DISSERTATION
IN
CHIRAYU MEDICAL COLLEGE & HOSPITAL, BHOPAL

ANALYSING THE GAPS IN ADOPTING QUALITY SYSTEM OF CHIRAYU MEDICAL COLLEGE & HOSPITAL WITH REFERENCE TO NABH STANDARDS

A dissertation submitted in partial fulfillment of the requirements for the award of

Post Graduate Diploma in Hospital and Health Management

by

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MAY, 2013

Certificate of Dissertation Completion

Date:

TO WHOM IT MAY CONCERN

This is to certify Ms. Monika B Saxena has successfully completed her Dissertation Report in our organization from January 04, 2013 till date. During this intern she has worked on "**ANALYSING THE GAPS IN ADOPTING QUALITY SYSTEM OF CHIRAYU MEDICAL COLLEGE & HOSPITAL WITH REFERENCE TO NABH STANDARDS"** under the guidance of me and my team at Chirayu Medical College & Hospital. We wish her good luck for her future assignments

(Signature)
Dr. Pradip K. Bhattacharya
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Certificate of Approval

The following dissertation titled " **ANALYSING THE GAPS IN ADOPTING QUALITY SYSTEM OF CHIRAYU MEDICAL COLLEGE & HOSPITAL WITH REFERENCE TO NABH STANDARDS"** is hereby approved as a certified study in management carried out and presented in a manner satisfactory 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.

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This is to certify that **Ms. Monika B Saxena** , 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 " **ANALYSING THE GAPS IN ADOPTING QUALITY SYSTEM OF CHIRAYU MEDICAL COLLEGE & HOSPITAL WITH REFERENCE TO NABH STANDARDS"** in partial fulfillment of the requirements for the award of the **Post-Graduate Diploma in Health and Hospital Management**.
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FEEDBACK FORM

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Monika B Saxena.

ABBREVIATIONS

ICU	-	Intensive Care Unit
AIDS	-	Acquired Immune Deficiency Syndrome
ENT	-	Ear, Nose, Tongue
USG	-	Ultra Sonography
SWOT	-	Strengths, Weakness, Opportunity, Strength.
OT	-	Operation Theatre
BLS	-	Basic Life Support
BOR	-	Bed Occupancy Rate
FTA	-	Full Time Anesthetist
QCI	-	Quality Council of India\
TB	-	Tuberculosis

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HOSPITAL PROFILE

Chirayu Medical College and Hospital is a unit of Chirayu Charitable foundation & is a teaching Hospital. It is situated on Indore- Bhopal State Highway near Bairagarh.

The Hospital consists of multi super speciality department with 584 beds in total. Future prospects of expansion upto 1000 beds. It has got state of art infrastructure, equipments, and competent manpower to run the entire hospital.

The departments which are providing their services inside the hospital are as under.

Department of General Medicine: The department has got OPD, IPD as well as Intensive Care Services. The Department is well equipped with TMT, Multi channel ECG machine Echo cardiography, Colour Doplar etc. it is headed by well qualified professor under whom associate & Assistant Professor along with Residents handle the entire patient load of the department.

1.1.2. Department of General Surgery

The Department provides its services as OPD, IPD, which are well equipped with required instruments. They also provide their services in Operation Theatre [OT] and Intensive Care Unit [ICU]. The unit is headed by well qualified professor under whom Associate and Assistant Professor along with Residents handle the entire patient load of the department.

1.1.3. Department of Obstetrics and Gynaecology

Obstetrics Department handles all those patients who comes for perinatal care whereas Gynaecology unit handles all other problems related to females reproductive system. Both OPD and IPD services along with services in the operation theatre is provided by this department. The department has got well equipped labour room for normal delivery. Anti & Post partum units are specially designed for anti and post partum care of sick patients. The department has got two independent well equipment operation theatres; one is used for all Gynecology Surgery and another one for Obstetrics Surgery.

The unit is headed by well qualified Professor under whom Associate and Assistant Professor along with Residents handle the entire patient load of the department.

1.1.4. Department of ENT

The department of ENT provides OPD, IPD as well as services in Operation Theatre for surgeries related to Ear, Nose and Throat. It is headed by well qualified professor under whom Associate and Assistant Professor along with Residents handle the entire patient load of the department. The department also has got specialized service for Endoscopy surgeries. Audiometry room is attached to the OPD block of the department.

1.1.5. Department of Ophthalmology

The Ophthalmology department is one of the state of art department of this hospital which provides OPD, IPD as well as services in the operation theatre. In a span of two years the department has conducted more than 3000 surgeries related to various ophthalmic problems. The unit is headed by well qualified professor under whom Associate and Assistant Professor along with Residents handle the entire patient load of the department

1.1.6. Department of Anesthesiology

Department of Anesthesiology provides OPD services in the form of PAC clinic and PAIN clinic, IPD services in the form of intensive care unit, and operation theatre services in the form of giving anesthesia to various surgical procedures, it also provide peripheral anesthesia services as and when required and resuscitation services to the entire hospital. The unit is headed by well qualified Professor under whom Associate and Assistant Professor along with Residents handle the entire patient load of the department. The department is well equipped with ultra modern anesthesia delivery system, ventilators, monitors, Infusion pump and many other modern equipments.

1.1.7. Department of Pediatrics

The Pediatrics department provide OPD and IPD services in hospital along with their services in PICU and NICU. The department is well equipped with ultra modern equipments required

to take care of ICU, IPD and OPD services. The department also has got a play room for children's along with vaccination facility in their OPD. It is headed by well qualified Professor under whom Associate and Assistant Professor along with Residents handle the entire patient load of the department

1.1.8. Department of Orthopedics

Orthopedics department deals with problems related to bones diseases along with trauma care. The department provides OPD and IPD services along with their services in operation theatre. The department is well equipped with the ultra moderns equipments required for operation theatre IPD and OPD services. It is headed by well qualified Professor under whom Associate and Assistant Professor along with Residents handle the entire patient load of the department

1.1.9. Department of Radio diagnosis

Department of Radio diagnosis is situated in the ground floor of the hospital with one of the most advanced equipments settings in the state.

1. It has got 1.5 Tesla MRI machine capable of doing MR angio, MR veno, MR perfusion, MR spectro and diffusion weighted imaging.
2. A high speed dual CT scanner system which acquires volumetric CT data, it has capacity to perform advanced imaging techniques like 3 D reformation, Perfusion CT, Cranial, abdominal and angiography.
3. Mammography machine for detection of breast cancer at early stages. It is fully compatible with digital stereotactic biopsy device to perform FNA, FNL, and core biopsy.
4. There are five fixed X-ray machine of 500 and 300 MA along with two portable machines in the department which are used for different imagine purposes of the body.
5. Ultrasound Machine: The department has got three ultra sound machines two are installed in the department itself and another one is used for portable ultra sound

purposes. The above machines are well capable of doing Doppler imaging as and when required.

The department also has got an ultra modern CR system for printing and reporting purposes. It is headed by well qualified Professor under whom Associate and Assistant Professor along with Residents handle the entire patient load of the department

1.1.10. Department of Central Laboratory

The central laboratory consists of Department of Micro biology, Department of Pathology and Department of Bio chemistry.

A. Department of Microbiology: The department of microbiology is well equipped with modern equipments for identification of bacteria, viruses, parasite and fungus in various specimens of the body. The department headed by well qualified professor under whom Associate and Assistant Professor along with Residents all to gather handle the entire specimen load of a department.

B. Department of Pathology: provides its services by identifying defects in blood, blood components and other body specimens the normal and abnormal profile along with histopathology study of different tissues (Abnormal and normal of the body)

It is headed by well qualified Professor under whom Associate and Assistant Professor along with Residents handle the entire specimen load of the department

C. Department of Biochemistry: The department investigates and diagnoses the chemical abnormalities related to blood, stool, urine and other body fluid of the body. It is again well equipped with advanced equipments required for the above purposes. It is headed by well qualified professor under whom Associate and Assistant Professor along with Residents handle the entire patient load of the department

1.1.11. Department of Transfusion medicine

The hospital has got a licensed blood bank facility with a provision to process most type of blood and components. The blood bank caters the need of blood and components required by the hospital as well as in other hospital of the city. It is equipped with advanced machines like $(-80)^{o}$ freezer, cell separator, component separator etc.

Super Specialty Departments

1.1.12. Department of cardiology

The department has got TMT, multi channel ECG machine, Echo cardiography and Color Doppler.

The department also has got highly advanced flat panel Cath Lab unit for performing angiography, angioplasty and other interventional cardiology procedures. The department is headed by well trained DM Cardiologist.

1.1.13. Department of Cardiothoracic Surgery

Well designed and equipped modular operation theatre for performing surgeries like CABG, valve surgery, peripheral vascular surgery, congenital abnormalities in pediatrics patients are routine procedures performed in this department. It is most advanced state of art department in the hospital.

The department is headed by Mch cardiothoracic surgeon.

1.1.14. Gastroenterology

A separate gastroenterology unit equipped with upper GI endoscope, colonoscopy for performing upper GI endoscopy, colonoscopy, sigmoidoscopy along with ERCP .

1.1.15. Department of Oncology

The department deals with the medical management of different types of body cancers. The department is headed by DM Oncologist.

1.1.16. Department of Oncosurgery

The department deals with the surgical management of different body cancers. The department is headed by Mch Oncosurgery.

1.1.17. Department of Emergency and Critical Care Medicine

The hospital has got 35 beds in emergency department and 50 beds in critical care unit. It deals with all emergency surgical / medical, traumatic / non traumatic emergencies coming

to the hospital. Every bed of emergency department is equipped with multi parameter monitors along with high level nursing backup services.

Every bed of critical care unit is well equipped with multi parameter invasive monitoring system, ventilators, infusion pump and high level nursing backup facilities.

The department is headed by Director Emergency and Critical Care services. The department is also running diploma and fellowship courses for training of post graduate students.

The department has managed more than 3000 cases with various critical care problems since its inception.

1.1.18. Department of Skin & VD

The department is deals with different deceases related to skin and venereal diseases. It is equipped with modern amenities to deal with various skin & venereal problems. The department is laid by MD Skin & VD.

1.1.19. Department of Psychiatry

The Psychiatry department deals with patients suffering from functional illnesses of brain. The unit is headed by well trained qualified Psychiatrist.

The functional division of the hospital

I. OPD Services – (General)

- Department of Medicine
- Department of surgery
- Department of Obs. & gynaecology
- Department of ENT
- Department of Ophthalmology
- Department of Paediatrics
- Department of Orthopaedics
- Department of Dentistry
- Department of Psychiatry
- Department of Skin & VD

II. OPD Services – (Super Speciality)

- Department of Cardiology
- Department of Cardiothoracic surgery
- Department of Oncology
- Department of Onco- surgery
- Department of Nephrology
- Department of Urology
- Department of Pulmonary medicine
- Department of Gastrosurgery
- Department of Gastroenterology
- Department of Anaesthesia

III. OPD Services (Supportive)*:*

- Department of Radiology
- Department of Pathology

- Department of Biochemistry
- Department of microbiology
- Department of Blood Bank
- Department of Physiotherapy

IV. Allied Services

- CSSD
- Manifold
- Boiler
- Laundry
- Kitchen
- Mortuary
- Air conditioning
- Electricity
- Civil
- Horticulture
- Security

Operation Theatre Services

Third Floor

- Department of General Surgery
- Department of Orthopedics surgery
- Department of ENT
- Department of Ophthalmology
- Department of Cardiothoracic surgeries
- Department of plastic surgery
- Department of Urology
- Department of Gastro-surgery
- Department of onco surgery
- Department of Pediatrics surgery

Second Floor

- Department of Obs. & Gynecology

Ground Floor

- Emergency Operation Theater.

BUILDING AND SPACE REQUIREMENT: The building is complied with local municipal by-laws. The floor space available for the patient is approximately 100 Sq. Ft./Bed. One general ward consist of 30 beds which is of size 3255 Sq. Ft. with extra space for treatment room, nurses duty room, resident doctors duty room, pantry & janitors closets which cover approximately 879.73 Sq. Ft. with common toilets & utility of 590.08 Sq. Ft.

Isolation arrangements are available for burn patient's septic & Infectious cases.

A separate labor room is provided in emergency within OT complex measures around 475.70 Sq. Ft.

The hospital is equipped with backup generator of 563 KVA in emergency in case of power failure. The total plan layout floor wise along with their measurement is enclosed for your reference.

MANPOWER STATUS: Chirayu Medical College and Hospital having adequate manpower both medical & paramedical staff including specialist.

INSTRUMENT/EQUIPMENT: Chirayu Medical College and Hospital is well equipped with all high-tech instruments for operation theatres & wards.

ACHIEVEMENTS OF HOSPITAL:

- **First kidney transplant of Bhopal was conducted at Chirayu Medical College & Hospital**
- **Permission for second batch of MBBS for 150 seats accredited by Medical Council of India.**

- **Permission for 100 seats of GNM Nursing course and 100 seats for B.Sc. Nursing course accredited by Nursing Council of India.**
- **Permission to run Paramedical Courses by the State Govt. in 14 (fourteen) subjects.**
- **Permission to run diploma in critical care accredited by Indian society of Critical Care medicine**
- **Permission to run Fellowship in critical care accredited by College of Critical Care, Mumbai.**
- **Empanelment for treatment of patients with more than 25 government & non government organizations**
- **Conducted more than 200 educational activities in the form of CME's workshops and, conferences in last two years.**

Opened and started Super Speciality Departments in the hospital, like Cardiology Cardiac Surgery, Neurology, Neurosurgery, Nephrology, Urology, Gastroenterology, GI Surgery, Plastic Surgery, Oncology, Oncosurgery

INTRODUCTION

NABH (NATIONAL ACCREDITATION BOARD FOR HOSPITALS & HEALTHCARE PROVIDERS)

NABH is an acronym for **National Accreditation Board for Hospitals & Healthcare Providers** is a constituent board of Quality Council of India, set up to establish and operate accreditation programme for healthcare organizations. NABH was established in year 2006.

