	Radiation hazard symbol is present		√	
13	PNDT license is available	√		
	PROCESS			
14	Is maintenance of radiology equipments done?		√	

15	Are radiology equipments calibrated?		√	
16	Is radiology staff aware about the safety precautions?	√		
17	Is radiology staff taking safety measures?	√		
18	Quality Assurance program is followed or not		√	
19	Radiology test requisition form is signed by doctor.	√		
20	Radiology reports are signed by Radiologist.	√		
21	Is time frame defined for dispatching reports?	√		
22	Is turnaround time for reports monitored?		√	
OUTCOME				
23	Number of reporting errors per 1000 investigations		√	
24	% of reports having clinical correlation with provisional diagnosis		√	
25	% of adherence to safety precautions		√	
26	% of redo's		√	

11.6 WARDS

Checklist for Ward Management				
SL.NO	**Check points**	**Yes**	**No**	**Remarks**

STRUCTURE				
1	Is Medical Gas Facility available in the ward?	√		
2	Are basic facilities for staffs present (toilet/ drinking water)?		√	
3	Is needle cutter present in each ward?	√		
4	Emergency crash cart is present in the ward?		√	
5	Color coded BMW bins are present in each ward?	√		
6	Is there a nursing station in the ward?	√		
7	Is there adequate number of nurses in each shift?		√	
8	Racks are present to store linen?		√	
9	Ish basin is present in each ward.		√	
10	PPE is provided in each ward?		√	Only mask and Gloves are provided
PROCESS				
11	Is staff aware of the admission process?	√		
12	Does the cleaning of the department take place?	√		
13	Are the vitals of the patient checked every day?		√	
14	Administration of medication is done by qualified nurse?	√		
15	Indent of medicines and other items is placed by nurses regularly?		√	
16	PPE is used by the nurses?		√	
17	Are the BMW segregated at the point of		√	

	generation?			
18	Does the nurse on duty record the details of the patient in the BHT on a daily basis?		√	
19	Are the nurses trained in BLS(CPR)		√	Staff are not Trained
20	Is infection control practices being followed		√	
21	Is bio medical iste management practice followed		√	
22	Is the staff aware about transfer IN/OUT system		√	
23	Is cost estimate for treatment provided to the patient/attendant		N.A	
24	Is discharge process defined and documented?		√	

11.7 ICCU

ICCU				
Sr. No		**Yes**	**No**	**Remarks**
STRUCTURE				
1	Is the required equipments available (Crash cart, Defib, oxygen cylinder, multi para monitors, central line connection, ventilator, pulse oximetre, oxygen concentrator		√	
2	Qualified and trained nurses available.	√		
3	Is air condition available	√		

4	Is fowler's bed available		√	
PROCESS				
5	Are the admission and discharge criteria for ICU and high dependency units defined?		√	
6	Is the staff trained to apply these criteria?	√		
7	Are the infection control practices documented and followed?		√	
8	Is the quality assurance programme documented and implemented?		√	
9	Procedures for situation of bed shortages are defined and followed?		√	
10	Do the policies and procedures guide the care of patients under restraints?		√	
11	Are the reasons for restraints documented?		√	
12	Is the patient under restrain frequently monitored?		√	
13	Is the staff aware about the end of life care policy?		√	
14	Are the policy for initial assessment and re-assessment of patient documented and present?		√	
15	Does the Initial assessment include screening for nutritional needs?		√	
16	Is the time frame for doing and documenting initial assessment defined?		√	
17	Is the frequency of reassessment defined and followed by the staff?		√	
18	Does the documented policies and procedures on uniform use of resuscitation present?		√	
19	Is the staff trained on resuscitation?		√	

20	Are the documented policies and procedures for rational use of blood and blood products available?		√	
21	Is the informed consent obtained before donation and transfusion of blood and blood products?		√	
22	Are the patient and family educated about donation?			
23	Are the post transfusion reaction monitored and analyzed for preventive and corrective actions?		√	
24	Is the scope of pediatric services defined and displayed?		√	
25	Does who care for children have age specific competency?		√	
26	Is there a written order for the diet?		√	
27	Is the nutritional therapy planned and provided in a collaborative manner?		√	
28	Are emergency medications available all the time and replenished in a timely manner when used?		√	
29	Are the medication orders written in a uniform location and are clear, legible, dated, timed, named and signed?		√	
30	Is a written order for high risk medication done?		√	
31	Do the policies and procedures guide the monitoring of patients after medication administration?		√	
32	Is the medication administration documented?		√	
33	Is the policy for patient's medications brought from outside the organization available?		√	
34	Knowledge to pick adverse drug events and		√	

