Gap Analysis of a Multi-Specialty Hospital

By

Bhavana Methwani

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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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. Bhavana Methwani student of MBA Hospital and Health Management from The IIHMR University, Jaipur has undergone internship training at Wockhardt Super specialty hospital, Nagpur from 1st Feb 2017 to 1st may 2017.

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

I wish him all success in all his future endeavors.

Dean, Academics and Student Affairs
The IIHMR University, Jaipur

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

THE IIHMR UNIVERSITY, JAIPUR

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled "**Gap Analysis of a Multi Specialty Hospital**" submitted by **Dr. Bhavana Methwani** Enrollment No. IIHMR-U/01/2015-17/0267 under the supervision of **Dr. Ashok Kaushik** for the award of MBA in Hospital and Health Management of the University carried out during the period from 6th February 2017to 5th May 2017. This 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.

Bmethwani.

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 **Gap Analysis of a Multi Specialty Hospital**

signature

Abstract

Gap analysis of a multi-speciality hospital

Author: Dr Bhavana Methwani
The IIHMR University, Jaipur
Email id: bhavanamethwani24@gmail.com

BACKGROUND:

Accreditation is "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". It shows that the hospital has undertaken a challenging, comprehensive evaluation. It has made a noteworthy extra effort to review and improve the key issues that can affect the quality and safety of patients. The hospital has gone through NABH evaluation shows an extraordinary obligation to provide safe, high quality care and preparedness to be measured against the highest standards of performance.

A study was conducted to find out the gaps between the current services and the standards of NABH in various departments of the hospital. Data collection tool applied for the study is NABH self-assessment toolkit.

OBJECTIVES:

To identify the gaps in terms of structure, process and outcome
To suggest alterations in the structural designs, process of the facilities to meet the requirement.
To give remedial and pre-emptive action of the gaps identified

METHEDOLOGY:

Study design: Descriptive study was done to find out the gap between the status of the hospital and NABH standards as per 4th edition.

Study Area: All departments of the hospital - Front office, OPD, Emergency department, ICU, Operation theatre, IPD, Laboratory (Pathology, microbiology, biochemistry), Radiology and imaging, CSSD, BMW department, Pharmacy, Kitchen, Maintenance, MRD, Human resource department, Dialysis, Security, Engineering and facility management department

Data collection tool: checklist, NABH self-assessment toolkit

Data collection technique:

Primary data:

1. Direct observation
2. Discussion with the hospital staff
3. Discussion with the patients of the hospital

Secondary data:

1. Hospital Manuals, Policies
2. Records (e.g. - Register of these departments), HMIS

Findings:

The study revealed that the average score as per NABH was 8.66 which makes the hospital eligible for appearing for final assessment, as minimum score required was 7. The area of concern lies with implementation of policies and procedures as documentation part was up to the mark. The hospital had maximum of process i.e. 48 % followed by structural gaps i.e. 27 % and then outcome gaps i.e. only 24 %. The hospital has fulfilled all the four criteria of accredited level. No individual standard has a zero score. No individual standard has an average score below 5. No individual chapter has an average score below 7. The overall average score is more than 7.

Recommendations: /Conclusion:

The hospital had score of 8.7 and in accreditation stage as per NABH standards and was fit for accreditation. Few gaps were identified, if fulfilled, will help in improving the efficiency of Hospital and attracts more patients.

Key words: Gap analysis**,** NABH self-assessment toolkit, accreditation

ACKNOWLEDGMENT

The internship opportunity I had with Wockhardt Group of Hospitals, was a great chance for learning and professional development.

I feel deeply privileged in expressing our deep sense of gratitude to Dr. Anupam Verma (President), Dr. Clive Fernandes' (Clinical Director), K. Sujatha (Centre Head, Nagpur) Wockhardt Group of Hospitals, for their expert guidance and encouragements which helped in the process of making this report. Without their support exploring such a vast organization could not have been possible.

I would like to express my deepest gratitude to Dr. Rajesh Gade for giving me this project and for their guidance and help throughout the work.

I am also grateful to all the department heads and staff for giving me time in spite for their hectic schedule. Without their active cooperation and participation, it would not have been possible to accomplish my task.

I am also thankful to my mentor Respected Dr. Ashok Kaushik, Dean, IIHMR Jaipur, who has always guided and encouraged me throughout my dissertation period and without his kind support my projects would not have been completed.

Sincerely,

Dr. Bhavana Methwani

Table of contents

List of Abbreviations

AAC	Access Assessment and Continuity of Care
AC	Air Conditioning
ACLS	Advance Cardiac Life Support
AERB	Atomic Energy Regulatory Board
BLS	Basic Life Support
BMW	Biomedical Waste Management
CCTV	Close Circuit Television
COP	Care Of Patients
CPR	Cardio Pulmonary Resuscitation
HMIS	Hospital Management Information System
HIS	Hospital Infection Control
ICU	Intensive care unit
IPD	Inpatient Wards
LAMA	Leave against medical advice
MOM	Management of Medication
NABH	National Accreditation board for Hospitals and Healthcare providers
OT	Operation Theatre
PM	Preventive Maintenance
PPE	Personal Protective Equipment
SOP	Standard Operating Procedures

List of Figures

Introduction

The NABH accreditation is currently voluntary system but the quality counsel of India strategizes to cover all the hospital in India, both, in the charitable sector and the government hospitals. The benefit to the hospital would be the national acknowledgement as a quality care hospital, various industries and companies, international and national funding agencies, etc. will subsequently go to only these NABH accredited hospitals for their health needs. In fact, those hospitals without NABH accreditation will drop out their credibility and will be excluded from any form of currently available loans, subsidy, exemptions from notified taxes and duty expenses, etc. The government of India will thus shelter the way to extend all the benefits only to NABH accredited hospitals and the citizen of India will have actions to officially 'recognize' 'accountable' QUALITY HELATH CARE. To give practical input for review of the accreditation, hospital has requested pan Wockhardt. The team visited the hospital in the month of April.

The assessment has recorded many medium compliance issues as per NABH standards, which needs to be considered. These needs/gaps will be explained in the subsequent pages. As per the arranged plan of action, it is recommended that the hospital will attempt to fill the identified gaps until the next gap analysis is carried out. Thus, in phased manner of serially scheduled gap assessments, the hospital will attain the standards prescribed by the NABH. Once this is done, the NABH assessment team from the quality council of India can be invited to officially assess the hospital and consensus the accreditation.

The role of the consultants from the Wockhardt Nagpur hospitals will be to progressively ease identification gaps, preparation of certification and ongoing training, thus helping the hospital in reaching a state of preparedness for the official NABH accreditation.

The preparatory assessment method follows norms and process like those that will be followed by the NABH team for the authentic assessment process. Therefore, it is obligatory to do a complete analysis of areas of 'non-compliant' as per NABH standards

Benefits of Accreditation

Accreditation has the following benefits:

1) It has the highest benefits for the patients and stakeholders.
2) Provides patients services that are safe and protected
3) Gives patients their rights
4) Patient satisfaction is the key for accreditation.
5) Staff are satisfied as it provides continuous learning, leadership and good working environment.
6) There is an unbiased system of assessment and empanelment by Third Parties
7) Provides access to consistent and certified information on services, infrastructure and level of care

Need for the Study

Hospitals form a vital part of the society and the responsibility of the care rendered by them to the society is heavy. With numerous small and large facilities coming up, the quality of services seems to be jeopardised. The only solution out seems to be standardization of the services to provide similar care to all the patients as per their treatment needs and laid down guidelines. This will not only ensure better quality patient care but also reduce burden on the facilities and the staff. The cases of mortality and morbidity are often due to lack of standardised practises. The number of such events is lower in a hospital with quality control mechanism. It is thus important to evaluate and scale up the quality standards for a larger good.

Objectives

- To identify the gaps in terms of structure, process and outcome
- To suggest alterations in the structural designs, process of the facilities to meet the requirement.
- To identify the compliance of the present services with NABH standards

Review of Literature

K. Francis Sudhakar, M. Kameshwar Rao, T. Rahul (1Jan 2012) is a s study on ''Gaps in quality of expected and perceived health services in public hospitals'' was found that as regard tangibles in public hospital services, there was a wide gap by 3 counts which was statistically significant. About reliability, by 3 counts was also statistically significant. About assurance, it was found that the gap was 3 units. Such gap was statically significant. Lastly, with empathy, it was gap to be 3 units, statistically significant.

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

Infrastructure related

Process related

Infrastructure related gaps are insufficient space, make shift buildings, improper signage, poor fir safety measure and disaster plan, piped medical gases not available, shortage of equipment engineering cell. Most of the infrastructure related gaps need external support from the ministry and bilateral agencies.

Most of the process related gaps can be worked out at the hospital level with the proper training and hand holding. Process gaps were lack of mission/vison and patient charters, lack of training in hospital operations, lack of control resources. Only few hospitals have quality control departments, however medical and nursing audits are not done. Equipment did not have AMC/CMC, utilization audit is not done, BMW management did not exist and security was not organised.

Research Methodology

Research question

What are the gaps and compliance of the hospital to 4th edition NABH standards?

Study Design

The study is non-experimental evidence based in nature. The study is based on the observations made. It is divided broadly in 2 types

1. Present status of the hospital
2. Compliance with the section 1 of NABH standards

Study location

Following various departments of Wockhardt Super speciality unit, Nagpur

- OPD
- Laboratory
- Radiology and Imaging
- Wards
- Intensive Care Units
- Pharmacy
- Housekeeping
- Blood Storage

Data collection tool

Checklist, NABH self-assessment toolkit

Data collection technique:

Primary data:

1. Direct observation
2. Discussion with the hospital staff
3. Discussion with the patients of the hospital

Secondary data:

1. Hospital Manuals, Policies
2. Records (e.g. - Register of these departments), HMIS

Study time

Study time was if 6 weeks which included preparing checklists, filling of checklist, compiling data, gap analysis and final report completion.

Study respondents

Nurse, customer care staff, duty doctors and staff of the departments

Scoring Technique

The scores will be imparted as per NABH standards

- 0 for non-compliance
- 5 for partial compliance
- 10 for full compliance

In the end, the scores of all the standards are summed up and divided by the total number of standards and after completion of each chapter, the scores of the chapter are divided by 10 to obtain a final score.

8.0 Department wise Gap Analysis

Signage System

Signage's	Displayed (yes/no/NA)	Bilingual (yes/no/NA)	Pictorial (yes/no/NA)	Remarks (yes/no/NA)
Citizen Charter	YES	YES	NO	Not displayed in one single board
Mission	YES	NO	NO	
Vision	YES	NO	NO	
Patient's rights and responsibilities	YES	NO	NO	
Scope of services	YES	NO	YES	partially
Tariff law	YES	NO	NO	
Doctor's list along with their other specialities	YES	NO	NO	Different on different levels
OPD schedule of doctors	NA	NA	NA	
Biohazard Symbols	YES	YES	NO	partially
Fir Exit Plan	YES	YES	NO	
Floor Directory	YES	NO	NO	
Wash Rooms	YES	NO	NO	
Toilets	YES	NO	NO	
Signage's	**Displayed (yes/no/NA)**	**Bilingual (yes/no/NA)**	**Pictorial (yes/no/NA)**	**Remarks (yes/no/NA)**

Ambulance Parking Area	YES	NO	NO	
Drinking Water	YES	YES	NO	

Statutory Requirements

Licenses	**Status *(A/NA)**	**Available (yes/no)**
Building occupancy/completion certificate	A	YES
Fire licence	A	YES
Licence under biomedical management and handling rules,1998	A	YES
NOC for air and water from state pollution control board	A	YES
Excise permit to store spirit	A	YES
Permit to operate lifts under lifts and escalator Act.	A	YES
Narcotics and psychotropic substances and license.	A	NO
Vehicle registration certificate	A	YES
Retail drug licence	A	YES
Licenses	Status *(A/NA)	Available (yes/no)

PNDT act	A	YES
Site and type approval	A	YES
Licence for blood bank	NA	NA
Noise and air pollution certificate	A	YES

*A = Applicable NA = Not Applicable

MANPOWERS

Sr. No	**Designation**	**sanctioned**	**Actual**	**Vacant (sanction-actual)**
1	Chief Medical Superintendent	1	1	0
2	MEDICAL SPECIALIST	2	2	0
3	General surgery specialist	2	1	1
4	Paediatrician	1	1	0
5	Anaesthesiologist	4	0	1
6	Ent surgeon	1	0	1
7	Ophthalmologist	2	2	0
Sr. No	**Designation**	**sanctioned**	**Actual**	**Vacant (sanction-actual)**

8	Orthopaedician	2	2	0
9	Radiologist	2	2	0
10	Pathologist	2	1	1
11	Medical officer	10	10	4
12	Dental surgeon	1	1	0
	Subtotal	32	33	8

Nursing Staff

Sr. No	**Designation**	**sanctioned**	**Actual**	**Vacant (sanction-actual)**
1	Matron/nursing superintendent	1	1	0
2	Nursing in charge	1	1	0
3	Staff nurse	60	48	12
4	Infection control nurse	1	0	0
	subtotal	63	50	12

Paramedical Staff

Sr. No	Designation	sanctioned	Actual	Vacant (sanction-actual)
1	Dental hygienist	1	1	0
2	OT technician	1	1	5
3	Lab supervisor	1	1	0
4	Lab technician	4	4	0
5	Radiographer	2	2	0
6	Dark room assistant	0	0	0
7	Ecg technician	1	1	0
8	Physiotherapist	1	1	0
9	CSSD technician	1	1	0
	subtotal	12	12	5

Pharmacist

Sr. No	Designation	sanctioned	Actual	Vacant (sanction-actual)
1	Pharmacy I/C	1	1	0
2	Chief pharmacist	4	2	2
3	pharmacist	1	5	2
	subtotal	6	8	4

Administrative

Sr. No	Designation	sanctioned	Actual	Vacant (sanction-actual)
1	Biomedical Engineer	2	1	1
2	Junior Engineer	1	1	0
3	Office Superintendent	1	1	0
4	Accountant	1	1	0
5	Head Clerk	1	1	0
6	Senior Clerk	1	1	0
7	Junior Clerk	1	1	0

Sr. No	Designation	sanctioned	Actual	Vacant (sanction-actual)
8	Registration Clerk	1	1	0
9	Store Keeper	1	1	0
10	Medical Record Clerk	1	1	0
11	Mortuary Attendant	1	1	0
12	Electrician	1	1	0
13	Plumber	1	1	0
14	Sr. Assistants	1	1	0
	subtotal	15	15	0

Class 4

Sr. No	Designation	sanctioned	Actual	Vacant (sanction-actual)
1	,Mali	2	0	2
2	Ward boy	28	26	2
3	Ward aya	2	2	2
4	Chaprasi	1	1	0
5	Kahar	5	2	3
6	Cook	5	2	3
7	Bhisti	1	1	0
8	Choukidar	4	4	0
9	Dhobi	2	2	0
010	Cleaner	1	0	1
11	Housekeeping staff	130	101	29
12	Driver	2	2	0
12	Security	0	0	0

	subtotal	183	145	42

Out Patient Department

Identified gaps:

Structural	• Bilingual display of signage not present
Process	• Complete data is not captured in HIS • Separate registration is not done for camp patients • No system of follow up of patients
Outcome	Following indicators were not captured properly • Patient satisfaction • Waiting time of OPD patients • OPD utilization is not done

Ambulance Services

There is no proper communication with the ambulance service as the ambulance service is outsourced. Required medicines are not present in the ambulance. Maintenance of the medical gas(o2) to 90% of the total capacity is not done. Calibration of equipment is not done. Medication and equipment checklist is not maintained.

