Dissertation in Octavo Solutions

"A Study on Gap Analysis of a Multi Specialty Hospital Gurgaon"

A Dissertation Proposal for

Post Graduate Diploma in Health and Hospital Management

by

Dr. Mohammad Sazid khan (PT)

Roll no. PG/11/049

International Institute of Health Management Research

New Delhi – 110075

April, 2013

Dissertation in Octavo Solutions

"A **Study on Gap Analysis of a Multi Specialty Hospital Gurgaon"**

A dissertation submitted in partial fulfillment of the requirements

for the award of

Post Graduate Diploma in Health and Hospital Management

by

Dr. Mohammad Sazid khan (PT)

International Institute of Health Management Research

New Delhi – 110075

April, 2013

OCTAVO
SOLUTIONS PVT. LTD.
The Health & Hospital Consultants

Registered with NABET NC07 01 | SE Asia Partners for ACHSI

Certificate of Internship Completion

Dated: 30th April'13

TO WHOM IT MAY CONCERN

This is to certify that **Dr. Mohammad Sazid Khan** has successfully completed his 3 months internship in our organization from **February 01, 2013** to **April 30, 2013**. During this internship period, he has worked on "**Gap Analysis of a Multi Specialty Hospital in Gurgaon**" under the guidance of Ms. Sonia Verma and her team at **Octavo Solutions Pvt. Ltd.**

He has successfully completed his dissertation, proven himself professionally, and his performance has been commendable throughout.

We wish him good luck for his future assignments.

Sonia Verma
Assistant Consultant

Gauri Madan
Asst. HR Manager

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

Corporate Office :
B-4/167, Basement, Safdarjung Enclave, New Delhi-110029
Ph. : 011-64550707, 40536561
Telefax : +91 11 41658335
Website : www.octavosolutions.com • E-mail : info@octavosolutions.com

Certificate of Approval

The following dissertation titled A Study on Gap Analysis of a Multi Speciality Hospital, in Gurgaon 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.

Dissertation Examination Committee for evaluation of dissertation

Name :	Signature:
DR. A. M. Khan.	02/05/13
Dr Dharmesh Lal	19/05/13
Dr. Nitish Degra	27/05/13
Dr VINAY TRIPATHI	

Certificate from Dissertation Advisory Committee

This is to certify that Mr. Mohammad Sazid Khan a graduate student of the Post- Graduate Diploma in Health and Hospital Management has worked under our guidance and supervision. He is submitting this dissertation "A Study on Gap Analysis of a Multi Speciality Hospital, in Gurgaon" in partial fulfillment of the requirements for the award of the Post- Graduate Diploma in Health and Hospital Management.

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

Faculty Mentor
Designation
IIHMR
New Delhi
Date

Organizational Advisor
Designation
Organization
Address Date

IIHMR, Delhi 5

FEEDBACK FORM

Name of the Student: Dr Mohammad Sajid Khan.

Dissertation Organisation: Octavo Solutions Pvt. Ltd.

Area of Dissertation: A study on Gap Analysis of a Multi Speciality Hospital

Attendance: Full.

Objectives achieved: ① Collection & verification of monthly deliverables from onsite Consultants.
② Assisted in Gap Analysis of Multi Speciality Hospital.

Deliverables: Submitted the Gap Analysis of Multi Speciality Hospital.

Strengths: Enthusiastic, Willing to learn & Hardworking.

Suggestions for Improvement: Needs to be more outspoken & improve upon on his interpersonal skills.

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

Sonia.V

Date: 2/5/2013.
Place: New Delhi

ABSTRACT

Dr. Mohammad Sazid khan

Topic: Gap analysis on the multi speciality hospital at gurgoan**.**

Keyword: Gap analysis, NABH, structure, processes, outcome and standard.

Back ground:

This Study is a Gap Analysis which is the initial step in the review of the available service system. It is an efficient base to implement a modern management system. The study identifies the significant **gaps in terms of Structure, Process and Outcome** observed on all the concerned areas .The **gaps are analyzed based on NABH (3nd edition)** standards.

Objective

To assess the gaps related to structure, processes of the multi speciality hospital in gurgaon and to see if outcomes are maintained.

Methodology

Evaluation of all departments is done under parameters of structure, processes and outcome. The organization is further evaluated against 102 standards and 636 objective elements using the NABH self assessment toolkit. A score of 0, 5 or 10 is given against each objective element i.e Compliance to the requirement – 10, Partial compliance – 5, Non Compliance – 0 and Not applicable – NA.Scoring will be done according to improvement of the scope of services

Findings

The analysis shows that overall score of multi-specialty hospital is 6.23 And the lowest score of individual chapter is of chapter No.5 HIC (Hospital infection control) ie and highest score of individual chapter is of chapter no.1AAC (access assessment and continuity of care) ie 6.5. It is concluded that there are some gaps in the hospital as per NABH norms and need for improvement. As the hospital wishes for NABH accreditation so it must be prepared according to the evaluation criteria for assessment.

Recommendations

There are major gaps in the implementation part as the documentation work has been done up to some extent. As of now the hospital fulfills the required criteria to some extent. Thus the hospital is presently prepared for pre assessment progressive level and requires great effort and focus on the weak points like hospital infection control (HIC) so as to cover the gaps and to be prepared for getting NABH accreditation.

Acknowledgements

I want to express gratitude to my mentor **Dr. Bidhan Das**, the MD of Octavo Solutions Pvt. Limited who provided his untiring support in facilitating, motivating and guiding me for the completion of my dissertation Report.

I am sincerely thankful to Mr. Anup Mishra and Sonia Verma, who were extremely helpful, proactive and cooperative to me throughout the interim study. I also convey my thanks to the entire staff of **Multi speciality Hospital in Gurgaon** for helping me while collecting the required data for this project.

I take this opportunity to express my deep sense of gratitude to my guide and mentor**, Prof. Pragya Tiwari Gupta Faculty, IIHMR, New Delhi** for his constant support and encouragement.

My dissertation at Octavo Solutions Pvt. Limited, New Delhi has been an enriching experience and gave me the cordial environment and platform to learn and link my theoretical knowledge with practical knowledge.

Mohammad sazid khan

Table of Contents

Abbreviations

S. No.	Abbreviated form	Full Form
1	AAC	Access, Assessment and Continuity of care
2	AHA	Assistant Hospital Administrator
3	ACHSI	Australian Council of Health Standard International
4	BMW	Bio-Medical Waste
5	COP	Care Of Patients
6	CSSD	Central Sterile and Supply Department
7	CSSD	Central Sterile and Supply Department
8	CDMO	Chief District Medical Officer
9	CQI	Continuous Quality Improvement
10	CAPA	Corrective and Preventive Action
11	FMS	Facility Management System
12	HIC	Hospital Infection Control
13	HMIS	Hospital Management Information System
14	HRM	Human Resource Management
15	IPD	In Patient Department
16	IMS	Information Management System
17	IHMR	Institute of Health Management Research
18	LAN	Local Area network
19	MOM	Management Of Medication
20	NABH	National Accreditation Board for Hospitals and Healthcare Providers
21	OSPL	Octavo Solutions Pvt. Ltd.
23	PRE	Patient Right and Education
24	RMO	Resident Medical Officer
25	ROM	Responsibilities Of Management
26	TBAP	Time Bound Action Plan
27	TQM	Total Quality Management

TABLE1.Abbrevitation

Part 1: INTERNSHIP

Part1. Internship

1.1 Objective of the Internship

The objective of the internship at Octavo Solutions Pvt. Ltd. was to gather an exhaustive knowledge about the Dimensions of a Healthcare Consulting Organization and apply the insights so gained to succeed in the same industry. The Dimensions of a Healthcare Consulting Organization are Planning, System Development and Operation, Quality Healthcare Certification, Public Private Partnership, Capacity Building, Information and Technology, Knowledge Management and Public and Rural Health. Main objective of the internship was to understand the working of my Organization on Quality Management System and Quality Assurance Program.

As a Management Consultant, my roles and responsibilities included understanding the current ongoing Projects being handle by my Organization and understand the functioning of the unit. We are involved in improving the Clinical and Non Clinical Performance Indicators of the Health Facilities. When we talk of improving the performance indicators and achieving the best out of available resources, role of a Healthcare Management Professionals like Management Consultant becomes crucial as they are the person who suggests measures for inputs rectify all the process flow of the healthcare facilities and finally will monitor the healthcare indicators.

1.2 Organization profile

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

Services

1. Project & Strategic Planning

- Business Case Writing
- Facility Plan Draft, Architect Briefs
- Equipment Planning
- Equipment Procurement
- Turn Key Project
- Vision Documents
- Resources Plan Draft

3. Quality Healthcare Certifications

- Gap Analysis & Preparation for Accreditation
- NABH Accreditation
- ISO 9001:2008 Certification
- ACHS International Certification

5. Public & Rural Health

we take up advisory/ consulting role on boards of NGO/ Government/ PSU/ Corporate for planning, implementing or monitoring of their projects in the fields of

- Epidemiology
- Bio Statistics
- Vital Statistics & Surveillance
- Environmental Health
- Health Services Administration
- Training & Education of Public health force

2. Operations & Systems Development

- Managed Operations Contract
- Systems & Policy Development
- Cross Sectional Studies/ Audits
- Process Flow & Mapping
- Change Management
- Facilities Management
- Supply Chain Management

4. Public Private Partnerships

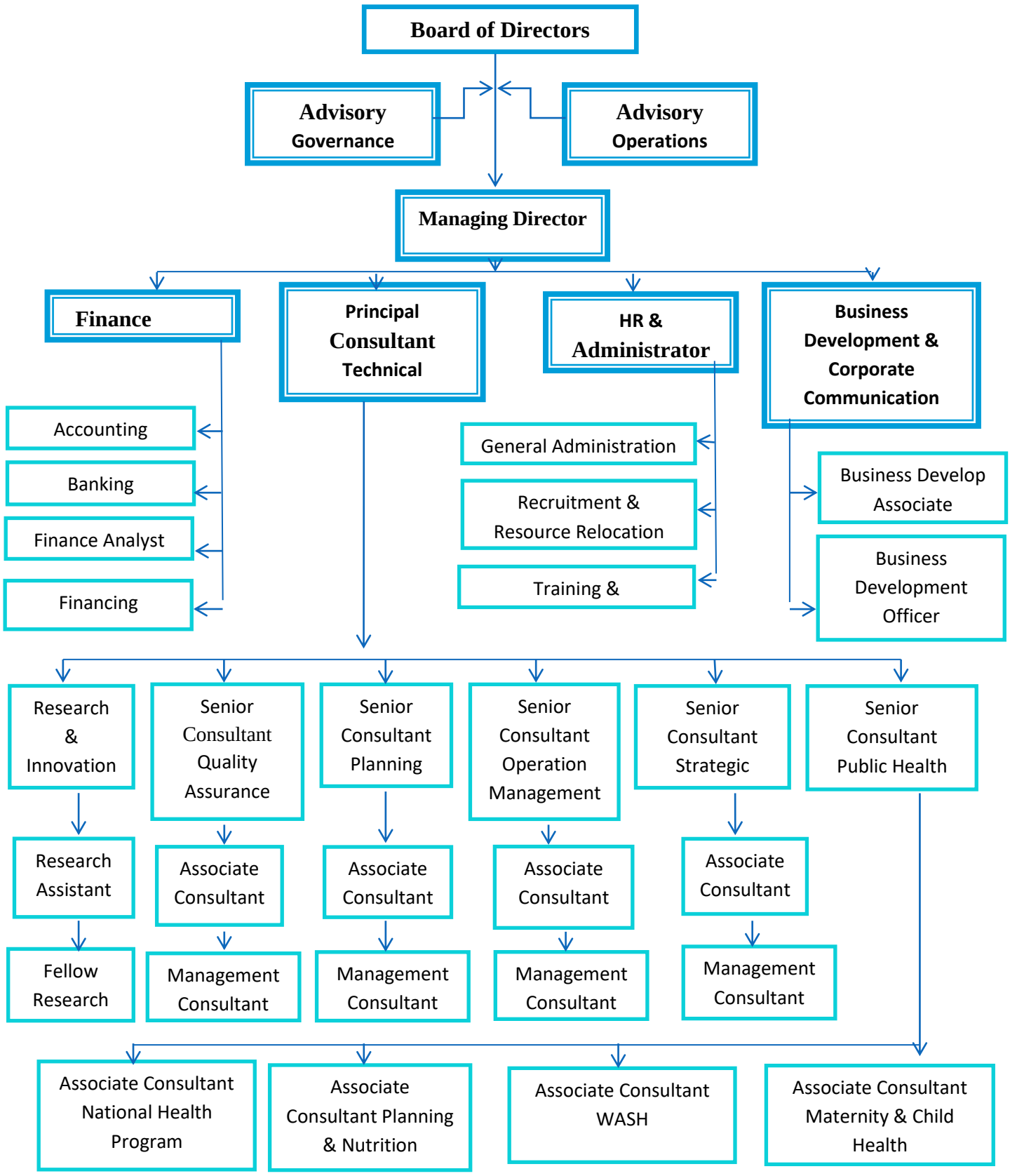
We partner with **Delloitte Teusche/ Feedback Ventures/ Abacus Legal Group** for taking up transaction advisors role in providing consulting services to Government for PPP projects

6. CapacityBuilding

- Manpower (Resource) Allocation & Planning
- Recruitment Contracts
- Continuous Education & Training

We collect, collate, analyze, store and share latest know how's within domain of healthcare sector

TABLE 2. Services


Board of Directors
Advisory Governance
Advisory Operations
Managing Director
Finance
Principal Consultant Technical
HR & Administrator
Business Development & Corporate Communication
Accounting
Banking
Finance Analyst
Financing
General Administration
Recruitment & Resource Relocation
Training &
Business Develop Associate
Business Development Officer
Research & Innovation
Senior Consultant Quality Assurance
Senior Consultant Planning
Senior Consultant Operation Management
Senior Consultant Strategic
Senior Consultant Public Health
Research Assistant
Fellow Research
Associate Consultant
Management Consultant
Associate Consultant
Management Consultant
Associate Consultant
Management Consultant
Associate Consultant
Management Consultant
Associate Consultant National Health Program
Associate Consultant Planning & Nutrition
Associate Consultant WASH
Associate Consultant Maternity & Child Health

OUR TEAM

The foundation upon which our team is created is based upon the premise that motivated people and long-standing relationships are the ultimate tools of success and creativity, energy, perseverance and loyalty are just as important as a platinum resume. We have a team of highly qualified and experienced professionals with proven problem solving, consulting and analytical skills. Our Team consists of Domain Experts & Technical Specialists to provide world class consulting solutions to our clients.

1.3 Key Strengths and Salient Features of OSPL

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

Key Strengths

- A **Private Limited Company** (Reg. No. U72400DL2007PTC159745)
- Short listed firm with **NHSRC** (National Health Systems Resource Centre) under aegis of Ministry of Health & Family Welfare (Government of India)
- **Talented Leadership** from leading institutes like
  - All India Institute of Medical Sciences (Delhi),
  - School of Planning and Architecture (Delhi),
  - Tata Institute of Social Sciences, (Mumbai)
  - Indian Institute of Health Management and Research (Jaipur)
  - Symbiosis Institute of Health Sciences (Pune)
  - Jamia Hamdard University (Delhi)
- Great Team with all essential skills
  - Dr. Bidhan Das- Member, Technical Committee of NABH for drafting standards
  - Dr T. Venkatesh- Member, Technical Committee of NABL for drafting standards
  - Dr Bidhan Das has Standards for Primary Healthcare (NABH) to his credit which is on its (likely) first test in State of Gujarat
- Dr. Bidhan Das- First ACHS International Surveyor (Australian Council for Health Standards) in India

1.4 My Contribution to the Organization

I am working as Management Consultant and being posted at corporate office of OSPL.
The following are some of the tasks that were performed during internship:

1. Preparation of "As Is" reports of various facilities. As is report is Gap analysis of the hospital Facilities.
2. Preparation of Time Bound Action Plan (TBAP) for the Non Conformities.
3. Corrective and Preventive Action (CAPA) report and Internal Audit report and compilation.
4. Monitoring of SOP implementation.
5. Identifying problems faced by the Onsite Consultant at different levels of service delivery and ensuring efficient and quick interventions.
6. Scheduling and going on field visits so as to impart monitor the implementation of various Quality Management System programme.

Special Tasks Performed

Working as a consultant for NABH Accreditation Certification Programme in following hospitals:-

1 Multi Speciality Hospital, Gurgaon
2 I was involved in preparation of checklist and training programme.

1.5 Lesson Learned and Difficulties Faced

- This internship period also taught me the importance of regular monitoring and supportive supervision. This ensures meticulous timely reporting of work progress and motivates the staff to work efficiently and effectively.
- Constant interactions with Onsite consultants and to other Clients whom we are providing the services improved my Communication skills.
- I had an opportunity to learn skills of event management, time management and scheduling.
- I learnt how important is the proper documentation of the work done and progress made in implementation of the schemes. This helps us find the gap areas and make targeted interventions.
- I learnt how important the training programs for the field staff are Regular training programs keeps the grass root level workers updated on the current program developments and this in turn would lead to a responsive society.

Difficulties faced

- It was also challenging to convince and motivate hospital staff to work towards quality certification programme.
- They initially preferred working individually and independent of each other. It was very difficult to make them understand that the work of each one of them is interdependent.

PART 2: DISSERTATION

PART 2 DISSERTATION TOPIC

A **STUDY ON GAP ANALYSIS OF MULTI SPECIALTY HOSPITAL IN, GURGAON.**

2.1 EXECUTIVE SUMMARY

This study of 'Gap Analysis' includes mainly Critical Gaps which are related to patient Physical Safety and security and review of equipment, infrastructure, processes including training, services and facilities etc against Standard Quality Management System. To capture the data as a checklist was used along with close observation of the Processes. This includes all support processes including nursing, housekeeping & laundry services, security services, dietary services, information services, etc.

The whole report is submitted as under:

- Describes the overall status of the relevant departments in the Multi Speciality Hospital, Gurgaon with the brief introduction or description of the department.
- Identifies the significant **gaps in terms of Structure, Process and Outcome** observed on all the concerned areas and explanation of the gap statement **with references to the NABH Standards** with objective elements. The **gaps are analyzed based on NABH (3nd edition)** standards.

The major findings of the study are as:

- No Setback area has been left outside the building.
- The hospital has no area defined for **parking**
- No signage outside the Medical Record Department.
- No SOP implementation for the ICU department.
- No SOP implementation for Disaster Management Plan.
- There was no proper Sterilization area.
- No Training to the Staff on Emergency codes and Fire Safety.
- No training has been provided to the staff for emergency codes and fire safety
- There is no zoning of CSSD.
- CSSD is present inside the OT complex
- Zoning System of the OT is not proper

2.2 Introduction

This Study is Gap Analysis which is the initial step in the review of the available service system. It is an efficient base to implement a modern management system. It can be measured against set NABH standards. It reveals the areas of improvement in the existing delivery service system. It investigates existing service facility against the benchmark of set standards. It focuses on the components of the management services and how effective they are? The scope of improvement will mark the level up to which services are to be upgraded. Scope of improvement will give the percentage of progress need to make to achieve the set standards

NABH

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

Accreditation

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

Benefits of accreditation

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

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

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

Accreditation provides an objective system of empanelment by insurance and other **Third Parties**. Accreditation provides access to reliable and certified information on facilities, infrastructure and level of care.

Multi Speciality Hospital, Gurgaon is a newly commissioned Hospital. This hospital is a 250 bedded Super specialty hospital located in the heart of Gurgaon. Therefore performing Gap Analysis on a hospital which is in the process of establishing its Infrastructure and facilities was a good opportunity. Changes required closing the Gaps in the Structure and Process of the hospital can be easily implemented. Scope of improvement in an upcoming hospital is faster and better.

2.3 PROBLEM STATEMENT:-

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

2.4 JUSTIFICATION OF THE STUDY:

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

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

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

2.3 AIM AND OBJECTIVE:

AIM:

- To assess the gaps related to structure, processes of the multi speciality hospital in gurgaon and to see if outcomes are maintained

OBJECTIVES

1. To assess the existing service delivery status of the hospital.
2. To identify the gaps as per NABH guideline
3. To give suggestions so as to meet the requirements.

2.4 LITERACTURE REVIEW

The management and the safety of the hospital facility is an important part of quality improvement and patient safety. The following literature reviews attempt to demonstrate and support the study.

1. **Henriksen K, Isaacson S, Sadler BL, et al, 2007 the following design elements were identified as critical in ensuring patient safety and quality care**, based on the six quality aims of the Institute of Medicine's report, 'Crossing the Quality Chasm: A New Health System for the 21stCentury':
   Patient-centeredness, including

- Using variable-acuity rooms and single-bed rooms
- Ensuring sufficient space to accommodate family members
- Enabling access to health care information
- Having clearly marked signs to navigate the hospital safety, including applying the design and improving the availability of assistive devices to avert patient falls
- Using ventilation and filtration systems to control and prevent the spread of infections
- Using surfaces that can be easily decontaminated
- Facilitating hand washing with the availability of sinks and alcohol hand rubs
- Preventing patient and provider injury
- Addressing the sensitivities associated with the interdependencies of care, including work spaces and work processes

Effectiveness, including

- Use of lighting to enable visual performance
- use of natural lighting
- controlling the effects of noise

Efficiency, including

- standardizing room layout, location of supplies and medical equipment
- minimizing potential safety threats and improving patient satisfaction by minimizing patient transfers with variable-acuity rooms

Timeliness, by

- ensuring rapid response to patient needs
- eliminating inefficiencies in the processes of care delivery
- facilitating the clinical work of nurses

Equity, by

- ensuring the size, layout, and functions of the structure meet the diverse care needs of patients

2. **K.Francis Sudhakar M.Kameshwar Rao T.Rahul: A study of gap analysis in hospitals and the relationship between patient satisfaction and quality of services in health care services**

   SUMMARY: The value of marketing today is now understood by health care leaders to revolve around a concept of educating patients, providers, payers, and employers about the unique manner in which the health care organization can legitimately maximize patient encounters through a two-pronged approach: (1) increasing patient compliance (2) matching an appropriate level of service with the correct diagnosis. In addition, increasing volume will still represent a goal of marketing efforts. However, the volume increases will not be focused on service utilization per service, but will instead be directed toward increasing the volume of patient members. A proactive, well-thought-out marketing plan is a sign of a sophisticated, forward thinking organization. Such an organization has control of its destiny and can succeed in this new era of health care initiatives that strive to simultaneously control costs, maintain quality, and increase access as technology improvements continuously enhance the products and services.

3. **Dr. Santosh Kumar, Brig. (Dr.) Swadesh Puri, Dr. S.D. Gupta in a study of Gap Analysis Report for Rehabilitation Centre** has found that is mainly a destitute centre having 20 beds for disable patients. Even though it is housed in poly clinic various sub specialties (such as Medicine, Surgery, ENT, Ophthalmology, and Dental) are available here which seems to be duplicity of resources. The centre does not proper diagnostic, inpatient or utility services (kitchen, laundry). There is no effective signage to guide the patient with in the canter. The radiology department is virtually open from three sides causing radiation hazards to staff and patients. Even though it is the rehabilitation centre it does not have even the basic physiotherapy equipments. The general housekeeping is very bad, all toilets are broken and sinking. Almost all working areas are dirty and unhygienic to work or live. Wards are crowded and lack proper ventilation. Most of the bed linen were dirty. There is shortage of drugs. ICD classification is not used. CSSD has only one autoclave which is not sufficient for entire hospital. It lacks quality control measures. There is no disaster plan for the hospital.

