DISSERTATION

IN

(FEBRUARY 1 -30 APRIL 2014)

GAP ANALYSIS OF DISTRICT HOSPITAL, AGRA AS PER NABH NORMS

BY

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UNDER THE GUIDANCE OF

DR. B. S. SINGH

Post Graduate Diploma in Hospital and Health Management

(2012-2014)

International Institute of Health Management Research

New Delhi

2014

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"GAP ANALYSIS OF DISTRICT HOSPITAL, AGRA 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.

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FEEDBACK FORM

Name of the Student: Dr. Amninder kaur

Dissertation Organisation: Octavo Solutions P Ltd.

Area of Dissertation: Quality Accreditation & Certification.

Attendance: Regular

Objectives achieved: Successfully completed the gap Analysis process of DH, Agra as per NABH standard

Deliverables: Preparation of gap analysis tool, conducting gap analysis & formulation of Report.

Strengths: Good confidance level, good interpersonal skill & hard working.

Suggestions for Improvement: Needs to put more effort in presentation skill

Tulamitra.

Signature of the Officer-in-Charge/ Organisation Mentor (Dissertation)

Date: 07/05/14
Place: New Delhi

Certificate Of Approval

The following dissertation titled **"GAP ANALYSIS OF DISTRICT HOSPITAL, AGRA 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
1	Dr. S. R. Chauhan	8-5-14
2	Dr A. K. KHOKHAR	8/5/14
3	Dr. B. S. Singh.	

TO WHOMSOEVER MAY CONCERN

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

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

The Internship is in fulfillment of the course requirements.

I wish her all success in all his future endeavors.

09/5/2014

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

Dr. B. S. Singh
Associate Professor
IIHMR, New Delhi

Certificate from Dissertation Advisory Committee

This is to certify that **Dr. Amninder Kaur,** a graduate student of the **Post- Graduate Diploma in Health and Hospital Management** has worked under our guidance and supervision. She is submitting this dissertation titled **"GAP ANALYSIS OF DISTRICT HOSPITAL, AGRA AS PER NABH STANDARDS"** in partial fulfillment of the requirements for the award of the **Post-Graduate Diploma in Health and Hospital Management.**

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

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Associate Professor
IIHMR, Delhi

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Assistant Consultant
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CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled Gap Analysis of District Hospital, Agra.
and submitted by (Name) Dr. Amanvinder Kaur
Enrollment No. PGH/12/007
under the supervision of Dr. B.S. Singh
for award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the period from February 1st to April 30th 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.

Amanvinder
Signature

ACKNOWLEDGEMENT

Any attempt at any level cannot be satisfactorily completed without the support and guidance of learned people. We owe a great debt to all the professionals at **Octavo Solutions Pvt. Ltd, New Delhi** for sharing generously their knowledge and time, which inspired me to do our best during my dissertation.

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I extend my words of thanks to all the staff octavo solutions for always being so cooperative and facilitating me.

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I would like to thank My Institute – **International Institute of Health Management Research (IIHMR), Delhi** and **Dr. L.P.Singh** (Director IIHMR, Delhi) for providing me the opportunities to understand my capabilities and took all the necessary to make sure that we are in right hands.

My sincere thanks to my mentor **Dr. B. S. Singh** for their continuous support in completion of the project right from the word go.

Dr. Amninder Kaur

LIST OF TABLES

LIST OF CHARTS

LIST OF ABBREVIATIONS

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

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

ORGANIZATION PROFILE

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

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

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

Key Strengths and Salient Features of OSPL

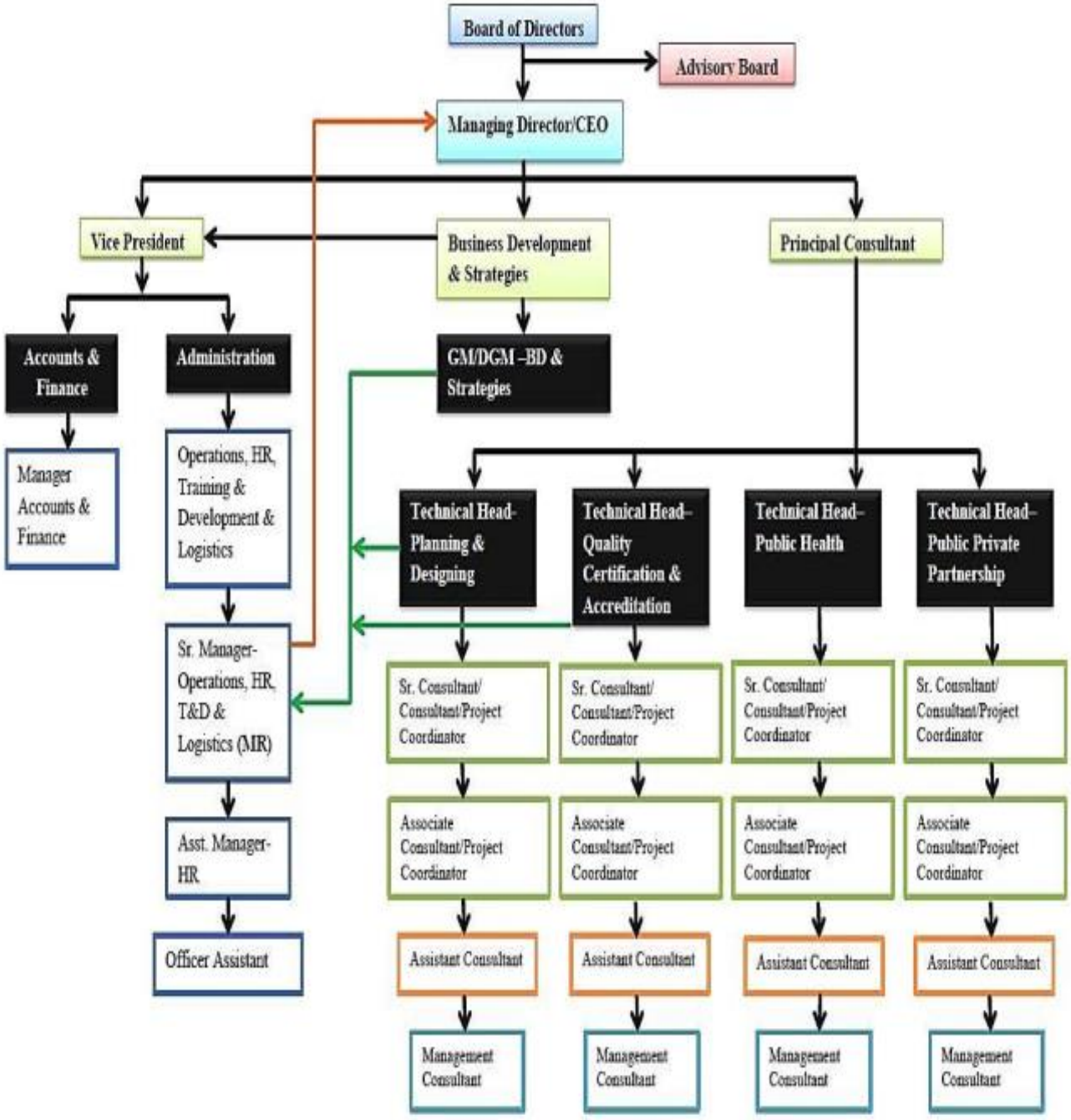
The primary **strength** of our company is to partner the client organization to optimize resources & implement the improvement strategies successfully. An assignment begins with an accurate assessment of people, processes, performance and strategies. Our consultants define competitive strengths, threats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

KEY STRENGTHS:

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

10. OSPL has presence in **14 states (**including Union Territories)
11. We have working offices at **7** different locations across India.
12. OSPL has one overseas **(International)** project to its credit.
13. In short span of just 4 years, OSPL has rendered its **consulting services to over 30,000 beds** within the healthcare sector
14. We have provided consulting services to over 100 Hospitals (bed range 30-1500), 07 Teaching Hospital & Medical Colleges, 01 Rehabilitation Hospital, 02 Dental Hospital & Colleges, 02 AYUSH Hospitals.
15. Combined Years of Experience of our Technical Personnel is 68 Man-Years in ISO/ NABL/ NABH/ QMS and Hospital Planning assignments. Our Key Personnel have rich experience of having conducted over 720 Audits/ Assessments and provided consulting services to 497 client organizations for establishing QMS.
16. We are one solution company for healthcare sector.

ORGANOGRAM


Board of Directors
Advisory Board
Managing Director/CEO
Vice President
Business Development & Strategies
Principal Consultant
Accounts & Finance
Administration
GM/DGM –BD & Strategies
Manager Accounts & Finance
Operations, HR, Training & Development & Logistics
Technical Head-Planning & Designing
Technical Head-Quality Certification & Accreditation
Technical Head-Public Health
Technical Head-Public Private Partnership
Sr. Manager-Operations, HR, T&D & Logistics (MR)
Sr. Consultant/ Consultant/Project Coordinator
Sr. Consultant/ Consultant/Project Coordinator
Sr. Consultant/ Consultant/Project Coordinator
Sr. Consultant/ Consultant/Project Coordinator
Asst. Manager-HR
Associate Consultant/Project Coordinator
Associate Consultant/Project Coordinator
Associate Consultant/Project Coordinator
Associate Consultant/Project Coordinator
Officer Assistant
Assistant Consultant
Assistant Consultant
Assistant Consultant
Assistant Consultant
Management Consultant
Management Consultant
Management Consultant
Management Consultant

PROJECT:-

GAP ANALYSIS OF DISTRICT HOSPITAL, AGRA AS PER NABH NORMS

EXECUTIVE SUMMARY

The **'Gap Analysis Report'** includes mainly **Structural Gap,** documentation and **review of manpower, equipment, infrastructure, processes including training, services & facilities provided legal compliances** etc against **NABH**. For this the defined format as per the requirement of NABH was used to capture the data. This includes major clinical and non clinical departments of hospital.

The whole report is prepared as under:

1. Scope of services in District Hospital, Agra.
2. Identifies the significant gaps in terms of Structure, Process and Outcome observed in all the concerned areas.
3. The data on status of the existing Manpower, Equipment and Statutory requirements.
4. Any other data or information as deemed necessary.

The major findings of the study are as:

- Emergency department needs certain redesigning so as to accommodate area for Triage.
- Essential equipments such as defibrillator, Ventilator etc are not available in patients care areas.
- The knowledge and practices about BMW management are rudimentary and need repeated training and monitoring.
- Space of X-ray Department is not adequate to cater the demand.
- Laundry services are in house but the segregation and disinfection of the contaminated linen is not done properly.
- No proper infection Control programme and practices followed in the hospital.
- There are no documented policies and procedures available in the hospital.
- There is an acute shortage of nurses as per the bed strength and national standards, which leads to dilution in quality of patient care.
- All the sanctioned posts are not filled up.
- Radiation Safety devices such as TLD batches, thyroid shield etc. are not available in the Radiology department.
- Space for pharmacy store and Medical Record department is not adequate

INTRODUCTION OF THE STUDY

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

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

NABH

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

Accreditation

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

Benefits of accreditation

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

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

The **Staff** in an accredited hospital are satisfied lot as it provides for continuous learning, good working environment, leadership and above all ownership of clinical processes. It improves overall professional development of Clinicians and Paramedical staff and provides leadership for quality improvement within medicine and nursing.

The gap analysis as per NABH norms is done so as to assess the existing status of the hospital and prepare it for NABH accreditation. The gap analysis is done with the help of **Self Assessment Toolkit**.

For getting the required data:-

- ❑ The various activities in the hospital are observed
- ❑ Policy manuals and records are referred
- ❑ Patients and hospital staff are interviewed.

According to the toolkit the documentation and implementation of each objective element is checked and scores are given accordingly. After this the average scores for the standards and chapters are calculated. Then these are checked against the evaluation criteria.

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

PROBLEM STATEMENT

Healthcare lags behind other industries with respect to attention to ensuring safety. Risk of dying as a result of medical error far exceeding that of dying with other problems. Healthcare has began to follow change in India, with upcoming of private hospitals in a big way. Rising costs of healthcare have pushed service providers to improve upon the facilities and services in the hospital.

Main aim for healthcare improvement

1. **Safe**: Avoiding injuries to patients from care that is intended to help them.
2. **Effective**: Providing services based on scientific knowledge to all.
3. **Patient-centered**: Providing care that is respectful of and responsive to individual patient preferences, needs & values and ensuring that patient values guide clinical decisions.
4. **Timely**: Reducing waits and sometimes harmful delays for both those who receive and give care.
5. **Efficient**: Avoiding waste, such as waste of equipment, supplies, ideas and energy.
6. **Equitable**: Providing care that does not differ in quality because of personal characteristics such as gender, ethnicity, geographic location and socioeconomic status.

So an effort towards reducing the error, **Gap analysis** is major tool which helps to reflect the current status of healthcare organization and helps in preparing roadmap to achieve the goal of certification.

RATIONALE OF STUDY

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

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

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

REVIEW OF LITERATURE

For developing a Research project Review of literature is an important source. It helps to gain deep insight into research problem and provide information of what has been done previously. It helped the researchers to be familiar with the existing studies and provide basis for methodology, tool for data collection and research design.

For the present Research report following studies have been reviewed -

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

1) Infrastructure related gaps
2) Process related gaps

Infrastructure related gaps are insufficient space, make shift buildings, improper signage, poor fire safety measure and disaster plan, piped medical gases not available, shortage of equipment and instruments, old and out of order equipments and instruments, lack of biomedical equipment engineering cell. Most of the gaps related to infrastructure related need, external support from the ministry and bilateral donor agencies.

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

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

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

3. **Di Mclntyre and Laura Anselmi, Health Economics Unit, School of Public Health and Family,**

Medicine, University of Cape Town Paper provides an overview of the methods used to promote an equitable distribution of healthcare resources. It highlights that resource allocations is extremely valuable in efficient budgeting. It also highlights the successful implementation of resource distribution can be facilitated by undertaking a detailed gap analysis. Gap analysis will provide basis for developing service development plans. There is also need to strengthen capacity for planning, budgeting and implementing plans to ensure use of limited healthcare resources. Monitoring and evaluation of these entire can enhance effective redistribution of resources to promote healthcare services.

OBJECTIVES

General Objective

To assess **District Hospital, Agra** as per National Accreditation Board for Hospitals & Healthcare Providers (NABH) standard.

Specific Objectives

1. To assess the existing service delivery status of the hospital as per NABH guidelines.
2. To identify the gap, if any, as per NABH guidelines.
3. To suggest viable recommendations for bridging the gaps in departments based on customized requirements for the hospital.

METHODOLOGY

Study Design: Cross-sectional and Observational study

Location of study: District Hospital, Agra

Duration of study: The study is conducted over a period of 3 months.

Data Collection Tool:

- Interview and Discussions with head of the departments.
- Checklist
- Observation
- NABH Toolkit

Data Collected Type:

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

- Secondary Data: - Records of various departments.

EXTERIORS OF THE HOSPITAL

District Male Hospital, Agra is a 128 bedded hospital on Land of 6.54 acres. Built up area of this hospital is 281266.4 sq. ft.

SERVICES/DEPARTMENTS

TABLE 1: Services provided in the Hospital.

GROUP A: CLINICAL SERVICES	
1. General Medicine	2. Paediatrics and Neonatology
3. Orthopaedics	4. Ophthalmology
5. Anaesthesiology	6. General Surgery
7. Dentistry	8. ENT
9. Dermatology	
GROUP B: CLINICAL SUPPORT SERVICES	
1. Laboratory	2. Radiology & Imaging
3. Blood Bank	
GROUP C: SUPPORT SERVICES	
1. Pharmacy	2. General Store
3. Kitchen & Dietary	4. Laundry
5. CSSD/TSSU	6. Ambulance & Transport
7. Housekeeping Services	8. Mortuary Services
GROUP D: ADMINISTRATIVE SERVICES	
1. General Administration	2. Account & Finance

BED DISTRIBUTION

TABLE 2: Bed Distribution of the Hospital

S. No.	FLOOR	CLASS / DEPARTMENT	BEDS
1.	GROUND FLOOR	MEDICAL WARD	25
2.		ICCU	10
3.		SURGICAL WARD	25
4.		ORTHOPAEDICS WARD	25
5.		PEDIATRIC WARD	13
6.		OPHTHALMOLOGY WARD	10
7.		ENT	10
8.		NEW DEVELOP WARD	10
TOTAL			**128**

SIGNAGE SYSTEM

Only few signage's were displayed in both the ways i.e. Bilingually and Pictorial form like Tariff List, Toilets, Wash Rooms for Differently able, Drinking water and Health Education related signage. Mission and Vision of the Hospital were not defined yet.

TABLE 3: Various Signage's displayed in the Hospital.

SIGNAGE'S	**Displayed (Yes / No / NA)**	**Bilingual (Yes / No / NA)**	**Pictorial (Yes / No / NA)**
Citizen Charter	No	No	No
Mission	No	No	No
Vision	No	No	No
Patients Rights and Responsibilities	No	No	No
Scope of Services	No	No	No
Tariff List	Yes	Yes	Yes
Doctors list along with their Specialities and Qualifications	Yes	No	Yes
OPD Schedule of Doctors (Speciality, Timings and Day of Availability)	Yes	No	Yes

Biohazard Symbols	No	No	No
Fire Exit Plan	No	No	No
Floor Directory	No	No	No
Wash Rooms (Handicap)	Yes	Yes	Yes
Toilets	Yes	Yes	Yes
Ambulance Parking Area	Yes	No	No
Drinking Water	Yes	Yes	Yes
Health Education Related Signage's (HIV & Immunization)	Yes	Yes	Yes

STATUTORY REQUIREMENTS

Only few licenses are available with the hospital like Retail drug license, Vehicle registration certificate for Ambulance, Narcotics and Psychotropic substances Act and License, PNDT certificate and License for blood Bank.

TABLE 4: Various Statutory requirements for the Hospital

LICENSES	STATUS *(A/NA)	AVAILABLE (YES/NO)
1. Building Occupancy/ Completion Certificate	A	No
2. Fire License	A	No
3. License under Bio- medical Management and handling Rules, 1998.	A	No
4. NOC for Air & Water from State Pollution Control Board	A	No
5. Excise permit to store Spirit.	NA	
6. Permit to operate lifts under the Lifts and escalators Act.	NA	
7. Narcotics and Psychotropic substances Act and License.	A	Yes (Centralized)
8. Vehicle registration certificates for Ambulances.	A	Yes
9. Retail drug license (Pharmacy).	A	Yes (Centralized)
10. PNDT Certificate	A	Yes
11. Site & Type Approval for X-Ray from AERB	A	No
12. License for Blood Bank	A	Yes

13. Noise & Air pollution certificate for Diesel Generators	A	No

*A – Applicable

*NA – Non-Applicable

MANPOWER PLANNING

TABLE 5: Manpower Planning of the Hospital.

S. No	Designations	Sanctioned	NABH Norms	Actual	Vacant (Sanction - Actual)	Vacant (NABH)
DOCTORS						
1	Superintendent in Chief	1	-	1	0	-
2	Physician	3	-	3	0	-
3	Uro Surgeon	1	-	0	1	-
4	Chest Physician	2	-	2	0	-
5	Neuro Surgeon	1	-	0	1	-
6	General Surgeon	3	2	3	0	0
7	Cardiologist	2	-	1	1	-
8	Dermatologist	1	-	1	0	-
9	Paediatrician	3	2	3	0	0
10	Anaesthetist	3	2	3	0	0
11	ENT Surgeon	2	1	2	0	0
12	Neuro Physician	1	-	0	1	-
13	Plastic Surgeon	1	-	0	1	-
14	Gastro Physician	1	-	0	1	-
15	Dental Surgeon	1	-	2	0	-
16	Ortho-surgeon	3	1	3	0	0

17	Radiologist	3	1	2	1	0
18	Pathologist	2	1	0	2	1
19	Eye –surgeon	3	-	3	0	-
20	E.M.O	4	-	4	0	-
21	Nephrologists	1	-	0	1	-
22	Store IC	1	-	1	0	-
SUB TOTAL		**43**	**10**	**33**	**11**	**1**
NURSING STAFF						
1	Matron	1	1	1	0	0
2	Staff Nurse	18	63	20	0	43
3	Ward sister	6	4	5	1	0
SUB TOTAL		**25**	**68**	**26**	**1**	**43**
PARAMEDICAL STAFF						
1	Senior Laboratory Technician (Lab)	1	1	1	0	0
2	Laboratory Technician (Lab)	4	5	4	0	1
3	X-ray Technician	1	3	1	0	2
4	ECG Technician	1	1	1	0	0
5	Optometrist	1	1	1	0	0
6	Dental Mechanic	1	-	1	0	-
SUB TOTAL		**9**	**11**	**9**	**0**	**3**
PHARMACIST						
1	HOD Pharmacy	1	-	0	1	-
2	Pharmacist	2	5	8	0	0
3	Chief Pharmacist	5	-	2	3	-

SUB TOTAL		**8**	**5**	**10**	**4**	**0**
CLASS –III STAFF						
1.	Head Clerk	1	-	1	0	-
2.	Junior Clerk	4	-	3	1	-
3.	Senior Clerk	2	2	2	0	0
4.	Store keeper cum clerk	1	-	1	0	-
5.	Generator Operator	1	-	1	0	-
6.	Driver	1	2	1	0	1
SUB TOTAL		**10**	**4**	**9**	**1**	**1**
CLASS IV						
1	Mali	1	-	1	0	-
2	Choukidar	2	5	2	0	3
3	Dhobi	2	1	2	0	0
4	Ardeli	1	-	1	0	-
5	Dark room Attendant	1	3	1	0	2
6	Lab Attendant	1	-	1	0	-
7	Cook	2	3	2	0	1
8	Kohar	2	-	1	1	-
9	Ward aya	21	7	20	1	0
10	Chaprasi	1	-	1	0	-
11	Sweeper	15	6	14	1	0
SUB TOTAL		**49**	**25**	**46**	**3**	**6**
TOTAL		**144**	**123**	**133**	**20**	**54**

GAP ANALYSIS

EMERGENCY DEPARTMENT

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

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

IDENTIFIED GAPS

STRUCTURE

- Triage area is not marked separately.
- Unavailability of Qualified staff member to manage triage activities.
- Unavailability of Defibrillator and Cardiac Monitor.
- Oral airways and Endotracheal tubes of various sizes are not available.
- Laryngoscope with various blades and Laryngoscope replacement batteries and bulbs are not present.

