Assessment & Gap Analysis of a Super Specialty Hospital Based on the Patient Centric NABH Standards

By

Aneesha Koul

Dissertation submitted for the partial fulfillment of the

MBA Hospital and Health Management

Academic year, 2015-2017

The IIHMR University, Jaipur

1, Prabhu Dayal Marg, Sanganer, Airport
Jaipur 302029, Rajasthan
Ph: 0141 3924700, Fax: 3924738
Website: **www.iihmr.edu.in**

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Ph: 0141 3924700, Fax: 3924738
Website: www.iihmr.edu.in

INSTITUTE OF HEALTH
MANAGEMENT RESEARCH
(WHO Collaborating Centre for District Health System Based on Primary Health Care)

IIHMR UNIVERSITY

TO WHOMSOEVER MAY CONCERN

This is to certify that **Dr. Aneesha Koul** student of MBA Hospital and Health Management from The IIHMR University, Jaipur has undergone internship training at **Shri Mata Vaishno Devi Narayana Superspeciality Hospital** from 6th February 2017 to 5th May 2017.

The Candidate has successfully carried out the study designated to her during internship training and her approach to the study has been sincere, scientific and analytical.
The Internship is in fulfillment of the course requirements.

I wish her all success in all her future endeavors.

Col (Dr.) Ashok Kaushik
Dean, Academics and Student Affairs
The IIHMR University, Jaipur

Dr. Sandesh Kumar Sharma
Associate Professor
The IIHMR University, Jaipur

1, Prabhu Dayal Marg, Near Sanganer Airport, Jaipur- 302029, Rajasthan, India.
Ph.: 0141- 3924700, 2791431- 32, Fax: 0141 3924738, E-mail: iihmr@iihmr.edu.in, Web.: www.iihmr.edu.in

SMVDNSH/HR/Intrn/009 **Dt.13th May' 2017**

INTERNSHIP CERTIFICATE

This is to certify that **Dr. Aneesha Koul D/O Dr. Ajay Koul** has successfully completed her **"Internship" in "Assessment & Gap Analysis of Superspeciality Hospital as per the Patient centric NABH Standards"** from **2nd Feb 2017 to 05th May '2017** at **Shri Mata Vaishno Devi Narayana Superspeciality Hospital,** Kakryal(Village & Post), Katra Tesil,Reasi District, Jammu & Kashmir-182320

During her internship period, she has shown keen interest of observing, learning and her conduct was good.

We wish her, all the best for her future endeavors.

for **Narayana Vaishno Devi Speciality Hospitals Pvt.Ltd**

Raman Kumar
Senior Manager
Human Resources

THE IIHMR UNIVERSITY, JAIPUR

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled "**Assessment & Gap Analysis of a Super Speciality Hospital based on the patient centric NABH Standards, 4th Edition**" and submitted by **Dr. Aneesha Koul** Enrolment No. **IIHMR-U/01/2015-17/0253** under the supervision of **Dr. Sandesh Kumar Sharma** for award of Postgraduate Diploma in Hospital and Health Management of the University carried out during the period from 6th February 2017 to 5th May 2017 embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.

Aneesha Koul

Signature

THE IIHMR UNIVERSITY, JAIPUR

CERTIFICATE BY SCHOLAR

This is to certify that all ethical issues have been considered while collecting data for my dissertation titled **"Assessment & Gap Analysis of a Super Speciality Hospital based on the Patient Centric NABH Standards"**

Signature of student

Assessment & Gap Analysis of a Super Speciality Hospital based on the patient centric NABH Standards, 4th Edition

Dr Aneesha Koul

ABSTRACT

Introduction: The budding healthcare sector is progressing towards a full bloom in the wake of the rising demand for its services. The consumers are becoming increasingly aware and quality oriented & do not hesitate to pay a little extra for better facilities offered. Owing to the increased preference for quality services the hospitals have to scale up the quality of services provided by them. In order to achieve a standard delivery of care in the hospitals, National Accreditation Board for Hospitals & Healthcare Providers was established in 2006. More and more hospitals are willing to have an accreditation by this quality council as a visible leap of standardization as well as to gain patient trust. In order to maintain the standards of service delivery, monitoring the performance, to bring about patient centric practices and to focus on safety to have a collective effort across the region in order to continually improve, there is a need to do gap analysis. Objective: To identify the gaps as per the patient centric chapters of NABH 4th Edition standards using the NABH Self-Assessment Toolkit. Methodology: Descriptive Cross sectional study. Results and Conclusion: The assessment score for the hospital is above average using the NABH 4th Self-Assessment toolkit and it fulfils all the criteria laid down by NABH to be eligible for the pre assessment audit. Staff has to be trained on a frequent basis to stress upon following the SOPs, improve the documentation in order to provide quality healthcare services to the patients. Policies, SOP and manuals have been prepared but the implementation of these policies has to be done meticulously throughout the hospital. The hospital is in the process of bringing in standardisation in its operations thus improving the quality of patient care. Quality being a continuous process, by streamlining the processes, reducing the waste and improving efficiency the hospital is on the right path to fulfil its quality goal of achieving accreditation.

Keywords: Accreditation, NABH (National Accreditation Board of Hospitals and Healthcare), Gap Analysis, Quality

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The support of my parents & family deserves a special thanks, who have guided and motivated me throughout the duration of my dissertation.

Dr. Aneesha Koul

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List of Abbreviations:

1. AAC: Access, Assessment and Continuity of Care
2. ACLS: Advanced Cardiac Life Support
3. ADE: Adverse drug event
4. ADR: Adverse drug reaction
5. AMC: Annual Maintenance Contract
6. BLS: Basic Life Support
7. BMW: Bio-Medical waste
8. Cath Lab: Catheterization Laboratory
9. CDC: Centre for Disease Control
10. CMC: Comprehensive Maintenance Contract
11. CMS: Complaint management system
12. COP: Care of Patient
13. CQI: Continuous Quality Improvement
14. ENT: Ear, Nose & Throat
15. FAW: Fairness At Workplace
16. FMS: Facility Management and Safety
17. HAI: Healthcare Associated Infection
18. HDU: High Dependency Unit
19. HIC: Hospital Infection Control
20. HRM: Human Resource Management
21. ICD: International Classification of Diseases
22. ICU: Intensive Care Unit
23. IMS: Information Management System
24. IPD: Inpatient Department
25. ITU: Intensive treatment Unit
26. LASA: Look Alike Sound Alike
27. MLC: Medicolegal Case
28. MOM: Management of Medication
29. MRD: Medical Record Department
30. NABH: National Accreditation Board of Hospitals and Healthcare

31. NSI: Needle stick injury
32. OPD: Outpatient Department
33. POSH: Prevention Of Sexual Harassment
34. PPE: Personal Protective Equipment
35. PRE: Patient Rights and Education
36. QCI: Quality Council of India
37. ROM: Responsibilities of Management
38. TAT: Turnaround Time
39. TQM: Total Quality Management
40. WHO: World Health Organization

1. INTRODUCTION:

Indian health care system is currently operating within an environment of rapid social, economic and technical changes and hospitals are an integral part of health care system. Such changes raise the concern for the quality of health care. The budding healthcare sector is progressing towards a full bloom in the wake of the rising demand for its services. The consumers of the healthcare delivery system services are becoming increasingly aware and quality oriented & do not hesitate to pay a little extra for better facilities offered. Owing to the increased preference for quality services the hospitals have to scale up the quality of services provided by them. Accreditation is a frame work which helps the hospitals to achieve standard delivery of care and improve patient experience in the hospital. National Accreditation Board for Hospitals & Healthcare Providers was established as a constituent of the Quality Council of India in 2006[1]. Accreditation would be the single most important approach for improving the quality of hospitals. It is a set up to establish and operate accreditation program for healthcare organizations. More and more hospitals are willing to have an accreditation by this quality council as a visible leap of standardization as well as to gain patient trust.

Shri Mata Vaishno Devi Narayana Super Speciality Hospital (SMVDNSH) is an emerging hospital in the state of J&K. It is providing state of the art super speciality quality healthcare services. It has attracted many patient from all over the state within a short span of one year since it has been operational in the state. The NABH accreditation is a benchmark of healthcare quality accreditation in India. In its location there is no other hospital which has NABH accreditation. NABH accreditation will further help SMVDNSH to establish its credibility and reliability and position itself firmly in the healthcare sector.

The study focuses on the five patient centric chapters of NABH namely Access, Assessment and Continuity of Care (AAC), Care of Patient (COP), Management of Medication (MOM), Patient Rights and Education (PRE) & Hospital Infection Control (HIC) . It also involves assessing the current situation of the healthcare delivery in the hospital

2. AIM OF STUDY:

Assessment & Gap Analysis of a Super Speciality Hospital based on the patient centric chapters as per NABH Standards, 4th Edition.

3. OBJECTIVE OF STUDY:

To identify the gaps as per the patient centric chapters of NABH 4th Edition standards using the NABH Self-Assessment Toolkit.

4. REVIEW OF LITERATURE:

The need for healthcare quality assurance and accreditation has been an established concept worldwide. India not being an exception. Quality can be defined as a set of attributes of service. The attributes differ from the perception of user, provider and the system involved. It can also be explained as appropriate application of medical knowledge with due regard to the balance between the hazard inherent in every medical intervention and benefits expected from it[7]. To achieve such quality accreditation is done. In the current era of heightened fiscal responsibility, aggravated accountability & transparency issues, growing market competition and escalating healthcare complexity and risk, accreditation contributes to ensuring that care meets the highest standards of healthcare decision making and provision. Accreditation can be defined as, "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[4]. It is the most comprehensive & powerful tool for quality improvement as it stimulates continuous improvement. It helps in enabling the organization in demonstrating commitment to quality healthcare, improving the confidence of the community in the services thus providing an opportunity to the hospital to benchmark with the best in the industry. It benefits all stake holders, patients being the biggest beneficiary resulting in high quality of care, patient safety and regular evaluation of the patient satisfaction. The patients get services by credential medical staff. Patient rights encompass legal and ethical issues in the provider-patient relationship, including a person's right to privacy, right to quality medical care without

prejudice, right to make informed decisions about care and treatment options, and right to refuse treatment[6]. Rights of patients are respected and protected. The staff in an accredited hospital are a satisfied lot as it provide 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 also provides an objective system of empanelment by insurance and other Third Parties[9].

National Accreditation Board for Hospitals & Healthcare Providers was established as a constituent of the Quality Council of India in 2006[1]. It was established to operate accreditation for health organizations. In India 458 hospitals are accredited. The board has full autonomy in its operations with support by all stakeholders. The NABH accreditation is currently a voluntary scheme but the QCI plans to cover all the hospitals in India, both, in the voluntary sector and government hospitals. NABH has provided well defined standards and parameters on which the organisation can be assessed. The standards provide framework for quality assurance and quality improvements for hospitals focusing on patient safety and quality of care. The standards call for continuous monitoring of sentinel events and comprehensive corrective action plan leading to building of quality culture at all levels and across all functions[8]. NABH has 10 chapters which reflect the two major aspects of the healthcare delivery i.e., Patient Centric Functions (chapter 1-5) and Organization Centered Functions (chapter 6-10) .

