STUDY ON PRE AND POST QUALITY ASSESSMENT OF HOSPITAL FACILITY IN RELATION TO NATIONAL ACCREDITATION BOARD FOR HOSPITAL AND HEALTHCARE PROVIDERS (NABH) ENTRY LEVEL STANDARDS IMPLEMENTATION

Internship Training
at
Zon Healthcare Consulting Private Limted

By
Gaurav Sharma

Under the guidance of
Dr. Vijay Pratap Raghuvanshi

MBA Hospital & Health Management
2013–15

Institute of Health Management Research
Jaipur
2015

Internship Training

at

120 bedded Multispecialty Hospital, Bhilwara, Rajasthan

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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. Gaurav Sharma student MBA Hospital and Health Management, IIHMR Jaipur has undergone Dissertation/ internship training at a Multispecialty Hospital, Bhilwara, Rajasthan as a Management Trainee of Zon Healthcare Consulting Pvt Ltd from 29.01.2015 to 30.04.2015.

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.

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

Dr. Vijay Pratap Raghuvanshi
Assistant Professor
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.org, Web.: www.iihmr.org

Zon Healthcare Consulting Private Limited
31, Ground Floor, Sai Dham Commercial Complex,
PK Road, Mulund(West), Mumbai - 400 080.
CIN No: U85100MH2010PTC207912
Ph. No.: (022) 67703374/75
info@zonhealthcare.com | www.zonhealthcare.com

The certificate is awarded to

Dr. Gaurav Sharma
In recognition of having successfully completed his
Internship in the department of
Implementation and Projects
and has successfully completed his Project on
"Study on Pre and Post Quality assessment of Hospital Facility in relation to National Accreditation Board for Hospitals and Healthcare providers (NABH) Entry Level Standards implementation"
Duration: 29 Jan 2015 to 30 April 2015
Organization: Zon Healthcare Consulting Pvt. Ltd
He comes across as a committed, sincere & diligent person who has
a strong drive & zeal for learning
We wish him/her all the best for future endeavors

Dr. Saurabh Ladha
Project Manager

Ms. Kashmira Rai
Manager Administration

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

IIHMR UNIVERSITY

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled "**Study on Pre and Post Quality assessment of Hospital Facility in relation to National Accreditation Board for Hospitals and Healthcare providers (NABH) Entry Level Standards implementation**" submitted by Dr. Gaurav Sharma, (1444) under the supervision of Mr. Vijaypratap Raghuvanshi for award of MBA Hospital and Health Management of the Institute carried out during the period from 29.01.2015 to 30.04.2015 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.

गौरव शर्मा

Signature

Dr Gaurav Sharma

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

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LIST OF ABBREVIATIONS

AERB	Atomic Energy Regulatory Board
AIDS	Acquired Immuno Deficiency Syndrome
BMW	Bio-medical waste
CSSD	Central Sterile Supply Department
ER	Emergency
HK	House Keeping
HR	Human Recourses
ICN	Infection Control Nurse
ICU	Intensive Care Unit
MRD	Medical Records Department
NABH	National Accreditation Board for Hospital& Healthcare
OPD	Out Patient Department
OT	Operation Theatre
PPE	Personal Protective Equipments
USG	Ultrasonography
ZHC	Zon Healthcare Consulting Pvt Ltd

Chapter1: Introduction

1.1 Quality in healthcare is a relatively novel concept for Hospitals in our country. It is the guiding principle in assessing how well the Hospital system is performing in its mission to improve the health of the citizens. Quality is the degree of adherence of a product or service to the predetermined specification. NABH Standards are the set of standards formed to provide optimal level of quality health care, with the aim to deliver high quality services which are fair and responsive to client's needs, which should provide equitably and deliver improvements in the health and wellbeing of the population.

Hospital has undertaken an initiative for quality improvement in the health facilities with the active technical assistance of Quality Consultant of Zon Healthcare Consultancy Pvt Ltd. Though, ZHC realizes the significance of increasing availability of health services, it is also aware that availability does not directly improve its utilization. It needs concerted efforts to bring about improvement in the quality and comprehensiveness of services through improvement initiatives for service delivery processes. With this understanding, ZHC had started a project to enhance the service quality level of hospital. It is time now to look at how evaluation of the hospital and subsequent improvement, go hand in hand leading to better access and quality service to all service seekers with focus on erstwhile deprived section of the society .The establishment of a quality system in a healthcare organization facilitates the standardization of the systems and processes (both clinical and administrative). This standardization further ensures improving the performance of the hospital with respect to above-stated key elements/components of quality. The quality system thus acts as a vehicle for healthcare organizations to focus on patient and provider needs and expectations.

To facilitate the above goals, comprehensive study was carried out on the current processes, practices and existing infrastructure with other available resources to identify the major gaps based on NABH standards of quality management system.

Patients	Hospital	Staff	Paying and regulatory bodies
• improved quality care and patient safety • serviced by trained & skilled medical staff • Rights of patients are respected and protected • Patient satisfaction is regularly evaluated.	• Stimulate a journey towards continuous improvement • Demonstrating commitment to quality care • Framework for organizational structure and management • Opportunity for benchmark with the best • Raises community confidence • Competitive edge in the marketplace	• Satisfied as it provides for continuous learning, good working environment, leadership and above all ownership of clinical processes • It improves overall professional development • Enhance staff education	• Empanelment by insurance and other third parties • provides access to reliable and certified information on facilities, infrastructure and level of care

Figure 1.1: Different Perspective of Quality Management

The overall objective of NABH is to provide health care that is quality oriented and sensitive to the needs of the people. The specific objectives of NABH for Hospitals are:

1. To provide comprehensive secondary and Tertiary healthcare (specialist and referral services) to the community through the Multispecialty Hospital.

2. To achieve and maintain an acceptable standard of quality of care.

3. To make the services more responsive and sensitive to the needs of the people of the community.

1.2 Aim of the Study:

To access and analysis the gaps in quality compliance of the facility as per NABH standards so as to prepare it for further accreditation process by NABH at Entry level certification.

1.3 Objectives of study:

- To describe the policy and procedures of respective chapters of NABH in the hospital with the identification of existing process Owners, Input(s), Outputs (s) and process flow of each process occurring at each section of the hospital with the relevant records.
- To identify the significant gaps observed on all the processes in each section and explanation of the gap statement with document evidences and photographs. The gaps are analyzed based on NABH entry level self assessment toolkit.
- To identify the area this needs to be focused upon primarily.
- To prepare actions to be taken to fulfill the gaps.

Chapter 2: Literature Review

The Indian healthcare industry has achieved considerable success in addressing the healthcare needs of the population since independence. The Indian hospital sector is a key component of Indian healthcare industry with contribution of nearly 70 per cent of total revenues of the industry. Until 1980s healthcare was delivered mainly by government-run and non-profit based institutions. From 1980 the Indian hospital sector started receiving private capital from corporate investors. From that point on, increase in population, incidence of non-communicable diseases, rising middle class incomes, technological intervention for better quality delivery etc have driven the growth for private sector hospitals in India.

Hospital Accreditation is a public recognition by a National Healthcare Accreditation Body, 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.

In India, Heath System currently operates within an environment of rapid social, economical and technical changes. Such changes raise the concern for the quality of health care. Hospital is an integral part of health care system.

Accreditation would be the single most important approach for improving the quality of hospitals. Accreditation is an incentive to improve capacity of national hospitals to provide quality of care. National accreditation system for hospitals ensure that hospitals, whether public or private, national or expatriate, play there expected roles in national health system.

Confidence in accreditation is obtained by a transparent system of control over the accredited hospital and an assurance given by the accreditation body that the accredited hospital constantly fulfills the accreditation criteria.

NABH is a genuine measure to strengthen the Hospital Management System and has aroused many hopes and expectations. The Mission seeks to provide effective and quality health care to the community throughout the country. Towards this NABH for Hospitals were developed, Renewed and released in April, 2011. This is used as the reference point for hospitals infrastructure planning and up gradation. NABH are a set of standards envisaged to improve the quality of health care delivery in the country.

Quality in Health Care

Quality in Health System has two components:

Technical Quality: on which, usually service providers (doctors, nurses & para-medical staff) are more concerned and has a bearing on outcome or end-result of services delivered.