	reporting of the same?			
35	Does the policy and procedure guide the use of narcotic drugs and psychotropic substances?		√	
36	Are the narcotic drugs stored in a safe manner?		√	
37	Is a proper record kept for the usage, administration and disposal of narcotic drugs?		√	
38	Is the antibiotic policy adhered and followed by the staff?		√	
39	Is the infection control data collected?		√	
40	Availability of various HAI rates of that area and action taken report?		√	
41	Is the layout of beds, its spacing, and visual privacy appropriate?		√	
42	Are all the equipments periodically inspected and calibrated?		√	
43	Service labels on Equipment and calibration records present?		√	Water in humidifier is replaced after once a week
44	Is the Information exchanged and documented during transfers between units/departments?		√	
45	Documented procedures guide the referral of patients to other departments/ specialties?		√	
46	Qualified individual identified as responsible for the patient's care?	√		
47	Is a policy in place for LAMA patients and patients being discharged on request?		√	
48	Is the policy for care of vulnerable patients available?		√	

49	Does the organization provide a safe and secure environment for the vulnerable patients?		√	
50	Is the informed consent obtained by a surgeon prior to the procedure?		√	
51	Are the instructions for proper hand ishing displayed and followed by the staff?		√	
52	Are the adequate PPE like gloves, masks available and used by the staff?		√	
53	Isolation /Barrier nursing facility available?		√	
54	Is the Segregation of bio-medical iste done as per the guidelines?		√	
55	Is the policy for obtaining consent present?		√	
56	Does the procedure describe who can give consent when patient is incapable of independent decision making?		√	
OUTCOME				
1	Re intubation rate		√	
2	ICU utilization		√	

11.8 OT

Checklist for Operation Theatre				
S. No.		**Yes**	**No**	**Remarks**
STRUCTURE				
1	Is HVAC System present inside OT	√		
2	Is proper Zoning concept followed(Clean zone, protective zone, sterile zone, and		√	

	disposal zone)			
3	Is the number of OT tables present in the hospital appropriate for the daily load		√	Not appropriate
4	If any OT has got more than one OT table	√		
5	Does the OT have a hand washing facility	√		Hand washing facility is not appropriate
6	Is the fire fighting system available in the unit	√		Only fire extinguisher
7	Is continuous water available for the unit?	√		
8	Is the changing room available for the doctors and nurses	√		Cleanliness of room is not proper
9	Is there a continuous power back up for OT	√		
10	Does the OT have a crash cart		√	
11	Does the OT have defibrillator		√	
12	Does the OT have an ECG monitor	√		
13	Does the OT have oxygen supply	√		
14	Does the OT have shadow less OT light	√		
15	Is the staff provided with the personnel protective devices	√		
16	Is scrubbing area present for the OT staff		√	
PROCESS				
17	Is the consent for the surgery and anesthesia taken from the patient		√	Only on BHT
18	Is the OT list prepared		√	

19	Is the OT booking being done		√	
20	Is the preparation of patient done before the operation	√		
21	Does the nurse enter the patient details in the OT register	√		
22	Are the number of OT instruments counted before and after operation	√		
23	Is OT disinfection done after every procedure	√		
24	Is the pre anesthesia check up done by the anesthetists	√		
25	Is pre, intra, post operative notes documented		√	
26	Is infection control practices being followed in OT		√	
27	Is pre operative checklist being followed		√	
28	Is bio medical iste management practices being followed		√	
OUTCOME				
29	Is % of anesthesia related adverse events being monitored		√	
30	% of anesthesia related mortality		√	
31	% of modification in plan of anesthesia		√	
32	% of unplanned ventilation following anesthesia		√	
33	Is % of Surgical site infection rate monitored		√	
34	Re Exploration rate		√	
35	Re scheduling of surgeries		√	