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

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

QCI (QUALIT Y COUNCIL OF INDIA)

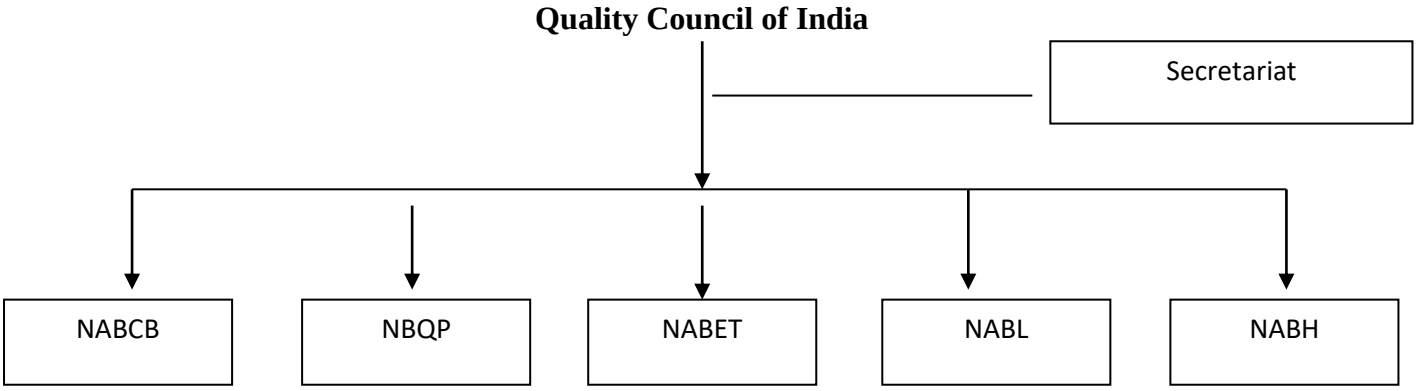
Quality Council of India (QCI) was set up jointly by the Government of India and the Indian Industry represented by the three premier industry associations i.e. Associated Chambers of Commerce and Industry of India (ASSOCHAM), Confederation of Indian Industry (CII) and Federation of Indian Chambers of Commerce and Industry (FICCI), to establish and operate national accreditation structure and promote quality through National Quality Campaign. QCI is registered as a non-profit society with its own Memorandum of Association. QCI is governed by a Council of 38 members with equal representations of government, industry and consumers. Chairman of QCI is appointed by the Prime Minister on recommendation of the industry to the government.

It functions through the executive boards in the specific areas i.e. Accreditation for :

a. Conformity Assessment Bodies,
b. Healthcare Establishments
c. Education & Vocational Training Providers.

In addition it has an exclusive Board for promotion of Quality.

STRUCTURE OF QCI



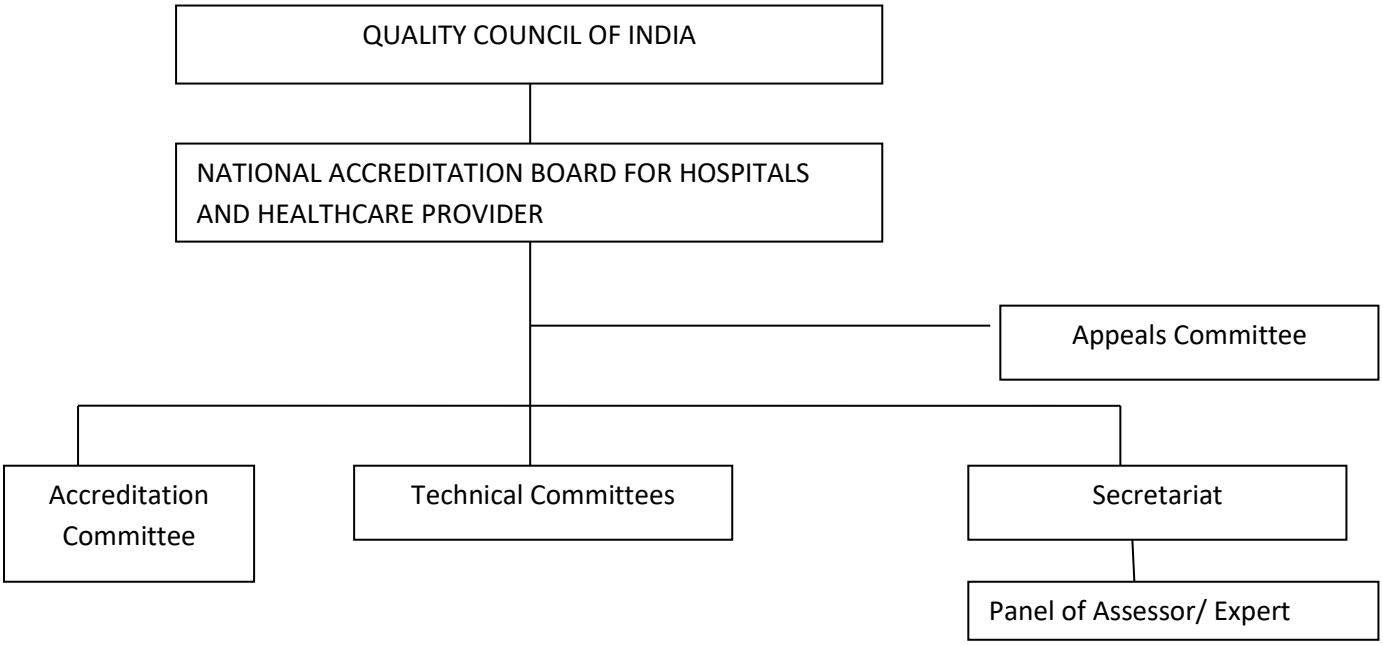
NABCB (National Accreditation Board for Certification Bodies):- undertakes assessment and accreditation of Certification Bodies applying for accreditation as per the Board's criteria in line with international standards & guidelines. It represents the interests of the India industry at international forums through membership & active participation with the objective of becoming a signatory to multilateral and mutually recognition of these certifications.

NABQP (National Board for Quality Promotion):- is entrusted with the task of carrying out National Quality Campaign. The Campaign aims to spread awareness on the importance of achieving international level of quality of products & services. The campaign looks at the other key areas like health, education & public services. An expert committee of eminent personalities provides the strategic direction to the activities of this lead.

NABET (National Accreditation Board for Education & Training):- certifies auditors & the training courses for such auditors, which meet the Board's criteria and provides a mechanism for international recognition of these certifications.

NABL (National Accreditation Board for Testing & Calibration Laboratories):- undertakes the assessment & accreditation of Testing & Calibration Laboratories, in accordance with the international standard ISO/IEC 17025 & ISO 15189

STRUCTURE OF NABH



ACHIEVEMENTS & INTERNATIONAL LINKAGES:

NABH is a Institutional member of the International Society for Quality in Healthcare (ISQUA). ISQUA is an International body which grants approval to Accreditation Bodies in the area of healthcare as mark of equivalence of accreditation program of member countries.

ISQua ACCREDITATION OF NABH STANDARD, INDIA

International Society for Quality in Healthcare (ISQua) "Standards for Hospitals" developed by National Accreditation Board for Hospitals & Healthcare standards (NABH, India). The approval of ISQua authenticates that NABH standards are assurance with the global benchmarks set by ISQua. The hospitals accredited by NABH will have International recognition. This will provide boost to medical tourism.

DEFINATION OF ACCREDATION

"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 standard-(ISQua)

Accreditation relies on establishing technical competence of healthcare organization in area of accreditation standards in delivering services with respect to its scope. It focuses on learning, self development, improved performance and reducing risk. Accreditation is based

on optimum standards, professional accountability and encourages healthcare organization to pursue continual excellence.

ADVANTAGES OF ACCREDITATION

- **TO PATIENTS:-**

Accreditation benefits all stake holders. Patients are the biggest beneficiary. Accreditation results in high quality of care and patient safety. The patients get services by credentialed medical staff. Rights of patients are respected and protected. Patient satisfaction is regularly evaluated.

- **HEALTHCARE ORGANIZATIONS**:-

Accreditation to the healthcare organization stimulates continuous improvement. It enables the organization in demonstrating commitment to quality care. It raises community confidence in the services provided by the organization. It also provides opportunity to healthcare unit to benchmark with the best. Staff in an accredited healthcare organization is satisfied lot as it provides for continuous learning, good working environment, leadership & above all ownership of clinical processes. It improves overall professional development of Clinicians & Paramedical staff & provides leadership for quality improvement within medicine & nursing.

- **THIRD PARTIES:-**

Finally accreditation provides an objective system of empanelment by insurance & other third parties. Accreditation provides access to reliable and certified information on facilities, infrastructure and level of care.

CHALLENGES AND OPPORTUNITIES

- Awareness on Accreditation:-

a) Health industry

b) Consumers

c) Regulators

- Creating enabling mechanism to assist hospitals on accreditations.

- How do we add value to accredited hospitals:

a) Clinical indicator program

b) Quality tools; Six sigma; Lean etc

c) HR, HIS (MIS)

d) Education programs

❖ Knowledge sharing with:-

- JCHS, JCI
- ISQua, ASQua
- Ownership of accreditation program by Health Industry
- Acceptance of accreditation program by Consumers.

QUALITY OF PROCESS

Process control involves laying down the policies and procedures in strict compliance with the law and as per the internationally accepted practices and their implementation .It is important that the department should have the written, duly approved **Quality manual** incorporating a system of internal quality control measures including all important activities of the department.

OVERVIEW OF THE STUDY

NABH accreditation ensures the quality criteria in the hospital and towards the safety of the patient through various activities been carried out in the Hospital that will affects the working environment and the status of the hospital. It act as a major tool for maintaining quality parameters of the hospital. International accreditation of any institute or centres is also a need of today to deliver better quality to the receptors. By taking the NABH standards as a base, gap analysis is been done which help in improving the patient care and the services of the hospital. In view of this , opting this subject for dissertation is better option , as the same is being implemented simultaneously in the hospital

RATIONALE OF THE STUDY:

It is believed that improving the quality of a hospital ensures the delivery of better services to the patients . NABH is a tool for providing quality in the system at par with international standards. Quality improvement is a continuous process & leaves a scope of improvement at every level.

NABH has taken an initial step to keep a check on the quality of the hospitals for the improvement of quality of the services provided by the hospital for patient satisfaction

LITERATURE REVIEW

1) Using quality indicators to improve hospital care:

Total twenty one studies [Details appended] were carried out towards improvement of hospital care. These studies focused on care processes rather than patient outcomes. Among these studies quality indicators found to be effective in some studies, in one partially effective and in one it was found to be ineffective.

Twenty studies focused on health care processes, and most of these studies reported significant improvement with respect to part of the measured process indicators. The implementation of quality indictors in hospitals is most effective if feedback reports are given in combination with an educational implementation strategy and/or the development of a quality improvement plan.

OBJECTIVES

GENERAL OBJECTIVE

- To compare the present status of Hospital with the NABH accreditation standards

SPECIFIC OBJECTIVES

- To study the process for implementing NABH standards in the hospital.
- Auditing the hospital functions as per NABH standards and make hospital functioning ready for pre-audit by NABH team
- To suggest recommendations to fill up the gaps for the achievement of NABH accreditation
- Careful adherence to SOPs by trained personnel
- To set up a quality parameters for various committee which deals with all the 10 chapters of the NABH

Projected outcome:

- To implement NABH system in the big health care institute is a challenge and adopting an International Quality System ensures the better quality services rendered to the patients.
- To assess the quality parameters of the Hospital.
- Reducing gaps found by analyzing objective elements of NABH from the previous status of the hospital
- Formulation of SOPs, Feedback forms, quality parameters etc.
- Improving Patient's status and working environment of the hospital
- Implementation of quality system in various Departments of the Hoapital
- After implementation of the quality system, the hospital shall be ready for the assessment by NABH team.

METHODOLOGY

TYPES OF INDICATORS USED FOR ANALYSIS

- ✓ **Structure Indicator**: Describes characteristics of the setting that supports & has an impact on care.
- ✓ **Process Indicator**: Measures an activity that is carried out to care for patients. Focuses on the nature & amount of care nurses provided during the hospital stay.
- ✓ **Outcome Indicator**: Describes the patient's status at the defined time following care interventions. Measures the result of nursing care/process

The type of indicator which is used in this study are the process indicator which are further categorized into output process indicators

NABH CRITERIA FOR ASSESSING QUALITY:

GENERAL CRITERIA:-

1. **Patient related-** monitoring safety, treatment standards & quality of care. This would include effectively meeting the expectation of patients & their attendants, families & visitors.
2. **Employee related-** monitoring competence, ongoing training, awareness of patient requirements & employee satisfaction.
3. **Regulatory related-** identifying, complying with & monitoring the effective implementation of meeting legal, statutory & regulatory requirements.

SPECIFIC CRITERIA:-

A) **Patient centered**:-

- ✓ Access, assessment & continuity of care
- ✓ Care of patients
- ✓ Management of medication
- ✓ Patient rights & education
- ✓ Hospital Infection control

B) Organization centered:-

- ✓ Continuous quality improvement
- ✓ Responsibilities of management
- ✓ Facility management & safety
- ✓ Human resource management
- ✓ Information management system

Based on the NABH criteria and checklist is been used as a tool for study and observations is been used as a technique for the study.

Following below diagram indicates how the gap is been analyzed and further action is been taken to reduce gaps in the quality for better working of the hospital.