4. **Eric S. Kastango, MBA, RPh, FASH : A Gap Analysis Review and Action Plan**

   SUMMARY: Overall, there are several opportunities for process and procedure improvement in the area of aseptic compounding at XX Medical Center. It is important to recognize that the principles of contamination control and good aseptic compounding have not been nor are today an inherent part of a pharmacist's didactic education and experiential training in pharmacy school. Morris, et. al. (2002) conducted and published a national survey in the December 15, 2003 issues of the American Journal of Health System Pharmacists regarding the compliance of hospital pharmacies with the 1993/2000 ASHP QA Guidelines. The overall rate of compliance was poor and speaks to an overall failure of the education and training

system of pharmacy vs. the failure of any one individual. There is now a significant awareness of the importance of good aseptic compounding procedures and a multitude of resources are available to help pharmacists and technicians address gaps and deficiencies that may exist. Using the issues identified and recommendations noted in this report, immediate and measurable results can be achieved, all which will have a direct and positive impact in the delivery of pharmaceutical care at XX Medical Center. It is the opinion of the consultants that the pharmacy management will need to actively engage in this endeavor and support the current efforts by the pharmacist working on this project. The greatest challenge that will be faced in correcting the issues will come from two areas:

a. Lack of physical space available in the pharmacy and in the immediate area to expand the pharmacy operations.

b. Direct and indirect employee resistance to change. There is a significant amount of dogma and misinformation relative to good aseptic compounding practices that can only be addressed through intensive education and objective qualitative testing.

5. **Dr. Santosh Kumar, Brig. (Dr.) Swadesh Puri, Dr. S.D. Gupta in a study of Gap Analysis Report for Ishtakal Hospital** have defined two kind of gaps

1) Infrastructure related gaps
2) Process related gaps

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

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

6. Di Mclntyre and Laura Anselmi, Health Economics Unit, School of Public Health and Family,Medicine, University of Cape Town Paper provides an overview of the methods used to promote an equitable distribution of healthcare resources. It highlights that resource allocations is extremely valuable in efficient budgeting. It also highlights the successful implementation of resource distribution can be facilitated by

undertaking a detailed gap analysis. Gap analysis will provide basis for developing service development plans. There is also need to strengthen capacity for planning, budgeting and implementing plans to ensure use of limited healthcare resources. Monitoring and evaluation of all these can enhance effective redistribution of resources to promote healthcare services.

2.5 SCOPE APPROACH AND METHODOLOGY

STUDY DESIGN: This study is descriptive observational study

STUDY AREA: Multi specialty hospital in Gurgaon

STUDY DURATION: Two month duration for complete this report.

STUDY TOOLS:

- Interview and discussions with head of the departments.
- Checklists
- Observation
- Using available information
- NABH tool kit

STUDY DATA TYPE:

- Primary data will be collected through direct observation and interview
- Secondary data will be collected through SOPs(standard operating processors)

METHODOLOGY:

There will be evaluation of all department under parameters of structure, processes and outcome will be observe, analysis and compared with NABH standard thus the gap will be identified after score will given on the basis of 0,5,10 its mean if we will find complain in norms and parameters then will give 0, if will find partial complain then give 5 score and 10 will given if we find they followed all the norms and parameters. Scoring will be done according to improvement of the scope of services

2.6 OVERVIEW OF RELEVANT DEPARTMENTS OF MULTI SPECIALITY HOSPITAL, GURGAON

2.6.1 EXTERIORS

The exteriors of the building are well maintained. There are navigation boards for the hospital. Services provided by the hospital properly displayed. There are two entries to the hospital one is main entry to the hospital other is the entry to the emergency. Both the entries are properly guarded. The road outside the hospital is a single lane road. Area covered by the building on the land is within the permissible limit.

Parking –All the permissible area have been covered by the construction of building, therefore no parking area have been marked or defined for either patients or staff vehicle. Ambulance parking area also not defined. On the back side of the hospital the boundary wall of the hospital is very close to the building wall.

Setback Area-It is the area left outside the hospital building for the from movement of the trolley. No such area is left outside the building.

BMW Temporary storage – BMW temporary storage is a pre fabricated structure made up of iron & aluminum with dimension of 8x10 feet. It is on the façade of the building .It is location have been temporarily made. The BMW is collected twice a day once in morning at 8 o' clock and another in evening at the same time. Waste is transported by trolleys. Documentation of amount of BMW generated is not done.

Generator and Transformer- Generators of the hospital is kept at a distance of approximately at a distance of 150 meters. There are no fire safety measures available at this place. The LT panel is also located next to it. Changing of power from direct to generator is automatic.

2.6.2 Infrastructure

The hospital is divided into three floors and 16 departments including clinical and non clinical both. Hospital has got enough waiting area for patients but lesser circulation area for movement of traffic inside the hospital. Beds are manually operated and have side rails to prevent patient falls. Floors are not slippery but few singes displayed. Disaster plan inside the hospital have not been prepared.

AREA

Total Land Present=1.25 acre

Total Covered Area-1000sq.feet=100000sq.meters

Total Plinth Area Covered=44000sq.meters (44%)

Total number of permissible Storey for the hospital=6

Total number of storey present in the hospital=2

2.7 FLOOR WISE DIRECTORY OF HOSPITAL

Basement	
1. Blood Bank 2. Dermatology 3. Diagnostics a. Imaging i. MRI ii. X-Ray iii. Ultrasound b. Laboratory i. Pathology ii. Microbiology 4. Physiotherapy 5. Mortuary 6. Accounts 7. IPD Billing	8. Store 9. Restaurant 10. Gas Manifold 11. OPD a. ENT b. Respiratory Medicine c. Ophthalmology d. OPD Psychology e. Psychiatry f. Chamber for visiting consultants g. Dental 12. Conference Room & Auditorium 13. Chairman's office 14. Admin Offices 15. Water pump room (for Fire Hose & Sprinklers)

Ground Floor	
	1. Casualty, Minor OT 2. Waiting Lounge 3. Costa Coffee

	4. Mother's nest (Obstetrics) a. 2 twin sharing rooms b. 2 LDR suite c. 1 Deluxe Room (single bed) d. NICU e. Labour OT 5. Server Room 6. ICU 7. Procedure Room 8. Doctors' room 9. Nurses room 10. Nursing station - B 11. OT complex a. Change room b. Recovery room c. OT-1, OT-2, OT-3 d. Gastro Lab
First Floor	
1. Inpatient wards a. Deluxe rooms b. Suites c. Twin sharing rooms 2. Medical ICU	
Second Floor	
1. Dialysis Unit 2. In Patient wards a. General Ward b. Twin sharing 3. Cardiac OT 4. Cath Lab 5. Heart Command (CCU) 6. MICU	

Terrace
1. Kitchen 2. ETO 3. Chillers 4. RO plant 5. Solar panels 6. Lift rooms

Engineering

Electrical Engineering department present in the basement at the left end of the building.

Electricity

Total Load Sanctioned = 500 KW
Actual consumption = 650 – 770 KW
Alternate source of electricity
DG: - 3 but only 2 are in use
1 X 500 KW
1 X 250 KW
1 X 500 KW

Transformer :- 1
Capacity: - 500 KW

UPS:- 7

Location	Capacity
OT	20KVA
ICU	15 KVA
NICU	5 KVA
Lab	10 KVA
CT	7 KVA
Ultrasound	7 KVA
Cardiology	10 KVA
Total	**74 KVA**

Water

Total storage: - 10,000 liters
Tank no. - 3
Sources of water: - 2 Submersible pump, Mono block Pump 2 and 1 RO Plant.
Fire storage: - 3lack lit, 3 tanks of capacity 1,50,000 lit, 1, 00,000 lit and 50,000 lit

Air Conditioning

Central AC
2 Chiller Plants
Capacity: - 80 TR
Split AC: - 42
Fire hydrant:-Same overhead tank of 10,000 ltr capacity is used as a fire hydrant.

2.8 SIGNAGE SYSTEM

The **signages are mainly in English only**, it is recommended that it should be bilingual (English/ Hindi). Symbolic/ pictorial signage can be used for showing essential utilities like drinking water, and enquiry and also for showing fire exits/ emergency exits, lifts/ escalators & stairs. The boards in the emergency displays names of the Consultants however following items were not displayed:

Signage's	Displayed (Yes / No / NA)	Bilingual (Yes / No / NA)	Pictorial (Yes / No / NA)
Citizen Charter	NO	NO	NA
Mission & Vision	YES	NO	NA
Quality Policy	NO	NO	NA
Patients Rights and Responsibilities	YES	NO	NA
Service Available	YES	NO	NO
Complaint Redressal box, whom to contact and how to lodge a Complaint	NO	NO	NO
Tariff List	YES	NO	NA
Doctors list along with their Specialities	YES	NO	NO

and Qualifications			
OPD Schedule of Doctors (Speciality, Timings and Day of Availability)	YES	NO	NO
Biohazard Symbols	YES	NO	NO
Fire Exit Plan	NO	NO	NO
Floor Directory	YES	NO	YES
Departmental Signages	YES	NO	NO
Wash Rooms (Handicap)	YES	NO	NO
Ambulance Parking Area	NO	NO	NO
Drinking Water	YES	NO	NO
Health Education Related Signages (HIV & Immunization)	YES	NO	YES

TABLE3. Signage table

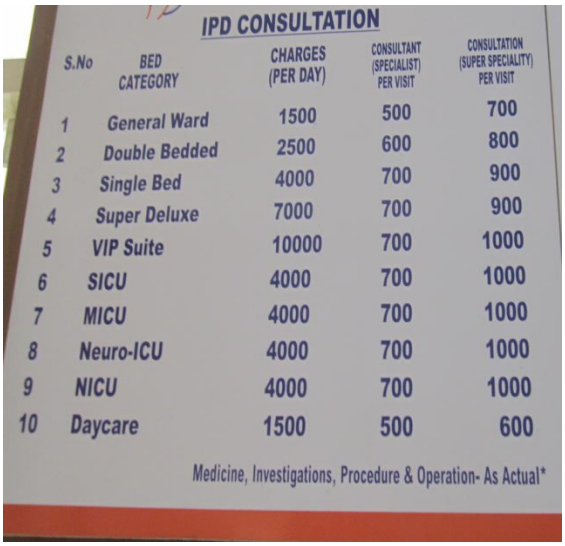


Fig1.TARIFF LIST DISPLAYED

Fig2. DOCTOR'S NAME, OPD NAME

2.9 STATUTORY REQUIREMENTS

Licenses	**Available**
1. Building Permit (From the Municipality).	YES
2. No objection certificate from the Chief Fire officer.	NO
3. License under Bio- medical Management and handling Rules, 1998.	Yes
4. No objection certificate under Pollution Control Act.	NO
5. Excise permit to store Spirit.	NA
6. Income tax PAN.	Yes
7. Permit to operate lifts under the Lifts and escalators Act.	Yes
8. Narcotics and Psychotropic substances Act and License.	NA
9. Sales Tax Registration certificate.	Yes
10. Vehicle registration certificates for Ambulances.	Yes
11. Retail drug license (Pharmacy).	Yes
12. Air (prevention and control of pollution) Act, 1981 and License	No
13. PNDT Certificate	Yes
14.Radiation Protection Certificate in respect of X-Ray equipments from AERB	yes
15.Atomic Energy Regulatory Body approvals	No
16..License for Blood Bank	No
Act	
1. Biomedical waste management handling rules 1998.	No
2. Central sales tax Act, 1956.	Yes
3. Consumer protection Act, 1986.	Yes
4. Contract Act, 1982.	No
5. Dentist regulations, 1976.	No
6. Drugs & cosmetics Act, 1940.	Yes
7. Employees provident fund Act, 1952.	Yes
8. Environment protection Act, 1986.	Yes

9. Equal remuneration Act, 1976.	Yes
10. Explosives Act, 1884.	Yes
11. Fatal accidents Act, 1855.	Yes
12. Income Tax Act, 1961.	Yes
13. Indian Lunacy Act, 1912.	No
14. Indian medical council Act and code of medical ethics, 1956.	Yes
15.Nurses and Midwives Act, 1953	No
16. Indian Nursing council Act1947.	No
17. Indian penal code, 1860.	Yes
18. Maternity benefits Act, 1961.	Yes
19. MTP Act, 1971.	No
20. Minimum wages Act, 1948.	Yes
21. National building code.	No
22. Negotiable instruments Act, 1881.	Yes
23. Payment of bonus Act, 1965.	Yes
24. Payment of gratuity Act, 1972.	Yes
25. Payment of wages Act, 1936.	Yes

SERVICES/ DEPARTMENTS

GROUP A: CLINICAL SERVICES	
	Yes/ No
Internal Medicine	Yes
Obstetrics and Gynecology	Yes
Pediatrics and Neonatology	Yes
Orthopedics	Yes
Ophthalmology	Yes
ENT	Yes
General Surgery	Yes
Dermatology	Yes
Dentistry	Yes
Emergency Medicine	Yes
Anesthesia	Yes
Critical Care Medicine	Yes
Psychiatry	Yes
Chest and TB	Yes
Rehabilitation	Yes
Radiology	Yes
Pathology	Yes
Cardiology	Yes

Cardiothoracic Surgery	No
Neurology	Yes
Neurosurgery	Yes
Gastroenterology	Yes
Gastroenetrology Surgery	Yes
Paediatrics Surgery	Yes
Nephrology	Yes
Oncology	No
Oncology Surgery	No
Urology	Yes
Plastic Surgery	Yes
Physiotherapy	Yes
IVF Centre	No
Blood Bank	Yes
GROUP B: SUPPORT SERVICES	
Maintenance	
Civil Works	Yes
Water	Yes
Electricity	Yes
Fire Safety	Yes
Telecommunication	Yes
Medical Records	No
Ambulance Service	Yes
Manifold Room	Yes
CSSD	No
TSSU	Yes
Laundry	Outsource
Security and Fire	Outsource
Kitchen	Yes
Parking service	Not
Zone **Functions** **Number.**	Outsource
GROUP C: ADMINISTRATIVE SERVICES	
General Administration	Yes
Finance	Yes
Housekeeping Services	Outsource
Training and Development	No
Materials Management	No
MIS services	No

2.10 GAP ANALYSIS

2.10.1 FRONT OFFICE

Front office is situated in ground floor having a reception area, May I Help You Desk, a registration and IPD admission counter.

Fig.3.FRONT OFFICE

IDENTIFIED GAPS

STRUCTURAL	1. List of services available and rate chart not displayed. 2. Non-availability of the List of nearest Blood Banks 3. Non-availability of the list of consultation charges 4. Patient's Rights and Responsibilities not displayed. 5. Mission and vision statement are display but not properly seen 6. Citizen charter is not displayed 7. Separate counters for registration in OPD for old patients (repeat visit) and new patients, male and female, senior citizens not present.
PROCESS	8. Policies and Procedures for Front Office are not implemented. 9. Policy for fixing appointments for the patients is not documented. 10. Policy not made for patient revisiting the facility for second consultation.

OUTCOME	Following outcomes are not monitored in HCO : 11. Average time taken in completing the admission documentation 12. Average time spent in the queue by a patient for registration in the OPD

2.10.2 OUT PATIENT DEPARTMENT

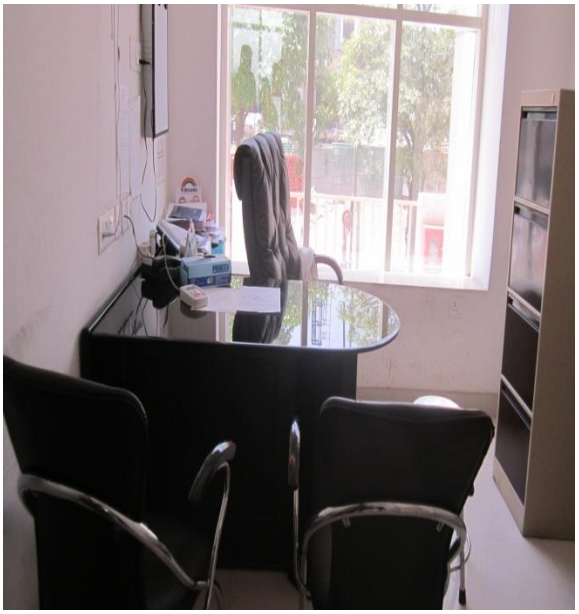


Fig.5. SHOW THE DOCTOR CHAMBER

Fig .6.OPD WAITING AREA FOR PATIENT

The outpatient department is located in the Ground Floor & Basement. Emergency, IPD and ICU is situated on the same floor. The OPD services provided in the basement includes:-

a. Respiratory Medicine
b. Ophthalmology
c. Psychology
d. Psychiatry
e. Dental

While the following OPD services are provided on ground floor

f. General & Laparoscopic surgery
g. Orthopaedics
h. Medicine
i. Gastroenterology

j. Paediatrics
k. Neurology, Neurosurgery
l. Cardiology, Cardio-thoracic surgery
m. Obstetrics & Gynecology

A common sub-waiting area is present .The consultation chamber have a proper examination area marked with a examination bed and curtains to maintain privacy of the patient.OPD rooms do not have toilet attached to it. Only One wash room is present on each floor that is common for all Patients and Staff.

STRUCTURAL	There are 12 OPD in ground floor area and 7 OPD in Basement area 16. The fire exit plans were not displayed in the OPD area. 17. Bi-lingual signage and information not displayed in the lobby of the OPD 18. Circulation area for trolley and stretchers is not sufficient. 19. Suggestion/complaint boxes not placed.
PROCESS	20. Registration policy in the hospital in not defined. 21. Admission, discharge and transfer policy not available. 22. Cleaning of toilets was not evident because of less number of housekeeping staff 23. Staff are not uniformly aware of the scope of service of the hospital
OUTCOME	24. OPD utilization **25.** Patient satisfaction is not done

2.10.3 OPD UILIZATION

MONTH	TOTAL	AVERAGE OPD
April 2012	862	= 1013
May 2012	1052	
June 2012	795	
July 2012	1064	
August 2012	1240	
September 2012	1715	
October 2012	1054	
November 2012	766	
December 2012	734	
January 2013	815	
February 2013	1301	
March2013	726	

Total number of Chambers	**13**
Working hours per day	**6 hours**
Total working hours for all Chambers	**78 Hours**
Number of working days in a month	**30 days**
Total working hours in a month	**2378 hours**
Average time per patient consultation	**15 minutes**
Average throughput per hour	**4**
Total expected (maximum) throughput in a month	**9512**
Actual throughput in a month	**1013**
Utilization in percentage (%)	**11%**

TABLE 4. This table shows that OPD services are underutilized and there is scope of improvement as there are adequate amount of resources available to serve more patients.

2.10.4 EMERGENCY (CASUALTY)

Emergency department is present on the ground floor with adequate access from the main road. It is a 7 bedded department

Fig.7. CRASH CART

Fig.8. EMERGANCY WARD

IDENTIFIED GAP

STRUCTURAL	26. No observation room and bed. 27. Emergency services provided by the hospital not defined, documented and displayed 28. Clean utility room and dirty utility room absent. 29. Check list of medicine in the crash cart not present. 30. No scrub area present. 31. No separate OPD desk for emergency billing is present. 32. No reception and enquiry area. 33. No observation bed or room available for initial assessment

PROCESS	34. Privacy of patients not maintained as beds are not covered by curtains. 35. Lists of other HCO in and around the vicinity with their address and phone no. not present 36. In Minor OT they are doing plaster related activities. 37. Emergency services provided by the hospital needs to be properly defined, and displayed 38. Crash cart is not checked daily by the nurse. 39. Near expiry medicines are not been removed from the crash cart. 40. Staff is not trained in BLS and ACLS. 41. Various emergency protocols for management of specific conditions like poisoning, burn, RTA etc are not defined and implemented. 42. Staff is not trained on managing patients during non-availability of beds. 43. Staff responsible during transfer of patient is not identified. Staffs are not trained on transfer of patient policy.
OUTCOME	Following needs to be monitored : 44. Response time of the consultants 45. Death rate 46. Time for initial assessment of emergency Patient 47. Number of referral cases. 48. Number of admission 49. Number of the patient return to home

.

2.10.5 LABORATORY

Laboratory: This unit is located on the basement and consists of microbiology, Serology, biochemistry and phlebotomy.

All equipment should be properly calibrated along with their annual and preventive maintenance. This will help to maintain the equipments in best of their condition and equipments will not pose any harm to the patients undergoing treatment

Fig .9. SHOWS LABORATORY DEPARTMENT IN HOSPITAL

IDENTIFIED GAP

STRUCTURAL	50. Separate Provision for hand washing is not present. 51. Fire extinguisher and fire escape routes are not present. 52. SOP for the various test are not been made. 53. Calibration of equipments is not done.
PROCESS	54. Preventive vaccination of all laboratory staff with tetanus and Hepatitis B is not been done 55. Staff is not trained on various policies and procedures of the lab 56. IQAS & EQAS is not been done 57. Disposal of the biomedical waste especially the liquid waste is not done as per the BMW rules. 58. Critical test results are not defined and displayed 59. Staff doesn't wear the various PPE like gloves, mask etc while doing the lab procedures. 60. MSDS sheets were not present.
OUTCOME	61. Number of samples rejected/functional unit/month 62. Number of tests redone/functional unit/month 63. Number of adverse events reported/month **64.** Number of equipment breakdowns observed/month/equipment **65.** Percentage of equipment calibration

2.10.6 INDOOR PATIENT DEPARTMENT

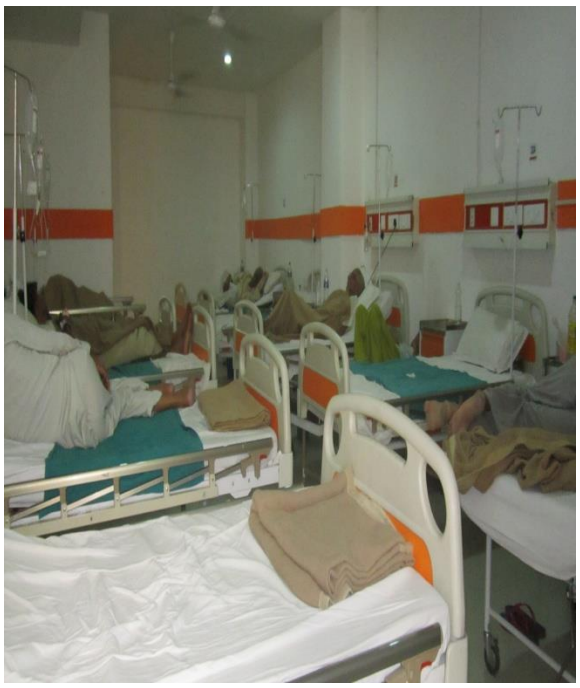


Fig .10. IPD GENERAL WARD

Fig.11. SUPERSPICILIST WARD OF HOSPITAL

Fig.12. IPD WAITING AREA FOR ATTENDENT

First Floor:

- **SEMI PRIVATE: 33 BEDS**
- **PRIVATE: 18 BEDS (INCLUDES CHAIRMAN SUITE,ROYAL SUITE,SUPER DELUXE,DELUXE)**
- **ICU: 20 BEDS**

Second Floor: GENERAL WARD: 56 BEDS (MALE AND FEMALE)

IDENTIFIED GAPS

STRUCTURAL	66. No separate isolation room in the hospital. 67. No sluicing room. 68. No Janitors closet room. 69. No separate hand washing facility. 70. No pantry or store room. 71. Suggestion/complain Box not placed 72. No spillage kit is available. 73. The hospital does not follow the standard norms for bed to bed distance. 74. Fire exit signage and fire escape routes are not displayed in the ward area.
PROCESS	75. Policy and procedure for care of patient under restraint, for administration of high risk medicines and for transfer of patient not followed. 76. Housekeeping of toilets and general environment is not up to the mark. 77. The space between the two beds (5-6sq feet) is not maintained in the general ward. 78. Segregation of BMW is done as per the BMW rules. 79. Patient ID bands are not used. 80. Polices and procedure for patient transfer, cleaning and disinfection and linen management are defined but not implemented. 81. No defined area for wheel chairs and trolleys 82. No proper infection control policies are followed in wards. 83. Alcohol based hand gels are not available beside each bed.
OUTCOME	Following needs to be monitored : 84. Number of admissions 85. Number of adverse events reported/month 86. Time taken for the discharge 87. Patient satisfaction 88. Nosocomial infection rate 89. Monitoring of medication errors, ADR, accidental removal of tubes & catheters, strip & falls, sentinel events.

