NABH Gap Analysis

Internship Training
at
District Hospital, Jalandhar
(Punjab Health Systems Corporation)

By
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Under the guidance of
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Post Graduate Diploma in Hospital & Health Management
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Institute of Health Management Research
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TO WHOMSOEVER IT MAY CONCERN

This is to certify that Dr Gargi Mehra, student of Post Graduate Diploma in Hospital and Health Management (PGDHM) from Institute of Health Management Research, Jaipur has undergone internship training at District Hospital,Jalandhar(Punjab Health Systems Corporation) from 3rd February 2014 to 30th April 2014.

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

Dean, Academics and Student Affairs
IIHMR, Jaipur

22 May 2014
Prof Seema Mehta
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No. PHSC/NABH/14/ 36 Dated 6.5.14

To whomsoever it may concern

Certificate of Dissertation Completion

This is to certify that Dr. Gargi Mehra, student of Postgraduate Diploma in Hospital and Health Management of IIHMR Jaipur, has successfully completed three months dissertation under Punjab Health Systems Corporation, Punjab, from 03.02.2014 to 30.04.2014

During the dissertation the student's performance was found to be satisfactory.

We wish him/her success in all his/her future endeavors.

Hussan Lal I.A.S.
Managing Director
Punjab Health Systems Corporation
-Cum-Secretary Health and Family Welfare, Pb.

ABSTRACT

Title: "NABH Gap Analysis at a district hospital ".

Key words: NABH(National Accreditation Board for Healthcare Providers),Gap Analysis,Compliance

Background of Study: Quality Management Systems and Accreditation are versatile tools to ensure equity in healthcare services and the meeting the increasing aspirations of people. This ideal state of affair can be achieved by the institution of a quality management system that focuses on compliance with accreditation standards of NABH and like bodies.Gap Analysis is a tool that helps an organization to compare its actual performance with its potential performance.

Objectives: To assess the existing service delivery standards of the Civil Hospital, Jalandhar and carry out a gap analysis between existing and desired standards of NABH.

Methodology:

Research design is descriptive and cross sectional in nature

Study began with indepth review of NABH guidelines.A self assessment toolkit provided by NABH was used to assess the existing gaps in Outpatient,Inpatient,Intensive care unit,Laboratory,Blood Bank and other functional areas of hospital.Information was gathered by means of patient and staff interviews,direct observation,hospital and clinical record review.

Graphical analysis was performed to analyse the data

The study was conducted for a period of three months.

Results:

The study revealed that all NABH chapters have average score below 5, which shows that they are non-compliant to NABH requirements. Hospital has shown maximum compliance in NABH chapter no.4 Patient Rights and Education and least compliance to Chapter No.8, Facility management and safety .

Conclusion:

The gap analysis has revealed non compliance as per NABH Standards which need to be addressed. As per the scheduled plan of action it is recommended that the hospital will attempt to fill the identified gaps. To conclude, the actions to be taken for compliance with accreditation standards are likely to impact the delivery of public health services positively, ensuring quality services, efficient outcomes with economy, risk management with patients, staff, and visitors safety, and above all equity in healthcare services for the citizens.

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This study is an accomplishment due to the timely help, guidance and consent support of several people. The investigator owes a deep sense of gratitude towards all those who have contributes to successful completion of this endeavour.

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I am also grateful to **Dr. Ashok Kaushik,** Dean, IIHMR, Jaipur, for giving me an opportunity to take up this study at District Hospital, Jalandhar, Punjab.

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Fig1 Average Score of AAC Standards **70**

Fig2 Average Score of COPStandards **71**

Fig3 Average Score of MOM Standards **72**

Fig4 Average Score of PRE Standards **72**

Fig5 Average Score of HIC Standards **73**

Fig6 Average Score of CQI Standards **74**

Fig7 Average Score of ROM Standards **74**

Fig8 Average Score of FMS Standards **75**

Fig9 Average Score of HRM Standards **76**

Fig10 Average Score of IMS Standards **76**

Fig11 Average Score of NABH Chapters **77**

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DISSERTATION REPORT

1 HOSPITAL INTRODUCTION

Shaheed Babu Labh Singh Civil Hospital, Jalandhar /Victoria Civil Hospital Jalandhar was established in 1909 and was renamed as Shaheed Babu Labh Singh Civil Hospital in 1975. It has 425 beds. It provides treatment in medicine, general surgery, eye, E.N.T., orthopedic, pediatric, skin diseases etc. The hospital is manned by Medical Superintendent, Medical Officers, Hospital Administrator, Doctors, Nurses, Laboratory Technicians, Pharmacists and other administrative staff. The hospital is also running a Nursing Training School. It has blood bank facilities also.