PATIENT CENTRIC CHAPTERS:

1. Access, Assessment and Continuity of Care (AAC)
2. Care of Patient (COP)
3. Management of Medication (MOM)
4. Patient Rights and Education (PRE)
5. Hospital Infection Control (HIC)

ORGANISATION CENTRIC CHAPTERS:

1. Continuous Quality Improvement (CQI)
2. Responsibilities of Management (ROM)
3. Facility Management and Safety (FMS)
4. Human Resource Management (HRM)
5. Information Management System (IMS)

In order to maintain the standards of service delivery, monitoring the performance, to bring about patient centric practices and to focus on safety to have a collective effort

across the region in order to continually improve, there is a need to do gap analysis. Gap Analysis is a very extensive, major & important activity. It is a means to determine how well a hospital meets the quality need or set of requirements & what steps are required in order to move from its present situation to the desired future state to provide quality healthcare services to the patients. It helps the hospital in attempting to bring in a level of uniformity, continuity, coordination and standardisation. It is a research extensive activity which involves finding and calculating the gaps on:

- Regulatory compliance
- Infrastructure & Engineering Gaps
- Manpower gaps, in terms of numbers, qualification, training, HR functions etc.
- Equipment gaps in terms of maintenance & safety.
- Process gaps as per quality standards applied, ethical & regulatory requirements.
- Other important & relevant issues specific to the hospital.

It acts as a tool to compare the actual performance with the desired performance. It helps to identify the gaps between optimal resource allocation & integration of the inputs (resources) & the current allocation level of resources. This reveals the areas that can be improved. Gap analysis includes following steps:

1. Identify the existing process.
2. Identify the existing outcome.
3. Identify the desired outcome.
4. Identify the process to achieve the desired outcome.
5. Identify gap and document the gap.
6. Develop the means to fill the gap.
7. Develop and prioritize requirements to bridge the gap.

The outcome of gap analysis activity is a clear understanding of quality gaps leading to the estimation of time and resource that would go in achieving quality accreditation . It acts as a powerful tool to kill ambiguity in the decision of going ahead with quality accreditation as a lot of clarification and objectivity in decision making is built by this activity .

Outcomes of Gap Analysis:

i. Detailed assessment of the facility on all elements that are otherwise also very crucial for patient care and safety.
ii. Legal non-compliance awakening.

iii. Safe building plans.
iv. Guidance for optimizing manpower and equipment.
v. Process gap identification leading to motivation for change.
vi. Road map for quality programme and accreditation.

Advantages of Gap Analysis:

i. Great stimulus for quality initiative for staff.
ii. Sensitization of management and staff on safety/quality requirements.
iii. Provides immediate change in behaviour of staff and their orientation to the work practices, safety and ethics.
iv. External peer review acts as an eye opener for many.
v. Provides objective evidence to the management foe taking the project further on and also a rough estimate about the cost of such initiative.

According to the Gap Assessment Report for Pondicherry Institute of Medical Sciences (2010), hospital care system has been broadly divided into two categories specifically for this hospital. This includes baseline assessment of the hospital as per normal workflow & basic system & processes followed and other criteria includes quality parameters followed in the department which includes documentation and assessment by the way of indicators". Infrastructural hospital is very strong and has huge resources as far as space is concerned. But on the other hand the premises are in unkempt condition and harbours many areas having a potential for infestation of microorganism that could encourage hospital cross infection. The ceilings are having seepage at many areas causing potential humid sites for fungal & related organisms. Hospital signage, another important NABH criteria, needs re -designing to follow uniformity for the standardization of design, colour coding, symbols, directional signs, etc. as per the standard signage system. Bio medical waste segregation & disposal is a major area of concern for the hospital as nowhere in the organisation, segregation is followed. Further, passageway, stairs, furniture were used to throw off infected swabs and consumed items. Hospital has a non-functional incinerator which has piled up waste in the same area. This practice is hazardous not only for the hospital staff also for the surrounding. In addition the hospital is violating many legal rules and the same may result in financial implication. Hospital Infection control needs attention with the most important NABH criteria of having a Formal and functional hospital infection control team and committee. This committee needs to review the present infection control system in the hospital and modify it by following the WHO recognised international standards for hospital.

Infection control formally evolved from the CDC (Centre for Disease Control, Atlanta, USA) Guidelines. Formal training needs to be done regarding Standard Hand Washing procedures, general housekeeping procedures in the hospital, equipment cleaning, infection control surveillance audits & clinical performance indicators. Surveillance of the premises concluded that there is an urgent need for space allocation for the housekeeping consumables. It is to be realised that the housekeeping staff should be trained through In House Training Programs, since they ultimately constitute the "grass root" level workers in the final and actual implementation of Hospital Infection Control measures. Biomedical Engineering also needs re-modulation in the form of more documentation and in house calibration and preventive maintenance of the equipment. Annual maintenance of all equipment is a must. Calibration of all machines is the highest priority for all hospital and this is a more specialized work different from repair and replacement . One major area of concern for the hospital is the improper and unnecessary space occupying practice of storing of condemned articles. The hospital requires a functional Condemnation Committee to implement disposal of equipment not in use and due for condemnation. This condemnation will help the organisation to free more space for alternative activities [13]. Government of Gujarat has recognised in its quality improvement programme that quality health services and efficient government managed hospitals are important factors for increasing the trust and confidence of the citizens of the state for hospitals. It has given a sense of pride to the government for ensuring quality services to the poorest of the poor. Confidence has been reposed of the community in the Govt. hospitals. NABH programme is committed strictly adhere to the quality manual in all its operations and to be abreast of the latest technology to become innovative and thus be a benchmark in healthcare services and support and to create an excellent work environment and maintain good housekeeping by continuing training of personnel to imbibe quality as a culture among its people . NABH programme has been introduced because of the growing recognition of the need for quality in health programme, which have, in the past, been beset with such problems as limited capacity, lack of programme standards and guidelines, and an obsession with quantified targets rather than client satisfaction. Worried by the lack of adequate standards; in public health services and the absence of written policies and procedures for healthcare delivery, the new quality parameters introduced by the state government seek to address problems of poor sanitation and cleanliness in hospitals, staff shortage in every category, damaged and pathetic condition of the building and campus, poor signage system in the hospitals, absence of patient satisfaction monitoring system, lack of a measurable parameter for

patient safety and absence of legal compliances. The Total Quality Management (TQM) system was introduced to tackle all these problems, as also the issues of lack of accountability and planning in delivery of care to patients, lack of blood bank/storage facility in some hospitals, and the absence of quality standards such as medical audit, management of medication, patient, facility management and safety, information management system and infection control [10]. Analysis report for Ishtakal Hospital has found two gaps- Infrastructure related gap and Process related gap. Infrastructure related gaps are insufficient space, make shift buildings, improper signage, poor fire safety and disaster plan, piped medical gas not available, shortage of equipment and instruments, old and out of order equipment and instruments, lack of biomedical equipment engineering cell. Most of the gaps related to the 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 roper training and hand holding. Process 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, equipment, ordinance/general stores) only few hospitals have quality control department however medical and nursing audits are not done. Equipment did not have AMC/CMC, utilization audits of equipment is not done, proper BMW management did not exist, security was not organised in three tier manner (outer, middle and inner ring)[11]. Dr. Santosh Kumar, Brig (Dr) Swadesh Puri, Dr S.D. Gupta in a study of Gap Analysis Report for a Rehabilitation Centre have found out that it is mainly a destitute centre having 20 beds for disabled patients. Even though it is housed in a polyclinic various sub specialities (such as medicine, surgery, ENT, Ophthalmology and dental) are available here which seem duplicity of resources. The centre does not have proper diagnostic, inpatient and utility services (kitchen and laundry). There is no effective signage to guide the patient within the centre. The radiology department is virtually open from three sides causing radiation hazards to the patients and staff. Even though it is a rehabilitation centre it does not have basic physiotherapy equipment. The general housekeeping is very bad, all the toilets are broken and stinking. Almost all working areas are unhygienic and dirty 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. The CSSD has only one autoclave which is not sufficient for the entire hospital. It lacks quality control measures. There is no disaster plan for hospital[12].

5. METHODOLOGY:

1. **Study Location**: Shri Mata Vaishno Devi Narayana Super Speciality Hospital, Kakriyal.
2. **Study Design**: Descriptive Cross sectional study.
3. **Study Duration**: 3 months (6th February 2017- 5th May 2017)
4. **Study Instruments:**

   a. Primary data:

   - Quantitative data obtained by scoring the NABH 4th Edition Self-assessment toolkit for the patient centric chapters.
   - Interviews and discussion with the key resource persons in various departments (doctors, nursing, housekeeping, laundry & linen, security, paramedical staff etc.) of the hospital.
   - Purposive sampling was done while interviewing the staff of the hospital.
   - Direct observation of the participants, facility and infrastructure.

   b. Secondary data:

   Qualitative data was obtained from:

   - Policies, SOPs & Manuals of the hospital.
   - Review of records and registers of the various departments of the hospital.
5. **Ethical Considerations**:
   - Privacy
   - Informed consent
   - Confidentiality

6. RESULTS:

The study was done based on the NABH 4th Edition Self-assessment Toolkit (annexure) and scoring was done. The assessment was based on the standard documents, policies, manuals, cross references, study materials and procedures followed on site verification and interview the concerned staff personnel of the various departments. The scoring was done on the basis of these observations and substantiated by the available documentation. Regarding scoring following criteria was used for each of the objective element:

1. Compliance to the requirement: 10
2. Partial compliance to the requirement: 5
3. Non-compliance to the requirement: 0
4. Not Applicable: NA

The chapter wise analysis is mentioned below. The average score for each chapter was calculated and the averages for all the chapters were compared:

ACCESS ASSESSMENT AND CONTINUITY OF CARE (AAC):

This chapter deals with the services provided by the hospital and to provide continuous care to the patients. The guidelines clearly define the role of organisation to provide utmost quality care to the patients and improve patient satisfaction. The patients are well informed of the scope of services the organisation provides. Only those patients who can be cared for are admitted in the organisation. Emergency patients receive life-stabilising treatment and are either admitted (if resources are available) or transferred to an organisation that has the resources to take care of such patients.

Patients that match the organisations resources are admitted using a definitive process and undergo an established initial assessment and periodic & regular reassessments. Assessments include planning for laboratory and imaging services. These assessments result in formulation of a definite Care plan.

Patient care is multidisciplinary in nature and encourages continuity of care through well-defined transfer and discharge protocols. These protocols include transfer of

adequate information with the patients.

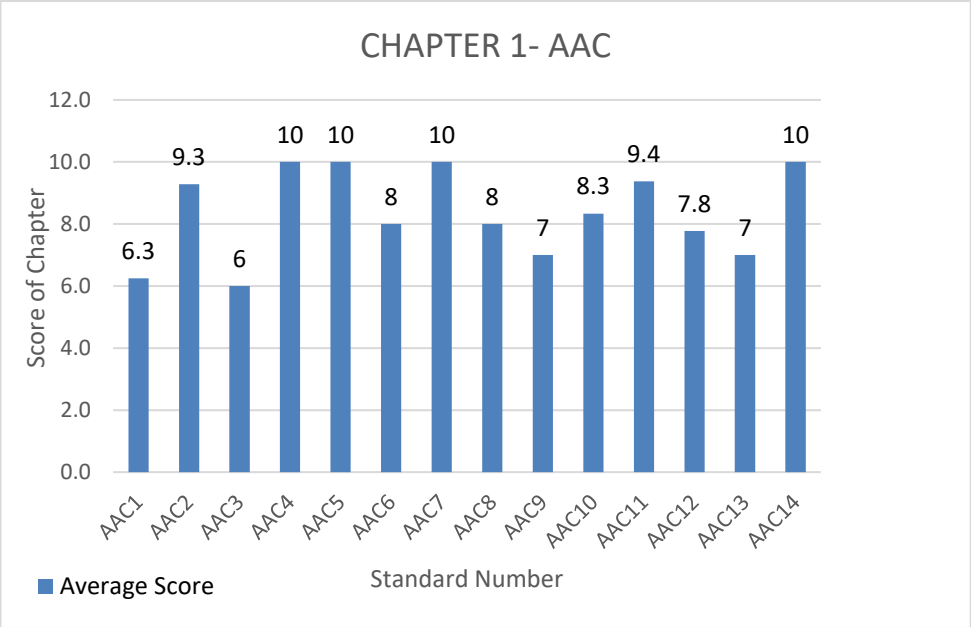

Figure 6.1 Graph showing the average score of Access, Assessment and Continuity of Care

Interpretation: On comparing the average score for the Chapter "Access, Assessment and Continuity of Care", it was found that AAC3 standard had the minimum score i.e., 6. AAC 3 deals with the appropriate mechanism for the transfer in/out or referral of the patients. There were gaps in documentation of the transfer summary for patients being transferred out from the hospital, knowledge and awareness of the staff regarding the policy procedures to be followed when a patient is being transferred to any other healthcare facility. The standards AAC 4, 5, 7 and 14 had the maximum score (i.e. 10).