2.10.7 OPERATION THEATRE

The hospital has 3 OT complexes which includes 5 functional Operating rooms.

- First complex is on ground floor of building which is used as Gynec OT (1 OR).
- Second is also on ground floor having 3 operating rooms used for neuro, ortho and general surgery.

Third is on 2nd floor of the building, which is being used for cardiothoracic surgery

Fig.13. OPRATION THEATRE ROOM

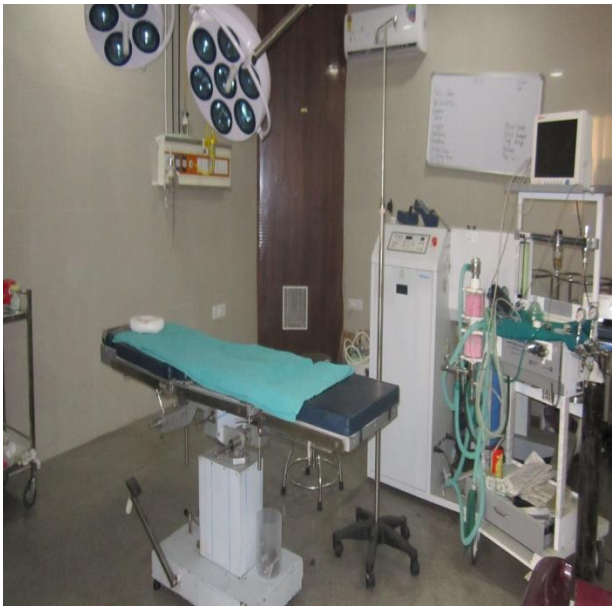


Fig .14 INNER IMAGE OF OPRATION THEATRE

Fig . 15. CORRIDOR SPACE

Fig.16. SCRUB AREA

IDENTIFIED GAPS

STRUCTURAL	90. Zoning is not proper TSSU is present in the sterile zone of the OT and it caters to all hospital needs and not consolidated. 91. Circulating area from where used instruments etc are removed & taken out is not present because of which one way traffic viz. inside the OR to outside is not maintained 92. OT does not have steel doors. Only two OT has Stainless steel sliding doors. 93. Insufficient storage area and no separate dirty utility room available. 94. There is no present HEPA filter
PROCESS	95. There is mixing of dirty and clean traffic as the wastes and linens are taken back through the sterile areas again. 96. No proper policy and producer implementation regarding Bio-Medical Waste. 97. Housekeeping services is not satisfactory. 98. Microbiological surveillance is not carried out. 99. Staff is not trained as per guideline of biomedical wastage.
OUTCOME	100. OT utilization rates not monitored. 101. Percentage of rescheduling & re exploration rates not monitored 102. Key performance indicators (percentage of modification of anaesthesia plan, percentage of unplanned ventilation following anaesthesia, percentage of adverse event.

2.10.8 INTENSIVE CARE UNIT

Surgical ICU – I present on ground floor nearby to OT complex. ICU –II present on first floor but is still under construction. ICU – III present on second floor beside the cardiac OT

Fig .17. INTENSIVE CARE UNIT

Fig.18. ICU NURSING STATION

Noise level in the ICU should be minimum to avoid any inconvenience to the admitted patients. Circulation area should be sufficient for the free and safe movement of patients.

IDENTIFIED GAPS

STRUCTURAL	103. No nurse duty room, janitor's room, dirty and clean utility room, sluices room. 104. There was less space between two beds (normal around 8-9 sq ft.)and also noise level (normal around 25 decibel)is high inside the ICU. 105. Sterile shoe cover and other personal protective equipments not satisfactory. 106. No provision of hand washing for patient visitor and staff inside ICU 107. No provision for sterilizer besides every bed to be made 108. Arrangements of fire fighting inadequate. There was no fire extinguisher in ICU-I 109. Number of ventilator and infusion pump not adequate 110. No separate entry and exits for dirty linen and biomedical wastage
PROCESS	111. Ideal nurse to patient ratio not maintained. 112. Policy and procedure for patient admission & discharge criteria not to be framed. 113. A unified CPR policy not implemented. 114. Staff to be trained on infection control guidelines. 115. Crash cart is not been checked daily by the nurse 116. LASA Drugs categorization not done **117.** All cardiac arrests not analyzed.
OUTCOME	118. Monitoring of patient satisfaction not done 119. Monitoring of utilization rate not done 120. Monitoring of hospital acquired infection not done 121. Rate of readmissions after transfer to HDU/month not recorded

2.10.9 BLOOD BANK

The blood bank is unit consists of reception and registration counter, donor waiting area, issue counter, donor examination room (blood bank in charge room), bleeding room, donor refreshment room, serology lab, sterilization room, aphaeresis, changing room, store, record room, infection marker lab, component storage, and component laboratory

Fig.19. SEMPLE COLLECTION ROOM

Fig.20.CORRIDOR SPACE

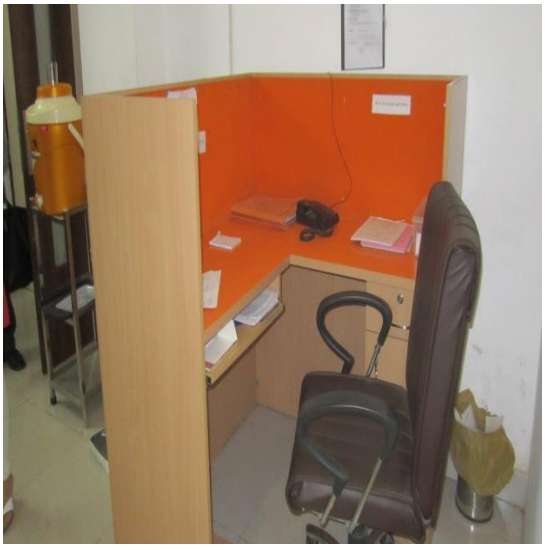


Fig .21.REGISTRATION COUNTER

Fig.22 WAITING AREA OF B.B.

IDENTIFIED GAPS

STRUCTURAL	122. Fire exit & fire escape route were not displayed 123. Spillage kit was not available.
PROCESS	124. Documented has done of rational use of blood and blood components and transfusion of blood and blood components but need implementation.
OUTCOME	125. Turnaround time for issue of blood and blood components are not defined and measured.

2.10.10 IMAGING AND RADIOLOGY

Imaging: This unit is located in the basement. The signage's and precautionary notes against radiation hazard were needs to be strengthened.

Fig.23. WAITING AREA

Fig.24. X-Ray ROOM

Fig.25. CONTROLING UNIT

Fig.26. LED APRON

IDENTIFIED GAPS

STRUCTURAL	126. Calibration and AMC of equipments not to be carried out by appropriate agencies. 127. No change room for patients. 128. Signage's for Patient protection not proper. 129. Color Coded waste bags are not present. 130. Emergency cash cart is not present . 131. Dark room digital room not present. 132. No separate area for keep protective equipment 133. Radiation hazard signage's not be prominently displayed in all appropriate place.

PROCESS	134. Service provided by the department should be displayed along with the schedule charges for information of patients 135. There has not a method of critical results reporting which is further documented for audit purpose. 136. A procedure of periodic performance tests of all X-ray and CT units not done.
OUTCOME	137. Turn-around time for investigations not measured. 138. Percent of Re-do not monitored 139. Percent of test results correlating with clinical diagnosis not monitored 140. Percent of staff adhering to safety precaution not monitored

X - RAY

MONTH	TOTAL
April 2012	149
May 2012	292
June 2012	477
July 2012	562
August 2012	616
September 2012	865
October 2012	990
November 2012	748
December 2012	511
January 2013	628
February 2013	911
March 2013	1018

2.10.11 C.S.S.D (CENTRAL STERILE SUPPLY DEPARTMENT)

The CSSD room size around 144 sq ft, there are two autoclaves machine. It is located in OT complex and new CSSD is under constructed.

Fig.27. AUTO CLAVE MACHINE

Fig.28. UNSTERILE ZONE

IDENTIFIED GAPS

STRUCTURAL	141. No zoning is present in TSSU. There is no separate receiving area, packing, equipment and sterile store area. Sections are not demarcated 142. Drainage system is not proper
PROCESS	143. Policies and procedures for the receiving of the materials, washing and sterilization and dispatch of the materials are not implemented 144. recall procedure not followed 145. Microbiological surveillance not carried out and recorded regularly 146. Provision for regular validation test for sterilization not made.

OUTCOME	147. Monitoring of service level of department not done 148. Recall not monitored

CSSD supplies linen, equipments and consumables to the hospital, therefore Infection Control Practices and Proper sterilization at CSSD will lead to safe and effective treatment to the patients.

2.10.12 LABOUR ROOM

The labour room is located on the ground floor adjacent to gyanae OPD. There is one labour room in the hospital.

Fig . 29.LABOUR ROOM

IDENTIFIED GAPS

STRUCTURAL	149. No elbow taps for wash basins in the labour room **150.** No designated washing area for instruments. **151.** No fire extinguisher and fire exit signages and the escape plan.

PROCESS	152. No implementation has done of SOP for the department. 153. No clinical protocols available in the department. 154. Proper infection control practices were not evident. 155. No signage is displayed for the scope of high risk obstetrics care. 156. Staffs need not trained on implementation of the policies and procedures.
OUTCOME	157. Utilization of labour room is not evident. 158. No data found related number of birth and death in monthly wise from labour room

.

2.10.13 BIO-MEDICAL WASTE STORAGE & TREATMENT FACILITY

This facility is outsourced and hospital only stores the segregated BMW outside the building temporarily.

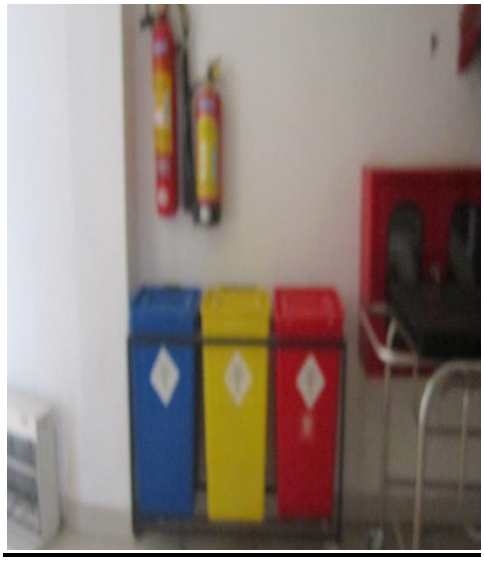


Fig .30. BIN IN OT DEPARTMENT

Fig.31 BIN IN EMERGENCY DEPARTMENT

IDENTIFIED GAPS

STRUCTURAL	159. Compartmentalization of the storage area should be there.
PROCESS	160. Segregation and collection of the waste is not as per the BMW rules 161. Training of staff regarding waste management not evidenced. 162. Unclean dustbins used for waste segregation 163. No policies and procedures regarding reporting of adverse events.
OUTCOME	164. Amount of waste generated per month not monitored

2.10.14 MEDICAL RECORD DEPARTMENT:-

The medical record department is located in the basement.

FIG.32.MEDICAL RECORD DEPARTMENT

IDENTIFIED GAPS

STRUCTURAL	165. Lack of storage space and there is no security for medical records stored. 166. There is no deficiency checklist available in the medical records of the patients. 167. No Coding 168. No fire exit & fire escape routes displayed in the department.
PROCESS	169. No documented SOP for the medical records department. 170. No evidence of corrective & preventive action taken on medical record audit findings. 171. No evidence of established system for audit of patient care services. 172. No MRD bulleting is being generated on monthly basis.
OUTCOME	173. Key performance indicators like percentage of medical records not having discharge summary, percentage of medical records not having initial assessment and the plan of care, percentage of medical records having incomplete and/or improper consent, percentage of missing records etc are not measured.

2.10.15 ENGINEERING

Identified Gaps

- No water testing and compressed testing.
- DG set is not sufficient to carry the load.
- Demand load is more than sanctioned load.
- UPS calculation is not proper for each department.
- Positive and negative pressure is not maintained.

Hospital should have sufficient power back up system to maintain the optimum temperature inside the hospital and to provide uninterrupted services to patients in emergency. Also to maintain proper positive and negative pressure essential for patients in isolation, ICU, OT etc.

Recommendations:

- Equipments files are to be maintained as per defined checklist.

- Appropriate Asset code for all equipments need to be developed.
- Documented SOP for biomedical department needs to be developed.
- Documented condemnation policy need to be developed.
- Documented preventive maintenance and break down plan should be developed.
- Response time for complaints needs to be monitored and analysed.

3.1. STANDARD

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

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

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

Chapter 1: ACCESS, ASSESSMENT AND CONTINUITY OF CARE (AAC)		
AAC 1	The Organization defines and displays the services that it can provide.	6.7
AAC 2	The Organization has a documented Registration, Admission and Transfer process	6.7
AAC 3	Patients cared for by the organization undergo an established initial assessment.	7
AAC 4	Patient care is continuous cared and all patients cared for by the organization undergo a regular reassessment.	6
AAC 5	Laboratory services are provided as per the scope of the hospital's services and adhering to best practices	7
AAC 6	Imaging services are provided as per the scope of the hospital's services and adhering to best practices	6.9
AAC 7	The Organization has a defined Discharge Process	6
AAC 8	There is an established laboratory safety programme.	7
AAC 9	Imaging services are provided as per the scope of services of the organization.	7.2
AAC 10	There is an established quality assurance programme for imaging services.	6
AAC 11	There is an established radiation safety programme.	6.4

AAC 12	Patient care is continuous and multidisciplinary in nature.	5
AAC 13	The organization has a documented discharge process.	7.5
AAC 14	Organization defines the content of the discharge summary	5
Chapter average		6.5

TABLE 5 Chapter1 AAC

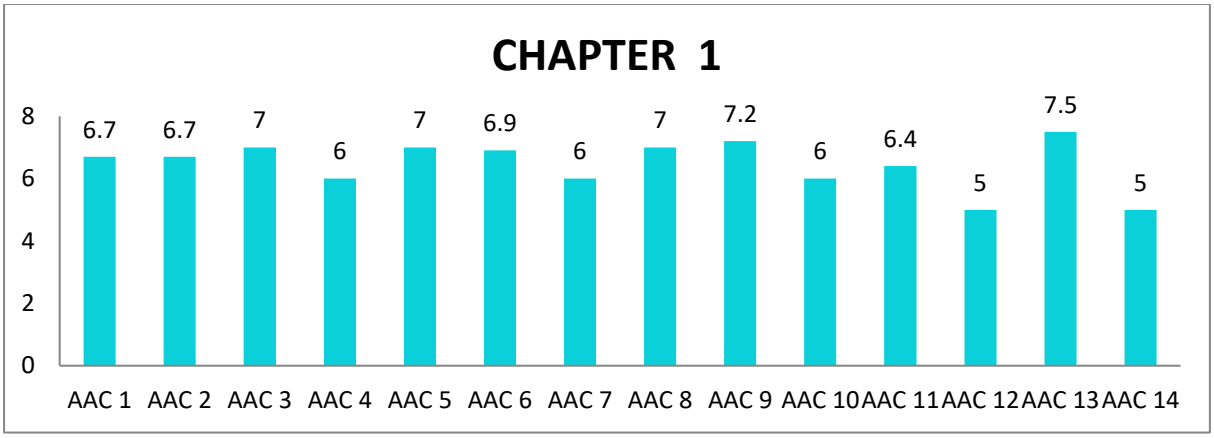


TABLE 6 Graph of AAC

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

AAC 2. The organization has well defined documentation and police and procedures for registration and patient are accepted about provide services but not properly implemented and managing patient during non availability of bed and also staffs are properly aware about police and procedure about admission and registration.

AAC 3. The policy guide the transfer of unstable and stable patients to another facility in an appropriate manner and hospital gives a summary of patient's condition and the treatment given.

AAC4.Documentation has been done about initial assessment and plane of care, implementation is required.

AAC 5.Patient reassessed at regular intervals and documentation is also maintained bus implementation is required.

AAC 6. Scope of laboratory services size with hospital services and lab staff is adequately qualified and trained and documented has done about policy of guide ordering if test, collection, identification, results are reported in standardized manner but they are not properly implemented.

AAC 7.laboratory quality assurance programme has been documented but implemented and validation has not been done till date.

AAC 8. Laboratory Safety programme has been documented, but implementation has not been done till date.

AAC 9. There is imagining(X-Raj, ultrasound CT-SCANE and other) services are available in time and critical result are give fast to the concerned consultant or doctors.

AAC10. Quality assurance programme for imagining has been documented but not implemented validation and verification calibration, maintenance and result of all imagining equipments.

AAC 11 The radiation safety programme has been document and scope and signage are properly displayed in all appropriate location but implementation has not been till date.

AAC 12. Policy and procedure of patient care has been documented but the part of polices implementation of information is exchanged and documented staffing shifts between and during transfers between units department and referral of patient to other specialist has not done till date.

AAC 13 the hospital discharge process has been documented and well planned and document of policies and procedure exist for coordination of various departments and in place for patients leaving against has not implemented.

AAC 14.The hospital has been define and documented the content of discharge summary but implemented has not done

Chapter 2: CARE OF PATIENTS (COP)		
COP 1	Uniform care to patients are provided in all settings of the organization and guided by the applicable laws, regulations and guidelines.	7.5
COP 2	Emergency services are guided by documented policies, procedures and applicable laws and regulations	7.1
COP 3	The ambulance services are commensurate with the scope of the services provided by the organization.	6.3
COP 4	Documented policies and procedures guide the care of patients requiring cardio-pulmonary resuscitation. Documented policies and procedures guide nursing care.	5
COP 5	Documented policies and procedures guide nursing care.	5
COP 6	Documented procedures guide the performance of various procedures.	5.7
COP 7	Documented policies and procedures define rational use of blood and blood product	7.5
COP 8	Documented policies and procedures guide the care of patients in the Intensive care and high dependency units	5.7
COP 9	Documented policies and procedures guide the care of vulnerable patients (elderly, physically and or mentally-challenged and children)	5
COP 10	Documented policies and procedures guide obstetric care.	7
COP 11	Documented policies and procedures guide paediatrics services.	5
COP 12	Documented policies and procedures guide the care of patients undergoing moderate sedation.	6.25

COP 13	Documented policies and procedures guide the administration of anaesthesia.	6.8
COP 14	Documented policies and procedures guide the care of patients undergoing surgical procedures	6.3
COP 15	Documented policies and procedures guide the care of patients under restrains	7
COP 16	Documented policies and procedures guide appropriate pain management.	5
COP 17	Documented policies and .procedures guide appropriate rehabilitative services.	6.7
COP18	Documented policies and procedures guide all research activities.	N/A
COP19	Documented policies and procedures guide nutritional therapy.	5.8
COP20	Documented policies and procedures guide the end of life care.	5
Chapter average		6.09

TABLE7.Chapter2 COP

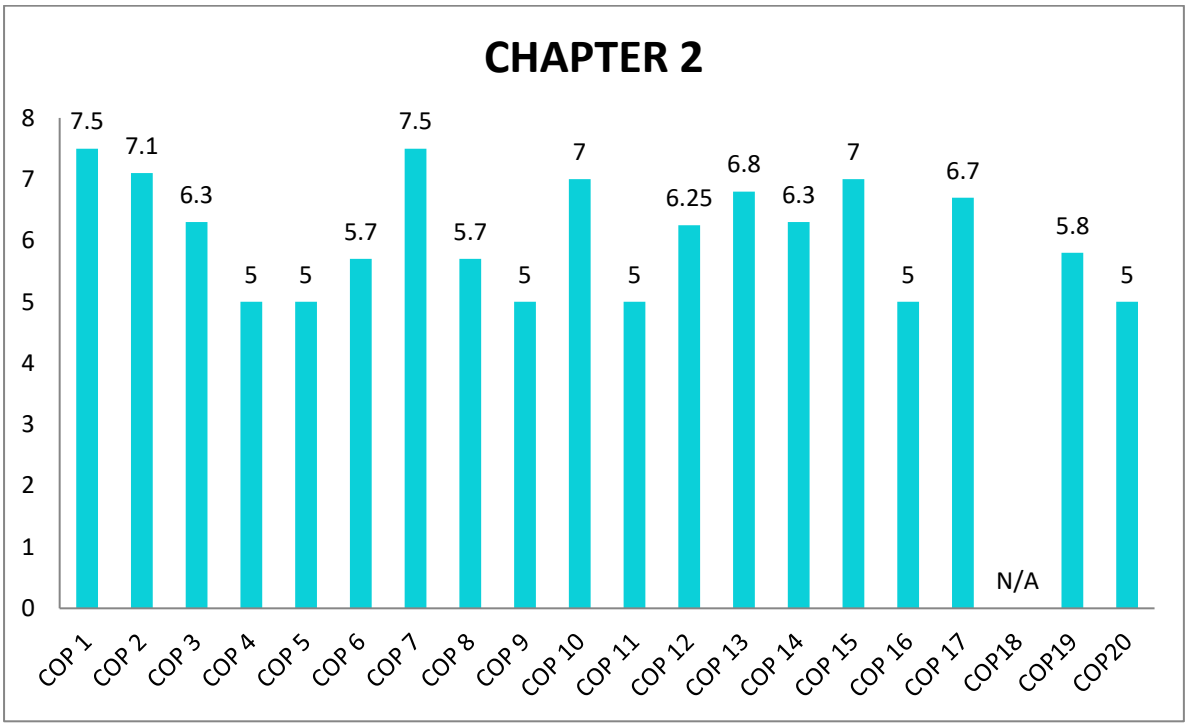


TABLE.8 Graph of COP

COP1. Documentation of policy and procedures for uniform care of patients in all setting of the hospital and guided by applicable law, regulation and guideline has done as per NABH standard but it have been documentation well but implementation has not done as per NABH standard.

