STUDY TO ANALYSE PRE AND POST NABH STANDARD IMPLEMENTATION SCENARIO OF A MULTI-SPECIALITY HOSPITAL FOR ENTRY LEVEL CERTIFICATION

Dissertation Submitted to

The IIHMR University, Jaipur

for the partial fulfilment for the award of the degree of

Master of Business Administration (MBA)

In

Hospital and Health Management

By

Joshua Jacinth T. P.

Under the Supervision and Guidance of

Dr P. R. Sodani

2021

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DECLARATION BY STUDENT

I hereby declare that this dissertation titled **'STUDY TO ANALYSE PRE AND POST NABH STANDARD IMPLEMENTATION SCENARIO OF A MULTI-SPECIALITY HOSPITAL FOR ENTRY LEVEL CERTIFICATION'** is the bonafide record of my original research work. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.

Name of Student

Date 02-07-2021

Vivekananda Hospital

(A Unit of Aditya Hospitals Pvt. Ltd.)

Date: 30/06/2021

TO WHOM SO EVER IT MAY CONCERN

This is to certify that **Dr Joshua Jacinth T. P.** pursuing MBA (Hospital and Health Management) from the IIHMR University, Jaipur has successfully completed his Dissertation titled '**Study to Analyse Pre and Post NABH Standard Implementation Scenario of a Multi-speciality Hospital for Entry Level Certification**' at **Vivekananda Hospital, Punjagutta** under the guidance of **Dhatree Healthcare Pvt. Ltd.** during April 21, 2021, to June 30, 20.

Place: Hyderabad

Date: 30-06-2021

Dr. Geetha Valluripalli

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CERTIFICATE

This is to certify that dissertation titled **'STUDY TO ANALYSE PRE AND POST NABH STANDARD IMPLEMENTATION SCENARIO OF A MULTI-SPECIALITY HOSPITAL FOR ENTRY LEVEL CERTIFICATION'** is a record of the research work undertaken by JOSHUA JACINTH T. P. in partial fulfilment of the requirements for the award of the degree of MBA (Hospital and Health Management) from the IIHMR University, Jaipur under my guidance and supervision and his/her approach to the research study has been sincere, scientific, and analytical.

Faculty guide

Dr. P. R. Sodani

President,

IIHMR University, Jaipur

Date 02-07-2021

School Dean

IIHMR University, Jaipur

Date 02-07-2021

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I also would like to thank my friends and family who supported me and encouraged at these times of trouble to keep the focus and complete the project.

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Abstract:

Introduction: Quality is a service attribute that ensures that healthcare efforts will continue to improve, as well as identifying rules that health systems must implement across all organizational activities to offer timely and quick care. Adoption of quality assurance procedures, putting down basic criteria for hospitals and professionals, creating an accreditation process, and controlling the quality of hospital treatment in India are all things that hospital managers and their professional forums must aim towards. NABH (National Accreditation Board for Hospitals and Healthcare Providers) is a Quality Council of India constituent board that was established to create and operate a healthcare accreditation programme. All stakeholders benefit from NABH accreditation, with patients benefiting the most. NABH has developed a comprehensive healthcare standard that consist of 600 specific requirement which a hospital must comply with to receive the NABH accreditation. The accreditation ensures more patient footfall because of the trust it develops within the patients and several incentives for facilities which provide cashless facilities, the IRDAI has mandated those facilities which provide cashless services must comply with at least NABH entry level certification. Hospitals having an operational bed strength of 50 are termed as Small Healthcare Organisations (SHCO) and can apply for entry level certification. In this study we will analyse the gap and prepare the facility for the entry level certification by NABH. **Objective:** The objective of this study is to perform a gap analysis in quality compliance using NABH self-assessment toolkit and to prepare the facility for further accreditation process for NABH entry-level certification. **Methodology:** The first phase of the study will involve scoring the hospital based on NABH self-assessment toolkit before the standards are implemented, the second phase would involve clinical record assessment to identify the gap and the third phase involves creating a report based on phase 1 and 2, the report would consist of steps to be taken to close the gap. Scoring the facility again post NABH standard implementation and getting ready for NABH entry level certification assessment by NABH. **Conclusion:** Implementation and complying with NABH standards made a **43.7% compliance change** prior to implementation the hospital was found to be **22.2% compliant** with NABH and post implementation the hospital was found to be **65.9% compliant** which made it possible to go for a desktop assessment and virtual assessment for entry level NABH certification on HOPE portal.

Keywords: NABH, quality, quality assurance, IRDAI, SHCO, NABH self-assessment toolkit, standards, compliance, entry level certification, gap analysis.

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ABBREVIATIONS

- NABH – National Accreditation Board for Hospitals and Healthcare providers
- SHCO – Small Healthcare Organisations
- HOPE – Healthcare Organisations Platform for Entry level certification
- QCI – Quality Council of India
- IRDAI – Insurance Regulatory and Development Authority of India
- CQI – Continuous Quality Improvement
- IHF – International Hospital Federation
- AAC – Access, Assessment and Continuity of care
- COP – Care Of Patients
- MOM – Management of Medication
- PRE – Patient Rights and Education
- HIC – Hospital Infection Control
- ROM – Responsibility of Management
- FMS – Facility Management and Safety
- HRM – Human Resource Management
- HOD – Head of the Department
- ICN – Infection Control Nurse
- QCC – Quality Control Committee
- ICC – Internal Complaints Committee
- PTC – Pharmacotherapeutics Committee
- QASC – Quality Assurance and Safety Committee
- HICC – Hospital Infection Control Committee
- AERB – Atomic Energy Regulatory Board
- NOC – No Objection Certificate
- PNDT – Pre-Natal Diagnostic Technique
- MTP – Medical Termination of Pregnancy
- OT – Operation theatre
- BMW – Bio-Medical Waste
- ER – Emergency Room
- GRN – Goods Received Note

Chapter 1:

Introduction

Quality:

Quality is a service attribute that ensures that healthcare efforts will continue to improve, as well as identifying rules that health systems must implement across all organizational activities to offer timely and quick care. [1]

Quality Management System in a Hospital:

Traditional Quality assurance tools include setting and monitoring clear standards, systematic statistical review of quality linked data, retrospective medical audit, peer review, credentialing and accreditation, mortality and morbidity audits, risk management, nursing audit, utilization review, nosocomial infection monitoring, and provider appraisal. Adoption of quality assurance procedures, putting down basic criteria for hospitals and professionals, creating an accreditation process, and controlling the quality of hospital treatment in India are all things that hospital managers and their professional forums must aim towards. Even governments are broadening their healthcare horizons, from access to quality. The government of Tamil Nadu will soon make it necessary for all hospitals certified for the TNCM Scheme to have or fulfil the NABH's (National Accreditation Board for Hospitals in India) basic minimal requirements. [2]

About NABH:

NABH (National Accreditation Board for Hospitals and Healthcare Providers) is a Quality Council of India constituent board that was established to create and operate a healthcare accreditation programme. All stakeholders benefit from NABH accreditation, with patients benefiting the most.

Accreditation also leads to high quality standards that protect patients' health and safety. Expert medical personnel provide services to the patient. Patients' rights are honored and protected. Patient satisfaction is assessed from time to time, and staff of an accredited hospital are graded and provided with opportunities for continuous learning in a supportive environment with strong leadership and, most importantly, ownership of the clinical process.

The National Accreditation Board for Hospitals and Healthcare Organizations (NABH) have developed a comprehensive healthcare standard for hospitals and other healthcare

providers in India. It consists of almost 600 specific requirements that the hospital must meet to receive NABH accreditation. [3]

There are two types of standards: patient-centric and organization-centric.

Patient Centered Standards:

a) Access, Assessment and Continuity of Care (AAC)

b) Care Of Patient (COP)

c) Management of Medication (MOM)

d) Patient Right and Education (PRE)

e) Hospital Infection Control (HIC)

Organization Centered Standards:

a) Continuous Quality Improvement (CQI)

b) Responsibilities of Management (ROM)

c) Facility Management and Safety (FMS)

d) Human Resource Management (HRM)

e) Information Management System (IMS)

About SHCO:

Healthcare facilities with up to fifty (50) beds and support and utility facilities that are appropriate at the same time related to the services which are provided by the organization are termed as Small Healthcare Organizations (SHCO) by NABH. The NABH Standards benefit all stakeholders by improving quality of care and patient safety. Patients are the biggest benefactors because they are treated by trained professionals. The adoption of entry-level SHCO standards will encourage a path toward continual quality improvement.[4]

About HOPE project:

Healthcare Organizations Platform for Entry Level Certification (HOPE), a new web platform launched by QCI (Quality Council of India), will redesign the entry level certification procedure for HCO/SHCO. Registration, documentation, and fee submission are all part of the procedure, which will take place on the HOPE site and a mobile app that is being built concurrently.