11.9 BLOOD BANK- Not Present

Checklist for Blood Bank				
Si. No	**Description**	**Yes**	**No**	**Remarks**
STRUCTURE				
1	Is the required layout available: (Reception, examination room, bleeding room, refreshment room, blood separation and storage area and doctors room?)			
2	Is power back up available			
3	A full time qualified Blood Bank In-charge manages the blood collection/distribution department.			
4	A couch/cot is provided during venipuncture & the correct equipment for blood agitation/ volume measurement is present			
5	Refrigerators, insulated carrier boxes with ice pack, warmers, Bio mixers, Tube scale, Component separator if applicable, Thawing bath, Centrifuge and freezers are in adequate quantity			
6	Blood bank Signage and Schedule of charges are displayed			
7	Blood Bank Technician is present			
8	Nurse is present			
9	All sections have bilingual signage			
10	Separate counseling section is present			
11	Is bilingual consent for blood donation available			

12	If patients are educated and given counseling.			
13	Donors are appropriately screened prior to blood donation.			
14	Evidence is present that blood is cross matched, labeled, recipient identified, compatibility level noted, units dispensed.			
15	Refrigerators, warmers and freezers must have temperature monitoring devices which are monitored daily			
16	A list of all department staff exist and is prominently displayed			
17	Is Policies and procedures for blood bank available			
18	Appropriate disposal of blood and blood products are done as per BMW management rules			
19	A blood collection/issue register exists.			
20	Is blood transfusion committee in existence			
21	Donated blood is labeled appropriately with adhesive labels.			
22	Register of all recipient adverse reactions to blood and blood products are maintained			
23	Data collected regarding recipient adverse reactions is collated, analyzed and reported to the blood transfusion committee.			
24	Work instructions are visibly displayed and prominent			
25	% of transfusion reactions			
26	% of blood and blood products istage			
27	% of component usage			

28	Turnaround time for issue of blood and blood products.			

11.10 PHARMACY

Checklist for Pharmacy				
Si. No	**Description**	**Yes**	**No**	**Remarks**
STRUCTURE				
1	The racks are available in sufficient number to store the items	√		
2	There is adequate ventilation and lighting in the department	√		
3	There is a security system available at the department	√		
4	Fire detecting &fire fighting systems are available at department	√		Only fire extinguisher is present
5	There is no water seepage/ dampness	√		
6	All items storage areas are marked and labeled		√	
7	There is a receiving area; segregation and storing area	√		Segregation is done in corridors
8	Is refrigerator for storing medicines(2-8 degree C) available		√	
9	Is qualified and trained staff available	√		
10	Provision for storage of narcotic drugs(double lock and key system)		√	
PROCESS				

11	The items are labeled & arranged as per alphabetical order.	√		Not appropriate
12	Pest/rodent control measures are regularly under taken		√	
13	Is stock register maintained properly	√		
14	Verification of stock is done every six months.	√		**Once in three months**
15	Is sound Inventory control practices followed (ABC, VED, FSN,FIFO)		√	
16	General items required by the hospital are purchased from vendors registered by management		√	
17	Is there a Drugs and therapeutics committee in the hospital?		√	
18	Is hospital drug formulary available		√	
19	Is adverse drug reactions are analyzed		√	
OUTCOME				
20	% of local purchase		√	
21	% of stock outs		√	
22	% of variation from the procurement process		√	
23	% of goods rejected before GRN		√	

11.11 BIOMEDICAL ISTE MANAGEMENT

Checklist for Biomedical Iste Management				
Sl.No	**Check Points**	**Yes**	**No**	**Remarks**

STRUCTURE				
1	Availability of colour coded Foot operated Bins at point of BMW generation	√		
2	Availability of colored plastic bags	√		
3	Display of proper work instructions at the point of segregation		√	
4	Is needle destroyer present	√		
5	Availability of PPE(Personal Protective Equipments) with biomedical iste handlers	√		
6	Availability of sodium hypochlorite solution and puncture proof boxes	√		
7	Availability of safe mode of transportation	√		
8	Is Temporary storage area available	√		
PROCESS				
9	Is segregation of BMW at point of generation		√	
10	Is the route for transportation of iste separate from the general traffic area		√	
11	Is there provision of regular health checkup for staff of this unit?		√	
12	Usage of PPE by staff is being practiced		√	
13	Is Annual report submitted to UP PCB		√	