PROCESS

- No system to review all imaging by a Radiologist.
- Inability to perform acute blood test and receive results within one hour.
- Security staff is not available when required in emergency.
- BMW management practices are not being followed.
- Triaging of patients is not done.
- Staff is not trained in BLS/ACLS.

OUTCOME

- Time for Initial assessment of patients is not being monitored.

AMBULANCE

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

• A driver's compartment

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

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

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

• Two-way radio communication

• Audible and Visual Traffic warning devices

Two Ambulances are there but both are Non-functional, Sumo us used as a Patient Caring Vehicle.

IDENTIFIED GAPS

STRUCTURE

- Adequate Communication system does not exist.
- Required Equipments are not available.
- Medicines required in Ambulance are not available.
- Maintenance of Medical Gas (oxygen) to 90% of total capacity is not being done.

PROCESS

- Staff is not trained in BLS.
- Infection Control practices are not being followed.

OPD

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

IDENTIFIED GAPS

STRUCTURE

- Scope of services has not been displayed.
- Citizen charter and Patient charter are not displayed.
- There is no provision of Patient privacy in consultation room.
- Calibration of BP apparatus, Weighing machine and Thermometer is not being done
- There is no availability of nurse to direct patients to

PROCESS

- UHID no. Is not being generated for the patients.
- There is no separate registration done for Old and New OPD patients.
- Patient privacy is not maintained during consultation time.

OUTCOME

- Waiting Time is not monitored.
- OPD Satisfaction survey is not being done.

LABORATORY

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

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

IDENTIFIED GAPS

STRUCTURE

- Hand Washing steps are not being followed by the staff.
- BMW management practices are not being followed.

PROCESS

- Maintenance of Laboratory equipments is not done.
- Equipments are not Calibrated.
- BMW Management practices are not being followed.
- Surveillance of Lab test is not being carried out.
- EQAS is not being monitored.
- Turnaround time for Lab reports is not monitored.
- Temperature monitoring of refrigerator is not done.

OUTCOME

Following outcomes are not being measured:-

- Number of reporting errors per 1000 investigations.
- % of Reports having clinical correlation with provisional diagnosis.
- % of adherence to safety precautions.
- % of redo's

RADIOLOGY & IMAGING

The main objectives of the radiology department are:

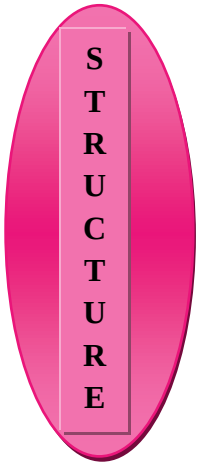
a) To provide comprehension high quality imaging service

b) Establishment and confirmation of clinical diagnosis

c) Providing high quality therapeutic radiology

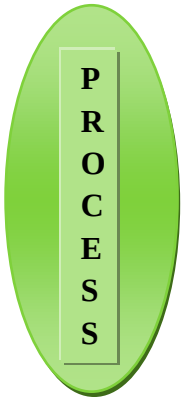
d) Commitment to training and research

e) Aiding in the effective implementation of therapeutic procedures

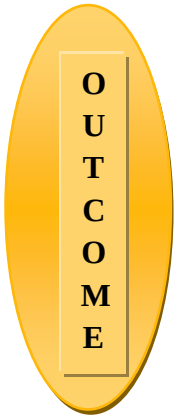


IDENTIFIED GAPS

- Unit does not have AERB (SITE/TYPE) approval.
- Unavailability of - TLD Badges
  Thyroid Shield



- Radiology equipments are not calibrated.
- Quality Assurance program is not being followed.
- Turnaround time for reports is not being monitored.



- Number of Reporting errors per 1000 investigations is not being monitored.
- % of reports having clinical correlation with provisional diagnosis is not being monitored.
- % of adherence to safety precautions and redo's are not being monitored.

WARDS

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

IDENTIFIED GAPS

STRUCTURE

- Emergency Crash Cart is not present.
- BMW management practices are not being followed.
- Unavailability of Racks for linen storage.

PROCESS

- Staff is not aware about the Admission process.
- PPE are not being used by the nurses.
- BMW management practices are not being followed.
- Nurses are not trained in BLS (CPR).
- Infection Control practices are not being followed.
- Staff is not aware about IN/OUT system.
- Discharge process is neither defined nor documented

ICU

The ICU is highly specified and sophisticated area of a hospital which is specifically designed, staffed, located, furnished and equipped, dedicated to management of critically ill patients, injuries or complications.

IDENTIFIED GAPS

STRUCTURE

- Unavailability of - Ventilator
  Monitor
  Crash Cart
- Centralized AC is not present.

PROCESS

- Time Frame for Admission and Discharge criteria for ICU and HDU are not being defined.
- Infection control practices are not being followed.
- Quality Assurance programme is not documented.
- No Policies and Procedures have been defined for situation of Bed shortage and Care of patients under restraints.
- Staff is not aware about the End of Life care policy.
- No Policies and procedures have been defined for Initial assessment and Re-assessment of patient.
- No policies have been defined for uniform use of resuscitation.
- Written order for diet is not present.
- Nutritional Therapy is neither planned nor provided in a collaborative manner.
- Written order for High Risk medication is not done.
- Policies and Procedures to guide the monitoring of patients after medication administration are not being defined.
- Knowledge to pick adverse drug events and reporting of the same is not being done.
- No policies and procedures have been defined for use of narcotic drugs and psychotropic substances.

PROCESS

- No policies and procedures have been defined for antibiotic policy.
- Infection Control practices are not being followed.
- Equipments are not being inspected and calibrated periodically.
- No exchange of information takes place during transfers between units/departments.
- No policies and procedures have been defined for:-
  i. Referring of patient to other departments/specialities.
  ii. LAMA patients and patients being discharged on request.
  iii. Care of vulnerable patents.
  iv. Obtaining consent
- Proper Hand washing steps are not being followed by the staff.
- Staff is not using PPE.
- Isolation/Barrier nursing facility is not available.
- BMW management practices are not being followed.

OUTCOME

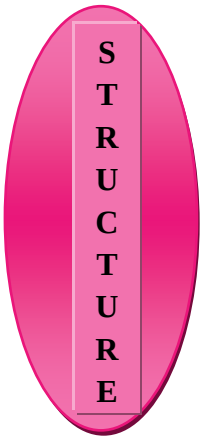
Following outcomes are not being measured:-

- Re-intubation rate.
- ICU utilization.

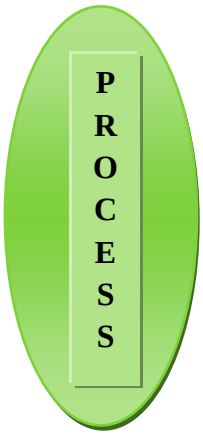
OT

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

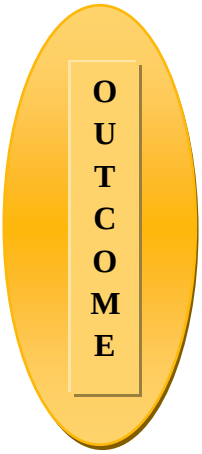
IDENTIFIED GAPS



- HVAC system is not present in the OT.
- Proper Zoning concept is not being followed.
- Adequate number of OT tables are not present as per daily workload.
- Unavailability of Defibrillator and ECG Monitor.



- OT Booking is not done.
- Documentation of OT instruments counted before and after operation is not being done.
- Disinfection of OT is not done after every procedure.
- Infection Control practices are not being followed.
- BMW management practices are not followed.

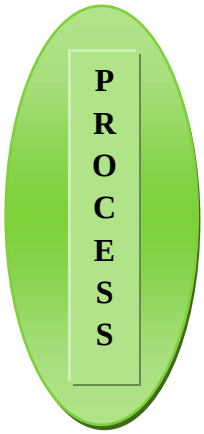


- % of anesthesia related adverse events and mortality are not being monitored.
- % of modification in plan of anesthesia and unplanned ventilation are not being monitored.
- % of SSI Rate is not monitored.
- Re-Exploration rate and Re-scheduling of surgeries are not monitored.

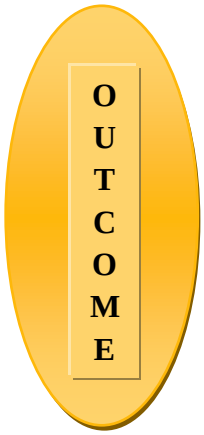
BLOOD BANK

In any hospital Blood Bank has a very special role to play. It is a place to receive stock and supply life saving blood, to save countless lives. Blood and blood products must be made available wherever and whenever they are required and its quality should be controlled by proper testing of HIV, Hep B, Hep C, Malaria and Syphilis.

IDENTIFIED GAPS



- Consent for blood donation is not available bilingually.
- BMW management practices are not being followed as per BMW handling rules.



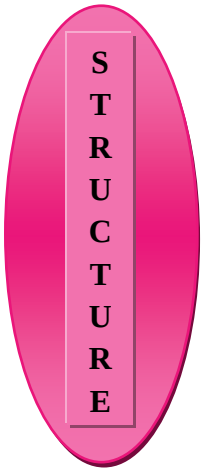
Following outcomes are not being measured:-

- % of transfusion reactions.
- % of blood and blood products wastage.
- % of component usage.
- Turnaround time for issue of blood and blood products.

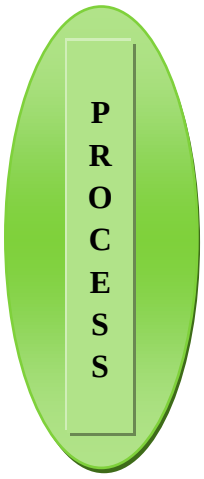
PHARMACY

Hospital Pharmacy is a department or service, responsible for the supply of medications to hospital wards as well as ambulatory patients. The department is headed by professionally competent, legally qualified pharmacist who directly supervises and ensures the correct dispensing, compounding and distribution of medication to in and out-patients.

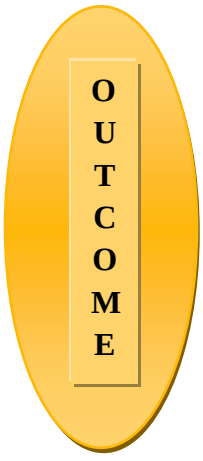
IDENTIFIED GAPS



- Unavailability of adequate number of Racks.
- Adequate ventilation and lighting is not present.
- No Security system is available in the department.
- Proper Fire fighting system is not present.
- There is no separate receiving area, segregation and storage area.
- Temperature monitoring is not done.



- Items are neither labelled nor arranged as per alphabetical order.
- Pest/Rodent control measures are not undertaken regularly.
- There is no Drug and Therapeutic committee in the hospital.
- Hospital Drug Formulary is not available.
- Adverse Drug reactions are not analyzed.



Following Outcome Indicators are not being monitored :-

- % of Local purchase and Stock outs.
- % of variation from procurement process.
- % of Goods rejected before GRN.

BIO-MEDICAL WASTE MANAGEMENT

Bio-Medical Waste management practices are not being followed in the hospital. Staff need to be trained in Waste management practices and should also follow the same strictly.

IDENTIFIED GAPS

STRUCTURE

- Color coded Foot operated bins are not adequate in number.
- Colored plastic bags are present but not being practiced.
- Work instructions at point of segregation are not being displayed everywhere.
- Needle cutter is not being used in every department.
- There is no availability of PPE with Bio-Medical waste handlers.
- Sodium hypochlorite solution and puncture proof boxes are not present.
- Safe mode of transportation and Temporary storage area are not being made available.

PROCESS

- Segregation of BMW at point of generation is not being done.
- There is no separate route for transportation of waste.
- There is no provision of regular health check up for staff of this unit.
- Annual Report is not submitted to UP PCB.
- Amount of BMW generated is not being monitored.

HOSPITAL INFECTION CONTROL

Infection Control includes the prevention and management of infection through the application of research based knowledge to practices that include: standard precautions, decontamination, waste management, surveillance and audit.

IDENTIFIED GAPS

STRUCTURE

- A designated and Qualified Infection control Nurse and Officer are not present.
- Adequate and appropriate facilities for hand hygiene in all patient care areas are not being provided.
- Adequate and appropriate personal protective equipments, soaps and disinfectants are not available.

PROCESS

- The hospital does not implement any policies and/or procedures to prevent infection in patient care areas.
- The organization does not adhere to standard precautions at all times.
- Equipment cleaning, disinfection and sterilization practices and policies are not followed.
- Appropriate antibiotic policy is not established and implemented.
- Hospital does not adhere to –
  - Laundry and linen management processes.
  - Kitchen sanitation and Food handling issues.
  - Mortuary practices.
- The hospital does not have appropriate engineering controls to prevent infections.
- The infection prevention and control programme is not updated in a year.
- HIC surveillance data is not collected regularly.
- Verification of data is not done on a regular basis by the infection control team.
- Tracking and analyzing of infection risks, rates and trends is not done.
- The surveillance activities does not include monitoring of the effectiveness of housekeeping services.

PROCESS

- HAI rates are not being monitored.
- A hospital infection control committee and team are not formed.
- Compliance with hand hygiene guidelines is not being monitored.
- Documented procedure for identifying an outbreak is not present.
- Implementation of laid down procedure is not done.
- No Documented procedure exists to guide the cleaning, packing, disinfection and/or sterilization, storing and issue of items.
- Isolation / barrier nursing facilities are not available. Appropriate personal protective equipment are not used by the BMW handlers.
- Visit by the hospital authorities to disposal site neither done nor documented.
- Resources required for the infection control programme are not made available by the hospital.
- The organization does not earmark adequate funds from its annual budget for infection control activities.
- Appropriate “in-service” training sessions for all staff are not conducted.
- Appropriate pre and post exposure prophylaxis is not provided to all concerned staff members.

OUTCOME

Following Outcome indicators are not being monitored:-

- UTI rate
- VAP rate
- SSI rate
- Central line associated blood stream infection rate

TSSU

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

STRUCTURE

- Sufficient space is not available (0.75sq mts/bed).
- Layout does not follow the functional flow: Receiving, Washing, decontamination, drying, packing, loading, unloading, storing and issuing.
- Calibration of pressure meter of autoclave is not done.
- Racks are not present in the department.
- Technician is not present in TSSU.
- Decontamination Solution is not available.
- Transport trolley is not present for items.

PROCESS

- TSSU sterilization register is not present.
- Labeling of drums in CSSD is not takes place.
- Chemical, biological and bowie-dick test is not performed.
- Recall system of items is not followed.
- Reuse policy for items is not available.

BIO-MEDICAL ENGINEERING

There is no dedicated Bio-Medical Engineering department available in the hospital. Qualified individual need to be appointed for the same.

IDENTIFIED GAPS

STRUCTURE

- There is no any designated Bio-medical Engineering department present in the Hospital.
- Unavailability of Qualified Bio-medical engineer.
- Central supply system for bio medical gases does not exist.
- Safety devices are not available.
- Preventive maintenance and calibration of equipment is not done.
- Traceability of calibration report is not present

PROCESS

- Documented procedure for equipment replacement and disposal is not present.
- Equipments are not inventoried and proper logs are not maintained as required.
- Training of staff when new equipment is installed is not being conducted.
- Documented Preventive and breakdown maintenance plans are not present.

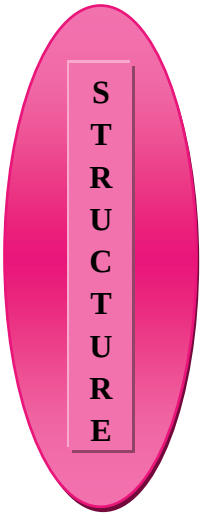
OUTCOME

- % of downtime of critical equipment is not being monitored

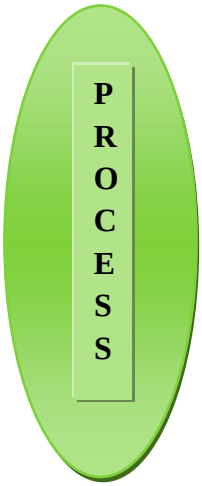
ENGINEERING AND MAINTENANCE

There is no dedicated Engineering and Maintenance department is available in the hospital. Qualified and Designated individual is not present for maintenance of the equipments.

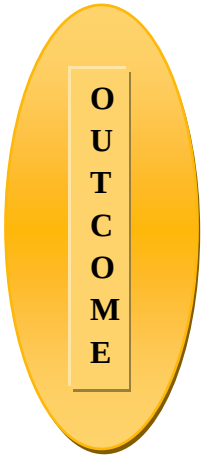
IDENTIFIED GAPS



- Various statutory requirements i.e., NOC Fire, Diesel storage license, Liquid oxygen and storage of medical cylinders license, NOC water & Air (DG set) pollution are not available.
- Up to date drawing, layout, escape route is not present and displayed.
- Required signage's are not been displayed everywhere.
- Designated individual for maintenance is not present.
- Alternative source of water and electricity is not available.
- Personnel safety devices are not present.
- Safety devices (Fire extinguishers, smoke detectors, sprinklers, grab bars, side rails, nurse CCTV, ALARMS ETC) are not available.



- No mechanism is there for renewing of licenses.
- No implementation of preventive and break down maintenance plan.
- Monitoring of Response time is not done.
- Water quality reports are not monitored.
- Facility inspection round is not done twice a year in patient care areas and once in non-patient care areas and not documented.
- No provision for safety education program.
- Safety committee not formed.
- Staff is not trained for disaster management and fire management; Mock Drills are not being conducted and documented properly.



- Number of variations during Mock drills are not being observed as they are not being conducted.

STORE

There is no proper demarcation of receiving, segregation and storage area. Sound Inventory control measures are not been taken. Lead Time for issuing materials is not being recorded.

IDENTIFIED GAPS

STRUCTURE

- Unavailability of Fire detection and fighting system.
- There is no receiving, segregation and storing area.

PROCESS

- Pest/rodent control measures are not regularly under taken
- No recording of Lead time for issuing materials to the department
- Stock turnover details are not calculated on monthly basis.
- Sound inventory control practices are not followed (ABC/VED/FSN/FIFO)
- No condemnation policy is present in the department
- Purchase and condemnation committee is not there.

OUTCOME

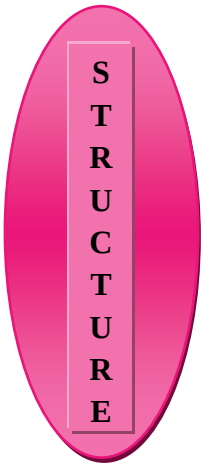
- Comparative list of rates of potential suppliers is not been maintained.
- % of stock outs & goods rejected before preparation of GRN are not monitored
- % of variation from procurement process are not monitored

KITCHEN/DIETARY

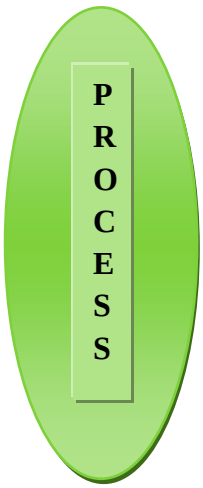
Department of food and beverages is a paramedical department, which forms an integral part of every in-patient's therapeutic care during their hospital stay.

The main purpose of the Dietary Department as a whole is to provide nutritious food to patients such that it improves the nutritional status of a hospitalized patient, keeping in mind restriction of certain nutrients as part of the therapy, by planning meals with the use of nutritional knowledge and to ensure that it is served in an attractive and acceptable manner to all patients admitted in the hospital.

IDENTIFIED GAPS



- Layout does not follow the functional flow: Receiving, storage, preparation, distribution and cleaning areas
- Refrigeration areas are not demarcated to ensure food preservation
- Dedicated Food storage area not demarcated
- Measures for fire detection/fire fighting are not installed in this unit



- Unavailability of Qualified Dietician or supervision from consultant dietician
- Annual Health check up of the staff is not done
- Patient's Nutritional assessment not done
- Diet sheet for the patients not prepared by the Dietician
- Patient Case sheets are not checked by doctor and dietician
- Food distribution to patients does not occur in covered trolleys
- Infection control practices are not followed

MEDICAL RECORD DEPARTMENT

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

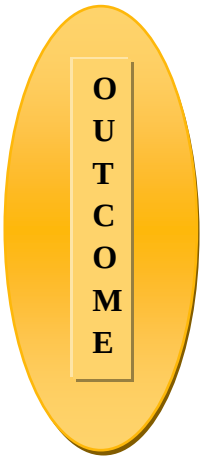
IDENTIFIED GAPS

STRUCTURE

- Sufficient space is not available for medical record department
- Proper ventilation is not present in the department
- Fire fighting system is not available in the unit
- Qualified and trained MRD technician are not available in the department
- Adequate number of racks are not available for the storage of records

PROCESS

- There is no functional flow at MRD : Receiving, assembling, deficiency check, coding, indexing , filing, issuing area
- ICD coding method is not used for complete and incomplete files
- MLC cases/dead cases are not stored separately under lock and key
- Retrieval of the records are not easy
- Deficiency checklist is not followed
- MRD Committee is not available
- MRD audits are not being conducted
- Hospital has no retention policy for documents
- Forms and formats are not standardized
- Destruction policy for records is not available
- Pest control not done on a regular basis



Following outcome indicators are not being followed:-

- Number of Deaths
- % of missing records
- % of records with ICD codification.
- % of records not having discharge summary and consent form

LINEN AND LAUNDRY

This department is outsourced. Soiled, Disinfected and Infected linen are not transported in different and covered trolleys. Linen items are not being replenished when contaminated.