Structural	• There is no proper communication with the ambulance service as the ambulance service is outsourced. • Required medicines are not present in the ambulance. Maintenance of the medical gas(o2) to 90% of the total capacity is not done. • Calibration of equipment is not done. • Medication and equipment checklist is not maintained.

Process	• Staff is not well trained in BLS/ACLS
Outcome	• Monitoring of TAT for ambulance id not done

Emergency Services

Structural	• Oral airways of different sizes are not kept • Emergency signage is not visible from the road
Process	• Triaging of the patients is not done • Staff is not well trained in BLS/ACLS
Outcome	• Time for initial assessment of nurses and doctors are not monitored

Laboratory

Structural	No issues
Process	• No proper channel of sending the samples to lab after collection • Critical results are not being informed to the consultants properly • Calibration of the equipment not done
Outcome	Following needs to be monitored properly • Percentage of re-dos • Percentage of employees adhering to safety precautions

Radiology And Imaging Department

Structural	• No change room available for the patient • Critical results are not defined, reported and documented • No pace for keeping the reports that are waiting to be dispatched
Process	• equipment is not calibrated • radiology test requisition form is not written properly • time frame is defined but not followed for the dispatch of the reports • HIS is not available for the x-ray department • Turnaround time for the reports is not monitored • Crash carts not checked as per daily basis • Improper queue management
Outcome	no monitoring of the following indicators percentage of re-dos, percentage of reports correlating with the clinical diagnosis

Wards

Structural	• Crash carts are not maintained as per the standard checklist • There is no adequate number of nurses in the staff • Air conditioners not working • Few curtains are broken • There is good evidence of seepage in the walls of the ward • Quantity of Materials stored in the wards do not match with materials in the system
Process	• Nurses are not trained • BMW are not segregated at the point of generation

Intensive Care Units:

Structural	• Air conditioners not working
Process	• Patients under restrains are not monitored frequently • Oral medication orders are not written separately • Medication orders are not written in a uniform order, are not clear, legible, dated, and signed • Staff not aware about the hand hygiene policy • Information is not transferred properly during handovers, and handovers are not signed.
Outcome	Following rates are not monitored • ICU utilization

Operation Theatre

Structural	• Proper zoning concept is not followed • Only 3 out of 4 OTs have crash carts • AMC/calibration of equipment not evident
Process	• Surgeries not being followed as per OT booking • No sign in, time out done in OT
Outcome	Following rates are not monitored • Rescheduling of procedures not being monitored

Pharmacy:

Structural	• No security available • No receiving area, segregation area, storing area • Refrigerator for storing medicines contains water bottles
Process	• Does not have licence for selling narcotics drugs • Pest/rodent control are regularly undertaken • Certificates for some staff is not valid

Outcome	Following rates are not monitored • Re order level • Percentage of local purchase • Percentage of drug return

Total Gaps Observed:54

Structural Gaps- 15

Process Gaps-26

Outcome Gaps- 13

COMPLIANCE CHECK
SECTION 1 NABH SELF ASESSMENT TOOLKIT

Chapter 1: ACCESS, ASSESSMENT AND CONTINUITY OF CARE (AAC)

AAC1	**7.5**
AAC2	9.2
AAC3	10
AAC4	8.8
AAC5	9.1
AAC6	9
AAC7	10
AAC8	8
AAC9	9
AAC10	9
AAC11	9.3
AAC12	8.3
AAC13	9
AAC14	8.5
Chapter Average	8.9

Fig: 9.1

Interpretation contains the chapter wise objective elements and those elements which are partially compliant are marked red.

Interpretation:

AAC1-

a. The social insurance administrations being given are unmistakably characterized and are in consonance with the necessities of the group.

b. Each characterized benefit has proper diagnostics and treatment offices however reasonable qualified work force who give out-patient, in-patient and crisis cover are absent.

c. The characterized social insurance administrations are unmistakably shown.

AAC2-

a. Documented strategies and techniques are utilized for enrolling and conceding patients.

b. The reported strategies address out-patients, in-patients and crisis patients.

c. A one of a kind ID number is created toward the finish of enrollment.

d. Patients are acknowledged just if the association can give the required administration.

e. The recorded arrangements and strategies additionally address overseeing patients amid non-accessibility of beds.

f. Access to the human services benefits in the association is organized per the clinical needs of the patient.

g. The staff don't know about these procedures.

AAC3-

a. Documented arrangements and techniques control the move in of patients to the association.

b. Documented strategies and methods control the exchange out/referral of insecure patients to another office in a suitable way.

c. Documented strategies and methods control the exchange out/referral of stable patients to another office in a suitable way.

d. The reported strategies recognize staff capable amid exchange/referral.

e. The association gives a rundown of patient's condition and the treatment given.

AAC4-

a. The association characterizes and reports the substance of the underlying appraisal for the out–patients, in-patients and crisis patients.

b. The association figures out who can play out the underlying appraisal.

c. The association characterizes the time allotment inside which the underlying appraisal is finished in light of patient's needs.

d. The starting appraisal for in-patients is recorded inside 24 hours or prior according to the patient's condition, as characterized in the association's approach.

e. Initial evaluation of in-patients incorporates nursing appraisal which is done at the season of confirmation and archived.

f. Initial evaluation does exclude screening of wholesome needs. Tallness and weight NOT measured.

g. The introductory appraisal brings about a reported care arrange.

h. The mind arrange reflects sought consequences of the treatment, care or administration.

i. The mind plan is countersigned by the clinician accountable for the patient inside 24 hours.

AAC5-

a. Patients are reassessed at proper interims.

b. Out-patients are in some cases not educated of their next development.

c. For in-patients amid reassessment the care plan is checked and changed, where discovered essential.

d. Staff included in direct clinical care record reassessments.

e. Patients are reassessed to decide their reaction to treatment and to arrange facilitate treatment or release.

f. The association sets down rules and actualizes procedures to recognize early cautioning indications of progress or crumbling in clinical conditions for starting brief mediation.

AAC6-

a. Scope of the research facility administrations comparable to the administrations given by the association.

b. The foundation (physical and hardware) is NOT satisfactory to give the characterized extent of administrations.

c. The labor is sufficient to give the characterized extent of administrations.

d. Qualified and prepared work force perform, administer and translate the examinations.

e. Documented techniques direct requesting of tests, accumulation, recognizable proof, taking care of, safe transportation, preparing and transfer of examples.

f. Laboratory results are accessible inside a characterized time period.

g. Critical results are hinted quickly to the work force concerned.

h. Results are accounted for in an institutionalized way.

i. There is a component to address review/revision of reports at whatever point appropriate.

j. Laboratory tests not accessible in the association are outsourced to organisation(s) in light of their quality confirmation framework.

AAC7-

a. The research facility quality confirmation program is recorded.

b. The program addresses check and/or approval of test strategies.

c. The program addresses reconnaissance of test outcomes.

d. The program incorporates occasional adjustment and upkeep of all gear

e. The program incorporates the documentation of restorative and preventive activities.

AAC8-

a. The research center wellbeing system is recorded.

b. This program is lined up with the association's security program.

c. Written methodology don't direct the dealing with and transfer of irresistible and risky materials.

d. Laboratory work force are fittingly not prepared in safe practices.

e. Laboratory work force are given proper security hardware/gadgets.

AAC9-

a. Imaging administrations agree to lawful and different prerequisites.

b. Scope of the imaging administrations is equivalent to the administrations given by the association.

c. The framework (physical and gear) and labor is satisfactory to accommodate its characterized extent of administrations.

d. Adequately qualified and prepared work force perform, regulate and decipher the examinations.

e. Documented arrangements and methodology exist to guarantee rectify distinguishing proof and sheltered and convenient transportation of patients to and from the imaging administrations.

f.Imaging results are accessible inside a characterized time period.

g.Critical results are not composed, or tended to promptly to the work force concerned.
h. Results are accounted for in an institutionalized way.

i.. There is a system to address review/correction of reports at whatever point material.
j. Imaging tests not accessible in the association are outsourced to organisation(s) in view of their quality affirmation framework.

AAC10

a. The quality confirmation program for imaging administrations is not recorded.

b. The program addresses occasional inner/outer associate audit of imaging conventions and results utilizing proper examining.

c. The program addresses observation of imaging results in a joint effort with alluding clinicians for follow up wherever pertinent

d. A framework is set up to guarantee the suitability of the examinations and methodology for the clinical sign.

e. The program incorporates occasional alignment and support of all gear.

AAC11-

a. The radiation-wellbeing project is recorded.

b. This program is lined up with the association's wellbeing program.

c. Patients are not suitably screened for security/chance before experiencing an imaging on a methodology.

d. Handling, utilization and transfer of radio-dynamic and dangerous materials are according to statutory prerequisites.

e. Imaging faculty and patients are furnished with proper radiation security and observing gadgets where pertinent.

f. Radiation-security and observing gadgets and are occasionally tried and results are reported.

g. Imaging and subordinate work force are prepared in imaging security practices and radiation-wellbeing measures.

h. Imaging signage are conspicuously shown in every single fitting area.

AAC12-

a. During all periods of care, there is a qualified individual recognized as in charge of the patient's care however is not accessible.

b. Care of patients is facilitated in all care settings inside the association.

c. Information about the patient's care and reaction to treatment is not shared legitimately among therapeutic, nursing and other care-suppliers.

d. No appropriate handover taken.

e. Transfers between offices/units are done in a sheltered way.

f. The patient's record(s) is accessible to the approved care-suppliers to encourage the trading of data.

g. Documented methods control the referral of patients to different offices/specialities.

h. The association guarantees coherence of care while sticking to characterized courses of events and illuminates the parental figure and additionally the patient/family at whatever point there is an adjustment in calendar.

i. he association has an instrument set up to screen whether satisfactory clinical intercession has occurred because of a basic esteem caution

AAC13-

a. The patient's release procedure is arranged in interview with the patient or potentially family.

b. Documented techniques exist for coordination of different offices and offices required in the release procedure (counting medico-lawful and departed suddenly cases).

c. Documented arrangements and systems are set up for patients leaving against restorative exhortation and patients being released on demand.

d. A release synopsis is given to every one of the patients leaving the association (counting patients leaving against therapeutic counsel and on demand).

e. The association characterizes the time taken for release yet does not screen it.

AAC14-

a. Discharge synopsis is given to the patients at the season of release.

b. Discharge synopsis contains the patient's name, one of a kind distinguishing proof number, date of confirmation and date of release.

c. Discharge synopsis contains the explanations behind confirmation, huge discoveries and finding and the patient's condition at the season of release.

d. Discharge rundown contains data in regards to examination comes about, any strategy performed, prescription managed and other treatment given.

e. Discharge synopsis does not contain follow-up guidance, pharmaceutical and different guidelines in a justifiable way.

f. Discharge outline does not consolidate guidelines about when and how to acquire earnest care.

g. In instance of death, the synopsis of the case additionally incorporates the reason for death.

CHAPTER 2- CARE OF PATIENTS

COP1	**10**
COP2	9.5
COP3	8.3
COP4	8
COP5	8
COP6	8.5
COP7	7.85
COP8	8.12
COP9	8.12
COP10	8
COP13	8.75
COP14	9.5
COP15	8.1
COP16	8.75
COP17	8
COP18	9.1
COP19	9.1
COP20	8.33
COP21	8
COP22	8
AVERAGE SCORE	8.5

Fig :9.2

Interpretation

COP 1-

- ✓ Care conveyance is uniform for a given medical issue when comparable care is given in more than one setting.
- ✓ Uniform care is guided by reported approaches and methods.
- ✓ These reflect material laws, controls and rules.
- ✓ The association adjusts confirm based drug and clinical practice rules to guide uniform patient care.

COP 2-

- ✓ There should be a recognized territory in the association which is effortlessly open to get and oversee crisis patients.
- ✓ Policies and methods for crisis care are archived and are in consonance with statutory prerequisites.
- ✓ This additionally addresses treatment of medico-lawful cases.
- ✓ The patients get mind in consonance with the approaches.
- ✓ Documented arrangements and methods manage the triage of patients for start of fitting consideration.
- ✓ Staff are not acquainted with the approaches and prepared on the systems for care of crisis patients.
- ✓ Admission or release to home or exchange to another association is likewise reported.

- ✓ In instance of release to home or exchange to another association, a release note might be given to the patient.
- ✓ Quality confirmation projects are reported and executed.
- ✓ The reported strategies and methodology direct administration of patients discovered dead on landing to the doctor's facility

COP3-

- ✓ The rescue vehicle does not stick to statutory necessities.
- ✓ The ambulance(s) is not suitably prepared.
- ✓ The ambulance(s) is not kept an eye on via prepared work force.
- ✓ The ambulance(s) is checked day by day.
- ✓ Equipment are checked day by day utilizing an agenda.
- ✓ Emergency solutions are checked day by day and before dispatch utilizing an agenda.
- ✓ The ambulance(s) has a legitimate correspondence framework.
- ✓ The crisis division distinguishes chances to start treatment at the most punctual when the patient is in travel to the association.

COP 4-

- ✓ The association recognizes potential crises.
- ✓ The association has an archived catastrophe administration arrange.
- ✓ Provision is made for accessibility of medicinal supplies, hardware and materials amid such crises.
- ✓ Staff are not very much prepared in the healing facility's catastrophe administration arrange.
- ✓ The plan is tried at any rate twice every year except just on papers.