COP2. Documentation of emergency services has been done but policy and procedure for the triage of patient s for initiation of appropriate care and staff familiar policy in emergency department has not implementation properly.

COP3. Ambulance Services provided by the hospital need to be improved a lot. Ambulances are not well equipped.

COP4. Documentation of policy and procedure of cardio pulmonary resuscitation has been done but implementation policy for staff training and record of cardio pulmonary resuscitation of during and post event has not been done properly.

COP5. The policy and procedure of guide nursing care has been documented but policy of adequate equipment for providing safe and efficient decisions for timing care of patient has not implemented at the time.

COP6. The documentation of the procedure are used to guide performance of various clinical by qualified personnel order, plan, perform and assist has been done properly and implementation of patient record and monitoring have not been done properly.

COP7.The hospital has done documentation policy and procedure for rational use of blood and blood product. There are well trained staffs but not properly implementation of policy about informed consent also includes patient and family education and donation process.

COP8.The hospital Intensive Care Unit and High Dependency Unit has been documented with adequate staff and equipments but not properly implemented and also the Quality assurance programme is also not implemented there.

COP9. Arrangements for the care of vulnerable patients (elderly, physically and/ or mentally challenged and children) need further improvement

COP10.hospital policy and procedure for obstetric services has been documented but the hospital caring for high risk obstetric cases has the facilities to take care of high risk is not applicable in the hospital and implementation of policy of maternal nutrition and monitoring performance of pre natal and post natal has not done.

COP11.hospital has a documented policy and procedure for the paediatric services and properly displays the scope of services and also properly assessment the patient regarding the patient nutrition, growth and also immunization but require implementation of care of neonatal patient in consonance with the national policy and prevent policy of child abduction and abuse.

COP12.The hospital policies and procedures guide the administration of moderate sedation has been documented but required proper implementation of equipment and manpower are available to manage patient who have gone into a deeper level of sedation then initially intended.

COP13 Documented policies and procedures exist for administration of anaesthesia with well qualified trained anesthesiologist and need proper need of implementation in some policy.

COP14. Policies and procedures are documented for the care of patients undergoing surgical procedures and are implemented also except the quality assurance programme for the operation theatre.

COP15 Policies and procedures for the care of patients under restraints (physical and/ or chemical) are documented but training policy programme not as per NABH Standards and these are not implemented.

COP16.The policy and procedure of guide the management of pain has been documented but not implemented that time.

COP17 The hospital provides the rehabilitation services and it has documented but not properly implemented now.

COP18. Research activities are not carried out in the hospital.

COP19 policy and procedures guide of nutritional assessment and reassessment has been documented but the implementation is not done properly according to clinical need.

COP20. End of life care, some policies have been documented, but hospital does not provide any specific facility for such care

Chapter 3: MANAGEMENT OF MEDICATION (MOM)		
MOM 1	Documented policies and procedures guide the organization of pharmacy services and usage of medication	7.5
MOM 2	There is a hospital formulary.	7
MOM 3	Documented policies and procedures exist for storage of medication.	5.71
MOM 4	Documented policies and procedures guide the safe and rational prescription of medications.	5.4
MOM 5	Documented policies and procedures guide the safe dispensing of medications.	5.83
MOM 6	There are documented policies procedures for medication management.	6.5
MOM 7	Patients are monitored after medication administration	7.5
MOM 8	Near misses; medication errors and adverse drug events are reported and analyzed.	6.75
MOM 9	Documented procedures guide the use of narcotic drugs and psychotropic substance	5
MOM 10	Documented policies and procedures guide the usage of chemotherapeutic agents.	NA
MOM 11	Documented policies and procedures govern usage of radioactive drugs.	NA
MOM 12	Documented policies and procedures guide the use of implantable prosthesis end medical devices	NA
MOM 13	Documented policies and procedures guide the use of medical supplies and consumables	6.25
Chapter average		6.34

TABLE 9. Chapter 3MOM

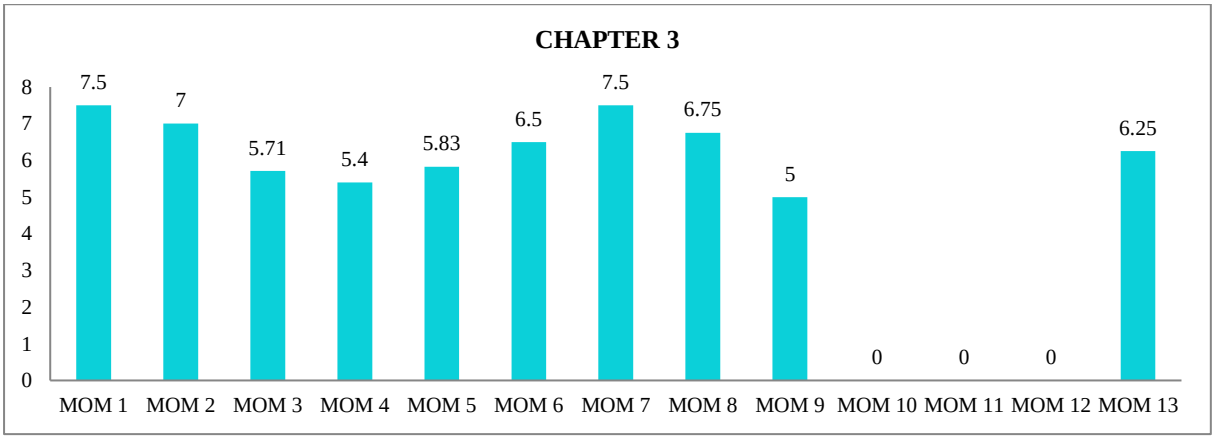


TABLE 10. Graph of MOM

MOM1.Documentation has been done regarding pharmacy services and usage of medication, but implementation needs to be done.

MOM2. Hospital formulary has not been developed and requires implementation to define process for acquisition of the medication.

MOM3. Medications are stored properly, are saved from theft or loss; but standards need to be maintained as per NABH.

MOM4. Policies and producers exist prescription of medicines has been documented but need implementation now a date.

MOM5. Documentation has been done for safe dispensing of medications. Implementation needs to be done.

MOM6. Documentation has been done for medication administration, but it is incomplete and implementation is also required.

MOM7. Documentation policies and procedure to guide the monitoring of patients after medication administration has been done now but other polices require implementation

MOM8. Documented procedure exists to capture near miss, medication error and adverse drug event has done now but need implementation.

MOM9. Narcotic drugs and psychotropic substances are not used in the hospital

MOM10: Chemotherapeutic agents are not used in the hospital.

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

MOM12: In the absence of orthopedician and physiotherapist, implantable prosthesis is not given to the patients.

MOM 13: Only Oxygen cylinders are used in the hospital, but no other medical gas is used.

Chapter 4: PATIENT RIGHTS AND EDUCATION (PRE)		
PRE 1	The organization protects patient and family rights and informs them about their responsibilities during care.	5
PRE 2	Patient and family rights support individual beliefs, values and involve the patient and family in decision-making processes.	6
PRE 3	The patient and/or family members are educated to make informed decisions and are involved in the care-planning and delivery process.	7.14
PRE 4	A documented procedure for obtaining patient and/or family's consent exists for informed decision making about their care.	6.25
PRE 5	Patient and families have a right to information and education about their healthcare needs.	7.5
PRE6	Patient and families have a right to information on expected costs.	6.25
PRE7	Organization has a complaint redressal procedure.	6.25
Chapter average		6.34

TABLE 11. Chapter4 of PRE

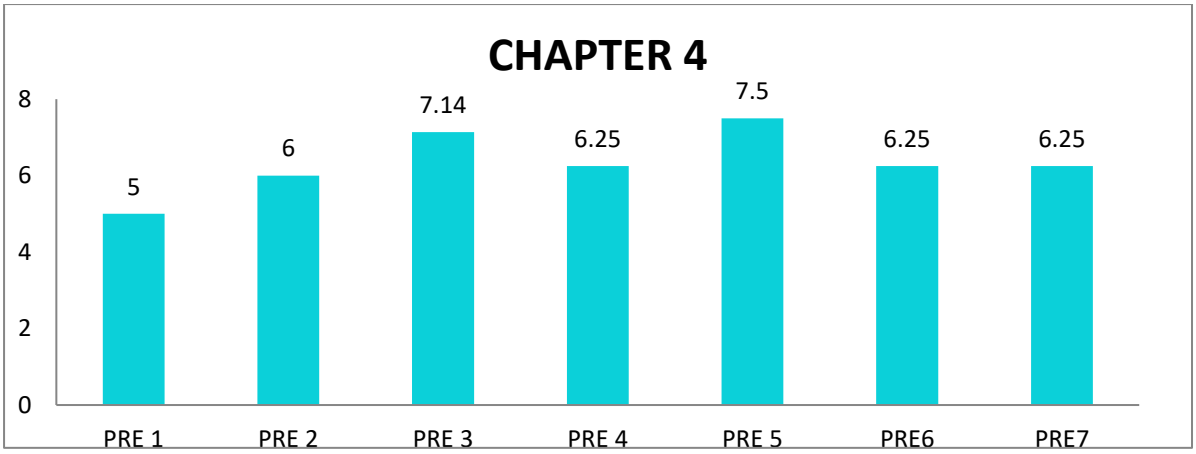


TABLE 12. Graph of chapter 4.

PRI 1. Documentation about protection of patient and family rights and responsibilities has been done and signages have been put in English language only for informing them about their rights and responsibilities but it should need in bilingual language in outside of every department implementation has not done properly.

PRI 2. Documentation about Patient and family rights for supporting individual beliefs values and involving the patient and family in decision-making processes has been done but patient family right includes protection; refusal of treatment voice complaint etc not has been implemented.

PRI 3. Hospitals patient and family members are educated to make informed decisions and are involved in the expected result .possible complain and including the risk and alternative care document has done but not properly implemented.

PRI 4. A documented process for obtaining patient and/ or family's consent exists for informed decision making about their care need to be prepared.

PRI 5. The documentation of the patient and family have to right to information and education about their healthcare need like food- drug interaction, diet and nutrition has been done but need a proper implementation.

PRI 6. Patients and family are educated about the estimated cost of treatment and its implication on change of treatment.

PRI 7. The policy and procedure of the organization redressal procedure documentation has done but implementation of the procedure has not done properly of the organization.

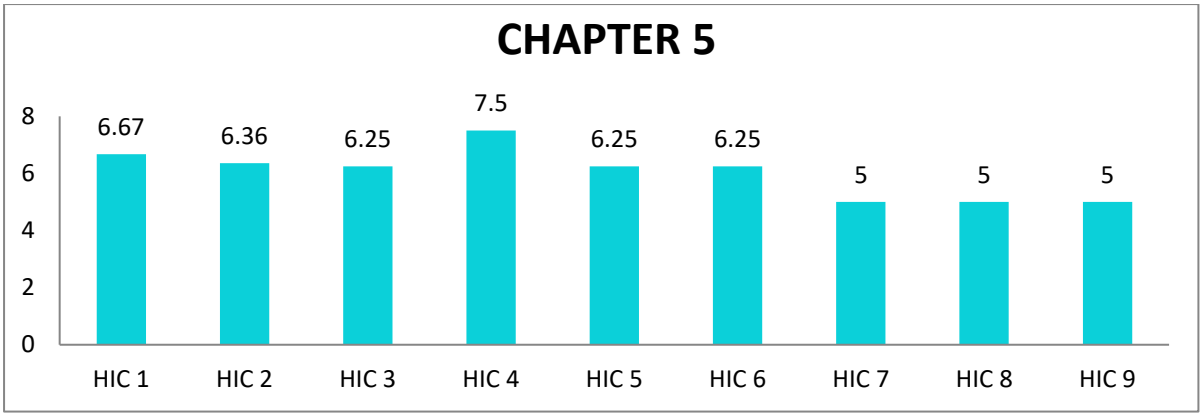


TABLE 14.Graph of chapter 6 HIC

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.	6.67
HIC 2	The organization implements the policies and procedures laid down in the Infection Control Manual.	6.36
HIC 3	The organization performs surveillance activities to capture and monitor infection prevention and control data.	6.25
HIC 4	The organization takes actions to prevent and control Healthcare Associated infections (HAI) in patients	7.5
HIC 5	The organization provides adequate and appropriate resources for prevention and control of Healthcare Associated Infections (HAI).	6.25
HIC 6	The organization identifies and takes appropriate actions to control outbreaks of infection	6.25
HIC 7	There are documented policies and procedures for sterilization activities in the organization.	5
HIC 8	Bio medical waste (BMW) is handled in an appropriate and safe manner.	5
HIC 9	The infection control programme is supported by the management and includes training of staff and employee health	5
Chapter average		6.03

TABLE 13.Chapter 5 HIC

HIC1. The hospital infection prevention and control programme is documented which aims at preventing and reducing risk of healthcare associated infections documentation has done and Hospital has an infection control committee, infection control team and nurse.

HIC2.Infection Control manual has been documented, but some standards have to be documented and implementation is also required.

HIC3.Survillance is done on timely basis and record is also maintained, but further improvements required.

HIC4.The organization takes actions to prevent or reduce the different risk of Hospital Associated Infections (HAI) in patients and employees.

HIC5.Facilities and resources provided to support the infection control programme are inadequate

HIC6. Actions to be taken to control outbreaks of infections has documented but inadequate.

HIC7. Documentation needs to be done for procedures for sterilisation activities in the organisation.

HIC8. Biomedical waste is segregated at source and disposed off properly as per statutory requirements.

HIC 9.The infection control programme is supported by the organisation's management and training to staff is regularly given

Chapter 6: CONTINUOUS QUALITY IMPROVEMENT (CQI)		
CQI 1	There is a structured quality improvement and continuous monitoring programme in the organization	6.67
CQI 2	There is a structured patient-safety programme in the organization.	7
CQI 3	The organization identifies key indicators to monitor the clinical structures, processes and outcomes which are used as tools for continual improvement	7
CQI 4	The organization identifies key indicators monitor the managerial structures, processes and outcomes, which are used as tools for continual improvement	6.67
CQI 5	The quality improvement programme is supported by the management.	3.75
CQI6	There is an established system for clinical audit.	7
CQI 7	Incidents, complaints and feedback are collected and analyzed to ensure continual quality improvement	7
CQI 8	Sentinel events are intensively analyzed.	6.25
Chapter average		6.42

TABLE15.Chapter 6 CQI

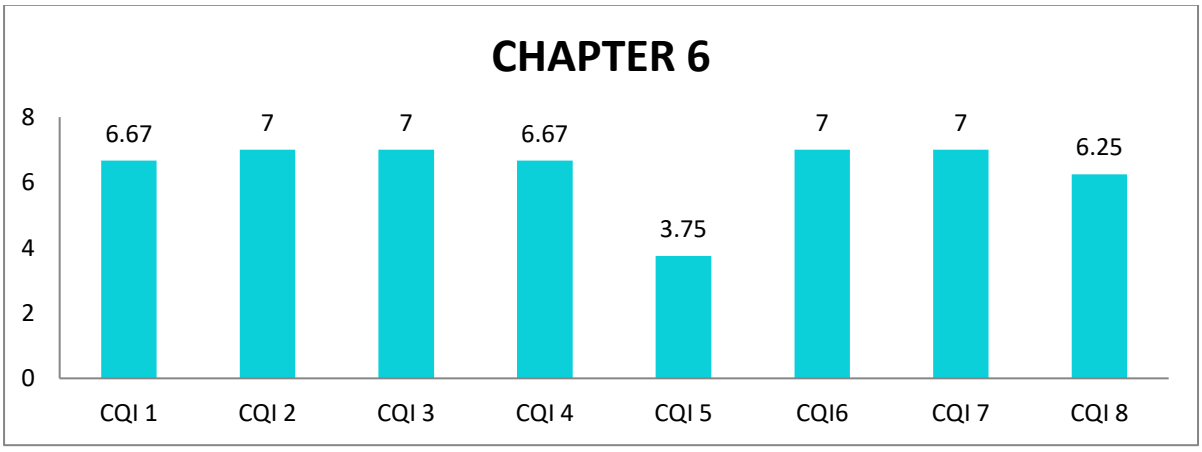


TABLE17.Graph of chapter 6 CQI

CQI1. Structured quality improvement and continuous monitoring programme in the organization is documented and implementation needs to be done.

CQI2. Safety and quality control programmes of the diagnostics services, invasive procedures, anesthesia, and infection control have been documented and need to be implemented

CQI3. The organization identifies key indicators to monitor the clinical structures, processes and outcomes which are used as tools for continual improvement has to be documented but need some a implementation.

CQI4.Hospitals Key indicators to monitor the managerial structures, processes and outcomes which are used as tools for continual improvement have been documented and need to be implemented.

CQI5. Quality Improvement progremme needs to be supported by the management.

CQI6. System for audit of patient care services has been documented and need to be implemented.

CQI7.Proper documentation has done of the Incidents, complaints and feedback are collected and analyzed to ensure continual quality improvement but need some require implementation.

CQI8. The organization has defined and created documented sentinel events and are analyzed whenever these events occur.

Chapter 7: RESPONSIBILITIES OF MANAGEMENT (ROM)		
ROM 1	The responsibilities of those responsible for governance are defined.	6.67
ROM 2	The organization complies with the laid-down and applicable legislations and regulations.	6.25
ROM 3	The services provided by each department are documented.	5
ROM 4	The organization is managed by the leaders in an ethical manner.	7
ROM5	The organization displays professionalism in management of affairs.	7.25
ROM 6	Management ensures that patient-safety aspects and risk-management issues are an integral part of patient care and hospital management.	5
Chapter average		6.20

TABLE18. Chapter 7 ROM

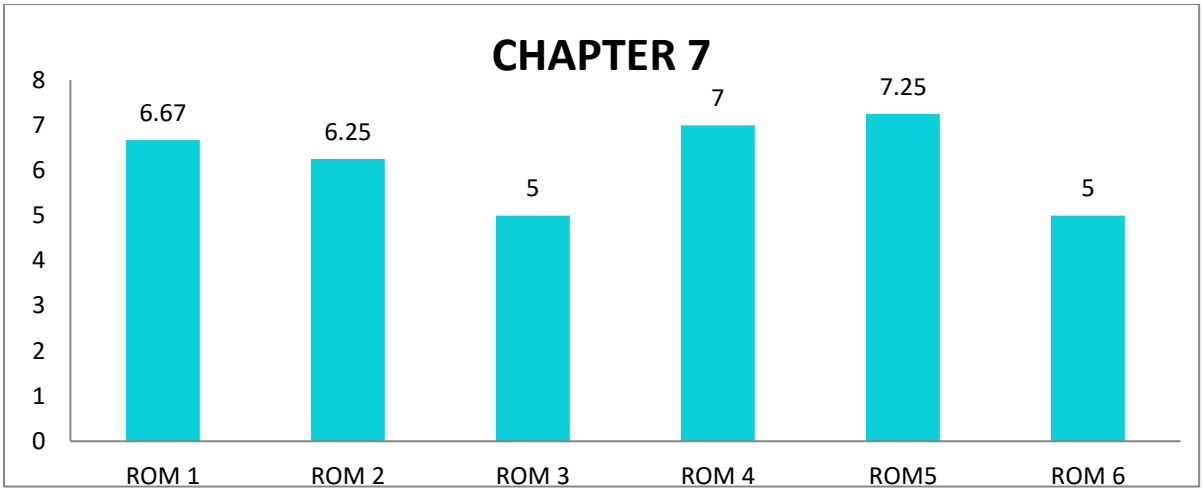


TABLE 19. Graph of chapter 7 ROM

ROM1.The organization has done documentation related governance, governance appoint, governance support and governance information and awareness but require some implementation.

ROM2.The policy and procedure of the organization complies with the laid down and applicable legislations and regulations had to be done but require some implementation.

ROM3.Services provided by each department are documented but not displayed and staff orientation is done through training.

ROM4.The organization has done documentation of ethical managemant but required documentation of honestly portrays its affiliations and accreditations and Organization's needs to be improved.

ROM5. A suitably qualified and experienced individual managerial heads the organization and is appointed human resource department of the hospital and its documentation has been completed regarding displays professionalism in management of affairs but still some implementation required.

ROM6. Documentation of sentinel events has been done, risk assessment and risk reduction activities are an integral part of patient care.

Chapter 8: FACILITY MANAGEMENT AND SAFETY (FMS)		
FMS 1	The organization has a system in place to provide a safe and secure environment.	6.67
FMS 2	The organization's environment and facilities operate to ensure safety of patients their families, staff and visitors.	6.82
FMS 3	The organization has a programme for engineering support services.	7.22
FMS 4	The organization has a programme for bio-medical equipment managed	5.71
FMS 5	The organization has a programme for medical gases, vacuum and compressed air.	5.83
FMS 6	The organization has plans for fire and non-fire emergencies within the facilities.	5
FMS 7	The organization plans for handling-community emergencies, epidemics and other disasters.	6
FMS 8	The organization has a plan for management of hazardous materials	7
Chapter average		6.28

TABLE20. Chapter 8 FMS

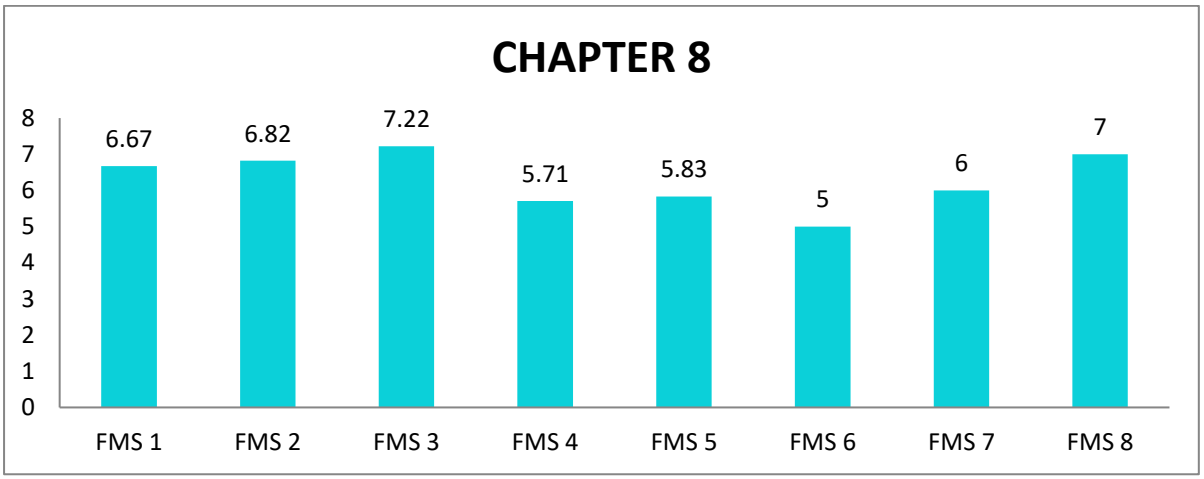


TABLE 21. Graph represent chapter 8

FMS1. The management is conversant with the laws and regulations and knows their applicability to the organization, but updating of amendments is required and the some implementation also require in the some policy and procedure in the hospital.

FMS2. Documentation has been done on the aspects to ensure safety of patients, their families, staff and visitors, but implementation is required

FMS3. The organization has documented a program for clinical and support service equipment management, but implementation is not done.