SECURITY

Security System in the hospital is a must because:-

- Hospital is a people intensive place.
- Provide services to stick people round the clock.
- Anybody has an access to any part of the hospital any time for advise and treatment.
- The hospital atmosphere is always filled with emotions, excitements care and happiness, death and sorrow.
- The hospital staff operates in a tense atmosphere resulting in irritation, conformation, conflicts and aggression, threatening life of hospital staff.

Security services are not available in the Hospital.

HOUSEKEEPING

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

IDENTIFIED GAPS

STRUCTURE

Adequate amount of PPEs are not being provided to the Housekeeping staff –

- Gown
- Slippers
- Masks
- Gloves
- Head Cover

PROCESS

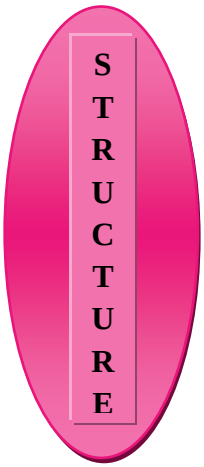
- The hand washing and floor washing agents are not being used
- The house keeping staff is not being trained in the infection control practices
- Daily cleaning schedule is not present.
- The staff are not aware about the preparation of cleaning solutions
- Pest control methods are not practiced
- Periodic medical examination of staff is not being conducted

MORTUARY

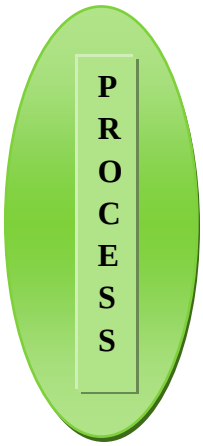
It is used for the storage of human corpses awaiting identification, or removal for autopsy or disposal by burial, cremation or otherwise. In modern times they have customarily been refrigerated to delay decomposition.

Mortuary is present in the Hospital but is Non-functional. Freezer is available but is non- functional.

IDENTIFIED GAPS



- Calibration and maintenance of equipments is done regularly
- Cold storage and back-up power are not available
- Measures for fire detection/fire fighting is not installed in this unit



- Temperature is not being regularly monitored.
- Process of infection control is not followed in the Mortuary

SCORE ANALYSIS

Findings:

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

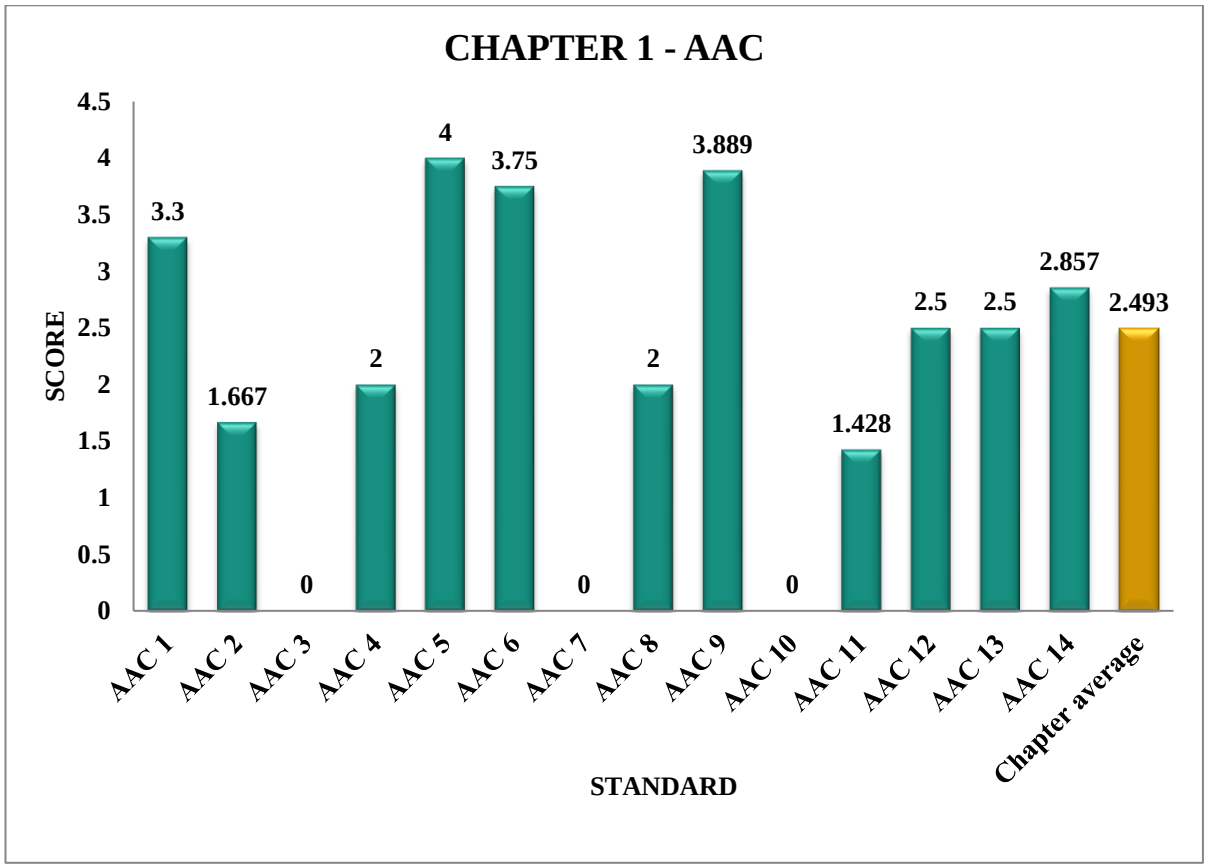
1. The average score of each individual standard
2. The average score of each chapter
3. The average score of all standards

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

TABLE 6 : Scores of Chapter AAC

Chapter 1: ACCESS, ASSESSMENT AND CONTINUITY OF CARE (AAC)	
AAC 1	**3.3**
AAC 2	**1.667**
AAC 3	**0**
AAC 4	**2**
AAC 5	**4**
AAC 6	**3.75**
AAC 7	**0**
AAC 8	**2**
AAC 9	**3.889**
AAC 10	**0**
AAC 11	**1.428**
AAC 12	**2.5**
AAC 13	**2.5**
AAC 14	**2.857**
CHAPTER AVERAGE	**2.493**

CHART 1: Scores of Chapter AAC



INTERPRETATION

AAC 1. - The services being provided are partially defined and are not displayed prominently. Staff is not properly oriented about services.

AAC 2. The organization does not have documented policies and procedures for registration and admission of patients. UHID is not being generated at the end of registration. It does not have policies & procedures for managing patients during non availability of beds. The staff is not aware about these processes.

AAC 3. The organization does not have appropriate mechanism for transfer (in and out) or referral of patients.

AAC 4. Documentation has not been done about initial assessment and plan of care but are partially implemented.

AAC 5. Patients are reassessed at regular intervals but documentation need to be maintained.

AAC 6. The scope of laboratory services need to be documented.

AAC 7. Laboratory quality assurance programme is neither documented nor practiced.

AAC 8. Laboratory Safety programme has neither been documented nor implemented. The staff are partially trained for the safe practices followed.

AAC 9. Documentation of scope of radiology & imaging services provided by the organization need to be done.

AAC 10. The quality assurance programme of Imaging services is neither documented nor implemented.

AAC 11 The radiation safety programme is neither documented nor implemented. Imaging personnel are provided with appropriate safety devices but staff is not trained in using the same and signage are partially displayed in appropriate locations.

AAC 12. Documentation of Policies and procedures for continuous and multi-disciplinary patient care need to be done.

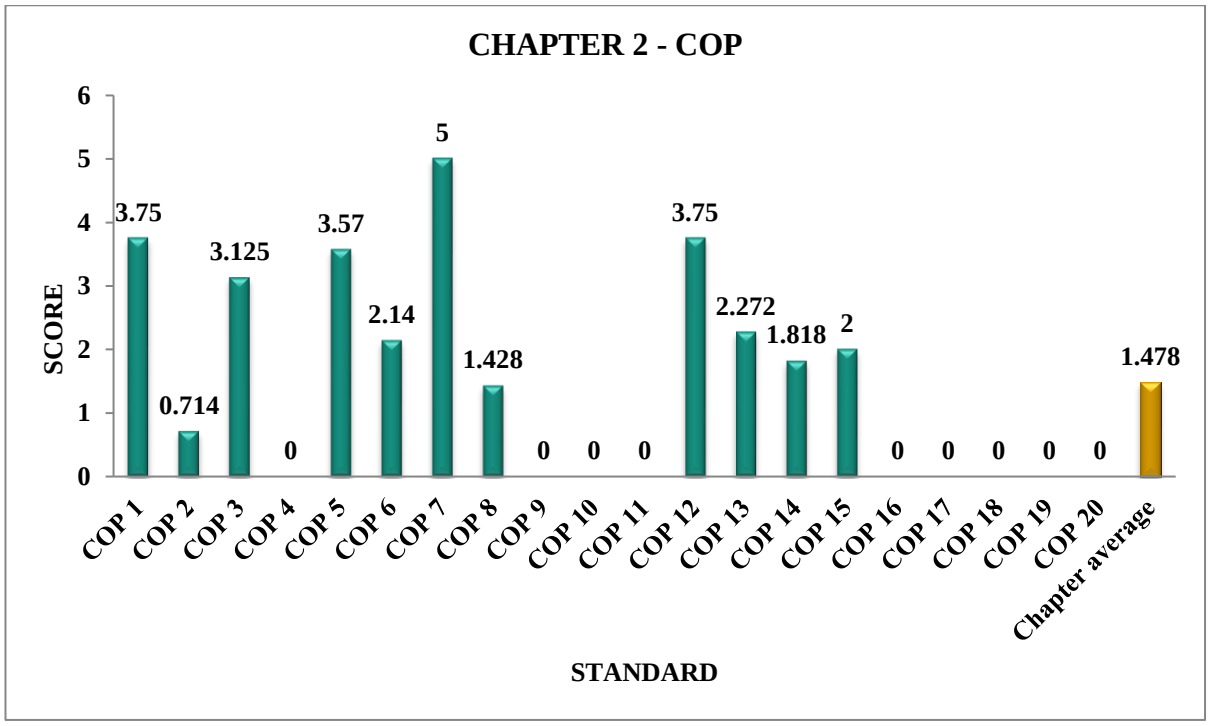
AAC 13 Policies and procedures for discharge process need to be documented and implemented properly.

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

TABLE 7: Scores of Chapter COP

CHAPTER 2: CARE OF PATIENTS (COP)	
COP 1	**3.75**
COP 2	**0.714**
COP 3	**3.125**
COP 4	**0**
COP 5	**3.57**
COP 6	**2.14**
COP 7	**5**
COP 8	**1.428**
COP 9	**0**
COP 10	**0**
COP 11	**0**
COP 12	**3.75**
COP 13	**2.272**
COP 14	**1.818**
COP 15	**2**
COP 16	**0**
COP 17	**0**
COP 18	**0**
COP 19	**0**
COP 20	**0**
Chapter average	**1.478**

CHART 2: Scores of Chapter COP



INTERPRETATION

COP-1. Documentation of policy and procedures for uniform care of patients in all setting of the hospital and guided by applicable law, regulation and guideline need to be done

COP-2. Emergency services provided by the organisation need to be documented and implemented.

COP-3. Documentation and implementation of policies and procedures for Ambulance Services provided by the hospital need to be done.

COP- 4. Policies and procedures to guide the care of patients requiring cardio-pulmonary resuscitation are not available.

COP-5.The policy and procedure of guide nursing care need to be documented.

COP-6. Policies to guide the performance of various procedures are not available. Qualified personnel order, plan, perform and assist in performing procedures. Informed consent is taken by the personnel performing procedure where applicable.

COP -7. Documentation of policies and procedures for rational use of blood and blood components need to be done.

COP- 8. Documentation of policies and procedures to guide the care of patients in Intensive care and High dependency unit need to be done.

COP- 9. There are no documented policies and procedures to guide the care of vulnerable patients (elderly, children, physically and/or mentally challenged)

COP-10. Hospital policy and procedure for obstetric services has neither been documented nor implemented.

COP-11. The organisation has no policies and procedures to guide the care of paediatric services.

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

COP- 13 Documentation of policies and procedures for guiding the administration of anaesthesia need to be done. Patient's post-anaesthesia status need to be monitored and documented.

COP- 14 Policies and procedures for the care of patients undergoing surgical procedures need to be documented and implemented.

COP-15 Policies and procedures for the care of patients under restraints (physical and/ or chemical) need to be documented and implemented properly.

COP-16. Documentation and Implementation of policies and procedures guiding the management of pain need to be done.

COP- 17 The hospital has no documented policies and procedures to guide appropriate rehabilitative services.

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

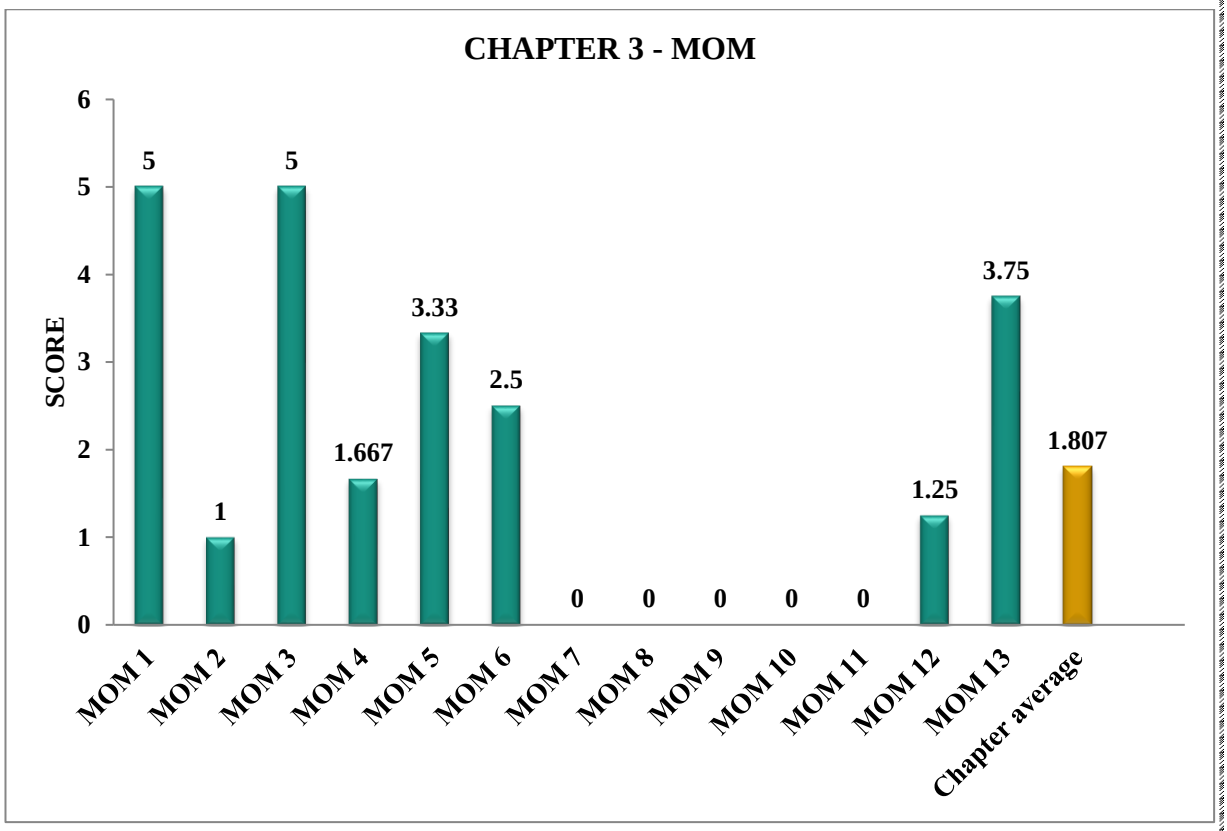
COP-19 The organization has no documented policies and procedures for nutritional therapy neither are practicing the same.

COP- 20. Policies for End of Life Care have neither been documented nor implemented.

TABLE 8: Scores of Chapter MOM

CHAPTER 3: MANAGEMENT OF MEDICATION (MOM)	
MOM 1	**5**
MOM 2	**1**
MOM 3	**5**
MOM 4	**1.667**
MOM 5	**3.33**
MOM 6	**2.5**
MOM 7	**0**
MOM 8	**0**
MOM 9	**0**
MOM 10	**0**
MOM 11	**0**
MOM 12	**1.25**
MOM 13	**3.75**
CHAPTER AVERAGE	**1.807**

CHART 3: Scores of Chapter MOM



INTERPRETATION

MOM-1. Documentation and implementation has been done partially regarding pharmacy services and usage of medication. There is no multidisciplinary committee to guide the formulation and implementation of these policies and procedures.

MOM-2. List of medications appropriate for the patients and as per the scope of the organization's clinical services is developed. Hospital formulary has not been developed and requires implementation to define process for acquisition of the medication.

MOM-3. Documentation for policies and procedures to guide the storage of medication need to be done. Sound alike and Look alike drugs are neither identified nor stored separately.

MOM-4. The organisation need to document policies and procedures to guide the safe and rational prescription of medications and implementation of some policies need to be done.

MOM-5. Documentation need to be done for safe dispensing of medications.

MOM-6. Documentation and implementation need to be done for policies and procedures for medication administration

MOM-7. Documentation and implementation of policies and procedure to guide the monitoring of patients after medication administration need to be done.

MOM-8. Policies and procedures for reporting and analysis of Near misses, medication errors and adverse drug events need to be documented and implemented.

MOM-9. Narcotics are not used in hospital

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

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

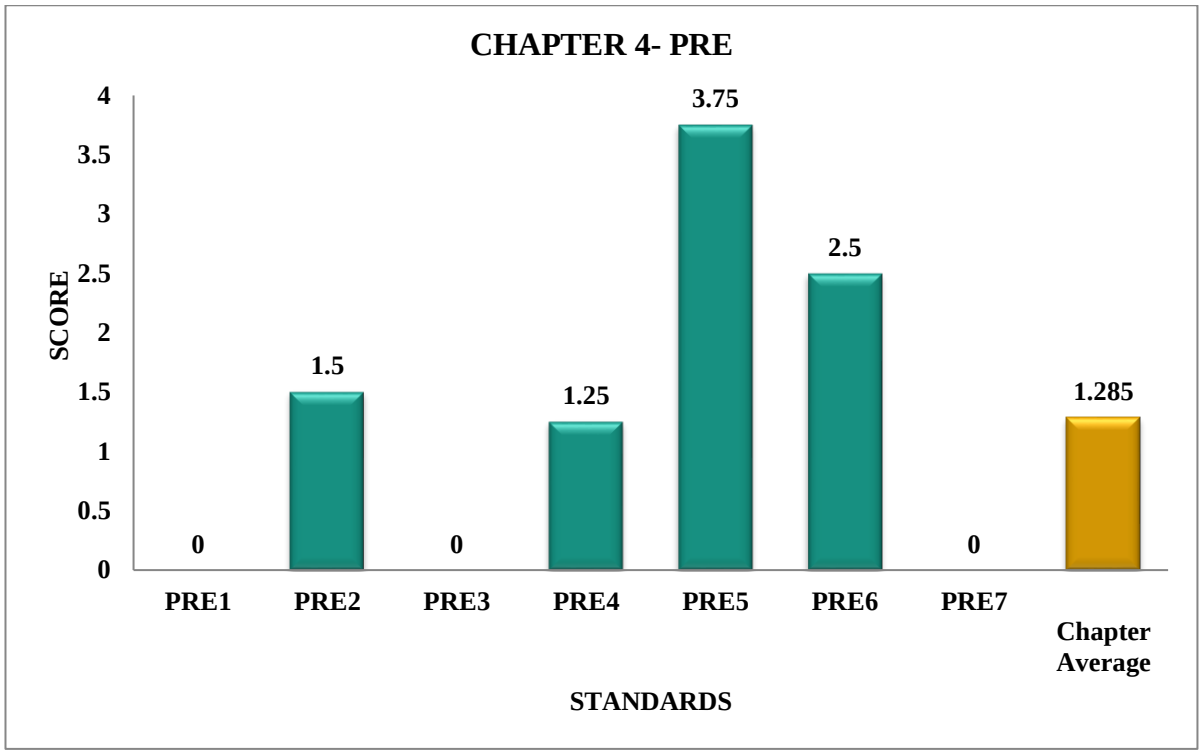
MOM-12: Policies and procedures to guide the use of Implantable prosthesis and medical devices need to be documented and implemented.

MOM- 13: Documentation of policies and procedures for use of medical gases and consumables need to be done.

TABLE 9: Scores of Chapter PRE

CHAPTER 4 : PATIENT RIGHT AND EDUCATION (PRE)	
PRE 1	**0**
PRE 2	**1.5**
PRE 3	**0**
PRE 4	**1.25**
PRE 5	**3.75**
PRE 6	**2.5**
PRE 7	**0**
CHAPTER AVERAGE	**1.285**

CHART 4: Scores of Chapter PRE



INTERPRETATION

PRI -1. Documentation and implementation of patient and family rights and responsibilities need to be done.