14	Is monitoring done for the amount of BMW generated		√	

11.12 HOSPITAL INFECTION CONTROL

Audit Checklist for HIC				
S.No		**Yes**	**No**	**Remarks**
INFRASTRUCTURE				
1	A designated and qualified infection control nurse(s) is present?		√	
2	Adequate and appropriate facilities for hand hygiene in all patient care areas Provided?		√	
3	Are adequate and appropriate personal protective equipment, soaps, and disinfectants available?	√		
4	A designated infection control officer is present?		√	
PROCESS				
5	Does the hospital implements policies and/or procedures to prevent infection in these areas?		√	No Written policy available
6	Does the organization adhere to standard precautions at all times?		√	
7	Equipment cleaning, disinfection and sterilization practices as polices?	√		
8	An appropriate antibiotic policy is established and implemented?		√	No Written Policy exists

9	Hospital adheres to laundry and linen management processes?		√	
10	Hospital adheres to kitchen sanitation and food handling issues?		√	
11	Does the hospital have appropriate engineering controls to prevent infections?		√	
12	Does the hospital adhere to mortuary practices?	√		
13	Is the infection prevention and control programme updated at least once in a year?		√	
14	Is the HIC surveillance data collected regularly?		√	There is no Microbiology Unit
15	Is the Verification of data done on a regular basis by the infection control team?		√	No Infection Control Team available
16	In cases of notifiable diseases, information (in relevant format) is sent to appropriate authorities?		√	
17	Tracking and analyzing of infection risks, rates and trends		√	
18	Do the surveillance activities include monitoring the effectiveness of housekeeping services?		√	
19	HAI rates monitored?		√	
20	Appropriate feedback regarding HAI rates provided on a regular basis to appropriate personnel?		√	
21	A hospital infection control committee and team are formed?		√	

22	Are the personal protective equipment used correctly by the staff?		√	
23	Compliance with hand hygiene guidelines monitored?		√	
24	Documented procedure for identifying an outbreak present?		√	
25	Implementation of laid down procedure done?		√	
26	Documented procedure guides the cleaning, packing, disinfection and/or sterilization, storing and issue of items?		√	
27	Isolation / barrier nursing facilities are available?		√	
28	Appropriate personal protective equipment used by the BMW handlers?		√	
29	Visit by the hospital authorities to the disposal site done and documented?		√	
30	Does the hospital makes available resources required for the infection control programme		√	
31	Does the organization earmarks adequate funds from its annual budget for infection control activities?		√	
32	Appropriate “in-service” training sessions for all staff at least once in a year conducted?		√	
33	Appropriate pre and post exposure prophylaxis is provided to all concerned staff members?		√	
OUTCOME				

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

11.13 CSSD / TSSU: CSSD - not present

Checklist for TSSU				
SL.NO	**CHECK POINTS**	**Yes**	**No**	**Remarks**
STRUCTURE				
1	Is sufficient space available(0.75sq mts/bed)		√	
2	Does the layout follow the functional flow: Receiving, Ishing, decontamination, drying, packing, loading, unloading, storing and issuing?		√	
3	Autoclaves are present?	√		3Horizontal type , 5 Vertical
4	Calibration of pressure meter of autoclave is done?	√		
5	Racks are present in the department?		√	
6	Technician is present in CSSD?		√	
7	Sterilizer drums are present?	√		
8	Is decontamination solution present?		√	

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

11.14BIOMEDICAL ENGINEERING- not Present

Audit Checklist for Biomedical Equipment Management: **Equipment, Medical Gases, Vacuum System etc.**				
SR. No		**Yes**	**No**	**Remarks**
INFRASTRUCTURE				
1	Does bio medical engineering department exist			
2	Does the department is managed by a qualified person			
3	Is Central supply system for bio medical gases exist			
4	Is Safety devices available			
5	Is the department manned by 24 hours			

6	Preventive maintenance and calibration			
7	Review of Preventive Maintenance record as per checklist like Anesthesia ventilator, IABP etc.			
8	Traceability of calibration report			
9	Is there a documented procedure for equipment replacement and disposal?			
10	Equipments are inventoried and proper logs are maintained as required.			
11	Training of staff when new equipment is installed (HRM 3b)			
12	Documented Preventive and breakdown maintenance plans			
13	Color coding of pipelines			
14	% of downtime of critical equipments			