Service Quality: pertains to those aspects of facility based care and services, which patients are often more concerned, and have bearing on patient satisfaction

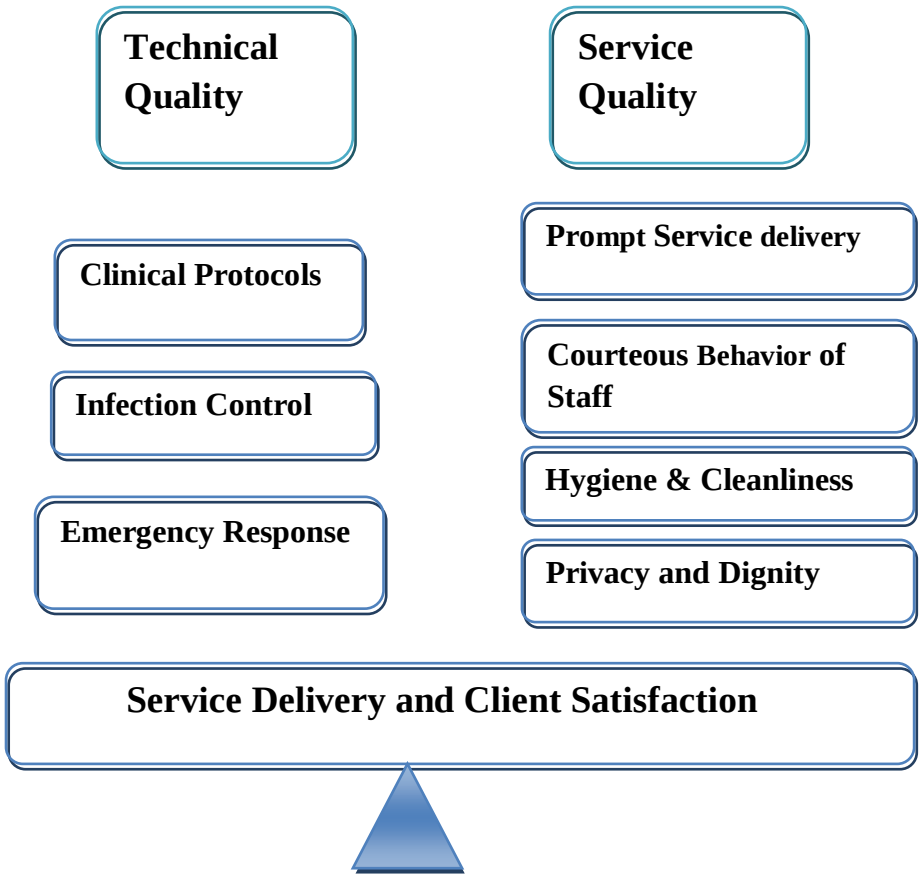

Figure No. 2.1: Sub components of Quality

The notion of enforcing quality care in medical profession can be traced back to early 1900s in the form of "Medical Audit" in the United States of America (USA). The medical audit gradually moved to "Hospital Standardization Program" in 1918 and finally took the form of "Quality Assurance activities" (i.e., delivery of relevant and effective medical care in accordance with the standards) with the formation of "Joint Commission on Accreditation of Hospitals" later named as "Joint Commission on Accreditation of Health Care Organizations" in 1960. The Geneva-based International Organization for Standardization (ISO) was raised in 1946. The ISO 9000 series of standards have generated maximum interest worldwide. In India, National Accreditation Board for Hospital and Health Care Providers (NABH), a constituent board of Quality Council of India (QCI), has been set up to establish and operate accreditation program for healthcare organizations. In order to ensure quality of

services IPHS have been set up for public health facilities so as to provide a yardstick to measure the services being provided there.

Singh (2010)[8], concluded that the important reasons to visit government hospitals are fewer charges, geographical proximity, recommended by their friends or relatives. Patients are found to be dissatisfied with the doctors' checkups. Mostly patients were found dissatisfied with the hygiene and overall condition of the basic amenities. Half of the patients were satisfied with the recovery since admission in the hospital. Majority of patients were satisfied with various diagnostic services provided by hospitals. Mostly patients did not lodge complaint against the behavior of staff and quality of services.

Karuna Dev Sharma (2012)[7] in his study on "Implementing Quality services in Public sector Hospitals in India" concluded that Effective implementation of the Quality Management System will address the major quality issues such as the staff deficit ,implementation of the health management information system, interpersonal communication, and other important unaddressed areas such as regular patient feedback and its evaluation, standardization of care processes, patient safety, safe transport, and continuity of care and will thus facilitate improvement in public sector hospital as envisaged under NRHM.

Chapter 3 : Research Methodology

Research question:

Assess the Initial level of quality compliance and post status of hospital quality system after implementation of Standards.

Area of Study: The study was under taken at 120 bedded Multispecialty hospital, Bhilwara, Rajasthan.

Study Design: Descriptive study, Exploratory in nature.

Target Sample: Doctors, Nurses, Hospital Administrator, housekeeping and Utility service staff, Patients.

Tools:

- NABH Self assessment tool kit was used as the main data tool.
- The data collection was done by 3 methods
    - ✓ Observation
    - ✓ Staff and Patient Interview
    - ✓ Documentation

Method: Facility Round, in depth interviews with the Staff.

Methodology

Stage I NABH self Assessment Toolkit was used for a total survey of the hospital in terms of services provided, Manpower, Physical infrastructure, Equipments, drugs and Lab services.

According to toolkit standards scoring is given to each concerned area.

Score '0' – Non compliance

Score '5'- Partial compliance

Score '10' - Complete compliance

Stage II Observation and personal interview were used to map the various processes of the hospital and to know the functioning of the each department.

Stage III Extensive analysis based on data collected from stage I and II. Based on this Report was prepared reflecting the processes, Infrastructure, Equipments, Manpower. The report reflects strengths of the hospital and various gaps observed in the processes and other parameters

Chapter 4 : Gap Analysis:

Chapter 1: ACCESS, ASSESSMENT AND CONTINUITY OF CARE (AAC)	
AAC.1: The organization defines and displays the services that it can provide.	3.3
AAC.2: The organization has a documented registration, admission and transfer process.	0
AAC.3 Patients cared for by the organization undergoes an established initial assessment.	1.3
AAC.4 Patient care is continuous and all patients cared for by the organization undergo a regular reassessment.	5
AAC.5 Laboratory services are provided as per the scope of the hospital's services and laboratory safety requirements.	4.1
AAC.6 Imaging services are provided as per the scope of the hospital's services and established radiation safety programme.	5
AAC.7 The organization has a defined discharge process.	5.8
Chapter Average Score	3.5

Standard 1: The services being provided are not clearly defined and displayed. All Staff is not oriented to these services.

Standard 2: There is no Standard policy and procedure documented registration, Admission and transfer (Stable or unstable patients) process. Staff is not oriented to these services.

Standard 3: There is no documentation of initial assessment and plan of care in patient care area.

Standard 4: Patients are reassessed at regular intervals but documents do not maintained.

Standard 5: Scope of Laboratory services commensurate with the hospital services and lab staff is also trained. There is no documentation of Laboratory Quality Assurance program.

Standard 6: MRI, X-Ray and CT scan facilities are available. Results are available in time and critical results are conveyed to the concerned consultant. There is no Radiation Safety program. There is semi skilled staff.

Standard 7: Documented discharge is done but not as per NABH standards. Discharge Summary is given to the patients while leaving the hospital, but its contents are not up to NABH Standards.

Chapter 2: CARE OF PATIENTS (COP)	
COP.1: Care of patients is guided by accepted norms & practice.	2.5
COP.2: Emergency services including ambulance are guided by documented procedures.	1
COP.3: Documented procedures define rational use of blood and blood products.	3.75
COP.4: Documented procedures guide the care of patients as per the scope of services provided by hospital in Intensive care and high dependency unit.	0
COP.5: Documented procedures guide the care of obstetrical patients as per the scope of services provided by hospital.	5
COP.6: Documented procedures guide the care of pediatric patients as per the scope of services provided by hospital.	2
COP.7: Documented procedures guide the administration of anesthesia.	1.6
COP.8: Documented procedure guides the care of patients undergoing surgical procedures.	5
Chapter Average Score	2.6

Standard 1: Policies and procedures for uniform care of patients is provided in all setting of the organization and is guided by the applicable laws, regulations and guidelines, is not documented. Nursing stations are not located properly for direct patient monitoring. Handrails not provided in patient care areas, to avoid patient fall. Disabled friendly toilets are not available.

Standard 2: There is no documentation about Emergency services. Ambulance Services provided by the hospital need to be improved a lot, Ambulance are not well equipped. Training should be provided about Cardio pulmonary resuscitation and it should be documented. There is no Triage system which needs to be implemented. No ET tubes, laryngoscopes, ECG machines or defibrillator in the emergency room. Emergency Crash Cart is not available.

Standard 3: Policies and procedures are not defined for the rational use of blood and blood products. There is no reporting of transfusion reactions.

Standard 4: For Intensive Care Unit and High Dependency Unit adequate staff and equipment are not there. Quality assurance program is also not there. ICU services not fulfill the standard criteria. Crash carts not available for emergency medicines and instruments instead kept in almirahs.

Standard 5: An Obstetrician is providing services for high risk cases, but specialized facilities require further improvement. Initial assessment is not documented as NABH requirements.

Standard 6: Pediatric services are not documented. Initial assessment is not documented as NABH requirements.

Standard 7: No documented policies and procedures exist for administration of anesthesia. Even PAC note documented.

Standard 8: No Policies and procedures are documented for the care of patients undergoing surgical procedures and No the quality assurance program for the operation theatre.

Chapter 3: MANAGEMENT OF MEDICATION (MOM)	
MOM.1: Documented procedures guide the organization of pharmacy services and usage of medication.	0
MOM.2: Documented policies & procedures guide the storage of medications.	4
MOM.3: Documented procedures guide the prescription of medications.	3.75
MOM.4: Policies & procedures guide the safe dispensing of medications.	5
MOM.5: There are defined procedures for medication administration.	3.75
MOM.6: Adverse drug events are monitored.	0
MOM.7: Documented policies & procedures govern usage of radioactive drugs.	NA
Chapter Average Score	2.75

Standard 1: There is no documented procedures guide the organization of pharmacy services and usage of medication. Hospital formulary has not been developed.

Standard 2: There is no policy for storage of medicine. Medications are stored properly, are saved from theft or loss; but standards need to be maintained as per NABH. Look alike and sound alike medicine should be store separately.

Standard 3: Documentation needs to be done for prescription of medication. There is need to be define High risk medicines and process to prescribe them

Standard 4: Documentation needs to be done for safe dispensing of medications.

Standard 5: Documentation has been done for medication administration, but it is incomplete & not legible and prepared medication is needed to be labeled prior to preparation of a second drug. Narcotic drugs and psychotropic substances are not used in the hospital.