PRI-2 Documentation of policies and procedure for patient and family rights and responsibilities need to be done.

PRI-3. There are no policies to educate family members about expected results and possible complications.

PRI -4.Informed consent policy is not documented but consent is taken by the person performing the procedure and staff is aware about the informed consent procedure.

PRI-5. Policies and procedures for the patient and families right to education need to be documented and implemented properly.

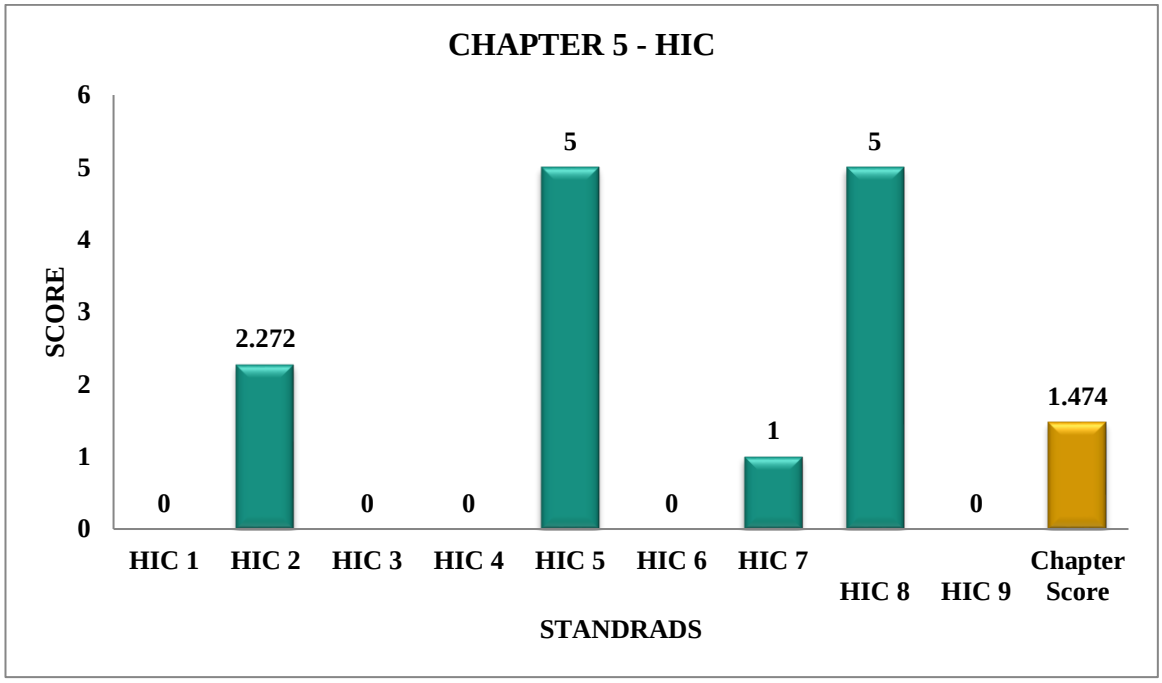
PRI-6. Policies for the patient and their family member's right to information on expected costs need to be documented and implemented. Tariff list is available to patients.

PRI-7. The documentation and implementation of organization redressed procedure need to be done.

TABLE 10: Scores of Chapter HIC

CHAPTER 5 : HOSPITAL INFECTION CONTROL (HIC)	
HIC 1	0
HIC 2	2.272
HIC 3	0
HIC 4	0
HIC 5	5
HIC 6	0
HIC 7	1
HIC 8	5
HIC 9	0
CHAPTER SCORE	1.474

CHART 5: Scores of Chapter HIC



INTERPRETATION

HIC-1. The hospital infection prevention and control programme need to be documented and implemented.

HIC-2.The organization adheres to standard precautions, hand hygiene guidelines, cleaning, disinfection and sterilization practices, laundry and linen management and housekeeping practices. But the Infection Control manual need to be documented and implemented.

HIC-3.Survillance activities to capture and monitor infection prevention and control data need to be documented and implemented.

HIC-4.Documentation and Implementation for policies of The organization taking actions to prevent and control Hospital Associated Infections (HAI) in patients and employees need to be done.

HIC-5.Facilities and resources are being provided to prevent the infection. Barrier nursing facility is not available and appropriate pre and post exposure prophylaxis is not provided to concerned staff.

HIC-6. Outbreaks of infections need to be documented and implemented.

HIC-7. Documentation and implementation of policies and procedures for sterilization activities need to be done.

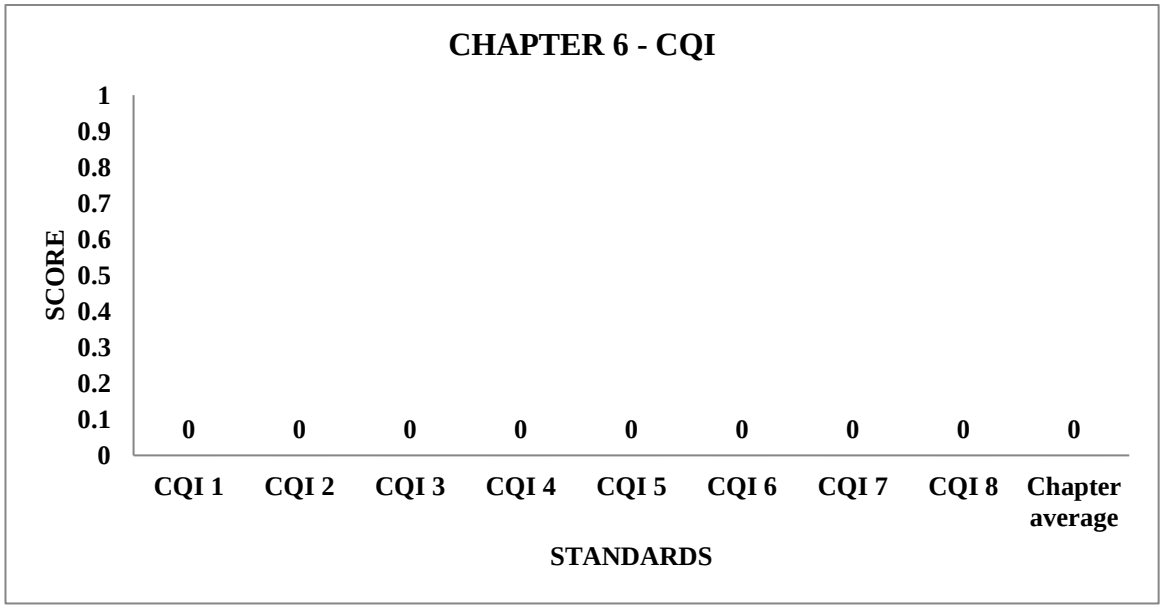
HIC-8. The organization does not adhere to statutory provisions with regard to biomedical waste. There is no proper segregation and collection of BMW uniformly from all patient care areas of the hospital. The hospital does not monitor that the BMW is transported safely within the time frame. Staffs are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

HIC-9. Infection control programme is neither supported by the management nor is implemented. Adequate resources and funds need to be made available and staff need to be trained for infection control practices.

TABLE 11: Scores of Chapter CQI

CHAPTER 6: CONTINUOUS QUALITY IMPROVEMENT (CQI)	
CQI 1	0
CQI 2	0
CQI 3	0
CQI 4	0
CQI 5	0
CQI 6	0
CQI 7	0
CQI 8	0
CHAPTER AVERAGE	0

CHART 6: Scores of Chapter CQI



INTERPRETATION

CQI-1. Structured quality improvement and continuous monitoring programme in the organization need to be documented and implemented.

CQI-2. Structured patient safety programme need to be documented and implemented.

CQI-3. Documentation and Implementation for identification of 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 need to be documented and implemented.

CQI-5. Quality improvement programme need to be documented and implemented.

CQI-6. Documentation and Implementation of established system for clinical audit need to be done.

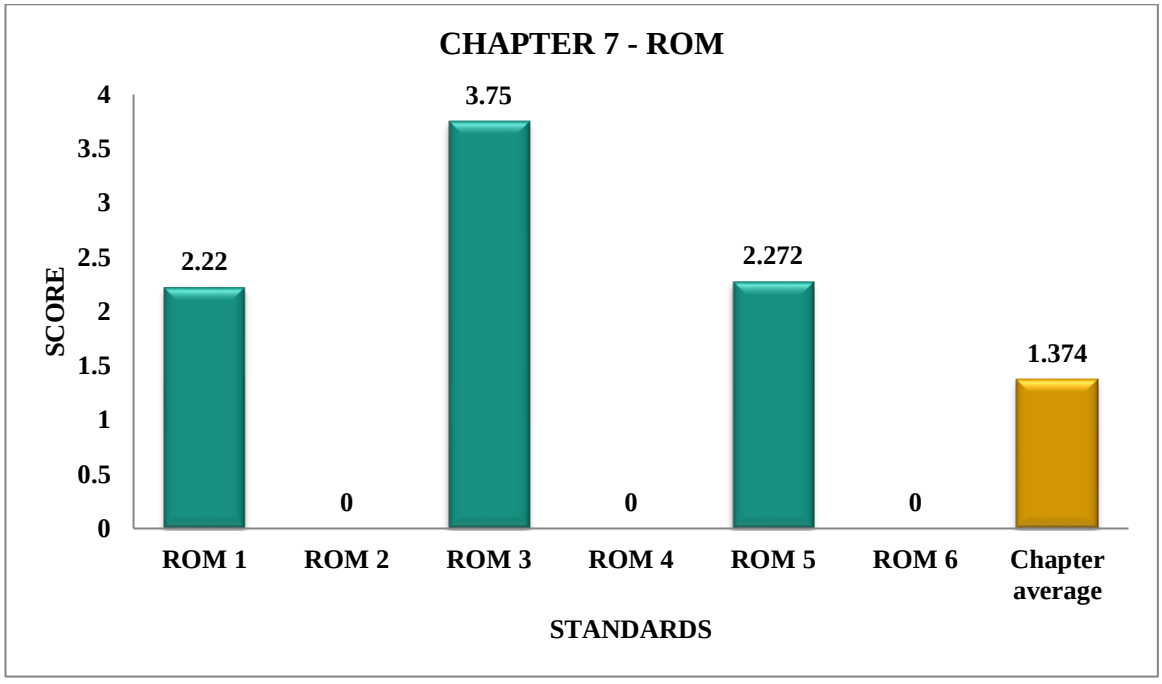
CQI-7. Incidents, complaints and feedback collecting system and analysis of the same to ensure continual quality improvement need to be documented and implemented.

CQI-8. Documentation and Implementation for intensive analysis of sentinel events need to be done.

TABLE 12: Scores of Chapter ROM

CHAPTER 7: RESPONSIBILITIES OF MANAGEMENT (ROM)	
ROM 1	2.22
ROM 2	0
ROM 3	3.75
ROM 4	0
ROM 5	2.272
ROM 6	0
CHAPTER AVERAGE	1.374

CHART 7: Scores of Chapter ROM



INTERPRETATION

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

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

ROM-3. Services provided by each department are displayed but not documented. Departmental leaders are not involved in quality improvement.

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

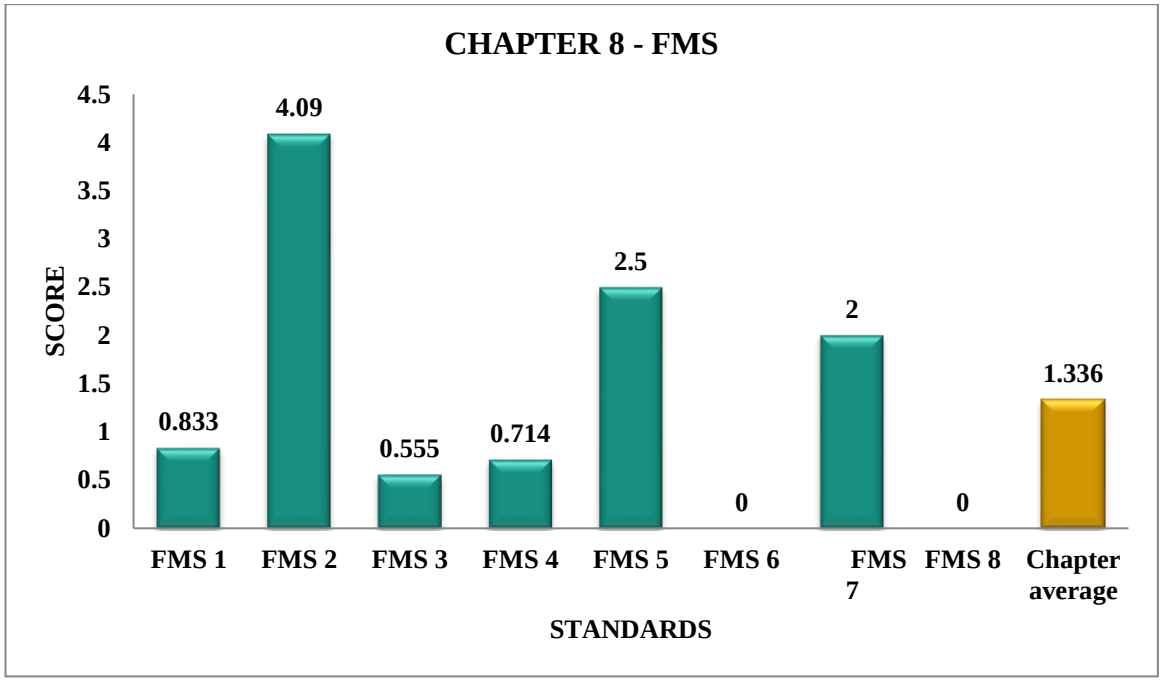
ROM-5. The organization displays partially the professionalism in management of affairs.

ROM-6. Documentation and Implementation of management ensuring patient safety aspects and risk management issues are integral part of patient care and hospital management.

TABLE 13: Scores of Chapter FMS

CHAPTER 8: FACILITY MANAGEMENT AND SAFETY (FMS)	
FMS 1	**0.833**
FMS 2	**4.090**
FMS 3	**0.555**
FMS 4	**0.714**
FMS 5	**2.5**
FMS 6	**0**
FMS 7	**2**
FMS 8	**0**
CHAPTER AVERAGE	**1.336**

CHART 8: Scores of Chapter FMS



INTERPRETATION

FMS-1. Safety committee is not present. Personal safety devices are not available with the staff. Facility inspection rounds are not taken. But there is a safety education programme for the staff.

FMS-2. Partial implementation has been done on the aspects to ensure safety of patients, their families, staff and visitors, but documentation is required.

FMS-3. Neither documentation nor implementation has been done for programme for engineering support services.

FMS-4. Documentation need to be done for programme of medical gases, vacuum and compressed air.

FMS-5. The organization does not have documented programme for medical gases, vacuum and compressed air. Medical gases are handled stored and distributed in safe manner. Procedures for medical gases address the safety issues at all levels.

FMS-6. The organization does not have plans for fire non-fire emergencies within the facilities.

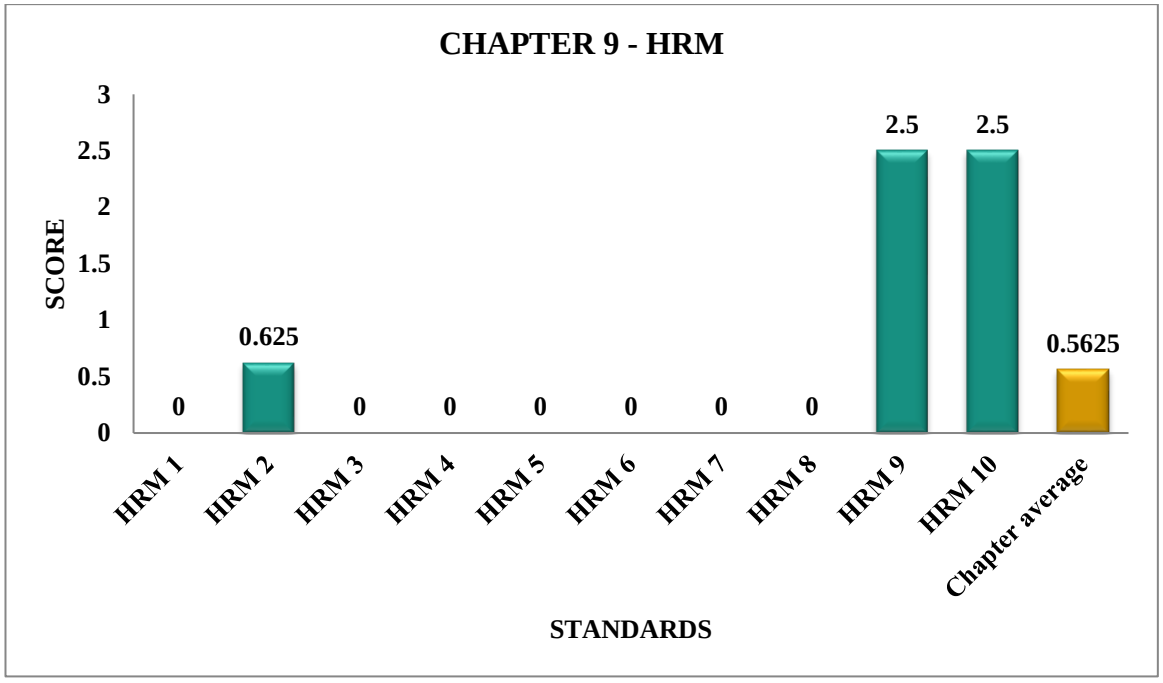
FMS-7. The organization does not have documented disaster management plan and staff is also not trained in the same.

FMS-8. Plan for management of hazardous materials has neither been documented nor implemented.

TABLE 14: Scores of Chapter HRM

CHAPTER 9: HUMAN RESOURCE MANAGEMENT (HRM)	
HRM 1	**0**
HRM 2	**0.625**
HRM 3	**0**
HRM 4	**0**
HRM 5	**0**
HRM 6	**0**
HRM 7	**0**
HRM 8	**0**
HRM 9	**2.5**
HRM 10	**2.5**
CHAPTER AVERAGE	**0.5625**

CHART 9: Scores of Chapter HRM



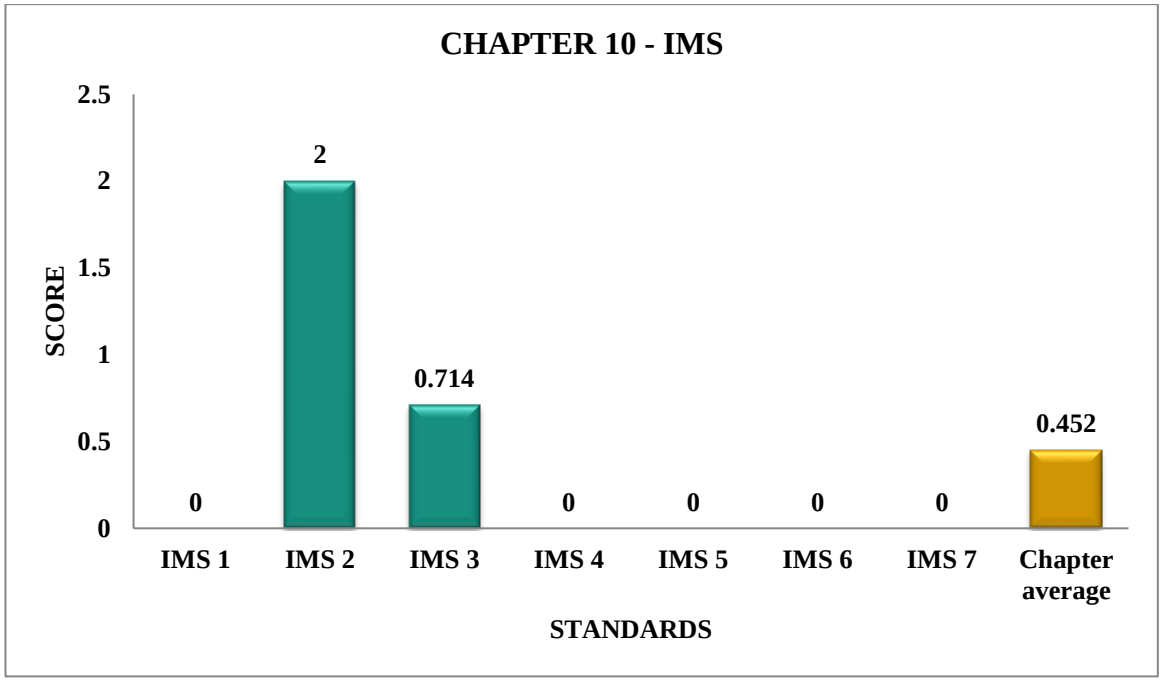
INTERPRETATION

No designated Human Resource department is available in the hospital. Credentialing and privileging are partially done in the hospital.

TABLE 15: Scores of Chapter IMS

CHAPTER 10: INFORMATION MANAGEMENT SYSTEM (IMS)	
IMS 1	0
IMS 2	2
IMS 3	0.714
IMS 4	0
IMS 5	0
IMS 6	0
IMS 7	0
CHAPTER AVERAGE	0.452

CHART 10: Score of Chapter IMS



INTERPRETATION

IMS-1. Policies and procedures are neither documented nor implemented 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 and implementation is not done for processes for effective management of data but standardized Formats for data collection and necessary resources for analysing data are available.

IMS-3. Documentation and Implementation for the organization having complete and accurate medical record for every patient has not been done. But every medical record has a unique identifier.

IMS-4. The medical record reflects continuity of care is neither documented nor implemented.