2 EXECUTIVE SUMMARY – OF THE GAP ANALYSIS

Quality Management Systems and Accreditation are versatile tools to ensure equity in healthcare services and the meeting the increasing aspirations of people. This ideal state of affair can be achieved by the institution of a quality management system that focuses on compliance with accreditation standards of NABH and like bodies.Gap Analysis is a tool that helps an organization to compare its actual performance with its potential performance.

3 REVIEW OF LITERATURE

Quality assurance by way of formal accreditation is considered as necessary part of the operation of any healthcare organization[i]

Gap analysis is a component of the preparatory phase of NABH accreditation program. The goal of gap analysis is to identify the gap between the optimized allocation and integration of the inputs, and the current level of allocation.

Gap analysis refers to a study where hospital compare the present policy, procedure, SOP's, infrastructure with defined laid down standards of accreditation body.[ii]

NABH is merely an enhancement of these processes to conform to National and International standards. Thus it is re-iterated that Non compliance suggests enhancement of current level of performance in order to placate the actual NABH Assessment Team. [iii]

4 AIM AND OBJECTIVES

4.1 AIM

To prepare **District Hospital Jalaandhar** to be accredited by the National Accreditation Board for Hospitals & Healthcare Providers (NABH)

4.2 OBJECTIVES

a. To assess the existing service delivery standards of the Civil Hospital, Jalandhar.

b. To carry out a gap analysis between existing level and desired level of NABH requirements.

c. To suggest recommendations for streamlining the processes.

d. To assist the Hospital in charting the further course of action which will lead to compliance with accreditation standards of the NABH and institutionalization of a quality management system, leading further to a continuous quality improvement plan

5 METHODOLOGY

5.1 Study Design

Descriptive Cross Sectional Study

5.2 Data Collection

Primary Data: Patient and staff interviews, direct observation

Secondary Data: Hospital documents review, clinical record review.

5.3 Study Area

Study was carried out in following functional departments:-

- Out Patient Department
- Intensive Care Unit
- Operation Theatres
- In-Patient Department
- Emergency Department
- Support Service Areas
  - Laboratory & Blood Bank
  - Radio-diagnostics
  - Physiotherapy
  - CSSD
  - Laundry
  - Kitchen
  - Medical Record Department

5.4 Duration Of Study

3 Months: 3rd February 2014-5th May 2014

5.5 Tools

NABH Self Assessment Toolkit

5.6 Data Management

Graphical representation of data analysis

Implicit interpretation of graphical representation

6 OBSERVATIONS

6.1 FLOOR WISE DIRECTORY OF HOSPITAL

There is no clear floor directory displayed in any of the floor**.**

6.2 SIGNAGE SYSTEM

Signage's	**Displayed (Yes / No / NA)**	**Bilingual (Yes / No / NA)**	**Pictorial (Yes / No / NA)**
Services available in the hospital (prominent board near the entry to the hospital)	YES	YES	NO
Citizen Charter	YES	YES	NO
Mission & Vision	NO	NO	NO
Quality Policy	NO	NO	NO
Patients Rights and Responsibilities	NO	NO	NO
Complaint Redressal box, whom to contact and how to lodge a Complaint	YES(whom to contact and how to lodge complaint not written)	NO	NO
Tariff List	YES	NO	NO
Doctors list along with their Specialities and Qualifications	YES	NO	NO
OPD Schedule of Doctors (Speciality ,Timings and Day of Availability)	NO	NO	NO
Radiation Hazard Symbols at respective functional areas	YES	NO	NO
Fire Exit Plan (on every floor)	NO	NO	NO
Floor Directory	NO	NO	NO

Departmental Signages	YES	NO	NO
Wash Rooms (Handicap)	NO	NO	NO
Ambulance Parking Area	YES	NO	NO
Drinking Water	NO	NO	NO
Health Education Related Signage's (Maternal health, HIV, Prevention of infections, Immunization programme, etc)	YES	NO	NO