Standard 6: Adverse drug events are not monitored and documented..

Standard 7: Radioactive drugs are not used in the hospital.

Chapter 4: PATIENT RIGHTS AND EDUCATION (PRE)	
PRE.1: Patient rights are documented displayed and support individual beliefs, values and involve the patient and family in decision making processes.	0
PRE.2: Patient and families have a right to information and education about their healthcare needs.	7.5
Chapter Average Score	3.25

Standard 1: There is no documentation and signage about protection of patient and family rights and supporting their individual beliefs values and involving the patient and family in decision-making processes.

Standard 2: A documented process for obtaining patient and/or family's consent exists for informed decision making about their care is perfectly done. Patient and families are educated about their specific disease process, medications and are taught in the language they can understand. Patients and family are educated about the estimated cost of treatment and its implication on change of treatment.

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

Standard 1: Hospital does not have an infection control committee, infection control team and manual. There is no surveillance system for infection control. Its need to be done that infection control program is supported by the organization's management and training to staff is start as soon as possible. There is no documented and periodic survey, and monitoring of urinary tract infections, respiratory tract infections, intra-vascular device infections, surgical site infections. Use of personal protective equipments like glove, mask etc not being used by the nursing staff. Non availability of liquid antiseptic hand wash, proper disinfectants, floor cleaners. No Autoclaving of instruments performed. Hand hygiene practices not followed. There is no procedure for periodic immunization of staff. No standard procedures for needle stick injuries, adverse reactions followed.

Standard 2: The Organization does not take actions to prevent or reduce the risk of Hospital Associated Infections (HAI) in patients and employees. There need to be Hepatitis vaccination for all staff. Documentation needs to be improving for procedures for sterilization activities in the organization.

Standard 3: Biomedical waste is not segregate properly at definite source and final disposal not done properly as per statutory requirements.

Chapter 6: CONTINUOUS QUALITY IMPROVEMENT (CQI)	
CQI.1: There is a structured quality improvement, patient safety and continuous monitoring programme in the organization.	0
CQI.2: The organization identifies key indicators to monitor the structures, processes and outcomes which are used as tools for continual improvement.	0
Chapter Average Score	0

Standard 1: It is needs to be structure a quality department, quality improvement and continuous monitoring program in the organization. Safety and quality control program of the diagnostics services, invasive procedures, anesthesia, and infection control needs to be documented and implemented.

Standard 2: Identify key indicators to monitor the managerial structures, processes and outcomes which are used as tools for continual improvement have been documented and need to be implemented.

Chapter 7: RESPONSIBILITIES OF MANAGEMENT (ROM)	
ROM.1: The responsibilities of the management are defined	3.33
ROM.2: The organization is managed by the leaders in an ethical manner.	6.25
ROM.3: The organization has set up multi-disciplinary committees to oversee specific areas of quality and patient safety.	0
Chapter Average Score	3.20

Standard 1: Responsibilities of Management are needs to be defined. There is no departmental classification of Services. Management Department works as HR, Finance department.

Standard 2: Organization's Ethical Management needs to be improved. A suitably qualified and experienced individual needs the organization to review these matters.

Standard 3: The organization need to set up multi-disciplinary committees to oversee specific areas of quality and patient safety.

Chapter 8: FACILITY MANAGEMENT AND SAFETY (FMS)	
FMS.1: The organization's environment and facilities operate to ensure safety of patients, their families, staff and visitors.	3
FMS.2: The organization has a program for clinical and support service equipment management.	0
FMS.3: The organization has provisions for safe water, electricity, medical gas and vacuum systems.	6.7
FMS.4: The organization has plans for fire and non-fire emergencies within the facilities.	0
Chapter Average Score	2.42

Standard 1: Documentation needs to be done on the aspects to ensure safety of patients, their families, staff and visitors. Training need to be start on safety measures in hospital.

Standard 2: The organization should be a documented program for clinical and support service equipment management. Preventive Maintains and calibration of equipments are needed to be done on time.

Standard 3: The organization has provisions for safe water and electricity, but not for medical gases and vacuum systems.

Standard 4: The organization has plans for fire only and not for non-fire emergencies within the facilities. This is needed to be documented. There is no provision for availability of medical supplies, equipment and materials during emergencies, as well as training is also required for disaster management. No fire exit plan.

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

Standard 1: The organization has not a documented system of human resource planning even they do not have human resource department.

Standard 2: Documentation needs to be done about employee rights and responsibilities, orientation and socialization is done through training and induction manual. Program for professional training and development of the staff are not taken up.

Standard 3: The organization need to develop a well-documented disciplinary procedure. A grievance handling mechanism needs to be documented in the organization.

Standard 4: There is no system of health checkups of staff and addressing of occupational hazards. It needs to be implementing for improvements of staff safety and health.

Standard 5: Documented personal record for each staff member is maintained but not as per NABH Standards.

Chapter 10: INFORMATION MANAGEMENT SYSTEM (IMS)	
IMS.1: The organization has a complete and accurate medical record for every patient	4
IMS.2: The medical record reflects continuity of care.	7.5
IMS.3: Documented policies and procedures are in place for maintaining confidentiality, integrity and security of records, data and information.	5
IMS.4: Documented procedures exist for retention time of records, data and information.	1.7
Chapter Average Score	4.5

Standard 1: Policies and procedures are documented to meet the information needs of the care providers, management of the organization as well as other agencies that require data and information from the organization.

Standard 2: Documentation is done for processes for effective management of data.

Standard 3: The medical records are not always complete.

Standard 4: The medical record reflects continuity of care, due to presence of HMIS.

Standard 5: Policies and procedures are in place for maintaining confidentiality, integrity and security of information proper implementation is not there.

Standard 6: Documented policies and procedures exist for retention time of records, data and information implementation is needed in proper way.

Standard 7: Review of Medical Records is not done.

Miscellaneous:

- Patient information and patient status is verbally communicated by the nurses from one shift to the other in wards. This may be a constraint in patient care management**.**
- No hand over take over charge practiced of medicines, equipments between shifts.
- Many a times, more than 2-3 attendants are present with a patient in wards.
- Attendants are also seen sitting on patients beds in the ward.
- No control on thefts, pilferage of linen, medicine.

Fig 4.1 Patient attendants in the wards

CHAPTER 5: Implementation of Standards

Here in, the gaps as identified will be taken up strategically and short term, long term goals will be identified in liaison with the hospital. Special consideration on gaps of the department is given and action plan is prepared and need to be monitored by internal experts.

5.1 Formation of Quality Department and Project Team

1. **Establish Quality Department**
    - HOD Quality
    - Quality Executive
2. **Establish Project team (All Full-time Employees)**
    - Quality Head & Project Head
    - Quality Executive
    - Maintenance In-charge
    - HOD - Human Resource
    - Nursing superintendent
    - Medical superintendent
    - Infection Control Nurse (2)
    - Stores Head
    - Head Pharmacy
    - Bio-Medical Engineer
    - Head Housekeeping

5.2 Implementation Parameters:

There are following works to be done to fulfill the NABH standards.

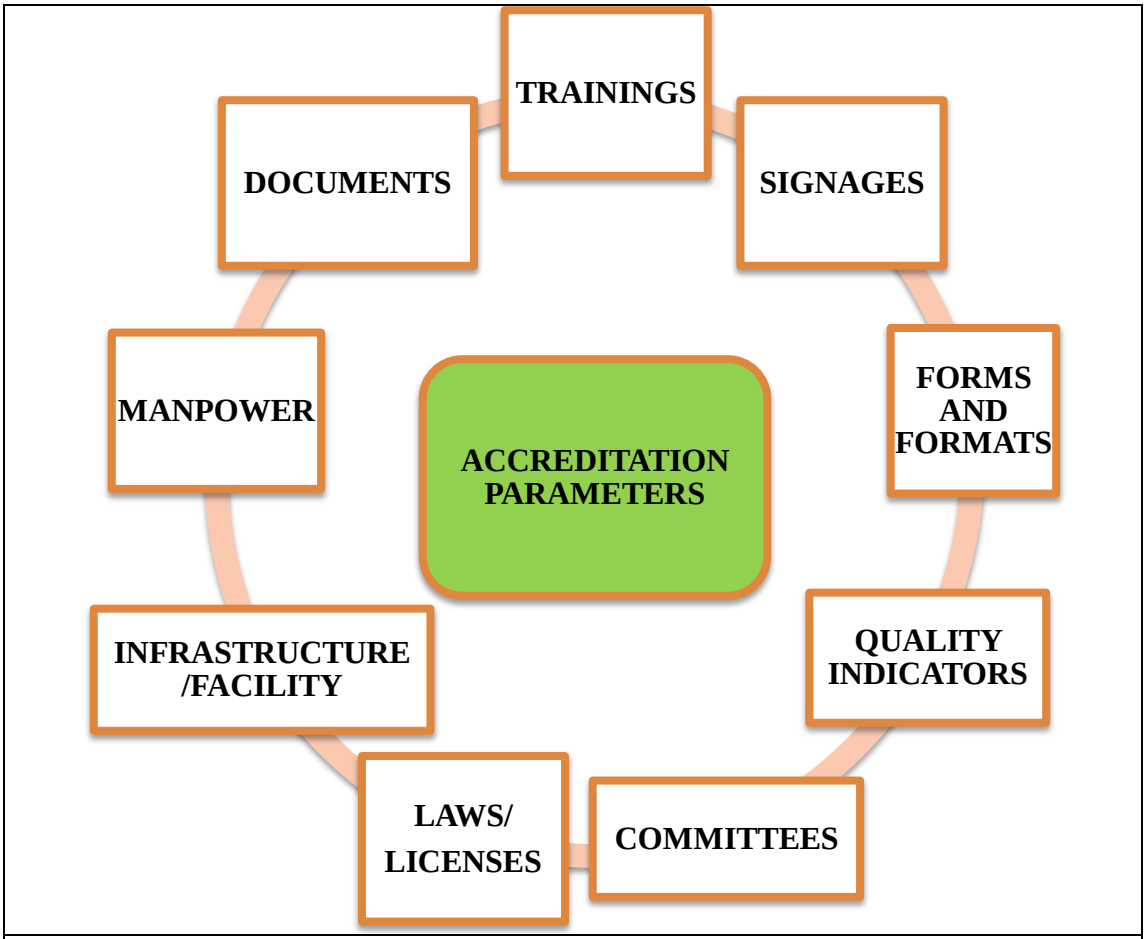

Fig: 5.1 **Work to do for Full fill the NABH Standards**

There is following works to need to be done on priority to fulfill the NABH standards criteria.