FMS4. A plan for management of biomedical equipment has been documented and implementation is awaited.

FMS5. The organization has documented for safe water and electricity and also for alternate sources for medical gases and vacuum compressed air are provided for in case of failure but need some implementation and trained staff.

FMS6. The organization has plans for fire only and not for non-fire emergencies not set back area within the facilities. Fire safety plan needs a lot of changes.

FMS7. Provision is made for availability of medical supplies, equipment and materials during emergencies, but training is required for disaster management.

FMS8. A plan for management of hazardous materials has been documented and requires some implementation.

Chapter 9: HUMAN RESOURCE MANAGEMENT (HRM)		
HRM 1	The organization has a documented system of human resource planning.	6.25
HRM 2	The organization has a documented procedure for recruiting staff and orienting them to the organization's environment.	7.5
HRM 3	There is an ongoing programme for professional training and development of the staff	6.25
HRM 4	Staffs are adequately trained on various safety-related aspects.	6.25
HRM 5	An appraisal system for evaluating the performance of an employee exists as an integral part of the human resource management process.	6
HRM 6	The organization has documented disciplinary grievance handling policies and procedures	6.43
HRM 7	The organization addresses the health needs of the employees.	6.25
HRM 8	There is a documented personal record for each staff member.	5

HRM 9	There is a process for credentialing and privileging of medical professionals permitted to provide patient care without supervision.	5.83
HRM 10	There is a process for credentialing and privileging of nursing professionals, permitted to provide patient care without supervision.	5.83
Chapter average		6.16

TABLE 22.Chapter 9 HRM

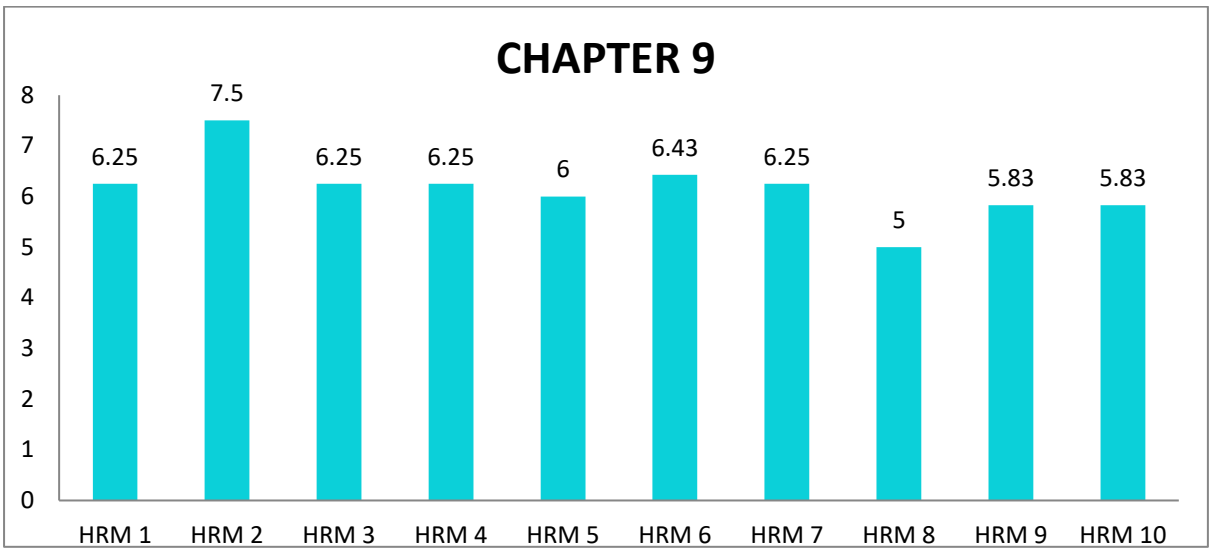


TABLE 23.Graph represent chapter 9 HRM

HRM1 The organization has a documented system of human resource planning and it is implemented and needs updation..

HRM2. Documentation has been done about employee rights and responsibilities, orientation and socialization is done through trainings and induction manual.

HRM3. Ongoing programme for professional training and development of the staff has done properly but need a some require implementation.

HRM4. Staff members are adequately trained on specific job duties or responsibilities related to safety as par hospital norms and condition.

HRM5. An appraisal system for evaluating the performance of an employee exists as an integral part of the human resource management process, per hospital rule and regulation.

HRM6. The organization has documented disciplinary and grievance handling policies and procedures but some implementation require and also for a grievance handling mechanism has been documented in the hospital, but needs implementation

HRM7. Documentation has been done for regular health checkups of staff and addressing of occupational hazards. Implementation needs improvements.

HRM8. Documented personal record for each staff member is maintained as per hospital norms rules.

HRM9. There is a process for collecting, verifying and evaluating the credentials (education, registration, training and experience) of medical professionals permitted to provide patient care without supervision and Documentation has been done for the process for authorising all medical professionals to admit and treat patients and provide other clinical services commensurate with their qualifications but implementation is still require.

HRM10. There is a process for collecting, verifying and evaluating the credentials (education, registration, training and experience) and to identify job responsibilities and make clinical work assignments to all nursing staff members commensurate with their qualifications and any other regulatory requirements.

Chapter 10: INFORMATION MANAGEMENT SYSTEM (IMS)		
IMS 1	Documented policies and procedures exist to meet the information needs of the care providers, management of the organization as well as other agencies that require data and information from the organization.	5
IMS 2	The organization has processes in place for effective management of data.	6
IMS 3	The organization has a complete and accurate medical record for every patient.	7.14
IMS 4	The medical record reflects continuity of care	6.25
IMS 5	Documented policies and procedures are in place for maintaining confidentiality integrity and security-of records, data and information	6.43
IMS 6	Documented policies and procedures exist for retention time of records data and information.	6.25
IMS 7	The organization regularly carries out review of medical records	6.43
Chapter average		6.21

TABLE 24. CHAPTER 10 IMS

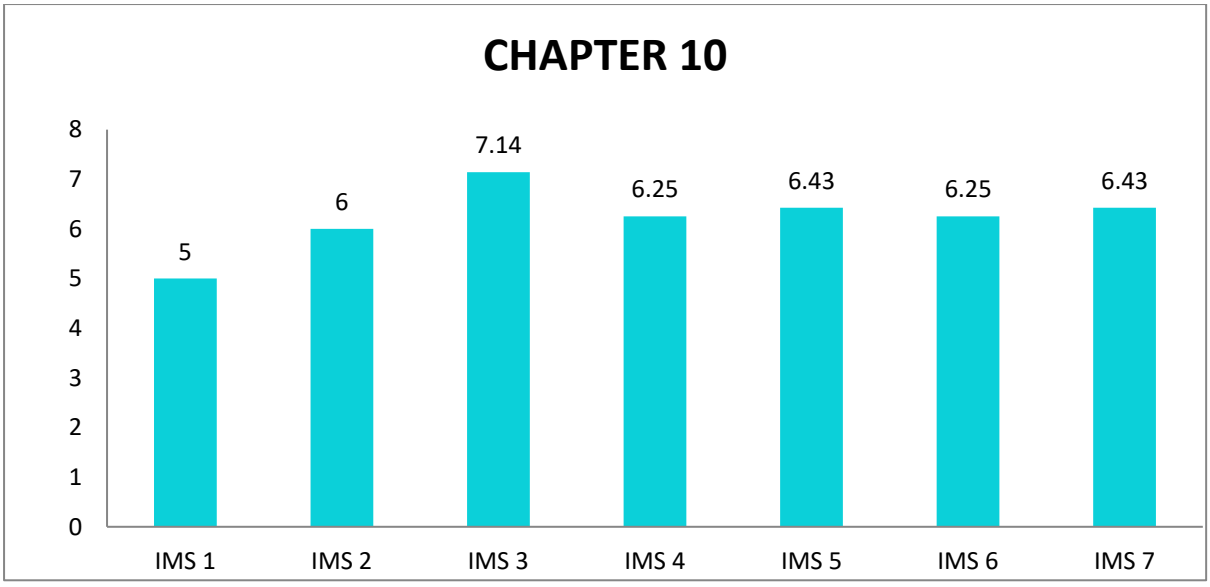


TABLE 25. Graph represent chapter 10

IMS1. Policies and procedures are documented to meet the information needs of the care providers, management of the organization as well as other agencies that require data and information from the Organization.

IMS2. Documentation is done for processes for effective management of data but implementation has not done.

IMS3. The hospital has a complete document of accurate medical record for every patient according to their name, signed, date and time of discharge but implementation require in up to date and chronological account of patient care.

IMS4. The medical record reflects continuity of care, due to presence of own hospital HMIS.

IMS5. Policies and procedures are in place for maintaining confidentiality, integrity and security of information, proper implementation is not there.

IMS6. Documented policies and procedures exist for retention time of records, data and information. Implementation is needed in proper way.

IMS7. Document has done of organization regularly carries out review of medical record but not proper implemented.

TABLE 26. OVER ALL SCORE OFALL CHAPETR

Evaluation Criteria:

1. Pre-accreditation entry level: Conditions for qualifying to this award are as below:

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

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

2. Pre-accreditation progressive level: Conditions for qualifying to this award are as below:

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

The overall average score for all standards must exceed 6.

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

3. Accredited: Conditions for qualifying for accreditation are as below:

- All the regulatory legal requirements should be fully met.
- No individual standard should have more than one zero to qualify.
- The average score for individual standards must not be less than 5.
- The average score for individual chapter must not be less than 7.
- The overall average score for all standards must exceed 7..

TOTAL AVERAGE OF ALL THE STANDARDS – 6.23

As the total average of all the standards is greater than 6 so it fulfils the criteria for **Pre-accreditation progressive level** Comparing the findings with the first evaluation criteria i.e No individual standard should have more than two zeros.

1 No standard is having more then two zeros

2 There is only one chapter i.e. CQI5 having average score less then 5.

3 There is no individual chapter having average score less then 6.

4 The fourth criteria we find that overall average of all the standards meets the criteria as it is greater than 6.

5 With the above analysis it is clear that the hospital is partially fulfilling the pre-accreditation progressive level criteria.

With the above analysis it is clear that the hospital is fulfilling the pre-accreditation progressive level criteria.

3.2 CONCLUSION

The analysis shows that there are some gaps in the hospital as per NABH norms. There are major gaps in the implementation part as the documentation work has been done upto some extent. So, major focus on implementation of norms is required. As the hospital wishes for NABH accreditation so it must be prepared according to the evaluation criteria for assessment. As of now the hospital fulfills the required criteria to some extent. Thus the hospital is presently prepared for pre assessment progressive level and requires great effort and focus on the weak points so as to cover the gaps and to be prepared for getting NABH accreditation.

4. RECOMMENDATION AND FINDING

4.1 FRONT OFFICE:-

In OPD proper patient waiting and registration process needs to be established. Placement of citizen charter, directional boards, fire extinguishers, fixture and electric fitting and also placement enough number of wheelchairs and trolley for patient convenience. Signage needs to be displayed in bilingual (Hindi & English) and patient has to be facilitated by the hospital staff.

4.2 OPD DEPARTMENT:-

The signages displayed in the OPD block are only in English language. It is recommended that the signages should be displayed in bilingual and pictorial. The services provided by the hospital need to be displayed in front of the entrance of the hospital and also Citizen Charter, patient rights & responsibilities, doctors OPD timings.

4.3 WARD AREA OR IN PATIENT DEPARTMENT:-

Establish fire exit plan on each floor. Place Signage for wet floor and directional board, room numbers. Develop waiting area for attendants having a call system**.** Placement of hand grabs in toilets in view of vulnerable patients. Modify the doors of toilets to open it from outside.

4.4 INTENSIVE CARE UNIT:-

The present available Intensive Care Unit does not satisfy the minimal requirements required for an intensive care unit. Space is not adequate, it is not properly ventilated, aseptic conditions are lacking, there are no utility rooms, and no toilet facilities etc. there is a need to establish Critical Care Unit in new casualty as soon as possible. Staff has to be trained for CPR-BLS/ALS. Proper implementation of manuals and policies needed. Noise level should be reduced by training staff. Crash cart needs to be arranged as per defined standard checklist and Calibration of equipments needs to be carried out periodically. Age specific competency of nurses taking care of pediatrics & neonates should be done and Drugs should be written in uniform location in medical records (Drug/Medication Chart). Initial assessment & plan of care should be counter signed by clinician in-charge within 24 hours.

4.5 CENTRAL STERILE SUPPLY DEPARTMENT:-

Current CSSD is in the operation theater it is not properly planned in the hospital. Hence a Central Sterile Supply Department with facility for un-sterile items receiving area , un-sterile items storage area , pack preparation area , washing area , sterilizing area , sterile packs storage area , trolley bay , issue window , staff change room ,CSSD in-charge office and CSSD store is required in view of infection control activities and streamline the sterilization process.

4.6 RADIOLOGY AND IMAGING DEPARTMENT:-

Radiation hazard signage's should be prominently displayed in all appropriate locations and Bilingual signage **"sex determination is a crime"** should be displayed outside the department. Fire exit & fire escape signage needs to be displayed in the department. Calibration of equipments should be done periodically. There is not Crash cart but must be kept in the x-ray department Radiation is hazardous to pregnant women needs to be displayed should be present lead aprons, thyroid shields & gonad shields should be periodically tested Health check up of staffs must be conducted on regular basis and also Quality assurance & validation of equipments must be carried out periodically.

4.7 SIGNAGE'S AND DIRECTIONAL BOARD:-

There are no appropriate directional boards in hospital premises and also scope of services needs to be displayed to acquaint patient and relatives about the services available in the hospital. Cross over of the internal & external traffic to be avoided by using directional maps, flow charts and differential timings.

4.8 FIRE EXIT AND FIRE PLAN:-

There is no separate fire exit points in the hospital and the same has to be constructed .Every floor should have a fire exit door and the same should be connected to the iron coated stairs connected from outside to one end of the hospital at every floor.

4.9 EMERGENCY WARD:

There is no Triage area and its need to be earmarked and proper training need to be provided to the staffs. No proper designated trolley and less wheel chair bay needs to be identified. Crash cart needs to be provided with all emergency medicines for round the clock. Staffs needs to be trained on BLS/ACLS. Elbow taps need to be fixed in the wash basin and also Disaster cupboard with all emergency medicines and equipments needs to provided Adequate number of equipments like monitors, suction apparatus, defibrillator needs to be provided

4.10. OPERATION THEATRE

The whole Operation theatre complex needs to be renovated as per NABH standards. Equipments in the operation theatres need to be calibrated. Surgeons, anesthetist & technician should have TLD badges. Narcotics drugs should be kept in cupboard with double lock and key. Spillage kit is required to be kept in the theatre. Fire exit and fire escape route must be displayed in the department. Surgical safety checklist should be made available. Quality assurance programme needs to be defined and monitored. Proper record of narcotic drugs usage needs to be maintained and also Sound alike and look alike medications are to be stored separately.

4.11 LABOUR ROOM

There is no implementation of the policy and procedure regarding labour room so as a recommendation Labour rooms needs to be renovated as per NABH standards High risk obstetric cases needs to be displayed. Elbow taps need to be fixed in all wash basin. Equipments need to be calibrated. Crash cart is to be arranged uniformly as per defined standard checklist Clinical protocols needs to be developed Staffs are to be trained uniformly in CPR – BLS/ALS. Foot prints are to be documented on the medical case sheet. Crash cart needs to be locked and also Sound alike & look alike medications should be stored separately.

4.12 DRUGS IN PHARMACY

Drugs are not inventoried properly. No inventory control methods are applied. Multiple sources of procurement, if need be, requires close monitoring & strong system development to ensure optimal utilization of resources. Prescription pattern needs to be confined to the drug formulary of Hospital.

4.13 AMBULANCES

Ambulances need to be modified BLS. Drivers to undergo training in BLS and no of ambulances need to be increased to at least 5-6, in view of location and size of the hospital.

5. REFERANCE

1. Henriksen K, Isaacson S, Sadler BL, et al. The role of the physical environment in crossing the quality chasm. Jt Comm J Qual Patient Safety 2007; 33 (11 Suppl):68-80.
2. K.Francis Sudhakar M.Kameshwar Rao T.Rahul,(2012), A study of gap analysis in hospitals and the relationship between patient satisfaction and quality of services in health care services,IJRIM,volume2,pageno.39.
3. Dr. Santosh Kumar, Brig. (Dr.) Swadesh Puri, Dr. S.D. Gupta 2009, study of Gap Analysis Report for Rehabilitation, book library.
4. Eric S. Kastango, MBA, RPh, FASHP, August 24, 2005, A Gap Analysis Review and Action Plan Relative to USP Chapter <797>
5. Dr. Santosh Kumar, Brig. (Dr.) Swadesh Puri, Dr. S.D. Gupta 2009, study of Gap Analysis Report for Rehabilitation, book library.
6. **Di Mclntyre and Laura Anselmi**, 2010,Health Economics Unit, School of Public Health and Family, Medicine, research report
7. Dr Sanjeev Singh and Col Sunil Kant, 2012, Hospital Infection Control Guidelines Principles & Practice, ISBN, volume 1.
8. Col Sunil Kant, 2004, Hospital and Healthcare Administration-Appraisal and Referral Treatise,ISBN, Edition1/e
9. Dr P K Dave, Lt Gen N K Parmar (Retd) and Col Sunil Kant,(January 2003), "Emergency Services & Disaster Management A Holistic Approach,volume1.
10. Dr.bidhandas,(2007)A giuide book for hospital administration,

ANNEXURE

SELF ASSESSMENT TOOLKIT						
Elements			**Documentation (Yes/ No)**	**Implementation (Yes/ No)**	**Evidence (cross reference to documents/ manuals etc.)**	**Scores (0/5/10)**
Chapter 1: ACCESS, ASSESSMENT AND CONTINUITY OF CARE (AAC)						
AAC.1: The organization defines and displays the services that it provides.						
	a	The services being provided are clearly defined and are in consonance with the needs of the community.	Y	Y	Scope of services	10
	b	The defined services are prominently displayed.	Y	N	Display at the entrance	5
	c	The staff is oriented to these services.	Y	N	Training Records	5
Average Score						6.7
AAC.2: The organization has a well-defined registration and admission process.						
	a	Documented policies and procedures are used for registering and admitting patients.	Y	Y	Policy for registration & admission of patients	10
	b	The documented procedures address out- patients, in-patients and emergency patients.	Y	N	Policy for registration & admission of patients	5

	c	A unique identification number is generated at the end of registration.	Y	Y	(a) Policy for registration & admission of patients (b) Patient registration slips (c) Patient Medical Records	10
	d	Patients are accepted only if the organization can provide the required service.	Y	N	Policy for registration & admission of patients; Interview the registration /admission staff.	5
	e	The documented policies andprocedures also address managing patients during non-availability of beds.	Y	N	Policy on Management of patient during non availability of bed	5
	f	The staff is aware of these processes.	Y	N	Interview the staff.	5
						6.7
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.	Y	Y	Patient Transfer Policy	10
	b	Documented policies and proceduresguide the transfer-out/referralof unstable patients to another facility in an appropriate manner.	Y	N	Patient Transfer Policy	5

	c	Documented policies andproceduresguide the transfer-out/referralof stable patients to another facility in an appropriate manner.	Y	N	Patient Transfer Policy	5
	d	The documented procedures identify staff responsible during transfer/referral	Y	N	Patient Transfer Policy	5
	e	The organization gives a summary of patient's condition and the treatment given	Y	Y	Patient Transfer Policy, Patient Discharge Policy	10
Average Score						7.0
AAC.4: Patients cared for by the organization undergo an established initial assessment.						
	a	The organization defines and documents the content of the initial assessment for the out–patients, in-patients and emergency patients	Y	Y	Policy on Initial Assessment of Patient	10
	b	The organization determines who can perform the initial assessment.	Y	N	Policy on Initial Assessment of Patient	5
	c	The organization defines the time frame within which the initial assessment is completed based on patient's needs	Y	N	Policy on Initial Assessment of Patient	5
	d	The initial assessment for in-patients is documented within 24 hours or earlier as per the patient's condition as defined in the organization's policy	Y	N	Policy on Initial Assessment of Patient, Patient Medical Records	5
	e	Initial assessment of in-patients includes nursing assessment which is done at the time of admission and documented.	Y	Y	Policy on Initial Assessment of Patient, Patient Medical Records	10

	f	Initial assessment includes screening for nutritional needs	Y	N	Policy on Initial Assessment of Patient, Patient Medical Records	5
	g	The initial assessment results in a documented plan of care	Y	N	Policy on Initial Assessment of Patient, Patient Medical Records	5
	h	The plan of care also includes preventive aspects of the care where appropriate	Y	N	Policy on Initial Assessment of Patient, Patient Medical Records	5
	i	The plan of care is countersigned by the clinician in-charge of the patient within 24 hours.	Y	N	Policy on Initial Assessment of Patient, Patient Medical Records	5
	j	The plan of care includes goals or desired results of the treatment, care or service	Y	N	Policy on Initial Assessment of Patient, Patient Medical Records	5
Average Score						6
AAC.5: Patients cared for by the organization undergo a regular reassessment						
	a	Patients are reassessed at appropriate intervals.	Y	Y	Policy on Re-assessment of Patient, Patient Medical	10