6.3 STATUTORY REQUIREMENTS

Licenses	**Applicable/ Not Applicable**	**Available**
1. Building Permit (From the Municipality).	Y	No
2. No objection certificate from the Chief Fire officer.	Y	No
3. License under Bio- medical Management and handling Rules, 1998.	Y	No
4. No objection certificate under Pollution Control Act.	Y	No
5. Excise permit to store Spirit.	Y	No
6. Income tax PAN.	Y	Yes
7. Permit to operate lifts under the Lifts and escalators Act.	Y	No
8. Narcotics and Psychotropic substances Act and License.	Y	No
9. Sales Tax Registration certificate.	Y	No
10. Vehicle registration certificates for Ambulances.	Y	Yes
11. Retail drug license (Pharmacy).	Y	No
12. Air (prevention and control of pollution) Act, 1981 and License	Y	No
13. PNDT Certificate	Y	No
14.Atomic Energy Regulatory Body approvals	Y	No
15. License for Blood Bank	Y	Yes
Act		
1. Biomedical waste management handling rules 1998.	Y	No
2. Central sales tax Act, 1956.	NA	
3. Consumer protection Act, 1986.	Y	No
4. Contract Act, 1982.	Y	No
5. Dentist regulations, 1976.	Y	No
6. Drugs & cosmetics Act, 1940.	Y	No
7. Employees provident fund Act, 1952.	Y	No
8. Environment protection Act, 1986.	Y	No
9. Equal remuneration Act, 1976.	Y	No
10. Explosives Act, 1884.	Y	No
11. Fatal accidents Act, 1855.	Y	No

12. Income Tax Act, 1961.	Y	No
13. Indian Lunacy Act, 1912.	Y	No
14. Indian medical council Act and code of medical ethics, 1956.	Y	No
15.Nurses and Midwives Act, 1953	Y	No
16. Indian Nursing council Act1947.	Y	No
17. Indian penal code, 1860.	Y	No
18. Maternity benefits Act, 1961.	Y	No
19. MTP Act, 1971.	Y	No
20. Minimum wages Act, 1948.	Y	No
21. National building code.	Y	No
22. Negotiable instruments Act, 1881.	Y	No
23. Payment of bonus Act, 1965.	Y	No
24. Payment of gratuity Act, 1972.	Y	No
25. Payment of wages Act, 1936.	Y	No
26. Persons with disability Act, 1995.	Y	No
27. Pharmacy Act, 1948.	Y	No
28. PNDT Act, 1996.	Y	No
29. BARC, Act.	Y	No
30. Registration of births and deaths Act, 1969.	Y	No
33. Constitution of India	Y	No
34. Workers compensation Act, 1923	Y	No
35.Indian Trade Union Act, 1926	Y	No
36.TAX Deducted at source Act	Y	No
37.Transplantation of Human Organ Act,1994	NA	
38.Water Prevention and control of Pollution Act	Y	No

6.4 COMMITTEES

COMMITTEE	Y/N	DATE OF FORMATION	MEETING FREQUENCY	MINUTES OF MEETING	ACTION TAKEN REPORT
Quality Management	N	Not evident	Not evident	Not evident	Not evident
Safety Management	N	Not evident	Not evident	Not evident	Not evident
Sentinel Events	N	Not evident	Not evident	Not evident	Not evident
Infection Control	N	Not evident	Not evident	Not evident	Not evident
Operation Theatre	N	Not evident	Not evident	Not evident	Not evident

Blood Transfusion	N	Not evident	Not evident	Not evident	Not evident
Drugs & Therapeutic	N	Not evident	Not evident	Not evident	Not evident
Code Blue	N	Not evident	Not evident	Not evident	Not evident
Morbidity & Mortality	N	Not evident	Not evident	Not evident	Not evident
Medical Record	N	Not evident	Not evident	Not evident	Not evident
Medical Audit	N	Not evident	Not evident	Not evident	Not evident
Research & Ethics	N	Not evident	Not evident	Not evident	Not evident
Credentialing & Privileging	N	Not evident	Not evident	Not evident	Not evident
Purchase	Y	Not evident	Fortnightly	Not evident	Evident
Condemnation	Y	Not evident	Not evident	Not evident	Evident