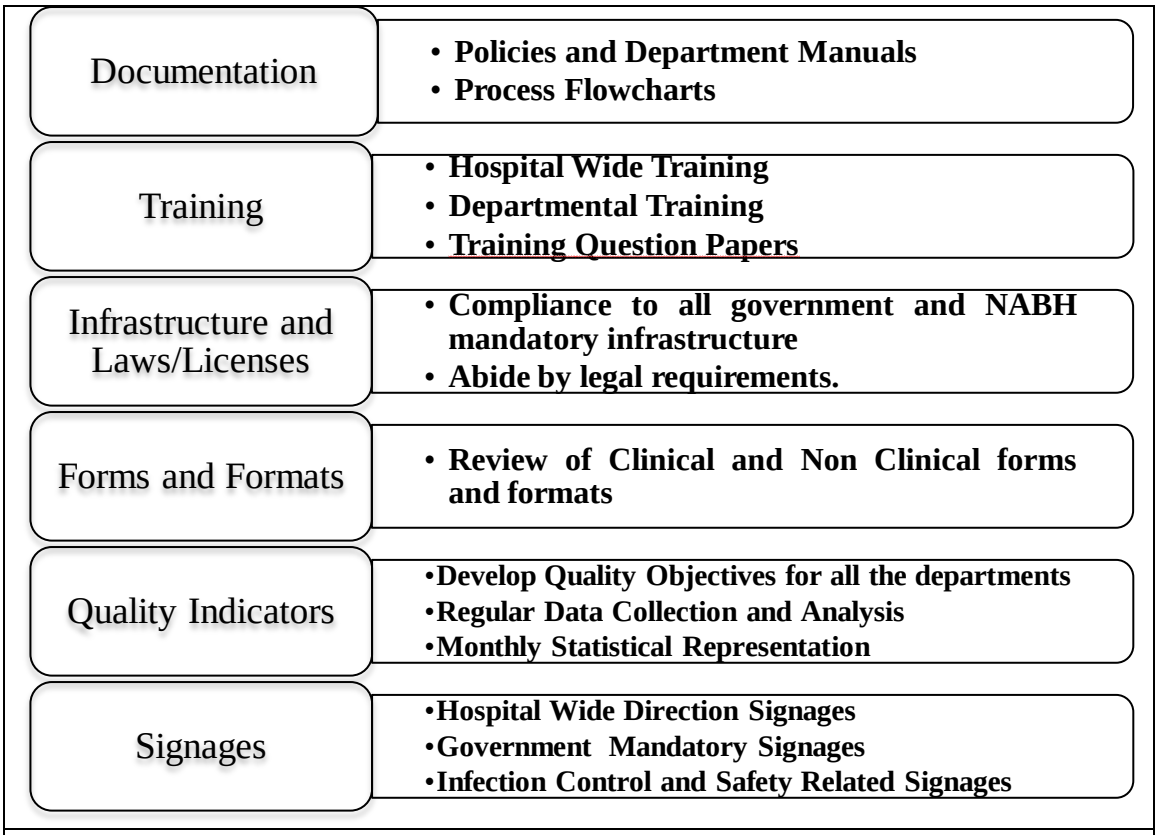

Fig 5.2: Plan to do

5.3 Establish committees:

To promote multidisciplinary and collaborative decision making actions authorities in hospital we established 4 committees to operate efficiently and effectively work.

The hospital had following committees for developing, implementing and monitoring programs to improve the patient care in the hospital.

List of committees are as follows:

1. Quality Committee
2. Hospital Safety Management Committee

3. Infection Control Committee
4. Pharmaco Therapeutic Committee

5.4 .Licenses and Legal compliances

- NOC from chief Fire officer
- NOC from pollution control board
- Radiation protection certificate
- RSO certificate
- Radiation Rooms Layout Approval
- Approval for Lift and Escalator
- Registration of ambulances
- Building registration
- Pharmacy Registration

5.5 Organogram:

All organizations have defined ownership and management team who govern the all higher level decisions in the organization which is define in the organogram. Various clinical and non-clinical departments head have been given responsibilities commensurate to their functions which have been depicted in the organogram.

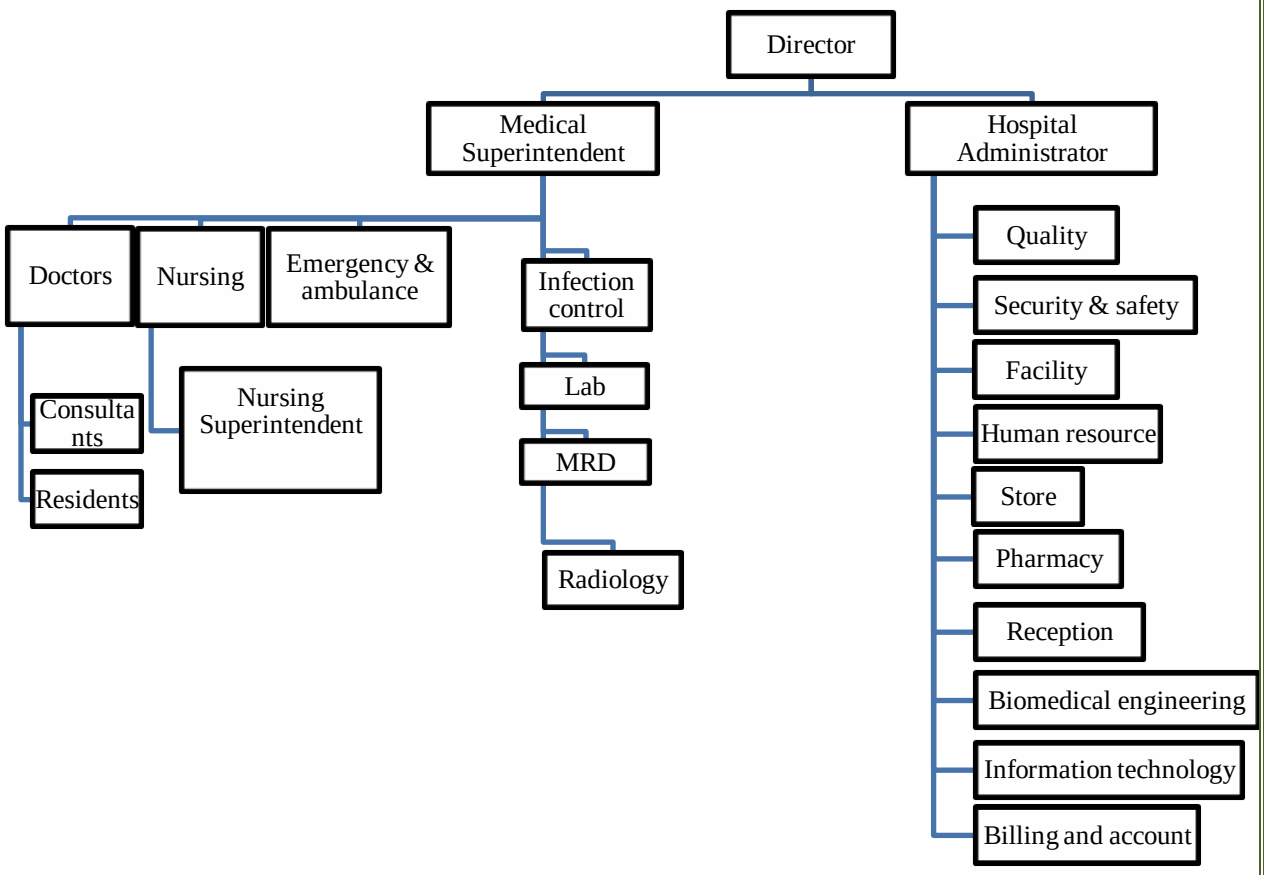

Fig 5.3: Organogram of Hospital

5.6 Policies and procedure:

Develop documents including quality manual, procedures and work instructions to institute processes, to maintain optimal functionality within the existing resources and processes

Documented all policy and procedure according to NABH Chapters.

For Eg:

- Policy of Registration admission and discharge
- Policy of Infection control Program
- Policy on Blood Transfusion
- Anesthesia Policy
- Emergency Policy

5.7 Facility findings

	
Before	After
Fig 5.4: After Laundry procedure Dry linen tied on ropes and not on floor	

	
Before	After
Fig 5.5: Chiller should be clean and no rust should be there, paint the chiller plant. The entire rusted pipe to be painted.	