					Records	
	b	Out-patients are informed of their next follow up where appropriate.	Y	N	Policy on Re-assessment of patient Interview patients	5
	c	For in-patients during reassessment the plan of care is monitored and modified where found necessary.	Y	N	Policy on Re-assessment of patient Review Medical Records	5
	d	Staff involved in direct clinical care document reassessments.	Y	N	Policy on Re-assessment of patient Review Medical Records	5
	e	Patients are reassessed to determine their response to treatment and to plan further treatment or discharge.	Y	Y	Policy on Re-assessment of patient Review Medical Records	10
Average Score						7
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.	Y	Y	Scope of services	10
	b	The infrastructure (physical and manpower) is adequate to provide for its defined scope of services.	Y	N	Physical visit to the department, Manpower on roll	5
	c	Adequately qualified and trained personnel perform,supervise and	Y	Y	Personal Files of	10

		interpret the investigations.			staff	
	d	Documented procedures guide ordering of tests, collection, identification, handling, safe transportation, processing and disposal of specimens.	Y	N	Lab Services Manual	5
	e	Laboratory results are available within a defined time frame.	Y	N	Lab Services Manual	5
	f	Critical results are intimated immediately to the concerned personnel.	Y	Y	Critical Results Information record	10
	g	Results are reported in a standardized manner.	Y	N	Lab Services Manual	5
	h	Laboratory tests not available in the organization are outsourced to organization(s) based on their quality assurance system.	Y	N	MoU - with Diagnostic Centre	5
Average Score						6.9
AAC.7:There is an established laboratory quality assurance programme						
	a	The laboratory quality assurance programme is documented.	Y	Y	Lab Services Manual Relevant Records	10
	b	The programme addresses verification and/or validation of test methods.	Y	N	Lab Services Manual Relevant Records	5
	c	The programme addresses surveillance of test results.	Y	N	Lab Services Manual Relevant Records	5
	d	The programme includes periodic calibration and maintenance of all equipment.	Y	N	Lab Services Manual Relevant Records	5
	e	The programme includes the documentation of corrective and preventive actions.	Y	N	Lab Services Manual Relevant Records	5
Average Score						6.0
AAC.8:There is an established laboratory						

safety programme.						
	a	The laboratory safety programme is documented.	Y	Y	Lab Services Manual	10
	b	This programme is aligned with the organization's safety programme.	Y	Y	Lab Services Manual	10
	c	Written procedures guide the handling and disposal of infectious and hazardous materials.	Y	N	Lab Services Manual	5
	d	Laboratory personnel are appropriately trained in safe practices.	Y	N	Lab Services Manual	5
	e	Laboratory personnel are provided with appropriate safety equipment / devices.	Y	N	Physical visit to the departme nt,	5
Average Score						7
AAC.9:Imaging services are provided as per the scope of services of the organization.						
	a	Imaging services comply with legal and other requirements.	Y	Y	Licences	10
	b	Scope of the imaging services are commensurate to the services provided by the organization.	Y	Y	Scope of services	10
	c	The infrastructure (physical and manpower) is adequate to provide for its defined scope of services.	Y	N	On site visit	5
	d	Adequately qualified and trained personnel perform,supervise and interpret the investigations.	Y	Y	Personal Files of staff	10
	e	Documented policies and procedures guide identification and safe transportation of patients to imaging services.	Y	N	Imaging services manual	5
	f	Imaging results are available within a defined time frame.	Y	N	Imaging services manual	5
	g	Critical results are intimated immediately to the concerned personnel.	Y	N	Critical Results Informati on record	5
	h	Results are reported in a standardized manner.	Y	Y	Imaging services manual	10
	i	Imaging tests not available in the organization are outsourced to organization(s) based on their quality	Y	N	MoU - with Diagnosti	5

		assurance system.			c Centre	
Average Score						7.2
AAC.10:There is an established Quality assurance programme for imaging services.						
	a	The quality assurance programme for imaging services is documented.	Y	Y	Imaging services manual	10
	b	The programme addresses verification and/or validation of imaging methods.	Y	N	Imaging services manual	5
	c	The programme addresses surveillance of imaging results.	Y	N	Imaging services manual	5
	d	The programme includes periodic calibration and maintenance of all equipment.	Y	N	Imaging services manual	5
	e	The programme includes the documentation of corrective and preventive actions.	Y	N	Imaging services manual	5
Average Score						6
AAC.11:There is an established radiation safety programme.						
	a	The radiation safety programme is documented.	Y	Y	Imaging services manual	10
	b	This programme is aligned with the organization's safety programme.	Y	N	Safety Manual	5
	c	Handling, usage and disposal of radio-active and hazardous materialsis as per statutory requirements.	Y	N	Imaging services Manual (Radioactive Material Not Applicable)	5
	d	Imaging personnel are provided with appropriate radiation safety devices.	Y	N	Imaging services manual	5
	e	Radiation safety devices are periodically tested and results documented.	Y	N	Imaging services manual	5
	f	Imaging personnel are trained in radiation safety measures.	Y	N	Imaging services manual	5
	g	Imaging signageare prominently displayed in all appropriate locations.	Y	Y	Imaging services manual	10

Average Score						6.4
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.	Y	N	Policy on Continuity of Care	5
	b	Care of patients is coordinated in all care settings within the organization.	Y	Y	Policy on Continuity of Care	10
	c	Information about the patient's care and response to treatment is shared among medical, nursing and other care providers.	Y	N	Policy on Continuity of Care	5
	d	Information is exchanged and documented during each staffing shift, between shifts, and during transfers between units/departments.	Y	N	Policy on Continuity of Care	5
	e	Transfers between departments/units are done in a safe manner.	Y	N	Policy on Continuity of Care & Patient Transfer Policy	5
	f	The patient's record (s) is available to the authorized care providers to facilitate the exchange of information.	N	N	Policy on Continuity of Care	0
	g	Documented procedures guide the referral of patients to other departments/ specialities.	Y	N	Policy on Referral of Patients	5
Average Score						5.0
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.	Y	Y	Patient Discharge Policy	10
	b	Documented procedures exist for coordination of various departments and agencies involved in the discharge process (including medico-legal and absconded cases).	Y	N	Patient Discharge Policy	5
	c	Documented policies and procedures are in place for patients leaving against medical advice and patients being discharged on request	Y	N	Patient Discharge Policy	5
	d	A discharge summary is given to all the patients leaving the organization (including patients leaving against medical advice and on request).	Y	Y	Patient Discharge Policy	10

Average Score						7.5
AAC.14: Organization defines the content of the discharge summary.						
	a	Discharge summary is provided to the patients at the time of discharge.	Y	Y	Patient Discharge Policy	10
	b	Discharge summary contains the patient's name, unique identification number, date of admission and date of discharge.	Y	N	Patient Discharge Policy	5
	c	Discharge summary contains the reasons for admission, significant findings and diagnosis and the patient's condition at the time of discharge.	Y	N	Patient Discharge Policy	5
	d	Discharge summary contains information regarding investigation results, any procedure performed, medication administered and other treatment given.	Y	N	Patient Discharge Policy	5
	e	Discharge summary contains follow up advice, medicationand other instructions in an understandable manner.	Y	N	Patient Discharge Policy	5
	f	Discharge summary incorporates instructions about when and how to obtain urgent care.	N	N	patient discharge	0
	g	In case of death, the summary of the case also includes the cause of death.	Y	N	Patient Discharge Policy	5
Average Score						5.0
Average Score for AAC						6.5
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.	Y	Y	Uniform care policy	10
	b	Uniform care is guided by documented policies and procedures	Y	N	Uniform care policy	5
	c	These reflect applicable laws, regulations and guidelines	Y	N	Uniform care policy	5
	d	The organization adapts evidence based medicine and clinical practice guidelines to guide uniform patient care.	Y	Y	Policy on practice of evidence	10

					based medicine Treatment Guidelines	
Average Score						7.5
COP.2: Emergency services are guided by documentedpolicies, procedures, applicable laws and regulations.						
	a	Policies and procedures for emergency care are documented and are in consonance with statutory requirements.	Y	Y	Emergency services manual	10
	b	This also addresses handling of medico-legal cases.	Y	Y	Emergency services manual	10
	c	The patients receive care in consonance with the policies.	Y	N	Emergency services manual	5
	d	Documented policies and procedures guide the triage of patients for initiation of appropriate care	Y	N	Emergency services manual	5
	e	Staff are familiar with the policies and trained on the procedures for care of emergency patients.	Y	Y	Emergency services manual	5
	f	Admission or discharge to home or transfer to another organization is also documented.	Y	N	Emergency services manual	5
	g	In case of discharge to home or transfer to another organization a discharge note shall be given to the patient.	Y	Y	Emergency services manual	10
Average Score						7.1
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).	Y	Y	on site verification	10
	b	The ambulance adheres to statutory requirements.	Y	Y	RC Available	10
	c	Ambulance(s) is appropriately equipped.	Y	N	Ambulance services manual	5
	d	Ambulance(s) is manned by trained personnel.	Y	N	Ambulance services manual	5

					Staff interview on site	
	e	Ambulance (s) is checked on a daily basis.	Y	N	Ambulance services manual Record of Daily Check	5
	f	Equipment are checked on a daily basis using a checklist.	Y	N	Ambulance services manual Record of Daily Check	5
	g	Emergency medications are checked daily and prior to dispatch using a checklist.	Y	N	Ambulance services manual Record of Checks	5
	h	The ambulance(s) has a proper communication system.	Y	N	Ambulance services manual (Mobile Phone)	5
Average Score						6.3
COP.4: Documented policiesand procedures guide the care of patients requiring cardio-pulmonary resuscitation.						
	a	Documented policies and procedures guide the uniform use of resuscitation throughout the organization	Y	N	CPR Policy	5
	b	Staff providing direct patient careare trained and periodically updated in cardio pulmonary resuscitation.	Y	N	CPR Policy Training Records	5
	c	The events during a cardio-pulmonary resuscitation are recorded.	Y	N	CPR Policy Patient Medical Records	5
	d	A post-event analysis of all cardio-pulmonary resuscitations is done by a multidisciplinary committee.	Y	N	On site review of the analysis	5

					records	
	e	Corrective and preventive measures are taken based on the post-event analysis.	Y	N	Records of the analysis done	5
Average Score						5
COP.5: Documented policies and procedures guide nursing care.						
	a	There are documented policies and procedures for all activities of the Nursing Services.	Y	Y	Nursing manual	10
	b	These reflect current standards of nursing services and practice, relevant regulations and the purposes of the services.	N	N	Nursing manual	0
	c	Assignment of patient care is done as per current good practice guidelines.	Y	N	Nursing manual	5
	d	Nursing care is aligned and integrated with overall patient care.	Y	N	Nursing manual	5
	e	Care provided by nurses is documented in the patient record.	Y	N	Nursing manual	5
	f	Nurses are provided with adequate equipment for providing safe and efficient nursing services.	Y	N	on siite verificati on	5
	g	Nurses are empowered to take nursing related decisions to ensure timely care of patients.	Y	N	Nursing manual Interview nurses	5
Average Score						5.0
COP.6: Documented procedures guide the performance of various procedures.						
	a	Documented procedures are used to guide the performance of various clinical procedures.	Y	N	OT manual	5
	b	Only qualified personnel order, plan, perform and assist in performing procedures.	Y	Y	OT manual Personal Files of staff	10
	c	Documented procedures exist to prevent adverse events like wrong site, wrong patient and wrong procedure.	Y	N	OT manual	5
	d	Informed consent is taken by the personnel performing the procedure where applicable.	Y	N	OT manual Medical Records	5
	e	Adherence to standard precautions and asepsis is adhered to during the	Y	N	Infection control	5

		conduct of the procedure.			Manual Interview staff	
	f	Patients are appropriately monitored during and after the procedure.	Y	N	OT manual Patient Medical Record	5
	g	Procedures are documented accurately in the patient record.	Y	N	OT manual Patient Medical Record	5
Average Score						5.7
COP.7: Documented policies and procedures define rational use of blood and blood products.						
	a	Documented policies and procedures are used to guide rational use of blood and blood products.	Y	Y	Policy on Rational use of Blood & Blood Products	10
	b	Documented procedures govern transfusion of blood and blood products.	Y	Y	Policy on Rational use of Blood & Blood Products	10
	c	The transfusion services are governed by the applicable laws and regulations.	Y	Y	Policy on Rational use of Blood & Blood Products	10
	d	Informed consent is obtained for donation and transfusion of blood and blood products.	Y	Y	Policy on Rational use of Blood & Blood Products	10
	e	Informed consent also includes patient and family education about donation.	Y	N	Policy on Rational use of Blood & Blood Products	5
	f	The organization defines the process for availability and transfusion of blood/blood components for use in	Y	N	Policy on Rational use of	5

		emergency.			Blood & Blood Products	
	g	Post transfusion form is collected; reactions if any identified and are analysed for preventive and corrective actions.	Y	N	Policy on Rational use of Blood & Blood Products	5
	h	Staff are trained to implement the policies.	Y	N	Rational use of Blood & Blood Products policy Training records	5
Average Score						7.5
COP.8: Documented policies and procedures guide the care of patients in the Intensive care and high dependency units.						
	a	Documented policies and procedures are used to guide the care of patients in the Intensive care and high dependency units.	Y	Y	ICU manual	10
	b	The organization has documented admission and discharge criteria for its intensive care and high dependency units.	Y	N	ICU manual	5
	c	Staff are trained to apply these criteria.	Y	N	ICU manual Training Records	5
	d	Adequate staff and equipment are available.	Y	N	ICU manual On site verificati on	5
	e	Defined procedures for situation of bed shortages are followed.	Y	N	ICU manual Interview Staff	5
	f	Infection control practices are documented and followed.	Y	N	Infection Control manual Interview Staff On site verificati on	5

	g	A quality assurance programme is documented and implemented.	Y	N	ICU manual Interview Staff	5
Average Score						5.7
COP.9: Documented policies andprocedures 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.	Y	N	Vulnerable patient policy	5
	b	Care is organized and delivered in accordance with the policies and procedures.	Y	N	Vulnerable patient policy	5
	c	The organization provides for a safe and secure environment for this vulnerable group.	Y	N	Vulnerable patient policy On site verification	5
	d	A documented procedure exists for obtaining informed consent from the appropriate legal representative.	Y	N	Vulnerable patient policy Medical Records	5
	e	Staff are trained to care for this vulnerable group.	Y	N	Vulnerable patient policy On site verification	5
Average Score						5
COP.10: Documented policies andprocedures guide obstetric care.						
	a	There is a documented policy and procedure for obstetric services.	Y	Y	Obstetrics & Gynecology manual	10
	b	The organization defines and displays whether high risk obstetric cases can be cared for or not.	Y	N	Displayed (Not provided)	5
	c	Persons caring for high risk obstetric cases are competent.	NA	NA	NA	NA
	d	Documented procedures guide provision of ante-natal services.	Y	Y	Obstetrics & Gynecolo	10

					gy manual	
	e	Obstetric patient's assessment also includes maternal nutrition.	Y	N	Obstetrics & Gynecology manual	5
	f	Appropriate pre-natal, peri-natal and post-natal monitoring is performed and documented.	Y	N	Obstetrics & Gynecology manual	5
	g	The organization caring for high risk obstetric cases has the facilities to take care of neonates of such cases.	NA	NA	NA	NA
Average Score						7
COP.11: Documented policies and procedures guide paediatric services.						
	a	There is a documented policy and procedure for paediatric services.	Y	Y	Pediatric manual	10
	b	The organization defines and displays the scope of its paediatric services.	Y	N	Pediatric manual	5
	c	The policy for care of neonatal patients is in consonance with the national/ international guidelines.	Y	N	Pediatric manual	5
	d	Those who care for children have age specific competency.	Y	N	Pediatric manual	5
	e	Provisions are made for special care of children.	Y	N	Evidence on site	5
	f	Patient assessment includes detailed nutritional, growth, psychosocial and immunization assessment.	Y	N	Pediatric manual Patient Medical Record	5
	g	Documented policies and procedures prevent child/neonate abduction and abuse.	Y	N	Policy on infant abduction & prevention	5
	h	The children's family members are educated about nutrition, immunization and safe parenting and this is documented in the medical record.	N	N	Pediatric manual	0
Average Score						5
COP.12: Documented policies andprocedures guide the care of patients undergoing moderate sedation.						
	a	Documented procedures guide the	Y	Y	Sedation	10

		administration of moderate sedation.			Policy	
	b	Informed consent for administration of moderate sedation is obtained.	Y	N	Sedation Policy	5
	c	Competent and trained persons perform sedation.	Y	N	Sedation Policy Personal Files of staff	5
	d	The person administering and monitoring sedation is different from the person performing the procedure.	Y	N	Sedation Policy On site verificati on	5
	e	Intra-procedure monitoring includes at a minimum the heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation, and level of sedation.	Y	Y	Patient Medical Record	10
	f	Patients are monitored after sedation and the same documented.	Y	N	Sedation Policy Patient Medical Record	5
	g	Criteria are used to determine appropriateness of discharge from the recovery area.	Y	N	Sedation Policy Patient Medical Record	5
	h	Equipment and manpower are available to manage patients who have gone intoa deeper level of sedation than initially intended.	Y	N	Sedation Policy & on site verificati on	5
Average Score						6.25
COP.13: Documented policies andprocedures guide the administration of anaesthesia.						
	a	There is a documented policy and procedure for the administration of anaesthesia.	Y	Y	Anesthesia Manual	10
	b	Patients for anaesthesia have a pre-anaesthesia assessment by a qualified anaesthesiologist.	Y	Y	Anesthesia Manual Personal File of the Doctor	10
	c	The pre-anaesthesia assessment results in formulation of an anaesthesia plan which is documented	Y	N	Anesthesia Manual Patient	5

					Medical Record	
	d	An immediate pre-operative re-evaluation is performed and documented.	Y	N	Anesthesia Manual Patient Medical Record	5
	e	Informed consent for administration of anaesthesia is obtained by the anaesthesiologist.	Y	Y	Anesthesia Manual Patient Medical Record	10
	f	During anaesthesia monitoring includes regular recording of temperature, heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation and end tidal carbon dioxide.	Y	Y	Anesthesia Manual Patient Medical Record	10
	g	Patient's post-anaesthesia status is monitored and documented.	Y	N	Anesthesia Manual Patient Medical Record	5
	h	The anaesthesiologist applies defined criteria to transfer the patient from the recovery area.	Y	N	Anesthesia Manual Patient Medical Record	5
	i	The type of anaesthesia and anaesthetic medications used are documented in the patient record.	Y	N	Patient Medical Record	5
	j	Procedures shall comply with infection control guidelines to prevent cross infection between patients.	Y	N	Infection Control manual On site verification	5
	k	Adverse anaesthesia events are recorded and monitored.	Y	N	Records of the Adverse Anaesthesia Events & Analysis	5
Average Score						6.8
COP.14: Documented policies and procedures guide the care of patients undergoing surgical procedures.						
	a	The policies and procedures are documented.	Y	Y	Operation theater	10

					manual	
	b	Surgical patients have a preoperative assessment and a provisional diagnosis documented prior to surgery.	Y	Y	Patient Medical Record	10
	c	An informed consent is obtained by a surgeon prior to the procedure.	Y	Y	Patient Medical Record	10
	d	Documented policies and procedures exist to prevent adverse events like wrong site, wrong patient and wrong surgery.	Y	Y	Operation theater manual Patient Medical Record	10
	e	Persons qualified by law are permitted to perform the procedures that they are entitled to perform.	Y	N	Operation theater manual	5
	f	A brief operative note is documented prior to transfer out of patient from recovery area.	Y	N	Operation theater manual Patient Medical Record	5
	g	The operating surgeon documents the post-operative plan of care.	Y	N	Operation theater manual Patient Medical Record	5
	h	Patient, personnel and material flow conforms to infection control practices.	N	N	Operation theater manual On site verification	0
	i	Appropriate facilities and equipment/appliances/instrumentation are available in the operating theatre.	Y	N	On site verification	5
	j	A quality assurance programme is followed for the surgical services.	Y	N	Operation theater manual	5
	k	The quality assurance programme includes surveillance of the operation theatre environment.	Y	N	Operation theater manual	5
Average Score						6.36
COP.15: Documented policies and procedures guide the care of patients under restraints (physical and / or chemical).						
	a	Documented policies and procedures	Y	Y	Patient	10

		guide the care of patients under restraints.			Restraint policy	
	b	These include both physical and chemical restraint measures.	Y	Y	Patient Restraint policy Patient Medical Record	10
	c	These include documentation of reasons for restraints.	Y	N	Patient Restraint policy Patient Medical Record	5
	d	These patients are more frequently monitored.	Y	N	Patient Restraint policy Patient Medical Record	5
	e	Staff receive training and periodic updating in control and restraint techniques.	Y	N	Patient Restraint policy Training Records	5
Average Score						7
COP.16: Documented policies and procedures guide appropriate pain management.						
	a	Documented policies and procedures guide the management of pain.	Y	N	Pain Management policy	5
	b	All patients are screened for pain.	Y	N	Pain Management policy Patient Medical Records	5
	c	Patients with pain undergo detailed assessment and periodic re-assessment.	Y	N	Pain Management policy Patient Medical Records	5
	d	The organization respects and supports management of pain for such patients.	Y	N	Pain Management policy	5
	e	Patient and family are educated on various pain management techniques	N	N	Pain Managem	5

		where appropriate.			ent policy Interview Patients	
Average Score						5
COP.17: Documented policies andprocedures guideappropriate rehabilitative services.						
	a	Documented policies and procedures guide the provision of rehabilitative services.	Y	Y	Physiotherapy manual	10
	b	These services are commensurate with the organizational requirements.	Y	N	Physiotherapy manual	5
	c	Care is guided by functional assessment and periodic re-assessment which is done and documented by qualified individual (s).	Y	N	Physiotherapy manual Patient Medical Records	5
	d	Care is provided adhering to infection control and safe practices.	Y	N	Physiotherapy manual	5
	e	Rehabilitative services are provided by a multidisciplinary team.	Y	N	Physiotherapy manual	5
	f	There is adequate space and equipment to perform these activities.	Y	Y	on site verification	10
Average Score						6.7
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.	NA	NA	NA	NA
	b	The organization has an ethics committee to oversee all research activities.	NA	NA	NA	NA
	c	The committee has the powers to discontinue a research trial when risks outweigh the potential benefits.	NA	NA	NA	NA
	d	Patient's informed consent is obtained before entering them in research protocols.	NA	NA	NA	NA
	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.	NA	NA	NA	NA
	f	Patients are assured that their refusal to participate or withdrawal from	NA	NA	NA	NA

		participation will not compromise their access to the organization's services.				
Average Score						
COP.19: Documented policies and procedures guide nutritional therapy.						
	a	Documented policies and procedures guide nutritional assessment and reassessment.	Y	N	Dietary and nutrition manual	5
	b	Patients receive food according to their clinical needs.	Y	Y	Dietary and nutrition manual	10
	c	There is a written order for the diet.	Y	N	Patient Medical Record	5
	d	Nutritional therapy is planned and provided in a collaborative manner.	Y	N	Patient Medical Record	5
	e	When families provide food, they are educated about the patient's diet limitations.	Y	N	Dietary and nutrition manual Interview Patients/ Relatives	5
	f	Food is prepared, handled, stored and distributed in a safe manner.	Y	N	Dietary and nutrition manual On site verificati on of practices	5
Average Score						5.8
COP.20: Documented policies and procedures guide the end of life care.						
	a	Documented policies and procedures guide the end of life care.	Y	Y	End of life policy	10
	b	These policies and procedures are in consonance with the legal requirements.	Y	N	End of life policy	5
	c	These also address the identification of the unique needs of such patient and family.	Y	N	End of life policy	5
	d	Symptomatic treatment is provided and where appropriate measures are taken for alleviation of pain.	N	N	End of life policy	0

	e	Staff are educated and trained in end of life care.	Y	N	End of life policy Training Records	5
Average Score						5
AVERAGE SCORE FOR COP						6.09
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.	Y	Y	Pharmacy manual	10
	b	These comply with the applicable laws and regulations.	Y	N	Pharmacy manual Licenses Available	5
	c	A multidisciplinary committee guides the formulation and implementation of these policies and procedures.	Y	N	Pharmacy manual Records of Committee Meeting	5
	d	There is a procedure to obtain medication when the pharmacy is closed.*	Y	Y	24 hrs pharmacy	10
Average Score						7.5
MOM.2. There is a hospital formulary.						
	a	A list of medications appropriate for the patients and as per the scope of the organization's clinical services is developed.	Y	Y	Formulary List	10
	b	The list is developed and updated collaboratively by the multidisciplinary committee.	Y	N	Records of the Committee Meetings	5
	c	The formulary is available for clinicians to refer and adhere to.	Y	N	Copy of the List available in OPD & IPD	5
	d	There is a defined process for acquisition of these medications	Y	N	Pharmacy manual	5
	e	There is a process to obtain medications not listed in the formulary.	Y	Y	Pharmacy manual	10
Average Score						7