11.15 ENGINEERING AND MAINTENANCE - Not Present

Checklist for Facility Management: Engineering and Maintenance				
SR. No	**Check points**	**Yes**	**No**	**Remarks**
STRUCTURE				
1	Various statutory requirements			
	o Fire			
	o Diesel storage			

	o Liquid oxygen and storage of medical cylinders.			
	o Boiler			
	o Lift			
	o Water (ETP/STP)			
	o Air (DG sets)			
2	Up to date drawing, layout, escape route present and displayed?			
3	Various required signage's displayed?			
4	Designated individual for maintenance present?			
5	Presence of staff round the clock for emergency repairs			
6	Alternative source of water and electricity			
7	Availability of (personnel) safety devices			
8	Availability of safety devices (Fire extinguishers, smoke detectors, sprinklers, grab bars, side rails, nurse CCTV, ALARMS ETC)			
9	Mechanism for renewing licenses			
10	Preventive and break down maintenance plan implemented?			
11	Alternate sources and their checking done?			
12	Response time monitored?			
13	Water quality reports			
14	Are staff using safety devices			
15	Facility inspection rounds twice a year in patient care areas and once in non-patient care areas			

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

11.16 STORE

CHECKLIST FOR STORE				
Si. No	**Description**	**Yes**	**No**	**Remarks**
STRUCTURE				
1	The racks are available in sufficient number to store the items	√		
2	There is adequate ventilation and lighting in the department	√		
3	Is there a qualified/ trained personnel available	√		
4	Fire detecting &fire fighting systems are available at department	√		
5	There is no water seepage/ damp in the store		√	
6	There is a receiving area; segregation and storing area	√		
PROCESS				

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

11.17 KITCHEN/DIETARY

Checklist for Kitchen/Dietary Services				
Sl. No.	**Check Points**	**Yes**	**No**	**Remarks**
STRUCTURE				
1	Does the layout follow the functional flow: Receiving, storage, preparation, distribution and cleaning?		√	
2	Is there continuous water supply (Hot/ Cold) to this unit?	√		No Hot Water Provision
3	Is adequate drainage system present in this unit?	√		
4	Is there DG power supply to this unit?		√	
5	Dedicated refrigeration areas exist to ensure food preservation	√		
6	Is dedicated food storage area exist		√	
7	Are measures for fire detection/fire fighting installed in this unit?		√	
8	The person responsible for this department is a qualified dietician or has supervision from a consultant dietician.		√	
PROCESS				
9	Health check up of all staff is done at least once a year.		√	

10	Record maintained for food materials	√		
11	If nutritional Assessment done for all the patients		√	
12	Diet Sheet is prepared by Dietician as per the treating Doctors instruction on the patient's case sheet.		√	
13	Each patient's Case sheet are checked by doctor and dietician and changes made in their diet depending on their condition		√	
14	Food distribution to patients occurs in covered trolleys		√	
15	Is infection control practices followed		√	

11.18 HUMAN RESOURCE – Not Present

CHECKLIST FOR HUMAN RESOURCE				
S. No.	**Check Points**	**Yes**	**No**	**Remarks**
STRUCTURE				
1	Is the HR department present			
2	Are racks available to store the documents?			
PROCESS				
3	HR Manpower planning			
4	job description and specification			
5	HR recruitment			

6	HR induction and training			
7	HR record keeping			
8	HR welfare-staff & family			
9	Performance appraisal			
10	Disciplinary procedure			
11	Staff grievance redressal			
12	If pre employment health checkup and annual health check up is being done			
13	Is Training In-charge present in the hospital?			
14	Is regular training conducted by the hospital?			
15	Is credentialing and privileging of doctors and nurses being done			
16	Are records of training being maintained?			
	OUTCOME			
17	Employee attrition rate is monitored?			
18	Is the employee absenteeism rate monitored			
19	% of employee provided pre exposure prophylaxis			
20	Is employee satisfaction survey being done and analyzed?			
21	% of employee who are aware of employee rights and responsibilities and welfare schemes			

11.19 MEDICAL RECORDS DEPARTMENT – Not present

CHECKLIST FOR MEDICAL RECORDS DEPARTMENT

S. No.	Check Points	Yes	No	Remarks
	STRUCTURE			
1	Is the sufficient space for medical record department available			
2	Is proper ventilation present in the department			
3	Is the fire fighting system available in the unit			
4	Is qualified and trained MRD technician available in the department			
5	Is table and chair provided to the MRD technician			
6	Is adequate number of racks available for the storage of records			
7	Is the functional flow at MRD : Receiving, assembling, deficiency check, coding, indexing , filing, issuing			
8	Is ICD coding method used for complete and incomplete files			
9	Are the MLC cases/dead cases stored separately under lock and key			
10	Is the retrieval of the records easy			
11	Is deficiency checklist is followed			
12	Is MRD Committee available ?			
13	MRD audits is being conducted			
14	Are the records kept under lock			
15	If the hospital has retention policy for documents			
16	Are the forms and formats standardized			