Quality Indicator, analysis, monitoring & feedback
Risk Management
Process Improvement & Planning
Routine audits
Quality Assurance Programme

GAP ANALYSIS OF THE CHIRAYU HOSPITAL AS PER NABH GUIDELINES

Based on the NABH self assessment tool kit following gap analysis has been executed in the Chirayu Hospital. The audit is been carried out for every department (clinical & non-clinical) in the hospital for all the 636 objective elements given by the third edition of NABH,2011.Impressions observed is as follows:

1. **Safety, Security & Dignity:**

❖ ***Patients' privacy in X-ray room remains compromised:***

- ✓ No arrangements to ensure patients' privacy during examination in X-ray room
- ✓ No facility to streamline patient flow
- ✓ No system for calling in patients one-by-one
- ✓ No staff to monitor the queue so that all patients do not throng the doctor's chamber with a request to be seen first

Impact:

- ➢ Discomfort of patients- especially female patients- during examination
- ➢ Compromising patients' dignity goes against ethical practice

Solutions:

- Use of patient addressal system
- A security system to monitor patient flow in examination room

❖ ***Health, safety & hazard notices are not displayed prominently within the hospital***

- ✓ Safety notices are not prominently displayed for the benefit of staff, patients & public
- ✓ Notices are not written in local language (cleaning in process; vision, mission statement; men at work etc)
- ✓ Signage's not used

Impact:

- ➢ Lack of proper display of hazard notices may cause harm to patients, their attendants and even the medical staff working in hospital

Solutions:

- Appropriate health and safety notices including hazard notices should be prominently displayed at identified spots and in local languages for easy comprehension to avoid potential injury to patients, attendants and hospital staff

❖ ***Patients files are kept within easy access of outsiders***

✓ Patient-related files are kept open in some wards like oncology ward, general ward etc which is easily accessed by the outsiders and patient attainders

✓ During rush hours, nurses are busy in attending patients and duty rooms remain supervised for considerable period of time. In such situation, it is easy to tamper with patient-related papers

Solutions:

- Adequate resources for safety & security of patients' property, eg. Bedside lockers should be provided
- 24 hours security services to prevent thefts, unauthorized entries & overcrowding
- Restricted entry within the hospital with complete security, especially to critical care areas
- Training to security personnel on hospital- related security requirements
- Behavioral training should be given to security staff

❖ ***Inadequate arrangements for the safety & security of hospital property & patients' personal property***

✓ There is no provision for round-the-clock security service to safeguard the patients' property

✓ The hospital has multiple access by design

✓ This gap in the safety & security has been attributed to the following:

- Lack of human resources in terms of security personnel to prevent unauthorized people, & even animals, from entering the hospital premises
- Protocols are not in place for security

Impact:

➢ May lead to damage & theft of hospitals & personal property

➢ Creates menace when animals enter the hospital premises and wreak havoc, putting patients in danger of getting physically harmed

Solutions:

- A system should be laid down for the identification and traceability of samples so as to avoid errors while handling them in patient care areas and laboratories
- Sample containers must have a labeled with an accompanying investigation requisition form
- Once a system is in place, it should be regularly check whether it is being scrupulously followed or not
- In addition to a regular internal audit, a system of cross-verification of test results with a credible outside lab may help the process

2. Regulatory Compliance:

❖ ***Hospitals are evaluated for fire safety but there is no display of plan and no training of fire safety to staff personnel:***

- ✓ Building fire safety guidelines for horizontal & vertical buildings are clearly laid down but no fire safety officers regularly assess hospital in terms of fire fighting arrangement & preparedness
- ✓ No evaluation is done on the number/validity of fire extinguishers & the training required to control fire from different sources
- ✓ No fire evacuation plan & escape route is displayed at specific locations in the hospitals' premises
- ✓ Lack of training to the personnel of hospital

Impact:

Lack of measures, training leaves the hospital open to the risk of a major disaster in the event of a fire outbreak

Solutions:

- Conduct fire fighting drills twice in a year
- Keep fire-fighting equipment in working order. Keep the necessary fire extinguishers & other systems such as water sprinklers at identified areas .
- Keep evacuation plan currently updated and should be displayed
- Training on regular intervals are to be provided to the staff
- Fire fighters should be as per standards & should be installed in accordance with good practice as recommended in the National Building Code of India,1970, and to

the satisfaction of directorate of fire service personnel (Reference: Fire Safety Works, Fire Safety Act,[Chapter 109A, Section 61(1)])

❖ ***The preparedness of hospital to handle disaster is not in evidence***

✓ National Disaster Management Guidelines (NDMG) laid down standard requirements for hospitals on how to handle disaster. However, the following requirements were not met by hospital:

- A designated area to handle disaster
- A room to store required drugs & consumables
- A well-defined triage system to sort patients based on the severity condition so that most critical patients get due attention at the earliest, thereby saving lives
- A hospital specific disaster handling plan with well-defined roles & responsibilities

Impact:

❖ Poor response of hospital in handling disaster

❖ Increased morbidity & mortality

❖ Poor image of hospital

Solutions:

- Color code should be allocated at the bed side.
- Training of the personnel on regular basis of the color codes provided
- Triaging been done by using wrist band
- Clinical steps of management of causalities should be followed as: reception, triage, admission of patients, utilization of supportive services
- Activate key departments for mobilization of resources, to plan for logistics & supplies, and to make security arrangements
- Mock drill should be conducted periodically and staff should be adequately trained

3. Administrative Process:

❖ ***Some doctors responsible for patient care do not visit patients in wards regularly***

✓ Doctors are unable to visit patients due to their hectic schedule

- ✓ Doctors were present only for key decision-making (diagnose that ailment, chart a treatment plan, and handle emergencies) and procedures (major and minor surgeries) while nurses took care of patients' progress
- ✓ Inadequate nurse staff in wards

Impact:

- Lack of confidence amongst patients regarding hospital patient care capabilities
- Instances of delay in treatment of patients

Solutions:

- Patient admitted in HDU need to be monitored at least every 4-6 hours
- Adequate numbers of doctors to be appointed for the proper care of the patents.
- Patients admitted in Low Care Units/Wards should be monitored in 12-24 hours to ensure early recovery and timely management of the treatment plan
- Training modules for nurses to handle ICU, HDU and wards patients

❖ ***Formal request and reporting forms are not available for Laboratory & X-ray tests***

- ✓ Doctors prescribe laboratory tests & X-ray tests to be undertaken by patients. Reporting for these tests in the laboratory/X-ray department is done on the OPD or IPD ticket itself

Impact:

Patients are not ready to give their OPD & IPD tickets to technicians or attainders as it also contains prescriptions which lead to chaos.

Solutions:

- Standardized printed forms should be made available in the doctor's chambers for referring a patient for investigation
- Standardized reporting forms should be available in X-ray units & laboratories for both, reports given to patients & those sent to referring doctors

❖ ***Lack of well defined inventory management system in hospital pharmacies***

- ✓ Inventory management in the pharmacy, is not properly maintained
- ✓ Procurement & indenting is not guided by past consumption & projected requirements. Items are not stored in an organized fashion
- ✓ Recording of temperature is not been taken for the medicines which is kept in cold area
- ✓ Expiry, near expiry etc is not been monitored which increase wastage of medicines

Impact:

- ➢ Expiry of items
- ➢ High inventory load
- ➢ Difficulty in retrieving sound alike & look alike drugs
- ➢ Impact on budget planning & projections

Solutions:

- Implementation of HIS
- Applying Inventory control technique like VED, ABC analysis etc
- Separate area of storage of Sound alike & look alike drugs
- Temperature monitoring sheet should be hanged near refrigerator
- Formation of drug list of all emergency drugs and other medicine drugs which help in maintaining inventory

❖ ***There is no system to assess the level of employee satisfaction in hospitals***

- ✓ There is a mutual dissatisfaction of the employee regarding salary, appreciation and yearly appreciation

Impact:

Dissatisfaction among employee may affect day-to-day functioning of the hospital

Solutions:

- Employee feedback form analysis which help to develop plans for areas where improvement is possible

4. Clinical Process:

❖ ***Delays in the patient discharge process or incomplete discharge summary***

- ✓ The treating doctor informs the patient during the morning clinical rounds that she/he would be discharged on that particular day
- ✓ The Medical officer attending on the patient is required to prepare the discharge summary & give prompt clearance. However, this process ends up taking several hours
- ✓ As a result, the actual discharge takes place late in the evening or early next day
- ✓ At times, discharge takes place late in the evening or early next day
- ✓ At times, discharge summaries are not completed & the details of investigation, eg., lab and radio-diagnostic reports, are not entered
- ✓ Lack of a system for review by the in-charge of the hospitals is one of the reasons for incomplete discharge summary
- ✓ The concerned doctor is responsible for the entire in-patient area, and prioritizes treating admitted patients over making a discharge summary

Impact:

- ➢ Inconvenience to patients
- ➢ Incomplete information on discharge slip affects the quality of the follow-up and treatment given to the patients

Solutions:

- Transparency should be ensured by mentioning discharge process in the patient record for increase patient satisfaction
- If doctors are unable to fill discharge form fully then discharge notes is given to junior surgeon or nurses for complete formation of discharge note and then to be verified and dully signed by the consult doctor
- A protocol for discharge summary should be followed so that the discharge summary is complete in terms of patient's clinical condition, patient's progress record in the hospital, investigations done in chronological fashion, condition of patient at the time of discharge, advice on medication post-discharge, and follow-up
- A system for sample review of discharge summaries by hospital in-charge or a designated person must be part of the clinical audit

❖ ***Hospitals do not conduct regular Medical Audits as required by NABH***

✓ Evaluation of quality care involves two basic concepts:

- Quality of technical care, i.e., adequacy of structure & procedure including diagnostic & therapeutic procedures
- The manner in which care is provided & perceived by consumers

✓ Quality of medical care can be assessed to a large extent by the analysis of medical records, termed Medical Audit. The same when used to analyze the cause of death is called death audit

Impact:

➢ Continuous assessment of technical care & perceived care is essential to bring about changes that will improve the image of the hospital & build credibility regarding its healthcare. Failure to evaluate quality care & consumer perception results in no positive changes done to improve the service delivery of healthcare & increases dissatisfaction among patients

Solutions:

- A system on medical audit conducted on a regular basis is essential
- To evaluate clinical care
- To monitor & manage errors related to clinical care, such as diagnosis error, dispensing error, medication error
- To ensure the quality of clinical care delivered
- Medical audit is been of following types which is been conducted:

- Death Audit: Retrospective evaluation of all the deaths in the hospital. Case record of patients is a key document
- Case Audit: Retrospective evaluation of all the cases related to a specific disease or procedure. Case record & discharge summary are the key document for review
- Tissue Audit: Retrospective evaluation of all the pathological slides related to a specific disease or procedure or during a given period. This has to be compared with case record
- Standard Indicators: Some of the indicators in use are case-fatality rate, average length of stay, percentage of deaths after 48 hours out of total deaths, percentage of LAMA (Left Against Medical Advice) cases of total discharge

- Hospitals should develop format for the audit, taking reference from standard literature on the subject of structure & procedure including diagnostic & therapeutic procedures
- Quality of care- relating to the manner in which care is provided & perceived by the patients- should be evaluated & analyzed to develop the best methods for improvement
- Hospital managers should play an important role in an audit as they are close related with patients

❖ ***<u>No triage area in the Emergency Department</u>***

✓ When the number of patients reaching the hospital following a disaster exceeds the capacity of the hospital, a need arises for segregation of patients based on the severity of their condition

✓ There is a need for hospitals to introduce the process of triage to treat cases according to severity of condition so that resource utilization and the efficacy of services is enhanced in the event of managing a disaster

<u>Impact:</u>

- ➢ Absence of triage makes it hard for doctors to locate & attend to critical patients promptly
- ➢ There are chances of the most critical patients being deprived of immediate attention

<u>Solutions:</u>

- Allocate area for triage in the emergency department
- Tagging is to be done as per the color code which has to be done as per priority
- Emergency medicines should be kept separately either in the emergency area or in the pharmacy and different emergency drug list is to be provided to the doctors of every department
- Identify the area by four standard colour codes at the bed side i.e.

Color coding	**Priority/Urgency**	**Rationale**
Red	First priority/ most immediate	• Life threatening shock or hypoxia occurs • Patient needs to be

		stabilized • May survive if given immediate care
Yellow	Second priority/ Urgent	• Injuries have systematic implications or effects • Patient is not yet in shock/hypoxia • Patient is in a position to wait for 30-45 minutes immediate risk
Green	Third Priority/ Non-urgent	• Localized injuries without immediate systematic effects, with need for minimum care • Condition of the patient will not deteriorate for up to several hours
Black	Dead	

5. **Support Process*:***

❖ ***<u>Kitchen conditions in the hospital are unhygienic</u>***

- ✓ Level of hygiene observed in hospital kitchens is poor
- ✓ Kitchen staff handles food without wearing aprons, caps & gloves
- ✓ Washing duct is open
- ✓ Hospital staff doesn't undergo regular health checkup

<u>Impact:</u>

- In the absence of regular health checks & lack of hygiene in the kitchen, hospital staff may be unknowingly carrying infections which may get transmitted to others leading to poor health status
- Contamination of food is frequent

Solutions:

- Use of aprons, gloves & caps while preparing food and delivering of food materials
- Kitchen washing duct should be closed which reduces contamination
- A sanitary method for handling & disposal of garbage should be established
- Health check up should be carried out periodically for all the staffs
- A periodic inspection has to be taken place i.e. in every three months for corrective & preventive actions for the defects taken

6. Human Resources:

❖ ***Employees are not aware of the roles and responsibilities***

✓ Even though the roles and responsibilities of each staff of the hospital are available and documented then also personnel of the hospital were unaware of their duties and responsibilities and about their rights

Impact:

- lack of clarity in the individual roles & responsibilities affects the efficiency of the hospital staff which impact the functioning of the hospital

Solutions:

- Display of the roles and responsibilities of every department outside the department
- Display of vision and mission over there ID card
- A copy of their roles and responsibilities should be given to every staff during Induction programme

❖ ***There is no system for orientation of newly induced staff***

✓ There is no structure for induced training to new employees
✓ No protocol for giving induction programme and trained personnel were not ready to give orientation
✓ No modules formed for induction training

Impact:

In the absence of any information on peers & other departments of the hospital, new doctors may find it difficult to find support from associated departments & function to the best of their capability

Solutions:

- Formation of Induction Modules for training which is to be distributed at the time staff is recruit
- Hospital authority has to take responsibility for giving Induction programme

7. **Tools, Tackle & Equipments:**

❖ ***No evidence of maintenance & upkeep of ambulances & other hospital vehicles***

✓ Lack of formal process for pre-operational check of hospital vehicles & ambulances based on a standard checklist

✓ No evidence of a log book that records regular preventive maintenance terms of filling & consumption of fuel as well as servicing of hospital vehicles

Impact**:**

- ➢ Ambulances that are not serviced or properly maintained run the risk of breaking down during an emergency
- ➢ Difficulty in gauging preparedness during emergencies

Solutions:

- Breakdown maintenance plan need to be formed
- Maintaining log sheet for recording maintenance
- Checklist for pre-operational of ambulance and other vehicles need to be formed which is filled dully on regular basis by every shift

❖ ***Ambulance are ill equipped to handle critical patients***

✓ Ambulance are often used to transport critically ill patients to the Accident & Emergency Departments of hospitals

✓ However, most ambulances are not well-equipped & do not stock sufficient life saving drugs to provide timely & prompt 'on-site' first aid & life saving measures for critically ill patients being transported

Impact:

- ➢ Absence of equipment, instruments and drugs to provide prompt 'on-site' first aid and failure to administer immediate life saving measures may prove fatal for critically ill patient

Solutions:

- Record is to be maintained for patient transported and treatment given enroute
- Checklist of drugs need to be maintained and based on that checklist Indent & Inventory should be maintained
- Trained paramedics need to be appoint
- Routine replacement of drugs to replenish stock

❖ ***Wheelchairs present in the hospital was not in a good condition***

✓ Poor repair and maintenance of existing wheelchairs and trolleys

Impact:

- ➢ Patients' attendants are left to their own devices to carry patients from OPD/Emergency Department
- ➢ Creates huge discomfort to patients who have just undergone surgery
- ➢ Leads to unnecessary crowding in OPD and Emergency Department