5.8 TRAINING:

Fig 5.6: BLS Training

Fig 5.7: Training on Infection control Practices

Fig 5.8: Fire Safety Training

There are following 4 training program runs into hospital:

1. Infection Control Training
2. Fire Safety Training
3. HR & NABH related Training
4. Basic Life Support Training

5.9 Signages:

Patient rights & responsibilities board and list of OPD services board and necessary IEC material displayed.

Hand hygiene posters displayed in all OPD clinics.

Fig 5.9: Signage for Fire Safety Responce

Fig 5.10: Signage for BMW Room

Fig 5.11: Signage For High Risk area

		
Fig 5.12: Warning Signage outside the Radiology department	Fig 5.13: WHO hand hygiene steps (Posters to reinforce hygiene)	Fig 5.14: How to use fire extinguisher

5.10 Forms and formats

There are following form which are essential accoroding to NABH Standards are introduce in the patient record:

1. Patient History & initial Assessment
2. Nursing Assessment
3. Pre and Post anesthesia check up
4. Surgical safety Checklist
5. Pre operative checklist
6. Dietary Assessment

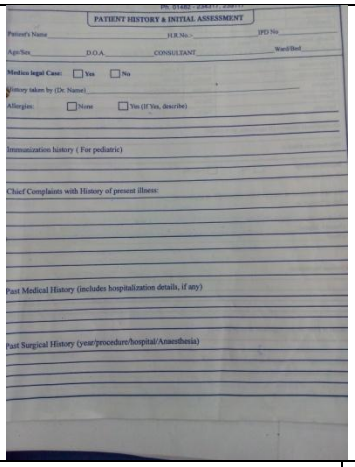

Fig 5.15 Patient Initial assessment Form

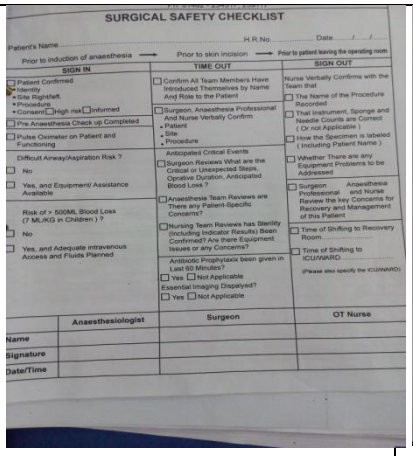

Fig 5.16 Surgical Safety Checklist

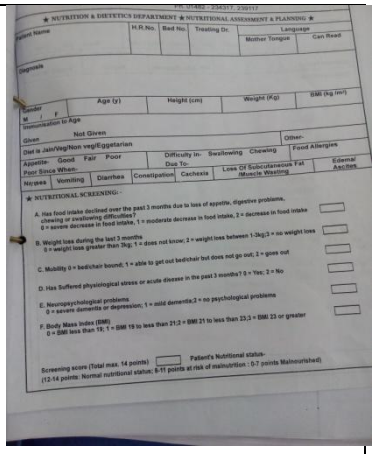

Fig 5.17: Nutrition Assessment Form

5.11 Implement emergency codes

We Implements 5 emergency codes in the hospitals which are as below:

Table No. 5.1 List of Emergency Code

Code	Condition
Red	Fire
Blue	Medical Emergency
Pink	Child Abduction
Yellow	Hazmat Spill
Orange	External Disaster

5.12 PERSONNEL FILES: (Human Resource Department)

We develop a Human resource department separately which deals with employees matters like Dress code, ID Cards, Employee code, Etc.

We prepared personal file of every employee of hospital which contains following documents:

Table No. 5.2 List of Contents in Personal File

	Employee Name - **Emp Code No. -**
S. no.	**Description**
1	Personal Performa *** (CV/ Employment Form)**
2	Latest photograph*****
3	Mobile Number *****
4	SSC Mark sheet *****
5	HSC Mark sheet *****
6	Diploma/Degree Mark sheet *****
7	Registration Certificate of Doctors (RMC), Nurses (RNC) ,Technicians and Others *****
8	Date of Birth Proof *****
9	Address Proof *****
10	Identity Proof (Driving License, PAN Card, Election Card, Passport etc., Aadhar ID) *****
11	Pre-employment medical checkup report*****
12	Hepatitis B Vaccination declaration form
13	Salary calculation sheet*****
14	Anti Sexual Harassment Form*****
15	Uniform (if applicable) *****
16	Appointment Letter*****
17	Patient Confidentiality Letter*****
18	Training Details*****
19	Job Description*****
20	Miscellaneous

5.13 QUALITY INDICATORS:

We select 18 Clinical and 17 Managerial Quality indicators from NABH 3rd book to assess the improvement in every department of hospitals. There are following Quality indicators which we followed there;

Table No. 5.3 List of Clinical Quality Indicators

S.No.	Clinical Indicators	Formula
1.	Number of reporting errors/1000 investigations	Number of reporting errors/ Number of tests performed X 1000
2.	Percentage of modification of anaesthesia plan	(Number of patients in whom the anaesthesia plan was modified /Number of patients who underwent anaesthesia) X 100
3.	Percentage of transfusion reactions	(Number of transfusion reactions/Number of transfusions) X 100
4.	Urinary tract infection rate	(Number of urinary catheter associated UTIs in a month /Number of urinary catheter days in that month) X 1000
5.	Mortality rate	(Number of deaths / Number of discharges and deaths) X 100
6.	Percentage of unplanned return to OT	Number of unplanned return to OT/Number of patients operated) X 100

Table No. 5.4 List of Managerial Quality Indicators

S.No.	Managerial Indicators	Formula
1.	Bed occupancy rate	(Number of inpatient days in a given month / Number of available bed days in that month) X 100
2.	Average length of stay	(Number of inpatient days in a given month / Number of discharge and death in that month) X 100
3.	Percentage of drugs and consumables procured by local purchase	(Number of items purchased by local purchase/Number of drugs listed in hospital formulary and hospital consumables list) X 100
4.	Incidence of falls	(Number of falls / Number of deaths and discharge) X 100
5.	Employee satisfaction index	(Score achieved/Maximum possible score) X 100
6.	Percentage of missing records	(Number of missing record /Number of records) X 100

5.14 Other works:

- Enquiry desk made and a person is assigned to sit over there in the OPD hours.
- Patient satisfaction survey performed for their feedback.
- Need for Water coolers and adequate chairs told to senior authorities.
- Autoclaving of instruments started every morning in every ward.
- One incharge out of available staff nurses of each ward is made to maintain the proper stocks, registers, and cleanliness.
- Personal equipments like gloves, mask provided, gum boots, heavy duty gloves available for staff.
- Immunization of all the staff members is done against tetanus, Hepatitis B
- Daily checks on availability of linen on every bed in the ward.
- Hand hygiene posters displayed at all nursing stations.
- Crash carts ordered for every floor and medicine list prepared by Anesthesiologist.
- List of emergency drugs, Look alike and sound alike medicine list given at every nursing station.

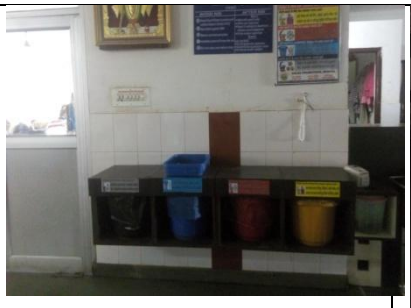

Fig 5.18: Segregation of Bio Medical Waste Management

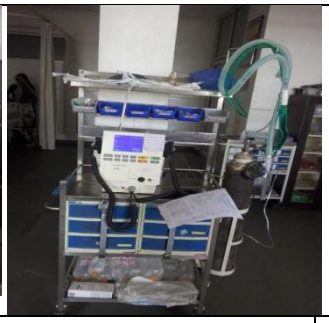

Fig 5.19: Crash cart

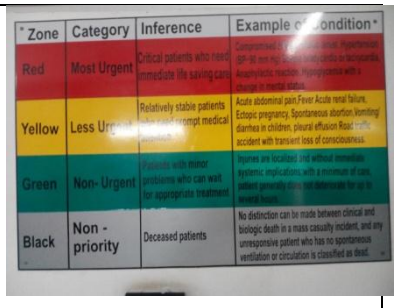

Fig 5.20: Triage in Emergency

- One staff nurse is made as in charge of emergency department to maintain stocks, medications, registers, maintenance.
- Prepared a crash cart for emergency.
- Autoclaving of instruments of dressing room made to be start.
- Hand over taken over registers maintained.
- All the out of order equipments were repaired from local biomedical engineer. Periodic preventive maintains and calibration of biomedical equipments start and record maintain by staff.
- Biomedical Waste Management training given to staff, with display of BMW posters.
- Safety belts on stretchers and wheelchairs need to be placed for patient safety.