It is a multifaceted platform for healthcare organisations' certification processes, providing comprehensive information on the simplified certification process, standards, and compliances. Several steps are being laid down to aid healthcare organisations.

They are as follows:

• Raising Awareness: HCOs will be informed about the certification process, requirements, and compliances through direct engagements and awareness seminars, with details available on the web.

• Using technology to assure transparency: The entire registration procedure will be completed on the HOPE site and mobile application, with geotagged and timestamped documentation required for compliance being directly uploaded.

• Ongoing Support: To make the certification process go as smoothly as possible, HCOs will be given support in the form of a guidebook, several videos, articles, and blogs, as well as helpline support for clarification and simple understanding. [5]

IRDAI (Insurance Regulatory and Development Authority of India) (Health Insurance) Regulation, 2016, IRDAI (Insurance Regulatory and Development Authority of India) (Health Insurance) Regulation, 2016.[6] Within two years of the date of notification of these Guidelines, all healthcare providers offering cashless services for allopathic treatment must meet the National Accreditation Board for Hospitals (NABH) pre-accreditation entry level standards or such other standards or requirements as the Authority may specify from time to time. This new law has compelled healthcare organisations to get NABH certificates, therefore upgrading and adhering to quality standards in order to comply with cashless service requirements. [7]

The Certification Process:

A revised process has been created to simplify the certification process and help more healthcare organisations to become a part of the NABH network. The goal of this certification procedure is to establish a quality culture at all levels and across all functions of healthcare organisations, since NABH assures excellent quality of treatment and patient safety.

The picture below shows stepwise process in detail:

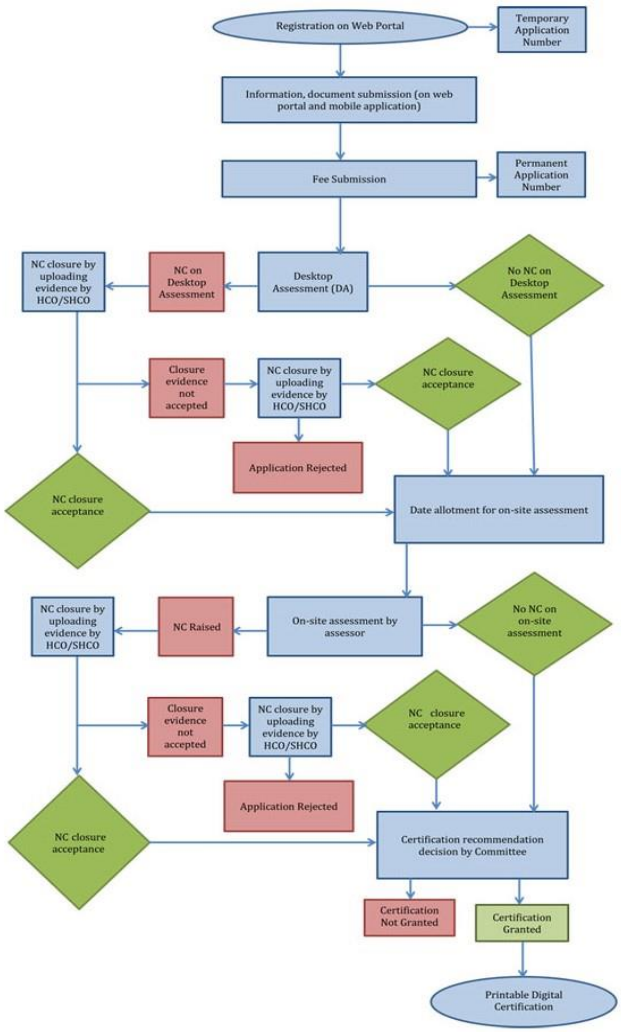

Figure 1.1 Certification process for NABH Entry level Certification

In this study we will analyse NABH compliance through NABH self-assessment toolkit before and after implementation of NABH standards in the hospital to prepare the hospital for entry level NABH certification

Chapter 2:

Review of Literature

According to the IRDAI (Insurance Regulatory and Development Authority of India) (Health Insurance) Regulation, 2016, all healthcare providers offering cashless services for allopathic treatment must meet the pre-accreditation entry level standards laid down by the National Accreditation Board for Hospitals (NABH) or such other standards as may be prescribed.[8]

Ms Deepthi (2018) said in her paper titled "Need and the conceptual model for continuous quality improvement (CQI) System in hospital business" that in the current economic climate, the demand for high-quality healthcare is growing among Indians. As a result, healthcare professionals are worried about maintaining a high level of service quality to ensure patient happiness. Hospitals should strive for continual quality improvement as a goal and primary goal in order to achieve success in their healthcare services beyond certification.

According to the International Hospital Federation (IHF), India has around 50,000 HCOs. NABH has accredited 201 large HCOs and 29 small (50 beds) HCOs as of February 28, 2014. In addition, 397 major HCOs and 123 minor HCOs are working to get accredited. As a result, only a tiny fraction of HCOs are accredited or in the process of being accredited. The fact that NABH certification is a voluntary procedure may be one factor for the low proportion. Not only is there no requirement for HCOs to pursue NABH accreditation, but the IRDA health insurance standards have practically forced HCOs to pursue it. Another factor might be the scarcity of specialists who can guide HCOs in the accreditation process. [8]

Gupta, Anshu (2016) stated that Monitoring NABH core indicators like quality and safety of blood transfusion has helped their organisation reduce incidence of transfusion reactions and adverse events associated with blood transfusion, according to her study titled " Role of National Accreditation Board of Hospitals and Healthcare Providers (NABH) core indicators monitoring in quality and safety of blood transfusion." [9]

Chapter 3:

Research Methodology:

Area where study was conducted:

The live project was conducted in Vivekananda Hospital, a multi-speciality 65 bedded small healthcare organisation at Punjagutta, Hyderabad.

Study design:

Descriptive, cross-sectional study

Tools utilized in the project:

Along with observing the structural and operational aspect clinical records were assessed and scoring was done based on NABH self-assessment toolkit. The scores were later analysed on Microsoft Excel

Study Duration:

The study was conducted in the client location for 2 months

Methodology:

Phase 1: The hospital was surveyed in terms of breadth of service offered, manpower, physical facilities, medicines, and lab services using the NABH self-assessment tools. Standard scores are assigned to the concerned region using the toolkit. The scoring standards are as follows:

Refer appendix for the assessment toolkit

Score

0 - non-compliance

5 - partial compliance

10 - complete compliance

The evaluation criteria are an overall score of minimum 50% in all standards and overall score of minimum 50% in each chapter. [10]

Phase 2: Phase 2 involved observation and reviewing clinical records to understand the hospital's procedures and learn how the various departments work.

Phase 3: A report is created based on the analysis of phases 1 and 2 and the data collected to reflect the process, infrastructure, equipment, and people, as well as the hospital's strength and different gaps found in the process and other characteristics. Based on this report, steps to close gaps can be taken.

Chapter 4:

Results and Discussions

Pre-NABH standard implementation scenario based on NABH self-assessment toolkit.:

Table no.4.1: Score on Access, Assessment and Continuity of Care (AAC)

Chapter 1: ACCESS, ASSESSMENT AND CONTINUITY OF CARE (AAC)		**SCORE**
AAC.1	The organisation defines and displays the services that it can provide.	1.3
AAC.2	The organisation has a documented registration, admission, and transfer process	3.5
AAC.3	Patients cared for by the organisation undergo an established initial assessment	1
AAC.4	Patient care is continuous, and all patients cared for by the organisation undergo a regular assessment	5
AAC.5	Laboratory services are provided as per the scope of the hospital's services and laboratory safety requirements	3.8
AAC.6	Imaging services are provided as per the scope of hospital's services and established radiation safety programme	2.5
AAC.7	The organisation has a defined discharge process	2.3
AVERAGE SCORE		**2.7**

Maximum standard score: 5

Chapter average score: 2.7

In the AAC chapter, the organisation was observed to have several non-compliances, like AAC.1, AAC.3 and AAC.7 which was not defined at all, the scope of services was not displayed, and the staff were not oriented and could not define the services offered by the organisation. AAC.4 and AAC.5 were partially compliant as they had continuous care

assessment done by respective care givers. Lab services were provided as per scope of services but were not outlined and displayed. The organisation did not have defined and documented discharge processes but had defined procedures on how to deal with medico legal cases. Radiation safety programme was not established but the services were provided as per scope.