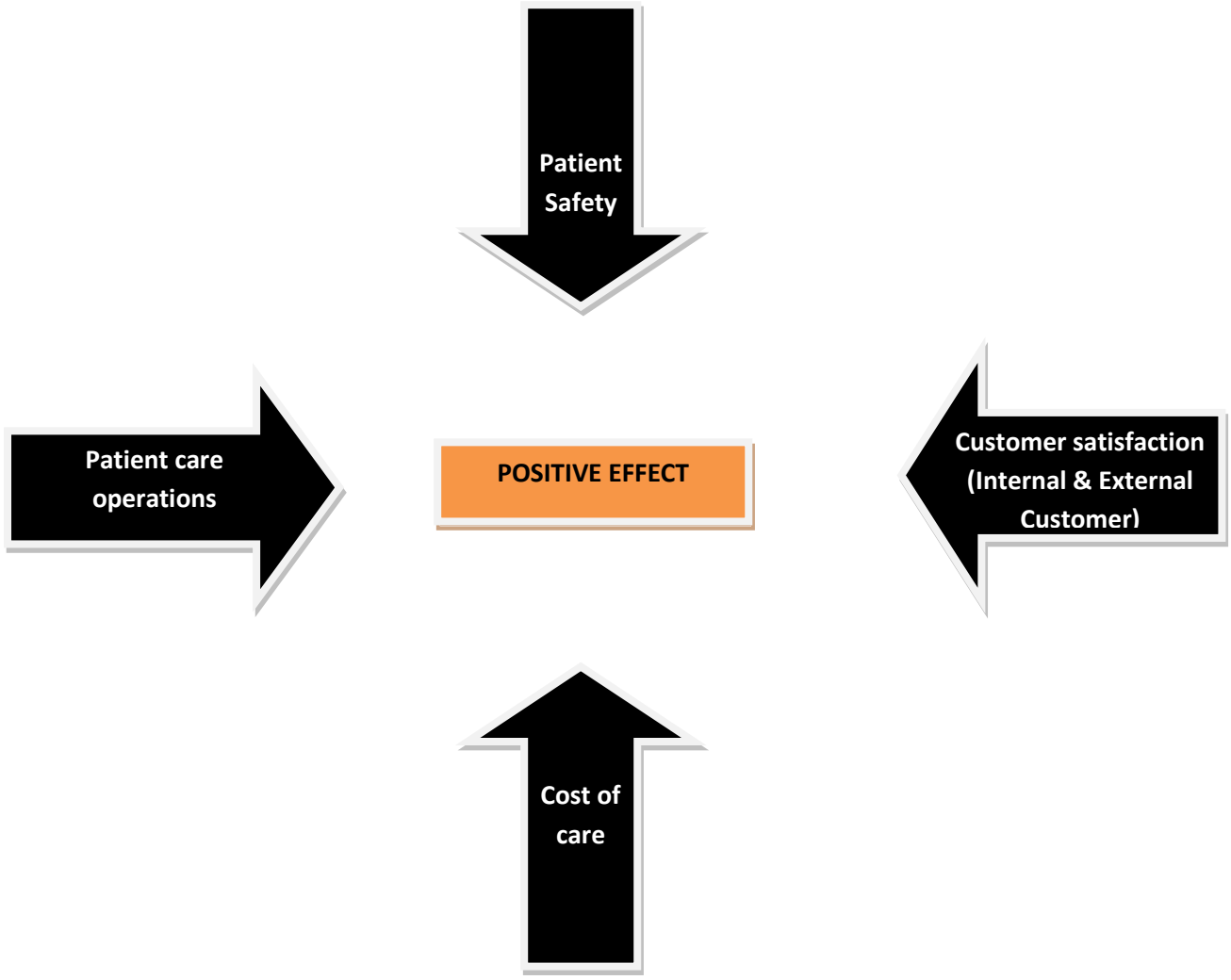
Solutions:

- Record of maintenance is to be maintained for all the wheelchairs and supporting instruments
- Make a lubrication & maintenance schedule to ensure that wheels of wheelchairs & trolleys function smoothly over a long period

  Check the functioning of the wheelchairs and trolleys after every shift and send the damaged

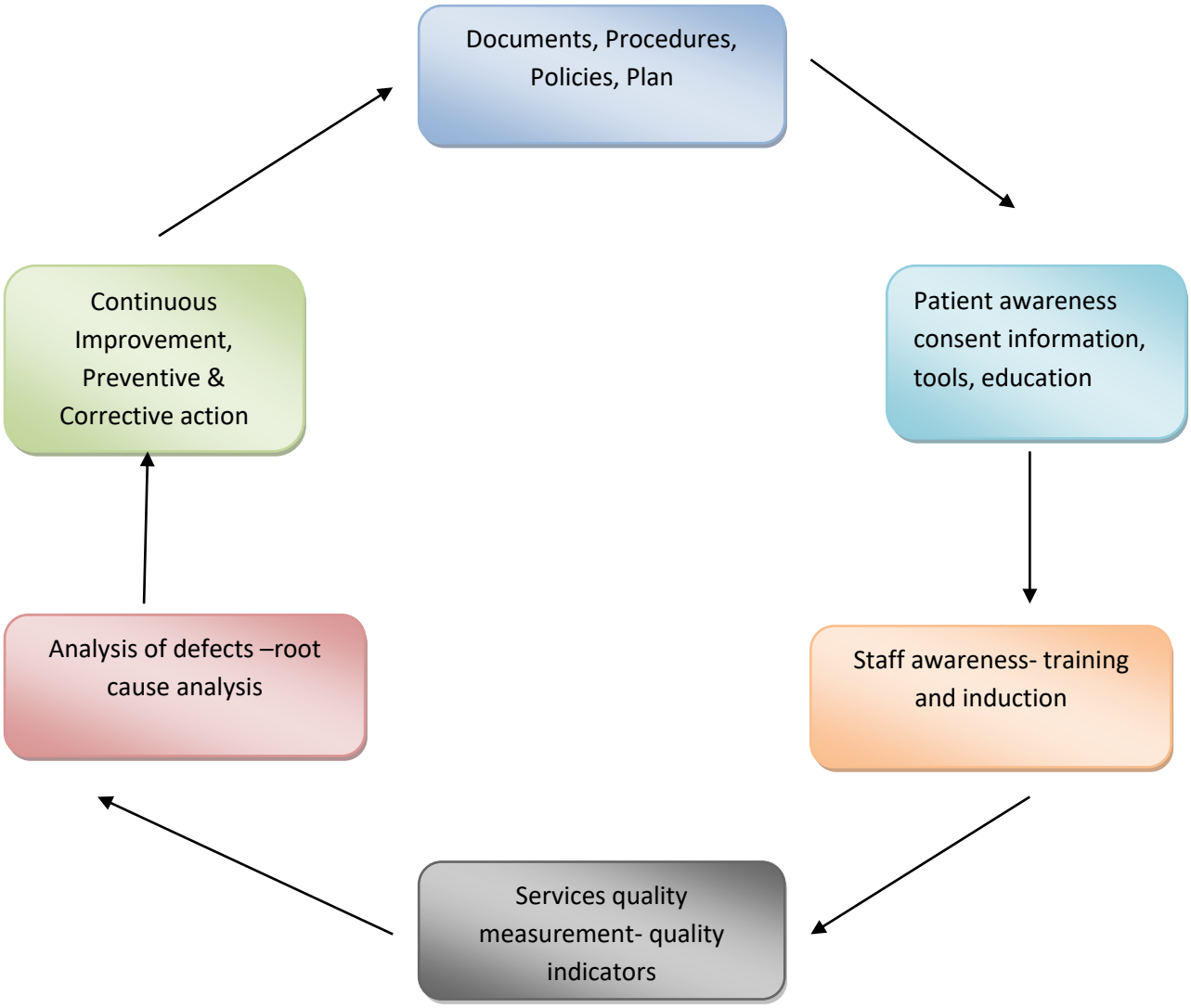
OBSERVATIONS

A general concept:



ACTIVITY FLOW

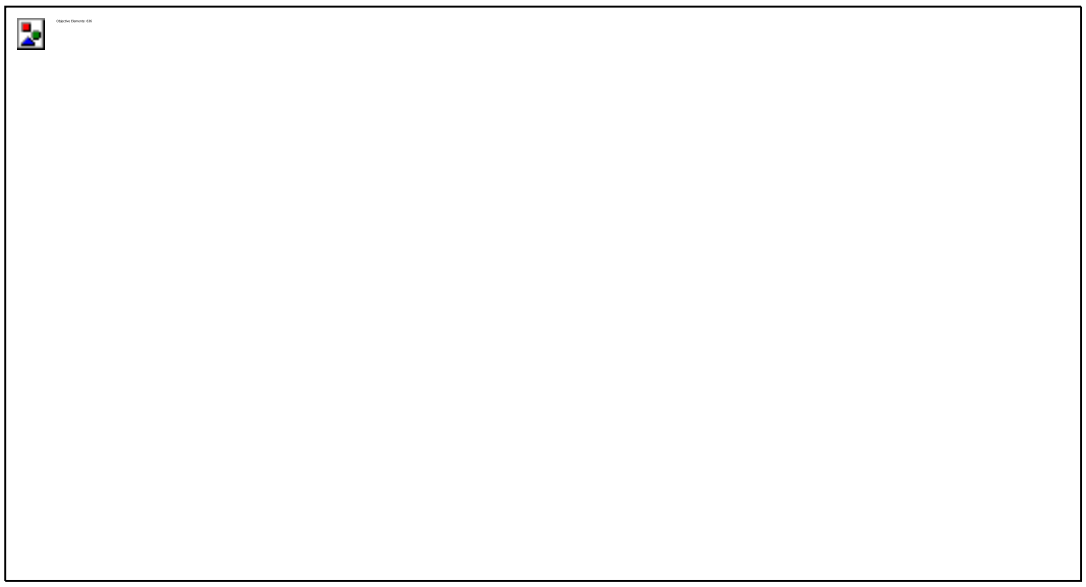
Activity flow determines how quality improvement took place in an hospital after root cause analysis



ANALYSIS

From the analysis, it is found that out of 636 objective elements 120 objective elements yet to achieve before pre-audit. Major part to be achieved is the training programme for all the staff and their orientation. For that training module is been prepared. Analysis data is been collected by regular audit as per the self-assessment checklist provided by NABH.

Objective Element Achieved	Objective Element Partially Achieved	Objective Element Not Yet Achieved
512	22	98
80.50%	0.03%	0.15%



From the auditing it was found that the basic improvement areas which have to be kept in priority, which will affect the status of the hospital if not improved, were:

- ✓ Operative & other invasive & non-invasive procedures that place patients at risk
- ✓ Medication
- ✓ Clinical pertinence & timeliness of Medical Record
- ✓ Infection control
- ✓ Risk Management & Medical Liability
- ✓ Safety management
- ✓ Utilization management
- ✓ Pharmacy function including adverse drug reactions, medication errors

- ✓ Clinical laboratory function
- ✓ Patient feedback

The above quality indicators should improved on regular basis for better services provided by the hospital as these indicators is directly related to patient satisfaction.

CONCLUSION

The main conclusions of this study are as follows:

The process of accreditation undergoes different stages, for acquiring NABH accreditation in hospital - Pre-Assessment, Final Assessment, Surveillance & Re-Assessment.

Feedback of Assessors is the best ways to judge the task performed by an individual or a system. The assessors visit a hospital for the assessment, the organization provides necessary information to the assessors & the observers, about how the whole procedure was in operation . The assessor assess the whole system , whether it is in order as per the quality standards laid down by NABH. After achieving the NABH to the hospital , the hospital ensures to provide services towards patient satisfaction and improve patient safety to provide excellent hygienic treatment process. The employees must participate in improving quality in medicare services etc,. NABH standards have to be maintained.

RECOMMENDATIONS

- Formulation of Quality Indicators
- Formulation of various forms like patient referral forms, Existing forms should be Bilingual, New prescribing form, Patient & Attendant including Nursing Staff Feedback form etc.
- Installation of LIS in Laboratory.
- Installation of Software in Blood Bank, Pharmacy, Store etc.
- Routine audits has to be perform
- Induction programme need to be conducted
- Training modules need to be scheduled
- Formulation of committees
- Formulation of SOPs of store, blood bank and pharmacy

- Formation of complaint registers and service tariff card at the reception
- Formation of donor education broachers' at blood bank

Limitations of study:

The study is based only on the auditing of the Hospital, based on the self assessment kit and quality indicators given by NABH .

REFERENCES

- **www.Nabh.co.in**
- **NABH: Standards for Hospitals: www.nabh.co/main/hospitals/standard.asp**
- **Implementation of NABH Hospital Standards- Nation Accreditation…: nabh.co/main/programme/PIH3D.asp**
- **National Accreditation Board for Hospitals & Healthcare Providers: nabh.co/main/**
- **NABH standards-Department of Medical Health and Family Welfare: uphealth.up.nic.in/NABH/NABHSTANDARDS-VKS_AKA.ppt**
- **NABH Accreditation and its status in the country-AJMS: ajms.alameenmedical.org/ArticlePDFs%5CAJMS%20V6.N1.2013%20p..**
- **NABH Standards- Quality Council of India: qcin.org/nabet/consultants/HandH/NABH_H&H_Consultants.pdf**

ANNEXURE:

Checklist provided by NABH:

Scoring is been done based on the self assessment tool kit provided by NABH which include Documentation, Implementation and Evidence which justify the Objective elements.