MOM.3: Documented policies and procedures guide the storage of medication						
	a	Documented policies and procedures exist for storage of medication	Y	N	Pharmacy manual On site verification	5
	b	Medications are stored in a clean; safe and secure environment; and incorporating manufacturer's recommendation (s).	Y	N	On site verification	5
	c	Sound inventory control practices guide storage of the medications.	Y	N	Pharmacy manual On site verification	5
	d	Sound alike and look alike medications are identified and stored separately.*	Y	N	List of the LASA medications, On site verification	5
	e	The list of emergency medications is defined and is stored in a uniform manner	Y	N	on site verification	5
	f	Emergency medications are available all the time.	Y	Y	Pharmacy manual On site verification	10
	g	Emergency medications are replenished in a timely manner when used.	Y	N	Pharmacy manual On site verification	5
Average Score						5.71
MOM.4: Documented policies and procedures guide the safe and rational prescription of medications						
	a	Documented policies and procedures exist for prescription of medications.	Y	Y	Medication Policy	10
	b	These incorporate inclusion of good practices/guidelines for rational prescription of medications.	Y	N	Patient Medical Record	5
	c	The organization determines the minimum requirements of a prescription.	Y	N	Medication Policy	5
	d	Known drug allergies are ascertained	Y	N	Medicatio	5

		before prescribing.			n Policy	
	e	The organization determines who can write orders.*	Y	N	Medicatio n Policy	5
	f	Orders are written in a uniform location in the medical records.	Y	N	Medicatio n Policy Patient Medical Records	5
	g	Medication orders are clear, legible, dated, timed, named and signed.	Y	N	Medicatio n Policy Patient Medical Records	5
	h	Medication orders contain the name of the medicine, route of administration, dose to be administered and frequency/time of administration.	Y	N	Medicatio n Policy Patient Medical Records	5
	i	Documented policy and procedure on verbal orders is implemented.	Y	N	Medicatio n Policy Patient Medical Records	5
	j	The organization defines a list of high risk medication (s).	Y	N	Medicatio n Policy (High risk medicatio n policy)	5
	k	Audit of medication orders/prescription is carried out to check for safe and rational prescription of medications.	Y	N	Audit records	5
	l	Corrective and/or preventive action (s) is taken based on the analysis where appropriate.	Y	N	Audit records	5
Average Score						5.4
MOM.5: Documented policies and procedures guide the safe dispensing of medications.						
	a	Documented policies and procedures guide the safe dispensing of medications	Y	Y	Pharmacy manual	10
	B	The procedure addresses medication recall.	Y	N	Pharmacy manual	5
	c	Expiry dates are checked prior to dispensing.	Y	N	Pharmacy manual	5
	D	There is a procedure for near expiry medications.	Y	N	Pharmacy manual Interview Staff	5

	e	Labelling requirements are documented and implemented by the organization.	Y	N	On site verification	5
	F	High risk medication orders are verified prior to dispensing.	Y	N	Medication Policy (High risk medication policy)	5
Average Score						5.83
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.	Y	Y	Medication policy	10
	B	Prepared medication is labelled prior to preparation of a second drug.	Y	N	On site verification	5
	c	Patient is identified prior to administration.	Y	Y	On site verification	10
	D	Medication is verified from the order prior to administration.	Y	N	On site verification	5
	e	Dosage is verified from the order prior to administration.	Y	N	On site verification	5
	F	Route is verified from the order prior to administration.	Y	N	On site verification	5
	g	Timing is verified from the order prior to administration.	Y	N	On site verification	5
	H	Medication administration is documented.	Y	Y	Patient Medical Record	10
	i	Documented policies and procedures govern patient's self- administration of medications.	Y	N	Medication policy	5
	j	Documented policies and procedures govern patient's medications brought from outside the organization.*	Y	Y	Medication policy	5
Average Score						6.50
MOM.7: Patients are monitored after medication administration.						
	a	Documented policies and procedures guide the monitoring of patients after medication administration.	Y	Y	Adverse drug reaction policy	10

	B	The organization defines those situations where close monitoring is required.*	Y	N	Adverse drug reaction policy	5
	c	Monitoring is done in a collaborative manner.	Y	N	Adverse drug reaction policy	5
	d	Medications are changed where appropriate based on the monitoring.	Y	Y	Adverse drug reaction policy Patient Medical Records	10
Average Score						7.50
MOM.8: Near misses, medication errors and adverse drug events are reported and analysed.						
	a	Documented procedure exists to capture **near miss, medication error** and adverse drug event.	Y	N	Safety Manual Adverse drug reaction policy	5
	b	Near miss, medication error and adverse drug event are defined.	Y	Y	Safety Manual Adverse drug reaction policy	10
	c	These are reported within a specified time frame.	Y	N	Safety Manual Adverse drug reaction policy	5
	d	They are collected and analysed.	Y	N	Safety Manual Adverse drug reaction policy Analysis Records	5
	e	Corrective and/or preventive action (s) is taken based on the analysis where appropriate.	Y	N	Safety Manual Adverse drug	5

					reaction policy Analysis Records CAPA Records	
Average Score						6.75
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.	Y	N	Medication Policy	5
	b	These drugs are stored in a secure manner.	Y	N	On site verification (Not stored in bulk)	5
	c	A proper record is kept of the usage, administration and disposal of these drugs.	Y	N	Medication Policy	5
	d	These drugs are handled by appropriate personnel in accordance with the documented procedure.	Y	N	Medication Policy	5
Average Score						5
MOM.10: Documented policies and procedures guide the usage of chemotherapeutic agents.						
	a	Documented policies and procedures guide the usage of chemotherapeutic agents.	NA	NA	NA	NA
	b	Chemotherapy is prescribed by those who have the knowledge to monitor and treat the adverse effect of chemotherapy.	NA	NA	NA	NA
	c	Chemotherapy is prepared in a proper and safe manner and administered by qualified personnel.	NA	NA	NA	NA
	d	Chemotherapy drugs are disposed off in accordance with legal requirements.	NA	NA	NA	NA
Average Score						
MOM.11: Documented policies and procedures govern usage of radioactive drugs.						
	a	Documented policies and procedures govern usage of radioactive drugs.	NA	NA	NA	NA

	b	These policies and procedures are in consonance with laws and regulations.	NA	NA	NA	NA
	c	The policies and procedures include the safe storage, preparation, handling, distribution and disposal of radioactive drugs.	NA	NA	NA	NA
	d	Staff, patients and visitors are educated on safety precautions.	NA	NA	NA	NA
Average Score						
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).	NA	NA	NA	NA
	b	Documented policies and procedures govern procurement, storage / stocking, issuance and usage of implantable prosthesis and medical devices incorporating manufacturer's recommendation(s).*	NA	NA	NA	NA
	c	Patient and his / her family are counselled for the usage of implantable prosthesis and medical device including precautions, if any.	NA	NA	NA	NA
	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.	NA	NA	NA	NA
Average Score						
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.	Y	N	Purchase policy	5
	b	Medical supplies and consumables are used in a safe manner where appropriate.	Y	Y	Purchase policy On site verification of the practices	10
	c	Medical supplies and consumables are stored in a clean; safe and secure environment; and incorporating manufacturer's recommendation (s).	Y	N	Purchase policy	5

	d	Sound inventory control practices guide storage of medical supplies and consumables.	Y	N	On site verification	5
Average Score						6.25
AVERAGE SCORE FOR MOM						6.34
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.	Y	N	Policy on Patients right & responsibilities	5
	b	Patients and families are informed of their rights and responsibilities in a format and language that they can understand.	Y	N	Policy on Patients right & responsibilities Displayed	5
	c	The organization's leaders protect patient and family rights.	Y	N	Policy on Patients right & responsibilities	5
	d	Staff is aware of their responsibility in protecting patient and family rights.	Y	N	Policy on Patients right & responsibilities	5
	e	Violation of patient and family rights is recorded, reviewed and corrective / preventive measures taken.	Y	N	Policy on Patients right & responsibilities	5
Average Score						5.00
PRE.2: Patient and family rights support individual beliefs, values and involve the patient and family in decision making processes.						
	a	Patients and family rights include respecting any special preferences, spiritual and cultural needs.	N	N	Policy on Patients right & responsibilities	0

	b	Patient and family rights include respect for personal dignity and privacy during examination, procedures and treatment.	Y	Y	Policy on Patients right & responsibilities	10
	c	Patient and family rights include protection from physical abuse or neglect.	Y	N	Policy on Patients right & responsibilities	5
	d	Patient and family rights include treating patient information as confidential.	Y	Y	Policy on Patients right & responsibilities	10
	e	Patient and family rights include refusal of treatment.	Y	N	Policy on Patients right & responsibilities	5
	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.	Y	N	Policy on Patients right & responsibilities	5
	g	Patient and family rights include right to complain and information on how to voice a complaint.	Y	N	Policy on Patients right & responsibilities	5
	h	Patient and family rights include information on the expected cost of the treatment.	Y	N	Policy on Patients right & responsibilities	5
	i	Patient and family rights include access to his / her clinical records.	Y	N	Policy on Patients right & responsibilities	5
	j	Patient and family rights include information on plan of care, progress and information on their health care needs.	Y	Y	Policy on Patients right & responsibilities	10
Average Score						6.00
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.	Y	N	Interview Patient, Relative	5
	b	The patient and/or family members are explained about the expected results.	Y	N	Interview Patient, Relative	5
	c	The patient and / or family members are explained about the possible complications.	Y	Y	Filled Consent Forms (Patient Medical Record) Interview Patient, Relative	10
	d	The care plan is prepared and modified in consultation with patient and/or family members.	Y	N	Policy on patient education	5
	e	The care plan respects and where possible incorporates patient and/or family concerns and requests.	Y	Y	Policy on Patients right & responsibilities	10
	f	The patient and/or family members are informed about the results of diagnostic tests and the diagnosis	Y	Y	Policy on Patients right & responsibilities	10
	g	The patient and/or family members are explained about any change in the patient's condition.	Y	N	Policy on Patients right & responsibilities	5
Average Score						7.14
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.	Y	Y	Informed consent policy	10
	b	General consent for treatment is obtained when the patient enters the organization.	Y	N	General consent policy	5

	c	Patient and/or his family members are informed of the scope of such general consent.	Y	N	General consent policy & Interview Patient, Relative	5
	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.	Y	N	Filled Consent Forms (Patient Medical Record) Interview Patient, Relative	5
	e	The procedure describes who can give consent when patient is incapable of independent decision making.	Y	N	Informed consent policy	5
	f	Informed consent is taken by the person performing the procedure.	Y	Y	Informed consent policy	10
	g	Informed consent process adheres to statutory norms.	Y	N	Informed consent policy	5
	h	Staff are aware of the informed consent procedure.	Y	N	Training Records	5
Average Score						6.25
PRE.5: Patient and families have a right to information and education about their healthcare needs.						
	a	Patient and/or family are educated about the safe and effective use of medication and the potential side effects of the medication, when appropriate.	Y	N	Policy on patient education on treatment	5
	b	Patient and/or family are educated about food-drug interactions.	Y	N	Policy on patient education on treatment & Medication Policy	5
	c	Patient and/or family are educated about diet and nutrition.	Y	Y	Policy on patient education on treatment Interview	10

					Patients/ Relatives	
	d	Patient and/or family are educated about immunizations.	Y	Y	Policy on patient education on treatment Interview Patients/ Relatives	10
	e	Patient and/or family are educated about organ donation, when appropriate.	Y	N	Policy on patient education on treatment Interview Patients/ Relatives	5
	f	Patient and/or family are educated about their specific disease process, complications and prevention strategies.	Y	Y	Policy on patient education on treatment Interview Patients/ Relatives	10
	g	Patient and/or family are educated about preventing healthcare associated infections.	Y	N	Policy on patient education on treatment Interview Patients/ Relatives	5
	h	Patient and/or family are educated in a language and format that they can understand.	Y	Y	Policy on patient education on treatment Interview Patients/ Relatives	10
Average Score						7.50
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).	Y	Y	Policy on Patient right and	10

					responsibility	
	b	The tariff list is available to patients.	Y	N	Policy on Patient right and responsibility	5
	c	The patient and/or family members are explained about the expected costs.	Y	N	Policy on Patient right and responsibility	5
	d	Patient and/or family are informed about the financial implications when there is a change in the patient condition or treatment setting.	Y	N	Policy on Patient right and responsibility	5
Average Score						6.25
PRE.7: Organization has a complaint redressal procedure.						
	a	The organization has a documented complaint redressal procedure.	Y	Y	Policy on Patient right and responsibility	10
	b	Patient and/or family members are made aware of the procedure for lodging complaints.	Y	N	Policy on Patient right and responsibility	5
	c	All complaints are analysed.	Y	N	Records of the analysis done	5
	d	Corrective and/or preventive action (s) is taken based on the analysis where appropriate.	Y	N	Records of the analysis done	5
Average Score						6.25
AVERAGE SCORE FOR PRE						6.34
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.	Y	Y	Hospital infection control manual	10
	b	The infection prevention and control programme is a continuous process and updated at least once in a year.	Y	Y	Hospital infection control manual	10
	c	The hospital has a multi-disciplinary infection control committee which co-ordinates all infection prevention and control activities.	Y	N	Hospital infection control manual Records of Committee Meetings	5
	d	The hospital has an infection control team which co-ordinates implementation of all infection prevention and control activities.	Y	N	Hospital infection control manual Records of Committee Meetings	5
	e	The hospital has designated infection control officer as part of the infection control team.	Y	N	Hospital infection control manual	5
	f	The hospital has designated infection control nurse(s) as part of the infection control team.	Y	N	Hospital infection control manual	5
Average Score						6.67
HIC.2: The organization implements the policies and procedures laid down in the Infection Control Manual.						
	a	The organization identifies the various high-risk areasand procedures and implements policies and/or procedures to prevent infection in these areas	Y	N	Hospital infection control manual	5
	b	The organization adheres to standard precautions at all times.	Y	Y	Hospital infection control manual	10
	c	The organization adheres to hand hygiene guidelines.	Y	Y	Hospital infection control	10

					manual	
	d	The organization adheres to safe injection and infusion practices.	Y	Y	Hospital infection control manual	10
	e	The organization adheres to transmission based precautions at all times.	Y	N	Hospital infection control manual	5
	f	The organization adheres to cleaning, disinfection and sterilization practices	Y	Y	Hospital infection control manual	10
	g	An appropriate antibiotic policy is established and implemented.	Y	Y	Hospital infection control manual	5
	h	The organization adheres to laundry and linen management processes.	N	N	Hospital infection control manual	0
	i	The organization adheres to kitchen sanitation and food handling issues.	Y	N	Hospital infection control manual	5
	j	The organization has appropriate engineering controls to prevent infections.	Y	N	Hospital infection control manual	5
	k	The organization adheres to housekeeping procedures.	Y	N	Hospital infection control manual	5
Average Score						6.36
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.	Y	Y	Hospital infection control manual	10
	b	Collection of surveillance data is an on-going process.	Y	N	Hospital infection control manual	5
	c	Verification of data is done on a regular basis by the infection control team.	Y	Y	Hospital infection control manual	10

	d	Scope of surveillance activities incorporates tracking and analysing of infection risks, rates and trends.	Y	N	Hospital infection control manual	5
	e	Surveillance activities include monitoring the compliance with hand hygiene guidelines.	Y	N	Hospital infection control manual	5
	f	Surveillance activities include monitoring the effectiveness of housekeeping services.	Y	N	Hospital infection control manual	5
	g	Appropriate feedback regarding HAI rates are provided on a regular basis to appropriate personnel.	Y	N	Hospital infection control manual	5
	h	In cases of notifiable diseases, information (in relevant format) is sent to appropriate authorities.	Y	Y	Hospital infection control manual	5
Average Score						6.25
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.	Y	Y	Hospital infection control manual	10
	b	The organization takes action to prevent respiratory tract infections.	Y	N	Hospital infection control manual	5
	c	The organization takes action to prevent intra-vascular device infections.	Y	N	Hospital infection control manual	5
	d	The organization takes action to prevent surgical site infections.	Y	Y	Hospital infection control manual	10
Average Score						7.50
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	Y	Y	Hospital infection control	5

		correctly.			manual	
	b	Adequate and appropriate facilities for hand hygiene in all patient care areas are accessible to health care providers.	Y	Y	Hospital infection control manual	10
	c	Isolation / barrier nursing facilities are available.	Y	N	Hospital infection control manual	5
	d	Appropriate pre and post exposure prophylaxis is provided to all concerned staff members.	Y	N	Hospital infection control manual	5
Average Score						6.25
HIC.6: The organization identifies and takes appropriate action to control outbreaks of infections.						
	a	Organization has a documented procedure for identifying an outbreak.	Y	Y	Hospital infection control manual	10
	b	Organization has a documented procedure for handling such outbreaks.	Y	N	Hospital infection control manual	5
	c	This procedure is implemented during outbreaks.	Y	N	Hospital infection control manual	5
	d	After the outbreak is over appropriate corrective actions are taken to prevent recurrence.	Y	N	Hospital infection control manual	5
Average Score						6.25
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.	Y	N	On site verification	5
	b	Documented procedure guides the cleaning, packing, disinfection and/or sterilization, storing and issue of items.	Y	N	CSSD Manual	5
	c	Reprocessing of instruments and equipment are covered.	Y	N	Infection Control manual	5
	d	Regular validation tests for	Y	N	CSSD	5

		sterilizationare carried out and documented.			Manual Records available	
	e	There is an established recall procedure when breakdown in the sterilization system is identified.	Y	N	CSSD Manual	5
Average Score						5.00
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.	Y	N	Approval available	5
	b	Proper segregation and collection of biomedical waste from all patient care areas of the hospital is implemented and monitored.	Y	N	Biomedical waste management manual	5
	c	The organization ensures that biomedical waste is stored and transported to the site of treatment and disposal in proper covered vehicles within stipulated time limits in a secure manner.	Y	N	Biomedical waste management manual	5
	d	Biomedical waste treatment facility is managed as per statutory provisions (if in-house) or outsourced to authorised contractor(s).	Y	N	Biomedical waste management manual	5
	e	Appropriate personal protective measures are used by all categories of staff handling biomedical waste.	Y	N	Biomedical waste management manual	5
Average Score						5.00
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.	Y	N	Hospital infection control manual	5
	b	The organization earmarks adequate funds from its annual budget in this regard.	Y	N	Hospital infection control manual	5
	c	The organization conducts induction training for all staff.	Y	N	Human Resource manual	5

					(Inductio n policy)	
	d	The organization conducts appropriate "in-service" training sessions for all staff at least once in a year.	Y	N	Human Resource manual (Training & developm ent policy) Records of Training	5
Average Score						5.0 0
AVERAGE SCORE FOR HIC						6.0 3
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.	Y	Y	Quality Manual (Terms of reference of Quality committe e)	10
	b	The quality improvement programme is documented.	Y	N	Quality Manual(Quality improve ment program me)	5
	c	There is a designated individual for coordinating and implementing the quality improvement programme.	Y	N	Accredita tion co ordinator	5
	d	The quality improvement programme is comprehensive and covers all the major elements related to quality assurance and supports innovation.	Y	N	Quality Manual(Quality improve ment program me)	5
	e	The designated programme is communicated and coordinated amongst all the staff of the organization through appropriate	Y	Y	Human Resource s (Training	10

		training mechanism.			& developm ent policy)	
	f	The quality improvement programme identifies opportunities for improvement based on review at pre-defined intervals.	Y	N	Quality Manual(Quality improve ment program me)	5
	g	The quality improvement programme is a continuous process and updated at least once in a year.	Y	N	Quality Manual (Terms of reference of Quality committe e)	5
	h	Audits are conducted at regular intervals as a means of continuous monitoring.	Y	N	Quality Manual (Terms of reference of Quality committe e)	5
	i	There is an established process in the organization to monitor and improve quality of nursing and complete patient care.	Y	Y	Quality Manual (Terms of reference of Quality committe e)	10
Average Score						6.67
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.	Y	Y	Quality Manual (Terms of refrence of safety managem ent committie e)	10
	b	The patient safety programme is documented.	Y	N	Safety Manual	5
	c	The patient safety programme is comprehensive and covers all the major elements related to patient safety	Y	Y	Safety Manual	10

		and risk management.				
	d	The scope of the programme is defined to include adverse events ranging from “no harm” to “sentinel events”.	Y	N	Safety Manual	5
	e	There is a designated individual for coordinating and implementing the patient safety programme.	Y	N	Safety Manual	5
	f	The designated programme is communicated and coordinated amongst all the staff of the organization through appropriate training mechanism.	Y	N	Training Records	5
	g	The patient safety programme identifies opportunities for improvement based on review at pre-defined intervals.	Y	Y	Safety Manual	10
	h	The patient safety programme is a continuous process and updated at least once in a year.	Y	N	Safety Manual	5
	i	The organization adapts and implements national/international patient safety goals/solutions.	Y	N	Safety Manual	5
	j	The organization uses at least two identifiers to identify patients across the organization.	Y	Y	Medictaio n Policy	10
Average Score						7.0 0
CQI.3: The organization identifies key indicators to monitor the clinical structures, processes and outcomes which are used as tools for continual improvement.						
	a	Monitoring includes appropriate patient assessment.	Y	N	Quality manual & relevant records	5
	b	Monitoring includes safety and quality control programmes of all the diagnostic services.	Y	N	Quality manual & relevant records	5
	c	Monitoring includes medication management.	Y	N	Adverse Drug Reaction Policy & relevant records	5
	d	Monitoring includes use of anaesthesia.	Y	Y	Quality manual &	10

					relevant records	
	e	Monitoring includes surgical services.	Y	N	Quality manual & relevant records	5
	f	Monitoring includes use of blood and blood products.	Y	Y	Quality manual & relevant records	10
	g	Monitoring includes infection control activities.	Y	N	Quality manual & relevant records	5
	h	Monitoring includes review of mortality and morbidity indicators.	Y	Y	Quality manual & relevant records	10
	i	Monitoring includes clinical research.	NA	NA	NA	NA
	j	Monitoring includes data collection to support further improvements.	Y	N	Quality manual	5
	k	Monitoring includes data collection to support evaluation of these improvements.	Y	Y	Quality manual	10
Average Score						7.00
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.	Y	Y	Quality manual	10
	b	Monitoring includes risk management.	Y	N	Quality manual	5
	c	Monitoring includes utilisation of space, manpower and equipment.	Y	N	Quality manual	5
	d	Monitoring includes patient satisfaction which also incorporates waiting time for services.	Y	Y	Quality manual	10
	e	Monitoring includes employee satisfaction.	Y	N	Quality manual	5
	f	Monitoring includes adverse events and near misses.	Y	Y	Quality manual	10
	g	Monitoring includes availability and	N	N	Quality	0

		content of medical records.			manual	
	h	Monitoring includes data collection to support further improvements.	Y	N	Quality Manual(Terms of reference of Quality committe e)	5
	i	Monitoring includes data collection to support evaluation of these improvements.	Y	Y	Quality Manual(Terms of reference of Quality committe e)	10
Average Score						6.67
CQI.5: The quality improvement programme is supported by the management.						
	a	The management makes available adequate resources required for quality improvement programme.	Y	Y	Quality Manual(Terms of reference of Quality committe e)	5
	b	Organization earmarks adequate funds from its annual budget in this regard.	Y	N	Quality Manual(Terms of reference of Quality committe e)	5
	c	The management identifies organizational performance improvement targets.	N	N	Quality manual	0
	d	The management supports and implements use of appropriate quality improvement, statistical and management tools in its quality improvement programme.	Y	Y	Quality manual	5
Average Score						3.75
CQI.6: There is an established system for clinical audit.						
	a	Medical and nursing staff participates in this system.	Y	Y	Quality Manual(Terms of reference of	10