6.5 FRONT OFFICE

GAPS IDENTIFIED

STRUCTURAL	1. Fire extinguishers are not in proper condition to work. 2. Patients Rights & Responsibilities and Fire Exit Plan are not displayed.
PROCESS	3. There are no documented Policies and Procedures for Services available, Front Office, IPD Admission, IP & OP billing. 4. No Training schedule for the staff.
OUTCOME	5. Monitoring of waiting time for consultation not done. 6. Number of patient complaints received/day is not known

6.6 OUT PATIENT DEPARTMENT

GAPS IDENTIFIED

STRUCTURAL	7. The fire exit plans are not displayed in the OPD area. 8. Patients Rights & Responsibilities, signages showing the basic utilities (toilets/drinking water) are not displayed. 9. Hand wash basins are not available in al the chambers. 10. Hand wash liquids are not provided and used adequately 11. Waiting area is inadequate (100-110).
PROCESS	12. No Training schedule for the staff. 13. Departmental Policies & Procedure Manual is not existent 14. Housekeeping services of the waiting area and the toilets is not satisfactory.
OUTCOME	5. Monitoring of Patient satisfaction is not done. 6. OPD utilization is not done & monitored. 7. Monitoring of the waiting time is not defined & monitored.

6.7 AMBULANCE SERVICES

The basic life support vehicle should have two compartments: driver's cabin & patient's cabin.		
DRIVERS CABIN	Communication System (Wireless or Mobile phone)	Yes (Mobile phone)
	Siren & Light Switch	No
PATIENTS CABIN	Room height of at least 6 ½ feet	Yes
	Two stretchers with one trolley	No
	Railing/hook for IV suspension	Yes
	Oxygen cylinder	Yes
	Suction machine (foot operated)	Yes
	ET tube	No
	Ambu bag	No
	Laryngoscope	No

	Suction catheters	No
	Foley's catheter	No
	EMERGENCY DRUGS	**No**
	Atropine, Adrenaline	
	Sodabicarbonate, Digoxin	
	Decadron	
	Dopamine, 25% Dextrose	
	IV fluids, Plasma Expanders	

IDENTIFIED GAP

STRUCTURAL	18. There is no communication system between the driver's cabin and the patient's cabin**.** 19. Checklist for essential equipments & drugs not available 20. Both ambulances had nothing inside the ambulance except a patient stretcher trolley and an oxygen cylinder.
PROCESS	21. Staffs (Ambulance driver, staff nurses) are not trained in BLS/ALS. 22. Policy and procedures for ambulance services not defined & documented.
OUTCOME	23. Monitoring of turnaround time for ambulance services not done

6.8 EMERGENCY (CASUALTY)

Zone	Functions	Remarks
Entrance	Trolley & Wheel chair bay	Yes
	Waiting area for patients and family	No
	Public Utilities (Toilet and bathroom and Telephone etc.)	Yes. Common with OPD
Reception	Enquiry	Common with OPD
	Registration	Common with OPD
	Cash Counter	Common with OPD

Department	Nursing Station Clean Utility Room Dirty Utility Room E.C.G Laboratory X-Ray Store	Yes Nil No 1 machine Common Common Nil
Patient Accommodation Areas	Examination Cubicles Emergency Beds Observation beds Plaster Room	No 4 6 Common
Operating Rooms	Emergency O.T Scrub and Gowning Area TSSU Dirty Utility Anaesthesia	Yes Nil Nil Nil Nil
Staff Accommodation	Nursing Duty Room Doctors Duty Room Store room Toilet	Yes Yes No Yes

IDENTIFIED GAPS

STRUCTURAL	24. There is no proper crash cart available in the department; emergency drugs are kept in a tray.. 25. Triage area not marked/displayed. 26. No zoning facility and changing room for the emergency OT.
PROCESS	27. No documented Policy & procedure Manual for Emergency Services & MLCs. 28. Staffs are not trained on triaging system, emergency and ambulance policies. 29. Structured assessment format to assess patients in emergency department is not evident**.**
OUTCOME	30. Monitoring of the time taken for initial assessment Is not monitored. 31. Monitoring of admissions through emergency, transfer to another facility, etc are not clearly evident.