	Elements	Documentation (Yes/ No)	Implementation (Yes/ No)	Evidence (cross reference to documents/ manuals etc.)
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.	YES	YES	SOP
b	The defined services are prominently displayed.	YES	NO	Board need to be framed
c	The staff is oriented to these services.	YES	NO	Induction training module, record need to be formed
AAC.2: The organization has a well-defined registration and admission process.				
a	Documented policies and procedures are used for registering and admitting patients.	YES	YES	HIS, Forms
b	The documented procedures address out-patients, in-patients and emergency patients.	YES	YES	SOP
c	A unique identification number is generated at the end of registration.	YES	YES	UHID generation
d	Patients are accepted only if the organization can provide the required service.	YES	YES	SOP
e	The documented policies and procedures also address managing patients during non-availability of beds.	YES	YES	SOP
f	The staffs are aware of these processes.	YES	YES	Induction programme, SOP, HR policy
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.	YES	YES	SOP, transfer form
	b	Documented policies and procedures guide the transfer-out/referral of unstable patients to another facility in an appropriate manner.	YES	YES	SOP, transfer form
	c	Documented policies and procedures guide the transfer-out/referral of stable patients to another facility in an appropriate manner.	YES	YES	SOP, transfer form
	d	The documented procedures identify staff responsible during transfer/referral	YES	YES	SOP
	e	The organization gives a summary of patient's condition and the treatment given	YES	YES	SOP, Discharge ticket
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	YES	NO	Initial assessment form need to be formed
	b	The organization determines who can perform the initial assessment.	YES	YES	Byduty doctors
	c	The organization defines the time frame within which the initial assessment is completed based on patient's needs	YES	YES	SOP
	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	YES	YES	Included in Organization policy
	e	Initial assessment of in-patients includes nursing assessment which is done at the time of admission and documented.	YES	YES	Includes in Nursing Notes
	f	Initial assessment includes screening for nutritional needs	YES	YES	SOP
	g	The initial assessment results in a documented plan of care	YES	YES	SOP
	h	The plan of care also includes preventive aspects of the care where appropriate	YES	YES	Physically verification
	i	The plan of care is countersigned by the clinician in-charge of the patient within 24 hours.	YES	YES	Physically verification
	j	The plan of care includes goals or desired results of the treatment, care or service	YES	YES	Physically verification
AAC.5: Patients cared for by the organization undergo a regular reassessment.					
	a	Patients are reassessed at appropriate intervals.	YES	YES	Physically verification

	b	Out-patients are informed of their next follow up where appropriate.	YES	YES	Included in Discharge ticket
	c	For in-patients during reassessment the plan of care is monitored and modified where found necessary.	YES	YES	Physically verification
	d	Staff involved in direct clinical care document reassessments.	YES	YES	Physically verification
	e	Patients are reassessed to determine their response to treatment and to plan further treatment or discharge.	YES	YES	Physically verification
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.	YES	YES	SOP as per NABL guidelines
	b	The infrastructure (physical and manpower) is adequate to provide for its defined scope of services.	YES	YES	As per MCI guidelines as well as NABL guidelines
	c	Adequately qualified and trained personnel perform, supervise and interpret the investigations.	YES	YES	SOP & training module
	d	Documented procedures guide ordering of tests, collection, identification, handling, safe transportation, processing and disposal of specimens.	YES	YES	SOP as per NABL guidelines
	e	Laboratory results are available within a defined time frame.	YES	YES	24 hrs is mentioned in SOP
	f	Critical results are intimated immediately to the concerned personnel.	YES	YES	Physically verification
	g	Results are reported in a standardized manner.	YES	YES	As per guidelines
	h	Laboratory tests not available in the organization are outsourced to organization(s) based on their quality assurance system.	YES	YES	Certificates available
AAC.7: There is an established laboratory quality assurance programme.					
	a	The laboratory quality assurance programme is documented.	YES	YES	SOP formed
	b	The programme addresses verification and/or validation of test methods.	YES	YES	SOP formed
	c	The programme addresses surveillance of test results.	YES	YES	SOP formed

	d	The programme includes periodic calibration and maintenance of all equipment.	YES	YES	AMCs
	e	The programme includes the documentation of corrective and preventive actions.	YES	YES	AMCs record
AAC.8: There is an established laboratory safety programme.					
	a	The laboratory safety programme is documented.	YES	YES	SOP as per NABL
	b	This programme is aligned with the organization's safety programme.	YES	YES	SOP as per NABL
	c	Written procedures guide the handling and disposal of infectious and hazardous materials.	YES	YES	SOP as per NABL, forms are formed
	d	Laboratory personnel are appropriately trained in safe practices.	YES	NO	SOP as per NABL , Training module has to be formed
	e	Laboratory personnel are provided with appropriate safety equipment / devices.	YES	YES	SOP as per NABL
AAC.9: Imaging services are provided as per the scope of services of the organization.					
	a	Imaging services comply with legal and other requirements.	YES	YES	Approval certificate is present
	b	Scope of the imaging services are commensurate to the services provided by the organization.	YES	YES	SOP as per NABL
	c	The infrastructure (physical and manpower) is adequate to provide for its defined scope of services.	YES	YES	SOP as per NABL & MCI guidelines
	d	Adequately qualified and trained personnel perform, supervise and interpret the investigations.	YES	NO	Investigation record
	e	Documented policies and procedures guide identification and safe transportation of patients to imaging services.	YES	YES	SOP as per NABL , signage's etc
	f	Imaging results are available within a defined time frame.	YES	YES	Time frame are decided to be 24 hrs which is documented
	g	Critical results are intimated immediately to the concerned personnel.	YES	YES	Job assigned by HR maintained in HR records

	h	Results are reported in a standardized manner.	YES	NO	New forms & formats
	i	Imaging tests not available in the organization are outsourced to organization(s) based on their quality assurance system.	YES	YES	All tests is done in the organization
AAC.10: There is an established Quality assurance programme for imaging services.					
	a	The quality assurance programme for imaging services is documented.	No	No	Programme need to be formed, formats need to be formed
	b	The programme addresses verification and/or validation of imaging methods.	YES	YES	AMCs maintained yearly
	c	The programme addresses surveillance of imaging results.	YES	YES	Monitoring by GM services
	d	The programme includes periodic calibration and maintenance of all equipment.	YES	YES	AMCs maintianed
	e	The programme includes the documentation of corrective and preventive actions.	YES	YES	Maintained by GM services
AAC.11: There is an established radiation safety programme.					
	a	The radiation safety programme is documented.	YES	YES	SOP formed
	b	This programme is aligned with the organization's safety programme.	YES	YES	SOP formed
	c	Handling, usage and disposal of radio-active and hazardous materials is as per statutory requirements.	YES	YES	SOP formed, recorded in registers
	d	Imaging personnel are provided with appropriate radiation safety devices.	YES	YES	Badges, apron issued
	e	Radiation safety devices are periodically tested and results documented.	YES	YES	Test records available
	f	Imaging personnel are trained in radiation safety measures.	YES	YES	Training records maintained
	g	Imaging signage are prominently displayed in all appropriate locations.	YES	YES	Signage are displayed but not in a systematic manner
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.	YES	YES	Patient medical record

b	Care of patients is coordinated in all care settings within the organization.	YES	YES	Patient medical record, HIS, patient handover details
c	Information about the patient's care and response to treatment is shared among medical, nursing and other care providers.	YES	YES	Patient medical record, HIS, patient handover details
d	Information is exchanged and documented during each staffing shift, between shifts, and during transfers between units/departments.	YES	YES	Patient handover details. Forms
e	Transfers between departments/units are done in a safe manner.	YES	YES	SOP of Triage & Transfer Protocol
f	The patient's record (s) is available to the authorized care providers to facilitate the exchange of information.	YES	YES	SOP of Triage & Transfer Protocol, Intra transfer protocol
g	Documented procedures guide the referral of patients to other departments/ specialities.	YES	YES	SOP of Triage & Transfer Protocol, Intra transfer protocol
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.	YES	YES	SOP
b	Documented procedures exist for coordination of various departments and agencies involved in the discharge process (including medico-legal and absconded cases).	YES	YES	Discharge Summary
c	Documented policies and procedures are in place for patients leaving against medical advice and patients being discharged on request	YES	YES	LAMA SOP & forms
d	A discharge summary is given to all the patients leaving the organization (including patients leaving against medical advice and on request).	YES	YES	Discharge Summary protocol, SOP
AAC.14: Organization defines the content of the discharge summary.				

	a	Discharge summary is provided to the patients at the time of discharge.	YES	YES	SOP, Summary file, Transfer protocol
	b	Discharge summary contains the patient's name, unique identification number, date of admission and date of discharge.	YES	YES	Discharge summary, SOP
	c	Discharge summary contains the reasons for admission, significant findings and diagnosis and the patient's condition at the time of discharge.	YES	YES	Discharge summary
	d	Discharge summary contains information regarding investigation results, any procedure performed, medication administered and other treatment given.	YES	YES	Discharge summary
	e	Discharge summary contains follow up advice, medicationand other instructions in an understandable manner.	YES	YES	Discharge summary
	f	Discharge summary incorporates instructions about when and how to obtain urgent care.	YES	YES	Follow up include in discharge summary, SOP
	g	In case of death, the summary of the case also includes the cause of death.	YES	No	Death Summary form need to be formed, Follow up include in discharge summary, SOP
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.	YES	YES	SOP
	b	Uniform care is guided by documented policies and procedures	YES	YES	SOP
	c	These reflect applicable laws, regulations and guidelines	YES	YES	SOP
	d	The organization adapts evidence based medicine and clinical practice guidelines to guide uniform patient care.	YES	YES	SOP

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.	YES	YES	Emergency care policy
	b	This also addresses handling of medico-legal cases.	YES	YES	Monitored (Seen by MRD head and further action taken by Medical Director)
	c	The patients receive care in consonance with the policies.	YES	YES	Monitored
	d	Documented policies and procedures guide the triage of patients for initiation of appropriate care	YES	YES	Monitored triage during admission
	e	Staff are familiar with the policies and trained on the procedures for care of emergency patients.	YES	NO	Training module need to be formed, awareness present but have to be systematic
	f	Admission or discharge to home or transfer to another organization is also documented.	YES	YES	SOP, Discharge form
	g	In case of discharge to home or transfer to another organization a discharge note shall be given to the patient.	YES	YES	Discharge form
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).	YES	YES	Space allocated
	b	The ambulance adheres to statutory requirements.	NO	NO	x
	c	Ambulance(s) is appropriately equipped.	NO	NO	x
	d	Ambulance(s) is manned by trained personnel.	YES	YES	ALS, BLS trained, certification available
	e	Ambulance (s) is checked on a daily basis.	NO	NO	X
	f	Equipment are checked on a daily basis using a checklist.	NO	NO	X

	g	Emergency medications are checked daily and prior to dispatch using a checklist.	NO	NO	X
	h	The ambulance(s) has a proper communication system.	YES	YES	Central communicatio n system
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	YES	YES	Code Blue policy
	b	Staff providing direct patient care are trained and periodically updated in cardio pulmonary resuscitation.	YES	YES	Training module need to be formed
	c	The events during a cardio-pulmonary resuscitation are recorded.	YES	YES	Record form
	d	A post-event analysis of all cardio-pulmonary resuscitations is done by a multidisciplinary committee.	YES	YES	Post analysis form were analysed by committee
	e	Corrective and preventive measures are taken based on the post-event analysis.	YES	YES	Decision taken by committee
COP.5: Documented policies and procedures guide nursing care.					
	a	There are documented policies and procedures for all activities of the Nursing Services.	NO	NO	X
	b	These reflect current standards of nursing services and practice, relevant regulations and the purposes of the services.	NO	NO	X
	c	Assignment of patient care is done as per current good practice guidelines.	NO	NO	X
	d	Nursing care is aligned and integrated with overall patient care.	NO	NO	X
	e	Care provided by nurses is documented in the patient record.	NO	NO	X
	f	Nurses are provided with adequate equipment for providing safe and efficient nursing services.	NO	NO	X
	g	Nurses are empowered to take nursing related decisions to ensure timely care of patients.	NO	NO	X
COP.6: Documented procedures guide the performance of various procedures.					
	a	Documented procedures are used to guide the performance of various clinical procedures.	YES	YES	Defined by organisation

	b	Only qualified personnel order, plan, perform and assist in performing procedures.	YES	YES	-do-
	c	Documented procedures exist to prevent adverse events like wrong site, wrong patient and wrong procedure.	YES	YES	Adverse event form
	d	Informed consent is taken by the personnel performing the procedure where applicable.	YES	YES	Consent form
	e	Adherence to standard precautions and asepsis is adhered to during the conduct of the procedure.	YES	YES	Asepsis chart in critical and clinical areas
	f	Patients are appropriately monitored during and after the procedure.	YES	YES	Patient sheet
	g	Procedures are documented accurately in the patient record.	YES	YES	Patient sheet
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.	YES	YES	SOP
	b	Documented procedures govern transfusion of blood and blood products.	YES	YES	SOP, form
	c	The transfusion services are governed by the applicable laws and regulations.	YES	YES	Liscense
	d	Informed consent is obtained for donation and transfusion of blood and blood products.	YES	YES	Consent form
	e	Informed consent also includes patient and family education about donation.	YES	YES	Consent form, Brochures, Chart
	f	The organization defines the process for availability and transfusion of blood/blood components for use in emergency.	YES	YES	SOP
	g	Post transfusion form is collected; reactions if any identified and are analysed for preventive and corrective actions.	YES	YES	-do-
	h	Staff are trained to implement the policies.	YES	YES	Training module
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.	YES	YES	SOP
	b	The organization has documented admission and discharge criteria for its intensive care and high dependency units.	YES	YES	SOP
	c	Staff are trained to apply these criteria.	YES	In process	SOP, Training Module

	d	Adequate staff and equipment are available.	YES	In process	SOP, available in shortage
	e	Defined procedures for situation of bed shortages are followed.	YES	YES	SOP
	f	Infection control practices are documented and followed.	YES	YES	SOP (waste segregation)
	g	A quality assurance programme is documented and implemented.	YES	YES	SOP
COP.9: Documented policies and procedures guide the care of vulnerable patients (elderly, children, physically and/or mentally challenged).					
	a	Policies andprocedures are documented and are in accordance with the prevailing laws and the national and international guidelines.	YES	YES	SOP
	b	Care is organized and delivered in accordance with the policies and procedures.	YES	YES	SOP
	c	The organization provides for a safe and secure environment for this vulnerable group.	YES	YES	SOP
	d	A documented procedure exists for obtaining informed consent from the appropriate legal representative.	YES	YES	SOP
	e	Staff are trained to care for this vulnerable group.	YES	YES	SOP
COP.10: Documented policies and procedures guide obstetric care.					
	a	There is a documented policy and procedure for obstetric services.	YES	YES	SOP
	b	The organization defines and displays whether high risk obstetric cases can be cared for or not.	YES	In process	Board need to be formed
	c	Persons caring for high risk obstetric cases are competent.	YES	YES	SOP
	d	Documented procedures guide provision of ante-natal services.	YES	YES	SOP
	e	Obstetric patient's assessment also includes maternal nutrition.	YES	No	Assessment form need to be formed
	f	Appropriate pre-natal, peri-natal and post-natal monitoring is performed and documented.	YES	YES	SOP
	g	The organization caring for high risk obstetric cases has the facilities to take care of neonates of such cases.	YES	YES	SOP
COP.11: Documented policies and procedures guide paediatric services.					