Table no. 4.2: Score on Care of Patients (COP)

Chapter 2: CARE OF PATIENTS (COP)		**SCORE**
COP.1	Care of patients is guided by accepted norms & policies	2.5
COP.2	Emergency services including ambulance are guided by documented procedures	3.2
COP.3	Documented procedures define rational use of blood and blood products	4.2
COP.4	Documented procedures guide the care of patients as per the scope of services provided by hospital in intensive care and high dependency unit	1.5
COP.5	Documented procedures guide the care of obstetrical patients as per the scope of services provided by hospital	6.3
COP.6	Documented procedures guide the care of paediatric patients as per the scope pf services provided by hospital	2.6
COP.7	Document procedures guide the administration of anaesthesia	2.3
COP.8	Documented procedure guides the care of patients undergoing surgical procedures	3.7
AVERAGE SCORE		3.2

Maximum standard score: 6.3

Chapter average score: 3.2

The COP chapter audit resulted in several non-compliances including COP.1, COP.4, COP.7 and several others. Documented procedures and policies were missing regarding patients' norms and policies, administration of anaesthesia and even procedures for ICUs.

Obstetrical patient care was well documented as per services but signatures by concerned doctors were missing. The staff is not oriented to these services and failed to explain procedures and policies related to their concerned departments. The operation theatre (OT) did not have a quality assurance programme or documented procedures and policies on cleaning of OT. Several checklists were missing, and anaesthesia administration and post anaesthesia documentation was missing.

Table no.4.3: Score on Management of Medication (MOM)

Chapter 3: MANAGEMENT OF MEDICATION (MOM)		**SCORE**
MOM.1	Documented procedures guide the organisation of pharmacy services and usage of medicines	0
MOM.2	Documented policies and procedures guide the storage of medications	0.8
MOM.3	Documented procedures guide the prescription of medications	1.5
MOM.4	Policies and procedures guide the safe dispensing of medications	1
MOM.5	There are defined procedures for medication administration	3.8
MOM.6	Adverse drug events are monitored	0
MOM.7	Documented policies and procedures govern usage of radioactive drugs	NA
AVERAGE SCORE		1.1

Maximum standard score: 3.8

Chapter average score: 1.1

The MOM chapter was totally non-compliant except MOM.5. MOM.1, MOM.2, MOM.3, MOM.4, MOM.6 were non-compliant. MOM.7 was not applicable as radioactive drugs were not used in the organisation. There are no documented procedures for guiding pharmacy services and usage of drugs, the storage of drugs were not properly documented and no policies were in place to monitor it. Look-alike, sound-alike drugs were not stored separately, list of high-risk drugs were not defined and marked or stored separately. Emergency drug list was also missing. Narcotic drugs were not stored as per guidelines and access to narcotic locker was present with the pharmacy supervisor. Documentation on near expiry drugs, local purchase and hospital formulary were missing or not maintained or not updated from time to time. Ordering and indenting are mostly done on phone and are not documented. Proper registries are not maintained. Quality indicators

for pharmacy performance are not calculated and maintained from time to time. Adverse drug event monitoring procedures and policies are not in place. Medication administration is documented but not neat or legible.

Table no.4.4: Score on Patient Rights and Education (PRE)

Chapter 4: PATIENT RIGHTS AND EDUCATION (PRE)		**SCORE**
PRE.1	Patient rights are documented displayed and support individual beliefs, values and involve the patient and family in decision making processes	0
PRE.2	Patient and families have a right to information and education about their healthcare needs	7
AVERAGE SCORE		3.5

Maximum standard score: 7

Chapter average score: 3.5

The PRE chapter was incompliant as PRE.1 where the rights of the patient were neither documented nor displayed. The patient or their family are not informed for decision making process. PRE.2 showed partial compliance as patient and families have the right to information, but it is not documented and displayed in languages which they understand. It is done only verbally and not documented and displayed. There are no signages displaying the rights of patients in bilingual manner.

Table no. 4.5: Score on Hospital Infection Control (HIC)

Chapter 5: HOSPITAL INFECTION CONTROL (HIC)		**SCORE**
HIC.1	The hospital has an infection control manual, which is periodically updated and conducts surveillance activities	0
HIC.2	The hospital takes actions to prevent or reduce the risks of Hospital Associated Infections (HAI) in patients and employees	4.3
HIC.3	Bio-Medical Waste (BMW) management practices are followed	3.4
AVERAGE SCORE		2.5

Maximum standard score: 4.3

Chapter average score: 2.5

Within the HIC chapter HIC.2 appeared to be partially complying because of some practices followed by employees in preventing HAIs but because they are not documented and displayed its near partial compliance. The organisation had BMW management practices in place but were not followed by all staff hence partially complied with. The infection control committee was not constituted, and infection control team and manual were absent. Quality monitoring parameters like urinary tract infections, surgical site infections were monitored but no proper documentation exists. Hand hygiene provision are not present at all patient care areas, and no signages regarding hand hygiene were present.

Table no.4.6: Score on Continuous Quality Improvement (CQI)

Chapter 6: CONTINUOUS QUALITY IMPROVEMENT (CQI)		**SCORE**
CQI.1	There is a structured quality improvement, patient safety and continuous monitoring programme in the organisation	0
CQI.2	The organisation identifies key indicators to monitor the structures, processes and outcomes which are used as tolls for continuous improvement	1.5
AVERAGE SCORE		0.7

Maximum standard score: 1.5

Chapter average score: 0.7

The CQI chapter was entirely non-compliant, there were no structured laid down policies or guidelines for quality improvement. Clinical quality indicators like blood packs wasted, transfusion reactions were recorded but never analysed or updated

Table no.4.7: Score on Responsibility of Management (ROM)

Chapter 7: RESPONSIBILITY OF MANAGEMENT (ROM)		**SCORE**
ROM.1	The responsibilities of the management are defined	2.3
ROM.2	The organisation is managed by the leaders in an ethical manner	5
ROM.3	The organisation has set up multi-disciplinary committees to oversee specific areas of quality and patient safety	0
AVERAGE SCORE		2.4

Maximum standard score: 5

Chapter average score: 2.4

ROM chapter has seen non-compliance in ROM.1 and ROM.3 as the hospital did not set any committees to oversee areas of quality and patient safety. Although the management were managing the hospital in an ethical manner which made partial compliance in ROM.2. The responsibilities of managed were not defined and on paper. Clear span of control was not established. No specific committees were made for patient safety as well.

Table no. 4.8: Score on Facility Management and Safety (FMS)

Chapter 8: FACILITY MANAGEMENT AND SAFETY (FMS)		**SCORE**
FMS.1	The organisation's environment and facilities operate to ensure safety of patients, their families, staff, and visitors	1
FMS.2	The organisation has a program or clinical and support service equipment management	1
FMS.3	The organisation has provisions for safe water, electricity, medical gas, and vacuum systems	6
FMS.4	The organisation has plans for fire and non-fire emergencies within the facilities	2.5
AVERAGE SCORE		2.6

Maximum standard score: 6

Chapter average score: 2.6

The FMS chapter with an average score of 2.6 was audited as non-compliant as the staff did not have operating procedures and policies laid down which specify safety to patients, families, staff, and visitors. No procedures, maintenance checklists, preventive measure scheduling, equipment management programmes were in place. Fire exit plan was also not displayed in every floor or trainings regarding disaster management was not done. The hospital had safe water, electricity, medical gas, and vacuum systems provisions which partially complied with FMS.3.