6.9 LABORATORY

IDENTIFIED GAPS

STRUCTURAL	32. None of the refrigerators have a temperature display/monitoring system. 33. Personal protective devices such as aprons, masks, gloves, etc are not provided adequately**.** 34. The microbiology section does not have bio-safety cabinet system. 35. Fire exit is not identified and displayed in the area. 36. Inadequate (one/two) number of BMWM bins in the area. 37. In the evening and night shift there is only one technician in the department.
PROCESS	38. Documented Policy and Procedures on departmental functioning, Quality assurance and Lab safety Programme is not evident. 39. Critical results are not defined.
OUTCOME	40. Turnaround time for investigations not measured. 41. Safety & Quality controls for the department not defined & measured (No of reporting errors/1000 investigation, no of re-do, percentage of reports co-relating with clinical diagnosis & percentage of adherence to safety precautions by the employees working in diagnostics)

6.10 BLOOD BANK

GAPS IDENTIFIED

STRUCTURAL	42. All equipments/ instruments of laboratory does not have unique identifier code and are not under AMC and did not have calibrations 43. There is no dedicated area as refreshment room. 44. The blood storage refrigerator does not display the temperature properly and is monitoring is done.
PROCESS	45. Documented Policy & Procedure on Blood bank and Blood transfusions is not available**.** 46. Time frame(turnaround time is not defined for availability of blood during emergency)is not defined
OUTCOME	47. Turnaround time not monitored. 48. Outcome indicators such as percentage of adverse transfusion reactions, percentage of waste of blood, etc are not monitored.

6.11 IMAGING DEPARTMENT

IDENTIFIED GAPS

STRUCTURAL	49. AERB approvals are not available 50. No evidence of Calibration and AMC of equipments 51. No Radiation Safety Officer 52. Fire exit is not identified or displayed. Imaging signage is not displayed prominently in imaging department.
PROCESS	53. Documented Policy and Procedures on Operations, Quality assurance and Imaging safety Programme is not evident. 54. Special instructions on PNDT testing are neither adequately educated to the patient or family members nor prominently displayed near the department. 55. Improper queue management for the USG patients. 56. No written documentation on Training about radiation safety to staff 57. No periodic health checkup records for staff were found.
OUTCOME	58. Turnaround time for investigations not measured. 59. Safety & Quality controls for the department not defined & measured (No of reporting errors/1000 investigation, no of re-do ,percentage of reports co-relating with clinical diagnosis & percentage of adherence to safety precautions by the employees working in diagnostics)

6.12 OPERATION THEATRE

IDENTIFIED GAPS

STRUCTURAL	60. HEPA filters are not installed 61. AMC and calibration of the equipments were not evident.
PROCESS	62. No documented Polices and Procedure for OT, Informed consent, Anaesthesia Sedation, Restraints**,** Pain management wrong site wrong surgery and surgical services. 63. Periodic health checkup record for staff not found. 64. Infection control practices are not practiced
OUTCOME	65. OT utilization rates not monitored. 66. Percentage of rescheduling & re exploration rates not monitored. Key performance indicators (percentage of modification of anaesthesia plan, percentage of unplanned ventilation following anaesthesia, percentage of adverse anaesthesia events & anaesthesia related mortality) not measured.

IDENTIFIED GAPS

STRUCTURAL	67. There is no crash cart in the wards. 68. The other isolation is in one of the female ward is not followed in true sense. 69. There is no sluicing room. 70. There is good evidence of seepage in the walls and ceilings of the wards in the Old Building. 71. Windows of the wards were found damaged. 72. Personal protective devices (gloves, aprons, masks, etc) are not adequately provided to the nursing staff. 73. None of the patient toilets are provided with grab bars.
PROCESS	74. Infection control practices not being followed. 75. No documented policy & Procedure regarding Nursing services, IPD, linen management, medication policy and discharge policy. 76. Monitoring of UTI, RTI, and Device induced infections not done 77. Look Alike- Sound Alike drugs not stored separately 78. Especial provisions for storing administering Narcotics & Psychotropic drugs not available.
OUTCOME	79. Monitoring of patient satisfaction not done 80. Monitoring of time taken for discharge not being done.