a	There is a documented policy and procedure for paediatric services.	YES	YES	SOP
b	The organization defines and displays the scope of its paediatric services.	YES	NO	SOP, Board need to be formed
c	The policy for care of neonatal patients is in consonance with the national/ international guidelines.	YES	YES	SOP
d	Those who care for children have age specific competency.	YES	YES	HR criteria
e	Provisions are made for special care of children.	YES	YES	Different area maintained
f	Patient assessment includes detailed nutritional, growth, psychosocial and immunization assessment.	YES	YES	Assessment form
g	Documented policies and procedures prevent child/neonate abduction and abuse.	YES	YES	SOP
h	The children's family members are educated about nutrition, immunization and safe parenting and this is documented in the medical record.	YES	YES	SOP, Educational Boards & Brochures
COP.12: Documented policies and procedures guide the care of patients undergoing moderate sedation.				
a	Documented procedures guide the administration of moderate sedation.	YES	YES	SOP
b	Informed consent for administration of moderate sedation is obtained.	YES	In process	Form need to be approved
c	Competent and trained persons perform sedation.	YES	YES	HR document
d	The person administering and monitoring sedation is different from the person performing the procedure.	YES	YES	Record
e	Intra-procedure monitoring includes at a minimum the heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation, and level of sedation.	YES	YES	Record
f	Patients are monitored after sedation and the same documented.	YES	YES	Record ,patient assessment form
g	Criteria are used to determine appropriateness of discharge from the recovery area.	YES	YES	Discharge summary
h	Equipment and manpower are available to managepatients who have gone intoa deeper level of sedation than initially intended.	YES	YES	As per guidelines

COP.13: Documented policies and procedures guide the administration of anaesthesia.					
	a	There is a documented policy and procedure for the administration of anaesthesia.	YES	YES	SOP
	b	Patients for anaesthesia have a pre-anaesthesia assessment by a qualified anaesthesiologist.	YES	YES	Assessment form & SOP
	c	The pre-anaesthesia assessment results in formulation of an anaesthesia plan which is documented	YES	YES	SOP
	d	An immediate pre-operative re-evaluation is performed and documented.	YES	YES	SOP, evaluation register
	e	Informed consent for administration of anaesthesia is obtained by the anaesthesiologist.	YES	YES	Consent form
	f	During anaesthesia monitoring includes regular recording of temperature, heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation and end tidal carbon dioxide.	YES	YES	Patient record, monitor sheet
	g	Patient's post-anaesthesia status is monitored and documented.	YES	YES	Monitor sheet
	h	The anaesthesiologist applies defined criteria to transfer the patient from the recovery area.	YES	YES	Transfer form by consent doctors
	i	The type of anaesthesia and anaesthetic medications used are documented in the patient record.	YES	YES	Patient file, patient sheet
	j	Procedures shall comply with infection control guidelines to prevent cross infection between patients.	YES	YES	HIC manual
	k	Adverse anaesthesia events are recorded and monitored.	YES	YES	Adverse event form
COP.14: Documented policies and procedures guide the care of patients undergoing surgical procedures.					
	a	The policies and procedures are documented.	YES	YES	SOP
	b	Surgical patients have a preoperative assessment and a provisional diagnosis documented prior to surgery.	YES	YES	Assessment form
	c	An informed consent is obtained by a surgeon prior to the procedure.	YES	YES	Consent form
	d	Documented policies and procedures exist to prevent adverse events like wrong site, wrong patient and wrong surgery.	YES	YES	Adverse event form

	e	Persons qualified by law are permitted to perform the procedures that they are entitled to perform.	YES	YES	HR policy
	f	A brief operative note is documented prior to transfer out of patient from recovery area.	YES	YES	Notes by doctor
	g	The operating surgeon documents the post-operative plan of care.	YES	YES	SOP, patient sheet
	h	Patient, personnel and material flow conforms to infection control practices.	YES	YES	HIC manual
	i	Appropriate facilities and equipment/appliances/instrumentation are available in the operating theatre.	YES	YES	Monitored as per checklist
	j	A quality assurance programme is followed for the surgical services.	No	NO	X
	k	The quality assurance programme includes surveillance of the operation theatre environment.	NO	NO	x
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.	YES	YES	SOP
	b	These include both physical and chemical restraint measures.	YES	YES	SOP
	c	These include documentation of reasons for restraints.	YES	YES	Patient sheet
	d	These patients are more frequently monitored.	YES	YES	SOP
	e	Staff receive training and periodic updating in control and restraint techniques.	YES	YES	Training record
COP.16: Documented policies and procedures guide appropriate pain management.					
	a	Documented policies and procedures guide the management of pain.	YES	YES	SOP
	b	All patients are screened for pain.	YES	YES	SOP
	c	Patients with pain undergo detailed assessment and periodic re-assessment.	YES	NO	Assessment sheet need to be printed and distributed
	d	The organization respects and supports management of pain for such patients.	YES	YES	SOP
	e	Patient and family are educated on various pain management techniques where appropriate.	YES	YES	Counselling

COP.17: Documented policies and procedures guide appropriate rehabilitative services.					
	a	Documented policies and procedures guide the provision of rehabilitative services.	YES	YES	SOP
	b	These services are commensurate with the organizational requirements.	YES	YES	Present
	c	Care is guided by functional assessment and periodic re-assessment which is done and documented by qualified individual (s).	YES	NO	Assessment sheet need to be formed, SOP exist
	d	Care is provided adhering to infection control and safe practices.	YES	YES	HIC manual
	e	Rehabilitative services are provided by a multidisciplinary team.	YES	YES	Team formed
	f	There is adequate space and equipment to perform these activities.	YES	YES	Physically present
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.	YES	YES	SOP
	b	The organization has an ethics committee to oversee all research activities.	YES	YES	Physically monitored
	c	The committee has the powers to discontinue a research trial when risks outweigh the potential benefits.	YES	YES	Monitored
	d	Patient's informed consent is obtained before entering them in research protocols.	YES	YES	Consent form
	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.	YES	YES	Verbally
	f	Patients are assured that their refusal to participate or withdrawal from participation will not compromise their access to the organization's services.	YES	YES	Consent form
COP.19: Documented policies and procedures guide nutritional therapy.					
	a	Documented policies and procedures guide nutritional assessment and reassessment.	YES	YES	SOP
	b	Patients receive food according to their clinical needs.	YES	YES	Diet chart
	c	There is a written order for the diet.	YES	YES	Diet chat

	d	Nutritional therapy is planned and provided in a collaborative manner.	YES	YES	Monitored
	e	When families provide food, they are educated about the patient's diet limitations.	YES	YES	Verbally
	f	Food is prepared, handled, stored and distributed in a safe manner.	YES	YES	Feedback form
COP.20: Documented policies and procedures guide the end of life care.					
	a	Documented policies and procedures guide the end of life care.	YES	YES	SOP (end of life care)
	b	These policies and procedures are in consonance with the legal requirements.	YES	YES	Certificate
	c	These also address the identification of the unique needs of such patient and family.	YES	YES	SOP
	d	Symptomatic treatment is provided and where appropriate measures are taken for alleviation of pain.	YES	YES	Patient record
	e	Staff are educated and trained in end of life care.	YES	YES	Training module
Chapter 3: Management of Medication (MOM)					
MOM.1: Documented policies and procedures guide the organization of pharmacy services and usage of medication.					
	a	There is a documented policy and procedure for pharmacy services and medication usage.	YES	Yes	Pharmacy Manual
	b	These comply with the applicable laws and regulations.	YES	YES	Law available
	c	A multidisciplinary committee guides the formulation and implementation of these policies and procedures.	YES	YES	Pharmacy Committee
	d	There is a procedure to obtain medication when the pharmacy is closed.*	YES	YES	24 x 7 Open
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.	YES	YES	Drug List to be approved
	b	The list is developed and updated collaboratively by the multidisciplinary committee.	YES	YES	Sign of approval pending

	c	The formulary is available for clinicians to refer and adhere to.	YES	YES	Distribution record not available.
	d	There is a defined process for acquisition of these medications	YES	YES	Evidence in Purchase dept.
	e	e. There is a process to obtain medications not listed in the formulary.	NO	NO	X
MOM.3: Documented policies and procedures guide the storage of medication					
	a	Documented policies and procedures exist for storage of medication	YES	YES	Pharmacy Manual
	b	Medications are stored in a clean; safe and secure environment; and incorporating manufacturer's recommendation (s).	XXX	YES	To be observed
	c	Sound inventory control practices guide storage of the medications.	NO	NO	
	d	Sound alike and look alike medications are identified and stored separately.*	YES	YES	Separate List available
	e	The list of emergency medications is defined and is stored in a uniform manner	YES	YES	Crash cart to be maintained in Casualty, ICUs & OTs
	f	Emergency medications are available all the time.	YES	YES	To be verified by observation method
	g	Emergency medications are replenished in a timely manner when used.	YES	YES	Crash cart inventory record
MOM.4: Documented policies and procedures guide the safe and rational prescription of medications					
	a	Documented policies and procedures exist for prescription of medications.	YES	YES	Circular to be issued
	b	These incorporate inclusion of good practices/guidelines for rational prescription of medications.	YES	YES	Do
	c	The organization determines the minimum requirements of a prescription.	YES	YES	model prescription format
	d	Known drug allergies are ascertained before prescribing.	YES	YES	BY OBSERVATION

e	The organization determines who can write orders.*	YES	YES	List of approved doctors
f	Orders are written in a uniform location in the medical records.	YES	YES	Observation of prescriptions
g	Medication orders are clear, legible, dated, timed, named and signed.	YES	YES	To be audited by clinical audit team
h	Medication orders contain the name of the medicine, route of administration, dose to be administered and frequency/time of administration.	YES	YES	Do
i	Documented policy and procedure on verbal orders is implemented.	YES	YES	to be revised/ discussed with
j	The organization defines a list of high risk medication (s).	YES	YES	List to be approved
k	Audit of medication orders/prescription is carried out to check for safe and rational prescription of medications.	YES	NO	To be done by Clinical Audit Committee
l	Corrective and/or preventive action (s) is taken based on the analysis where appropriate.	YES	NO	Do
MOM.5: Documented policies and procedures guide the safe dispensing of medications.				
a	Documented policies and procedures guide the safe dispensing of medications	NO	YES	TRAINING TO BE PROVIDED TO PHARMACY
b	The procedure addresses medication recall.	YES	YES	Recall in wards to be recorded in nursing notes
c	Expiry dates are checked prior to dispensing.	YES	YES	Checklist/ Instructions for Pharmacy to be developed
d	There is a procedure for near expiry medications.	YES	YES	BY OBSERVATION
e	Labelling requirements are documented and implemented by the organization.			
f	High risk medication orders are verified prior to dispensing.	YES	YES	Verification by interview

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.	YES	YES	List of nurse authorized for administration. Patient file to contain name of nurse and doctor
	b	Prepared medication is labelled prior to preparation of a second drug.	YES	YES	By observation
	c	Patient is identified prior to administration.	YES	YES	
	d	Medication is verified from the order prior to administration.	YES	YES	Drug administration record
	e	Dosage is verified from the order prior to administration.	YES	YES	Do
	f	Route is verified from the order prior to administration.	YES	YES	Do
	g	Timing is verified from the order prior to administration.	YES	YES	Do
	h	Medication administration is documented.	YES	YES	Do
	i	Documented policies and procedures govern patient's self- administration of medications.	YES	YES	to be discussed
	j	Documented policies and procedures govern patient's medications brought from outside the organization.*	NO	NO	to be discussed
MOM.7: Patients are monitored after medication administration.					
	a	Documented policies and procedures guide the monitoring of patients after medication administration.	NO	NO	to be documented
	b	The organization defines those situations where close monitoring is required.	NO	NO	to be documented
	c	Monitoring is done in a collaborative manner.	YES	YES	case sheet
	d	Medications are changed where appropriate based on the monitoring.	YES	YES	case sheet
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	YES	YES	

		event.			
	b	Near miss, medication error and adverse drug event are defined.	YES	YES	
	c	These are reported within a specified time frame.	NO	NO	To be discussed
	d	They are collected and analysed.	YES	YES	Case Sheet
	e	Corrective and/or preventive action (s) is taken based on the analysis where appropriate.	YES	YES	ADE Format circulated in wards
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.	YES	YES	Pharmacy Manual
	b	These drugs are stored in a secure manner.	YES	YES	do
	c	A proper record is kept of the usage, administration and disposal of these drugs.	YES	YES	Inventory record of Narcotic medicines
	d	These drugs are handled by appropriate personnel in accordance with the documented procedure.	YES	YES	Pharmacy Manual
MOM.10: Documented policies and procedures guide the usage of chemotherapeutic agents.					
	a	Documented policies and procedures guide the usage of chemotherapeutic agents.	YES	YES	Pharmacy Manual
	b	Chemotherapy is prescribed by those who have the knowledge to monitor and treat the adverse effect of chemotherapy.	YES	YES	List of trained doctors and nurse
	c	Chemotherapy is prepared in a proper and safe manner and administered by qualified personnel.	YES	YES	Competency criteria as per MCI Guidelines
	d	Chemotherapy drugs are disposed off in accordance with legal requirements.	YES	YES	Pharmacy manual to be revised
MOM.11: Documented policies and procedures govern usage of radioactive drugs.					