CARE OF PATIENTS (COP):

This chapter deals with uniform care to all patients in different settings. The different settings include care provided in outpatient units, various categories of wards , ICUs, critical care areas, procedure rooms and operation theatre. When similar care is provided in these different settings , care delivery is uniform. Policies, procedures, applicable laws and regulations guide emergency and ambulance services , cardio pulmonary resuscitation, use of blood and blood components , care of patients in the intensive care and high dependency units .

Policies, procedures, applicable laws and regulations also guide care of vulnerable patients (elderly, physically and/or mentally challenged children), high risk obstetrical patients, paediatric patients, patients undergoing moderate sedation, administration of anaesthesia, patients undergoing surgical procedures , patients under restraints , research activities and end of life care .

Pain management, nutritional therapy and rehabilitative services are also addressed with a view to providing comprehensive health care .

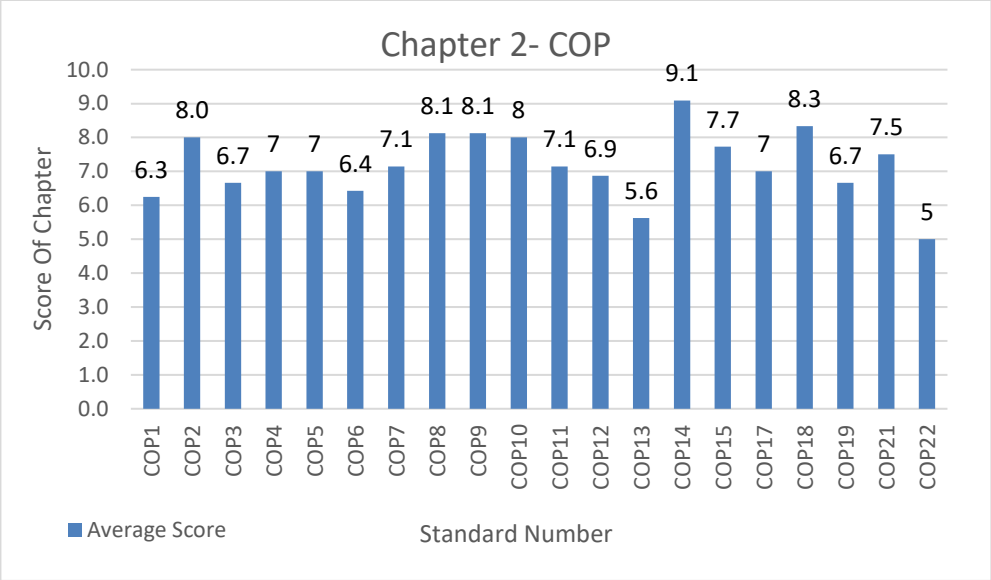

Figure 6.2 Graph showing the average score of Care of Patients

Interpretation: On analysing it was found that least score (i.e.5) was for the standard COP 22. There is absence of any provision in the policy guiding the end of life care. There is lack of equipment and manpower to manage patients who have gone into deeper level of sedation than initially intended. There are no policies and documentation regarding the organ transplant program as is it beyond the scope of services being offered at the hospital. Also there is no policy and procedure guiding the research activities which can be carried out in the hospital. Hence the standards COP16 and COP 22 are not applicable for this hospital.

MANAGEMENT OF MEDICATIONS (MOM):

This chapter deals with the pharmacy services provided to the outpatient, inpatient and emergency patients. The organisation has policies and procedures that guide availability,

safe storage .The standards encourage integration of pharmacy into everyday functioning of hospitals and patient care. The pharmacy should guide and audit medication processes and also have an oversight of all medications stocked out of the pharmacy. The pharmacy should ensure correct storage (temperature, light, lookalike, sound-alike etc.,), expiry dates and maintenance of documentation.

The availability of emergency drugs should be stressed upon. The organisation should have a mechanism to ensure emergency medications are standardised throughout the organisation, readily available and replenished in a timely manner. There should be monitoring mechanism to ensure that the required medicines are always stocked and well within expiry dates.

Every high risk medication order should be verified by an appropriate person so as to ensure accuracy of the dose, frequency and route of administration. The "appropriate person" could be another doctor, registered nurse or, a clinical pharmacist. Safe use of high risk medication like narcotics, chemotherapeutic agents and radioactive isotopes are guided by policies and procedures.

The process also includes monitoring of patients after administration and procedures for reporting and analysing medication errors. Patients and family members are educated about safe medication and food-drug interactions . Medications also include blood, implants and devices.

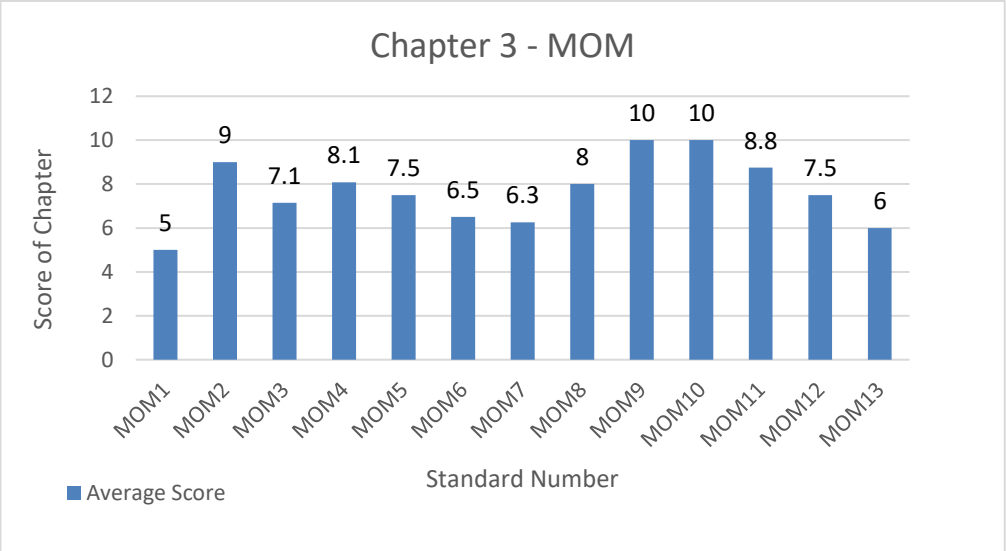

Figure 6.3 Graph showing average score of Management of Medications

Interpretation: On comparing the average scores it was found that MOM1 had the least score i.e., 5.

There is lack of a defined policy regarding obtaining the drugs when the pharmacy is closed. All the designated doctors do not follow the policy of writing the drugs in capitals in the medicine card and prescribing by using the generic name of the drug.

PATIENT RIGHTS AND EDUCATION (PRE):

This chapter deals with educating the patients and their family members regarding their rights and responsibilities and guiding them or provision of utmost care .The hospital defines the patient and family‘s rights and responsibilities.

The staff is aware of these rights and is trained to protect them. Patients are informed of their rights and educated about their responsibilities at the time of admission. They are informed about the disease, the possible outcomes and are involved in decision making. The costs are explained in a clear manner to patient and/or family. Patients are educated about the mechanisms available for addressing grievances. A documented process for obtaining patient and/or families consent exists for informed decision making about their care . Patients and families have a right to seek and get information and education about their healthcare needs in a language and manner that is understood by them .

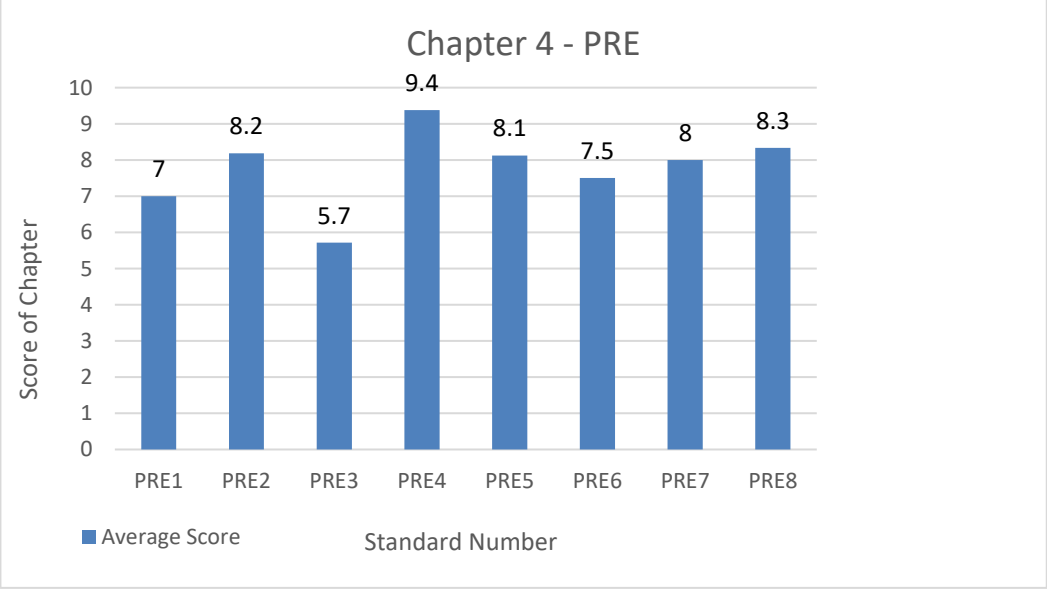

Figure 6.4 Graph showing average score of Patient Rights and Education

On examining the scores for PRE, it was found that PRE 3 had the minimum score of 5.7. The standard deals with educating the patient and/or family members to make informed decisions and involving them in the care planning and delivery process. There are gaps in documentation and implementation of the same. On observing the inpatient areas it was found that regularly the patients and attendants were not being informed about the diagnostic test results, any possible complications etc.

HOSPITAL INFECTION CONTROL (HIC):

This chapter deals with infection control practices and which prevents infections and protects patients, visitors and the employees. The hospital has the provision of effective infection control program in the organisation. The standards guide the provision of an effective healthcare-associated infection prevention and control programme in the organisation. The programme is documented and aims at reducing/eliminating infection risks to patients, visitors and providers of care.

The organisation measures and takes action to prevent or reduce the risk of Healthcare Associated Infection (HAI) in patients and employees. It provides proper facilities and adequate resources to support the Infection Control Programme. The organisation has effective antimicrobial management program through regularly updated antibiotic policy based on local data and monitors its implementation. Program also includes monitoring of antimicrobials usage in the organisation.

The programme includes an action plan to control outbreaks of infection, disinfection/ sterilization activities, biomedical waste (BMW) management, training of staff and employee health.