Table no.4.9: Score on Human Resource Management (HRM)

Chapter 9: HUMAN RESOURCE MANAGEMENT (HRM)		**SCORE**
HRM.1	The organisation has staffing commensurate with patient care needs	2.5
HRM.2	There is an ongoing programme for professional training and development of the staff	0
HRM.3	The organisation has a well-documented disciplinary and grievance handling procedure	0
HRM.4	The organisation addresses the health needs of the employees	2
HRM.5	There is documented personal records for each staff member	2.2
AVERAGE SCORE		1.3

Maximum standard score: 2.5

Chapter average score: 1.3

Implementation of HRM chapter was non-compliant in the hospital as HRM.2 and HRM.3 were completely not present and hence non -compliance. HRM.1, HRM.4 and HRM.5 were very partially compliant as they had practices of maintaining documents of personal records for each staff member and addressed to healthcare needs of the staff. The hospital did not have any programs for training and development of staff, nor they had a well-documented grievance handling policy or procedure. The hospital did not produce and display the employee rights and no system of periodic or annual health check-up for staff was not in place.

Chapter 10: INFORMATION MANAGEMENT SYSTEM (IMS) – NA

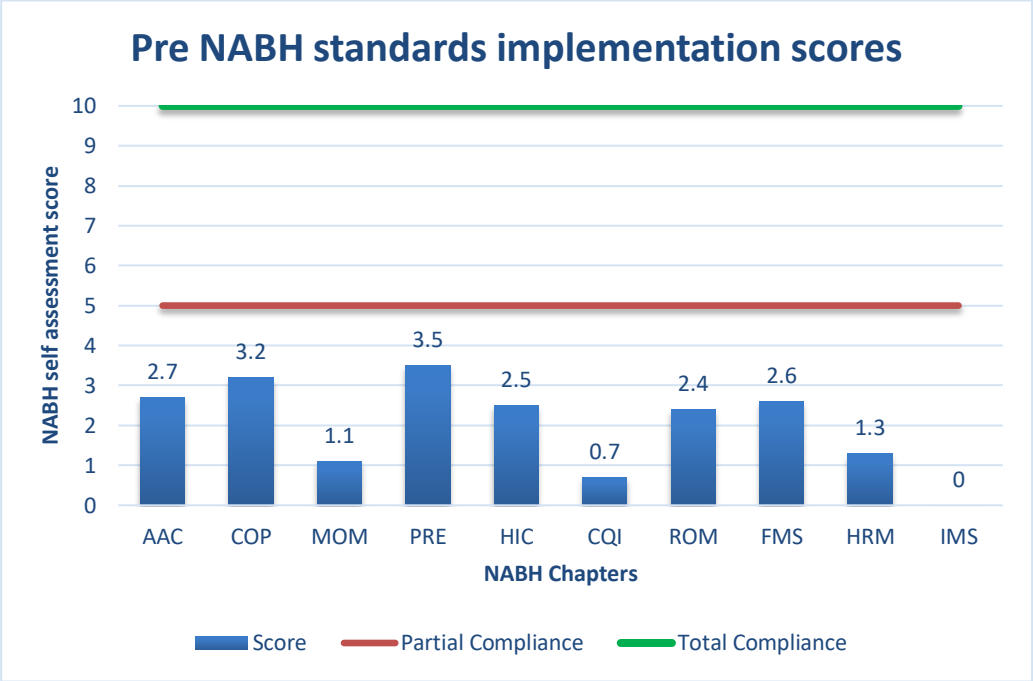

Figure 4.1 Graphical representation of NABH compliance score (Pre NABH scenario)

Implementation of standards:

After the gaps have been identified, a strategic plan was laid down which included short term and long-term goals. Several discussions were held with all the stakeholders involved with NABH standard implementation and an action plan was laid down.

Constitution of a quality department and project team.

Establishment of the quality department which recruited the quality team which constituted of:

1. Head of the Department: He or she would be involved in streamlining the functions of the department (i.e. know and understand policies and procedures, monitor quality indicators, train and generate awareness about quality)
2. Quality executives: Quality executive report to the HOD and ensure all the functions are being acted upon, they also act on compiling and monitoring quality data and report to HOD
3. Constitution of committees like blood transfusion committee, medical audit committee, Pharmacotherapeutics committee, Quality core committee.
4. Grievance committee to prevent violence

5. Additional responsibilities were given to Medical Superintendent to organise accreditation processes.
6. Lab in charge was given responsibility to ensure calibrations of instruments and physical requirements within the laboratory
7. Pharmacy in charge was given responsibility to prepare hospital formulary, document procedures to procure drugs and monitor the drug adverse events inside the hospital
8. ICN (Infection Control nurse) was recruited, and the roles and responsibilities were briefed
9. A dedicated dietician was recruited to ensure nutritional assessments for the patients
10. Quality manager was recruited who will ensure the implemented processes go smoothly and fulfil any physical requirement in the hospital.

Implementation parameters/accreditation parameters:

The road to obtaining accreditation process was laid down which involved

1. Putting up signages
2. Formulating standard forms and formats for various processes in the care areas and as well as maintenance areas
3. Formation and constitution of committees
4. Obtaining and pending licenses and renewing if any, obtaining requirements regarding infrastructure and human resource
5. Training staff in all areas of care and management (fire safety, disaster management)
6. Documenting, monitoring, and analysing quality indicators for clinical and managerial related areas.

Establishing committees:

Committees were constituted and established along with frequency of meetings

- Quality core committee (QCC) – Monthly/as and when needed
- Internal complaints committee (ICC) – Quarterly / as and when needed
- Pharmacotherapeutics committee (PTC) – Quarterly / as and when needed
- Quality assurance and Safety committee (QASC) – Monthly
- Hospital infection control committee (HICC)
- Blood transfusion committee – Monthly
- Medical audit committee – Monthly
- Resuscitation / Code blue committee

Licenses and legal compliance:

- Registering under hospital act (Clinical establishment act, 2017)
- Pollution control certificate and agreement (Agreement for air, water, and BMW)
- Atomic Energy Regulatory Board (AERB) licenses for Xray and radiology department
- NOC from fire department
- Drug and pharmacy licenses (Drug and cosmetics controller)
- PNDT certificate (Pre-Natal Diagnostic Techniques)
- MTP/Degree license (Medical Termination of Pregnancy) allowing termination of pregnancy up to 20 weeks

Organogram:

Staff and management were unaware about the different management levels and span of control respectively, so organogram of the hospital was designed and implemented.

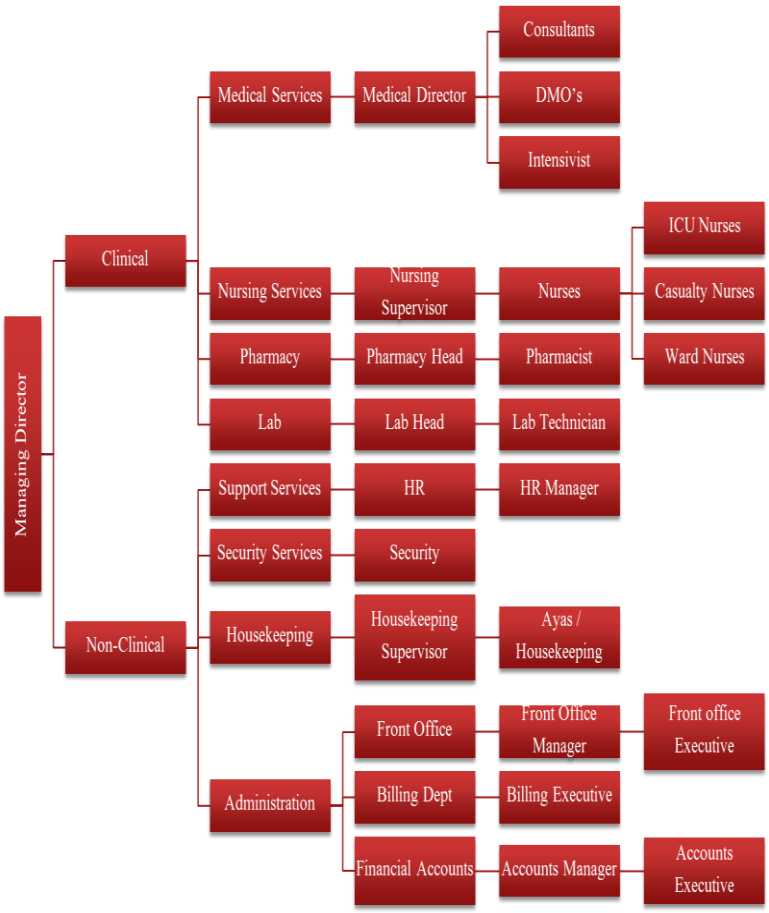

Figure 4.2 Organogram of the Hospital

Policies and Procedures:

SOPs were designed and prepared to be sent to all departments which are prepared according to NABH chapters

1. A quality manual was prepared to establish optimal functionality of the hospital
2. Policies and procedures for admission and discharge processes
3. Policies and procedures for blood transfusion and recording transfusion related problems
4. Policies and procedures for anaesthesia consent
5. Policies and procedures for surgical consent
6. Policies and procedures for infection control
7. Policies and procedures for BMW management
8. Policies and procedures for equipment maintenance

Facility findings:

Signages:

Before implementation, there were no proper display of scope of services and non-scope of services, along with many other important information which needs to be displayed for the reference of staff, patients, and families. Installed triage coding system at the casualty and patient feedback and complaint procedure

Handwashing facility in the OT was made to be elbow operational and proper handwashing steps signages were installed through patient care areas along with bilingual BMW segregation information

Floor directory, mission, vision and patient rights and responsibilities are properly displayed throughout the hospital to ensure patient and families are made aware of it.

Forms and formats:

Several changes have been made to the existing forms and formats like, patient case sheets, anaesthesia monitoring, consent forms, medication charts, indenting and ordering procedures, patient feedback forms, medical record audit checklist, maintenance checklists, etc which comply with NABH standards.

Trainings:

The staff were trained based on NABH standards, uses, benefits, quality improvement. They were also trained on aspects of patient safety, patient rights, employee rights and responsibilities, procedures in times of emergencies, colour coding of the hospital, hand hygiene, BMW waste segregation, needle prick injuries. They were also trained on various committees and their responsibilities, fire, and disaster management. All the procedures for periodic checks and maintenance scheduling were taught and how to deal with such real-life scenarios were also practically explained with mock drills.

Colour coding of various emergencies followed by the hospital.

COLOUR CODE	**ACTION**
Code Red	Fire
Code Blue	Medical emergency
Code Pink	Child abduction
Code Yellow	External disaster
Code Orange	Spill
Code Violet	Violence

Post-NABH standards implementation scoring:

Scoring was again done based on NABH self-assessment toolkit and it was found that all the chapters have achieved a par partial assessment score which made it possible to go forward for a virtual assessment with NABH for granting entry level certification. Post NABH standard implementation the scores were as follows.

Post-NABH standard implementation scenario based on NABH self-assessment toolkit.:

Table:4.10: Score on Access, Assessment and Continuity of Care (AAC) (Post NABH scenario)

Chapter 1: ACCESS, ASSESSMENT AND CONTINUITY OF CARE (AAC)		**SCORE**
AAC.1	The organisation defines and displays the services that it can provide.	8
AAC.2	The organisation has a documented registration, admission, and transfer process	7
AAC.3	Patients cared for by the organisation undergo an established initial assessment	6
AAC.4	Patient care is continuous, and all patients cared for by the organisation undergo a regular assessment	7
AAC.5	Laboratory services are provided as per the scope of the hospital's services and laboratory safety requirements	7
AAC.6	Imaging services are provided as per the scope of hospital's services and established radiation safety programme	6
AAC.7	The organisation has a defined discharge process	8
AVERAGE SCORE		7

The AAC chapter had an average score of 7 and highest score of 8 in AAC.1 and AAC.8 thereby complying with the partial compliance of NABH assessment

Table 4.11: Score on Care of Patients (COP) (Post NABH scenario)

Chapter 2: CARE OF PATIENTS (COP)		**SCORE**
COP.1	Care of patients is guided by accepted norms & policies	7
COP.2	Emergency services including ambulance are guided by documented procedures	5
COP.3	Documented procedures define rational use of blood and blood products	7
COP.4	Documented procedures guide the care of patients as per the scope of services provided by hospital in intensive care and high dependency unit	6.2
COP.5	Documented procedures guide the care of obstetrical patients as per the scope of services provided by hospital	7
COP.6	Documented procedures guide the care of paediatric patients as per the scope of services provided by hospital	6.1
COP.7	Document procedures guide the administration of anaesthesia	7
COP.8	Documented procedure guides the care of patients undergoing surgical procedures	6
AVERAGE SCORE		6.4

The COP chapter had an average score of 6.4 and highest scores in COP.1, COP.3, COP.5, and COP.7. The total average has partially complied with NABH assessment

Table 4.12: Score on Management of Medication (MOM) (Post NABH scenario)

Chapter 3: MANAGEMENT OF MEDICATION (MOM)		**SCORE**
MOM.1	Documented procedures guide the organisation of pharmacy services and usage of medicines	6
MOM.2	Documented policies and procedures guide the storage of medications	7

MOM.3	Documented procedures guide the prescription of medications	7
MOM.4	Policies and procedures guide the safe dispensing of medications	6
MOM.5	There are defined procedures for medication administration	7
MOM.6	Adverse drug events are monitored	5
MOM.7	Documented policies and procedures govern usage of radioactive drugs	NA
AVERAGE SCORE		6.3

The MOM chapter had high scores of 7 in MOM.2, MOM.3, MOM.5 and a chapter average score of 6.3 thereby partially complying with NABH assessment

Table 4.13: Score on Patient Rights and Education (PRE) (Post NABH scenario)

Chapter 4: PATIENT RIGHTS AND EDUCATION (PRE)		**SCORE**
PRE.1	Patient rights are documented displayed and support individual beliefs, values and involve the patient and family in decision making processes	8
PRE.2	Patient and families have a right to information and education about their healthcare needs	7
AVERAGE SCORE		7.5

PRE chapter had a highest score of 8 in PRE.1 and an average score of 7.5 thereby partially complying with NABH assessment.

Table 4.14: Score on Hospital Infection Control (HIC) (Post NABH scenario)

Chapter 5: HOSPITAL INFECTION CONTROL (HIC)		**SCORE**
HIC.1	The hospital has an infection control manual, which is periodically updated and conducts surveillance activities	6
HIC.2	The hospital takes actions to prevent or reduce the risks of Hospital Associated Infections (HAI) in patients and employees	6.3

HIC.3	Bio-Medical Waste (BMW) management practices are followed	8
AVERAGE SCORE		6.7

HIC chapter with its implementation of HIC committee made an average score of 6.7 with a highest score of 8 in HIC.3 and partially complying with NABH assessment.

Table 4.15: Score on Continuous Quality Improvement (CQI) (Post NABH scenario)

Chapter 6: CONTINUOUS QUALITY IMPROVEMENT (CQI)		**SCORE**
CQI.1	There is a structured quality improvement, patient safety and continuous monitoring programme in the organisation	6
CQI.2	The organisation identifies key indicators to monitor the structures, processes and outcomes which are used as tolls for continuous improvement	6
AVERAGE SCORE		6

The CQI chapter scored an average of 6 and partially complied with NABH assessment, the CQI programme was implemented after the pre NABH standard implementation

Table 4.16: Score on Responsibility of Management (ROM) (Post NABH scenario)

Chapter 7: RESPONSIBILITY OF MANAGEMENT (ROM)		**SCORE**
ROM.1	The responsibilities of the management are defined	6.3
ROM.2	The organisation is managed by the leaders in an ethical manner	7.3
ROM.3	The organisation has set up multi-disciplinary committees to oversee specific areas of quality and patient safety	6
AVERAGE SCORE		6.5

ROM chapter scored an average of 6.5 and highest being 7.3 in ROM.2 thereby partially complying with NABH assessment

Table 4.17: Score on Facility Management and Safety (FMS) (Post NABH scenario)

Chapter 8: FACILITY MANAGEMENT AND SAFETY (FMS)		**SCORE**
FMS.1	The organisation's environment and facilities operate to ensure safety of patients, their families, staff, and visitors	7.3
FMS.2	The organisation has a program for clinical and support service equipment management	6.3
FMS.3	The organisation has provisions for safe water, electricity, medical gas, and vacuum systems	7
FMS.4	The organisation has plans for fire and non-fire emergencies within the facilities	6.7
AVERAGE SCORE		6.8

The FMS chapter scored an average of 6.8 and highest in FMS.1 thereby partially complying with NABH assessment