	a	Documented policies and procedures govern usage of radioactive drugs.	NA		
	b	These policies and procedures are in consonance with laws and regulations.	NA		
	c	The policies and procedures include the safe storage, preparation, handling, distribution and disposal of radioactive drugs.	NA		
	d	Staff, patients and visitors are educated on safety precautions.	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).	YES	YES	Pharmacy Manual
	b	Documented policies and procedures govern procurement, storage / stocking, issuance and usage of implantable prosthesis and medical devices incorporating manufacturer's recommendation(s).*	NO	NO	SOP From Orthopedics, dental etc. to be procured
	c	Patient and his / her family are counselled for the usage of implantable prosthesis and medical device including precautions, if any.	YES	YES	Patient education and consent form
	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.	YES	YES	To be verified
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.	YES	YES	Store and Purchase Manual
	b	Medical supplies and consumables are used in a safe manner where appropriate.	YES	YES	Inventory management by HIS, List of HAZMAT in each ward to be verified
	c	Medical supplies and consumables are stored in a clean; safe and secure environment; and incorporating manufacturer's recommendation (s).	YES	YES	By observation

	d	Sound inventory control practices guide storage of medical supplies and consumables.	YES	YES	Reorder level to be verified
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.	YES	On going	SOP, Boards has to be formed
	b	Patients and families are informed of their rights and responsibilities in a format and language that they can understand.	YES	On going	Boards has to be formed
	c	The organization's leaders protect patient and family rights.	YES	YES	SOP
	d	Staff is aware of their responsibility in protecting patient and family rights.	YES	YES	SOP
	e	Violation of patient and family rights is recorded, reviewed and corrective / preventive measures taken.	YES	YES	SOP
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.	YES	YES	visual
	b	Patient and family rights include respect for personal dignity and privacy during examination, procedures and treatment.	YES	YES	visual
	c	Patient and family rights include protection from physical abuse or neglect.	YES	YES	visual
	d	Patient and family rights include treating patient information as confidential.	YES	YES	Confidential
	e	Patient and family rights include refusal of treatment.	YES	YES	Consent form
	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.	YES	YES	Consent form
	g	Patient and family rights include right to complain and information on how to voice a complaint.	YES	YES	PCC, Feedback form
	h	Patient and family rights include information on the expected cost of the treatment.	YES	YES	Case sheet

	i	Patient and family rights include access to his / her clinical records.	YES	YES	Case sheet
	j	Patient and family rights include information on plan of care, progress and information on their health care needs.	YES	YES	SOP, case sheet
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.	YES	YES	Verbally
	b	The patient and/or family members are explained about the expected results.	YES	YES	Verbally
	c	The patient and / or family members are explained about the possible complications.	YES	YES	Verbally
	d	The care plan is prepared and modified in consultation with patient and/or family members.	YES	YES	Verbally
	e	The care plan respects and where possible incorporates patient and/or family concerns and requests.	YES	YES	SOP
	f	The patient and/or family members are informed about the results of diagnostic tests and the diagnosis	YES	YES	Verbally
	g	g. The patient and/or family members are explained about any change in the patient's condition.	YES	YES	Verbally
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.	YES	YES	Case sheet
	b	General consent for treatment is obtained when the patient enters the organization.	YES	YES	Consent form
	c	Patient and/or his family members are informed of the scope of such general consent.	YES	YES	Verbally
	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.	YES	YES	Consent form
	e	The procedure describes who can give consent when patient is incapable of	YES	YES	HR policy

		independent decision making.			
	f	Informed consent is taken by the person performing the procedure.	YES	YES	Consent form
	g	Informed consent process adheres to statutory norms.	YES	YES	SOP
	h	Staff are aware of the informed consent procedure.	YES	YES	Verbally
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.	YES	YES	Counselling
	b	Patient and/or family are educated about food-drug interactions.	YES	YES	Counselling
	c	Patient and/or family are educated about diet and nutrition.	YES	YES	Counselling , diet chart
	d	Patient and/or family are educated about immunizations.	YES	YES	Counselling, immunization chart
	e	Patient and/or family are educated about organ donation, when appropriate.	YES	YES	Counselling, consent form
	f	Patient and/or family are educated about their specific disease process, complications and prevention strategies.	YES	YES	Counselling
	g	Patient and/or family are educated about preventing healthcare associated infections.	YES	YES	Counselling
	h	Patient and/or family are educated in a language and format that they can understand.	YES	YES	Verbally
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).	YES	YES	SOP
	b	The tariff list is available to patients.	YES	YES	Tariff card
	c	The patient and/or family members are explained about the expected costs.	YES	YES	Verbally, Tariff card, Packages displayed on website
	d	Patient and/or family are informed about the financial implications when there is a change in the patient condition or treatment setting.	YES	YES	Counselling

PRE.7: Organization has a complaint redressal procedure.					
	a	The organization has a documented complaint redressal procedure.	YES	YES	Feedback form
	b	Patient and/or family members are made aware of the procedure for lodging complaints.	YES	YES	Counselling
	c	All complaints are analysed.	YES	YES	--
	d	Corrective and/or preventive action (s) is taken based on the analysis where appropriate.	YES	YES	--
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.	YES	YES	SOP
	b	The infection prevention and control programme is a continuous process and updated at least once in a year.	YES	YES	Prevention & Complaint register
	c	The hospital has a multi-disciplinary infection control committee which co-ordinates all infection prevention and control activities.	YES	YES	Minutes of meeting
	d	The hospital has an infection control team which co-ordinates implementation of all infection prevention and control activities.	YES	YES	Register of preventive action taken
	e	The hospital has designated infection control officer as part of the infection control team.	YES	YES	--
	f	The hospital has designated infection control nurse(s) as part of the infection control team.	YES	YES	--
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	YES	YES	SOP
	b	The organization adheres to standard precautions at all times.	YES	YES	SOP
	c	The organization adheres to hand hygiene guidelines.	YES	NO	SOP, chart need to be

				displayed
d	The organization adheres to safe injection and infusion practices.	YES	NO	Needle stick injury policy, trainng module need to be formed
e	The organization adheres to transmission based precautions at all times.	YES	YES	Isolated area present
f	The organization adheres to cleaning, disinfection and sterilization practices	YES	YES	Monitored
g	An appropriate antibiotic policy is established and implemented.	NO	NO	x
h	The organization adheres to laundry and linen management processes.	NO	NO	x
i	The organization adheres to kitchen sanitation and food handling issues.	NO	NO	x
j	The organization has appropriate engineering controls to prevent infections.	YES	YES	Monitor sheet
k	The organization adheres to housekeeping procedures.	YES	YES	Monitored
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.	NO	NO	x
b	Collection of surveillance data is an on-going process.	NO	NO	x
c	Verification of data is done on a regular basis by the infection control team.	NO	NO	x
d	Scope of surveillance activities incorporates tracking and analysing of infection risks, rates and trends.	NO	NO	x
e	Surveillance activities include monitoring the compliance with hand hygiene guidelines.	NO	NO	x
f	Surveillance activities include monitoring the effectiveness of housekeeping services.	NO	NO	x
g	Appropriate feedback regarding HAI rates are provided on a regular basis to appropriate personnel.	NO	NO	x
h	In cases of notifiable diseases, information (in relevant format) is sent to appropriate authorities.	NO	NO	x
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.	YES	YES	Quality indicator

	b	The organization takes action to prevent respiratory tract infections.	YES	YES	Quality indicator
	c	The organization takes action to prevent intra-vascular device infections.	YES	YES	Quality indicator
	d	The organization takes action to prevent surgical site infections.	YES	YES	Quality indicator
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.	YES	YES	
	b	Adequate and appropriate facilities for hand hygiene in all patient care areas are accessible to health care providers.	YES	YES	
	c	Isolation / barrier nursing facilities are available.	YES	YES	
	d	Appropriate pre and post exposure prophylaxis is provided to all concerned staff members.	YES	YES	
HIC.6: The organization identifies and takes appropriate action to control outbreaks of infections.					
	a	Organization has a documented procedure for identifying an outbreak.	YES	YES	Outbreak sheet
	b	Organization has a documented procedure for handling such outbreaks.	YES	YES	Outbreak sheet
	c	This procedure is implemented during outbreaks.	YES	YES	Outbreak sheet
	d	After the outbreak is over appropriate corrective actions are taken to prevent recurrence.	YES	YES	By HIC committee
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.	YES	YES	--
	b	Documented procedure guides the cleaning, packing, disinfection and/or sterilization, storing and issue of items.	YES	YES	SOP
	c	Reprocessing of instruments and equipment are covered.	YES	YES	SOP

	d	Regular validation tests for sterilization are carried out and documented.	YES	YES	SOP, Test report
	e	There is an established recall procedure when breakdown in the sterilization system is identified.	NO	NO	X
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.	YES	YES	SOP, Segregation chart displayed
	b	Proper segregation and collection of biomedical waste from all patient care areas of the hospital is implemented and monitored.	YES	YES	SOP, Segregation displayed
	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.	YES	YES	SOP, Segregation displayed
	d	Biomedical waste treatment facility is managed as per statutory provisions (if in-house) or outsourced to authorised contractor(s).	YES	YES	SOP
	e	Appropriate personal protective measures are used by all categories of staff handling biomedical waste.	YES	YES	SOP
HIC.9: The infection control programme is supported by the management and includes training of staff.					
	a	The management makes available resources required for the infection control programme.	YES	YES	SOP
	b	The organization earmarks adequate funds from its annual budget in this regard.	YES	YES	SOP
	c	The organization conducts induction training for all staff.	YES	YES	Training record
	d	The organization conducts appropriate "in-service" training sessions for all staff at least once in a year.	NO	NO	X
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.	YES	YES	SOP

	b	The quality improvement programme is documented.	YES	YES	SOP
	c	There is a designated individual for coordinating and implementing the quality improvement programme.	YES	YES	SOP
	d	The quality improvement programme is comprehensive and covers all the major elements related to quality assurance and supports innovation.	NO	NO	Quality assurance programme
	e	The designated programme is communicated and coordinated amongst all the staff of the organization through appropriate training mechanism.	YES	YES	-
	f	The quality improvement programme identifies opportunities for improvement based on review at pre-defined intervals.	NO	NO	X
	g	The quality improvement programme is a continuous process and updated at least once in a year.	NO	NO	X
	h	Audits are conducted at regular intervals as a means of continuous monitoring.	NO	NO	X
	i	There is an established process in the organization to monitor and improve quality of nursing and complete patient care.	YES	YES	Training Record
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.	YES	YES	Committee formed
	b	The patient safety programme is documented.	YES	YES	SOP
	c	The patient safety programme is comprehensive and covers all the major elements related to patient safety and risk management.	YES	YES	Risk management policy
	d	The scope of the programme is defined to include adverse events ranging from “no harm” to “sentinel events”.	YES	NO	Sentinel events, adverse events form need to be reviewed
	e	There is a designated individual for coordinating and implementing the patient safety programme.			
	f	The designated programme is communicated and coordinated amongst all the staff of the organization through appropriate training mechanism.	NO	NO	x

	g	The patient safety programme identifies opportunities for improvement based on review at pre-defined intervals.	YES	YES	Patient feedback form
	h	The patient safety programme is a continuous process and updated at least once in a year.	YES	YES	CME
	i	The organization adapts and implements national/international patient safety goals/solutions.	YES	YES	
	j	The organization uses at least two identifiers to identify patients across the organization.	YES	YES	Hospital manager
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.	YES	YES	Patient assessment sheet
	b	Monitoring includes safety and quality control programmes of all the diagnostic services.	YES	YES	SOP
	c	Monitoring includes medication management.	YES	YES	SOP
	d	Monitoring includes use of anaesthesia.	YES	YES	SOP
	e	Monitoring includes surgical services.	YES	YES	SOP
	f	Monitoring includes use of blood and blood products.	YES	YES	SOP
	g	Monitoring includes infection control activities.	YES	YES	SOP
	h	Monitoring includes review of mortality and morbidity indicators.	YES	YES	SOP
	i	Monitoring includes clinical research.	YES	YES	SOP
	j	Monitoring includes data collection to support further improvements.	YES	YES	SOP
	k	Monitoring includes data collection to support evaluation of these improvements.	YES	YES	SOP
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.			

	b	Monitoring includes risk management.	YES	YES	SOP
	c	Monitoring includes utilisation of space, manpower and equipment.	YES	YES	SOP
	d	Monitoring includes patient satisfaction which also incorporates waiting time for services.	YES	YES	SOP
	e	Monitoring includes employee satisfaction.	YES	YES	SOP
	f	Monitoring includes adverse events and near misses.	YES	YES	SOP
	g	Monitoring includes availability and content of medical records.	YES	YES	SOP
	h	Monitoring includes data collection to support further improvements.	YES	YES	Data collection sheet
	i	Monitoring includes data collection to support evaluation of these improvements.	YES	YES	Office orders
CQI.5: The quality improvement programme is supported by the management.					
	a	The management makes available adequate resources required for quality improvement programme.	NO	NO	x
	b	Organization earmarks adequate funds from its annual budget in this regard.	NO	NO	x
	c	The management identifies organizational performance improvement targets.	NO	NO	x
	d	The management supports and implements use of appropriate quality improvement, statistical and management tools in its quality improvement programme.	NO	NO	x
CQI.6: There is an established system for clinical audit.					
	a	Medical and nursing staff participates in this system.	YES	YES	Clinical Audit sheet
	b	The parameters to be audited are defined by the organization.	YES	YES	Clinical Audit sheet
	c	Patient and staff anonymity is maintained.	YES	YES	Clinical Audit sheet
	d	All audits are documented.	YES	YES	Clinical Audit sheet
	e	Remedial measures are implemented.	YES	YES	Clinical Audit sheet
CQI.7: Incidents, complaints and feedback are collected and analysed to ensure continual quality improvement.					

	a	The organization has an incident reporting system.	YES	YES	Feedback form
	b	The organization has a process to collect feedback and receive complaints.	YES	YES	Feedback form
	c	The organization has established processes for analysis of incidents, feedbacks and complaints.	NO	NO	Feedback form, Complaint register
	d	Corrective and preventive actions are taken based on the findings of such analysis.	YES	YES	SOP
	e	Feedback about care and service is communicated to staff.	YES	YES	SOP
CQI.8: Sentinel events are intensively analysed.					
	a	The organization has defined sentinel events.	NO	NO	x
	b	The organization has established processes for intense analysis of such events.	NO	NO	x
	c	Sentinel events are intensively analysed when they occur.	NA		
	d	Corrective and Preventive Actions are taken based on the findings of such analysis.	-	-	-
Chapter 7: Responsibilities of Management (ROM)					
ROM.1: The responsibilities of those responsible for governance are defined.					
	a	Those responsible for governance lay down the organization's vision, mission and values.	NO	NO	x
	b	Those responsible for governance approve the strategic and operational plans and organization's budget.	NO	NO	x
	c	Those responsible for governance monitor and measure the performance of the organization against the stated mission.	NO	NO	x
	d	Those responsible for governance establish the organization's organogram.	NO	NO	x
	e	Those responsible for governance appoint the senior leaders in the organization.	NO	NO	x
	f	Those responsible for governance support safety initiatives and quality improvement plans.	NO	NO	x
	g	Those responsible for governance support research activities.	NO	NO	x
	h	Those responsible for governance address the organization's social responsibility.	NO	NO	x

	i	Those responsible for governance inform the public of the quality and performance of services.	NO	NO	x
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.	NO	NO	x
	b	The management ensures implementation of these requirements.	NO	NO	x
	c	Management regularly updates any amendments in the prevailing laws of the land.	NO	NO	X
	d	There is a mechanism to regularly update licenses/ registrations/certifications.	NO	NO	X
ROM.3: The services provided by each department are documented.					
	a	Scope of services of each department is defined	NO	NO	X
	b	Administrative policies and procedures for each department are maintained.	NO	NO	X
	c	Each organizational programme, service, site or department has effective leadership.	NO	NO	X
	d	Departmental leaders are involved in quality improvement.	NO	NO	X
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.	NO	NO	x
	B	The leaders establish the organization's ethical management.	NO	NO	x
	C	The organization discloses its ownership.	NO	NO	x
	D	The organization honestly portrays the services which it can and cannot provide.	NO	NO	x
	E	The organization honestly portrays its affiliations and accreditations.	NO	NO	x
	F	The organization accurately bills for its services based upon a standard billing tariff.	NO	NO	x
ROM.5: The organization displays professionalism in management of affairs.					
	a	The person heading the organization has requisite and appropriate administrative qualifications.	NO	NO	x
	b	The person heading the organizationhas requisite and appropriate administrative experience.	NO	NO	x