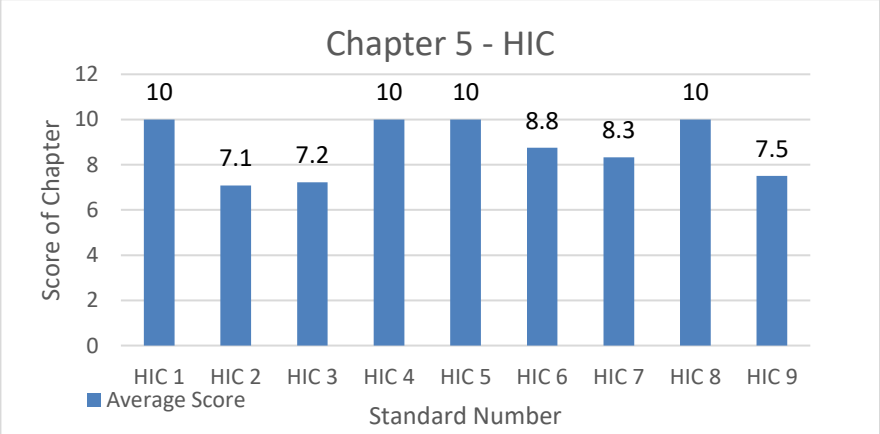

Figure 6.5 Graph depicting the average score for Hospital Infection Control

Interpretation: On analyzing it was found that HIC 2 had minimum score. There was lack in adherence to the hand hygiene practices, kitchen sanitation and food handling practices and management of the laundry and linen. Dirty linen was being carried to the laundry in open trolleys.

The chapter wise average scores based on the available documentation and observation of the involved departments for the patient centric chapters of NABH 4th edition is given below:

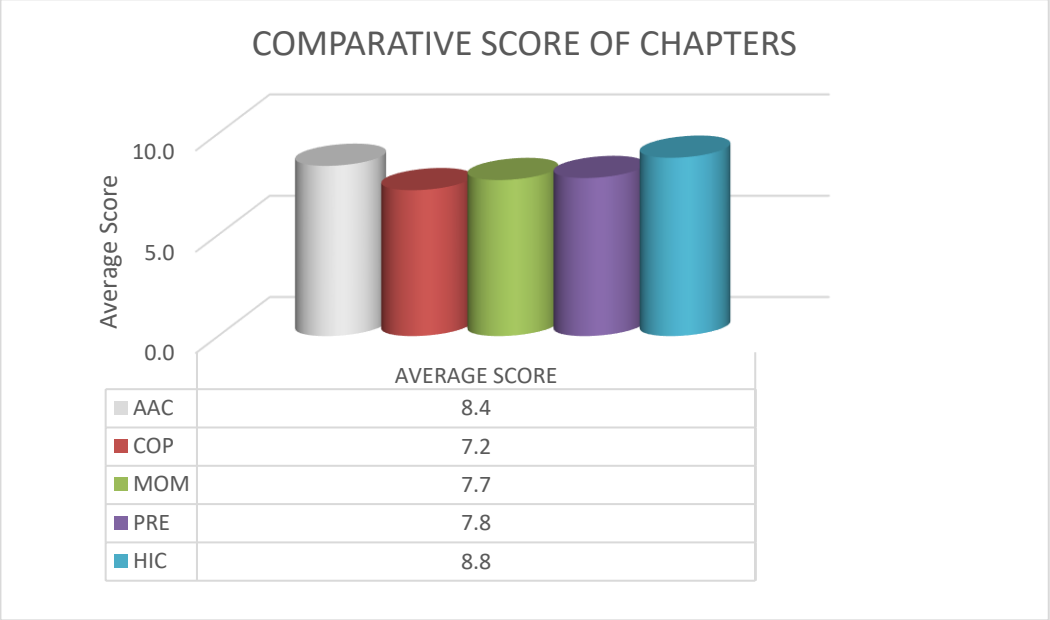

Figure 6.6 Graph depicting the comparative average scores of the patient centric chapters of NABH

It was observed as the graph shows that for all the patient centric chapters the scores were above average, **least score** being **7.2** (**COP Chapter**) & **highest score** being **8.8** (**HIC Chapter**) and the total average score for the patient centric chapters is **8.0**.

Criteria of Evaluation for NABH Accreditation:

1. **No individual standard should have more than one zero to qualify.**
   No individual standard is having more than one zero. COP16 & COP20 have zero score but both these standards are not applicable as they are beyond the current scope of services offered by the hospital.
2. **The average score for individual standard must not be less than 5.**
   The average score for all standards is not less than 5.
3. **The average score for individual chapter must not be less than 7.**
   No individual chapter is having average score less than 7.

CHAPTERS	AVERAGE SCORE
Access, Assessment &Continuity of Care	8.4
Care of Patient	7.2
Management of Medication	7.7
Patient Rights and Education	7.8
Hospital Infection Control	8.8
TOTAL AVERAGE	**8.0**

4. **The overall average score for all standards must exceed 7 .**

   The overall average score for all the patient centric standards is 8, hence exceeding 7.

7. DISCUSSION:

Along with the self-assessment toolkit, data was collected by interviewing the concerned staff, observing the process & working of various departments to find out the issues prevalent throughout the hospital. Along with finding the gaps in the system due to non-conformance with the policies and SOPs, the status of the various findings whether being followed to ensure closure was also monitored. Some of the findings thus generated and status of these are compiled and given below. The following recommendations were given on observing the gaps in conformance to the NABH standards and the status of these were also followed during the duration of the study as given below:

1. Staff training was one of the common finding for most of departments. The staff interviewed was not aware of the Emergency codes, protocol for NSI (needle stick injury), BMW management etc. Meticulously trainings have to be done for employees of all departments (clinical/non clinical) for BMW management, NSI, Emergency codes, Spill management, Hand hygiene protocol etc.

   STATUS: Trainings are being carried out by the HR department on a regular basis.
2. Fire Exit Directional signage have to be placed throughout the hospital.

   STATUS: The designing of the Fire Directional Signage has been done by the Quality department and the designated locations for these signage is yet to be finalised.
3. The staff has to be trained about how to evacuate in case of emergency & fire exit near their respective department areas.

STATUS: Departmental Fire Training has to be started to sensitize the staff about it.

4. It was found that in most of the areas like IPD, ICU & Cath lab the refrigerator temperature log sheets weren't being regularly maintained.
   STATUS: The staff of the respective department have started maintained data for the refrigerator temperature log sheet.
5. Chemicals opened weren't having the date of opening in the 3rd floor IPD. Any chemical opened has to be marked with the date of opening and date of expiry. The refrigerator had patients' sample lying around, medicines were scattered in the rack. Insulin of various patients discharged was lying down in the refrigerator.
   STATUS: The nursing in-charge of the floor instructed the nursing staff to write these dates and segregate each patient's medicine and properly store the medicines in the refrigerator.
6. The refrigerator cleaning protocol was not clear to the OP pharmacy staff. It has to be very clearly communicated to them.
   STATUS: The staff is yet to be trained about the same.
7. In the IPD nursing stations, all the patient files were lying on the nursing station. All files should be kept at the designated places on the file rack available at the nursing station.
   STATUS: All the nursing in-charges have been instructed to make the nursing staff follow this practice. In 3rd floor IPD a new rack has been placed to store the files to avoid cluttering of the nursing station.
8. Forms were lying on the floor in the store at the nursing station. They should be properly stacked so that they are easily accessible when required.
   STATUS: Staff was informed about the same but still in some areas the forms are not being stored properly.
9. **Files Auditing**: there were many gaps in maintaining the patient file in the inpatient area which have to be closed:
   a. Patient identification stickers were missing.
   b. Medicine cards weren't proper filled.
   c. Consents weren't properly filled.
   d. Sequence of the documents according to the MRD checklist was not being maintained for most of the files.
   e. Nurses' notes were written on doctors' progress notes.
   f. Many files had torn forms and sheets.

STATUS: Many deficiencies in the patients' files had been closed when the files were again checked. The patient identification stickers were being used for all files, torn sheet in a file were being replaced or restored. The sequence of filling the documents in the patient file was still not being followed.

10. High value medication register has to be maintained for the IPD (missing in 1st floor IPD).

    STATUS: The register has still not being kept for the 1st floor IPD.

11. Humidifiers were absent in many locations.

    STATUS: Still not placed at many places.

12. Hygrometer was absent in 1st floor IPD.

    STATUS: Still not placed.

13. The clean and dirty utility has to be segregated as it was found during visit in the ward that they were being kept in the same room.

    STATUS: The housekeeping staff was informed about the same and they changed their practice of not keeping the clean utility segregated.

14. All wards should have signage on the various rooms around the nursing station.

    STATUS: The rooms in the IP area have been decided to be used for what purpose but signage are still pending.

15. The hanging directional room signage in the 3rd floor IPD area was wrong and needs to be replaced.

    STATUS: Still pending.

16. Standardisation and availability of various signage and posters depicting BMW waste management, hand hygiene, infection control, spill management, complaint helpline number, directional signage, fire exits, floor directory, patient rights and responsibilities etc. throughout the hospital premises should be taken care of.

    STATUS: The signage for BMW management, spill management, infection control, CMS have been placed at almost all the designated and decided locations from them in throughout the hospital.

17. BMW segregation should be strictly done according to the colour coding and the staff should be aware of the same.

    STATUS: All the clinical and non-clinical is not following the practice of segregating the BMW.

18. Mission, Vision, Quality policy of the hospital has to be displayed in the main reception area of the hospital building.

    STATUS: Still pending.

19. A prayer area has to be made in the OPD/atrium area of the hospital.

    STATUS: Not defined yet.

20. Tariff card should be made available at the admission and counselling counter.

    STATUS: Not made yet.

21. The staff have to be made aware of the various committees like Grievance redressal committee, F.A.W. (Fairness against Workplace Harassment), P.O.S.H (Prevention of sexual harassment) and the escalation matrix to be followed for raising a complaint to these committees.

    STATUS: HR department has not yet started working on it.

22. OPD Prescription audit has to be done by the clinical pharmacist.

    STATUS: Started by the clinical pharmacist.

23. State Retention Guidelines needs to be followed for the retention of OP/IP MRD Documents.

    STATUS: The hospital has written to the State Authority for the same so that the guidelines are known and can be followed in the hospital.

24. Periodic maintenance of the various machines should be done e.g., the defibrillator daily checking, oxygen cylinder checklist, Autoclave checklist.

    STATUS: The biomedical department was looking into the pending maintenance of machines of various departments.

25. The crash cart designated for each specific area should be daily checked and updated by the respective departmental staff as well as periodically checked by the clinical pharmacist. It should have properly labelled drawers, LASA and High concentration Electrolytes drugs properly labelled, near expiry drugs replaced, checking of the defibrillator, oxygen etc. done on a regular basis and data should be maintained for the same.

    STATUS: The clinical pharmacist is regularly checking the crash carts of all areas.

26. The emergency department staff should be aware of transfer summary, Brought Dead policy, MLC case policy of the hospital. Triage Policy should be known to staff and Mock Drills for triage of patients in emergency should be performed.

    STATUS: Quality department has given the format for the transfer summary to the department.

27. All emergency staff should be ACLS trained.

    STATUS: Still pending as all the nursing staff is not ACLS trained but the doctors, nursing in-charge are trained.

28. Initial Assessment: Who does it and the time frame for it should be known to all staff members in emergency and should be strictly adhered to.

    STATUS: Still pending as all the emergency staff is not aware of it.

29. Disaster Drill to be conducted for emergency staffs and training on the same to be provided to all staff. Disaster Kit to be prepared and kept ready.

    STATUS: Still pending.

30. There is no signage or poster showing the scope of services being offered in the hospital at the emergency entrance.

    STATUS: Poster placed.

31. Daily checking of the ambulance has to be done for the medications, expired medications, equipment and data has to be maintained for the same.

    STATUS: Started doing it.

32. Ambulance logbook to be maintained and data to be tracked as to when was ambulance sent for patient pick up (TAT).

    STATUS: Still pending.

33. Ambulance communication protocol should be clear and known to the staff (how the call for patient transport is received, who are supposed to respond to it, defined time frame based patient's need when ambulance leaves, exchange of information etc.).

    STATUS: Still pending.