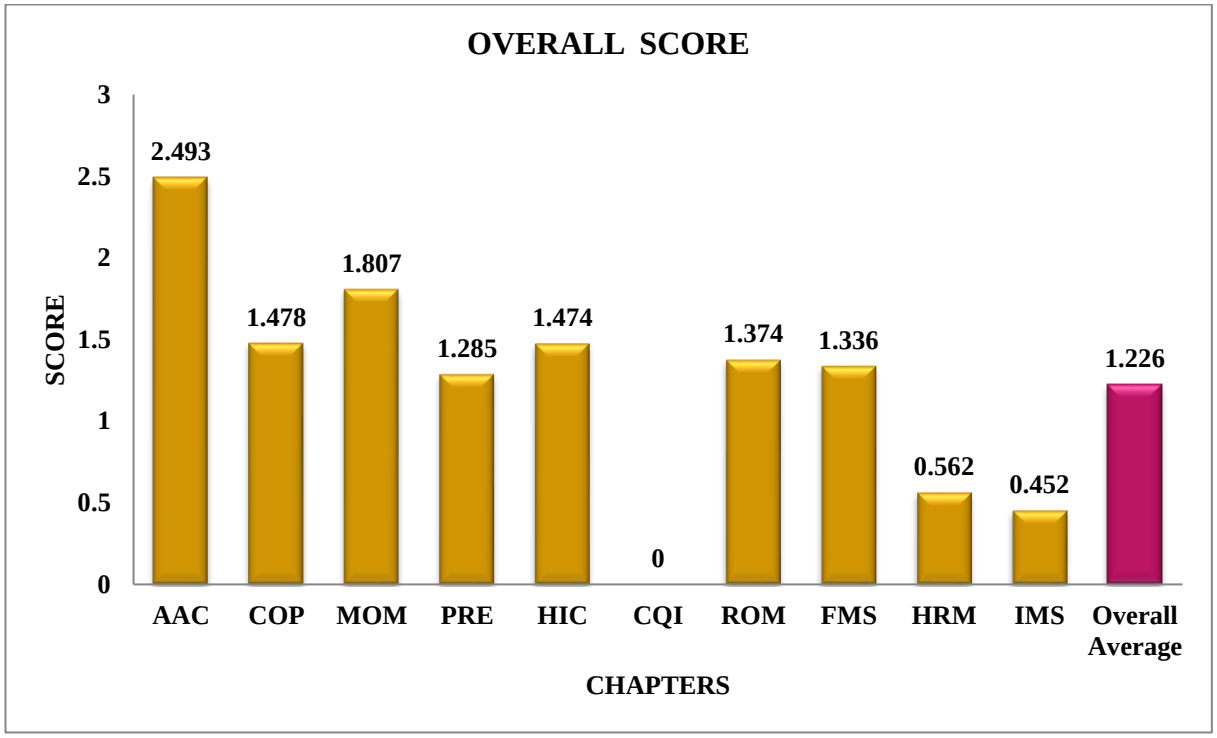
IMS-5. Policies and procedures for maintaining confidentiality, integrity and security of information is neither documented nor implemented.

IMS-6. Documentation and Implementation for policies and procedures for retention time of records, data and information need to be done.

IMS-7. Documentation and Implementation for regular reviewing of medical records need to be done.

Overall average score of all Chapters

CHART 11: Overall Score of all Chapters



Analysis

1. Pre-accreditation entry level:

Conditions for qualifying to this award are as below:

• All the regulatory legal requirements should be fully met.

• No individual standard should have more than two zeros.

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

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

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

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

2. Pre-accreditation progressive level:

Conditions for qualifying to this award are as below:

• All the regulatory legal requirements should be fully met.

• No individual standard should have more than two zeros.

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

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

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

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

3. Accredited:

Conditions for qualifying for accreditation are as below:

• All the regulatory legal requirements should be fully met.

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

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

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

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

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

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

1) Total Score of all the chapters is below 2.
2) Only AAC has score more than 2.
3) Many Standards have got more than one zero.
4) Total Score of chapter CQI is zero.

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

RECOMMENDATIONS

- Citizen Charter, Patient Charter, Scope of Services and other signage need to be displayed bilingually
- Scope of Services of the hospital need to be defined & displayed in bilingual at the entrance of the hospital.
- Emergency department needs certain redesigning so as to accommodate area for Triage.
- Essential equipments such as defibrillator, Ventilator etc need to be procured and made available in patients care areas.
- The knowledge and practices about BMW management are rudimentary and need repeated training and monitoring.
- Staff need to be trained in BLS/ACLS and their training records needs to be documented.
- Required medicines, equipments and communication system need to be procured for ambulance.
- UHID need to be generated for all the patients.
- Hospital need to procure license for AERB (SITE/TYPE approval).
- Admission process and Transfer IN/OUT system of the Hospital should be known to the staff.
- Maintenance and calibration of equipments should be done.
- Elbow taps are to be fixed in wash basins in all patient care areas.
- Fire fighting system and temperature monitoring devices need to be procured for some departments.
- Quality assurance programme need to be documented and implemented.
- Staff should be provided Bio-Medical Engineering department need to be constructed which should be managed by qualified Bio-Medical Engineer.
- Various licenses necessary for the hospital need to be procured.
- Separate store need to be constructed for storage of items.
- Adequate space for X-ray Department needs to be made available to cater the demand.
- Segregation and disinfection of the contaminated linen should be done properly in Laundry.

- Security staff need to be appointed.
- Quality indicators of all departments should be monitored.
- Proper infection Control programme and practices should be followed in the hospital.
- All the policies and procedures required in the hospital need to be documented.
- Adequate number of Nursing staff need to be appointed to deliver quality service.
- All the sanctioned posts should be filled up with qualified staff.
- Radiation Safety devices such as TLD batches, thyroid shield etc. Need to be procured and made available to the staff.
- Pharmacy store and Medical Record department should be constructed in adequate space.

CONCLUSION

The analysis shows that there are gaps in the hospital as per NABH norms. Documentation and implementation of almost all policies and procedures is required. As the hospital wishes for NABH accreditation so it must be prepared according to the evaluation criteria for assessment. There are different stages of accreditation which needs to be fulfilled by the organization. As of now the hospital does not fulfil the criteria for entry level as no chapter has scored more than 2. We conducted gap analysis to analyze the present status of the hospital and concluded that the hospital is not even at entry level and need to implement changes so that every standard should score at least 5. Thus the hospital is presently not prepared for pre – assessment and requires great effort and focus on the weak points so as to cover the gaps and to be prepared for getting NABH accreditation

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- **Di Mclntyre and Laura Anselmi**, Health Economics Unit, School of Public Health and Family,Medicine

ANNEXURE

Self Assessment Toolkit

Elements		Documentation (Yes/ No)	Implementation (Yes/ No)	Scores (0/5/10)
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.	N	Y	5
b	The defined services are prominently displayed.	N	N	0
c	The staff is oriented to these services.	N	Y	5
Average Score				3.3
AAC.2: The organization has a well-defined registration and admission process.				
a	Documented policies and procedures are used for registering and admitting patients.	N	N	0
b	The documented procedures address out-patients, in-patients and emergency patients.	N	Y	5
c	A unique identification number is generated at the end of registration.	N	N	0
d	Patients are accepted only if the organization can provide the required service.	N	Y	5
e	The documented policies and procedures also address managing patients during non-availability of beds.	N	N	0
f	The staff is aware of these processes.	N	N	0
Average Score				1.667
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.	N	N	0
b	Documented policies and procedures guide the transfer-out/referral of unstable patients to another facility in an appropriate manner.	N	N	0
c	Documented policies and procedures guide the transfer-out/referral of stable patients to another facility in an appropriate manner.	N	N	0
d	The documented procedures identify staff responsible during transfer/referral	N	N	0
e	The organization gives a summary of patient's condition and the treatment given	N	N	0
Average Score				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	N	Y	5
b	The organization determines who can perform the initial assessment.	N	Y	5
c	The organization defines the time frame within which the initial assessment is completed based on patient's needs	N	N	0
d	The initial assessment for in-patients is documented within 24 hours or earlier as per the patient's condition as defined in the organization's policy	N	N	0
e	Initial assessment of in-patients includes nursing assessment which is done at the time of admission and documented.	N	Y	5
f	Initial assessment includes screening for nutritional needs	N	N	0
g	The initial assessment results in a documented plan of care	N	N	0
h	The plan of care also includes preventive aspects of the care where appropriate	N	N	0
i	The plan of care is countersigned by the clinician in-charge of the patient within 24 hours.	N	N	0
j	The plan of care includes goals or desired results of the treatment, care or service	N	Y	5
Average Score				2
AAC.5: Patients cared for by the organization undergo a regular reassessment				
a	Patients are reassessed at appropriate intervals.	N	Y	5
b	Out-patients are informed of their next follow up where appropriate.	N	Y	5
c	For in-patients during reassessment the plan of care is monitored and modified where found necessary.	N	Y	5
d	Staff involved in direct clinical care document reassessments.	N	N	0
e	Patients are reassessed to determine their response to treatment and to plan further treatment or discharge.	N	Y	5
Average Score				4
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.	N	Y	5
b	The infrastructure (physical and manpower) is adequate to provide for its defined scope of services.	N	Y	5

c	Adequately qualified and trained personnel perform, supervise and interpret the investigations.	N	Y	5
d	Documented procedures guide ordering of tests, collection, identification, handling, safe transportation, processing and disposal of specimens.	N	N	0
e	Laboratory results are available within a defined time frame.	N	Y	5
f	Critical results are intimated immediately to the concerned personnel.	N	N	0
g	Results are reported in a standardized manner.	Y	Y	10
h	Laboratory tests not available in the organization are outsourced to organization(s) based on their quality assurance system.	N	N	0
Average Score				3.75
AAC.7:There is an established laboratory quality assurance programme				
a	The laboratory quality assurance programme is documented.	N	N	0
b	The programme addresses verification and/or validation of test methods.	N	N	0
c	The programme addresses surveillance of test results.	N	N	0
d	The programme includes periodic calibration and maintenance of all equipment.	N	N	0
e	The programme includes the documentation of corrective and preventive actions.	N	N	0
Average Score				0
AAC.8: There is an established laboratory safety programme.				
a	The laboratory safety programme is documented.	N	N	0
b	This programme is aligned with the organization's safety programme.	N	N	0
c	Written procedures guide the handling and disposal of infectious and hazardous materials.	N	N	0
d	Laboratory personnel are appropriately trained in safe practices.	N	Y	5
e	Laboratory personnel are provided with appropriate safety equipment / devices.	N	Y	5
Average Score				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.	N	Y	5
b	Scope of the imaging services are commensurate to the services provided by the	N	Y	5

	organization.			
c	The infrastructure (physical and manpower) is adequate to provide for its defined scope of services.	N	Y	5
d	Adequately qualified and trained personnel perform, supervise and interpret the investigations.	N	Y	5
e	Documented policies and procedures guide identification and safe transportation of patients to imaging services.	N	N	0
f	Imaging results are available within a defined time frame.	N	Y	5
g	Critical results are intimated immediately to the concerned personnel.	N	Y	5
h	Results are reported in a standardized manner.	N	Y	5
i	Imaging tests not available in the organization are outsourced to organization(s) based on their quality assurance system.	N	N	0
Average Score				3.889
AAC.10: There is an established Quality assurance programme for imaging services.				
a	The quality assurance programme for imaging services is documented.	N	N	0
b	The programme addresses verification and/or validation of imaging methods.	N	N	0
c	The programme addresses surveillance of imaging results.	N	N	0
d	The programme includes periodic calibration and maintenance of all equipment.	N	N	0
e	The programme includes the documentation of corrective and preventive actions.	N	N	0
Average Score				0
AAC.11: There is an established radiation safety programme.				
a	The radiation safety programme is documented.	N	N	0
b	This programme is aligned with the organization's safety programme.	N	N	0
c	Handling, usage and disposal of radio-active and hazardous materials is as per statutory requirements.	N	N	0
d	Imaging personnel are provided with appropriate radiation safety devices.	N	Y	5
e	Radiation safety devices are periodically tested and results documented.	N	N	0
f	Imaging personnel are trained in radiation safety measures.	N	N	0
g	Imaging signage are prominently displayed in	N	Y	5

	all appropriate locations.			
Average Score				1.428
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.	N	Y	5
b	Care of patients is coordinated in all care settings within the organization.	N	Y	5
c	Information about the patient's care and response to treatment is shared among medical, nursing and other care providers.	N	N	0
d	Information is exchanged and documented during each staffing shift, between shifts, and during transfers between units/departments.	N	N	0
e	Transfers between departments/units are done in a safe manner.	N	N	0
f	The patient's record (s) is available to the authorized care providers to facilitate the exchange of information.	N	Y	5
g	Documented procedures guide the referral of patients to other departments/ specialties.	N	N	0
Average Score				2.5
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.	N	Y	5
b	Documented procedures exist for coordination of various departments and agencies involved in the discharge process (including medico-legal and absconded cases).	N	N	0
c	Documented policies and procedures are in place for patients leaving against medical advice and patients being discharged on request	N	N	0
d	A discharge summary is given to all the patients leaving the organization (including patients leaving against medical advice and on request).	N	Y	5
Average Score				2.5
AAC.14: Organization defines the content of the discharge summary.				
a	Discharge summary is provided to the patients at the time of discharge.	N	Y	5
b	Discharge summary contains the patient's name, unique identification number, date of admission and date of discharge.	N	Y	5
c	Discharge summary contains the reasons for admission, significant findings and diagnosis and the patient's condition at the time of discharge.	N	Y	5

d	Discharge summary contains information regarding investigation results, any procedure performed, medication administered and other treatment given.	N	N	0
e	Discharge summary contains follow up advice, medication and other instructions in an understandable manner.	N	N	0
f	Discharge summary incorporates instructions about when and how to obtain urgent care.	N	N	0
g	In case of death, the summary of the case also includes the cause of death.			5
Average Score				2.857
Average Score for AAC				2.493
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.	N	Y	5
b	Uniform care is guided by documented policies and procedures	N	N	0
c	These reflect applicable laws, regulations and guidelines	N	Y	5
d	The organization adapts evidence based medicine and clinical practice guidelines to guide uniform patient care.	N	Y	5
Average Score				3.75
COP.2: Emergency services are guided by documented policies, procedures, applicable laws and regulations.				
a	Policies and procedures for emergency care are documented and are in consonance with statutory requirements.	N	N	0
b	This also addresses handling of medico-legal cases.	N	Y	5
c	The patients receive care in consonance with the policies.	N	N	0
d	Documented policies and procedures guide the triage of patients for initiation of appropriate care	N	N	0
e	Staff are familiar with the policies and trained on the procedures for care of emergency patients.	N	N	0
f	Admission or discharge to home or transfer to another organization is also documented.	N	N	0
g	In case of discharge to home or transfer to another organization a discharge note shall be given to the patient.	N	N	0
Average Score				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).	N	Y	5
b	The ambulance adheres to statutory requirements.	N	Y	5
c	Ambulance(s) is appropriately equipped.	N	N	0
d	Ambulance(s) is manned by trained personnel.	N	Y	5
e	Ambulance (s) is checked on a daily basis.	N	N	0
f	Equipment are checked on a daily basis using a checklist.	N	N	0
g	Emergency medications are checked daily and prior to dispatch using a checklist.	N	N	0
h	The ambulance(s) has a proper communication system.	Y	Y	10
Average Score				3.125
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	N	N	0
b	Staff providing direct patient care are trained and periodically updated in cardio pulmonary resuscitation.	N	N	0
c	The events during a cardio-pulmonary resuscitation are recorded.	N	N	0
d	A post-event analysis of all cardio-pulmonary resuscitations is done by a multidisciplinary committee.	N	N	0
e	Corrective and preventive measures are taken based on the post-event analysis.	N	N	0
Average Score				0
COP.5: Documented policies and procedures guide nursing care.				
a	There are documented policies and procedures for all activities of the Nursing Services.	N	N	0
b	These reflect current standards of nursing services and practice, relevant regulations and the purposes of the services.	N	Y	5
c	Assignment of patient care is done as per current good practice guidelines.	N	Y	5
d	Nursing care is aligned and integrated with overall patient care.	N	Y	5
e	Care provided by nurses is documented in the patient record.	N	Y	5
f	Nurses are provided with adequate equipment for providing safe and efficient nursing services.	N	Y	5

g	Nurses are empowered to take nursing related decisions to ensure timely care of patients.	N	N	0
Average Score				3.5714
COP.6: Documented procedures guide the performance of various procedures.				
a	Documented procedures are used to guide the performance of various clinical procedures.	N	N	0
b	Only qualified personnel order, plan, perform and assist in performing procedures.	N	Y	5
c	Documented procedures exist to prevent adverse events like wrong site, wrong patient and wrong procedure.	N	N	0
d	Informed consent is taken by the personnel performing the procedure where applicable.	N	Y	5
e	Adherence to standard precautions and asepsis is adhered to during the conduct of the procedure.	N	N	0
f	Patients are appropriately monitored during and after the procedure.	N	Y	5
g	Procedures are documented accurately in the patient record.	N	N	0
Average Score				2.14
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.	Y	Y	10
b	Documented procedures govern transfusion of blood and blood products.	N	Y	5
c	The transfusion services are governed by the applicable laws and regulations.	N	Y	5
d	Informed consent is obtained for donation and transfusion of blood and blood products.	N	Y	5
e	Informed consent also includes patient and family education about donation.	N	Y	5
f	The organization defines the process for availability and transfusion of blood/blood components for use in emergency.	N	N	0
g	Post transfusion form is collected; reactions if any identified and are analysed for preventive and corrective actions.	N	Y	5
h	Staff are trained to implement the policies.	N	Y	5
Average Score				5
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.	N	N	0
b	The organization has documented admission and discharge criteria for its intensive care and	N	N	0

	high dependency units.			
c	Staff are trained to apply these criteria.	N	N	0
d	Adequate staff and equipment are available.	N	Y	5
e	Defined procedures for situation of bed shortages are followed.	N	Y	5
f	Infection control practices are documented and followed.	N	N	0
g	A quality assurance programme is documented and implemented.	N	N	0
Average Score				1.428
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.	N	N	0
b	Care is organized and delivered in accordance with the policies and procedures.	N	N	0
c	The organization provides for a safe and secure environment for this vulnerable group.	N	N	0
d	A documented procedure exists for obtaining informed consent from the appropriate legal representative.	N	N	0
e	Staff are trained to care for this vulnerable group.	N	N	0
Average Score				0
COP.10: Documented policies and procedures guide obstetric care.				
a	There is a documented policy and procedure for obstetric services.	N	N	0
b	The organization defines and displays whether high risk obstetric cases can be cared for or not.	N	N	0
c	Persons caring for high risk obstetric cases are competent.	N	N	0
d	Documented procedures guide provision of ante-natal services.	N	N	0
e	Obstetric patient's assessment also includes maternal nutrition.	N	N	0
f	Appropriate pre-natal, peri-natal and post-natal monitoring is performed and documented.	N	N	0
g	The organization caring for high risk obstetric cases has the facilities to take care of neonates of such cases.	N	N	0
Average Score				0
COP.11: Documented policies and procedures guide paediatric services.				
a	There is a documented policy and procedure for paediatric services.	N	N	0
b	The organization defines and displays the scope of its paediatric services.	N	N	0

c	The policy for care of neonatal patients is in consonance with the national/ international guidelines.	N	N	0
d	Those who care for children have age specific competency.	N	N	0
e	Provisions are made for special care of children.	N	N	0
f	Patient assessment includes detailed nutritional, growth, psychosocial and immunization assessment.	N	N	0
g	Documented policies and procedures prevent child/neonate abduction and abuse.	N	N	0
h	The children's family members are educated about nutrition, immunization and safe parenting and this is documented in the medical record.	N	N	0
Average Score				0
COP.12: Documented policies and procedures guide the care of patients undergoing moderate sedation.				
a	Documented procedures guide the administration of moderate sedation.	N	N	0
b	Informed consent for administration of moderate sedation is obtained.	N	Y	5
c	Competent and trained persons perform sedation.	Y	Y	10
d	The person administering and monitoring sedation is different from the person performing the procedure.	N	Y	5
e	Intra-procedure monitoring includes at a minimum the heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation, and level of sedation.	N	Y	5
f	Patients are monitored after sedation and the same documented.	N	N	0
g	Criteria are used to determine appropriateness of discharge from the recovery area.	N	N	0
h	Equipment and manpower are available to manage patients who have gone into a deeper level of sedation than initially intended.	N	Y	5
Average Score				3.75
COP.13: Documented policies and procedures guide the administration of anaesthesia.				
a	There is a documented policy and procedure for the administration of anaesthesia.	N	N	0
b	Patients for anaesthesia have a pre-anaesthesia assessment by a qualified anaesthesiologist.	N	Y	5
c	The pre-anaesthesia assessment results in formulation of an anaesthesia plan which is documented	N	Y	5
d	An immediate pre-operative re-evaluation is	N	Y	5

	performed and documented.			
e	Informed consent for administration of anaesthesia is obtained by the anaesthesiologist.	N	Y	5
f	During anaesthesia monitoring includes regular recording of temperature, heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation and end tidal carbon dioxide.	N	Y	5
g	Patient's post-anaesthesia status is monitored and documented.	N	N	0
h	The anaesthesiologist applies defined criteria to transfer the patient from the recovery area.	N	N	0
i	The type of anaesthesia and anaesthetic medications used are documented in the patient record.	N	N	0
j	Procedures shall comply with infection control guidelines to prevent cross infection between patients.	N	N	0
k	Adverse anaesthesia events are recorded and monitored.	N	N	0
Average Score				2.2727
COP.14: Documented policies and procedures guide the care of patients undergoing surgical procedures.				
a	The policies and procedures are documented.	N	N	0
b	Surgical patients have a preoperative assessment and a provisional diagnosis documented prior to surgery.	N	Y	5
c	An informed consent is obtained by a surgeon prior to the procedure.	N	Y	5
d	Documented policies and procedures exist to prevent adverse events like wrong site, wrong patient and wrong surgery.	N	N	0
e	Persons qualified by law are permitted to perform the procedures that they are entitled to perform.	N	Y	5
f	A brief operative note is documented prior to transfer out of patient from recovery area.	N	N	0
g	The operating surgeon documents the post-operative plan of care.	N	Y	5
h	Patient, personnel and material flow conforms to infection control practices.	N	N	0
i	Appropriate facilities and equipment/appliances/instrumentation are available in the operating theatre.	N	N	0
j	A quality assurance programme is followed for the surgical services.	N	N	0
k	The quality assurance programme includes surveillance of the operation theatre environment.	N	N	0