6.13 INTENSIVE CARE UNIT

IDENTIFIED GAPS

STRUCTURAL	81. No crash cart available in the department. 82. There are no cardiac monitors, defibrillators and ventilators 83. The door remains open of the intensive care unit. 84. There is no demarcation as SICU/ICU/HDU etc.
PROCESS	85. Policies & Procedures on Admission & Discharge criteria and on shortage of beds for all the intensive care units are to be framed & documented. 86. A unified CPR policy is not framed and the cardiac arrests are not analysed. 87. Improper measures of infection control practices followed.
OUTCOME	88. Monitoring of patient satisfaction not done. 89. Monitoring of utilization rate not done. 90. Monitoring of nosocomial infection not done.

6.14 PAEDIATRICS & NEO-NATALWARDS

IDENTIFIED GAPS

STRUCTURAL	91. No Crash cart available
PROCESS	92. No policies and procedures for the Paediatrics department. 93. Scope of paediatrics services not defined and displayed. 94. No policies and procedures for child abduction and abuse.
OUTCOME	95. Monitoring of patient satisfaction not done. 96. Monitoring of nosocomial infection not done.

6.15 MEDICAL RECORD

IDENTIFIED GAPS

STRUCTURAL	97. Lack of storage space 98. No security provision for storage area**.** 99. Specimen signature logbook of clinical staff not evident 100. Tracer card system for upkeep of records not evident.
PROCESS	101. No policies and procedures for Medical Records Department (departmental, information needs , storage, retention ,destroying records, etc. 102. Medical record audit are not carried out periodically to assess the completeness and continuity of care. 103. Patient care audit (medical care audit) not done. 104. Departmental training is not evident
OUTCOME	105. Key performance indicators (like percentage of missing records, Percentage of cases where nutritional assessment has been done, etc) for the department not measured.

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

There is no proper CSSD located in the hospital. The OTs have TSSU which serves the sterilization activities.

IDENTIFIED GAPS

There are no bacteriological tests (surveillance) carried out for the sterilized items. Validations of test are not done (HIC.7.b)

6.17 PHARMACY STORE

IDENTIFIED GAPS

STRUCTURAL	106. No provision of Cooling and ventilation in the department. 107. Storage of drugs is not satisfactory 108. No double lock provision for Narcotics and Psychotropic drugs 109. A drugs and therapeutics committee not constituted.
PROCESS	110. Policy and procedures for pharmacy services like prescription of drugs, verbal orders, high-risk medications, safe dispensing of drugs,use &storage of drugs and use of narcotics etc not framed 111. Inventory control practices and store management practices and pilferage control are to be strengthened. ABC, VED, EOQ analysis not evident.
OUTCOME	112. Monitoring of Percentage of stock outs, incidents of variations from procurement process& percentage of consumables rejected before preparation of GRN, etc not done.

6.18 REHABILITATION SERVICES

IDENTIFIED GAPS

STRUCTURAL	113. Seepage was seen at various areas (walls & ceilings) in the department. 114. The equipments are not covered under any AMC/CMC and are not calibrated.
PROCESS	115. No documented policy and procedure on Rehabilitative services
OUTCOME	. 116. Patient satisfaction not monitored

6.19 KITCHEN

IDENTIFIED GAPS

STRUCTURAL	117. There is no kitchen located in the hospital. The patients/ relatives get food from home.
PROCESS	118. No documented policy and procedure on dietary services 119. No proper nutritional assessment of patients done, so the patients does not receive food according to their clinical needs 120. Patients/relatives are not uniformly educated on food drug interactions**.**
OUTCOME	121. No Monitoring is done on Percentage of cases where nutritional assessment is not done.