34. Ambulance record (license or driver, fitness certificate, pollution control certificate, insurance and registration of the vehicle, servicing scheduling etc.).

    STATUS: Still pending.

35. Proper documentation of conscious sedation patient has to be followed in the radiology department and sedation antidote has to be kept.

    STATUS: Antidote is still unavailable and regarding the documentation part, the quality department is working with the radiology department head.

36. The Laboratory needs to maintain the data for the outsource lab visit schedule, reports and the external quality control & proper checking of performance for the outsourced tests.

    STATUS: Still pending but lab in-charge is working on it.

37. Phlebotomist at sample collection area was not aware about discarding of sharp container protocol and the blood drawing protocol was also not displayed at the phlebotomy room.

    STATUS: Still pending.

38. The laboratory staff has to wear full sleeves apron and strictly follow PPE.

    STATUS: The lab staff placed an indent with the store for the aprons but yet to receive the same.

39. List of outsourced tests not displayed in the laboratory.

    STATUS: Display done.

40. Labelling for all machines was not there in the laboratory.

    STATUS: Completed for machines.

41. The clinical staff in all patient care areas should be aware about whom to contact in case of shortage of beds, sedative administration policy, verbal order policy, what steps need to be followed for anaphylaxis, ADR & ADE, disposal of cytotoxic drugs.

    STATUS: The nursing superintendent had been informed to educate all the nursing staff about the same.

42. In the patient care areas like ICU, ITU, HDU need to start maintaining a Narcotics Master Register and it should have the data regarding the amount of narcotics and the patient details to whom it is being administered.

    STATUS: The clinical staff has started maintaining the registers for the Narcotics administered to the patients.

43. The OP pharmacy has to display the list of medications to be kept in refrigerator and the defrosting protocol needs to be known to all staff. Medications requiring 2-8 degree temperature should not be kept in the door of the refrigerators. They need to display the updated license of the pharmacy staff. Packets given to the patients should have doses properly mentioned on them. The products of the company "Himalaya" were at display in the pharmacy which need to be removed.

    STATUS: License of pharmacy staff & refrigerated medicine display is not being done. "Himalaya" products were taken off the shelves.

44. The quality indicator data for various departments should be maintained and updated on a regular basis.

    STATUS: All the department head were informed to start maintain the records for their respective departments. Still pending for some departments.

45. The pharmacy main store in the basement was not maintaining the narcotics register properly and the narcotics were not being kept in double lock.

    STATUS: Still pending.

46. In the day-care chemotherapy ward, cleaning protocol for bio safety cabinet needs to be displayed and data is to be maintained regularly. Bilingual consent for

chemotherapy needs to be developed and a copy of it is to be kept in the doctor's OPD.

STATUS: The cleaning protocol is yet to be displayed for the biosafety cabinet.

47. The housekeeping checklist, water purifier checklist & curtain change protocol (after 15 days) should be known to the staff across the hospital.

    STATUS: The housekeeping manager was appraised of the same and the staff was directed to regularly update this data, change the curtains in all areas periodically.

48. BLS training & induction training of the physiotherapy staff was not done.

    STATUS: Training still pending.

49. Smoke detectors were found to be covered in the chiller plant area and IT server area. The covers have to be removed immediately as it compromises safety.

    STATUS: The smoke detector were found to be still covered in the chiller plant area.

50. Throughout the hospital labelling of the electric panels was not done.

    STATUS: The maintenance department has started labelling the electric panel cabinets in the hospital.

8. CONCLUSION:

The recommendations provided to achieve conformance to the NABH standards have started being looked into by each respective department and steps have been taken to close the gaps in adherence to the NABH standards and guidelines. Policies, SOP and manuals have been prepared but the implementation of these policies has to be done meticulously throughout the hospital. Staff has to be trained on a frequent basis to stress upon following the SOPs, improve the documentation in order to provide quality healthcare services to the patients. The assessment score shows that the patient centric chapters have an above average score which is appreciable as the hospital's systems are still in the process of being placed and getting streamlined. The hospital is doing a commendable job ensuring patient care and safety are being taken care of & in turn adding to the patient loyalty. Quality being a continuous process, by streamlining the processes, reducing the waste and improving efficiency the hospital is on the right path to fulfil its quality goal of achieving accreditation.

9. BIBLIOGRAPHY:

1. Gap Analysis of EHCC hospital as per the NABH standards

   Available from: https://iihmr.edu.in/student-dissertation/2012-2014/gap-analysis-of-ehcc-hospital-as-per-the-nabh-standards

2. NABH 4th Edition.
3. http://blueoceanconsultants.in/2014/08/nabh-gap-analysis/
4. http://nabh.co/BenefitsofAccreditation.aspx
5. Assessment and Gap Analysis of the Mission Hospital, Durgapur according to NABH standards, 3rd edition.

   Available from: https://www.iihmr.edu.in/student-dissertation/2011-2013/Assessment-and-Gap-Analysis-of-the-Mission-Hospital-Durgapur-According-to-NABH-Standards-3rd-Edition

6. Shreedevi D. Hospital preparedness for NABH accreditation with respect to patient rights and education. International Journal of Business Management & Research (IJBMR). 2013 Oct: 1 (3):9-18.
7. Prakash Anjan, Bharadwaj Deepali Medical Audit (Internet). India: Jaypee Brothers Medical Publishers; 2011
8. http://nabh.co/standard.aspx
9. http://nabh.co/faq.aspx
10. "A Success Story" Quality Improvement Programme- Gujarat, India, "An attempt to improve health services in public healthcare centers"
    Available from: https://nrhm.gujarat.gov.in/images/pdf/qip_awards.pdf
11. Dr. Santosh Kumar, Brig (Dr) Swadesh Puri, Dr S.D. Gupta in a study of Gap Analysis Report for Ishtakal Hospital.
12. Dr. Santosh Kumar, Brig (Dr) Swadesh Puri, Dr S.D. Gupta in a study of Gap Analysis Report for a Rehabilitation Centre
13. Gap Assessment Report for Pondicherry Institute of Medical Sciences (2010)

SELF ASSESSMENT TOOLKIT

	Elements	Documentation (Y/N)	Implementation (Yes/ No)	Score (0\5\10)
Chapter 1: ACCESS, ASSESSMENT AND CONTINUITY OF CARE (AAC)				
AAC.1: The organisation defines and displays the healthcare services that it provides.				
a	The healthcare services being provided are clearly defined and are in consonance with the needs of the community.	Y	Y	10
b	Each defined service should have appropriate diagnostics and treatment facilities with suitably qualified personnel who provide out-patient, in-patient and emergency cover.	N	Y	5
c	The defined healthcare services are prominently displayed.	N	Y	5
d	The staff are oriented to these services.	N	Y	5
AAC.2: The organisation has a well-defined registration and admission process.				
a	Documented policies and procedures are used for registering and admitting patients. *	Y	Y	10
b	The documented procedures address out-patients, in-patients and emergency patients. *	Y	Y	10

c	A unique identification number is generated at the end of registration.	Y	Y	10
d	Patients are accepted only if the organisation can provide the required service.	Y	Y	10
e	The documented policies and procedures also address managing patients during non-availability of beds. *	Y	Y	10
f	Access to the healthcare services in the organisation is prioritised according to the clinical needs of the patient.	N	Y	5
g	The staff are aware of these processes.	Y	Y	10
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 organisation. *	Y	N	5
b	Documented policies and procedures guide the transfer-out/referral of unstable patients to another facility in an appropriate manner. *	Y	N	5
c	Documented policies and procedures guide the transfer- out/referral of stable patients to another facility in an appropriate manner. *	Y	N	5
d	The documented procedures identify staff responsible during transfer/referral.*	Y	N	5
e	The organisation gives a summary of patient's condition and the treatment given.	Y	Y	10
AAC.4: Patients cared for by the organisation undergo an established initial assessment.				
a	The organisation defines and documents the content of the initial assessment for the out–patients, in-patients and emergency patients. *	Y	Y	10

b	The organisation determines who can perform the initial assessment. *	Y	Y	10
c	The organisation defines the time frame within which the initial assessment is completed based on patient's needs. *	Y	Y	10
d	The initial assessment for in-patients is documented within 24 hours or earlier as per the patient's condition, as defined in the organisation's policy. *	Y	Y	10
e	Initial assessment of in-patients includes nursing assessment which is done at the time of admission and documented.	Y	Y	10
f	Initial assessment includes screening for nutritional needs.	Y	Y	10
g	The initial assessment results in a documented care plan.	Y	Y	10
h	The care plan reflects desired results of the treatment, care or service.	Y	Y	10
i	The care plan is countersigned by the clinician in-charge of the patient within 24 hours.	Y	Y	10
AAC.5: Patients cared for by the organisation undergo a regular reassessment.				
a	Patients are reassessed at appropriate intervals.	Y	Y	10
b	Out-patients are informed of their next follow-up, where appropriate.	Y	Y	10
c	For in-patients during reassessment the care plan is monitored and modified, where found necessary.	Y	Y	10
d	Staff involved in direct clinical care document reassessments.*	Y	Y	10

e	Patients are reassessed to determine their response to treatment and to plan further treatment or discharge.	Y	Y	10
f	The organisation lays down guidelines and implements processes to identify early warning signs of change or deterioration in clinical conditions for initiating prompt intervention.	Y	Y	10
AAC.6: Laboratory services are provided as per the scope of services of the organisation.				
a	Scope of the laboratory services commensurate to the services provided by the organisation.	Y	Y	10
b	The infrastructure (physical and equipment) is adequate to provide the defined scope of services.	N	Y	5
c	The manpower is adequate to provide the defined scope of services.	N	Y	5
d	Qualified and trained personnel perform, supervise and interpret the investigations.	N	Y	5
e	Documented procedures guide ordering of tests, collection, identification, handling, safe transportation, processing and disposal of specimens. *	Y	Y	10
f	Laboratory results are available within a defined time frame. *	Y	Y	10
g	Critical results are intimated immediately to the personnel concerned. *	Y	Y	10
h	Results are reported in a standardised manner.	Y	Y	10
i	There is a mechanism to address recall / amendment of reports whenever applicable.	N	Y	5
j	Laboratory tests not available in the organisation are outsourced to organisation(s) based on their quality assurance system.*	Y	Y	10

AAC.7: There is an established laboratory quality assurance programme.				
a	The laboratory quality assurance programme is documented. *	Y	Y	10
b	The programme addresses verification and / or validation of test methods. *	Y	Y	10
c	The programme addresses surveillance of test results. *	Y	Y	10
d	The programme includes periodic calibration and maintenance of all equipment.*	Y	Y	10
e	The programme includes the documentation of corrective and preventive actions.*	Y	Y	10
AAC.8: There is an established laboratory safety programme.				
a	The laboratory safety programme is documented. *	Y	Y	10
b	This programme is aligned with the organisation's safety programme.	Y	Y	10
c	Written procedures guide the handling and disposal of infectious and hazardous materials. *	Y	Y	10
d	Laboratory personnel are appropriately trained in safe practices.	N	Y	5
e	Laboratory personnel are provided with appropriate safety equipment/devices.	N	Y	5
AAC.9: Imaging services are provided as per the scope of services of the organisation.				