CHAPTER 6: Results and Findings

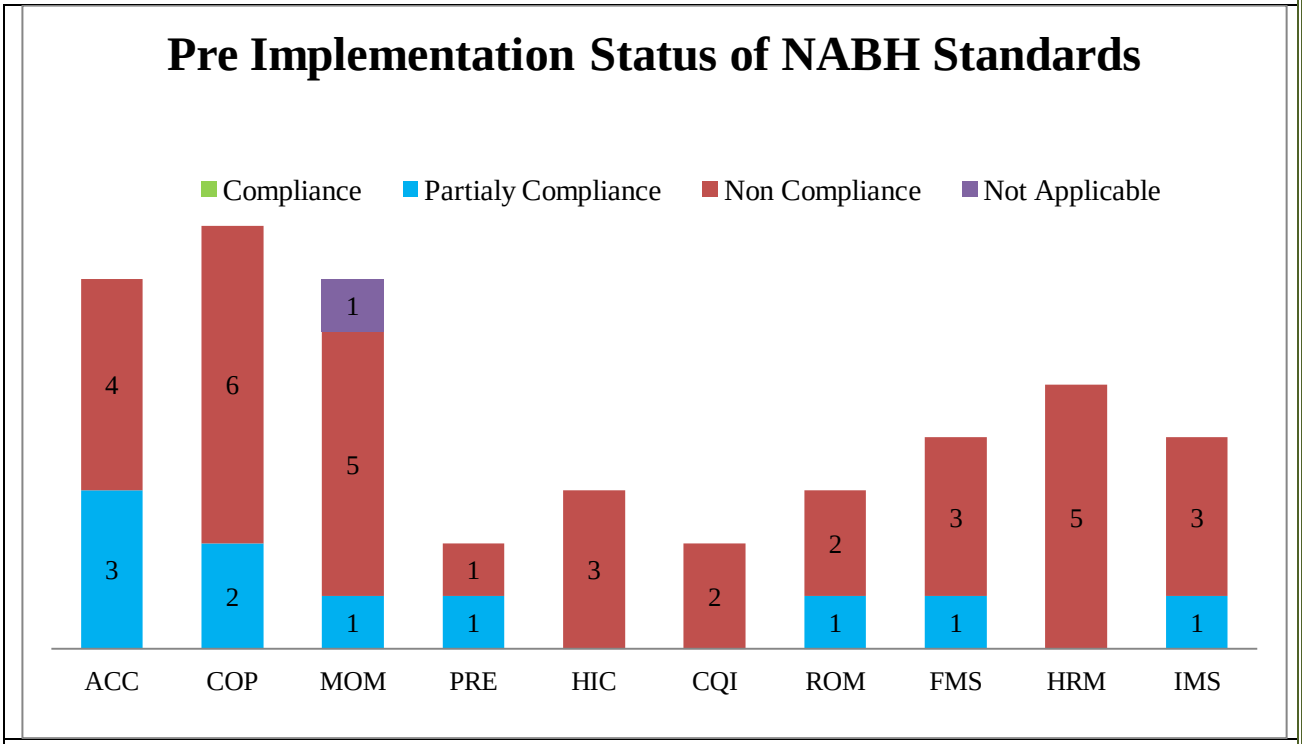

Fig. 6.1 Average score of every chapter indicates Compliance of standards in beginning of study.

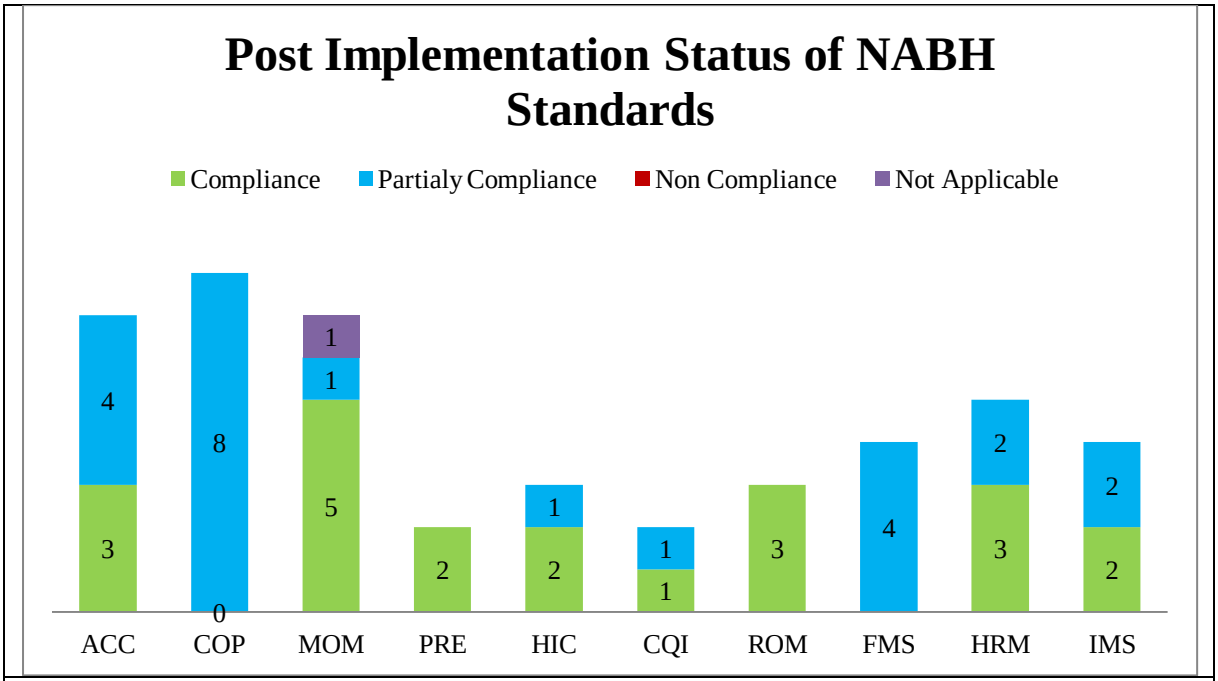

Fig. 6.2 Average score of every chapter indicates Compliance of standards after implementation work.

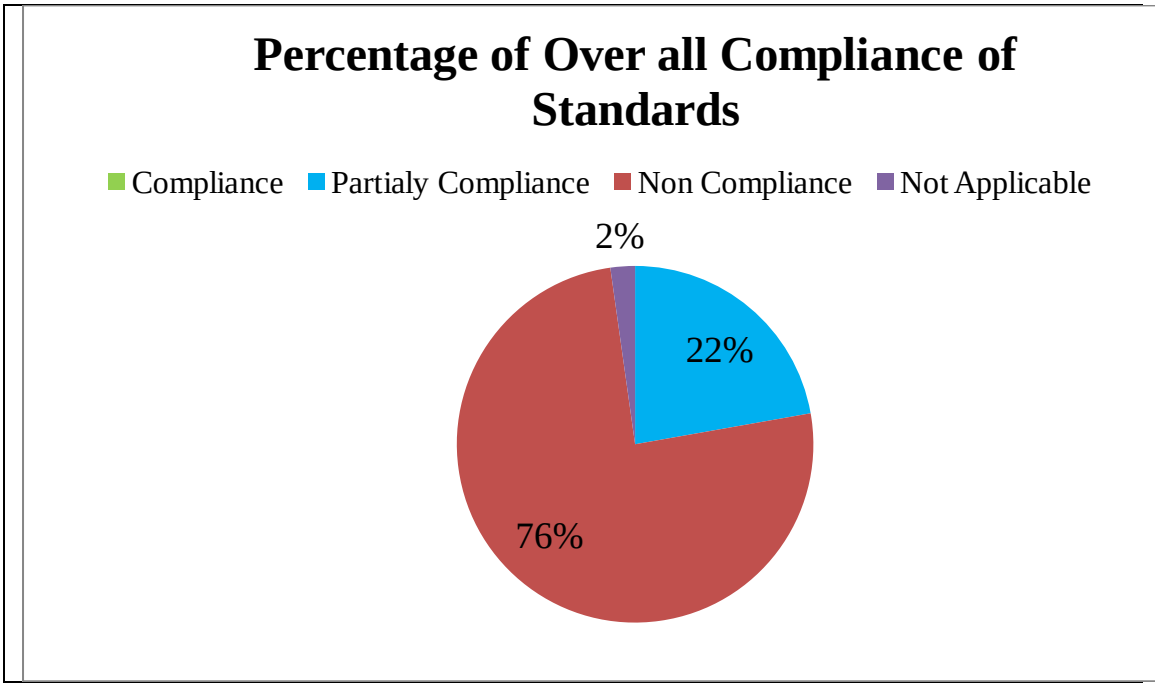

Fig. 6.3 Over all Compliance of standards in beginning of study

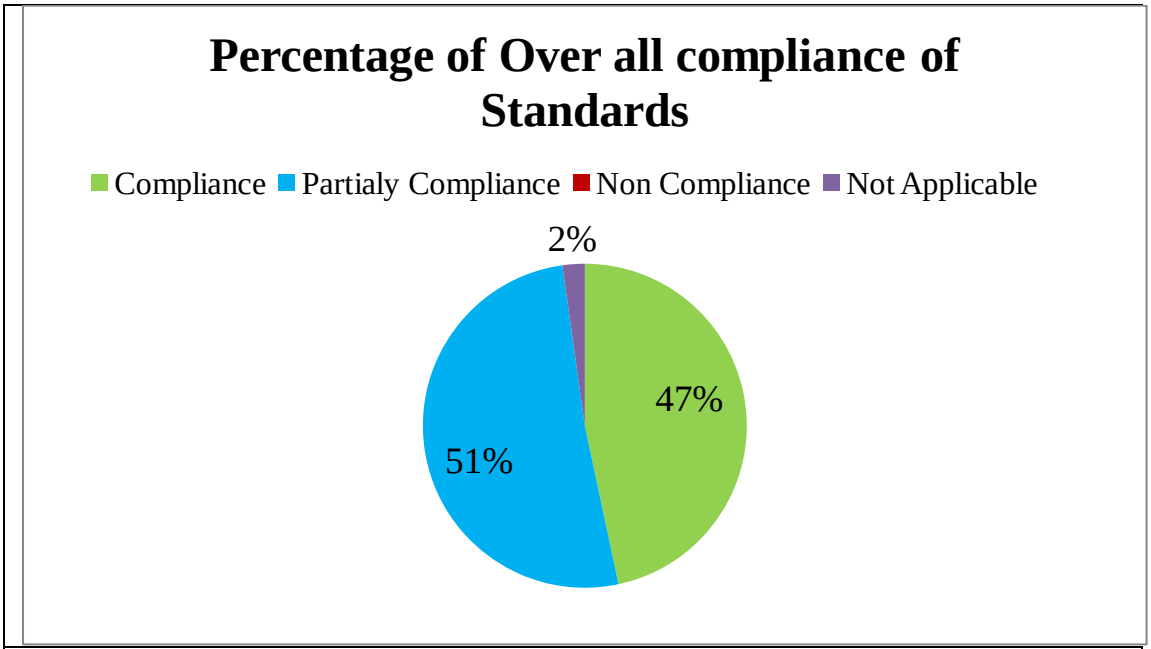

Fig. 6.4 Over all Compliance of standards after implementation work

Note: Most of the standards which are considered as partially compliance have score between 8 to 9.9.