6.20 LAUNDRY

IDENTIFIED GAPS

STRUCTURAL	122. Storing area includes the clean and dirty linens. 123. Sorting area not maintained properly 124. Inappropriate space for storing & dispatch of linen/ clean supplies
PROCESS	`` 125. Departmental manual, policies and procedures, receiving & distribution policies and practices, etc not evident**.** 126. Infection practices are not followed in the department**.**
OUTCOME	127. Monitoring of Percentage of torn/worn linen is not done in a way to enable find the user links/ reason of damage

6.21 SECURITY & SAFETY SERVICES

STRUCTURAL	128. No measures on physical check in entrance to the hospital or entrance to the main buildings. 129. Inadequate measures on access/ traffic control across the hospital 130. No exits plans for fire & non fire emergencies
PROCESS	131. No written documented manual, policies and procedures on patient or hospital safety, civil disturbance, emergency codes, fire and disaster management, etc. 132. Training of staff regarding disaster management, fire & non-fire emergencies are not evidenced. 133. No mock-drills conducted 134. Hazardous materials are not identified and the staffs are not trained on its management.
OUTCOME	135. Monitoring Data on theft cases, no. of security related incidences, etc not available.

6.22 BIO-MEDICAL WASTE STORAGE & TREATMENT FACILITY

IDENTIFIED GAPS

STRUCTURAL	136. There is no license for BMWM 137. The Temporary storage area in the hospital has no segregations in terms of category of waste and the area in unhygienic.
PROCESS	138. No written documented manual, policies and procedures for the BMWM. 139. Training of staff regarding waste management not evidenced. 140. Monitoring of transportation and treatment is not evident**.** 141. Personal protective devices are not used adequately.
OUTCOME	142. Amount of waste generated per month not monitored by the responsible hospital authority.

6.23 MORTUARY SERVICES

STRUCTURAL	143. Highly untidy and unhygienic environment. 144. No security provision towards the mortuary area.

PROCESS	145. No written documented manual, policies and procedures for the Mortuary services. 146. No monitoring of temperatures.
OUTCOME	147. No monitoring of infection rates.

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6.24 BIOMEDICAL ENGINEERING

IDENTIFIED GAPS

STRUCTURAL	148. No dedicated proper department. 149. The current bio-medical equipment related issues are **handled by one person**. 150. AMC & Calibrations are not evidenced on equipments.
PROCESS	151. Policy and Procedure is not defined and documented for equipment (medical) procurement, maintenance, calibration and break down plan**.** 152. Training of staff on use, maintenance and reporting of failures is not evident**.**
OUTCOME	153. Turnaround time for complaints needs to be monitored

6.25 HUMAN RESOURCE DEPARTMENT

IDENTIFIED GAPS

STRUCTURA	1. Well documented Organogram of the hospital and Organogram of each department is not available.

PROCESS	2. No documented Policies for Manpower planning (), Recruitment and selection, job descriptions, performance appraisal grievance redressal training & Development etc. 3. Regular health checks of the employees are not carried out. 4. Training Plan & Training Calendar for employee not found. 5. Structured Performance appraisal for all categories of employees not evident. No evidence of privileging of the Clinical staff
OUTCOME	6. Monitoring of Employee Satisfaction rate, Attrition and absenteeism rate of employees are not calculated

6.26 ENGINEERING

IDENTIFIED GAPS

STRUCTURAL	7. Up to date drawings (as built) of the building not available for OLD building block(maternity wards, ENT and Ortho wards, etc) 8. Lift installed in the OLD building is not in working condition.
PROCESS	9. Policies and Procedures are not defined for sewage water management, waste water disposal, drinking water management, electrical & building safety, break down plan, etc 10. Water quality test reports not done at defined periodicity 11. Disaster Management preparedness not evident 12. Training records of staff on safety mgmt issues not evident 13. No evidence of any mock drills. 14. No inspection reports on lift inspection.
OUTCOME	15. Turnaround time for complaints needs to be monitored

6.27 PERFORMANCE INDICATORS

Particulars	**Quality Indicators**	**Monitored YES / NO**	**Frequency of Monitoring**
Patient Assessment	Time for initial assessment of indoor and emergency patients.	NO	
	Percentage of cases wherein care plan is	NO	