COP5 –

- ✓ Documented approaches and strategies direct the uniform utilization of revival all through the association.
- ✓ Staff giving direct patient care are not very much prepared and occasionally refreshed in cardio-aspiratory revival.
- ✓ The occasions amid a cardiopulmonary revival are recorded infrequently
- ✓ A post-occasion examination of every single cardiopulmonary revival is finished by a multidisciplinary advisory group.
- ✓ Corrective and preventive measures are taken in view of the post-occasion examination.

COP6-

- ✓ Assignment of patient care is not done according to current great practice rules.
- ✓ Nursing consideration is adjusted and coordinated with general patient care.
- ✓ Care given by medical caretakers is archived in the patient record however not marked
- ✓ Nurses are given satisfactory gear for giving sheltered and productive nursing administrations.
- ✓ Nurses are enabled to take nursing-related choices to guarantee the auspicious care of patients.

COP7-

- ✓ Documented methods are utilized to control the execution of different clinical strategies.
- ✓ Only qualified staff arrange, arrange, perform and help with performing strategies
- ✓ Documented techniques exist to avert antagonistic occasions like a wrong site, wrong patient and wrong methodology yet are not taken after.
- ✓ Sometimes educated assent is taken by the work force playing out the strategy, where it's not relevant.
- ✓ Adherence to standard safety measures and asepsis is clung to amid the lead of the method.
- ✓ Patients are properly checked amid and after the method.

COP8-

- ✓ Documented approaches and strategies are utilized to direct the objective utilization of blood and blood parts.
- ✓ Documented systems administer transfusion of blood and blood parts.
- ✓ The transfusion administrations are represented by the relevant laws and controls.
- ✓ Informed assent is acquired for gift and transfusion of blood and blood parts.
- ✓ Informed assent likewise incorporates patient and family instruction about the gift.
- ✓ The association characterizes the procedure for accessibility and transfusion of blood/blood segments for use in crisis circumstances.
- ✓ Post-transfusion shape is gathered, responses if any distinguished and are dissected for preventive and restorative activities.
- ✓ Staff are prepared to actualize the arrangements.

COP9

- ✓ Documented approaches and techniques are utilized to control the care of patients in the concentrated care and high reliance units.
- ✓ The association has not reported affirmation and release criteria for its serious care and high reliance units.
- ✓ Staff are prepared to apply these criteria.

- ✓ Adequate staff and gear are accessible.
- ✓ Defined techniques for the circumstance of bed deficiencies are taken after.
- ✓ Infection control practices are recorded however are once in a while not took after.
- ✓ A quality affirmation program is archived and executed.
- ✓ Patients and families are some of the time not guided by the treating medicinal expert at intermittent interims and when there is a noteworthy change in the state of the patient. What's more, if its directed then it's not archived nor marked by the patient/relative.

COP10

- ✓ Policies and systems are reported and are as per the overarching laws and the national and universal rules.
- ✓ Care is sorted out however some of the time not conveyed as per the arrangements and techniques.
- ✓ The association accommodates a sheltered and secure condition for the helpless gathering.
- ✓ A reported system exists for getting educated assent from the suitable lawful delegate.
- ✓ Staff are not very much prepared to look after this helpless gathering.

COP13-

- ✓ Documented methods control the organization of direct sedation.
- ✓ Informed assent for organization of direct sedation is gotten.
- ✓ Competent and prepared people perform sedation.
- ✓ The individual overseeing and observing sedation is not quite the same as the individual playing out the method.
- ✓ Intra-methodology observing incorporates at any rate the heart rate, cardiovascular musicality, respiratory rate, circulatory strain, oxygen immersion, and level of sedation.

- ✓ Criteria are utilized to decide fittingness of release from the perception/recuperation range.
- ✓ Equipment and labor are accessible to oversee patients who have gone into a more profound level of sedation than at first expected.

COP14-

- ✓ There is a recorded strategy and technique for the organization of anesthesia.
- ✓ Patients for anesthesia have a pre-anesthesia appraisal by a qualified
- ✓ The pre-anesthesia appraisal brings about detailing of an anesthesia plan is not archived.
- ✓ An quick preoperative re-assessment is performed and recorded.
- ✓ Informed assent for organization of anesthesia is acquired by the anaesthesiologist.

- ✓ During anesthesia observing incorporates normal recording of temperature, heart rate, cardiovascular cadence, respiratory rate, circulatory strain, oxygen immersion and end tidal carbon dioxide.
- ✓ Patient's post-anesthesia status is observed and recorded.
- ✓ The anaesthesiologist applies characterized criteria to exchange the patient from the recuperation territory.
- ✓ The kind of anesthesia and analgesic drugs utilized are reported in the patient record.
- ✓ Procedures might consent to contamination control rules to counteract cross-disease between patients.
- ✓ Adverse anesthesia occasions are recorded and observed.

COP15-

- ✓ The strategies and techniques are recorded.
- ✓ Surgical patients have a preoperative evaluation and a temporary finding recorded preceding surgery.
- ✓ An educated assent is acquired by a specialist before the technique.
- ✓ Documented strategies and techniques exist to anticipate unfriendly occasions like wrong site, wrong patient and wrong surgery yet they are not taken after.
- ✓ Persons qualified by law are allowed to play out the systems that they are qualified for perform.
- ✓ A brief agent note is recorded before exchange out of patient from recuperation zone.
- ✓ The working specialist records the postoperative care arrange.
- ✓ Patient, work force and material stream fit in with disease control hones.
- ✓ Sometimes suitable offices and hardware/apparatuses/instrumentation are not accessible in the working theater.
- ✓ A quality affirmation program is taken after for the surgical administrations.
- ✓ The quality affirmation program incorporates reconnaissance of the operation theater condition.

COP16-

- ✓ The organ transplant program should be in consonance with the lawful prerequisites and might be led in a moral way.
- ✓ Documented arrangements and techniques manage the organ transplant program.
- ✓ The association guarantees instruction and advising of beneficiary and contributor through prepared/qualified instructors before organ transplantation.
- ✓ The association does not take measures to make mindfulness in regards to organ gift.

COP17-

- ✓ Documented arrangements and methodology manage the care of patients under restrictions.
- ✓ The arrangements and methodology incorporate both physical and synthetic restriction measures.

- ✓ The explanations behind restrictions are not reported.
- ✓ Patients on limitations are not every now and again observed.
- ✓ Staff gets preparing and intermittent refreshing in charge and restriction systems.

COP18-

- ✓ Documented strategies and methods direct the administration of torment.
- ✓ All patients are screened for agony.
- ✓ Patients with agony experience point by point appraisal and intermittent reassessment.
- ✓ Pain lightening measures or prescriptions are started and titrated per patient's need and reaction
- ✓ The staff some of the time does not regard and backings administration of agony for such patients.

COP19

- ✓ Documented arrangements and strategies manage the arrangement of rehabilitative administration.
- ✓ These administrations are proportionate with the authoritative necessities.
- ✓ Care is guided by useful appraisal and occasional re-evaluation which is done and reported by qualified individual(s).
- ✓ Care is given clinging to contamination control and safe practices.
- ✓ Rehabilitative administrations are given by a multidisciplinary group.
- ✓ There is no sufficient space and hardware to play out these exercises.

COP20-

- ✓ Documented arrangements and methodology manage all examination exercises in consistence with administrative, national and worldwide rules.
- ✓ There is no different morals board of trustees to administer all exploration exercises.
- ✓ The board of trustees has the forces to stop an exploration trial when dangers exceed the potential advantages.
- ✓ Patient's educated assent is acquired before entering them in research conventions.
- ✓ Patients are educated of their entitlement to pull back from the exploration at any stage and of the outcomes (assuming any) of such withdrawal.
- ✓ are guaranteed that their refusal to take an interest or withdrawal from support won't trade off their entrance to the association's administrations.

COP21-

- ✓ Documented strategies and methods don't control wholesome treatment including evaluation and reassessment.
- ✓ Nutritional treatment is arranged and given in a community way.
- ✓ There is a composed request for the eating regimen.

- ✓ Patients get nourishment per their clinical needs.
- ✓ Food is readied, taken care of, put away and circulated in a protected way.
- ✓ When families give nourishment, they are taught about the patient's eating routine impediments

COP22-

- ✓ Documented approaches and strategies direct the finish of life care.
- ✓ These arrangements and methods are in consonance with the lawful prerequisites.
- ✓ Sometimes, no one addresses the recognizable proof of the one of a kind needs of such patient and family
- ✓ Symptomatic treatment is given and where proper measures are taken for the easing of torment.
- ✓ Staff are instructed and prepared in end of life care.

MOM1	**10**
MOM2	9
MOM3	7.1
MOM4	9.2
MOM5	9.1
MOM6	8.5
MOM7	8.75
MOM8	7
MOM9	8.75
MOM10	9
MOM11	7.5
MOM12	8
MOM13	8.1
AVERAGE SCORE	8.3

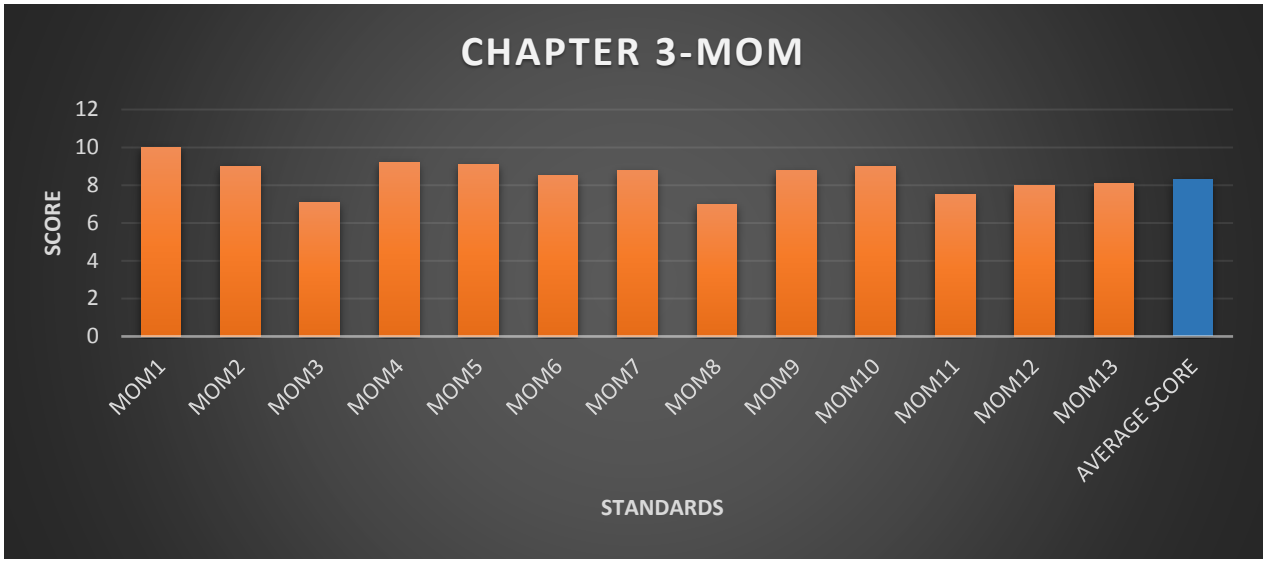

Fig:9.3

Interpretation:

- ✓ **MOM1 -**
- ✓ There is an archived strategy and method for drug store administrations and solution use
- ✓ Policies and methods consent to the material laws and directions.
- ✓ A multidisciplinary board controls the detailing and usage of these arrangements and methodology
- ✓ There is a method to acquire prescription when the drug store is shut.

MOM2 –

- ✓ A rundown of medicines suitable for the patients and according to the extent of the association's clinical administrations is produced cooperatively by the multidisciplinary panel.
- ✓ The rundown is evaluated and refreshed cooperatively by the multidisciplinary board at any rate yearly.
- ✓ The model is accessible for clinicians to allude and cling to.
- ✓ There is a characterized procedure for securing of these medicine
- ✓ There is a procedure to acquire solutions not recorded in the model but rather it is not being taken after.

MOM3 –

- ✓ Documented strategies and systems exist for capacity of pharmaceutical.
- ✓ Medications are put away in a spotless, sheltered and secure condition; and consolidating producer's recommendation(s).
- ✓ Sound stock control rehearses manage capacity of the pharmaceuticals in all zones all through the association.
- ✓ Some, Resemble the other alike and Sound-alike solutions are not distinguished nor put away physically separated from each other.
- ✓ The rundown of crisis prescriptions is not characterized and is put away in a uniform way.
- ✓ Emergency prescriptions are not accessible constantly.
- ✓ Emergency prescriptions are not recharged in an opportune way when utilized.

MOM 4-

- ✓ Documented strategies and methodology exist for solution of meds.
- ✓ These join incorporations of good practices/rules for discerning medicine of drugs.
- ✓ The association decides the base prerequisites of a medici
- ✓ Known medicate sensitivities are found out before endorsing.
- ✓ The association figures out who can compose orders.
- ✓ Orders are composed in a uniform area in the restorative records which likewise mirrors patient's name and one of a kind recognizable proof number.
- ✓ Medication requests are not clear, decipherable, dated, planned, named and marked.
- ✓ Medication orders contain the name of the medication, measurement to be regulated and recurrence/time of organization yet don't contain course of organization.
- ✓ Documented approach and methodology on verbal requests is actualized
- ✓ The association characterizes a rundown of high-hazard medication(s).
- ✓ Audit of pharmaceutical requests/solution is completed to check for sheltered and objective remedy of meds.
- ✓ Reconciliation of solutions happen at move purposes of patient care.
- ✓ Corrective or potentially preventive action(s) is taken in light of the investigation, where proper.

MOM5 –

- ✓ Documented arrangements and methods manage the safe apportioning of solutions.
- ✓ The system addresses medicine review.
- ✓ Expiry dates are checked preceding apportioning.
- ✓ There is a system for close expiry medicines.
- ✓ Labelling prerequisites are recorded and actualized by the association.
- ✓ High-hazard medicine requests are now and again not checked preceding apportioning.