a	Imaging services comply with legal and other requirements.	Y	Y	10
b	Scope of the imaging services is commensurate to the services provided by the organisation.	Y	Y	5
c	The infrastructure (physical and equipment) and manpower is adequate to provide for its defined scope of services.	N	Y	5
d	Adequately qualified and trained personnel perform, supervise and interpret the investigations.	N	Y	5
e	Documented policies and procedures exist to ensure correct identification and safe and timely transportation of patients to and from the imaging services. *	Y	Y	10
f	Imaging results are available within a defined timeframe. *	Y	Y	10
g	Critical results are intimated immediately to the personnel concerned.*	Y	Y	10
h	Results are reported in a standardised manner.	Y	Y	10
i	There is a mechanism to address recall / amendment of reports whenever applicable.	N	Y	5
j	Imaging tests not available in the organisation are outsourced to organisation(s) based on their quality assurance system.*	N	N	0
AAC.10: There is an established quality assurance programme for imaging services.				
a	The quality assurance programme for imaging services is documented. *	Y	Y	10
b	The programme addresses periodic internal / external peer review of imaging protocols and results using appropriate sampling.	Y	Y	10

c	The programme addresses surveillance of imaging results in collaboration with referring clinicians for follow up wherever applicable *	N	Y	5
d	A system is in place to ensure the appropriateness of the investigations and procedures for the clinical indication.	N	Y	5
	The programme includes periodic calibration and maintenance of all equipment.*	Y	Y	10
e	The programme includes the documentation of corrective and preventive actions.*	Y	Y	10
AAC.11: There is an established safety programme in the Imaging services.				
a	The radiation-safety programme is documented. *	Y	Y	10
b	This programme is aligned with the organisation's safety programme.	Y	Y	10
c	Patients are appropriately screened for safety / risk prior to undergoing an imaging on a particular modality.	Y	Y	10
d	Handling, usage and disposal of radio-active and hazardous materials are as per statutory requirements.	Y	Y	10
e	Imaging personnel and patients are provided with appropriate radiation safety and monitoring devices where applicable.	Y	Y	10
f	Radiation-safety and monitoring devices and are periodically tested and results are documented.*	Y	Y	10
g	Imaging and ancillary personnel are trained in imaging safety practices and radiation-safety measures.	N	Y	5
h	Imaging signage are prominently displayed in all appropriate locations.	Y	Y	10

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	Y	10
b	Care of patients is coordinated in all care settings within the organisation.	N	Y	5
c	Information about the patient's care and response to treatment is shared among medical, nursing and other care-providers.	N	Y	5
d	Information is exchanged and documented during each staffing shift, between shifts, and during transfers between units/departments.	Y	Y	10
e	Transfers between departments/units are done in a safe manner.	Y	Y	10
f	The patient's record(s) is available to the authorised care-providers to facilitate the exchange of information.	Y	Y	10
g	Documented procedures guide the referral of patients to other departments/ specialities. *	Y	Y	10
h	The organisation ensures continuity of care while adhering to defined timelines and informs the caregiver and/or the patient/family whenever there is a change in schedule.	N	Y	5
i	The organisation has a mechanism in place to monitor whether adequate clinical intervention has taken place in response to a critical value alert.	N	Y	5
AAC.13: The organisation has a documented discharge process.				
a	The patient's discharge process is planned in consultation with the patient and/or family.	N	Y	5

b	Documented procedures exist for coordination of various departments and agencies involved in the discharge process (including medico-legal and absconded cases). *	Y	Y	10
c	Documented policies and procedures are in place for patients leaving against medical advice and patients being discharged on request. *	Y	Y	10
d	A discharge summary is given to all the patients leaving the organisation (including patients leaving against medical advice and on request).	N	Y	5
e	The organisation defines the time taken for discharge and monitors the same.	N	Y	5
AAC.14: Organisation defines the content of the discharge summary.				
a	Discharge summary is provided to the patients at the time of discharge.	Y	Y	10
b	Discharge summary contains the patient's name, unique identification number, date of admission and date of discharge.	Y	Y	10
c	Discharge summary contains the reasons for admission, significant findings and diagnosis and the patient's condition at the time of discharge.	Y	Y	10
d	Discharge summary contains information regarding investigation results, any procedure performed, medication administered and other treatment given.	Y	Y	10
e	Discharge summary contains follow-up advice, medication and other instructions in an understandable manner.	Y	Y	10
f	Discharge summary incorporates instructions about when and how to obtain urgent care.	Y	Y	10
g	In case of death, the summary of the case also includes the cause of death.	Y	Y	10

Chapter 2: CARE OF PATIENTS (COP)

COP.1: Uniform care to patients is provided in all settings of the organisation 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	10
b	Uniform care is guided by documented policies and procedures.	N	Y	5
c	These reflect applicable laws, regulations and guidelines.	N	Y	5
d	The organisation adapts evidence-based medicine and clinical practice guidelines to guide uniform patient care.	N	Y	5

COP.2: Emergency services are guided by documented policies, procedures, applicable laws and regulations.

a	There shall be an identified area in the organisation which is easily accessible to receive and manage emergency patients.	N	Y	5
b	Policies and procedures for emergency care are documented and are in consonance with statutory requirements. *	Y	Y	10
c	This also addresses handling of medico-legal cases. *	Y	Y	10
d	The patients receive care in consonance with the policies.	N	Y	5
e	Documented policies and procedures guide the triage of patients for initiation of appropriate care. *	Y	Y	10

f	Staff are familiar with the policies and trained on the procedures for care of emergency patients.	N	Y	5
g	Admission or discharge to home or transfer to another organisation is also documented.	Y	Y	10
h	In case of discharge to home or transfer to another organisation, a discharge note shall be given to the patient.	Y	Y	10
i	Quality assurance programmes are documented and implemented.	N	Y	5
j	The documented policies and procedures guide management of patients found dead on arrival to the hospital.*	Y	Y	10
COP.3: The ambulance services are commensurate with the scope of the services provided by the organisation.				
a	There is adequate access and space for the ambulance(s).	Y	Y	10
b	The ambulance adheres to statutory requirements.	Y	Y	10
c	The ambulance(s) is appropriately equipped.	N	Y	5
d	The ambulance(s) is manned by trained personnel.	N	Y	5
e	The ambulance(s) is checked on a daily basis.	N	Y	5
f	Equipment are checked on a daily basis using a checklist.*	Y	Y	10
g	Emergency medications are checked daily and prior to dispatch using a checklist.	N	Y	5

h	The ambulance(s) has a proper communication system.	N	Y	5
i	The emergency department identifies opportunities to initiate treatment at the earliest when the patient is in transit to the organisation.	N	Y	5
COP.4: The organisation plans for handling community emergencies, epidemics and other disasters.				
a	The organisation identifies potential emergencies. *	Y	Y	10
b	The organisation has a documented disaster management plan. *	Y	Y	10
c	Provision is made for availability of medical supplies, equipment and materials during such emergencies.	N	Y	5
d	Staff are trained in the hospital's disaster management plan.	N	Y	5
e	The plan is tested at least twice a year.	N	Y	5
COP.5: Documented policies and procedures guide the care of patients requiring cardio-pulmonary resuscitation.				
a	Documented policies and procedures guide the uniform use of resuscitation throughout the organisation. *	Y	Y	10
b	Staff providing direct patient care are trained and periodically updated in cardio-pulmonary resuscitation.	N	Y	5
c	The events during a cardiopulmonary resuscitation are recorded.	Y	Y	10
d	A post-event analysis of all cardiopulmonary resuscitations is done by a multidisciplinary committee.	Y	Y	10

e	Corrective and preventive measures are taken based on the post-event analysis.	N	N	0
COP.6: Documented policies and procedures guide nursing care.				
a	There are documented policies and procedures for all activities of the nursing services. *	Y	Y	10
b	These reflect current standards of nursing services and practice, relevant regulations and purposes of the services.	N	Y	5
c	Assignment of patient care is done as per current good practice guidelines.	N	Y	5
d	Nursing care is aligned and integrated with overall patient care.	N	Y	5
e	Care provided by nurses is documented in the patient record.*	Y	Y	10
f	Nurses are provided with adequate equipment for providing safe and efficient nursing services.	N	Y	5
g	Nurses are empowered to take nursing-related decisions to ensure the timely care of patients.	N	Y	5
COP.7: Documented procedures guide the performance of various procedures.				
a	Documented procedures are used to guide the performance of various clinical procedures. *	Y	Y	10
b	Only qualified personnel order, plan, perform and assist in performing procedures.	N	Y	5
c	Documented procedures exist to prevent adverse events like a wrong site, wrong patient and wrong procedure. *	Y	Y	10
d	Informed consent is taken by the personnel performing the procedure, where applicable.	N	Y	5

e	Adherence to standard precautions and asepsis is adhered to during the conduct of the procedure.	N	Y	5
f	Patients are appropriately monitored during and after the procedure.	N	Y	5
g	Procedures are documented accurately in the patient record.*	Y	Y	10
COP.8: Documented policies and procedures define rational use of blood and blood components.				
a	Documented policies and procedures are used to guide the rational use of blood and blood components. *	Y	Y	10
b	Documented procedures govern transfusion of blood and blood components. *	Y	Y	10
c	The transfusion services are governed by the applicable laws and regulations.	N	Y	5
d	Informed consent is obtained for donation and transfusion of blood and blood components.	Y	Y	10
e	Informed consent also includes patient and family education about the donation.	Y	Y	10
f	The organisation defines the process for availability and transfusion of blood/blood components for use in emergency situations.*	Y	Y	10
g	Post-transfusion form is collected, reactions if any identified and are analysed for preventive and corrective actions.	N	Y	5
h	Staff are trained to implement the policies.	N	Y	5
COP.9: 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	10
b	The organisation has documented admission and discharge criteria for its intensive care and high dependency units. *	Y	Y	10
c	Staff are trained to apply these criteria.	N	Y	5
d	Adequate staff and equipment are available.	N	Y	5
e	Defined procedures for the situation of bed shortages are followed. *	Y	Y	10
f	Infection control practices are documented and followed. *	Y	Y	10
g	A quality assurance programme is documented and implemented.*	Y	Y	10
h	Patients and families are counselled by the treating medical professional at periodic intervals and when there is a significant change in the condition of the patient, and same is documented.*	N	Y	5
COP.10: Documented policies and procedures guide the care of vulnerable patients.				
a	Policies and procedures are documented and are in accordance with the prevailing laws and the national and international guidelines. *	Y	Y	10
b	Care is organised and delivered in accordance with the policies and procedures.	N	Y	5
c	The organisation provides for a safe and secure environment for the vulnerable group.	Y	Y	10

d	A documented procedure exists for obtaining informed consent from the appropriate legal representative. *	Y	Y	10
e	Staff are trained to care for this vulnerable group.	N	Y	5
COP.11: Documented policies and procedures guide obstetric care.				
a	There is a documented policy and procedure for obstetric services. *	Y	Y	10
b	The organisation defines and displays whether high-risk obstetric cases can be cared for or not.	N	Y	5
c	Persons caring for high-risk obstetric cases are competent.	N	Y	5
d	Documented procedures guide the provision of ante-natal services. *	Y	Y	10
e	Obstetric patient's assessment also includes maternal nutrition.	N	Y	5
f	Appropriate pre-natal, peri-natal and post-natal monitoring is performed and documented.*	Y	Y	10
g	The organisation caring for high-risk obstetric cases has the facilities to take care of neonates of such cases.	N	Y	5
COP.12: Documented policies and procedures guide paediatric services.				
a	There is a documented policy and procedure for paediatric services. *	Y	Y	10

b	The organisation defines and displays the scope of its paediatric services.	N	Y	5
c	The policy for care of neonatal patients is in consonance with the national/ international guidelines. *	Y	Y	10
d	Those who care for children have age-specific competency.	N	Y	5
e	Provisions are made for special care of children.	N	Y	5
f	Patient assessment includes detailed nutritional, growth, developmental and immunisation assessment.	Y	Y	10
g	Documented policies and procedures prevent child/neonate abduction and abuse. *	NA	NA	0
h	The children's family members are educated about nutrition, immunisation and safe parenting and this is documented.*	Y	Y	10
COP.13: Documented policies and procedures guide the care of patients undergoing moderate sedation.				
a	Documented procedures guide the administration of moderate sedation. *	Y	Y	10
b	Informed consent for administration of moderate sedation is obtained.	Y	Y	10
c	Competent and trained persons perform sedation.	N	Y	5
d	The person administering and monitoring sedation is different from the person performing the procedure.	N	Y	5