Average Score				1.818
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.	N	N	0
b	These include both physical and chemical restraint measures.	N	Y	5
c	These include documentation of reasons for restraints.	N	N	0
d	These patients are more frequently monitored.	N	Y	5
e	Staff receive training and periodic updating in control and restraint techniques.	N	N	0
Average Score				2
COP.16: Documented policies and procedures guide appropriate pain management.				
a	Documented policies and procedures guide the management of pain.	N	N	0
b	All patients are screened for pain.	N	N	0
c	Patients with pain undergo detailed assessment and periodic re-assessment.	N	N	0
d	The organization respects and supports management of pain for such patients.	N	N	0
e	Patient and family are educated on various pain management techniques where appropriate.	N	N	0
Average Score				0
COP.17: Documented policies and procedures guide appropriate rehabilitative services.				
a	Documented policies and procedures guide the provision of rehabilitative services.	N	N	0
b	These services are commensurate with the organizational requirements.	N	N	0
c	Care is guided by functional assessment and periodic re-assessment which is done and documented by qualified individual (s).	N	N	0
d	Care is provided adhering to infection control and safe practices.	N	N	0
e	Rehabilitative services are provided by a multidisciplinary team.	N	N	0
f	There is adequate space and equipment to perform these activities.	N	N	0
Average Score				0
COP.18: Documented policies and procedures guide all research activities.				
a	Documented policies and procedures guide all research activities in compliance with national and international guidelines.	N	N	0
b	The organization has an ethics committee to	N	N	0

	oversee all research activities.			
c	The committee has the powers to discontinue a research trial when risks outweigh the potential benefits.	N	N	0
d	Patient's informed consent is obtained before entering them in research protocols.	N	N	0
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	N	0
f	Patients are assured that their refusal to participate or withdrawal from participation will not compromise their access to the organization's services.	N	N	0
Average Score				0
COP.19: Documented policies and procedures guide nutritional therapy.				
a	Documented policies and procedures guide nutritional assessment and reassessment.	N	N	0
b	Patients receive food according to their clinical needs.	N	N	0
c	There is a written order for the diet.	N	N	0
d	Nutritional therapy is planned and provided in a collaborative manner.	N	N	0
e	When families provide food, they are educated about the patient's diet limitations.	N	N	0
f	Food is prepared, handled, stored and distributed in a safe manner.	N	N	0
Average Score				0
COP.20: Documented policies and procedures guide the end of life care.				
a	Documented policies and procedures guide the end of life care.	N	N	0
b	These policies and procedures are in consonance with the legal requirements.	N	N	0
c	These also address the identification of the unique needs of such patient and family.	N	N	0
d	Symptomatic treatment is provided and where appropriate measures are taken for alleviation of pain.	N	N	0
e	Staff are educated and trained in end of life care.	N	N	0
Average Score				0
AVERAGE SCORE FOR COP				1.478
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	Y	Y	10

	for pharmacy services and medication usage.			
b	These comply with the applicable laws and regulations.	N	Y	5
c	A multidisciplinary committee guides the formulation and implementation of these policies and procedures.	N	N	0
d	There is a procedure to obtain medication when the pharmacy is closed.*	N	Y	5
Average Score				5
MOM.2. There is a hospital formulary.				
a	A list of medications appropriate for the patients and as per the scope of the organization's clinical services is developed.	N	Y	5
b	The list is developed and updated collaboratively by the multidisciplinary committee.	N	N	0
c	The formulary is available for clinicians to refer and adhere to.	N	N	0
d	There is a defined process for acquisition of these medications	N	N	0
e	There is a process to obtain medications not listed in the formulary.	N	N	0
Average Score				1
MOM.3: Documented policies and procedures guide the storage of medication				
a	Documented policies and procedures exist for storage of medication	N	Y	5
b	Medications are stored in a clean; safe and secure environment; and incorporating manufacturer's recommendation (s).	N	Y	5
c	Sound inventory control practices guide storage of the medications.	Y	Y	10
d	Sound alike and look alike medications are identified and stored separately.*	N	N	0
e	The list of emergency medications is defined and is stored in a uniform manner	N	Y	5
f	Emergency medications are available all the time.	N	Y	5
g	Emergency medications are replenished in a timely manner when used.	N	Y	5
Average Score				5
MOM.4: Documented policies and procedures guide the safe and rational prescription of medications				
a	Documented policies and procedures exist for prescription of medications.	N	N	0
b	These incorporate inclusion of good practices/guidelines for rational prescription of medications.	N	N	0
c	The organization determines the minimum	N	N	0

	requirements of a prescription.			
d	Known drug allergies are ascertained before prescribing.	N	N	0
e	The organization determines who can write orders.*	Y	Y	10
f	Orders are written in a uniform location in the medical records.	N	N	0
g	Medication orders are clear, legible, dated, timed, named and signed.	N	Y	5
h	Medication orders contain the name of the medicine, route of administration, dose to be administered and frequency/time of administration.	N	Y	5
i	Documented policy and procedure on verbal orders is implemented.	N	N	0
j	The organization defines a list of high risk medication (s).	N	N	0
k	Audit of medication orders/prescription is carried out to check for safe and rational prescription of medications.	N	N	0
l	Corrective and/or preventive action (s) is taken based on the analysis where appropriate.	N	N	0
Average Score				1.667
MOM.5: Documented policies and procedures guide the safe dispensing of medications.				
a	Documented policies and procedures guide the safe dispensing of medications	N	N	0
b	The procedure addresses medication recall.	N	Y	5
c	Expiry dates are checked prior to dispensing.	N	Y	5
d	There is a procedure for near expiry medications.	N	Y	5
e	Labelling requirements are documented and implemented by the organization.	N	Y	5
f	High risk medication orders are verified prior to dispensing.	N	N	0
Average Score				3.333
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.	N	N	0
b	Prepared medication is labelled prior to preparation of a second drug.	N	N	0
c	Patient is identified prior to administration.	N	N	0
d	Medication is verified from the order prior to administration.	N	Y	5
e	Dosage is verified from the order prior to administration.	N	Y	5
f	Route is verified from the order prior to administration.	N	Y	5
g	Timing is verified from the order prior to	N	Y	5

	administration.			
h	Medication administration is documented.	N	N	5
i	Documented policies and procedures govern patient's self- administration of medications.	N	N	0
j	Documented policies and procedures govern patient's medications brought from outside the organization.*	N	N	0
Average Score				2.5
MOM.7: Patients are monitored after medication administration.				
a	Documented policies and procedures guide the monitoring of patients after medication administration.	N	N	0
b	The organization defines those situations where close monitoring is required.*	N	N	0
c	Monitoring is done in a collaborative manner.	N	N	0
d	Medications are changed where appropriate based on the monitoring.	N	N	0
Average Score				0
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.	N	N	0
b	Near miss, medication error and adverse drug event are defined.	N	N	0
c	These are reported within a specified time frame.	N	N	0
d	They are collected and analysed.	N	N	0
e	Corrective and/or preventive action (s) is taken based on the analysis where appropriate.	N	N	0
Average Score				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.			
b	These drugs are stored in a secure manner.			
c	A proper record is kept of the usage, administration and disposal of these drugs.			
d	These drugs are handled by appropriate personnel in accordance with the documented procedure.			
Average Score				NA
MOM.10: Documented policies and procedures guide the usage of chemotherapeutic agents.				
a	Documented policies and procedures guide the usage of chemotherapeutic agents.			

b	Chemotherapy is prescribed by those who have the knowledge to monitor and treat the adverse effect of chemotherapy.			
c	Chemotherapy is prepared in a proper and safe manner and administered by qualified personnel.			
d	Chemotherapy drugs are disposed off in accordance with legal requirements.			
Average Score				NA
MOM.11: Documented policies and procedures govern usage of radioactive drugs.				
a	Documented policies and procedures govern usage of radioactive drugs.			
b	These policies and procedures are in consonance with laws and regulations.			
c	The policies and procedures include the safe storage, preparation, handling, distribution and disposal of radioactive drugs.			
d	Staff, patients and visitors are educated on safety precautions.			
Average Score				NA
MOM.12: Documented policies and procedures guide the use of implantable prosthesis and medical devices.				
a	Usage of implantable prosthesis and medical devices is guided by scientific criteria for each individual item and national / international recognized guidelines / approvals for such specific item(s).	N	N	0
b	Documented policies and procedures govern procurement, storage / stocking, issuance and usage of implantable prosthesis and medical devices incorporating manufacturer's recommendation(s).*	N	N	0
c	Patient and his / her family are counselled for the usage of implantable prosthesis and medical device including precautions, if any.	N	N	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.	N	Y	5
Average Score				1.25
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.	N	N	0
b	Medical supplies and consumables are used in a safe manner where appropriate.	N	Y	5
c	Medical supplies and consumables are stored in a clean; safe and secure environment; and	N	Y	5

	incorporating manufacturer's recommendation (s).			
d	Sound inventory control practices guide storage of medical supplies and consumables.	N	Y	5
Average Score				3.75
AVERAGE SCORE FOR MOM				1.807
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.	N	N	0
b	Patients and families are informed of their rights and responsibilities in a format and language that they can understand.	N	N	0
c	The organization's leaders protect patient and family rights.	N	N	0
d	Staff is aware of their responsibility in protecting patient and family rights.	N	N	0
e	Violation of patient and family rights is recorded, reviewed and corrective / preventive measures taken.	N	N	0
Average Score				0
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.	N	Y	5
b	Patient and family rights include respect for personal dignity and privacy during examination, procedures and treatment.	N	Y	5
c	Patient and family rights include protection from physical abuse or neglect.	N	Y	5
d	Patient and family rights include treating patient information as confidential.	N	N	0
e	Patient and family rights include refusal of treatment.	N	N	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.	N	N	0
g	Patient and family rights include right to complain and information on how to voice a complaint.	N	N	0
h	Patient and family rights include information	N	N	0

	on the expected cost of the treatment.			
i	Patient and family rights include access to his / her clinical records.	N	N	0
j	Patient and family rights include information on plan of care, progress and information on their health care needs.	N	N	0
Average Score				1.5
PRE.3: The patient and/ or family members are educated to make informed decisions and are involved in the care planning and delivery process.				
a	The patient and/or family members are explained about the proposed care including the risks, alternatives and benefits.	N	N	0
b	The patient and/or family members are explained about the expected results.	N	N	0
c	The patient and / or family members are explained about the possible complications.	N	N	0
d	The care plan is prepared and modified in consultation with patient and/or family members.	N	N	0
e	The care plan respects and where possible incorporates patient and/or family concerns and requests.	N	N	0
f	The patient and/or family members are informed about the results of diagnostic tests and the diagnosis	N	N	0
g	The patient and/or family members are explained about any change in the patient's condition.	N	N	0
Average Score				0
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.	N	N	0
b	General consent for treatment is obtained when the patient enters the organization.	N	N	0
c	Patient and/or his family members are informed of the scope of such general consent.	N	N	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.	N	N	0
e	The procedure describes who can give consent when patient is incapable of independent decision making.	N	N	0
f	Informed consent is taken by the person performing the procedure.	N	Y	5
g	Informed consent process adheres to statutory norms.	N	N	0

h	Staff are aware of the informed consent procedure.	N	Y	5
Average Score				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.	N	Y	5
b	Patient and/or family are educated about food-drug interactions.	N	N	0
c	Patient and/or family are educated about diet and nutrition.	N	Y	5
d	Patient and/or family are educated about immunizations.	N	Y	5
e	Patient and/or family are educated about organ donation, when appropriate.	N	Y	5
f	Patient and/or family are educated about their specific disease process, complications and prevention strategies.	N	N	0
g	Patient and/or family are educated about preventing healthcare associated infections.	N	N	0
h	Patient and/or family are educated in a language and format that they can understand.	Y	Y	10
				3.75
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).	N	Y	5
b	The tariff list is available to patients.	N	Y	5
c	The patient and/or family members are explained about the expected costs.	N	N	0
d	Patient and/or family are informed about the financial implications when there is a change in the patient condition or treatment setting.	N	N	0
Average Score				2.5
PRE.7: Organization has a complaint redressal procedure.				
a	The organization has a documented complaint redressal procedure.	N	N	0
b	Patient and/or family members are made aware of the procedure for lodging complaints.	N	N	0
c	All complaints are analysed.	N	N	0
d	Corrective and/or preventive action (s) is taken based on the analysis where appropriate.	N	N	0
Average Score				0
AVERAGE SCORE FOR PRE				1.285
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.	N	N	0
b	The infection prevention and control programme is a continuous process and updated at least once in a year.	N	N	0
c	The hospital has a multi-disciplinary infection control committee which co-ordinates all infection prevention and control activities.	N	N	0
d	The hospital has an infection control team which co-ordinates implementation of all infection prevention and control activities.	N	N	0
e	The hospital has designated infection control officer as part of the infection control team.	N	N	0
f	The hospital has designated infection control nurse(s) as part of the infection control team.	N	N	0
Average Score				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	N	N	0
b	The organization adheres to standard precautions at all times.	N	Y	5
c	The organization adheres to hand hygiene guidelines.	N	Y	5
d	The organization adheres to safe injection and infusion practices.	N	N	0
e	The organization adheres to transmission based precautions at all times.	N	N	0
f	The organization adheres to cleaning, disinfection and sterilization practices	N	Y	5
g	An appropriate antibiotic policy is established and implemented.	N	N	0
h	The organization adheres to laundry and linen management processes.	N	Y	5
i	The organization adheres to kitchen sanitation and food handling issues.	N	N	0
j	The organization has appropriate engineering controls to prevent infections.	N	N	0
k	The organization adheres to housekeeping procedures.	N	Y	5
Average Score				2.272
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.	N	N	0
b	Collection of surveillance data is an on-going process.	N	N	0
c	Verification of data is done on a regular basis by the infection control team.	N	N	0
d	Scope of surveillance activities incorporates tracking and analyzing of infection risks, rates and trends.	N	N	0
e	Surveillance activities include monitoring the compliance with hand hygiene guidelines.	N	N	0
f	Surveillance activities include monitoring the effectiveness of housekeeping services.	N	N	0
g	Appropriate feedback regarding HAI rates are provided on a regular basis to appropriate personnel.	N	N	0
h	In cases of notifiable diseases, information (in relevant format) is sent to appropriate authorities.	N	N	0
Average Score				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.	N	N	0
b	The organization takes action to prevent respiratory tract infections.	N	N	0
c	The organization takes action to prevent intra-vascular device infections.	N	N	0
d	The organization takes action to prevent surgical site infections.	N	N	0
Average Score				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.	Y	Y	10
b	Adequate and appropriate facilities for hand hygiene in all patient care areas are accessible to health care providers.	Y	Y	10
c	Isolation / barrier nursing facilities are available.	N	N	0
d	Appropriate pre and post exposure prophylaxis is provided to all concerned staff members.	N	N	0
Average Score				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.	N	N	0
b	Organization has a documented procedure for handling such outbreaks.	N	N	0
c	This procedure is implemented during outbreaks.	N	N	0
d	After the outbreak is over appropriate corrective actions are taken to prevent recurrence.	N	N	0
Average Score				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.	N	N	0
b	Documented procedure guides the cleaning, packing, disinfection and/or sterilization, storing and issue of items.	N	N	0
c	Reprocessing of instruments and equipment are covered.	N	Y	5
d	Regular validation tests for sterilization are carried out and documented.	N	N	0
e	There is an established recall procedure when breakdown in the sterilization system is identified.	N	N	0
Average Score				1
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.	N	N	0
b	Proper segregation and collection of biomedical waste from all patient care areas of the hospital is implemented and monitored.	N	Y	5
c	The organization ensures that biomedical waste is stored and transported to the site of treatment and disposal in proper covered vehicles within stipulated time limits in a secure manner.	N	Y	5
d	Biomedical waste treatment facility is managed as per statutory provisions (if in-house) or outsourced to authorized contractor(s).	Y	Y	10
e	Appropriate personal protective measures are used by all categories of staff handling biomedical waste.	N	Y	5
Average Score				5
HIC.9: The infection control programme is supported by the management and includes training of staff.				
a	The management makes available resources	N	N	0

	required for the infection control programme.			
b	The organization earmarks adequate funds from its annual budget in this regard.	N	N	0
c	The organization conducts induction training for all staff.	N	N	0
d	The organization conducts appropriate "in-service" training sessions for all staff at least once in a year.	N	N	0
Average Score				0
AVERAGE SCORE FOR HIC				1.474
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.	N	N	0
b	The quality improvement programme is documented.	N	N	0
c	There is a designated individual for coordinating and implementing the quality improvement programme.	N	N	0
d	The quality improvement programme is comprehensive and covers all the major elements related to quality assurance and supports innovation.	N	N	0
e	The designated programme is communicated and coordinated amongst all the staff of the organization through appropriate training mechanism.	N	N	0
f	The quality improvement programme identifies opportunities for improvement based on review at pre-defined intervals.	N	N	0
g	The quality improvement programme is a continuous process and updated at least once in a year.	N	N	0
h	Audits are conducted at regular intervals as a means of continuous monitoring.	N	N	0
i	There is an established process in the organization to monitor and improve quality of nursing and complete patient care.	N	N	0
Average score				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.	N	N	0
b	The patient safety programme is documented.	N	N	0
c	The patient safety programme is comprehensive and covers all the major elements related to patient safety and risk	N	N	0

	management.			
d	The scope of the programme is defined to include adverse events ranging from “no harm” to “sentinel events”.	N	N	0
e	There is a designated individual for coordinating and implementing the patient safety programme.	N	N	0
f	The designated programme is communicated and coordinated amongst all the staff of the organization through appropriate training mechanism.	N	N	0
g	The patient safety programme identifies opportunities for improvement based on review at pre-defined intervals.	N	N	0
h	The patient safety programme is a continuous process and updated at least once in a year.	N	N	0
i	The organization adapts and implements national/international patient safety goals/solutions.	N	N	0
j	The organization uses at least two identifiers to identify patients across the organization.	N	N	0
Average Score				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.	N	N	0
b	Monitoring includes safety and quality control programmes of all the diagnostic services.	N	N	0
c	Monitoring includes medication management.	N	N	0
d	Monitoring includes use of anaesthesia.	N	N	0
e	Monitoring includes surgical services.	N	N	0
f	Monitoring includes use of blood and blood products.	N	N	0
g	Monitoring includes infection control activities.	N	N	0
h	Monitoring includes review of mortality and morbidity indicators.	N	N	0
i	Monitoring includes clinical research.	N	N	0
j	Monitoring includes data collection to support further improvements.	N	N	0
k	Monitoring includes data collection to support evaluation of these improvements.	N	N	0
Average Score				0
CQI.4: The organization identifies key indicators to monitor the managerial structures, processes and outcomes which are used as tools for continual improvement.				
a	Monitoring includes procurement of medication essential to meet patient needs.	N	N	0
b	Monitoring includes risk management.	N	N	0
c	Monitoring includes utilisation of space,	N	N	0