					medical audit committe e)	
	b	The parameters to be audited are defined by the organization.	Y	N	Quality Manual(Terms of reference of medical audit committe e)	5
	c	Patient and staff anonymity is maintained.	Y	Y	Quality Manual(Terms of reference of medical audit committe e)	10
	d	All audits are documented.	Y	N	Quality Manual(Terms of reference of medical audit committe e)	5
	e	Remedial measures are implemented.	Y	N	Quality Manual(Terms of reference of medical audit committe e)	5
Average Score						7.00
CQI.7: Incidents, complaints and feedback are collected and analysed to ensure continual quality improvement.						
	a	The organization has an incident reporting system.	Y	Y	Safety Manual	10
	b	The organization has a process to collect feedback and receive complaints.	Y	Y	Patient Right and responsib	10

					ility Policy	
	c	The organization has established processes for analysis of incidents, feedbacks and complaints.	Y	N	Safety Manual, Patient Right and responsib ility Policy	5
	d	Corrective and preventive actions are taken based on the findings of such analysis.	Y	N	Records of the analysis done	5
	e	Feedback about care and service is communicated to staff.	Y	N	Patient Right and responsib ility Policy	5
Average Score						7.00
CQI.8: Sentinel events are intensively analysed.						
	a	The organization has defined sentinel events.	Y	Y	Sentinel Events Policy	10
	b	The organization has established processes for intense analysis of such events.	Y	N	Sentinel Events Policy	5
	c	Sentinel events are intensively analysed when they occur.	Y	N	Sentinel Events Policy	5
	d	Corrective and Preventive Actions are taken based on the findings of such analysis.	Y	N	Sentinel Events Policy Records of Analysis done	5
Average Score						6.25
AVERAGE SCORE FOR CQI						6.42
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.	Y	Y	Responsi bility of managem	10

					ent Manual (Functions of governing body)	
	b	Those responsible for governance approve the strategic and operational plans and organization's budget.	Y	Y	Responsibility of management Manual	10
	c	Those responsible for governance monitor and measure the performance of the organization against the stated mission.	Y	N	Responsibility of management Manual	5
	d	Those responsible for governance establish the organization's organogram.	Y	N	Responsibility of management Manual	5
	e	Those responsible for governance appoint the senior leaders in the organization.	Y	Y	Responsibility of management Manual	10
	f	Those responsible for governance support safety initiatives and quality improvement plans.	Y	N	Responsibility of management Manual	5
	g	Those responsible for governance support research activities.	Y	N	Responsibility of management Manual	5
	h	Those responsible for governance address the organization's social responsibility.	Y	N	Responsibility of management Manual	5
	i	Those responsible for governance inform the public of the quality and performance of services.	Y	N	Responsibility of management Manual	5
Average Score						6.67
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.	Y	Y	Responsibility of management Manual	10
	b	The management ensures implementation of these requirements.	Y	N	Responsibility of management Manual	5
	c	Management regularly updates any amendments in the prevailing laws of the land.	Y	N	Responsibility of management Manual	5
	d	There is a mechanism to regularly update licenses/ registrations/certifications.	Y	N	Responsibility of management Manual	5
Average Score						6.25
ROM.3: The services provided by each department are documented.						
	a	Scope of services of each department is defined	Y	N	Responsibility of management Manual	5
	b	Administrative policies and procedures for each department are maintained.	Y	N	Responsibility of management Manual (Different Departmental Manuals /Policies)	5
	c	Each organizational programme, service, site or department has effective leadership.	Y	N	Responsibility of management Manual	5
	d	Departmental leaders are involved in quality improvement.	Y	N	Responsibility of management Manual	5

					(Quality improvement programme)	
Average Score						5.00
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.	Y	Y	Displayed acorss the hospital	10
	b	The leaders establish the organization's ethical management.	Y	N	Responsibility of management Manual	5
	c	The organization discloses its ownership.	Y	Y	Letter heads, website	10
	d	The organization honestly portrays the services which it can and cannot provide.	Y	N	Displayed at entrance	5
	e	The organization honestly portrays its affiliations and accreditations.	NA	NA	NA	NA
	f	The organization accurately bills for its services based upon a standard billing tariff.	Y	N	Schedule of charges available	5
Average Score						7.00
ROM.5: The organization displays professionalism in management of affairs.						
	a	The person heading the organization has requisite and appropriate administrative qualifications.	Y	Y	Human Resource Manual (CV of Managing Director)	10
	b	The person heading the organizationhas requisite and appropriate administrative experience.	Y	N	Human Resource Manual (CV of Managing Director)	5
	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	Y	Y	Responsibility of management Manual	10

		consultation with the various stake holders.			,Meeting with the Managing Director	
	d	The organization coordinates the functioning with departments and external agencies, and monitors the progress in achieving the defined goals and objectives.	Y	N	Responsibility of management Manual	5
	e	The organization plans and budgets for its activities annually.	Y	N	Responsibility of management Manual	5
	f	The performance of the senior leaders is reviewed for their effectiveness.	Y	N	Human Resource manual	5
	g	The functioning of committees is reviewed for their effectiveness.	Y	N	Responsibility of management Manual	5
	h	The organization documents employee rights and responsibilities.	Y	Y	Human Resource manual	10
	i	The organization documents the service standards.	Y	N	Quality Manual	5
	j	The organization has a formal documented agreement for all outsourced services.	Y	Y	Copies of the MoU's	10
	k	The organization monitors the quality of the outsourced services.	Y	Y	Record the of the inspections done On site verification	10
Average Score						7.27
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.	Y	N	Quality Manual	5
	b	Management provides resources for proactive risk assessment and risk reduction activities.	Y	N	Quality Manual (Terms of reference of safety	5

					management committee)	
	c	Management ensures implementation of systems for internal and external reporting of system and process failures.	Y	N	Quality Manual (Terms of reference of safety management committee)	5
	d	Management ensures that appropriate corrective and preventive action is taken to address safety related incidents.	Y	N	Records	5
Average Score						5.00
AVERAGE SCORE FOR ROM						6.20
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	Y	Y	Quality Manual (Terms of reference of safety management committee)	10
	b	Patient safety devices are installed across the organization and inspected periodically.	Y	N	Bed railing, Belt in stretcher and wheel chair	5
	c	The organization is a non-smoking area.	Y	Y	Safety Manual (No smoking policy)	10
	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.	Y	N	Facility inspection records	5

	e	Inspection reports are documented and corrective and preventive measures are undertaken.	Y	N	Quality Manual (Terms of reference of safety management committee)	5
	f	There is a safety education programme for staff.	Y	N	Safety Manual (Hazard communication) Training Records	5
Average Score						6.67
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.	Y	Y	On site visit	10
	b	Up-to-date drawings are maintained which detail the site layout, floor plans and fire escape routes.	Y	N	Drawings	5
	c	There is internal and external sign posting in the organization in a language understood by patient, families and community.	Y	N	Evidence on site - Signage's	5
	d	The provision of space shall be in accordance with the available literature on good practices (Indian or International Standards) and directives from government agencies.	Y	N	Evidence on site - Hospital drawings Various approvals from Govt agencies	5
	e	Potable water and electricity are available round the clock.	Y	Y	RO plant installed, electricity supply available (backup available)	10
	f	Alternate sources for electricity and water are provided as backup for any failure/shortage.	Y	N	Engineering Manual	5

	g	The organization regularly tests these alternate sources.	Y	Y	Engineering Manual Records of tests	10
	h	There are designated individuals responsible for the maintenance of all the facilities.	Y	N	Engineering Manual (Job description of manager maintainence)	5
	i	There is a documented operational and maintenance (preventive and breakdown) plan.	Y	N	Plans available with respective Engg depts	5
	j	Maintenance staff is contactable round the clock for emergency repairs.	Y	N	Contacts of all available at the main desk	5
	k	Response times are monitored from reporting to inspection and implementation of corrective actions.	Y	Y	Indicator Records	10
Average Score						6.82
FMS.3: The organization has a programme for engineering support services.						
	a	The organization plans for equipment in accordance with its services and strategic plan.	Y	N	List of the equipment available	5
	b	Equipment are selected, rented, updated or upgraded by a collaborative process.	Y	Y	Purchase Policy	10
	c	Equipment are inventoried and proper logs are maintained as required.	Y	N	Inventory List,	5
	d	Qualified and trained personnel operate and maintain equipment and utility systems.	Y	Y	Job Descriptions, Qualifications certificate of the staff	10

	e	There is a documented operational and maintenance (preventive and breakdown) plan.	Y	N	Plans available with respective Engg depts	5
	f	There is a maintenance plan for water management.	Y	Y	Plans available with respective Engg depts	10
	g	There is a maintenance plan for electrical systems.	Y	Y	Plans available with respective Engg depts	10
	h	There is a maintenance plan for heating, ventilation and air-conditioning.	Y	N	Plans available with respective Engg depts	5
	i	There is a documented procedure for equipment replacement and disposal.	Y	N	Bio medical engineering manual	5
Average Score						7.22
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.	Y	Y	Scope of services policy	10
	b	Equipment are selected, rented, updated or upgraded by a collaborative process.	Y	N	Purchase Policy	5
	c	Equipment are inventoried and proper logs are maintained as required.	Y	N	List of the equipment, Logs	5
	d	Qualified and trained personnel operate and maintain the medical equipment.	Y	N	Bio medical engineering manual	5
	e	Equipment are periodically inspected and calibrated for their proper	Y	N	Calibration records	5

		functioning.				
	f	There is a documented operational and maintenance (preventive and breakdown) plan.	Y	N	Plan	5
	g	There is a documented procedure for equipment replacement and disposal.*	Y	N	Bio medical engineering manual	5
Average Score						5.71
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.	Y	N	Gas Manifold manual	5
	b	Medical gases are handled, stored, distributed and used in a safe manner.	Y	N	Gas Manifold manual	5
	c	The procedures for medical gases address the safety issues at all levels.	Y	N	Gas Manifold manual	5
	d	Alternate sources for medical gases, vacuum and compressed air are provided for, in case of failure.	Y	Y	Gas Manifold manual	10
	e	The organization regularly tests these alternate sources.	Y	N	Gas Manifold manual	5
	f	There is an operational and maintenance plan for piped medical gas, compressed air and vacuum installation.*	Y	N	Gas Manifold manual	5
Average Score						5.83
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.	Y	Y	Engineering Manual	5
			Y	N	Safety Manual (Fire safety Policy & Code Red Protocol)	

	b	The organization has a documented safe exit plan in case of fire and non-fire emergencies.	Y	N	Signages - Display Of Fire exit routes Safe assembly area	5
	c	Staff are trained for their role in case of such emergencies	Y	N	Training Records	5
	d	Mock drills are held at least twice in a year.	Y	N	Drills Records	5
	e	There is a maintenance plan for fire related equipment.	Y	N	Safety Manual	5
Average Score						5.00
FMS.7: The organization plans for handling community emergencies, epidemics and other disasters.						
	a	The organization identifies potential emergencies.	Y	Y	Safety manual (Disaster Management Plan)	10
	b	The organization has a documented disaster management plan.	Y	N	Safety manual (Disaster Management Plan)	5
	c	Provision is made for availability of medical supplies, equipment and materials during such emergencies.	Y	N	Safety manual (Disaster Management Plan)	5
	d	Staff are trained in the hospital's disaster management plan.	Y	N	Training Records	5
	e	The plan is tested at least twice in a year.	Y	N	Safety manual (Disaster Management Plan)	5
Average Score						6.00
FMS.8: The organization has a plan for management of hazardous materials.						
	a	Hazardous materials are identified within the organization.	Y	Y	Safety Manual (Hazardous Material	10

					policy)	
	b	The organization implements processes for sorting, labelling, handling, storage, transporting and disposal of hazardous material.	Y	N	Safety Manual (Hazardous Material policy)	5
	c	Requisite regulatory requirements are met in respect of radioactive materials.	Y	Y	Safety Manual (Hazardous Material policy)	10
	d	There is a plan for managing spills of hazardous materials.	Y	N	Safety Manual (Hazardous Material policy)	5
	e	Staff are educated and trained for handling such materials.	Y	N	Training Records	5
Average Score						7.00
AVERAGE SCORE FOR FMS						6.28
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.	Y	Y	Human Resource Manual (HR Planning)	10
	b	The organization maintains an adequate number and mix of staff to meet the care, treatment and service needs of the patient.	Y	N	Human Resource Manual (HR Planning)	5
	c	The required job specification and job description are well defined for each category of staff.	Y	N	Human Resource Manual (HR Planning)	5
	d	The organization verifies the antecedents of the potential employee with regards to criminal/negligence background.	Y	N	Human Resource Manual (HR Planning)	5

Average Score						6.25
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.	Y	Y	Human Resource Manual (HR Planning)	10
	b	Recruitment is based on pre-defined criteria	Y	N	Human Resource Manual (HR Planning)	5
	c	Every staff member entering the organization is provided induction training	Y	Y	Human Resource Manual-- Induction Training Records	10
	d	The induction training includes orientation to the organization's vision, mission and values.	Y	Y	Human Resource (Induction policy)	10
	e	The induction training includes awareness on employee rights and responsibilities.	Y	N	Human Resource (Induction policy)	5
	f	The induction training includes awareness on patient's rights and responsibilities.	Y	N	Human Resource (Induction policy)	5
	g	The induction training includes orientation to the service standards of the organization.	Y	N	Human Resource (Induction policy)	5
	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.	Y	Y	Human Resource (Induction policy)	10
Average Score						7.50
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.	Y	Y	Human resource manual	10

					(Training & development policy)	
	b	The organization maintains the training record.	Y	N	Training Records	5
	c	Training also occurs when job responsibilities change/ new equipment is introduced.	Y	N	Human resource manual (Training & development policy)	5
	d	Feedback mechanisms for assessment of training and development programme exist and the feedback is used to improve the training programme.	Y	N	Feedback Analysis Record	5
Average Score						6.25
HRM.4. Staff are adequately trained on various safety related aspects.						
	a	Staff are trained on the risks within the organization's environment.	Y	N	Training Records	5
	b	Staff members can demonstrate and take actions to report, eliminate / minimize risks.	Y	Y	Safety Manual (Hazard communication)	10
	c	Staff members are made aware of procedures to follow in the event of an incident.	Y	N	Safety Manual (Hazard communication)	5
	d	Staff are trained on occupational safety aspects.	Y	N	Training Records	5
Average Score						6.25
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.*	Y	Y	Human resource manual (Performance appraisal	10

					policy)	
	b	The employees are made aware of the system of appraisal at the time of induction.	Y	N	Human resource manual (Performance appraisal policy)	5
	c	Performance is evaluated based on the pre-determined criteria.	Y	N	Human resource manual (Performance appraisal policy)	5
	d	The appraisal system is used as a tool for further development.	Y	N	Human resource manual (Performance appraisal policy)	5
	e	Performance appraisal is carried out at pre-defined intervals and is documented.	Y	N	Appraisal Records	5
Average Score						6.00
HRM.6. The organization has documented disciplinary and grievance handling policies and procedures.						
	a	Documented policies and procedures exist.	Y	Y	Human resource manual (Disciplinary policy)	10
	b	The policies and procedures are known to all categories of staff of the organization.	Y	N	Human resource manual (Disciplinary policy)	5
	c	The disciplinary policy and procedure is based on the principles of natural justice.	Y	N	Human resource manual (Disciplinary policy)	5

	d	The disciplinary procedure is in consonance with the prevailing laws.	Y	Y	Human resource manual (Disciplinary policy)	10
	e	There is a provision for appeals in all disciplinary cases.	Y	N	Human resource manual (Disciplinary policy)	5
	f	The redress procedure addresses the grievance.	Y	N	Human Resource (Grievance handling policy)	5
	g	Actions are taken to redress the grievance.	Y	N	Human Resource (Grievance handling policy)	5
Average Score						6.43
HRM.7. The organization addresses the health needs of the employees.						
	a	A pre-employment medical examination is conducted on all the employees.	Y	Y	Human resource manual (Health policy)	10
	b	Health problems of the employees are taken care of in accordance with the organization's policy.	Y	N	Human resource manual (Health policy)	5
	c	Regular health checks of staff dealing with direct patient care are done at-least once a year and the findings/ results are documented.	Y	N	Human resource manual (Health policy)	5
	d	Occupational health hazards are adequately addressed.	Y	N	Human resource manual (Health policy)	5
Average Score						6.25

HRM.8. There is documented personal information for each staff member.						
	a	Personal files are maintained in respect of all staff.	Y	N	Human resource manual (Personnel file management policy)	5
	b	The personal files contain personal information regarding the staff's qualification, disciplinary background and health status.	Y	N	Human resource manual (Personnel file management policy)	5
	c	All records of in-service training and education are contained in the personal files.	Y	N	Human resource manual (Personnel file management policy)	5
	d	Personal files contain results of all evaluations.	Y	N	Human resource manual (Personnel file management policy)	5
Average Score						5.00
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.	Y	Y	Human resource manual (Credential privilege policy)	10
	b	The education, registration, training and experience of the identified medical professionals is documented	Y	N	Human resource manual	5

		and updated periodically.			(Credential privilege policy)	
	c	All such information pertaining to the medical professionals is appropriately verified when possible.	Y	N	Human resource manual (Credential privilege policy)	5
	d	Medical professionals are granted privileges to admit and care for patients in consonance with their qualification, training, experience and registration.	Y	N	Human resource manual (Credential privilege policy)	5
	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.	Y	N	Human resource manual (Credential privilege policy)	5
	f	Medical professionals admit and care for patients as per their privileging.	Y	N	Human resource manual (Credential privilege policy)	5
Average Score						5.83
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.	Y	Y	Human resource manual (Credential privilege policy)	10
	b	The education, registration, training and experience of nursing staff is documented and updated periodically.	Y	N	Human resource manual (Credential	5

					privilege policy)	
	c	All such information pertaining to the nursing staff is appropriately verified when possible.	Y	N	Human resource manual (Credential privilege policy)	5
	d	Nursing staff are granted privileges in consonance with their qualification, training, experience and registration.	Y	N	Human resource manual (Credential privilege policy)	5
	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.	Y	N	Human resource manual (Credential privilege policy)	5
	f	Nursing professionals care for patients as per their privileging.	Y	N	Human resource manual (Credential privilege policy)	5
Average Score						5.83
AVERAGE SCORE FOR HRM						6.16
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.	Y	N	IT manual	5
	b	Documented policies and procedures to meet the information needs exist.	Y	N	IT manual	5
	c	These policies and procedures are in compliance with the prevailing laws	Y	N	IT manual	5

		and regulations.				
	d	All information management and technology acquisitions are in accordance with the documented policies and procedures.	Y	N	IT manual	5
	e	The organization contributes to external databases in accordance with the law and regulations.	Y	N	IT manual	5
Average Score						5.00
IMS.2. The organization has processes in place for effective management of data.						
	a	Formats for data collection are standardized.	Y	Y	IT manual	10
	b	Necessary resources are available for analysing data.	Y	N	IT manual	5
	c	Documented procedures are laid down for timely and accurate dissemination of data.	Y	N	IT manual	5
	d	Documented procedures exist for storing and retrieving data.	Y	N	IT manual	5
	e	Appropriate clinical and managerial staff participates in selecting, integrating and using data.	Y	N	IT manual	5
Average Score						6.00
IMS.3. The organization has a complete and accurate medical record for every patient.						
	a	Every medical record has a unique identifier.	Y	Y	Medical Records Manual	10
	b	Organization policy identifies those authorized to make entries in medical record.	Y	N	Medical Records Manual	5
	c	Entry in the medical record is named, signed, dated and timed.	Y	Y	Medical Records Manual	10
	d	The author of the entry can be identified.	Y	Y	Medical Records Manual	10
	e	The contents of medical record are identified and documented.	Y	N	Medical Records Manual	5
	f	The record provides a complete, up-to-date and chronological account of patient care.	Y	N	Medical Records Manual	5
	g	Provision is made for 24-hour availability of the patient's record to healthcare providers to ensure	Y	N	Medical Records Manual	5

		continuity of care.				
Average Score						7.14
IMS.4. The medical record reflects continuity of care.						
	a	The medical record contains information regarding reasons for admission, diagnosis and plan of care.	Y	Y	Medical Records Manual	10
	b	The medical record contains the results of tests carried out and the care provided.	Y	N	Medical Records Manual	5
	c	Operative and other procedures performed are incorporated in the medical record.	Y	N	Medical Records Manual	5
	d	When patient is transferred to another hospital, the medical record contains the date of transfer, the reason for the transfer and the name of the receiving hospital.	Y	N	Medical Records Manual	5
	e	The medical record contains a copy of the discharge summary duly signed by appropriate and qualified personnel.	Y	Y	Medical Records Manual	10
	f	In case of death, the medical record contains a copy of the cause of death certificate.	Y	N	Medical Records Manual	5
	g	Whenever a clinical autopsy is carried out, the medical record contains a copy of the report of the same.	Y	N	Medical Records Manual	5
	h	Care providers have access to current and past medical record.	Y	N	Medical Records Manual	5
Average Score						6.25
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.	Y	Y	Medical Records Manual	10
	b	Documented policies and procedures are in consonance with the applicable laws.	Y	N	Medical Records Manual	5
	c	The policies and procedure (s) incorporate safeguarding of data/ record against loss, destruction and tampering.	Y	N	Medical Records Manual	5
	d	The organization has an effective	Y	Y	Medical	10

		process of monitoring compliance of the laid down policy and procedure.			Records Manual	
	e	The organization uses developments in appropriate technology for improving confidentiality, integrity and security.	Y	N	Medical Records Manual	5
	f	Privileged health information is used for the purposes identified or as required by law and not disclosed without the patient's authorization.	Y	N	Medical Records Manual	5
	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.*	Y	N	Medical Records Manual	5
Average Score						6.43
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.	Y	Y	Medical records manual (Retention policy)	10
	b	The policies and procedures are in consonance with the local and national laws and regulations.	Y	N	Medical records manual (Retention policy)	5
	c	The retention process provides expected confidentiality and security.	Y	N	Medical records manual (Retention policy)	5
	d	The destruction of medical records, data and information is in accordance with the laid down policy.	Y	N	Medical records manual (Retention policy)	5
Average Score						6.25
IMS.7. The organization regularly carries out review of medical records.						
	a	The medical records are reviewed periodically.	Y	Y	Quality manual (Terms of reference of medical	10

					audit committee) Medical records manual	
	b	The review uses a representative sample based on statistical principles.	Y	N	Quality manual (Terms of reference of medical audit committee)	5
	c	The review is conducted by identified care providers.	Y	N	Quality manual (Terms of reference of medical audit committee)	5
	d	The review focuses on the timeliness, legibility and completeness of the medical records.	Y	N	Quality manual (Terms of reference of medical audit committee)	5
	e	The review process includes records of both active and discharged patients.	Y	N	Quality manual (Terms of reference of medical audit committee)	5
	f	The review points out and documents any deficiencies in records.	Y	Y	Quality manual (Terms of reference of medical audit committe	10

					e)	
	g	Appropriate corrective and preventive measures are undertaken within a defined period of time and are documented.	Y	N	Quality manual (Terms of reference of medical audit committe e)	5
Average Score						6.43
AVERAGE SCORE FOR IMS						6.21