CHAPTER 7: Recommendations

1. Need for revise documentation of policies and guidelines (In cases of partially compliance standards)
2. Need for improve training program, where actions not performed according to policy or guidelines.
3. Complete construction work as soon as possible.
4. Implement Nursing assessment form.
5. Appropriate anti biotic policy should be developed
6. Ensure to conduct Committee meetings every month.
7. Get sprit storage permit from authority.
8. Orientation and training of new employees and old employees given new job responsibility.
9. Curtains for all Patient OPD and Wards for patient Privacy
10. Side rail for patient beds

CHAPTER 7: CONCLUSION

The study revealed and find out the gaps which need to be full filled for the quality improvement of the hospital. By achieving the quality care services the Hospital is able get quality certifications of NABH. Gaps of all the departments are mainly process gaps, some of those gaps are infrastructure, equipment and manpower gaps. Study also revealed that what specific and general action to be taken for full filling those gaps. What kind of trainings is required and will be given to the staff including nurses, housekeepers, ward boys and medical officers. Special consideration on gaps of the department is given and action plan is prepared and need to be monitored by internal experts.

Study shows that after implementation of the standards most of the gaps and findings close as required for the NABH certification. Post implementation results show that 45% of standers are compliance with respect to to pre implementation study where compliance of standards shows 0%.

ANNEXURE -I

NABH Self Assessment Toolkit (Entry Level)

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

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

Evaluation Criteria during final assessment:

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

SELF ASSESSMENT TOOLKIT

		Elements	Documentation (Yes/ No)	Implementation (Yes/ No)	Evidence (cross reference to documents/ manuals etc.)	Scores (0/ 5/ 10)
Chapter 1: ACCESS, ASSESSMENT AND CONTINUITY OF CARE (AAC)						
AAC.1: The organization defines and displays the services that it can provide.						
	a	The services being provided are clearly defined.				
	b	The defined services are prominently displayed.				
	c	The staff is oriented to these services.				
AAC.2: The organization has a documented registration, admission and transfer process.						
	a.	Process addresses registering and admitting out-patients, in-patients and emergency patients.				
	b.	Process addresses mechanism for transfer or referral of patients who do not match the organizational resources.				
AAC.3 Patients cared for by the organization undergo an established initial assessment.						
	a.	The organization defines the content of the assessments for the out-patients, in-patients and emergency patients.				
	b.	The organization determines who can perform the assessments.				
	c.	The initial assessment for in-patients is documented within 24 hours or earlier.				

	d.	Initial assessment of inpatients includes nursing assessment which is done at the time of admission and documented.				
AAC.4 Patient care is continuous and all patients cared for by the organization undergo a regular reassessment.						
	a.	During all phases of care, there is a qualified individual identified as responsible for the patient's care who coordinates the care in all the settings within the organization.				
	b.	All patients are reassessed at appropriate intervals.				
	c.	Staff involved in direct clinical care document reassessments.				
	d.	Patients are reassessed to determine their response to treatment and to plan further treatment or discharge.				
AAC.5 Laboratory services are provided as per the scope of the hospital's services and laboratory safety requirements.						
	a.	Scope of the laboratory services are commensurate to the services provided by the organization.				
	b.	Procedures guide collection, identification, handling, safe transportation, processing and disposal of specimens.				
	c.	Laboratory results are available within a defined time frame and critical results are intimated immediately to the concerned personnel.				
	d.	Adequately trained personnel perform, supervise & interpret the investigations.				
	e.	Laboratory personnel are trained in safe practices and are provided with appropriate safety equipment/ devices.				
	f.	Laboratory tests not available in the organization are outsourced.				
AAC.6 Imaging services are provided as per the scope of the hospital's services and established radiation safety programme.						

	a.	Scope of the imaging services are commensurate to the services provided by the organization.				
	b.	Imaging signages are prominently displayed in all appropriate locations.				
	c.	Imaging results are available within a defined time frame and critical results are intimated immediately to the concerned personnel.				
	d.	Imaging personnel are trained in safe practices and are provided with appropriate safety equipment/ devices.				
AAC.7 The organisation has a defined discharge process.						
	a.	Process addresses discharge of all patients including Medico-legal cases and patients leaving against medical advice.				
	b.	A discharge summary is given to all the patients leaving the organization (including patients leaving against medical advice).				
	c.	Discharge summary contains the reasons for admission, significant findings, investigation results, diagnosis, procedure performed (if any), treatment given and the patient's condition at the time of discharge.				
	d.	Discharge summary contains follow up advice, medication and other instructions in an understandable manner.				
	e.	Discharge summary incorporates instructions about when and how to obtain urgent care.				
	f.	In case of death the summary of the case also includes the cause of death.				
Chapter 2: CARE OF PATIENTS (COP)						
COP.1: Care of patients is guided by accepted norms & practice.						
	a	The care and treatment orders are signed and dated by the concerned doctor.				

	b	Critical Practice Guidelines are adopted to guide patient care wherever possible.				
COP.2: Emergency services including ambulance are guided by documented procedures.						
	a	Documented procedures address care of patients arriving in the emergency including handling of medico-legal cases.				
	b	Staff should be well versed in the care of emergency patients in consonance with the scope of the services of hospital.				
	c	Admission or discharge to home or transfer to another organization is also documented.				
	d	Ambulance is appropriately equipped.				
	e	Ambulance(s) is manned by trained personnel.				
COP.3: Documented procedures define rational use of blood and blood products.						
	a	Documented policies and procedures are used to guide the rational use of blood and blood products.				
	b	Documented procedures govern transfusion of blood and blood products.				
	c	The transfusion services are governed by the applicable laws and regulations.				
	d	Informed consent is obtained for donation and transfusion of blood and blood products.				
	e	Procedure addresses documenting and reporting of transfusion reactions.				
COP.4: Documented procedures guide the care of patients as per the scope of services provided by hospital in Intensive care and high dependency unit.						

	a	Care of patients is in consonance with the documented procedures.				
	b	Adequate staff and equipment are available.				
COP.5: Documented procedures guide the care of obstetrical patients as per the scope of services provided by hospital.						
	a	The organization defines the scope of obstetric services.				
	b	Obstetric patient's care includes regular ante-natal check ups, maternal nutrition and post-natal care.				
	c	The organization has the facilities to take care of neonates.				
COP.6: Documented procedures guide the care of pediatric patients as per the scope of services provided by hospital.						
	a	The organization defines the scope of its pediatric services.				
	b	Provisions are made for special care of children by competent staff.				
	c	Patient assessment includes detailed nutritional, growth, and immunization assessment.				
	d	Procedure addresses identification and security measures to prevent child/ neonate abduction and abuse.				
	e	The children's family members are educated about nutrition and immunization				
COP.7: Documented procedures guide the administration of anesthesia.						
	a.	There is a documented policy & procedure for the administration of anesthesia.				
	b.	All patients for anesthesia have a pre-anesthesia assessment by a qualified/ trained anesthetist.				

	c.	The pre-anesthesia assessment results in formulation of an anesthesia plan which is documented.				
	d.	An immediate preoperative re-evaluation is documented.				
	e.	Informed consent for administration of anesthesia is obtained by the anesthetist.				
	f.	Anesthesia monitoring includes regular and periodic recording of heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation, airway security and patency and End tidal carbon dioxide.				
	g.	Each patient's post-anesthesia status is monitored and documented.				
	h.	Defined criteria are used to transfer the patient from the recovery area.				
	i.	Adverse anesthesia events are recorded and monitored.				
COP.8: Documented procedure guides the care of patients undergoing surgical procedures.						
	a.	Surgical patients have a preoperative assessment and a provisional diagnosis documented prior to surgery.				
	b.	An informed consent is obtained by a surgeon prior to the procedure.				
	c.	Documented procedure addresses the prevention of adverse events like wrong site, wrong patient and wrong surgery.				
	d.	Qualified persons are permitted to perform the procedures that they are entitled to perform.				
	e.	The operating surgeon documents the operative notes and post-operative plan of care.				
	f.	The operation theatre is adequately equipped and monitored for infection control practices.				