	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.	NO	NO	x
	d	d. The organization coordinates the functioning with departments and external agencies, and monitors the progress in achieving the defined goals and objectives.	NO	NO	x
	e	The organization plans and budgets for its activities annually.	NO	NO	x
	f	The performance of the senior leaders is reviewed for their effectiveness.	NO	NO	x
	g	The functioning of committees is reviewed for their effectiveness.	NO	NO	x
	h	The organization documents employee rights and responsibilities.	NO	NO	x
	i	The organization documents the service standards.	NO	NO	x
	j	The organization has a formal documented agreement for all outsourced services.	NO	NO	x
	k	The organization monitors the quality of the outsourced services.	NO	NO	x
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.	NO	NO	x
	b	Management provides resources for proactive risk assessment and risk reduction activities.	NO	NO	x
	c	Management ensures implementation of systems for internal and external reporting of system and process failures.	NO	NO	x
	d	Management ensures that appropriate corrective and preventive action is taken to address safety related incidents.	NO	NO	x
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	YES	YES	SOP
	b	Patient safety devices are installed across the organization and inspected periodically.	YES	YES	AMCs

	c	The organization is a non-smoking area.	YES	YES	Board Displayed
	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.	NO	NO	Inspection done in 5 years
	e	Inspection reports are documented and corrective and preventive measures are undertaken.	YES	YES	By GM Services
	f	There is a safety education programme for staff.	YES	YES	Mock drills
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.	YES	YES	SOP
	b	Up-to-date drawings are maintained which detail the site layout, floor plans and fire escape routes.	NO	NO	X
	c	There is internal and external sign posting in the organization in a language understood by patient, families and community.	YES	YES	Displayed
	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.	YES	YES	Displayed
	e	Potable water and electricity are available round the clock.	YES	YES	Monitored
	f	Alternate sources for electricity and water are provided as backup for any failure / shortage.	YES	YES	Backup present & tested regularly
	g	The organization regularly tests these alternate sources.	YES	YES	Testing report
	h	There are designated individuals responsible for the maintenance of all the facilities.	YES	YES	
	i	There is a documented operational and maintenance (preventive and breakdown) plan.	YES	YES	SOP
	j	Maintenance staff is contactable round the clock for emergency repairs.	YES	YES	Attendance sheet
	k	Response times are monitored from reporting to inspection and implementation of corrective actions.	YES	YES	Reports formed
FMS.3: The organization has a programme for engineering support services.					
	a	The organization plans for equipment in accordance with its services and strategic	YES	YES	SOP

	plan.			
b	Equipment are selected, rented, updated or upgraded by a collaborative process.	YES	YES	-
c	Equipment are inventoried and proper logs are maintained as required.	YES	YES	Maintenance sheet
d	Qualified and trained personnel operate and maintain equipment and utility systems.	YES	YES	HR policy
e	There is a documented operational and maintenance (preventive and breakdown) plan.	YES	YES	Maintenance report
f	There is a maintenance plan for water management.	NO	NO	x
g	There is a maintenance plan for electrical systems.	YES	YES	Maintenance sheet
h	There is a maintenance plan for heating, ventilation and air-conditioning.	YES	YES	Maintenance sheet
i	There is a documented procedure for equipment replacement and disposal.	YES	YES	Replacement & disposal policy
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.	NO	NO	x
b	Equipment are selected, rented, updated or upgraded by a collaborative process.	YES	YES	Maintenance sheet
c	Equipment are inventoried and proper logs are maintained as required.	YES	YES	Maintenance sheet
d	Qualified and trained personnel operate and maintain the medical equipment.	YES	YES	-
e	Equipment are periodically inspected and calibrated for their proper functioning.	YES	YES	Inspection report
f	There is a documented operational and maintenance (preventive and breakdown) plan.	YES	YES	Maintenance sheet
g	There is a documented procedure for equipment replacement and disposal.*	YES	YES	Replacement & disposal policy
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.	NO	NO	x

	b	Medical gases are handled, stored, distributed and used in a safe manner.	YES	YES	Maintenance sheet
	c	The procedures for medical gases address the safety issues at all levels.	YES	YES	Maintenance sheet
	d	Alternate sources for medical gases, vacuum and compressed air are provided for, in case of failure.	YES	YES	Maintenance sheet
	e	The organization regularly tests these alternate sources.	YES	YES	Maintenance sheet
	f	There is an operational and maintenance plan for piped medical gas, compressed air and vacuum installation.*	YES	YES	Maintenance sheet
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.	YES	YES	Layout plan
	b	The organization has a documented safe exit plan in case of fire and non-fire emergencies.	NO	NO	x
	c	Staff are trained for their role in case of such emergencies	NO	NO	x
	d	Mock drills are held at least twice in a year.	NO	NO	x
	e	There is a maintenance plan for fire related equipment.	NO	NO	x
FMS.7: The organization plans for handling community emergencies, epidemics and other disasters.					
	a	The organization identifies potential emergencies.	YES	YES	-
	b	The organization has a documented disaster management plan.	YES	YES	SOP
	c	Provision is made for availability of medical supplies, equipment and materials during such emergencies.	YES	YES	-
	d	Staff are trained in the hospital's disaster management plan.	YES	YES	SOP
	e	The plan is tested at least twice in a year.	YES	YES	Test sheet
FMS.8: The organization has a plan for management of hazardous materials.					
	a	Hazardous materials are identified within the organization.	NO	NO	x
	b	The organization implements processes for sorting, labelling, handling, storage, transporting and disposal of hazardous	YES	YES	-

		material.			
	c	Requisite regulatory requirements are met in respect of radioactive materials.	NA		
	d	There is a plan for managing spills of hazardous materials.	YES	YES	SOP
	e	Staff are educated and trained for handling such materials.	YES	YES	Training record
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.	YES	YES	SOP
	b	The organization maintains an adequate number and mix of staff to meet the care, treatment and service needs of the patient.	YES	YES	SOP
	c	The required job specification and job description are well defined for each category of staff.	YES	YES	SOP
	d	The organization verifies the antecedents of the potential employee with regards to criminal/negligence background.	YES	YES	SOP
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.	YES	YES	SOP
	b	Recruitment is based on pre-defined criteria	YES	YES	SOP
	c	Every staff member entering the organization is provided induction training	YES	NO	SOP, Induction book
	d	The induction training includes orientation to the organization's vision, mission and values.	YES	NO	SOP, Induction book
	e	The induction training includes awareness on employee rights and responsibilities.	YES	NO	SOP, Induction book
	f	The induction training includes awareness on patient's rights and responsibilities.	YES	NO	SOP, Induction book
	g	The induction training includes orientation to the service standards of the organization.	YES	NO	SOP, Induction book
	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.	YES	YES	SOP, Include beside ID card

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.	NO	NO	X
	b	The organization maintains the training record.	YES	YES	Training record
	c	Training also occurs when job responsibilities change/ new equipment is introduced.	YES	YES	Training record
	d	Feedback mechanisms for assessment of training and development programme exist and the feedback is used to improve the training programme.	NO	NO	x
HRM.4. Staff are adequately trained on various safety related aspects.					
	a	Staff are trained on the risks within the organization's environment.	NO	NO	x
	b	Staff members can demonstrate and take actions to report, eliminate / minimize risks.	NO	NO	x
	c	Staff members are made aware of procedures to follow in the event of an incident.	NO	NO	x
	d	Staff are trained on occupational safety aspects.	NO	NO	x
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.*	YES	YES	SOP
	b	The employees are made aware of the system of appraisal at the time of induction.	YES	YES	SOP
	c	Performance is evaluated based on the pre-determined criteria.	YES	YES	SOP
	d	The appraisal system is used as a tool for further development.	YES	YES	SOP
	e	Performance appraisal is carried out at pre-defined intervals and is documented.	YES	YES	SOP
HRM.6. The organization has documented disciplinary and grievance handling policies and procedures.					
	a	Documented policies and procedures exist.	YES	YES	SOP
	b	The policies and procedures are known to all categories of staff of the organization.	YES	YES	SOP

	c	The disciplinary policy and procedure is based on the principles of natural justice.	YES	YES	SOP
	d	The disciplinary procedure is in consonance with the prevailing laws.	YES	YES	SOP
	e	There is a provision for appeals in all disciplinary cases.	YES	YES	SOP
	f	The redress procedure addresses the grievance.	YES	YES	SOP
	g	Actions are taken to redress the grievance.	YES	YES	SOP
HRM.7. The organization addresses the health needs of the employees.					
	a	A pre-employment medical examination is conducted on all the employees.	YES	YES	Examination sheet
	b	Health problems of the employees are taken care of in accordance with the organization's policy.	YES	YES	SOP
	c	Regular health checks of staff dealing with direct patient care are done at-least once a year and the findings/ results are documented.	YES	YES	SOP
	d	Occupational health hazards are adequately addressed.	YES	YES	SOP
HRM.8. There is documented personal information for each staff member.					
	a	Personal files are maintained in respect of all staff.	YES	YES	Staff separate file
	b	The personal files contain personal information regarding the staff's qualification, disciplinary background and health status.	YES	YES	Staff separate file
	c	All records of in-service training and education are contained in the personal files.	YES	YES	Staff separate file
	d	Personal files contain results of all evaluations.	YES	YES	Staff separate file
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.	YES	YES	SOP
	b	The education, registration, training and experience of the identified medical professionals is documented and updated periodically.	YES	YES	

c	All such information pertaining to the medical professionals is appropriately verified when possible.	YES	YES	
d	Medical professionals are granted privileges to admit and care for patients in consonance with their qualification, training, experience and registration.	YES	YES	HR Policy
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.	YES	YES	
f	Medical professionals admit and care for patients as per their privileging.	YES	YES	Staff separate file

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.	YES	YES	SOP
b	The education, registration, training and experience of nursing staff is documented and updated periodically.	YES	YES	SOP
c	All such information pertaining to the nursing staff is appropriately verified when possible.	YES	YES	SOP
d	Nursing staff are granted privileges in consonance with their qualification, training, experience and registration.	YES	YES	SOP
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.	YES	YES	SOP
f	Nursing professionals care for patients as per their privileging.	YES	YES	SOP

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

	c	These policies and procedures are in compliance with the prevailing laws and regulations.	YES	YES	SOP
	d	All information management and technology acquisitions are in accordance with the documented policies and procedures.	YES	YES	SOP
	e	The organization contributes to external databases in accordance with the law and regulations.	YES	YES	SOP
IMS.2. The organization has processes in place for effective management of data.					
	a	Formats for data collection are standardized.	YES	YES	Through HIS
	b	Necessary resources are available for analysing data.	YES	YES	HIS
	c	Documented procedures are laid down for timely and accurate dissemination of data.	YES	YES	SOP
	d	Documented procedures exist for storing and retrieving data.	YES	YES	HIS, backup
	e	Appropriate clinical and managerial staff participates in selecting, integrating and using data.	YES	YES	Software password
IMS.3. The organization has a complete and accurate medical record for every patient.					
	a	Every medical record has a unique identifier.	YES	YES	UHID
	b	Organization policy identifies those authorized to make entries in medical record.	YES	YES	Password protection
	c	Entry in the medical record is named, signed, dated and timed.	YES	YES	HIS
	d	The author of the entry can be identified.	YES	YES	Password protection
	e	The contents of medical record are identified and documented.	YES	YES	HIS
	f	The record provides a complete, up-to-date and chronological account of patient care.	YES	YES	Identical record of every patient by UHID number
	g	Provision is made for 24-hour availability of the patient's record to healthcare providers to ensure continuity of care.	YES	YES	Maintained
IMS.4. The medical record reflects continuity of care.					
	a	The medical record contains information regarding reasons for admission, diagnosis and plan of care.	YES	YES	HIS

	b	The medical record contains the results of tests carried out and the care provided.	YES	YES	HIS
	c	Operative and other procedures performed are incorporated in the medical record.	YES	YES	HIS
	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.	YES	YES	HIS
	e	The medical record contains a copy of the discharge summary duly signed by appropriate and qualified personnel.	YES	YES	HIS
	f	In case of death, the medical record contains a copy of the cause of death certificate.	YES	YES	HIS
	g	Whenever a clinical autopsy is carried out, the medical record contains a copy of the report of the same.	YES	YES	HIS
	h	Care providers have access to current and past medical record.	YES	YES	HIS
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.	YES	YES	SOP
	b	Documented policies and procedures are in consonance with the applicable laws.	YES	YES	SOP
	c	The policies and procedure (s) incorporate safeguarding of data/ record against loss, destruction and tampering.	YES	YES	SOP
	d	The organization has an effective process of monitoring compliance of the laid down policy and procedure.	YES	YES	SOP
	e	The organization uses developments in appropriate technology for improving confidentiality, integrity and security.	YES	YES	SOP
	f	Privileged health information is used for the purposes identified or as required by law and not disclosed without the patient's authorization.	YES	YES	SOP, confidential
	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.*	NO	NO	X
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.	YES	YES	SOP
b	The policies and procedures are in consonance with the local and national laws and regulations.	YES	YES	SOP
c	The retention process provides expected confidentiality and security.	YES	YES	SOP
d	The destruction of medical records, data and information is in accordance with the laid down policy.	YES	YES	SOP

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

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a	The medical records are reviewed periodically.	YES	YES	HIS
b	The review uses a representative sample based on statistical principles.	YES	YES	Dashboard
c	The review is conducted by identified care providers.	YES	YES	HIS head
d	The review focuses on the timeliness, legibility and completeness of the medical records.	YES	YES	Maintained automatically
e	The review process includes records of both active and discharged patients.	YES	YES	HIS
f	The review points out and documents any deficiencies in records.	YES	YES	HIS pop up
g	Appropriate corrective and preventive measures are undertaken within a defined period of time and are documented.	YES	YES	SOP