Table 4.18: Score on Human Resource Management (HRM) (Post NABH scenario)

Chapter 9: HUMAN RESOURCE MANAGEMENT (HRM)		**SCORE**
HRM.1	The organisation has staffing commensurate with patient care needs	6
HRM.2	There is an ongoing programme for professional training and development of the staff	6
HRM.3	The organisation has a well-documented disciplinary and grievance handling procedure	6
HRM.4	The organisation addresses the health needs of the employees	6
HRM.5	There is documented personal records for each staff member	6.5
AVERAGE SCORE		6.1

The HRM chapter had to be completely rearranged in terms of documentations and new documentations were added making it partially compliant with an average score of 6.1 and scoring highest in HRM.5

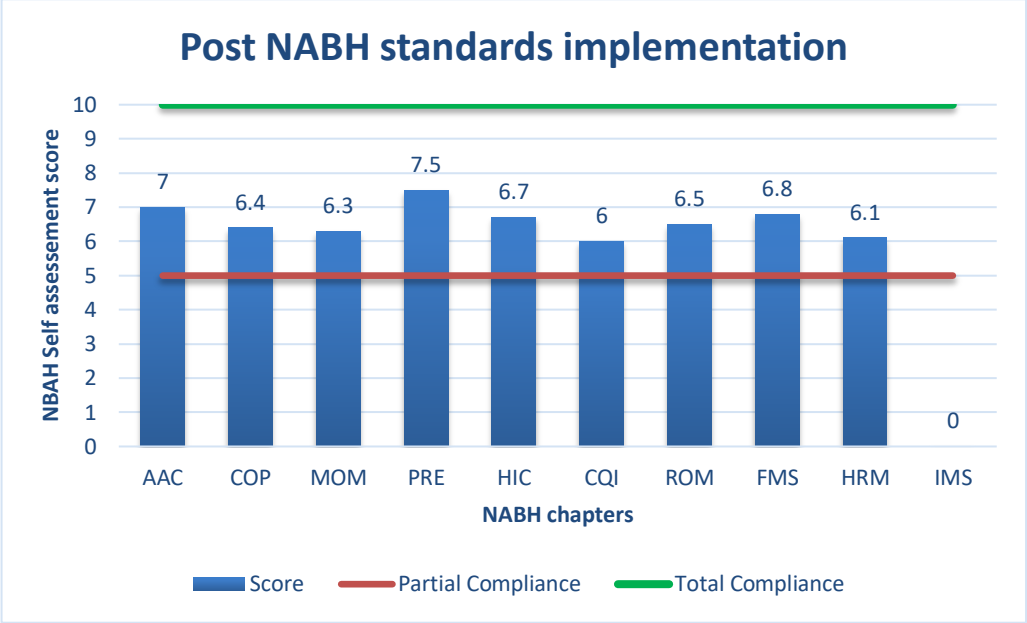

Figure 4.3 Graphical representation of NABH compliance score (Post NABH scenario)

Comparison:

The data from the NABH self-assessment toolkits were fed into excel and a comparison was done between both scenarios, pre- NABH standard implementation and post-NABH standard implementation. The following results were obtained.

NABH SELF ASSESSMENT TOOLKIT SCORES						
Chapter	Chapter name	Pre Implementation	Post Implementation		Partial Compliance	Total Compliance
AAC	ACCESS, ASSESSMENT AND CONTINUITY OF CARE	2.7	7		5	10
COP	CARE OF PATIENTS	3.2	6.4		5	10
MOM	MANAGEMENT OF MEDICATION	1.1	6.3		5	10
PRE	PATIENT RIGHTS AND EDUCATION	3.5	7.5		5	10
HIC	HOSPITAL INFECTION CONTROL	2.5	6.7		5	10
CQI	CONTINUOUS QUALITY IMPROVEMENT	0.7	6		5	10
ROM	RESPONSIBILITY OF MANAGEMENT	2.4	6.5		5	10
FMS	FACILITY MANAGEMENT AND SAFETY	2.6	6.8		5	10
HRM	HUMAN RESOURCE MANAGEMENT	1.3	6.1		5	10
IMS	INFORMATION MANAGEMENT SYSTEM	NA	NA		5	10
	AVERAGE	2.2	6.6	Percentage Change		
	PERCENTAGE	22.2	65.9	43.7		

Figure 4.4 Comparing scores of Pre and Post NABH standards implementation scenarios

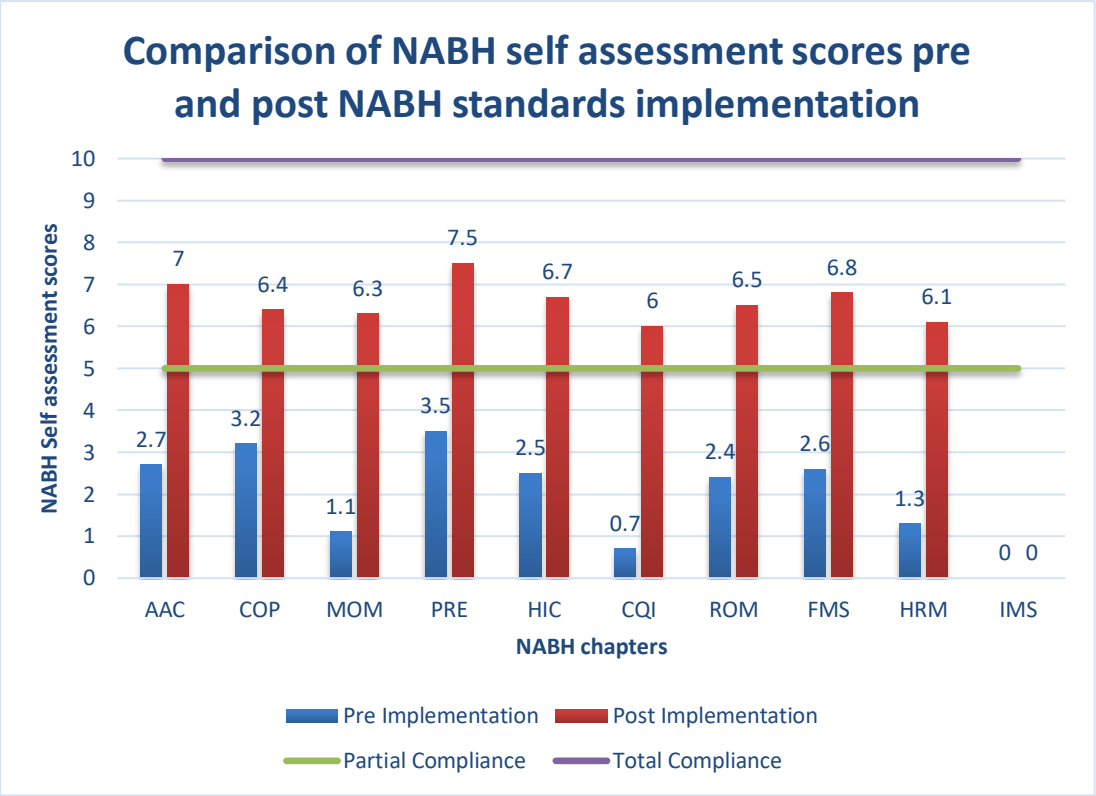

Figure 4.5 Graph comparing Pre and Post NABH standard implementation scenarios

Implementation and complying with NABH standards made a **43.7% compliance change** prior to implementation the hospital was found to be **22.2% compliant** with NABH and post implementation the hospital was found to be **65.9% compliant** which made it possible to go for a desktop assessment and virtual assessment for entry level NABH certification on HOPE portal.

Chapter 5:

Recommendations:

The hospital lacked some quality indicators to be monitored, so recommendations on the quality indicators and collection of data was made on the following.