MOM6 –

- ✓ Medications are controlled by the individuals who are allowed by law to do as such.
- ✓ Prepared solution is named before readiness of a moment tranquilize.
- ✓ Patient is not distinguished before organization.
- ✓ Medication is not checked from the request and physically assessed before administering
- ✓ Dosage is checked from the request before organization.
- ✓ Route is checked from the request before organization.
- ✓ Timing is confirmed from the request preceding organization.
- ✓ Medication organization is in some cases not reported.
- ✓ Documented approaches and methodology oversee patient's self-organization of meds.
- ✓ Documented approaches and methodology oversee patient's own meds brought from outside the association

MOM7 –

- ✓ Documented strategies and techniques direct the checking of patients after solution organization
- ✓ The association characterizes those circumstances where close observing is required.
- ✓ Monitoring is not done in a cooperative way.
- ✓ Medications are changed where fitting in light of the checking.

MOM8 –

- ✓ Documented methodology exists to catch close miss, pharmaceutical blunder and antagonistic medication occasion.
- ✓ Near miss, prescription blunder and antagonistic medication occasion are characterized.
- ✓ These are accounted for inside a predetermined time allotment.
- ✓ They are gathered and broke down.
- ✓ Corrective as well as preventive action(s) are taken in view of the examination where suitable.

MOM9 –

- ✓ Documented techniques manage the utilization of opiate medications and psychotropic substances which are in consonance with nearby and national directions.
- ✓ These medications are put away in a protected way.
- ✓ A appropriate record is kept of the utilization, organization and transfer of these medications.
- ✓ These medications are taken care of by fitting staff as per the archived methodology.

MOM10 –

- ✓ Documented arrangements and systems control the utilization of chemotherapeutic specialists.
- ✓ Sometimes chemotherapy is endorsed by the individuals who don't have the learning to screen and treat the unfriendly impact of chemotherapy.
- ✓ Chemotherapy is set up in a legitimate and safe way and managed by qualified staff.
- ✓ Chemotherapy medications are arranged as per legitimate prerequisites.

- ✓ Patient and family are instructed with respect to advantages/dangers of chemotherapy, safety measures to be taken and conceivable unfavorable responses.

MOM11 –

- ✓ Documented approaches and strategies oversee use of radioactive medications.

- ✓ These approaches and strategies are in consonance with laws and controls.
- ✓ The approaches and strategies incorporate the protected stockpiling, arrangement, taking care of, appropriation and transfer of radioactive medications.
- ✓ Staff, patients and guests are taught on wellbeing safety measures.

MOM12-

- ✓ Usage of implantable prosthesis and restorative gadgets is guided by logical criteria for every individual thing and national/universal perceived rules/endorsements for such thing. Be that as it may, these are not taken after without fail.
- ✓ Documented strategies and methodology represent acquirement, stockpiling/stocking, issuance and use of implantable prosthesis and restorative gadgets consolidating maker's recommendation(s).
- ✓ Patient and his/her family are directed for the utilization of implantable prosthesis and medicinal gadget including safety measures, assuming any.
- ✓ The cluster and serial number of the implantable prosthesis and medicinal gadgets are not recorded in the patient's therapeutic record and release synopsis yet recorded in the ace logbook

MOM13-

- ✓ There is a characterized procedure for securing of medicinal supplies and consumables.
- ✓ Medical supplies and consumables are utilized as a part of a sheltered way, where fitting.
- ✓ Medical supplies and consumables are put away in a perfect, sheltered and secure condition; and fusing maker's recommendation(s).
- ✓ There are no appropriate sound stock control rehearses which direct capacity of medicinal supplies and consumables.
- ✓ There is system set up to confirm the state of restorative supplies and consumables however it's not checked

CHAPTER 4: PATIENTS RIGHTS AND EDUCATION

PRE 1	**8**
PRE 2	8.1
PRE 3	7.8
PRE 4	10
PRE 5	8.1
PRE 6	9
PRE 7	8.33
AVERAGE SCORE	8.4

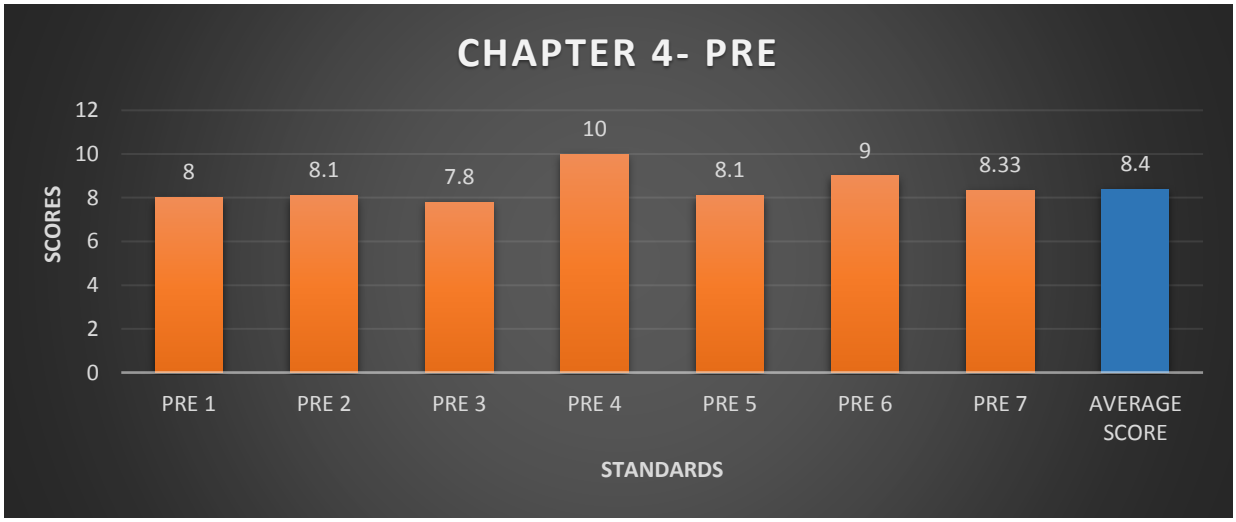

Fig:9.4

Interpretation

PRE.1

- ✓ Patient and family rights and obligations are reported and shown.
- ✓ Patients and families are some of the time not educated of their rights and duties in an organization and dialect that they can get it.
- ✓ The association's pioneers secure patient and family rights.
- ✓ Staff know about their obligation in securing patient and family rights.
- ✓ Violation of patient and family rights is every so often recorded, explored and remedial/preventive measures is not taken.

PRE.2

- ✓ Patients and family rights incorporate regarding any exceptional inclinations, otherworldly and social needs.
- ✓ Patient and family rights incorporate regard for individual respect and security amid examination, methods and treatment.
- ✓ Patient and family rights incorporate insurance from disregard or manhandle.
- ✓ Patient and family rights incorporate regarding quiet data as secret however in some cases its not took after

- ✓ Patient and family rights incorporate refusal of treatment.

- ✓ Patient and family have a privilege to look for an extra supposition with respect to clinical care.

- ✓ Patient and family rights incorporate educated assent before transfusion of blood and blood parts, anesthesia, surgery, start of any exploration convention and some other intrusive/high hazard techniques/treatment.

- ✓ Patient and family rights incorporate ideal to gripe and data on the best way to voice a protestation however they are not educated about how to voice their grumble

- ✓ Patient and family rights incorporate data on the normal cost of the treatment however total data is not given or just few are given the data

- ✓ Patient and family rights incorporate access to his/her clinical records.

- ✓ "Patient and family rights incorporate data on Care plan, advance and data on their medicinal services needs.

PRE.3

- ✓ The quiet as well as relatives are clarified about the proposed mind including the dangers, options and advantages however there is no confirmation about disclosing the dangers to the patients or relative.

- ✓ The understanding and additionally relatives are clarified about the normal outcomes.

- ✓ The persistent as well as relatives are clarified about the conceivable inconvenience however there is no confirmation.

- ✓ The mind plan is arranged and altered in counsel with patient and additionally relatives.

- ✓ The mind arrange regards and where conceivable fuses persistent or potentially family concerns and demands.

- ✓ The understanding as well as relatives are educated about the consequences of indicative tests and the determination.

- ✓ Few specialists clarify the patient as well as relatives about any adjustment in the patient's condition in an auspicious way.

PRE.4

- ✓ Documented methodology consolidates the rundown of circumstances where educated assent is required and the procedure for taking educated assent

- ✓ General assent for treatment is acquired when the patient enters the association.

- ✓ Patient as well as his relatives are educated of the extent of such broad assent.

- ✓ Informed assent incorporates data with respect to the strategy, it's dangers, advantages, options and in the matter of who will play out the system in a dialect that they can get it.

- ✓ The strategy portrays who can give assent when patient is unequipped for autonomous basic leadership

- ✓ Informed assent is taken by the individual playing out the strategy.

- ✓ Informed agree prepare clings to statutory standards.

- ✓ Staff know about the educated assent methodology.

PRE.5

- ✓ Patient and additionally family are instructed about the protected and compelling utilization of medicine and yet the potential reactions of the prescription are here and there not told.

- ✓ Patient or potentially family are not taught about sustenance medicate association
- ✓ Patient or potentially family are taught about eating regimen and sustenance.

- ✓ Patient or potentially family are taught about immunisations.

- ✓ Patient or potentially family are taught about their particular ailment process, difficulties and counteractive action procedures.

- ✓ Patient or potentially family are at times instructed about forestalling medicinal services related contaminations

- ✓ The patients and additionally relatives' exceptional instructive needs are recognized and tended to

- ✓ Patient or potentially family are instructed in a dialect and configuration that they can get it.

PRE.6

- ✓ There is a uniform valuing strategy in each setting (out-patient and ward classification).

- ✓ The pertinent levy rundown is accessible to patients.
- ✓ All quiet as well as relatives are not clarified about the normal expenses.
- ✓ Patient as well as family are some of the time educated about the monetary ramifications when there is an adjustment in the patient condition or treatment setting.

PRE.7

- ✓ The association has a system to catch criticisms from patients which incorporates quiet fulfilment and patient's understanding.

- ✓ The association has a reported protestation redressal method.

- ✓ Patient and additionally relatives are made mindful of the method for giving criticism and/or lodging grievances.

- ✓ All input and dissensions are evaluated and additionally investigated inside a characterized time period.

- ✓ Not constantly Remedial as well as preventive action(s) are taken in view of the investigation

PRE.8

- ✓ Documented arrangements and techniques manage the powerful correspondence with the patients and additionally families.

- ✓ The association should distinguish exceptional circumstances where improved correspondence would be required.

- ✓ The association sets out an approach for compelling correspondence in these recognized circumstances.

- ✓ The association additionally characterizes what constitutes an unsatisfactory correspondence and sharpens the staff about the same.

- ✓ The association don't have a successful framework to screen and audit the execution of viable correspondence

- ✓ Complete staff is not prepared in medicinal services correspondence procedures

CHAPTER 5 HOSPITAL INFECTION CONTROL

HIC 1	**10**
HIC 2	8.3
HIC 3	8.8
HIC 4	10
HIC 5	8.7
HIC 6	10
HIC 7	9.1
HIC 8	8
HIC 9	10
AVERAGE SCORE	9.2

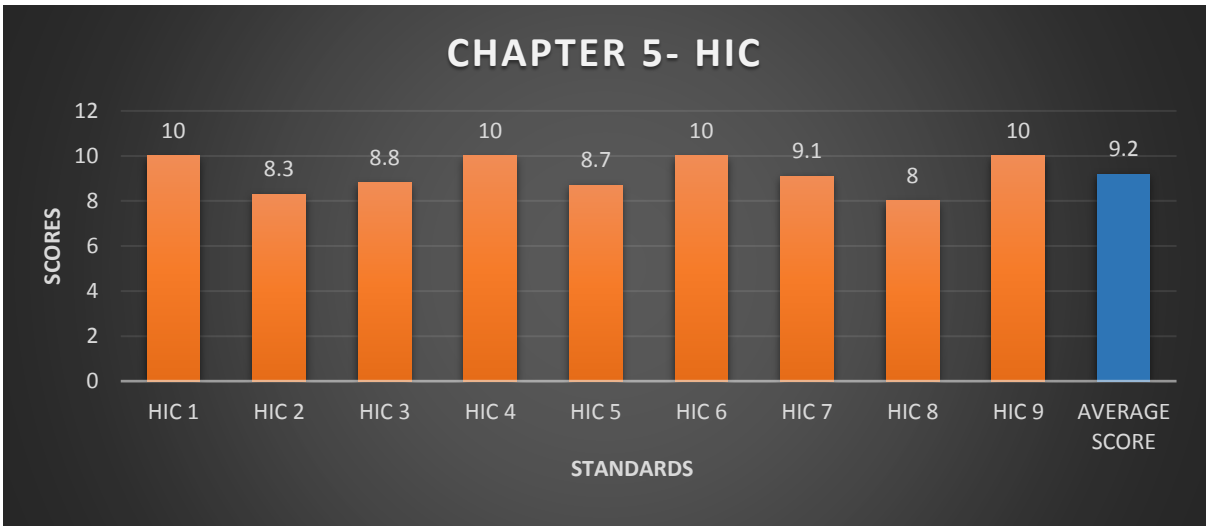

Fig:9.5

Interpretation

HIC.1:

- ✓ The doctor's facility disease counteractive action and control program is archived which goes for avoiding and diminishing the danger of medicinal services related contaminations in every aspect of the healing center.

- ✓ The contamination anticipation and control program is a consistent procedure and refreshed in any event once in a year.

- ✓ The clinic has a multi-disciplinary contamination control board, which co-ordinates all disease counteractive action and control exercises.

- ✓ The healing centre has a disease control group, which arranges usage of all contamination anticipation and control exercises.

- ✓ The healing facility has assigned contamination control officer as a component of the disease control group.

- ✓ The doctor's facility has assigned contamination control nurse(s) as a component of the disease control group

HIC.2

- ✓ The association distinguishes the different high-chance ranges and strategies and executes approaches and additionally techniques to anticipate disease in these zones.

- ✓ The association clings to standard insurances dependably.
- ✓ The association clings to hand-cleanliness rules.
- ✓ The association clings to transmission-based insurances dependably
- ✓ The association clings to safe infusion and mixture rehearses.
- ✓ The association, here and there, don't take after cleaning, purification and disinfection rehearses.
- ✓ An suitable anti-toxin strategy is built up and reported
- ✓ The association executes the anti-toxin strategy and screens balanced utilization of antimicrobial operators.
- ✓ The association now and then, don't take after clothing and material administration forms.
- ✓ The association in some cases, don't take after kitchen sanitation and sustenance dealing with issues.
- ✓ The association has suitable building controls to avoid contaminations.
- ✓ The association now and again, don't take after housekeeping methodology.

HIC.3.

- ✓ Surveillance exercises are fittingly coordinated towards the recognized high-chance zones and methods.