e	Intra-procedure monitoring includes at a minimum the heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation, and level of sedation.	N	Y	5
f	Patients are monitored after sedation and the same documented.*	N	Y	5
g	Criteria are used to determine appropriateness of discharge from the observation/recovery area. *	N	Y	5
h	Equipment and manpower are available to manage patients who have gone into a deeper level of sedation than initially intended.	N	N	0
COP.14: Documented policies and procedures guide the administration of anaesthesia.				
a	There is a documented policy and procedure for the administration of anaesthesia. *	Y	Y	10
b	Patients for anaesthesia have a pre-anaesthesia assessment by a qualified anaesthesiologist.	Y	Y	10
c	The pre-anaesthesia assessment results in formulation of an anaesthesia plan which is documented.	Y	Y	10
d	An immediate preoperative re-evaluation is performed and documented.	Y	Y	10
e	Informed consent for administration of anaesthesia is obtained by the anaesthesiologist..	Y	Y	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	10
g	Patient’s post-anaesthesia status is monitored and documented.	Y	Y	10

h	The anaesthesiologist applies defined criteria to transfer the patient from the recovery area. *	N	Y	5
i	The type of anaesthesia and anaesthetic medications used are documented in the patient record.*	Y	Y	10
j	Procedures shall comply with infection control guidelines to prevent cross-infection between patients.	N	Y	5
k	Adverse anaesthesia events are recorded and monitored.	Y	Y	10
COP.15: Documented policies and procedures guide the care of patients undergoing surgical procedures.				
a	The policies and procedures are documented. *	Y	Y	10
b	Surgical patients have a preoperative assessment and a provisional diagnosis documented prior to surgery.	N	Y	5
c	An informed consent is obtained by a surgeon prior to the procedure.	Y	Y	10
d	Documented policies and procedures exist to prevent adverse events like wrong site, wrong patient and wrong surgery. *	Y	Y	10
e	Persons qualified by law are permitted to perform the procedures that they are entitled to perform.	N	Y	5
f	A brief operative note is documented prior to transfer out of patient from recovery area.	Y	Y	10
g	The operating surgeon documents the postoperative care plan.	N	Y	5

h	Patient, personnel and material flow conform to infection control practices.	N	Y	5
i	Appropriate facilities and equipment/appliances/instrumentation are available in the operating theatre.	N	Y	5
j	A quality assurance programme is followed for the surgical services. *	Y	Y	10
k	The quality assurance programme includes surveillance of the operation theatre environment. *	Y	Y	10
COP.16: Documented policies and procedures guide organ transplant programme in the organisation.				
a	The organ transplant program shall be in consonance with the legal requirements and shall be conducted in an ethical manner.			0
b	Documented policies and procedures guide the organ transplant program.*			0
c	The organisation ensures education and counselling of recipient and donor through trained / qualified counsellors before organ transplantation.			0
d	The organisation shall take measures to create awareness regarding organ donation.			0
COP.17: Documented policies and procedures guide the care of patients under restraints (physical and/or chemical).				
a	Documented policies and procedures guide the care of patients under restraints. *	Y	Y	10
b	The policies and procedures include both physical and chemical restraint measures.	Y	Y	10

c	The reasons for restraints are documented.	Y	Y	10
d	Patients on restraints are more frequently monitored.	N	N	0
e	Staff receives training and periodic updating in control and restraint techniques.	N	Y	5
COP.18: Documented policies and procedures guide appropriate pain management.				
a	Documented policies and procedures guide the management of pain. *	Y	Y	10
b	All patients are screened for pain.	Y	Y	10
c	Patients with pain undergo detailed assessment and periodic reassessment.	Y	Y	10
d	Pain alleviation measures or medications are initiated and titrated according to patient's need and response.	N	Y	5
e	The organisation respects and supports management of pain for such patients.	N	Y	5
f	Patient and family are educated on various pain management techniques, where appropriate.	Y	Y	10
COP.19: Documented policies and procedures guide appropriate rehabilitative services.				
a	Documented policies and procedures guide the provision of rehabilitative services. *	Y	Y	10

b	These services are commensurate with the organisational requirements.	N	Y	5
c	Care is guided by functional assessment and periodic re-assessment which is done and documented by qualified individual(s).	Y	Y	10
d	Care is provided adhering to infection control and safe practices.	N	Y	5
e	Rehabilitative services are provided by a multidisciplinary team.	N	Y	5
f	There is adequate space and equipment to perform these activities.	N	Y	5
COP.20: Documented policies and procedures guide all research activities.				
a	Documented policies and procedures guide all research activities in compliance with regulatory, national and international guidelines. *			0
b	The organisation has an ethics committee to oversee all research activities.			0
c	The committee has the powers to discontinue a research trial when risks outweigh the potential benefits.			0
d	Patient's informed consent is obtained before entering them in research protocols.			0
e	Patients are informed of their right to withdraw from the research at any stage and also of the consequences (if any) of such withdrawal.			0
f	Patients are assured that their refusal to participate or withdrawal from participation will not compromise their access to the organisation's services.			0

COP.21: Documented policies and procedures guide nutritional therapy.				
a	Documented policies and procedures guide nutritional therapy including assessment and reassessment. *	Y	Y	10
b	Nutritional therapy is planned and provided in a collaborative manner.	Y	Y	10
c	There is a written order for the diet.	N	Y	5
d	Patients receive food according to their clinical needs.	N	Y	5
e	Food is prepared, handled, stored and distributed in a safe manner.	N	Y	5
f	When families provide food, they are educated about the patient's diet limitations.	Y	Y	10
COP.22: Documented policies and procedures guide the end of life care.				
a	Documented policies and procedures guide the end of life care. *	Y	Y	10
b	These policies and procedures are in consonance with the legal requirements.	Y	N	5
c	These also address the identification of the unique needs of such patient and family.	N	Y	5
d	Symptomatic treatment is provided and where appropriate measures are taken for the alleviation of pain.	N	Y	5

e	Staff are educated and trained in end of life care.	N	N	0
Chapter 3: Management of Medication (MOM)				
MOM.1: Documented policies and procedures guide the organisation of pharmacy services and usage of medication.				
a	There is a documented policy and procedure for pharmacy services and medication usage.*	Y	Y	10
b	Policies and procedures comply with the applicable laws and regulations.	N	Y	5
c	A multidisciplinary committee guides the formulation and implementation of these policies and procedures.*	N	Y	5
d	There is a procedure to obtain medication when the pharmacy is closed.*	N	N	0
MOM.2. There is a hospital formulary.				
a	A list of medications appropriate for the patients and as per the scope of the organisation's clinical services is developed collaboratively by the multidisciplinary committee.	Y	Y	10
b	The list is reviewed and updated collaboratively by the multidisciplinary committee at least annually.	N	Y	5
c	The formulary is available for clinicians to refer and adhere to.	Y	Y	10

d	There is a defined process for acquisition of these medications*	Y	Y	10
e	There is a process to obtain medications not listed in the formulary. *	Y	Y	10
MOM.3: Documented policies and procedures guide the storage of medication.				
a	Documented policies and procedures exist for storage of medication. *	Y	Y	10
b	Medications are stored in a clean, safe and secure environment; and incorporating manufacturer's recommendation(s).	N	Y	5
c	Sound inventory control practices guide storage of the medications in all areas throughout the organisation.	Y	N	5
d	Look-alike and Sound-alike medications are identified and stored physically apart from each other.*	Y	Y	10
e	The list of emergency medications is defined and is stored in a uniform manner.*	Y	Y	10
f	Emergency medications are available all the time.	N	Y	5
g	Emergency medications are replenished in a timely manner when used.	N	Y	5
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	10

b	These incorporate inclusion of good practices/guidelines for rational prescription of medications.	N	Y	5
c	The organisation determines the minimum requirements of a prescription.*	N	N	0
d	Known drug allergies are ascertained before prescribing.	Y	Y	10
e	The organisation determines who can write orders.*	Y	Y	10
f	Orders are written in a uniform location in the medical records which also reflects patient's name and unique identification number.	Y	Y	10
g	Medication orders are clear, legible, dated, timed, named and signed.	Y	Y	10
h	Medication orders contain the name of the medicine, route of administration, dose to be administered and frequency/time of administration.	Y	Y	10
i	Documented policy and procedure on verbal orders is implemented.*	Y	Y	10
j	The organisation defines a list of high-risk medication(s).*	Y	Y	10
k	Audit of medication orders/prescription is carried out to check for safe and rational prescription of medications.	Y	Y	10
l	Reconciliation of medications occur at transition points of patient care.	N	Y	5
m	Corrective and/or preventive action(s) is taken based on the analysis, where appropriate.	N	Y	5
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	10
b	The procedure addresses medication recall.*	N	Y	5
c	Expiry dates are checked prior to dispensing.	N	Y	5
d	There is a procedure for near expiry medications.*	N	Y	5
e	Labelling requirements are documented and implemented by the organisation.*	Y	Y	10
f	High-risk medication orders are verified prior to dispensing.	Y	Y	10
MOM.6: There are documented policies and procedures for medication administration.				
a	Medications are administered by those who are permitted by law to do so.	Y	Y	10
b	Prepared medication is labelled prior to preparation of a second drug.	Y	Y	10
c	Patient is identified prior to administration.	N	Y	5
d	Medication is verified from the order and physically inspected prior to administration.	Y	N	5
e	Dosage is verified from the order prior to administration.	N	Y	5

f	Route is verified from the order prior to administration.	N	Y	5
g	Timing is verified from the order prior to administration.	N	Y	5
h	Medication administration is documented.	Y	Y	10
i	Documented policies and procedures govern patient's self-administration of medications. *	N	N	0
j	Documented policies and procedures govern patient's own medications brought from outside the organisation.*	Y	Y	10
MOM.7: Patients are monitored after medication administration.				
a	Documented policies and procedures guide the monitoring of patients after medication administration.*	Y	Y	10
b	The organisation defines those situations where close monitoring is required.*	Y	N	5
c	Monitoring is done in a collaborative manner.	N	Y	5
d	Medications are changed where appropriate based on the monitoring.	N	Y	5
MOM.8: Near misses, medication errors and adverse drug events are reported and analysed.				
a	Documented procedure exists to capture near miss, medication error and adverse drug event.*	Y	Y	10

b	Near miss, medication error and adverse drug event are defined.*	Y	Y	10
c	These are reported within a specified time frame. *	N	Y	5
d	They are collected and analysed.	Y	Y	10
e	Corrective and/or preventive action(s) are taken based on the analysis where appropriate.	N	Y	5
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	Y	10
b	These drugs are stored in a secure manner.	Y	Y	10
c	A proper record is kept of the usage, administration and disposal of these drugs.	Y	Y	10
d	These drugs are handled by appropriate personnel in accordance with the documented procedure.	Y	Y	10
MOM.10: Documented policies and procedures guide the usage of chemotherapeutic agents.				
a	Documented policies and procedures guide the usage of chemotherapeutic agents.*	Y	Y	10
b	Chemotherapy is prescribed by those who have the knowledge to monitor and treat the adverse effect of chemotherapy.	Y	Y	10