Quality Indicators:

1. Average time taken for initial assessment by doctor in wards (min)
2. Average time taken for initial assessment by nurses in wards (min)
3. Average time taken for initial assessment by doctor in ER (min)
4. Average time taken for initial assessment by nurse in ER (min)
5. Percentage of cases in which screening for nutritional needs has been done
6. Percentage of cases where modification of anaesthesia plan was done
7. Percentage of cases where unplanned ventilation following anaesthesia was done
8. Percentage of cases where adverse anaesthesia events have occurred
9. Mortality rate related to Anaesthesia
10. Percentage of cases where unplanned return to OT has occurred
11. Percentage of cases where re-scheduling of surgeries was done
12. Percentage of cases where change of procedure was done
13. Percentage of cases where the organisation's procedure to prevent adverse events like wrong site, wrong patient and wrong surgery have been adhered to
14. Percentage of cases where appropriate prophylactic antibiotics within specified time frame were administered
15. Percentage of case where transfusion reactions have occurred
16. Blood and blood components wastage percentage
17. Bed occupancy percentage
18. Practice of Hand Hygiene Compliance
19. Percentage of medical records where discharge summary was not present
20. Percentage of medical records which had incomplete and/or improper consent
21. Percentage of missing records
22. Mortality rate
23. Percentage of drugs and consumables procured through local purchase
24. Percentages of stock outs including emergency drugs
25. Percentages of drugs and consumables rejected before preparation of GRN

These quality indicators would help monitor and assess monthly performances and changes to procedures and policies if need to be, to always be compliant with NABH standards. Several other recommendations included mock drill scheduling, crash cart arrangement and availability, fire rescue plans, evacuation plans, patient identification tags, adverse drug event monitoring, preventive maintenance scheduling.

Regular trainings and drills calendar was laid down to increase the knowledge and skill of the staff, laying down proper processes for onboarding new employees would facilitate proper knowledge transfer and skill upgradation in case of promotions.

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Appendix: NABH self-assessment toolkit

Self Assessment Toolkit

Organisation is required to provide self assessment report in the format 'Self Assessment Toolkit' given below. All the entries are to be properly filled up. Regarding scoring following criteria would be applicable.

Compliance to the requirement: 10
Partial compliance to the requirement: 5 (If any of the sample is found to be noncomplying out of total samples selected)
Non-compliance to the requirement: 0
Not Applicable: NA

Evaluation Criteria:
- Overall score of minimum 50% in all standards
- Overall score of minimum 50% in each chapter

(Name & Address of the Hospital)

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 can provide.					
a	The services being provided are clearly defined.				
b	The defined services are prominently displayed.				
c	The staff is oriented to these services.				
AAC.2: The organization has a documented registration, admission and transfer process.					
a.	Process addresses registering and admitting out-patients, in-patients and emergency patients.				
b.	Process addresses mechanism for transfer or referral of patients who do not match the organizational resources.				
AAC.3 Patients cared for by the organization undergo an established initial assessment.					
a.	The organization defines the content of the assessments for the out-patients, in-patients and emergency patients.				
b.	The organization determines who can perform the assessments.				
c.	The initial assessment for in-patients is documented within 24 hours or earlier.				
d.	Initial assessment of inpatients includes nursing assessment which is done at the time of admission and documented.				
AAC.4 Patient care is continuous and all patients cared for by the organization undergo a regular reassessment.					
a.	During all phases of care, there is a qualified individual identified as responsible for the patient's care who coordinates the care in all the settings within the organization.				
b.	All patients are reassessed at appropriate intervals.				
c.	Staff involved in direct clinical care document reassessments.				
d.	Patients are reassessed to determine their response to treatment and to plan further treatment or discharge.				
AAC.5 Laboratory services are provided as per the scope of the hospital's services and laboratory safety requirements.					
a.	Scope of the laboratory services are commensurate to the services provided by the organization.				
b.	Procedures guide collection, identification, handling, safe transportation, processing and disposal of specimens.				
c.	Laboratory results are available within a defined time frame and critical results are intimated immediately to the concerned personnel.				
d.	Adequately trained personnel perform, supervise & interpret the investigations.				
e.	Laboratory personnel are trained in safe practices and are provided with appropriate safety equipment/ devices.				
f.	Laboratory tests not available in the organization are outsourced.				
AAC.6 Imaging services are provided as per the scope of the hospital's services and established radiation safety programme.					
a.	Scope of the imaging services are commensurate to the services provided by the organization.				
b.	Imaging signages are prominently displayed in all appropriate locations.				
c.	Imaging results are available within a defined time frame and critical results are intimated immediately to the concerned personnel.				
d.	Imaging personnel are trained in safe practices and are provided with appropriate safety equipment/ devices.				
AAC.7 The organisation has a defined discharge process.					
a.	Process addresses discharge of all patients including Medico-legal cases and patients leaving against medical advice.				
b.	A discharge summary is given to all the patients leaving the organization (including patients leaving against medical advice).				
c.	Discharge summary contains the reasons for admission, significant findings, investigation results, diagnosis, procedure performed (if any), treatment given and the patient's condition at the time of discharge.				
d.	Discharge summary contains follow up advice, medication and other instructions in an understandable manner.				
e.	Discharge summary incorporates instructions about when and how to obtain urgent care.				
f.	In case of death the summary of the case also includes the cause of death.				
Chapter 2: CARE OF PATIENTS (COP)					
COP.1: Care of patients is guided by accepted norms & practice.					
a	The care and treatment orders are signed and dated by the concerned doctor.				
b	Critical Practice Guidelines are adopted to guide patient care wherever possible.				
COP.2: Emergency services including ambulance are guided by documented procedures.					
a	Documented procedures address care of patients arriving in the emergency including handling of medico-legal cases.				
b	Staff should be well versed in the care of emergency patients in consonance with the scope of the services of hospital.				
c	Admission or discharge to home or transfer to another organization is also documented.				
d	Ambulance is appropriately equipped.				
e	Ambulance(s) is manned by trained personnel.				
COP.3: Documented procedures define rational use of blood and blood products.					
a	Documented policies and procedures are used to guide the rational use of blood and blood products.				
b	Documented procedures govern transfusion of blood and blood products.				
c	The transfusion services are governed by the applicable laws and regulations.				
d	Informed consent is obtained for donation and transfusion of blood and blood products.				
e	Procedure addresses documenting and reporting of transfusion reactions.				
COP.4: Documented procedures guide the care of patients as per the scope of services provided by hospital in Intensive care and high dependency unit.					
a	Care of patients is in consonance with the documented procedures.				
b	Adequate staff and equipment are available.				
COP.5: Documented procedures guide the care of obstetrical patients as per the scope of services provided by hospital.					
a	The organization defines the scope of obstetric services.				
b	Obstetric patient's care includes regular ante-natal check ups, maternal nutrition and post-natal care.				
c	The organization has the facilities to take care of neonates.				
COP.6: Documented procedures guide the care of pediatric patients as per the scope of services provided by hospital.					
a	The organization defines the scope of its pediatric services.				
b	Provisions are made for special care of children by competent staff.				
c	Patient assessment includes detailed nutritional, growth, and immunization assessment.				
d	Procedure addresses identification and security measures to prevent child/ neonate abduction and abuse.				
e	The children's family members are educated about nutrition and immunization				
COP.7: Documented procedures guide the administration of anesthesia.					
a.	There is a documented policy & procedure for the administration of anesthesia.				
b.	All patients for anesthesia have a pre-anesthesia assessment by a qualified/ trained anesthetist.				
c.	The pre-anesthesia assessment results in formulation of an anesthesia plan which is documented.				
d.	An immediate preoperative re-evaluation is documented.				
e.	Informed consent for administration of anesthesia is obtained by the anesthetist.				
f.	Anesthesia monitoring includes regular and periodic recording of heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation, airway security and patency and End tidal carbon dioxide.				
g.	Each patient's post-anesthesia status is monitored and documented.				
h.	Defined criteria are used to transfer the patient from the recovery area.				
i.	Adverse anesthesia events are recorded and monitored.				