- ✓ A accumulation of reconnaissance information is an on-going procedure.

- ✓ Verification of information is done all the time by the disease control group.

- ✓ The extent of reconnaissance exercises consolidates following and dissecting of disease dangers, rates and patterns.

- ✓ Surveillance exercises incorporate observing the consistence with hand-cleanliness rules.

- ✓ Surveillance exercises incorporate systems to catch the event of epidemiological huge sicknesses and multi-sedate safe creatures, and very destructive diseases.

- ✓ Surveillance exercises incorporate observing the viability of housekeeping administrations.

- ✓ Appropriate criticism with respect to human services related infection(HAIs) rates is not given all the time to fitting staff.

- ✓ In instances of notifiable ailments, data (in applicable organization) is sent to proper specialists.

HIC.4

- ✓ The association acts to counteract catheter related urinary tract Contaminations.

- ✓ The association acts to forestall Ventilator Related Pneumonia.

- ✓ The association acts to avoid catheter connected circulation system contaminations.

- ✓ The association acts to avoid surgical site diseases.

HIC.5

- ✓ Adequate and proper individual defensive hardware, cleansers, and disinfectants are accessible yet are not checked.

- ✓ Adequate and proper offices for hand cleanliness in all patient-mind ranges are open to human services suppliers.

- ✓ Isolation/obstruction nursing offices are accessible.

- ✓ Appropriate pre-and post-introduction prophylaxis is given to all staff individuals concern

HIC.6

- ✓ Organisation has a recorded technique for distinguishing a flare-up.

- ✓ Organisation has a recorded technique for dealing with such flare-ups

- ✓ This technique is executed amid flare-ups.

- ✓ After the flare-up is over fitting remedial moves are made to counteract repeat.

HIC.7

- ✓ The association does not give sufficient space and fitting zoning for cleansing exercises.

- ✓ Documented strategy directs the cleaning, pressing, sanitization as well as disinfection, putting away and issue of things.

- ✓ Reprocessing of instruments and hardware are secured.

- ✓ The association might have a reported strategy and methodology for reprocessing of gadgets at whatever point material.

- ✓ Regular approval tests for sanitization are done and reported.

- ✓ There is a set up review strategy when breakdown in the sanitization framework is distinguished.

HIC.8

- ✓ The association clings to statutory arrangements about biomedical waste.

- ✓ Proper isolation and accumulation of biomedical waste from all patient-mind regions of the clinic is not actualized and not observed.

- ✓ The association guarantees that biomedical waste is put away and transported to the site of treatment and transfer in appropriately secured vehicles inside stipulated time restrains in a safe way.

- ✓ The biomedical waste treatment office is not overseen according to statutory arrangements (if in-house) or outsourced to approved contractor(s).

- ✓ Appropriate individual defensive measures are utilized by all classifications of staff taking care of biomedical waste.

HIC.9

- ✓ The administration makes accessible assets required for the disease control program.

- ✓ The association reserves satisfactory assets from its yearly spending plan in such manner.

- ✓ The association conducts acceptance preparing for all staff.

- ✓ The association conducts suitable "in-administration" instructional meetings for all staff in any event once in a year.

OVERALL SCORE FOR SECTION 1	
AAC	**9.2**
COP	8.4
MOM	8.3
PRE	8.5
HIC	8.9
OVERALL AVERAGE	8.66

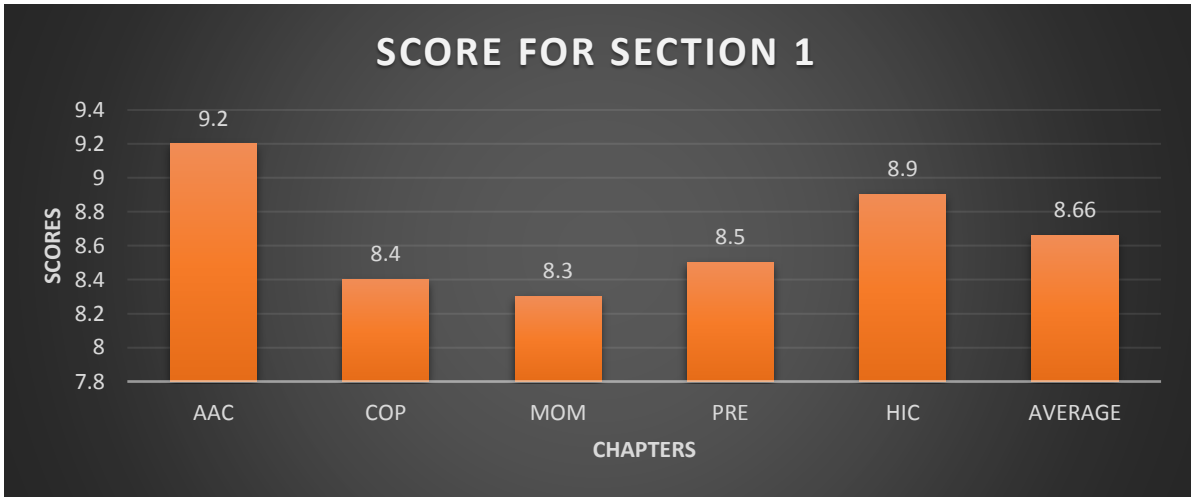

Fig: 9.6

Compliance check	
Full compliance	**552**
Partial compliance	313
Non-compliance	0

Fig: 9.7

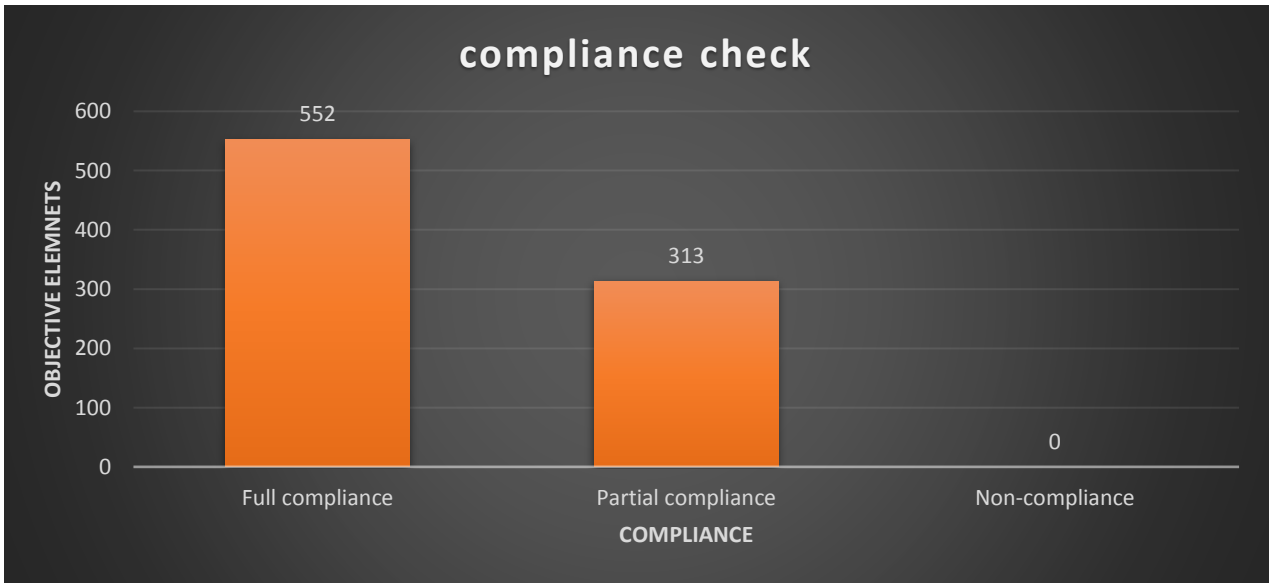

Fig: 9.8

Gaps Observed

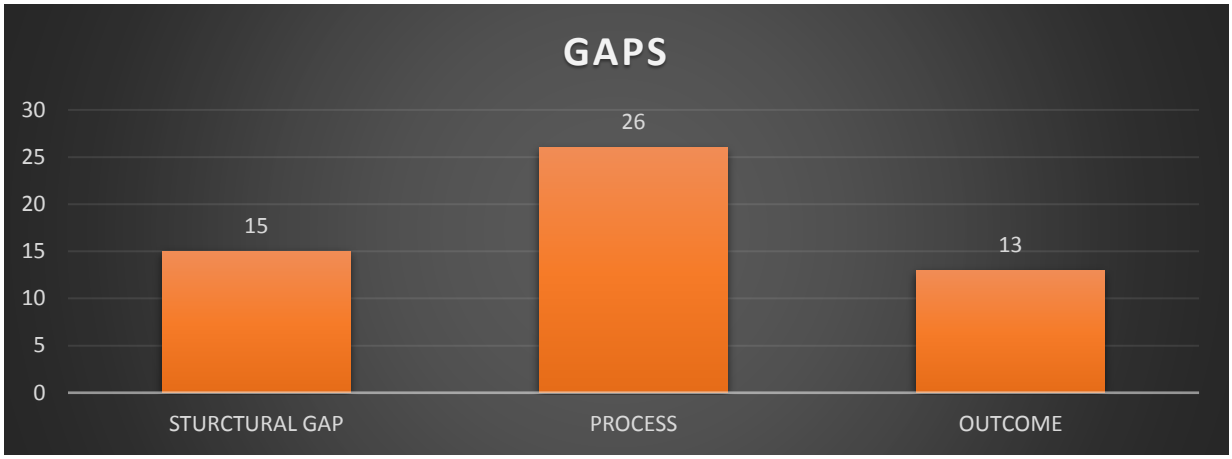

Fig: 9.9

Total gaps observed- 54

Structural gaps- 15

Process gaps – 26

Outcome gaps 13

Analysis

ON COMPARING THE HOSPITAL PRESENT STATUS WITH THE CRITERIA OF NABH ACCREDITED LEVEL, I FIND

- All regulatory legal requirements are fully met
- No individual standard has a zero score
- No individual standard has an average score below 5
- No individual chapter has an average score below 7
- The overall average score is more than 7

With the above analysis, the hospital is fulfilling the criteria for NABH ACCREDITED LEVEL.

Study Findings

1) Each characterized benefit has proper diagnostics and treatment offices yet appropriate qualified staff who give out-patient, in-patient and crisis cover are absent.
2) The staff don't know about these procedures.
3) Initial evaluation does exclude screening of nutritious needs. Tallness and weight NOT measured.
4) The framework (physical and gear) is NOT satisfactory to give the characterized extent of administrations.
5) Written methods don't direct the dealing with and transfer of irresistible and risky
6) materials.
7) Laboratory work force are suitably not prepared in safe practices.
8) Critical outcomes are not composed, or tended to promptly to the staff concerned.
9) The quality confirmation program for imaging administrations is not recorded.
10) Patients are not suitably screened for wellbeing/hazard preceding experiencing an imaging on a methodology.
11) During all periods of care, there is a qualified individual recognized as in charge of the patient's care yet is not accessible.
12) Information about the patient's care and reaction to treatment is not shared legitimately among restorative, nursing and other care-suppliers.
13) No appropriate handover taken.
14) The association characterizes the time taken for release yet does not screen it.
15) Discharge rundown does not contain follow-up guidance, pharmaceutical and different directions in a reasonable way.
16) Discharge synopsis does not consolidate guidelines about when and how to get earnest care.
17) Staff are not acquainted with the strategies and prepared on the methodology for care of crisis patients.
18) The emergency vehicle does not cling to statutory prerequisites.

19) The ambulance(s) is not suitably prepared.
20) The ambulance(s) is not kept an eye on via prepared work force.
21) Staff are not very much prepared in the healing center's catastrophe administration arrange.
22) The arrangement is tried at any rate twice per year yet just on papers.
23) Staff giving direct patient care are not very much prepared and intermittently refreshed in cardio-pneumonic revival.
24) The occasions amid a cardiopulmonary revival are recorded once in a while.
25) Assignment of patient care is not done according to current great practice rules.
26) Care given by medical attendants is archived in the patient record however not marked
27) Documented techniques exist to avert unfriendly occasions like a wrong site, wrong patient and wrong methodology yet are not taken after.
28) Sometimes educated assent is taken by the staff playing out the methodology, where it's not material.
29) The association has not recorded affirmation and release criteria for its escalated care and high reliance units.
30) Infection control practices are archived however are once in a while not took after.
31) Patients and families are now and then not guided by the treating medicinal expert at intermittent interims and when there is a noteworthy change in the state of the patient. What's more, if its guided then it's not archived nor marked by the patient/relative.
32) Care is sorted out however at times not conveyed as per the strategies and techniques.
33) Staff are not all around prepared to nurture this powerless gathering.
34) Patients are not checked after sedation
35) The pre-anesthesia appraisal brings about definition of an anesthesia plan is not reported.
36) Documented arrangements and systems exist to avoid unfriendly occasions like wrong site, wrong patient and wrong surgery yet they are not taken after.
37) Sometimes fitting offices and gear/machines/instrumentation are not accessible in the working theater.
38) The association does not take measures to make mindfulness in regards to organ gift.
39) The explanations behind limitations are not archived.
40) Patients on limitations are not often checked.
41) The staff some of the time does not regard and backings administration of agony for such patients
42) There is no sufficient space and gear to play out these exercises.
43) There is no different morals council to direct all examination exercises.
44) Documented arrangements and systems don't manage wholesome treatment including appraisal and reassessment.
45) Sometimes, no one addresses the distinguishing proof of the interesting needs of such patient and family
46) There is a procedure to get solutions not recorded in the model but rather it is not being taken after.
47) Some, Resemble the other alike and Sound-alike pharmaceuticals are not distinguished nor put away physically separated from each other.
48) The rundown of crisis solutions is not characterized and is put away in a uniform way.