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

	communicated to staff.			
Average Score				0
CQI.8: Sentinel events are intensively analyzed.				
a	The organization has defined sentinel events.	N	N	0
b	The organization has established processes for intense analysis of such events.	N	N	0
c	Sentinel events are intensively analyzed when they occur.	N	N	0
d	Corrective and Preventive Actions are taken based on the findings of such analysis.	N	N	0
Average Score				0
AVERAGE SCORE FOR CQI				0
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.	N	N	0
b	Those responsible for governance approve the strategic and operational plans and organization's budget.	N	Y	5
c	Those responsible for governance monitor and measure the performance of the organization against the stated mission.	N	N	0
d	Those responsible for governance establish the organization's organogram.	N	Y	5
e	Those responsible for governance appoint the senior leaders in the organization.	N	Y	5
f	Those responsible for governance support safety initiatives and quality improvement plans.	N	N	0
g	Those responsible for governance support research activities.	N	N	0
h	Those responsible for governance address the organization's social responsibility.	N	Y	5
i	Those responsible for governance inform the public of the quality and performance of services.	N	N	0
Average Score				2.22
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.	N	N	0
b	The management ensures implementation of these requirements.	N	N	0
c	Management regularly updates any amendments in the prevailing laws of the land.	N	N	0
d	There is a mechanism to regularly update	N	N	0

	licenses/ registrations/certifications.			
Average Score				0
ROM.3: The services provided by each department are documented.				
a	Scope of services of each department is defined	N	Y	5
b	Administrative policies and procedures for each department are maintained.	N	Y	5
c	Each organizational programme, service, site or department has effective leadership.	N	Y	5
d	Departmental leaders are involved in quality improvement.	N	N	0
Average Score				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.	N	N	0
b	The leaders establish the organization's ethical management.	N	N	0
c	The organization discloses its ownership.	N	N	0
d	The organization honestly portrays the services which it can and cannot provide.	N	N	0
e	The organization honestly portrays its affiliations and accreditations.	N	N	0
f	The organization accurately bills for its services based upon a standard billing tariff.	N	N	0
Average Score				0
ROM.5: The organization displays professionalism in management of affairs.				
a	The person heading the organization has requisite and appropriate administrative qualifications.	Y	Y	10
b	The person heading the organization has requisite and appropriate administrative experience.	Y	Y	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.	N	N	0
d	The organization coordinates the functioning with departments and external agencies, and monitors the progress in achieving the defined goals and objectives.	N	N	0
e	The organization plans and budgets for its activities annually.	N	Y	5
f	The performance of the senior leaders is reviewed for their effectiveness.	N	N	0
g	The functioning of committees is reviewed for their effectiveness.	N	N	0

h	The organization documents employee rights and responsibilities.	N	N	0
i	The organization documents the service standards.	N	N	0
j	The organization has a formal documented agreement for all outsourced services.	N	N	0
k	The organization monitors the quality of the outsourced services.	N	N	0
Average Score				2.272
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.	N	N	0
b	Management provides resources for proactive risk assessment and risk reduction activities.	N	N	0
c	Management ensures implementation of systems for internal and external reporting of system and process failures.	N	N	0
d	Management ensures that appropriate corrective and preventive action is taken to address safety related incidents.	N	N	0
Average Score				0
AVERAGE SCORE FOR ROM				1.374
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	N	N	0
b	Patient safety devices are installed across the organization and inspected periodically.	N	N	0
c	The organization is a non-smoking area.	N	N	0
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.	N	N	0
e	Inspection reports are documented and corrective and preventive measures are undertaken.	N	N	0
f	There is a safety education programme for staff.	N	Y	5
Average Score				0.833
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.	N	Y	5
b	Up-to-date drawings are maintained which	N	N	0

	detail the site layout, floor plans and fire escape routes.			
c	There is internal and external sign posting in the organization in a language understood by patient, families and community.	N	Y	5
d	The provision of space shall be in accordance with the available literature on good practices (Indian or International Standards) and directives from government agencies.	N	N	0
e	Potable water and electricity are available round the clock.	N	Y	5
f	Alternate sources for electricity and water are provided as backup for any failure/shortage.	Y	Y	10
g	The organization regularly tests these alternate sources.	N	N	0
h	There are designated individuals responsible for the maintenance of all the facilities.	Y	Y	10
i	There is a documented operational and maintenance (preventive and breakdown) plan.	N	Y	5
j	Maintenance staff is contactable round the clock for emergency repairs.	N	Y	5
k	Response times are monitored from reporting to inspection and implementation of corrective actions.	N	N	0
Average Score				4.090
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.	N	N	0
b	Equipment are selected, rented, updated or upgraded by a collaborative process.	N	N	0
c	Equipment are inventoried and proper logs are maintained as required.	N	N	0
d	Qualified and trained personnel operate and maintain equipment and utility systems.	N	Y	5
e	There is a documented operational and maintenance (preventive and breakdown) plan.	N	N	0
f	There is a maintenance plan for water management.	N	N	0
g	There is a maintenance plan for electrical systems.	N	N	0
h	There is a maintenance plan for heating, ventilation and air-conditioning.	N	N	0
i	There is a documented procedure for equipment replacement and disposal.	N	N	0
Average Score				0.55
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.	N	Y	5
b	Equipment are selected, rented, updated or	N	N	0

	upgraded by a collaborative process.			
c	Equipment are inventoried and proper logs are maintained as required.	N	N	0
d	Qualified and trained personnel operate and maintain the medical equipment.	N	N	0
e	Equipment are periodically inspected and calibrated for their proper functioning.	N	N	0
f	There is a documented operational and maintenance (preventive and breakdown) plan.	N	N	0
g	There is a documented procedure for equipment replacement and disposal.*	N	N	0
Average Score				0.714
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.	N	N	0
b	Medical gases are handled, stored, distributed and used in a safe manner.	N	Y	5
c	The procedures for medical gases address the safety issues at all levels.	N	Y	5
d	Alternate sources for medical gases, vacuum and compressed air are provided for, in case of failure.	N	N	0
e	The organization regularly tests these alternate sources.	N	N	0
f	There is an operational and maintenance plan for piped medical gas, compressed air and vacuum installation.*	N	Y	5
Average Score				2.5
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.	N	N	0
b	The organization has a documented safe exit plan in case of fire and non-fire emergencies.	N	N	0
c	Staff are trained for their role in case of such emergencies	N	N	0
d	Mock drills are held at least twice in a year.	N	N	0
e	There is a maintenance plan for fire related equipment.	N	N	0
Average Score				0
FMS.7: The organization plans for handling community emergencies, epidemics and other disasters.				
a	The organization identifies potential emergencies.	N	Y	5
b	The organization has a documented disaster management plan.	N	N	0
c	Provision is made for availability of medical	N	Y	5

	supplies, equipment and materials during such emergencies.			
d	Staff are trained in the hospital's disaster management plan.	N	N	0
e	The plan is tested at least twice in a year.	N	N	0
Average Score				2
FMS.8: The organization has a plan for management of hazardous materials.				
a	Hazardous materials are identified within the organization.	N	N	0
b	The organization implements processes for sorting, labelling, handling, storage, transporting and disposal of hazardous material.	N	N	0
c	Requisite regulatory requirements are met in respect of radioactive materials.	N	N	0
d	There is a plan for managing spills of hazardous materials.	N	N	0
e	Staff are educated and trained for handling such materials.	N	N	0
Average Score				0
AVERAGE SCORE FOR FMS				1.336
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.	N	N	0
b	The organization maintains an adequate number and mix of staff to meet the care, treatment and service needs of the patient.	N	N	0
c	The required job specification and job description are well defined for each category of staff.	N	N	0
d	The organization verifies the antecedents of the potential employee with regards to criminal/negligence background.	N	N	0
Average Score				0
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.	N	N	0
b	Recruitment is based on pre-defined criteria	N	Y	5
c	Every staff member entering the organization is provided induction training	N	N	0
d	The induction training includes orientation to the organization's vision, mission and values.	N	N	0
e	The induction training includes awareness on	N	N	0

	employee rights and responsibilities.			
f	The induction training includes awareness on patient's rights and responsibilities.	N	N	0
g	The induction training includes orientation to the service standards of the organization.	N	N	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.	N	N	0
Average Score				0/625
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.	N	N	0
b	The organization maintains the training record.	N	N	0
c	Training also occurs when job responsibilities change/ new equipment is introduced.	N	N	0
d	Feedback mechanisms for assessment of training and development programme exist and the feedback is used to improve the training programme.	N	N	0
Average Score				
HRM.4. Staff are adequately trained on various safety related aspects.				
a	Staff are trained on the risks within the organization's environment.	N	N	0
b	Staff members can demonstrate and take actions to report, eliminate / minimize risks.	N	N	0
c	Staff members are made aware of procedures to follow in the event of an incident.	N	N	0
d	Staff are trained on occupational safety aspects.	N	N	0
Average Score				0
HRM.5. An appraisal system for evaluating the performance of an employee exists as an integral part of the human resource management process.				
a	A documented performance appraisal system exists in the organization.*	N	N	0
b	The employees are made aware of the system of appraisal at the time of induction.	N	N	0
c	Performance is evaluated based on the pre-determined criteria.	N	N	0
d	The appraisal system is used as a tool for further development.	N	N	0
e	Performance appraisal is carried out at pre-defined intervals and is documented.	N	N	0
Average Score				0
HRM.6. The organization has documented disciplinary and grievance handling policies and procedures.				
a	Documented policies and procedures exist.	N	N	0

b	The policies and procedures are known to all categories of staff of the organization.	N	N	0
c	The disciplinary policy and procedure is based on the principles of natural justice.	N	N	0
d	The disciplinary procedure is in consonance with the prevailing laws.	N	N	0
e	There is a provision for appeals in all disciplinary cases.	N	N	0
f	The redress procedure addresses the grievance.	N	N	0
g	Actions are taken to redress the grievance.	N	N	0
Average Score				0
HRM.7. The organization addresses the health needs of the employees.				
a	A pre-employment medical examination is conducted on all the employees.	N	N	0
b	Health problems of the employees are taken care of in accordance with the organization's policy.	N	N	0
c	Regular health checks of staff dealing with direct patient care are done at-least once a year and the findings/ results are documented.	N	N	0
d	Occupational health hazards are adequately addressed.	N	N	0
Average Score				0
HRM.8. There is documented personal information for each staff member.				
a	Personal files are maintained in respect of all staff.	N	N	0
b	The personal files contain personal information regarding the staff's qualification, disciplinary background and health status.	N	N	0
c	All records of in-service training and education are contained in the personal files.	N	N	0
d	Personal files contain results of all evaluations.	N	N	0
Average Score				0
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.	N	Y	5
b	The education, registration, training and experience of the identified medical professionals is documented and updated periodically.	N	N	0
c	All such information pertaining to the medical professionals is appropriately verified when possible.	N	N	0
d	Medical professionals are granted privileges to admit and care for patients in consonance with their qualification, training, experience and	Y	Y	10

	registration.			
e	The requisite services to be provided by the medical professionals are known to them as well as the various departments / units of the organization.	N	N	0
f	Medical professionals admit and care for patients as per their privileging.	N	N	0
Average Score				2.5
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.	N	Y	5
b	The education, registration, training and experience of nursing staff is documented and updated periodically.	N	N	0
c	All such information pertaining to the nursing staff is appropriately verified when possible.	N	N	0
d	Nursing staff are granted privileges in consonance with their qualification, training, experience and registration.	Y	Y	10
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.	N	N	0
f	Nursing professionals care for patients as per their privileging.	N	N	0
Average Score				2.5
AVERAGE SCORE FOR HRM				0.562
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.	N	N	0
b	Documented policies and procedures to meet the information needs exist.	N	N	0
c	These policies and procedures are in compliance with the prevailing laws and regulations.	N	N	0
d	All information management and technology acquisitions are in accordance with the documented policies and procedures.	N	N	0
e	The organization contributes to external databases in accordance with the law and regulations.	N	N	0
Average Score				0

IMS.2. The organization has processes in place for effective management of data.				
a	Formats for data collection are standardized.	N	Y	5
b	Necessary resources are available for analysing data.	N	Y	5
c	Documented procedures are laid down for timely and accurate dissemination of data.	N	N	0
d	Documented procedures exist for storing and retrieving data.	N	N	0
e	Appropriate clinical and managerial staff participates in selecting, integrating and using data.	N	N	0
Average Score				2
IMS.3. The organization has a complete and accurate medical record for every patient.				
a	Every medical record has a unique identifier.	N	Y	5
b	Organization policy identifies those authorized to make entries in medical record.	N	N	0
c	Entry in the medical record is named, signed, dated and timed.	N	N	0
d	The author of the entry can be identified.	N	N	0
e	The contents of medical record are identified and documented.	N	N	0
f	The record provides a complete, up-to-date and chronological account of patient care.	N	N	0
g	Provision is made for 24-hour availability of the patient's record to healthcare providers to ensure continuity of care.	N	N	0
Average Score				0.7142
IMS.4. The medical record reflects continuity of care.				
a	The medical record contains information regarding reasons for admission, diagnosis and plan of care.	N	N	0
b	The medical record contains the results of tests carried out and the care provided.	N	N	0
c	Operative and other procedures performed are incorporated in the medical record.	N	N	0
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.	N	N	0
e	The medical record contains a copy of the discharge summary duly signed by appropriate and qualified personnel.	N	N	0
f	In case of death, the medical record contains a copy of the cause of death certificate.	N	N	0
g	Whenever a clinical autopsy is carried out, the medical record contains a copy of the report of the same.	N	N	0
h	Care providers have access to current and past	N	N	0

	medical record.			
Average Score				
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.	N	N	0
b	Documented policies and procedures are in consonance with the applicable laws.	N	N	0
c	The policies and procedure (s) incorporate safeguarding of data/ record against loss, destruction and tampering.	N	N	0
d	The organization has an effective process of monitoring compliance of the laid down policy and procedure.	N	N	0
e	The organization uses developments in appropriate technology for improving confidentiality, integrity and security.	N	N	0
f	Privileged health information is used for the purposes identified or as required by law and not disclosed without the patient's authorization.	N	N	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.*	N	N	0
Average Score				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.	N	N	0
b	The policies and procedures are in consonance with the local and national laws and regulations.	N	N	0
c	The retention process provides expected confidentiality and security.	N	N	0
d	The destruction of medical records, data and information is in accordance with the laid down policy.	N	N	0
Average Score				0
IMS.7. The organization regularly carries out review of medical records.				
a	The medical records are reviewed periodically.	N	N	0
b	The review uses a representative sample based on statistical principles.	N	N	0
c	The review is conducted by identified care providers.	N	N	0
d	The review focuses on the timeliness, legibility	N	N	0

	and completeness of the medical records.			
e	The review process includes records of both active and discharged patients.	N	N	0
f	The review points out and documents any deficiencies in records.	N	N	0
g	Appropriate corrective and preventive measures are undertaken within a defined period of time and are documented.	N	N	0
Average score				0
AVERAGE SCORE FOR IMS				0.452
TOTAL SCORE OF ALL CHAPTERS				**1.22**

CHECKLIST

CHECKLIST FOR NABH

EMERGENCY:

S.No.	CRITERIA	YES/NO
	STRUCTURE	
1.	Whether the triage area is marked separately	No. Space is there but no triage area is marked
2.	Does the Emergency department have a separate entrance?	Yes
3.	Is the Emergency signage visible from the road with proper lighting and signs?	Yes
4.	Is the doctor available round the clock for emergency care of patients?	Yes
5.	Is there a nurse available round the clock for emergency care of patients?	Yes. 2 nurses in each shift
6.	Does the number of trolleys and wheelchairs commensurate to the need?	Yes. 1 wheelchair is there
7.	Does the emergency room retain a list of all staff that contains Name, Contact details, Designation?	Yes
8.	Is Doctor's name and contact number kept posted at all times in the emergency room?	Yes
9.	Is there an appropriate waiting area for the relatives of the patient?	Yes
10.	An appropriately qualified staff member is scheduled to manage triage activities.	No. Triaging is not done.
11.	Is Emergency Crash Cart available?	Yes
12.	Defibrillator	No
13.	Cardiac Monitor	No
14.	Emergency drugs	Yes
15.	Resuscitation bags (i.e. AMBU) of various sizes	Yes
16.	Oral Airways of various sizes	No
17.	Laryngoscope with various blades	No
18.	Laryngoscope replacement batteries and bulbs.	No
19.	Endotracheal tubes of various sizes.	No

PROCESS		
20.	Is there a system to review all imaging by a radiologist within 24 hours	No
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.	No
22.	Security staffs are immediately available when required in the emergency room.	No.
23.	Electrical equipment (e.g. defibrillator) is charged at all times.	Defibrillator is not present.
24.	Is Crash cart checked daily regarding regular testing?	Yes. But not documented.
25.	The documentation from a medico-legal and treatment view point is detailed, professional and accurate.	Yes
26.	Are the separate registers maintained for medico legal cases, discharge, admissions to ward?	Yes
27.	Is BMW segregated and handled properly.	No. BMW practices are not followed.
28.	Is Triaging of the patients done?	No
29.	Does the initial assessment of the patient take place?	Yes
30.	Are the patients attended by attendants when they come or when they are transferred to wards?	Yes
31.	Is staff trained in BLS/ACLS	No
OUTCOME		
32.	Time for initial assessment of emergency patient	No

AMBULANCE:

S. No.	CRITERIA	YES/NO
	STRUCTURE	
1	Adequate communication system exists in ambulance	No
2	Required equipments (stetho, sphygno, suction app, defib, monitor, oxygen cylinder) are available in the ambulance.	No
3	Required medicines are available in the ambulance.	No
4	Is Vehicle license available?	Yes
5	Is driver license present?	Yes
6	Maintenance of the medical gas (oxygen) to 90% of the total capacity.	No
7	Calibration of Equipments present	No
	PROCESS	
8	Is staff trained in BLS	No
9	Is Medication and equipment checklist maintained	No
10	Is infection control practices followed	No

OPD:

S. No.	CRITERIA	YES/NO
	STRUCTURE	
1	Availability of enquiry counter	Yes
2	Availability of registration counter	Yes
3	Availability of separate queue for Differently able.	Yes
4	Availability of designated waiting area with adequate sitting arrangement	Yes
5	Availability of drinking water facility	Yes
6	Availability of separate and functional toilet for differently able.	Yes
7	Availability of fan & lights in waiting area	Yes
8	Is the Scope of services displayed?	No
9	Is citizen charter and Patient charter displayed	No
10	Is list of doctors along with OPD Timings displayed	Yes
11	Are the different OPD rooms numbered	Yes
12	Is there provision of patient privacy in the consultation room	No
13	Is BP apparatus with stethoscope present	Yes
14	Is weighing machine present	Yes
15	Is thermometer present	Yes
16	Is calibration of BP apparatus, weighing machine and thermometer	No
	MANPOWER	
17	Availability of dedicated registration clerk	Yes
18	Availability of nurse to direct patients to specific OPDs	No
	PROCESS	
19	Is UHID generated for all patients	No

20	Is separate registration done for old and new OPD patients	No
21	Is the tariff rates defined and made aware to the patients/ attendant	NA
22	Is patient privacy maintained during consultation time	No
23	Is the staff aware of all the information like Doctors OPD timings, charges etc	Yes
OUTCOME		
24	Monitoring of waiting time	No
25	OPD patient satisfaction survey	No

LABORATORY:

S. No.	CRITERIA	YES/NO
	STRUCTURE	
1	Is laboratory present in hospital?	Yes. In-House
2	Specify the functional units of laboratories present in the hospital	Haemogram, Urea, Sugar, Billirubin etc.
3	Is there continuous water supply to this unit?	Yes
4	Is adequate drainage system present in this unit?	Yes
5	Is there provision for hand washing facility in this unit?	Yes. Hand washing steps are followed.
6	Is there provision of personal protective devices for staff?(if yes mention the name)	Yes. Gloves, Apron are there
7	Is the staff licensed and competent in knowledge and skill?	Yes
8	Is there separate area available for sample collection?	Yes
9	Is pathologist available?	Yes
10	Are BMW bins are present in the department?	Yes. But BMW practices are not followed
11	Is there power back up facility available	Yes
	PROCESS	
12	Is the scope of services defined	Yes
13	Is maintenance of laboratory equipments done?	No
14	Are laboratory equipments calibrated?	No
15	Is laboratory staff aware about the safety precautions while handling samples?	Yes
16	Is laboratory staff taking necessary precautions while handling samples?	Yes
17	Is BMW segregation done as per BMW guidelines?	No

18	Is critical results defined, reported, and documented.	Yes
19	Is surveillance for lab test being carried out	No
20	Is EQAS being monitored	No
21	Laboratory reports are signed by Pathologist.	Yes
22	Is labeling of sample done?	Yes
23	Is time frame defined for dispatching lab reports?	Yes
24	Is turnaround time for lab reports monitored?	No
25	Is MOU available for outsourced tests	NA
26	Is temperature monitoring of refrigerator is done?	No
OUTCOME		
27	Number of reporting errors per 1000 investigations	No
28	% of reports having clinical correlation with provisional diagnosis	No
29	% of adherence to safety precautions	No
30	% of redo's	No

RADIOLOGY & IMAGING:

S. No.	CRITERIA	YES/NO
	STRUCTURE	
1	Is this unit has AERB (SITE/TYPE approval)	No. X-ray room space is not adequate
2	Are basic facilities for staff present? (toilet/drinking water/change room)	Yes
3	Is the staff licensed and competent in knowledge and skill?	Yes
4	Is there a change room available for patients?	Yes
5	TLD badges available (Are they sufficient in number)	No
6	Lead glass available (Are they sufficient in number)	Yes
7	Lead apron available (Are they sufficient in number)	Yes
8	Gonad shield available (Are they sufficient in number)	Yes
9	Thyroid shield available (Are they sufficient in number)	No
10	Is radiologist available?	Yes
11	Is critical results defined, reported, and documented.	Yes
12	Radiation hazard symbol is present	Yes
13	PNDT license is available	Yes
	PROCESS	
14	Is maintenance of radiology equipments done?	Yes
15	Are radiology equipments calibrated?	No
16	Is radiology staff aware about the safety precautions?	Yes. Only Lead Apron

17	Is radiology staff taking safety measures?	Yes
18	Quality Assurance program is followed or not	No
19	Radiology test requisition form is signed by doctor.	Yes
20	Radiology reports are signed by Radiologist.	Yes
21	Is time frame defined for dispatching reports?	Yes
22	Is turnaround time for reports monitored?	No
OUTCOME		
23	Number of reporting errors per 1000 investigations	No
24	% of reports having clinical correlation with provisional diagnosis	No
25	% of adherence to safety precautions	No
26	% of redo's	No

WARDS:

S.NO	CRITERIA	YES/NO
	STRUCTURE	
1	Is Medical Gas Facility available in the ward?	Yes. Centralized gas pipeline
2	Are basic facilities for staffs present (toilet/ drinking water)?	Yes
3	Is needle cutter present in each ward?	Yes
4	Emergency crash cart is present in the ward?	No
5	Color coded BMW bins are present in each ward?	Yes.
6	Is there a nursing station in the ward?	Yes
7	Is there adequate number of nurses in each shift?	Yes
8	Racks are present to store linen?	No
9	Wash basin is present in each ward.	Yes
10	PPE is provided in each ward?	Yes
	PROCESS	
11	Is staff aware of the admission process?	No
12	Does the cleaning of the department take place?	Yes
13	Are the vitals of the patient checked every day?	Yes
14	Administration of medication is done by qualified nurse?	Yes
15	Indent of medicines and other items is placed by nurses regularly?	Yes
16	PPE is used by the nurses?	No
17	Are the BMW segregated at the point of generation?	BMW practices are not followed
18	Does the nurse on duty record the details of the patient in the BHT on a daily basis?	Yes
19	Are the nurses trained in BLS(CPR)	No