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

11.20 HOUSEKEEPING

Checklist for Housekeeping Department				
S. No.	**Check Points**	**Yes**	**No**	**Remarks**
STRUCTURE				
1	Does the housekeeping being provided with the personal protective equipment(dedicated gownslippers/masks/gloves/head cover)	√		
2	Does the housekeeping staff have basic facilities like (toilet/drinking water/change room)	√		
PROCESS				
3	Are the hand ishing and floor ishing agent being used?	Yes		Appropriate Solution like Hypochlorite, or R1, R2 or D125

				Solution not used. Only phenyl, bleaching and acid available
4	Is the house keeping staff being trained in the infection control practices		√	
5	Is staff using PPE		√	Provided to the staff but awareness is poor
6	Is daily cleaning schedule available		√	
7	Are the staff aware about the preparation of cleaning solutions		√	
8	Is the pest control methods being practiced		√	
9	Is the medical examination of staff being done periodically		√	

11.21 LABOUR DEPARTMENT

Checklist for Labor Department				
Si. No	**Description**	**Yes**	**No**	**Remarks**
INFRASTRUCTURE				
1	Are there separate areas demarcated for septic and aseptic deliveries?		√	
2	Does the Labour room have a toilet facility?		√	

3	Are number of Labour tables present appropriate for the daily load?	√		2 labour tables present but in one labor room only
4	Is continuous water available for the unit?	√		
5	Does the Labour Room have a hand ishing facility?	√		
6	Is scrubbing area present for the Labour Room staff?	√		
7	Is the firefighting system available in the unit?	√		
8	Is the changing room available for the doctors and nurses?	√		
9	Is there a continuous power back up for Labour Room?	√		
10	Is the Labour Room having a demarcated New Born Care Area with the appropriate equipments?	√		Though present but not in use
11	Does the Labour Room have any sterilization equipment?	√		
12	Are there Disposable Delivery Kits in required quantities?		√	
13	Does the Labour Room have a Crash Cart?	√		
14	Is there an ECG monitor?		√	

15	Does the Labour Room have adequate Oxygen supply as per demand?	√		Oxygen cylinders are available
16	Is the staff provided with the Personnel Protective Devices/ Equipments?	√		
17	Does the Labour Room have round the clock coverage by Trained Nurses/ Mid wives for conducting supervised deliveries?	√		
18	Are there screens for privacy?	√		
19	Are there Cusco's vaginal speculum (each of small, medium and large size); Sim's vaginal speculum – single & double ended - (each of small, medium and large size); Anterior Vaginal wall retractor; Sterile Gloves; Sterilized cotton swabs and swab sticks in a jar with lid; Kidney tray for keeping used instruments; Bowl for antiseptic solution; Antiseptic solution: Chlorhexidine 1% or Cetrimide 2% (if povidone iodine solution is available, it is preferable to use that); Chittle forceps; Proper light source / torch	√		
PROCESS				
20	Are Bio Medical Iste Management followed?	√		
21	Are Work Instructions prominently displayed?		√	

22	Does the Labour Room Register have a record of referred cases?		√	
23	Is the part preparation of the patient done before the operation?		√	
24	Are the number of Labour Room instruments counted before and after use?	√		
25	Are Partograms used for all patients?	√		
26	Is Labour Room disinfection done after every procedure?	√		Not appropriate
27	Is APGAR SCORE being used?		√	
28	Are Standard Operating Procedures being followed for Induction of Labour and progress of labour?		√	
OUTCOME				
29	Is Maternal mortality rate monitored?		√	
30	Is still birth rate monitored?		√	

11.22 MORTUARY

Checklist for Mortuary				
Sl. No.	**Check Points**	**Yes**	**No**	**Remarks**
STRUCTURE				
1	Is this unit present in the hospital?	√		

2	Is freezer available for dead bodies	√		
3	Is calibration and maintenance is done regularly		√	
4	Cold storage and back-up power available?	√		
5	Are measures for fire detection/firefighting installed in this unit?		√	
PROCESS				
6	Is temperature being regularly monitored		√	
7	Is there any process of infection control followed		√	