49) Emergency solutions are not accessible constantly.
50) Emergency solutions are not recharged in an auspicious way when utilized.
51) Medication requests are not clear, neat, dated, planned, named and marked.
52) Medication requests contain the name of the prescription, dosage to be directed and recurrence/time of organization however don't contain course of organization.
53) High-chance solution requests are some of the time not confirmed preceding apportioning
54) Patient is not distinguished before organization.
55) Medication is not checked from the request and physically examined before organization.
56) Medication organization is in some cases not recorded.
57) Sometimes chemotherapy is recommended by the individuals who don't have the information to screen and treat the unfriendly impact of chemotherapy.
58) Usage of implantable prosthesis and restorative gadgets is guided by logical criteria for every individual thing and national/worldwide perceived rules/endorsements for such particular thing. In any case, these are not taken after inevitably.
59) The group and serial number of the implantable prosthesis and medicinal gadgets are not recorded in the patient's restorative record and release rundown however recorded in the ace logbook.
60) There are no appropriate sound stock control rehearses which direct capacity of medicinal supplies and consumables.
61) There is component set up to confirm the state of restorative supplies and consumables however it's not checked
62) Patients and families are some of the time not educated of their rights and obligations in an organization and dialect that they can get it.
63) Violation of patient and family rights is incidentally recorded, looked into and remedial/preventive measures is not taken
64) Patient and family rights incorporate regarding persistent data as secret yet some of the time it's not taken after
65) Patient and family rights incorporate ideal to gripe and data on the most proficient method to voice a protestation however they are not educated about how to voice them grumble
66) Patient and family rights incorporate data on the normal cost of the treatment however entire data is not given or just few are furnished with the data
67) The patient as well as relatives are clarified about the proposed mind including the dangers, options and advantages however there is no proof about disclosing the dangers to the patients or relative.
68) The patient and additionally relatives are clarified about the conceivable confusion however there is no confirmation.
69) Few experts clarify the patient as well as relatives about any adjustment in the patient's condition in an auspicious way.
70) Patient and additionally family are instructed about the protected and viable utilization of drug and however the potential reactions of the solution are some of the time not told.
71) Patient and additionally family are not instructed about nourishment sedate collaboration

72) Patient and additionally family are now and then taught about anticipating human services related diseases
73) All patient as well as relatives are not clarified about the normal expenses.
74) Patient as well as family are now and then educated about the money related ramifications when there is an adjustment in the patient condition or treatment setting.
75) Not constantly Remedial as well as preventive action(s) are taken in view of the examination
76) The association don't have a successful framework to screen and survey the usage of viable correspondence
77) Complete staff is not prepared in human services correspondence procedures
78) The association, some of the time, don't take after cleaning, sanitization and cleansing practices.
79) The association now and then, don't take after clothing and material administration forms.
80) The association at times, don't take after kitchen sanitation and sustenance taking care of issues.
81) The association now and again, don't take after housekeeping methodology.

Recommendations

Signage:

- Signage should be bilingual. The signage for consultant should be present at each level and should be bilingual and symbolic/pictorial.

Licences

- Licenses and acts should be available with the responsible authority at the hospital.

OPD

- There should be tracking mechanism for patient follow up. There should be a system generated message and a phone call that will be automatically sent to the patient a day before the follow up date.
- Staff should be trained to capture complete data in minimum time frame.
- Separate registration should be done for camp patients

Ambulance services

- The emergency staff including doctors and nurses and driver should be BLS trained
- Checklist of the drugs should be maintained on regular basis and for this a staff should be assigned.

Emergency department

- Signage should be made that would be visible from the road
- Oral airways of different sizes should be kept in the department.

Laboratory

- A proper channel of sending the samples to lab after collection should be assigned. This responsibility should be given to a single housekeeping person who will do the work of collecting the samples from phlebotomy and bringing the samples to the laboratory.
- There should be a system of informing the assigned consultant as soon as the critical result is feed in the system. It should be a system generated call and message regarding critical result
- Calibration of the equipment should be done on regular basis. At present, there is no data in the HIS stating how many equipment are calibrated and how many are due for the maintenance. This should be updated as soon as possible.

Radiology and imaging department

- A register should be maintained for crash carts
- Intimation of the critical results should be documented in a register with details of date, time person intimated to and by.
- The radiology staff should be trained on necessary safety precautions required in the lab
- Requisition should be made in HIS prior to sending in patients in the imaging department

- A person should be assigned for monitoring the turnaround time of dispatching the reports on a regular basis.
- Staff should be trained about managing the queue.

Wards

- Management should hire more nurses and housekeeping staff for the wards. At present the ration of housekeeping is 1:10 patients. At times, it gets difficult to handle the patients when they require housekeeping at the same time.
- Crash carts should be regularly checked and refilled
- Stock of the materials should be checked and refilled.
- Civil works should be carried out immediately to replace/repair the broken curtains
- Damp repairs or treatment of the seepage in the walls should be done immediately.
- Medications should be verified prior administering.

Intensive Care Units

- Patients under restrains should be monitored frequently
- Oral medication orders should be written with red ink to demarcate it form the rest of the medication orders.
- Medication orders should be written in a uniform order, clear, legible, dated, and signed
- Staff should be aware about the hand hygiene policy and should be asked regularly
- Handovers should be taken bed side and should be signed immediately.

Operation Theatre

There should be cameras in the operating room to check whether sign in , sign out, time out is done.

A registrar should be appointed, so that he/she could perform the site marking before wheeling in the patient in OT.

All OTs should have crash carts

Pharmacy

- In pharmacy, it is advisable to have a double locking system with security cameras.
- Refrigerators are not meant for keeping water bottles in pharmacy, hence this is should be checked from time to time.

Other recommendations:

Documented policies and procedures are needed to be developed and followed.

Parking facility is required to be organised

The knowledge and practise about BMW management is required to be strengthened and needs proper training and monitoring of the staff

The sewage treatment plan should be well maintained

Conclusion

The analysis shows that there are gaps in the hospital as per NABH standards, but can be solved by giving proper responsibility to the staff. As the hospital is waiting for the review audit in the month of May, it should implement the following the recommendations before the review audit of NABH. All regulatory legal requirements are fully met. No individual standard has a zero score. No individual standard has an average score below 5. No individual chapter has an average score below 7. The overall average score is more than 7.

With the above analysis, the hospital is fulfilling the criteria for NABH ACCREDITED LEVEL.

Limitations of The Study:

- The data obtained is based on the existing setup, which prevails in the hospital at the time of the system study
- The study being subjective, is based on the perception of the employees working in the hospital and mat be biased
- The time frame of 3 months is a limitation, enabling me to perform study on only one section of the NABH standard.

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ANNEXURE

Elements			**Scores (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.	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.	5
	c	The defined healthcare services are prominently displayed.	10
	d	The staff are oriented to these services.	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.	10
	b	The documented procedures address out-patients, in-patients and emergency patients.	10
	c	A unique identification number is generated at the end of registration.	10
	d	Patients are accepted only if the organisation can provide the required service.	10
	e	The documented policies and procedures also address managing patients during non-availability of beds.	10
	f	Access to the healthcare services in the organisation is prioritised according to the clinical needs of the patient.	10
	g	The staff are aware of these processes.	5
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.	10
	b	Documented policies and procedures guide the transfer-out/referral of unstable patients to another facility in an appropriate manner.	10
	c	Documented policies and procedures guide the transfer-out/referral of stable patients to another facility in an appropriate manner.	10
	d	The documented procedures identify staff responsible during transfer/referral	10

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

	d	Qualified and trained personnel perform, supervise and interpret the investigations.	10
	e	Documented procedures guide ordering of tests, collection, identification, handling, safe transportation, processing and disposal of specimens.	10
	f	Laboratory results are available within a defined time frame.	10
	g	Critical results are intimated immediately to the personnel concerned.	10
	h	Results are reported in a standardised manner.	10
	i	There is a mechanism to address recall / amendment of reports whenever applicable.	10
	j	Laboratory tests not available in the organisation are outsourced to organisation(s) based on their quality assurance system	5
AAC.7:There is an established laboratory quality assurance programme.			
	a	The laboratory quality assurance programme is documented. *	10
	b	The programme addresses verification and / or validation of test methods.	10
	c	The programme addresses surveillance of test results.	10
	d	The programme includes periodic calibration and maintenance of all equipment	10
	e	The programme includes the documentation of corrective and preventive actions	10
AAC.8: There is an established laboratory safety programme.			
	a	The laboratory safety programme is documented.	10
	b	This programme is aligned with the organisation's safety programme.	10
	c	Written procedures guide the handling and disposal of infectious and hazardous materials.	5
	d	Laboratory personnel are appropriately trained in safe practices.	5
	e	Laboratory personnel are provided with appropriate safety equipment / devices.	10
AAC.9: Imaging services are provided as per the scope of services of the organisation.			
	a	Imaging services comply with legal and other requirements.	10
	b	Scope of the imaging services is commensurate to the services provided by the organisation.	10

	c	The infrastructure (physical and equipment) and manpower is adequate to provide for its defined scope of services.	10
	d	Adequately qualified and trained personnel perform, supervise and interpret the investigations.	5
	e	Documented policies and procedures exist to ensure correct identification and safe and timely transportation of patients to and from the imaging services.	10
	f	Imaging results are available within a defined timeframe.	10
	g	Critical results are intimated immediately to the personnel concerned	5
	h	Results are reported in a standardised manner.	10
	i	There is a mechanism to address recall / amendment of reports whenever applicable.	10
	j	Imaging tests not available in the organisation are outsourced to organisation(s) based on their quality assurance system.	10
AAC.10:There is an established quality assurance programme for imaging services.			
	a	The quality assurance programme for imaging services is documented. *	5
	b	The programme addresses periodic internal / external peer review of imaging protocols and results using appropriate sampling.	10
	c	The programme addresses surveillance of imaging results in collaboration with referring clinicians for follow up wherever applicable	10
	d	A system is in place to ensure the appropriateness of the investigations and procedures for the clinical indication.	10
		The programme includes periodic calibration and maintenance of all equipment.	
	e	The programme includes the documentation of corrective and preventive actions	10
AAC.11:There is an established safety programme in the Imaging services.			
	a	The radiation-safety programme is documented.	10
	b	This programme is aligned with the organisation's safety programme.	10
	c	Patients are appropriately screened for safety / risk prior to undergoing an imaging on a particular modality.	5
	d	Handling, usage and disposal of radio-active and hazardous materials are as per statutory requirements.	10
	e	Imaging personnel and patients are provided with appropriate radiation safety and monitoring devices where applicable.	10
	f	Radiation-safety and monitoring devices and are periodically tested and results are documented	10
	g	Imaging and ancillary personnel are trained in imaging safety practices and radiation-safety measures.	10

	h	Imaging signage are prominently displayed in all appropriate locations.	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.	5
	b	Care of patients is coordinated in all care settings within the organisation.	10
	c	Information about the patient's care and response to treatment is shared among medical, nursing and other care-providers.	5
	d	Information is exchanged and documented during each staffing shift, between shifts, and during transfers between units/departments.	5
	e	Transfers between departments/units are done in a safe manner.	10
	f	The patient's record(s) is available to the authorised care-providers to facilitate the exchange of information.	10
	g	Documented procedures guide the referral of patients to other departments/ specialities.	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.	10
	i	The organisation has a mechanism in place to monitor whether adequate clinical intervention has taken place in response to a critical value alert.	10
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.	10
	b	Documented procedures exist for coordination of various departments and agencies involved in the discharge process (including medico-legal and absconded cases).	10
	c	Documented policies and procedures are in place for patients leaving against medical advice and patients being discharged on request.	10
	d	A discharge summary is given to all the patients leaving the organisation (including patients leaving against medical advice and on request).	10
	e	The organisation defines the time taken for discharge and monitors the same.	5
AAC.14: Organisation defines the content of the discharge summary.			
	a	Discharge summary is provided to the patients at the time of discharge.	10
	b	Discharge summary contains the patient's name, unique identification number, date of admission and date of discharge.	10
	c	Discharge summary contains the reasons for admission, significant findings and diagnosis and the patient's condition at the time of discharge.	10

	d	Discharge summary contains information regarding investigation results, any procedure performed, medication administered and other treatment given.	10
	e	Discharge summary contains follow-up advice, medication and other instructions in an understandable manner.	5
	f	Discharge summary incorporates instructions about when and how to obtain urgent care.	5
	g	In case of death, the summary of the case also includes the cause of death.	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.	10
	b	Uniform care is guided by documented policies and procedures.	10
	c	These reflect applicable laws, regulations and guidelines.	10
	d	The organisation adapts evidence-based medicine and clinical practice guidelines to guide uniform patient care.	10
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.	10
	b	Policies and procedures for emergency care are documented and are in consonance with statutory requirements.	10
	c	This also addresses handling of medico-legal cases.	10
	d	The patients receive care in consonance with the policies.	10
	e	Documented policies and procedures guide the triage of patients for initiation of appropriate care.	10
	f	Staff are familiar with the policies and trained on the procedures for care of emergency patients.	5
	g	Admission or discharge to home or transfer to another organisation is also documented.	10
	h	In case of discharge to home or transfer to another organisation, a discharge note shall be given to the patient.	10
	i	Quality assurance programmes are documented and implemented.	10
	j	The documented policies and procedures guide management of patients found dead on arrival to the hospital	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).	10
	b	The ambulance adheres to statutory requirements.	5
	c	The ambulance(s) is appropriately equipped.	5
	d	The ambulance(s) is manned by trained personnel.	5
	e	The ambulance(s) is checked daily.	10
	f	Equipment are checked daily using a checklist.	10
	g	Emergency medications are checked daily and prior to dispatch using a checklist.	10
	h	The ambulance(s) has a proper communication system.	10
	i	The emergency department identifies opportunities to initiate treatment at the earliest when the patient is in transit to the organisation.	10
COP.4: The organisation plans for handling community emergencies, epidemics and other disasters.			
	a	The organisation identifies potential emergencies.	10
	b	The organisation has a documented disaster management plan.	5
	c	Provision is made for availability of medical supplies, equipment and materials during such emergencies.	10
	d	Staff are trained in the hospital's disaster management plan.	5
	e	The plan is tested at least twice a year.	10
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.	10
	b	Staff providing direct patient care are trained and periodically updated in cardio-pulmonary resuscitation.	5
	c	The events during a cardiopulmonary resuscitation are recorded.	5
	d	A post-event analysis of all cardiopulmonary resuscitations is done by a multidisciplinary committee.	10
	e	Corrective and preventive measures are taken based on the post-event analysis.	10
COP.6: Documented policies and procedures guide nursing care.			
	a	There are documented policies and procedures for all activities of the nursing services.	10