c	Chemotherapy is prepared in a proper and safe manner and administered by qualified personnel.	Y	Y	10
d	Chemotherapy drugs are disposed in accordance with legal requirements.	Y	Y	10
e	Patient and family are educated regarding benefits/risks of chemotherapy, precautions to be taken and possible adverse reactions.	Y	Y	10
MOM.11: Documented policies and procedures govern usage of radioactive drugs.				
a	Documented policies and procedures govern usage of radioactive drugs.*	Y	Y	10
b	These policies and procedures are in consonance with laws and regulations.	Y	Y	10
c	The policies and procedures include the safe storage, preparation, handling, distribution and disposal of radioactive drugs.	Y	Y	10
d	Staff, patients and visitors are educated on safety precautions.	N	Y	5
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 recognised guidelines/ approvals for such specific item(s).	N	Y	5
b	Documented policies and procedures govern procurement, storage/stocking, issuance and usage of implantable prosthesis and medical devices incorporating manufacturer's recommendation(s).*	Y	Y	10

c	Patient and his/her family are counselled for the usage of implantable prosthesis and medical device including precautions, if any.	N	Y	5
d	The batch and serial number of the implantable prosthesis and medical devices are recorded in the patient's medical record, the master logbook and the discharge summary.	Y	Y	10
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	Y	10
b	Medical supplies and consumables are used in a safe manner, where appropriate.	N	Y	5
c	Medical supplies and consumables are stored in a clean, safe and secure environment; and incorporating manufacturer's recommendation(s).	N	Y	5
d	Sound inventory control practices guide storage of medical supplies and consumables.	N	Y	5
e	There is a mechanism in place to verify the condition of medical supplies and consumables.	N	Y	5
Chapter 4: Patient Rights and Education (PRE)				
PRE.1. The organisation 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	Y	10
b	Patients and families are informed of their rights and responsibilities in a format and language that they can understand.	Y	Y	10

c	The organisation's leaders protect patient and family rights.	N	Y	5
d	Staff are aware of their responsibility in protecting patient and family rights.	N	Y	5
e	Violation of patient and family rights is recorded, reviewed and corrective/preventive measures taken.	N	Y	5
PRE.2: Patient and family rights support individual beliefs, values and involve the patient and family in decision making processes.				
a	Patients and family rights include respecting any special preferences, spiritual and cultural needs.	N	Y	5
b	Patient and family rights include respect for personal dignity and privacy during examination, procedures and treatment.	Y	Y	10
c	Patient and family rights include protection from neglect or abuse.	N	Y	5
d	Patient and family rights include treating patient information as confidential.	Y	Y	10
e	Patient and family rights include refusal of treatment.	N	Y	5
f	Patient and family have a right to seek an additional opinion regarding clinical care.	N	Y	5
g	Patient and family rights include informed consent before transfusion of blood and blood components, anaesthesia, surgery, initiation of any research protocol and any other invasive / high risk procedures / treatment.	Y	Y	10
h	Patient and family rights include right to complain and information on how to voice a complaint	Y	Y	10

i	Patient and family rights include information on the expected cost of the treatment.	Y	Y	10
j	Patient and family rights include access to his / her clinical records.	Y	Y	10
k	Patient and family rights include information on Care plan, progress and information on their health care needs.	Y	Y	10
PRE.3: The patient and/or family members are educated to make informed decisions and are involved in the care planning and delivery process.				
a	The patient and/or family members are explained about the proposed care including the risks, alternatives and benefits.	N	Y	5
b	The patient and/or family members are explained about the expected results.	N	Y	5
c	The patient and/or family members are explained about the possible complications.	N	Y	5
d	The care plan is prepared and modified in consultation with patient and/or family members.	N	Y	5
e	The care plan respects and where possible incorporates patient and/or family concerns and requests.	N	Y	5
f	The patient and/or family members are informed about the results of diagnostic tests and the diagnosis.	N	Y	5
g	The patient and/or family members are explained about any change in the patient's condition in a timely manner.	Y	Y	10
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	10
b	General consent for treatment is obtained when the patient enters the organisation.	Y	Y	10
c	Patient and/or his family members are informed of the scope of such general consent.	N	Y	5
d	Informed consent includes information regarding the procedure, its risks, benefits, alternatives and as to who will perform the procedure in a language that they can understand.	Y	Y	10
e	The procedure describes who can give consent when patient is incapable of independent decision making.*	Y	Y	10
f	Informed consent is taken by the person performing the procedure.	Y	Y	10
g	Informed consent process adheres to statutory norms.	Y	Y	10
h	Staff are aware of the informed consent procedure.	Y	Y	10
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	Y	10
b	Patient and/or family are educated about food-drug interaction	N	Y	5
c	Patient and/or family are educated about diet and nutrition.	Y	Y	10
d	Patient and/or family are educated about immunisations.	Y	Y	10
e	Patient and/or family are educated about their specific disease process, complications and prevention strategies.	Y	N	5

f	Patient and/or family are educated about preventing healthcare associated infections	Y	N	5
g	The patients and/or family members' special educational needs are identified and addressed	Y	Y	10
h	Patient and/or family are educated in a language and format that they can understand.	Y	Y	10
PRE.6: Patients and families have a right to information on expected costs.				
a	There is a uniform pricing policy in a given setting (out-patient and ward category).	Y	Y	10
b	The relevant tariff list is available to patients.	Y	Y	10
c	The patient and/or family members are explained about the expected costs.	N	Y	5
d	Patient and/or family are informed about the financial implications when there is a change in the patient condition or treatment setting.	N	Y	5
PRE.7: The organisation has a mechanism to capture patient's feedback and redressal of complaints.				
a	The organisation has a mechanism to capture feedbacks from patients which includes patient satisfaction and patient's experience.	Y	Y	10
b	The organisation has a documented complaint redressal procedure.*	Y	Y	10
c	Patient and/or family members are made aware of the procedure for giving feedback and /or lodging complaints.	Y	N	5
d	All feedback and complaints are reviewed and/or analysed within a defined time frame.	Y	N	5
e	Corrective and/or preventive action(s) are taken based on the analysis where appropriate.	Y	Y	10

PRE.8: The organisation has a system for effective communication with patients and /or families.				
a	Documented policies and procedures guide the effective communication with the patients and/or families.*	Y	Y	10
b	The organisation shall identify special situations where enhanced communication would be required.*	Y	Y	10
c	The organisation lays down an approach for effective communication in these identified situations.	N	Y	5
d	The organisation also defines what constitutes an unacceptable communication and sensitizes the staff about the same.*	Y	Y	10
e	The organisation has a system to monitor and review the implementation of effective communication	Y	N	5
f	The staff are trained in healthcare communication techniques periodically.	Y	Y	10
Chapter 5: Hospital Infection Control (HIC)				
HIC.1: The organisation 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 the risk of healthcare associated infections in all areas of the hospital.*	Y	Y	10
b	The infection prevention and control programme is a continuous process and updated at least once in a year.	Y	Y	10

c	The hospital has a multi-disciplinary infection control committee, which co-ordinates all infection prevention and control activities.*	Y	Y	10
d	The hospital has an infection control team, which coordinates implementation of all infection prevention and control activities.*	Y	Y	10
e	The hospital has designated infection control officer as part of the infection control team.*	Y	Y	10
f	The hospital has designated infection control nurse(s) as part of the infection control team.*	Y	Y	10
HIC.2: The organisation implements the policies and procedures laid down in the Infection Control Manual in all areas of the hospital.				
a	The organisation identifies the various high-risk areas and procedures and implements policies and/or procedures to prevent infection in these areas. *	Y	Y	10
b	The organisation adheres to standard precautions at all times.*	Y	N	5
c	The organisation adheres to hand-hygiene guidelines. *	Y	N	5
d	The organisation adheres to transmission-based precautions at all times.*	Y	Y	10
e	The organisation adheres to safe injection and infusion practices.*	Y	Y	10
f	The organisation adheres to cleaning, disinfection and sterilization practices.*	Y	Y	10
g	An appropriate antibiotic policy is established and documented *	Y	Y	10

h	The organisation implements the antibiotic policy and monitors rational use of antimicrobial agents.	Y	N	5
i	The organisation adheres to laundry and linen management processes.*	N	Y	5
j	The organisation adheres to kitchen sanitation and food-handling issues.*	N	Y	5
k	The organisation has appropriate engineering controls to prevent infections. *	N	Y	5
l	The organisation adheres to housekeeping procedures.*	N	Y	5
HIC.3: The organisation 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	10
b	A collection of surveillance data is an on-going process.	Y	N	5
c	Verification of data is done on a regular basis by the infection control team.	Y	N	5
d	The scope of surveillance activities incorporates tracking and analysing of infection risks, rates and trends.	Y	Y	10
e	Surveillance activities include monitoring the compliance with hand-hygiene guidelines.	Y	N	5
f	Surveillance activities include mechanisms to capture the occurrence of epidemiological significant diseases and multi-drug-resistant organisms, and highly virulent infections.	Y	N	5
g	Surveillance activities include monitoring the effectiveness of housekeeping services.	Y	N	5

h	Appropriate feedback regarding healthcare associated infection (HAIs) rates is provided on a regular basis to appropriate personnel.	Y	Y	10
i	In cases of notifiable diseases, information (in relevant format) is sent to appropriate authorities.	Y	Y	10
HIC.4: The organisation takes actions to prevent and control Healthcare Associated Infections (HAI) in patients.				
a	The organisation takes action to prevent catheter associated urinary tract Infections.	Y	Y	10
b	The organisation takes action to prevent Ventilator Associated Pneumonia.	Y	Y	10
c	The organisation takes action to prevent catheter linked blood stream infections.	Y	Y	10
d	The organisation takes action to prevent surgical site infections.	Y	Y	10
HIC.5: The organisation provides adequate and appropriate resources for prevention and control of Healthcare Associated Infections (HAI).				
a	Adequate and appropriate personal protective equipment, soaps, and disinfectants are available and used correctly.	Y	Y	10
b	Adequate and appropriate facilities for hand hygiene in all patient-care areas are accessible to healthcare providers.	Y	Y	10
c	Isolation/barrier nursing facilities are available.	Y	Y	10

d	Appropriate pre- and post-exposure prophylaxis is provided to all staff members concerned.*	Y	Y	10
HIC.6: The organisation identifies and takes appropriate action to control outbreaks of infections.				
a	Organisation has a documented procedure for identifying an outbreak.*	Y	Y	10
b	Organisation has a documented procedure for handling such outbreaks.*	Y	Y	10
c	This procedure is implemented during outbreaks.	Y	Y	10
d	After the outbreak is over appropriate corrective actions are taken to prevent recurrence.	N	Y	5
HIC.7: There are documented policies and procedures for sterilization activities in the organisation.				
a	The organisation provides adequate space and appropriate zoning for sterilization activities.	Y	Y	10
b	Documented procedure guides the cleaning, packing, disinfection and/or sterilization, storing and issue of items.*	Y	Y	10
c	Reprocessing of instruments and equipment are covered.*	N	Y	5
d	The organisation shall have a documented policy and procedure for reprocessing of devices whenever applicable.*	Y	Y	10
e	Regular validation tests for sterilization are carried out and documented.*	Y	Y	10
f	There is an established recall procedure when breakdown in the sterilization system is identified.*	Y	N	5

HIC.8: Biomedical waste (BMW) is handled in an appropriate and safe manner.				
a	The organisation adheres to statutory provisions with regard to biomedical waste.	Y	Y	10
b	Proper segregation and collection of biomedical waste from all patient-care areas of the hospital is implemented and monitored.	Y	Y	10
c	The organisation ensures that biomedical waste is stored and transported to the site of treatment and disposal in properly covered vehicles within stipulated time limits in a secure manner.	Y	Y	10
d	The biomedical waste treatment facility is managed as per statutory provisions (if in- house) or outsourced to authorized contractor(s).	Y	Y	10
e	Appropriate personal protective measures are used by all categories of staff handling biomedical waste.	Y	Y	10
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.	N	Y	5
b	The organisation earmarks adequate funds from its annual budget in this regard.	N	Y	5
c	The organisation conducts induction training for all staff.	Y	Y	10
d	The organisation conducts appropriate “in-service” training sessions for all staff at least once in a year.	Y	Y	10