COP.8: Documented procedure guides the care of patients undergoing surgical procedures.						
a.	Surgical patients have a preoperative assessment and a provisional diagnosis documented prior to surgery.					
b.	An informed consent is obtained by a surgeon prior to the procedure.					
c.	Documented procedure addresses the prevention of adverse events like wrong site, wrong patient and wrong surgery.					
d.	Qualified persons are permitted to perform the procedures that they are entitled to perform.					
e.	The operating surgeon documents the operative notes and post-operative plan of care.					
f.	The operation theatre is adequately equipped and monitored for infection control practices.					
g.	Patients, personnel and material flow conform to infection control practices.					
Chapter 3: MANAGEMENT OF MEDICATION (MOM)						
MOM.1: Documented procedures guide the organization of pharmacy services and usage of medication.						
a	Documented procedure shall incorporate purchase, storage, prescription and dispensation of medications.					
b	Documented procedures address procurement and usage of implantable prostheses.					
MOM.2: Documented policies & procedures guide the storage of medications.						
a	Documented policies and procedures exist for storage of medication					
b	Medications are stored in a clean, safe and secure environment, and incorporate manufacturer's recommendations.					
c	Sound alike and look alike medications are stored separately.					
d	Beyond expiry date medications are not stored/used.					
e	List of emergency medicines is defined, stored, and available all the time.					
MOM.3: Documented procedures guide the prescription of medications.						
a	The organization determines who can write orders.					
b	Orders are written in a uniform location in the medical records.					
c	Medication orders are clear, legible, dated and signed.					
d	The organization defines a list of high risk medication & process to prescribe them.					
MOM.4: Poilicies & procedures guide the safe dispensing of medications.						
a	Medications are checked prior to dispensing, including the expiry date to ensure that they are fit for use.					
b	High risk medication orders are verified prior to dispensing.					
MOM.5: There are defined procedures for medication administration.						
a	Medications are administered by trained personnel.					
b	Prior to administration medication order including patient, dosage, route and timing are verified.					
c	Prepared medication is labelled prior to preparation of a second drug.					
d	Medication administration is documented.					
e	A proper record is kept of the usage, administration and disposal of narcotics and psychotropic medications.					
MOM.6: Adverse drug events are monitored.						
a	Adverse drug events are defined & monitored.					
b	Adverse drug events are documented and reported within a specified time frame.					
MOM.7: Documented policies & procedures govern usage of radioactive drugs.						
a	Documented policies and procedures govern usage of radioactive drugs.					
b	Policies and procedures include the safe storage, preparation, handling, distribution and disposal of radioactive drugs.					
Chapter 4: PATIENT RIGHTS AND EDUCATION (PRE)						
PRE.1: Patient rights are documented displayed and support individual beliefs, values and involve the patient and family in decision making processes.						
a.	Patient rights include respect for personal dignity and privacy during examination, procedures and treatment.					
b.	Patient rights include protection from physical abuse or neglect.					
c.	Patient rights include treating patient information as confidential.					
d.	Patient rights include obtaining informed consent before carrying out procedures.					
e.	Patient rights include information on how to voice a complaint.					
f.	Patient rights include information on the expected cost of the treatment.					
g.	Patient has a right to have an access to his / her clinical records.					
PRE.2: Patient and families have a right to information and education about their healthcare needs.						
a	Patients and families are educated on plan of care, preventive aspects, possible complications, medications, the expected results and cost as applicable.					
b	Patients are taught in a language and format that they can understand.					
Chapter 5: HOSPITAL INFECTION CONTROL (HIC)						
HIC.1: The hospital has an infection control manual, which is periodically updated and conducts surveillance activities.						
a	It focuses on adherence to standard precautions at all times.					
b	Cleanliness and general hygiene of facilities will be maintained and monitored.					
c	Cleaning and disinfection practices are defined and monitored as appropriate.					
d	Equipment cleaning, disinfection and sterilization practices are included.					
e	Laundry and linen management processes are also included					
HIC.2: The hospital takes actions to prevent or reduce the risks of Hospital Associated Infections (HAI) in patients and employees.						
a	Hand hygiene facilities in all patient care areas are accessible to health care providers.					
b	Adequate gloves, masks, soaps, and disinfectants are available and used correctly.					
c	Appropriate pre and post exposure prophylaxis is provided to all concerned staff members.					
HIC.3: Bio-medical Waste (BMW) management practices are followed.						
a	The hospital is authorised by prescribed authority for the management and handling of Bio-Medical Waste.					
b	Proper segregation and collection of Bio-Medical Waste from all patient care areas of the hospital is implemented and monitored.					
c	Bio-Medical Waste treatment facility is managed as per statutory provisions (if in-house) or outsourced to authorised contractor(s).					
d	Requisite fees, documents and reports are submitted to competent authorities on stipulated dates.					
e	Appropriate personal protective measures are used by all categories of staff handling Bio-Medical Waste.					
Chapter 6: CONTINUOUS QUALITY IMPROVEMENT (CQI)						
CQI.1: There is a structured quality improvement, patient safety and continuous monitoring programme in the organization.						
a	There is a designated individual for coordinating and implementing the quality improvement and patient safety programme.					
b	The quality improvement and patient safety programme is a continuous process and updated at least once in a year.					
c	Hospital Management makes available adequate resources required for quality improvement and patient safety programme.					
CQI.2: The organization identifies key indicators to monitor the structures, processes and outcomes which are used as tools for continual improvement.						
a	Organization may identify the appropriate key performance indicators in both clinical and managerial areas.					
b	These indicators shall be monitored.					
Chapter 7: RESPONSIBILITIES OF MANAGEMENT (ROM)						
ROM.1: The responsibilities of the management are defined						
a	The organization has a documented organogram.					
b	The organization is registered with appropriate authorities as applicable.					
c	The organization has a designated individual(s) to oversee the hospital wide quality and safety programme.					
ROM.2: The organization is managed by the leaders in an ethical manner.						
a	The management makes public the mission statement of the organization.					
b	The leaders/management guide the organization to function in an ethical manner.					
c	The organization discloses its ownership.					
d	The organization's billing process is accurate and ethical.					
ROM.3: The organization has set up multi-disciplinary committees to oversee specific areas of quality and patient safety.						
a	These committees include Quality and Safety, Infection Control, Pharmacy and Therapeutics, Blood Transfusion, and Medical Records.					
b	The membership, responsibilities, and periodicity of meetings shall be defined.					
Chapter 8: FACILITY MANAGEMENT AND SAFETY (FMS)						
FMS.1: The organization's environment and facilities operate to ensure safety of patients, their families, staff and visitors.						
a	Internal and External Signage's shall be displayed in a language understood by the patients and families.					
b	Maintenance staff is contactable round the clock for emergency repairs.					
c	There the hospital has a system to identify the potential safety and security risks including hazardous materials.					
d	Facility inspection rounds to ensure safety are conducted periodically.					
e	There is a safety education programme for relevant staff.					
FMS.2: The organization has a program for clinical and support service equipment management.						
a	The organization plans for equipment in accordance with its services.					
b	There is a documented operational and maintenance (preventive and breakdown) plan.					
FMS.3: The organization has provisions for safe water, electricity, medical gas and vacuum systems.						
a	Potable water and electricity are available round the clock.					
b	Alternate sources are provided for in case of failure and tested regularly.					
c	There is a maintenance plan for medical gas and vacuum systems.					
FMS.4: The organization has plans for fire and non-fire emergencies within the facilities.						
a	The organization has plans and provisions for detection, abatement and containment of fire and non-fire emergencies.					
b	The organization has a documented safe exit plan in case of fire and non-fire emergencies.					
c	There is a maintenance plan for medical gas and vacuum systems.					
d	Mock drills are held at least twice in a year.					
Chapter 9: HUMAN RESOURCE MANAGEMENT (HRM)						
HRM.1: The organization has staffing commensurate with patient care needs.						
a	The mix of staff is commensurate with the volume and scope of the services.					
b	Staff recruitment process is well defined.					
HRM.2: There is an ongoing programme for professional training and development of the staff.						
a	All staff is trained on the relevant risks within the hospital environment.					
b	Staff members can demonstrate and take actions to report, eliminate/ minimize risks.					
c	Training also occurs when job responsibilities change/ new equipment is introduced.					
HRM.3: The organization has a well-documented disciplinary and grievance handling procedure.						
a	A documented procedure with regard to these is in place.					
b	The documented procedure is known to all categories of employees in the organization.					
c	Actions are taken to redress the grievance.					
HRM.4: The organization addresses the health needs of the employees						
a	Health problems of the employees are taken care of in accordance with the organization's policy.					
b	Occupational health hazards are adequately addressed.					
HRM.5: There is documented personal record for each staff member						
a	Personal files are maintained in respect of all employees.					
b	The personal files contain personal information regarding the employees qualification, disciplinary actions and health status. The disciplinary procedure is in consonance with the prevailing laws.					
Chapter 10: INFORMATION MANAGEMENT SYSTEM (IMS)						
IMS.1: The organization has a complete and accurate medical record for every patient						
a	Every medical record has a unique identifier.					