	b	These reflect current standards of nursing services and practice, relevant regulations and purposes of the services.	10
	c	Assignment of patient care is done as per current good practice guidelines.	10
	d	Nursing care is aligned and integrated with overall patient care.	10
	e	Care provided by nurses is documented in the patient record.	5
	f	Nurses are provided with adequate equipment for providing safe and efficient nursing services.	5
	g	Nurses are empowered to take nursing-related decisions to ensure the timely care of patients.	10
COP.7: Documented procedures guide the performance of various procedures.			
	a	Documented procedures are used to guide the performance of various clinical procedures.	10
	b	Only qualified personnel order, plan, perform and assist in performing procedures.	5
	c	Documented procedures exist to prevent adverse events like a wrong site, wrong patient and wrong procedure.	10
	d	Informed consent is taken by the personnel performing the procedure, where applicable.	5
	e	Adherence to standard precautions and asepsis is adhered to during the conduct of the procedure.	10
	f	Patients are appropriately monitored during and after the procedure.	10
	g	Procedures are documented accurately in the patient record	5
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.	10
	b	Documented procedures govern transfusion of blood and blood components.	10
	c	The transfusion services are governed by the applicable laws and regulations.	10
	d	Informed consent is obtained for donation and transfusion of blood and blood components.	5
	e	Informed consent also includes patient and family education about the donation.	5
	f	The organisation defines the process for availability and transfusion of blood/blood components for use in emergency situations.	10
	g	Post-transfusion form is collected, reactions if any identified and are analysed for preventive and corrective actions.	10
	h	Staff are trained to implement the policies.	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.	10
	b	The organisation has documented admission and discharge criteria for its intensive care and high dependency units.	5
	c	Staff are trained to apply these criteria.	10
	d	Adequate staff and equipment are available.	10
	e	Defined procedures for the situation of bed shortages are followed.	10
	f	Infection control practices are documented and followed.	5
	g	A quality assurance programme is documented and implemented.	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.	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.	10
	b	Care is organised and delivered in accordance with the policies and procedures.	5
	c	The organisation provides for a safe and secure environment for the vulnerable group.	10
	d	A documented procedure exists for obtaining informed consent from the appropriate legal representative.	5
	e	Staff are trained to care for this vulnerable group.	10
COP.13: Documented policies and procedures guide the care of patients undergoing moderate sedation.			
	a	Documented procedures guide the administration of moderate sedation.	10
	b	Informed consent for administration of moderate sedation is obtained.	5
	c	Competent and trained persons perform sedation.	10
	d	The person administering and monitoring sedation is different from the person performing the procedure.	10

	e	Intra-procedure monitoring includes at a minimum the heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation, and level of sedation.	10
	f	Patients are monitored after sedation and the same documented.	5
	g	Criteria are used to determine appropriateness of discharge from the observation/recovery area.	10
	h	Equipment and manpower are available to manage patients who have gone into a deeper level of sedation than initially intended.	10
COP.14: Documented policies and procedures guide the administration of anaesthesia.			
	a	There is a documented policy and procedure for the administration of anaesthesia.	10
	b	Patients for anaesthesia have a pre-anaesthesia assessment by a qualified anaesthesiologist.	10
	c	The pre-anaesthesia assessment results in formulation of an anaesthesia plan which is documented.	5
	d	An immediate preoperative re-evaluation is performed and documented.	10
	e	Informed consent for administration of anaesthesia is obtained by the anaesthesiologist.	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.	10
	g	Patient's post-anaesthesia status is monitored and documented.	10
	h	The anaesthesiologist applies defined criteria to transfer the patient from the recovery area.	10
	i	The type of anaesthesia and anaesthetic medications used are documented in the patient record.	10
	j	Procedures shall comply with infection control guidelines to prevent cross-infection between patients.	10
	k	Adverse anaesthesia events are recorded and monitored.	10
COP.15: Documented policies and procedures guide the care of patients undergoing surgical procedures.			10
	a	The policies and procedures are documented.	10
	b	Surgical patients have a preoperative assessment and a provisional diagnosis documented prior to surgery.	10
	c	An informed consent is obtained by a surgeon prior to the procedure.	10

	d	Documented policies and procedures exist to prevent adverse events like wrong site, wrong patient and wrong surgery.	0
	e	Persons qualified by law are permitted to perform the procedures that they are entitled to perform.	10
	f	A brief operative note is documented prior to transfer out of patient from recovery area.	10
	g	The operating surgeon documents the postoperative care plan.	10
	h	Patient, personnel and material flow conform to infection control practices.	5
	i	Appropriate facilities and equipment/appliances/instrumentation are available in the operating theatre.	5
	j	A quality assurance programme is followed for the surgical services.	10
	k	The quality assurance programme includes surveillance of the operation theatre environment.	10
COP.16: Documented policies and procedures guide organ transplant programme in the organisation.			10
	a	The organ transplant program shall be in consonance with the legal requirements and shall be conducted in an ethical manner.	10
	b	Documented policies and procedures guide the organ transplant program.	10
	c	The organisation ensures education and counselling of recipient and donor through trained / qualified counsellors before organ transplantation.	10
	d	The organisation shall take measures to create awareness regarding organ donation.	5
COP.17: Documented policies and procedures guide the care of patients under restraints (physical and/or chemical).			10
	a	Documented policies and procedures guide the care of patients under restraints.	10
	b	The policies and procedures include both physical and chemical restraint measures.	10
	c	The reasons for restraints are documented.	5
	d	Patients on restraints are more frequently monitored.	5
	e	Staff receives training and periodic updating in control and restraint techniques.	10
COP.18: Documented policies and procedures guide appropriate pain management.			10
	a	Documented policies and procedures guide the management of pain.	10

	b	All patients are screened for pain.	10
	c	Patients with pain undergo detailed assessment and periodic reassessment.	10
	d	Pain alleviation measures or medications are initiated and titrated per patient's need and response.	10
	e	The organisation respects and supports management of pain for such patients.	5
	f	Patient and family are educated on various pain management techniques, where appropriate.	10
COP.19: Documented policies and procedures guide appropriate rehabilitative services.			10
	a	Documented policies and procedures guide the provision of rehabilitative services.	10
	b	These services are commensurate with the organisational requirements.	10
	c	Care is guided by functional assessment and periodic re-assessment which is done and documented by qualified individual(s).	10
	d	Care is provided adhering to infection control and safe practices.	10
	e	Rehabilitative services are provided by a multidisciplinary team.	10
	f	There is adequate space and equipment to perform these activities.	5
COP.20: Documented policies and procedures guide all research activities.			10
	a	Documented policies and procedures guide all research activities in compliance with regulatory, national and international guidelines.	10
	b	The organisation has an ethics committee to oversee all research activities.	5
	c	The committee has the powers to discontinue a research trial when risks outweigh the potential benefits.	10
	d	Patient's informed consent is obtained before entering them in research protocols.	10
	e	Patients are informed of their right to withdraw from the research at any stage and of the consequences (if any) of such withdrawal.	10
	f	Patients are assured that their refusal to participate or withdrawal from participation will not compromise their access to the organisation's services.	10
COP.21: Documented policies and procedures guide nutritional therapy.			10

	a	Documented policies and procedures guide nutritional therapy including assessment and reassessment.	5
	b	Nutritional therapy is planned and provided in a collaborative manner.	10
	c	There is a written order for the diet.	10
	d	Patients receive food per their clinical needs.	10
	e	Food is prepared, handled, stored and distributed in a safe manner.	10
	f	When families provide food, they are educated about the patient's diet limitations.	5
COP.22: Documented policies and procedures guide the end of life care.			
	a	Documented policies and procedures guide the end of life care.	10
	b	These policies and procedures are in consonance with the legal requirements.	10
	c	These also address the identification of the unique needs of such patient and family.	5
	d	Symptomatic treatment is provided and where appropriate measures are taken for the alleviation of pain.	10
	e	Staff are educated and trained in end of life care.	5
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	10
	b	Policies and procedures comply with the applicable laws and regulations.	10
	c	A multidisciplinary committee guides the formulation and implementation of these policies and procedures.	10
	d	There is a procedure to obtain medication when the pharmacy is closed.	10
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.	10
	b	The list is reviewed and updated collaboratively by the multidisciplinary committee at least annually.	5

	c	The formulary is available for clinicians to refer and adhere to.	10
	d	There is a defined process for acquisition of these medications	10
	e	There is a process to obtain medications not listed in the formulary.	5
MOM.3: Documented policies and procedures guide the storage of medication.			
	a	Documented policies and procedures exist for storage of medication.	10
	b	Medications are stored in a clean, safe and secure environment; and incorporating manufacturer's recommendation(s).	10
	c	Sound inventory control practices guide storage of the medications in all areas throughout the organisation.	10
	d	Look-alike and Sound-alike medications are identified and stored physically apart from each other.	5
	e	The list of emergency medications is defined and is stored in a uniform manner.	5
	f	Emergency medications are available all the time.	5
	g	Emergency medications are replenished in a timely manner when used.	5
MOM.4: Documented policies and procedures guide the safe and rational prescription of medications.			10
	a	Documented policies and procedures exist for prescription of medications.	10
	b	These incorporate inclusions of good practices/guidelines for rational prescription of medications.	10
	c	The organisation determines the minimum requirements of a prescription.	10
	d	Known drug allergies are ascertained before prescribing.	10
	e	The organisation determines who can write orders.	10
	f	Orders are written in a uniform location in the medical records which also reflects patient's name and unique identification number.	10
	g	Medication orders are clear, legible, dated, timed, named and signed.	5
	h	Medication orders contain the name of the medicine, route of administration, dose to be administered and frequency/time of administration.	5
	i	Documented policy and procedure on verbal orders is implemented.	10

	j	The organisation defines a list of high-risk medication(s).	10
	k	Audit of medication orders/prescription is carried out to check for safe and rational prescription of medications.	10
	l	Reconciliation of medications occur at transition points of patient care.	10
	m	Corrective and/or preventive action(s) is taken based on the analysis, where appropriate.	10
MOM.5: Documented policies and procedures guide the safe dispensing of medications.			10
	a	Documented policies and procedures guide the safe dispensing of medications.	10
	b	The procedure addresses medication recall.	10
	c	Expiry dates are checked prior to dispensing.	10
	d	There is a procedure for near expiry medications.	10
	e	Labelling requirements are documented and implemented by the organisation.	10
	f	High-risk medication orders are verified prior to dispensing.	5
MOM.6:There are documented policies and procedures for medication administration.			10
	a	Medications are administered by those who are permitted by law to do so.	10
	b	Prepared medication is labelled prior to preparation of a second drug.	10
	c	Patient is identified prior to administration.	5
	d	Medication is verified from the order and physically inspected prior to administration.	5
	e	Dosage is verified from the order prior to administration.	10
	f	Route is verified from the order prior to administration.	10
	g	Timing is verified from the order prior to administration.	10
	h	Medication administration is documented.	5
	i	Documented policies and procedures govern patient's self-administration of medications.	10
	j	Documented policies and procedures govern patient's own medications brought from outside the organisation.	10

MOM.7: Patients are monitored after medication administration.			
	a	Documented policies and procedures guide the monitoring of patients after medication administration.	10
	b	The organisation defines those situations where close monitoring is required.	10
	c	Monitoring is done in a collaborative manner.	5
	d	Medications are changed where appropriate based on the monitoring.	10
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.	5
	b	Near miss, medication error and adverse drug event are defined.	10
	c	These are reported within a specified time frame.	5
	d	They are collected and analysed.	10
	e	Corrective and/or preventive action(s) are taken based on the analysis where appropriate.	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.	5
	b	These drugs are stored in a secure manner.	10
	c	A proper record is kept of the usage, administration and disposal of these drugs.	10
	d	These drugs are handled by appropriate personnel in accordance with the documented procedure.	10
MOM.10: Documented policies and procedures guide the usage of chemotherapeutic agents.			
	a	Documented policies and procedures guide the usage of chemotherapeutic agents.	10
	b	Chemotherapy is prescribed by those who have the knowledge to monitor and treat the adverse effect of chemotherapy.	10
	c	Chemotherapy is prepared in a proper and safe manner and administered by qualified personnel.	5
	d	Chemotherapy drugs are disposed in accordance with legal requirements.	10

	e	Patient and family are educated regarding benefits/risks of chemotherapy, precautions to be taken and possible adverse reactions.	10
MOM.11: Documented policies and procedures govern usage of radioactive drugs.			
	a	Documented policies and procedures govern usage of radioactive drugs.	10
	b	These policies and procedures are in consonance with laws and regulations.	10
	c	The policies and procedures include the safe storage, preparation, handling, distribution and disposal of radioactive drugs.	10
	d	Staff, patients and visitors are educated on safety precautions.	10
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).	10
	b	Documented policies and procedures govern procurement, storage/stocking, issuance and usage of implantable prosthesis and medical devices incorporating manufacturer's recommendation(s)	5
	c	Patient and his/her family are counselled for the usage of implantable prosthesis and medical device including precautions, if any.	10
	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.	5
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.	10
	b	Medical supplies and consumables are used in a safe manner, where appropriate.	10
	c	Medical supplies and consumables are stored in a clean, safe and secure environment; and incorporating manufacturer's recommendation(s).	10
	d	Sound inventory control practices guide storage of medical supplies and consumables.	5
	e	There is a mechanism in place to verify the condition of medical supplies and consumables.	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.	10
	b	Patients and families are informed of their rights and responsibilities in a format and language that they can understand.	5
	c	The organisation's leaders protect patient and family rights.	10
	d	Staff are aware of their responsibility in protecting patient and family rights.	10
	e	Violation of patient and family rights is recorded, reviewed and corrective/preventive measures taken.	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.	10
	b	Patient and family rights include respect for personal dignity and privacy during examination, procedures and treatment.	10
	c	Patient and family rights include protection from neglect or abuse.	5
	d	Patient and family rights include treating patient information as confidential.	5
	e	Patient and family rights include refusal of treatment.	10
	f	Patient and family have a right to seek an additional opinion regarding clinical care.	10
	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.	10
	h	Patient and family rights include right to complain and information on how to voice a complaint	5
	i	Patient and family rights include information on the expected cost of the treatment.	5
	j	Patient and family rights include access to his / her clinical records.	10
	k	Patient and family rights include information on Care plan, progress and information on their health care needs.	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.	5
	b	The patient and/or family members are explained about the expected results.	10