	g.	Patients, personnel and material flow conform to infection control practices.				
Chapter 3: MANAGEMENT OF MEDICATION (MOM)						
MOM.1: Documented procedures guide the organization of pharmacy services and usage of medication.						
	a	Documented procedure shall incorporate purchase, storage, prescription and dispensation of medications.				
	b	Documented procedures address procurement and usage of implantable prostheses.				
MOM.2: Documented policies & procedures guide the storage of medications.						
	a	Documented policies and procedures exist for storage of medication				
	b	Medications are stored in a clean, safe and secure environment, and incorporate manufacturer's recommendations.				
	c	Sound alike and look alike medications are stored separately.				
	d	Beyond expiry date medications are not stored/used.				
	e	List of emergency medicines is defined, stored, and available all the time.				
MOM.3: Documented procedures guide the prescription of medications.						
	a	The organization determines who can write orders.				
	b	Orders are written in a uniform location in the medical records.				
	c	Medication orders are clear, legible, dated and signed.				

	d	The organization defines a list of high risk medication & process to prescribe them.				
MOM.4: Poilicies & procedures guide the safe dispensing of medications.						
	a	Medications are checked prior to dispensing, including the expiry date to ensure that they are fit for use.				
	b	High risk medication orders are verified prior to dispensing.				
MOM.5: There are defined procedures for medication administration.						
	a	Medications are administered by trained personnel.				
	b	Prior to administration medication order including patient, dosage, route and timing are verified.				
	c	Prepared medication is labelled prior to preparation of a second drug.				
	d	Medication administration is documented.				
	e	A proper record is kept of the usage, administration and disposal of narcotics and psychotropic medications.				
MOM.6: Adverse drug events are monitored.						
	a	Adverse drug events are defined & monitored.				
	b	Adverse drug events are documented and reported within a specified time frame.				
MOM.7: Documented policies & procedures govern usage of radioactive drugs.						
	a	Documented policies and procedures govern usage of radioactive drugs.				

	b	Policies and procedures include the safe storage, preparation, handling, distribution and disposal of radioactive drugs.				
Chapter 4: PATIENT RIGHTS AND EDUCATION (PRE)						
PRE.1: Patient rights are documented displayed and support individual beliefs, values and involve the patient and family in decision making processes.						
	a.	Patient rights include respect for personal dignity and privacy during examination, procedures and treatment.				
	b.	Patient rights include protection from physical abuse or neglect.				
	c.	Patient rights include treating patient information as confidential.				
	d.	Patient rights include obtaining informed consent before carrying out procedures.				
	e.	Patient rights include information on how to voice a complaint.				
	f.	Patient rights include information on the expected cost of the treatment.				
	g.	Patient has a right to have an access to his / her clinical records.				
PRE.2: Patient and families have a right to information and education about their healthcare needs.						
	a	Patients and families are educated on plan of care, preventive aspects, possible complications, medications, the expected results and cost as applicable.				
	b	Patients are taught in a language and format that they can understand.				
Chapter 5: HOSPITAL INFECTION CONTROL (HIC)						

HIC.1: The hospital has an infection control manual, which is periodically updated and conducts surveillance activities.						
	a	It focuses on adherence to standard precautions at all times.				
	b	Cleanliness and general hygiene of facilities will be maintained and monitored.				
	c	Cleaning and disinfection practices are defined and monitored as appropriate.				
	d	Equipment cleaning, disinfection and sterilization practices are included.				
	e	Laundry and linen management processes are also included				
HIC.2: The hospital takes actions to prevent or reduce the risks of Hospital Associated Infections (HAI) in patients and employees.						
	a	Hand hygiene facilities in all patient care areas are accessible to health care providers.				
	b	Adequate gloves, masks, soaps, and disinfectants are available and used correctly.				
	c	Appropriate pre and post exposure prophylaxis is provided to all concerned staff members.				
HIC.3: Bio-medical Waste (BMW) management practices are followed.						
	a	The hospital is authorised by prescribed authority for the management and handling of Bio-Medical Waste.				
	b	Proper segregation and collection of Bio-Medical Waste from all patient care areas of the hospital is implemented and monitored.				
	c	Bio-Medical Waste treatment facility is managed as per statutory provisions (if in-house) or outsourced to authorised contractor(s).				
	d	Requisite fees, documents and reports are submitted to competent authorities on stipulated dates.				

	e	Appropriate personal protective measures are used by all categories of staff handling Bio-Medical Waste.				
Chapter 6: CONTINUOUS QUALITY IMPROVEMENT (CQI)						
CQI.1: There is a structured quality improvement, patient safety and continuous monitoring programme in the organization.						
	a	There is a designated individual for coordinating and implementing the quality improvement and patient safety programme.				
	b	The quality improvement and patient safety programme is a continuous process and updated at least once in a year.				
	c	Hospital Management makes available adequate resources required for quality improvement and patient safety programme.				
CQI.2: The organization identifies key indicators to monitor the structures, processes and outcomes which are used as tools for continual improvement.						
	a	Organization may identify the appropriate key performance indicators in both clinical and managerial areas.				
	b	These indicators shall be monitored.				
Chapter 7: RESPONSIBILITIES OF MANAGEMENT (ROM)						
ROM.1: The responsibilities of the management are defined						
	a	The organization has a documented organogram.				
	b	The organization is registered with appropriate authorities as applicable.				

	c	The organization has a designated individual(s) to oversee the hospital wide quality and safety programme.				
ROM.2: The organization is managed by the leaders in an ethical manner.						
	a	The management makes public the mission statement of the organization.				
	b	The leaders/management guide the organization to function in an ethical manner.				
	c	The organization discloses its ownership.				
	d	The organization's billing process is accurate and ethical.				
ROM.3: The organization has set up multi-disciplinary committees to oversee specific areas of quality and patient safety.						
	a	These committees include Quality and Safety, Infection Control, Pharmacy and Therapeutics, Blood Transfusion, and Medical Records.				
	b	The membership, responsibilities, and periodicity of meetings shall be defined.				
Chapter 8: FACILITY MANAGEMENT AND SAFETY (FMS)						
FMS.1: The organization's environment and facilities operate to ensure safety of patients, their families, staff and visitors.						
	a	Internal and External Signage's shall be displayed in a language understood by the patients and families.				
	b	Maintenance staff is contactable round the clock for emergency repairs.				
	c	There the hospital has a system to identify the potential safety and security risks including hazardous materials.				

	d	Facility inspection rounds to ensure safety are conducted periodically.				
	e	There is a safety education programme for relevant staff.				
FMS.2: The organization has a program for clinical and support service equipment management.						
	a	The organization plans for equipment in accordance with its services.				
	b	There is a documented operational and maintenance (preventive and breakdown) plan.				
FMS.3: The organization has provisions for safe water, electricity, medical gas and vacuum systems.						
	a	Potable water and electricity are available round the clock.				
	b	Alternate sources are provided for in case of failure and tested regularly.				
	c	There is a maintenance plan for medical gas and vacuum systems.				
FMS.4: The organization has plans for fire and non-fire emergencies within the facilities.						
	a	The organization has plans and provisions for detection, abatement and containment of fire and non-fire emergencies.				
	b	The organization has a documented safe exit plan in case of fire and non-fire emergencies.				
	c	There is a maintenance plan for medical gas and vacuum systems.				
	d	Mock drills are held at least twice in a year.				
Chapter 9: HUMAN RESOURCE MANAGEMENT (HRM)						

HRM.1: The organization has staffing commensurate with patient care needs.						
	a	The mix of staff is commensurate with the volume and scope of the services.				
	b	Staff recruitment process is well defined.				
HRM.2: There is an ongoing programme for professional training and development of the staff.						
	a	All staff is trained on the relevant risks within the hospital environment.				
	b	Staff members can demonstrate and take actions to report, eliminate/ minimize risks.				
	c	Training also occurs when job responsibilities change/ new equipment is introduced.				
HRM.3: The organization has a well-documented disciplinary and grievance handling procedure.						
	a	A documented procedure with regard to these is in place.				
	b	The documented procedure is known to all categories of employees in the organization.				
	c	Actions are taken to redress the grievance.				
HRM.4: The organization addresses the health needs of the employees						
	a	Health problems of the employees are taken care of in accordance with the organization's policy.				
	b	Occupational health hazards are adequately addressed.				

HRM.5: There is documented personal record for each staff member						
	a	Personal files are maintained in respect of all employees.				
	b	The personal files contain personal information regarding the employees qualification, disciplinary actions and health status. The disciplinary procedure is in consonance with the prevailing laws.				
Chapter 10: INFORMATION MANAGEMENT SYSTEM (IMS)						
IMS.1: The organization has a complete and accurate medical record for every patient						
	a	Every medical record has a unique identifier.				
	b	Organization identifies those authorized to make entries in medical record.				
	c	Every medical record entry is dated and timed.				
	d	The author of the entry can be identified.				
	e	The contents of medical record are identified and documented.				
IMS.2: The medical record reflects continuity of care.						
	a	The record provides an up-to-date and chronological account of patient care.				
	b	The medical record contains information regarding reasons for admission, diagnosis and plan of care.				
	c	Operative and other procedures performed are incorporated in the medical record.				

	d	The medical record contains a copy of the discharge note duly signed by appropriate and qualified personnel.				
	e	In case of death, the medical records contain a copy of the death certificate indicating the cause, date and time of death.				
	f	Care providers have access to current and past medical record.				
IMS.3: Documented policies and procedures are in place for maintaining confidentiality, integrity and security of records, data and information.						
	a	a. Documented procedures exist for maintaining confidentiality, security and integrity of information.				
	b	Privileged health information is used for the purposes identified or as required by law and not disclosed without the patient's authorization.				
IMS.4: Documented procedures exist for retention time of records, data and information.						
	a	Documented procedures are in place on retaining the patient's clinical records, data and information.				
	b	The retention process provides expected confidentiality and security.				
	c	The destruction of medical records, data and information is in accordance with the laid down procedure.				

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