20	Is infection control practices being followed	No
21	Is bio medical waste management practice followed	No
22	Is the staff aware about transfer IN/OUT system	No
23	Is cost estimate for treatment provided to the patient/attendant	NA
24	Is discharge process defined and documented?	No

ICU:

S. No	CRITERIA	YES/NO
	STRUCTURE	
1	Is the required equipments available (Crash cart, Defib, oxygen cylinder, multi para monitors, central line connection, ventilator, pulse oximetre, oxygen concentrator	No. Ventilator, Monitor, Crash cart are not present.
2	Qualified and trained nurses available.	Yes
3	Is air condition available	Yes
4	Is fowler's bed available	Yes
	PROCESS	
5	Are the admission and discharge criteria for ICU and high dependency units defined?	No
6	Is the staff trained to apply these criteria?	No
7	Are the infection control practices documented and followed?	No
8	Is the quality assurance programme documented and implemented?	No
9	Procedures for situation of bed shortages are defined and followed?	Policies and procedures are not defined
10	Do the policies and procedures guide the care of patients under restraints?	Policies and procedures are not defined
11	Are the reasons for restraints documented?	No
12	Is the patient under restrain frequently monitored?	No
13	Is the staff aware about the end of life care policy?	Policy is not defined
14	Are the policy for initial assessment and re-assessment of patient documented and present?	Policies and procedures are not defined
15	Does the Initial assessment include screening for nutritional needs?	No. Dietician is there

16	Is the time frame for doing and documenting initial assessment defined?	Policies and procedures are not defined
17	Is the frequency of reassessment defined and followed by the staff?	Policies and procedures are not defined
18	Does the documented policies and procedures on uniform use of resuscitation present?	No
19	Is the staff trained on resuscitation?	No
20	Are the documented policies and procedures for rational use of blood and blood products available?	NA
21	Is the informed consent obtained before donation and transfusion of blood and blood products?	NA
22	Are the patient and family educated about donation?	NA
23	Are the post transfusion reaction monitored and analyzed for preventive and corrective actions?	NA
24	Is the scope of paediatric services defined and displayed?	NA
25	Does who care for children have age specific competency?	No
26	Is there a written order for the diet?	No
27	Is the nutritional therapy planned and provided in a collaborative manner?	No
28	Are emergency medications available all the time and replenished in a timely manner when used?	Yes
29	Are the medication orders written in a uniform location and are clear, legible, dated, timed, named and signed?	Yes
30	Is a written order for high risk medication done?	No
31	Do the policies and procedures guide the monitoring of patients after medication administration?	Policies and procedures are not defined
32	Is the medication administration documented?	Yes

33	Is the policy for patient's medications brought from outside the organization available?	Policies and procedures are not defined
34	Knowledge to pick adverse drug events and reporting of the same?	No
35	Does the policy and procedure guide the use of narcotic drugs and psychotropic substances?	No
36	Are the narcotic drugs stored in a safe manner?	NA
37	Is a proper record kept for the usage, administration and disposal of narcotic drugs?	NA
38	Is the antibiotic policy adhered and followed by the staff?	Policies and procedures are not defined
39	Is the infection control data collected?	No
40	Availability of various HAI rates of that area and action taken report?	Policies and procedures are not defined
41	Is the layout of beds, its spacing, visual privacy appropriate?	Yes
42	Are all the equipments periodically inspected and calibrated?	No
43	Service labels on Equipment and calibration records present?	No
44	Is the Information exchanged and documented during transfers between units/departments?	No
45	Documented procedures guide the referral of patients to other departments/ specialties?	Policies and procedures are not defined
46	Qualified individual identified as responsible for the patient's care?	Yes
47	Is a policy in place for LAMA patients and patients being discharged on request?	No
48	Is the policy for care of vulnerable patients available?	No
49	Does the organization provide a safe and secure environment for the vulnerable patients?	No

50	Is the informed consent obtained by a surgeon prior to the procedure?	Yes
51	Are the instructions for proper hand washing displayed and followed by the staff?	Displayed but staff is not following them
52	Are the adequate PPE like gloves, masks available and used by the staff?	Yes. But Staff is not using them
53	Isolation /Barrier nursing facility available?	No
54	Is the Segregation of bio-medical waste done as per the guidelines?	BMW practices are not followed
55	Is the policy for obtaining consent present?	No
56	Does the procedure describe who can give consent when patient is incapable of independent decision making?	No
OUTCOME		
57	Re intubation rate	No
58	ICU utilization	No

OT:

S. No.	CRITERIA	YES/NO
	STRUCTURE	
1	Is HVAC System present inside OT	No
2	Is proper Zoning concept followed(Clean zone, protective zone, sterile zone, and disposal zone)	No
3	Is the number of OT tables present in the hospital appropriate for the daily load	2 tables are there but are not inadequate
4	If any OT has got more than one OT table	Yes. 2 table sin 1 OT
5	Does the OT have a hand washing facility	Yes. Soap is used
6	Is the fire fighting system available in the unit	Yes
7	Is continuous water available for the unit?	Yes
8	Is the changing room available for the doctors and nurses	Yes
9	Is there a continuous power back up for OT	Yes
10	Does the OT have a crash cart	Yes
11	Does the OT have defibrillator	No
12	Does the OT have an ECG monitor	No
13	Does the OT have oxygen supply	Yes
14	Does the OT have shadow less OT light	Yes
15	Is the staff provided with the personnel protective devices	Yes
16	Is scrubbing area present for the OT staff	Yes
	PROCESS	
17	Is the consent for the surgery and anaesthesia taken from the patient	Yes
18	Is the OT list prepared	Yes

19	Is the OT booking being done	No
20	Is the preparation of patient done before the operation	No
21	Does the nurse enter the patient details in the OT register	Yes
22	Are the number of OT instruments counted before and after operation	Yes. But not documented
[23	Is OT disinfection done after every procedure	No
24	Is the pre anaesthesia check up done by the anaesthetists	Yes
25	Is pre, intra, post operative notes are documented	Yes
26	Is infection control practices being followed in OT	No
27	Is pre operative checklist being followed	Yes
28	Is bio medical waste management practices being followed	No
OUTCOME		
29	Is % of anaesthesia related adverse events being monitored	No
30	% of anaesthesia related mortality	No
31	% of modification in plan of anaesthesia	No
32	% of unplanned ventilation following anaesthesia	No
33	Is % of Surgical site infection rate monitored	No
34	Re Exploration rate	No
35	Re scheduling of surgeries	No

BLOOD BANK:

S. No	CRITERIA	YES/NO
	STRUCTURE	
1	Is the required layout available: (Reception, examination room, bleeding room, refreshment room, blood separation and storage area and doctors room?)	Yes
2	Is power back up available	Yes
3	A full time qualified Blood Bank In-charge manages the blood collection/distribution department.	Yes
4	A couch/cot is provided during venipuncture & the correct equipment for blood agitation/ volume measurement is present	Yes
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	Yes
6	Blood bank signage and schedule of charges are displayed	Yes
7	Blood Bank Technician is present	Yes
8	Nurse is present	Yes
9	All sections have bilingual signage	Only in local language
10	Separate counselling section is present	Yes
	PROCESS	
11	Is bilingual consent for blood donation available	Only in local language
12	If patients are educated and given counselling.	Yes
13	Donors are appropriately screened prior to blood donation.	Yes
14	Evidence is present that blood is cross matched, labelled, recipient identified, compatibility level noted, units dispensed.	Yes

15	Refrigerators, warmers and freezers must have temperature monitoring devices which are monitored daily	Yes
16	A list of all department staff exist and is prominently displayed	Yes
17	Is Policies and procedures for blood bank available	SOP's are present
18	Appropriate disposal of blood and blood products are done as per BMW management rules	BMW practices are not followed
19	A blood collection/issue register exists.	Yes
20	Is blood transfusion committee in existence	Yes
21	Donated blood is labelled appropriately with adhesive labels.	Yes
22	Register of all recipient adverse reactions to blood and blood products are maintained	Yes
23	Data collected regarding recipient adverse reactions is collated, analyzed and reported to the blood transfusion committee.	Yes
24	Work instructions are visibly displayed and prominent	Yes
OUTCOME		
25	% of transfusion reactions	No
26	% of blood and blood products wastage	No
27	% of component usage	No
28	Turnaround time for issue of blood and blood products.	No

PHARMACY:

S. No	CRITERIA	YES/NO
	STRUCTURE	
1	The racks are available in sufficient number to store the items	No.
2	There is adequate ventilation and lighting in the department	Not in proper manner
3	There is a security system available at the department	No
4	Fire detecting & fire fighting systems are available at department	Yes. Only fire extinguisher
5	There is no water seepage/ dampness	Yes
6	All items storage areas are marked and labelled	Yes
7	There is a receiving area; segregation and storing area	No
8	Is refrigerator for storing medicines(2-8 degree C) available	No. Temp. Is not monitored.
9	Is qualified and trained staff available	Yes
10	Provision for storage of narcotic drugs(double lock and key system)	NA
	PROCESS	
11	The items are labelled & arranged as per alphabetical order.	No
12	Pest/rodent control measures are regularly under taken	No
13	Is stock register maintained properly	Yes
14	Verification of stock is done every six months.	Yes
15	Is sound Inventory control practices followed (ABC, VED, FSN,FIFO)	Yes. (FIFO)
16	General items required by the hospital are purchased from vendors registered by management	Yes

17	Is there a Drugs and therapeutics committee in the hospital?	No
18	Is hospital drug formulary available	No
19	Is adverse drug reactions are analyzed	No
OUTCOME		
20	% of local purchase	No
21	% of stock outs	No
22	% of variation from the procurement process	No
23	% of goods rejected before GRN	No

BIO-MEDICAL WASTE MANAGEMENT:

S.No	CRITERIA	YES/NO
	STRUCTURE	
1	Availability of colour coded Foot operated Bins at point of BMW generation	Yes. But not in adequate number.
2	Availability of coloured plastic bags	Yes but are not practiced
3	Display of work instructions at the point of segregation	Yes. But not everywhere
4	Is needle destroyer present	Yes
5	Availability of PPE(Personal Protective Equipments) with biomedical waste handlers	No
6	Availability of sodium hypochlorite solution and puncture proof boxes	No
7	Availability of safe mode of transportation	No
8	Is Temporary storage area available	No
	PROCESS	
9	Is segregation of BMW at point of generation	No
10	Is the route for transportation of waste separate from the general traffic area	No
11	Is there provision of regular health check up for staff of this unit?	No
12	Usage of PPE by staff is being practiced	No
13	Is Annual report submitted to UP PCB	No
14	Is monitoring done for the amount of BMW generated	No

HOSPITAL INFECTION CONTROL:

S.No	CRITERIA	YES/NO
	INFRA-STRUCTURE	
1	A designated and qualified infection control nurse(s) is present?	No
2	Adequate and appropriate facilities for hand hygiene in all patient care areas Provided?	No
3	Are adequate and appropriate personal protective equipment, soaps, and disinfectants available?	No
4	A designated infection control officer is present?	No
	PROCESS	
5	Does the hospital implements policies and/or procedures to prevent infection in these areas?	No
6	Does the organization adhere to standard precautions at all times?	No
7	Equipment cleaning, disinfection and sterilization practices as polices?	No
8	An appropriate antibiotic policy is established and implemented?	No
9	Hospital adheres to laundry and linen management processes?	No
10	Hospital adheres to kitchen sanitation and food handling issues?	No
11	Does the hospital have appropriate engineering controls to prevent infections?	No
12	Does the hospital adhere to mortuary practices?	No
13	Is the infection prevention and control programme updated at least once in a year?	No
14	Is the HIC surveillance data collected regularly?	No
15	Is the Verification of data done on a regular basis by the infection control team?	No

16	In cases of notifiable diseases, information (in relevant format) is sent to appropriate authorities?	Yes
17	Tracking and analyzing of infection risks, rates and trends	No
18	Do the surveillance activities include monitoring the effectiveness of housekeeping services?	No
19	HAI rates monitored?	No
20	Appropriate feedback regarding HAI rates provided on a regular basis to appropriate personnel?	No
21	A hospital infection control committee and team are formed?	No
22	Are the personal protective equipment used correctly by the staff?	No
23	Compliance with hand hygiene guidelines monitored?	No
24	Documented procedure for identifying an outbreak present?	No
25	Implementation of laid down procedure done?	No
26	Documented procedure guides the cleaning, packing, disinfection and/or sterilization, storing and issue of items?	No
27	Isolation / barrier nursing facilities are available?	No
28	Appropriate personal protective equipment used by the BMW handlers?	No
29	Visit by the hospital authorities to the disposal site done and documented?	No
30	Does the hospital makes available resources required for the infection control programme	No
31	Does the organization earmarks adequate funds from its annual budget for infection control activities?	No
32	Appropriate “in-service” training sessions for all staff at least once in a year conducted?	No
33	Appropriate pre and post exposure prophylaxis is provided to all concerned staff members?	No

OUTCOME		
34	UTI rate	No
35	VAP rate	No
36	SSI rate	No
37	Central line associated blood stream infection rate	No

*Infection Control practices are not followed.

CSSD/TSSU:

S.NO	CRITERIA	YES/NO
	STRUCTURE	
1	Is sufficient space available(0.75sq mts/bed)	No
2	Does the layout follow the functional flow: Receiving, Washing, decontamination, drying, packing, loading, unloading, storing and issuing?	No
3	Autoclaves are present?	Yes. But not used
4	Calibration of pressure meter of autoclave is done?	No
5	Racks are present in the department?	No
6	Technician is present in CSSD?	No
7	Sterilizer drums are present?	Yes
8	Is decontamination solution present?	No
9	Transport trolley present for items?	No
	PROCESS	
10	CSSD sterilization register present? (receipt/Issue)	No
11	Labelling of drums in CSSD takes place?	No
12	Is chemical, biological and bowie-dick test performed	No
13	If recall system of items followed	No
14	If reuse policy for items available	No

BIO-MEDICAL ENGINEERING:

S. No	CRITERIA	YES/NO
	STRUCTURE	
1	Does bio medical engineering department exist	No
2	Does the department is managed by a qualified person	No
3	Is Central supply system for bio medical gases exist	No
4	Is Safety devices available	No
5	Is the department manned by 24 hours	No
	PROCESS	
6	Preventive maintenance and calibration	No
7	Review of Preventive Maintenance record as per checklist like Anaesthesia ventilator, IABP etc.	No
8	Traceability of calibration report	No
9	Is there a documented procedure for equipment replacement and disposal?	No
10	Equipments are inventoried and proper logs are maintained as required.	No
11	Training of staff when new equipment is installed (HRM 3b)	No
12	Documented Preventive and breakdown maintenance plans	No
13	Color coding of pipelines	No
	OUTCOME	
14	% of downtime of critical equipments	No

ENGINEERING & MAINTENANCE:

S. No	CRITERIA	YES/NO
	STRUCTURE	
1	Various statutory requirements	
	o Fire	No
	o Diesel storage	No
	o Liquid oxygen and storage of medical cylinders.	No
	o Boiler	NA
	o Lift	NA
	o Water (ETP/STP)	No
	o Air (DG sets)	No
2	Up to date drawing, layout, escape route present and displayed?	No
3	Various required signage's displayed?	Yes. But not everywhere
4	Designated individual for maintenance present?	No
5	Presence of staff round the clock for emergency repairs	Yes
6	Alternative source of water and electricity	Not for water
7	Availability of (personnel) safety devices	No
8	Availability of safety devices (Fire extinguishers, smoke detectors, sprinklers, grab bars, side rails, nurse CCTV, ALARMS ETC)	No
	PROCESS	
9	Mechanism for renewing licenses	No
10	Preventive and break down maintenance plan implemented?	No
11	Alternate sources and their checking done?	No
12	Response time monitored?	No

13	Water quality reports	No
14	Are staff using safety devices	No
15	Facility inspection rounds twice a year in patient care areas and once in non-patient care areas	No
16	Documentation of facility inspection report	No
17	Safety education program for all staff	No
18	Safety committee present	No
19	Is staff trained for disaster management and fire management	No
20	Are the mock drills conducted at periodic intervals and documented	No
OUTCOME		
21	Number of variations observed during mock drills	No

STORE:

S. No	CRITERIA	YES/NO
	STRUCTURE	
1	The racks are available in sufficient number to store the items	Yes
2	There is adequate ventilation and lighting in the department	Yes
3	Is there a qualified/ trained personnel available	Yes
4	Fire detecting & fire fighting systems are available at department	No
5	There is no water seepage/ damp in the store	Yes
6	There is a receiving area; segregation and storing area	No
	PROCESS	
7	The items are labelled & arranged at designated place.	Yes
8	Items such as radiographic films, spirits etc (which are inflammable) are stored in a separate location.	Yes
9	Inventory recording system is present either computerized or on register	Yes
10	Frequently used items are arranged and located in most easily accessible area.	Yes
11	Pest/rodent control measures are regularly under taken	No
12	Lead time in issuing material to the department are recorded	No
13	Stock Turnover details are calculated on a monthly basis.	No
14	If sound inventory control practices followed (ABC/VED/FSN/FIFO)	No
15	Is condemnation policy followed?	No
16	Is there a purchase and condemnation committee in the hospital?	No
	OUTCOME	

17	A comparative list of rates of potential suppliers maintained	No
18	% of stock outs	No
19	% of goods rejected before preparation of GRN	Yes
20	% of variation from procurement process	No

KITCHEN/DIETARY:

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

MEDICAL RECORDS DEPARTMENT:

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

18	Is pest control done on a regular basis	No
OUTCOME		
19	Is number of births/deaths monitored	No
20	Is number of diseases notified to the local authority	No
21	% of missing records	No
22	% of records with ICD codification done	No
23	Percentage of medical records not having discharge summary	No
24	Percentage of medical records not having consent form	No

LINEN/LAUNDRY:

S. No.	CRITERIA	YES/NO
	STRUCTURE	
1	Number of linens as per no of beds (3 sets)	
2	(If laundry services are in house) Is there continuous water supply to this unit?	
3	(If laundry services are in house) Is adequate drainage system present in this unit?	
4	Is disinfectant available for infected linen? Specify the name	
5	Separate covered trolley for transporting dirty linen & washed linen available?	
6	Heavy duty rubber gloves, mask available to the linen handlers	
	PROCESS	
7	Are linen items being replenished when contaminated?	
8	Are linens are changed at least once daily?	
9	Segregation of soiled &contaminated linen is being done	
10	Sluicing of soiled linen is being done? (Specify location where sluicing is being done – ward or laundry)	
11	Packing of the soiled &contaminated linens in separate bags & labeling/color coding is being done	
12	The number and type of linen handed over is entered on the dirty linen register	
13	Linens are transported in covered trolley	
14	The number and type of linen handed over to the laundry by the ward boy is entered in laundry register.	
15	The clean linen is handed over to the ward boy against the received sign of Ward boy in the same laundry register.	
16	The ward boy is handing over the clean linen to the nurse In	

	charge in the ward against the issue register.	
17	Disinfection of decontaminated linen (Especially high risk areas) done	
18	Dirty linens & clean linens are stored in separate areas	
19	Are they following hand washing practices?	
20	Are they using disinfectant while washing contaminated linens?	
21	PPE are used by staff while handling soiled linens?	

***This department is outsourced.**

HOUSEKEEPING:

S. No.	CRITERIA	YES/NO
	STRUCTURE	
1	Does the housekeeping being provided with the personal protective equipment (dedicated gown slippers/ masks/ gloves/ head cover)	No
2	Does the housekeeping staff have basic facilities like (toilet/drinking water/change room)	Yes
	PROCESS	
3	Are the hand washing and floor washing agent being used?	No
4	Is the house keeping staff being trained in the infection control practices	No
5	Is staff using PPE	No
6	Is daily cleaning schedule available	No. Only one time cleaning is done
7	Are the staff aware about the preparation of cleaning solutions	No
8	Is the pest control methods being practiced	No
9	Is the medical examination of staff being done periodically	No

SECURITY:

S. No	CRITERIA	YES/NO
	STRUCTURE	
1	Is there a separate security room for security guards to work from?	
2	Is there a system of telephone connectivity from Emergency room?	
3	Is the room manned by at least one Security guard round the clock?	
4	Does the Emergency Room have a separate Security Guard?	
5	Are the main entrances to the hospital buildings and Labour Room manned by Security Guards?	
	PROCESS	
6	Does the duty hour of the security guard cover peak working hours?	
7	Is there a roster for the security guards prominently displayed?	
8	Do the security guards report daily to the security in charge?	
9	Do the security guards wear uniforms while on duty?	
10	Do the security guards restrict unauthorized entry of patients and relatives to the restricted areas of the hospital?	
11	Are the outgoing items checked and entered on a register?	
12	Are the security persons trained in disaster and fire management	
	OUTCOME	
13	No. of thefts and security related incidents	

***Security services are not available in the Hospital.**

MORTUARY:

S. No.	CRITERIA	YES/NO
	STRUCTURE	
1	Is this unit present in the hospital?	Yes
2	Is freezer available for dead bodies	Yes. But non-functional
3	Is calibration and maintenance is done regularly	No
4	Cold storage and back-up power available?	No
5	Are measures for fire detection/fire fighting installed in this unit?	No
	PROCESS	
6	Is temperature being regularly monitored	No
7	Is there any process of infection control followed	No

***This department is Non-functional.**