	c	The patient and/or family members are explained about the possible complications.	5
	d	The care plan is prepared and modified in consultation with patient and/or family members.	10
	e	The care plan respects and where possible incorporates patient and/or family concerns and requests.	10
	f	The patient and/or family members are informed about the results of diagnostic tests and the diagnosis.	10
	g	The patient and/or family members are explained about any change in the patient's condition in a timely manner.	5
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.	10
	b	General consent for treatment is obtained when the patient enters the organisation.	10
	c	Patient and/or his family members are informed of the scope of such general consent.	10
	d	Informed consent includes information regarding the procedure, it's risks, benefits, alternatives and as to who will perform the procedure in a language that they can understand.	10
	e	The procedure describes who can give consent when patient is incapable of independent decision making.	10
	f	Informed consent is taken by the person performing the procedure.	10
	g	Informed consent process adheres to statutory norms.	10
	h	Staff are aware of the informed consent procedure.	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.	5
	b	Patient and/or family are educated about food-drug interaction	5
	c	Patient and/or family are educated about diet and nutrition.	10
	d	Patient and/or family are educated about immunisations.	10
	e	Patient and/or family are educated about their specific disease process, complications and prevention strategies.	10
	f	Patient and/or family are educated about preventing healthcare associated infections	5

	g	The patients and/or family members' special educational needs are identified and addressed	10
	h	Patient and/or family are educated in a language and format that they can understand.	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).	5
	b	The relevant tariff list is available to patients.	10
	c	The patient and/or family members are explained about the expected costs.	5
	d	Patient and/or family are informed about the financial implications when there is a change in the patient condition or treatment setting.	10
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.	10
	b	The organisation has a documented complaint redressal procedure.	10
	c	Patient and/or family members are made aware of the procedure for giving feedback and /or lodging complaints.	10
	d	All feedback and complaints are reviewed and/or analysed within a defined time frame.	10
	e	Corrective and/or preventive action(s) are taken based on the analysis where appropriate.	5
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.	10
	b	The organisation shall identify special situations where enhanced communication would be required.	5
	c	The organisation lays down an approach for effective communication in these identified situations.	10
	d	The organisation also defines what constitutes an unacceptable communication and sensitizes the staff about the same.	10
	e	The organisation has a system to monitor and review the implementation of effective communication	5
	f	The staff are trained in healthcare communication techniques periodically.	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.	10
	b	The infection prevention and control programme is a continuous process and updated at least once in a year.	10
	c	The hospital has a multi-disciplinary infection control committee, which co-ordinates all infection prevention and control activities.	10
	d	The hospital has an infection control team, which coordinates implementation of all infection prevention and control activities.	10
	e	The hospital has designated infection control officer as part of the infection control team.	10
	f	The hospital has designated infection control nurse(s) as part of the infection control team.	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.	10
	b	The organisation adheres to standard precautions always.	10
	c	The organisation adheres to hand-hygiene guidelines.	10
	d	The organisation adheres to transmission-based precautions always.	10
	e	The organisation adheres to safe injection and infusion practices.	5
	f	The organisation adheres to cleaning, disinfection and sterilization practices.	10
	g	An appropriate antibiotic policy is established and documented	10
	h	The organisation implements the antibiotic policy and monitors rational use of antimicrobial agents.	10
	i	The organisation adheres to laundry and linen management processes.	5
	j	The organisation adheres to kitchen sanitation and food-handling issues.	5
	k	The organisation has appropriate engineering controls to prevent infections.	10

	l	The organisation adheres to housekeeping procedures.	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.	10
	b	A collection of surveillance data is an on-going process.	10
	c	Verification of data is done on a regular basis by the infection control team.	10
	d	The scope of surveillance activities incorporates tracking and analysing of infection risks, rates and trends.	10
	e	Surveillance activities include monitoring the compliance with hand-hygiene guidelines.	10
	f	Surveillance activities include mechanisms to capture the occurrence of epidemiological significant diseases and multi-drug-resistant organisms, and highly virulent infections.	10
	g	Surveillance activities include monitoring the effectiveness of housekeeping services.	10
	h	Appropriate feedback regarding healthcare associated infection(HAIs) rates is provided on a regular basis to appropriate personnel.	5
	i	In cases of notifiable diseases, information (in relevant format) is sent to appropriate authorities.	5
HIC.4: The organisation takes actions to prevent and control Healthcare Associated Infections (HAI) in patients.			
	a	The organisation acts to prevent catheter associated urinary tract Infections.	10
	b	The organisation acts to prevent Ventilator Associated Pneumonia.	10
	c	The organisation acts to prevent catheter linked blood stream infections.	10
	d	The organisation acts to prevent surgical site infections.	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.	10
	b	Adequate and appropriate facilities for hand hygiene in all patient-care areas are accessible to healthcare providers.	5
	c	Isolation/barrier nursing facilities are available.	10
	d	Appropriate pre- and post-exposure prophylaxis is provided to all staff members concerned	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.	10
	b	Organisation has a documented procedure for handling such outbreaks.	10
	c	This procedure is implemented during outbreaks.	10
	d	After the outbreak is over appropriate corrective actions are taken to prevent recurrence.	10
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.	5
	b	Documented procedure guides the cleaning, packing, disinfection and/or sterilization, storing and issue of items.	10
	c	Reprocessing of instruments and equipment are covered.	10
	d	The organisation shall have a documented policy and procedure for reprocessing of devices whenever applicable.	10
	e	Regular validation tests for sterilization are carried out and documented.	10
	f	There is an established recall procedure when breakdown in the sterilization system is identified.	10
HIC.8: Biomedical waste (BMW) is handled in an appropriate and safe manner.			
	a	The organisation adheres to statutory provisions regarding biomedical waste.	10
	b	Proper segregation and collection of biomedical waste from all patient-care areas of the hospital is implemented and monitored.	5
	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.	5
	d	The biomedical waste treatment facility is managed as per statutory provisions (if in- house) or outsourced to authorized contractor(s).	10
	e	Appropriate personal protective measures are used by all categories of staff handling biomedical waste.	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.	10
	B	The organisation earmarks adequate funds from its annual budget in this regard.	10
	C	The organisation conducts induction training for all staff.	10
	D	The organisation conducts appropriate “in-service” training sessions for all staff at least once in a year.	10

Checklist

	Emergency			
SR NO	Check points	Yes	No	Remarks
	Structure			
1	Whether the triage area is marked separately	✓		
2	Does emergency department have a separate entrance	✓		
3	Is emergency signage visible from the road with proper lighting and signs		✓	
4	Is the doctor available round the clock	✓		
5	Does the number of trolleys and wheelchair commensurate with the needs	✓		
6	Is doctor's name and contact number kept posted all the times	✓		
7	Does the room retain the list of all the staff that contains name, contact details, designation	✓		
8	Is there appropriate waiting area for the relatives of the patients	✓		
9	Is emergency crash cart available	✓		
10	An appropriately quality staff is scheduled to manage triage	✓		
11	Defibrillator	✓		
12	Cardiac monitor	✓		
13	Emergency drugs	✓		
14	Resuscitation bags	✓		
15	Oral airways of various sizes		✓	
16	Laryngoscope with various blades	✓		
17	Laryngoscope replacement batteries with bulb	✓		
18	Endotracheal tube of various sizes	✓		
	Process			
1	Is there a system to review all imaging by a radiologist within 24 hours	✓		
2	Ability to perform acute blood test and receive result within one hour for arterial blood pressure, full blood picture	✓		
3	Security staff are immediately available when needed	✓		
4	Electrical equipment is charged all the times	✓		
5	Is crash cart checked daily regarding regular testing	✓		
6	The documentation from medico legal and clinical view point is detailed, professional and accurate	✓		
7	Are the separate registers maintained for medico legal cases, discharge, admission to wards	✓		
8	Is BMW segregated and handled properly	✓		
9	Does the initial assessment of the patient take place		✓	

10	Are the patients attended by attendants when they come or when they are transferred from the wards	✓		
11	Is staff trained in BLS/ACLS		✓	
	Outcome			
1	Time for initial assessment		✓	Taken but not properly
	Ambulance			
SR NO	Check points	Yes	No	Remarks
	Structure			
1	Adequate communication system exists in ambulance		✓	
2	Required equipment are available in the ambulance		✓	
3	Requires medicine are available		✓	
4	Is vehicle licence available	✓		
5	Maintenance of the oxygen to 90% of the total capacity		✓	
6	Calibration of equipment present	✓		
7	Is driver licence available	✓		
	Process			
	Is staff trained in BLS		✓	
	Is medication and equipment checklist maintained	✓		
	Is infection control practises followed	✓		
	OPD			
SR NO	Check points	Yes	No	Remarks
	Structure			
	Availability of enquiry counter	✓		
	Availability of registration counter	✓		
	Availability of separate queue for differently able	✓		
	Availability of designated waiting area with adequate sitting arrangement	✓		
	Availability of drinking water facility	✓		
	Availability of separate and functional toilet for differently able	✓		
	Availability of fans and lights in the area	✓		
	Is the scope of services displayed	✓		
	Is citizen charter and patient charter displayed	✓		
	list of doctors along with the OPD timings displayed	✓		
	Are the different OPD rooms numbered	✓		
	Is there provision of patient privacy in the consultation room	✓		

	BP apparatus and stethoscope present	✓		
	Weighing machine	✓		
	Thermometer	✓		
	Calibration of the above	✓		
	Manpower			
	Availability of dedicated registration clerk	✓		
	Availability of nurse to direct the patients to specific OPD	✓		
	Process			
	Is UHID generated for all the patients is separate registration done for old and new is the tariff rates defined and made aware to the patients/attendant's is	✓		
	Is patient privacy maintained during consultation	✓		
	Is the staff aware of the information like doctor's OPD timings, charges etc.	✓		
	Outcome			
	Monitoring of waiting time		✓	Done but its biased
	OPD patient satisfaction survey	✓		
	Laboratory			
SR NO	Check points	Yes	No	Remarks
	Is the lab staff taking necessary precautions while handling samples	✓		
	Is BMW segregation done	✓		
	Is critical results defined, reported and documented		✓	
	Is surveillance for lab test being carried out	✓		
	Is EQAS being monitored	✓		
	Lab reports signed by pathologist	✓		
	Labelling	✓		
	Time frame defined for dispatching the reports	✓		
	Tat for lab reports monitored	✓		
	MOU available	✓		
	Process			
	Is the scope of service defined	✓		
	Is the maintenance of lab equipment done	✓		
	Calibration		✓	
	Is lab staff aware about the precautions	✓		But some are not aware
	Outcome			

	Number of reporting errors per 1000 investigations	✓		
	% Of reports having clinical correlation	✓		
	% Of reports having adherence to safety precautions		✓	Done but not properly
	% Of re dos		✓	Done but not properly
	Radiology and imaging services			
	Structure			
	Is the unit has AERB	✓		
	Are basic facilities for staff present	✓		
	Is the staff licenced and competent in knowledge and skills	✓		
	Is there a change room available		✓	
	Lead glass available	✓		
	Lead apron available	✓		
	Gonad shield available	✓		
	Is radiologist available	✓		
	Is critical results defining, reported and documented		✓	
	Radiation hazard symbol is present	✓		
	PNDT licence is available	✓		
	Process			
	Maintenance of equipment			
	Calibration		✓	
	Radiology staff aware about the safety precautions		✓	
	Is radiology staff taking safety measures	✓		
	Quality assurance program is followed or not	✓		
	Radiology test requisition form filled or not		✓	Sometimes
	Reports signed by radiologist	✓		
	Time frame defined for dispatching reports		✓	Defined but not followed
	Turnaround time of reports monitored		✓	
	Outcome			
	Number of reporting errors	✓		
	% Of reports having clinical correlation with provisional diagnosis		✓	
	% Of adherence of safety precautions	✓		
	% OF RE DOS		✓	
	Wards			
SR NO	Check points	Yes	No	Remarks
	Structure			

	Is medical gas facility available	✓		
	Are basic facilities of the staff present	✓		
	Is needle cutter present in each ward	✓		
	Emergency crash cart present	✓		Present but not monitored
	C0lor codes BMW bins are present	✓		
	Nursing station	✓		
	Adequate number of nurses		✓	
	Racks are present to store linen	✓		
	Wash basin is present	✓		
	PPE is provided	✓		
	Process			
	Staff aware of admission process	✓		
	Does the cleaning of department takes place	✓		
	Administration of medication is done a qualified doctor	✓		
	Indent of medicines and other items in placed by nurses regularly	✓		
	PPE is use by the nurses	✓		
	Are BMW segregated at the point of generation		✓	
	Does the nurse on duty record the details of the patient on daily basis	✓		
	Are nurses trained in BLS	✓		
	Is the staff aware about transfer in and out	✓		
	Is biomedical waste management practises being followed	✓		
	Is cost estimate for treatment provided	✓		
	Is discharge process defined and documented	✓		
	OT			
SR NO	Check points	Yes	No	Remarks
	Is HVAC system present	✓		
	Proper zoning concept being followed		✓	
	Number of OT tables present in the hospital appropriate for the daily load	✓		
	If any OT has got more than one OT table	✓		
	Hand washing facility	✓		
	Firefighting system	✓		
	Continuous water available	✓		
	Changing room available	✓		
	Continuous power backup	✓		
	Crash carts		✓	
	Defibrillator	✓		
	Ecg monitor	✓		

	Oxygen supply shadow less OT	✓		
	PPE provided to the staff	✓		
	Scrubbing area	✓		
	Process			
	Consent for surgery and anaesthesia taken from patient	✓		
	OT list prepared	✓		
	OT booking done	✓		
	Preparation of patient before the operation	✓		
	Nurse enters the details in the OT register	✓		
	OT instruments counted before and after operation	✓		
	OT disinfection done after every procedure	✓		
	Outcome			
	% Of anaesthesia related adverse events being monitored	✓		
	% Of anaesthesia related mortality	✓		
	% Of modification in plan of anaesthesia	✓		
	% Of SSI	✓		
	Re exploration rate	✓		
	Re scheduling rate		✓	
	Pharmacy			
SR NO	Check points	Yes	No	Remarks
	Racks are available in sufficient numbers	✓		
	Adequate ventilation and lighting	✓		
	Security system available		✓	
	Fire detecting and firefighting systems are available	✓		
	No water seepage	✓		
	All items storage areas are marked and labelled	✓		
	Receiving area, storing area and segregation area		✓	
	Qualified and trained staff available	✓		
	Provision for storage of narcotic drugs	✓		
	Process			
	The items are labelled and arranged as per alphabetical order	✓		
	Pest /rodent control		✓	
	Is stock register maintained	✓		
	Verification of stock is done every six months		✓	Yearly
	Is there a drug and therapeutic committee in the hospital	✓		
	Hospital drug formulary available	✓		
	Adverse drug reactions are analysed	✓		

	Outcome			
	% Of local purchase		✓	
	% Stock outs	✓		
	% Of variation from the procurement process	✓		
	% Of goods rejected	✓		
	Re order level		✓	
	% Drug return		✓	