	documented and counter-signed by the clinician.		
	Percentage of cases wherein screening for nutritional needs has been done.	NO	
	Percentage of cases wherein the pre-defined initial nursing assessment is completed within 30 minutes.	NO	
Invasive Procedures	Re-exploration rate	NO	
	Percentage of accidental removal of tubes and catheters.	NO	
	Incidence of haematoma at puncture site.	NO	
	Percentage of re-scheduling of procedures.	NO	
	Incidences when Consent for invasive procedure is missed.	NO	
Anaesthesia Use	Percentage of modification of anesthesia plan.	NO	
	Percentage of unplanned ventilation following anesthesia.	NO	
	Percentage of adverse anesthesia events.	NO	
	Anesthesia related mortality rate.	NO	
Blood and Blood products use	Percentage of transfusion reactions.	NO	
	Percentage of wastage of blood and blood products.	YES	
	Percentage of blood component usage.	YES	
	Turnaround time for issue of blood and blood components.	NO	
Infection Control	Urinary tract infection rate	NO	
	Respiratory infection rate.	NO	
	Intra-vascular device infection rate.	NO	
	Surgical site infection rate.	NO	
Adverse Drug Events	Percentage of medication errors.	NO	
	Incidence of adverse drug reactions.	NO	
	Percentage of medication charts with illegible writing over a given period.	NO	
	Percentage of contrast related reactions.	NO	
Clinical Research	Number of research activities being carried out.	NO	
	Percentage of patients withdrawing from the study.	NO	
	Percentage of protocol violations/deviations reported.	NO	
	Percentage of serious adverse events (which have occurred in the HCO) reported to the ethics committee within the defined timeframe	NO	

Management	Bed occupancy rate and average length of stay.	YES	BOR(monthly)
	OT and ICU utilization rate.	NO	
	Equipment down time.	NO	
	Nurse-patient ratio	NO	
Patient Satisfaction	Out patient satisfaction index.	NO	
	In patient satisfaction index.	NO	
	Waiting time for services including diagnostics and outpatient.	NO	
	Time taken for discharge.	NO	
Employee Satisfaction	Employee satisfaction index.	NO	
	Employee attrition rate.	NO	
	Employee absenteeism rate.	NO	
	Percentage of employees who are aware of employee rights, responsibilities and welfare schemes.	NO	
Diagnostic Services	Number of reporting errors/1000 investigations.	NO	
	Percentage of re-dos.	NO	
	Percentage of reports co-relating with clinical diagnosis.	NO	
	Percentage of adherence to safety precautions by employees working in diagnostics.	NO	
	Report timeliness for the report dispatch.	YES	Daily
Medical Records	Percentage of medical records not having discharge summary.	NO	
	Percentage of medical records not having initial assessment and the plan of care.	NO	
	Percentage of medical records having incomplete and/or improper consent.	NO	
	Percentage of missing records.	NO	
Adverse Events and Near Misses	Number of sentinel events.	NO	
	Percentage of near misses analyzed.	NO	
	Number of security related incidents including thefts.	NO	
	Incidence of needle sticks injuries.	NO	
Risk Management	Number of variations observed in mock drills.	NO	
	Incidence of falls.	NO	
	Incidence of bed sores after admission.	NO	
	Percentage of employees provided pre-exposure prophylaxis.	NO	
Reporting of	Number of births and deaths.	YES	

Activities as required by Laws and Regulations	Number of notifiable diseases.	YES	
	Submission of report/ data/form pertaining to bio-medical waste, PNDT act and radiation safety within the defined timeframe.	YES	
	Submission of tax returns and deduction of taxes at the specified time frame.	YES	
Pharmacy	Percentage of drugs procured by local purchase.	NO	
	Percentage of stock outs including emergency drugs.	YES	
	Percentage of consumables rejected before preparation of Goods Receipt Note.	NO	
	Incidence of variations from the procurement process.	NO	
	Bounced Prescriptions	NO	
Biomedical Engineering	Turn Around time for Complaints	NO	

SELF ASSESSMENT TOOLKIT			
Elements			**Scores (0/5/10)**
Chapter 1: ACCESS, ASSESSMENT AND CONTINUITY OF CARE (AAC)			
AAC.1: The organization defines and displays the services that it provides.			
	a	The services being provided are clearly defined and are in consonance with the needs of the community.	5
	b	The defined services are prominently displayed.	5
	c	The staff is oriented to these services.	0
		AVERAGE SCORE	3.3
AAC.2: The organization has a well-defined registration and admission process.			
	a	Documented policies and procedures are used for registering and admitting patients.	0
	b	The documented procedures address out- patients, in-patients and emergency patients.	0
	c	A unique identification number is generated at the end of registration.	0
	d	Patients are accepted only if the organization can provide the required service.	5

	e	The documented policies and procedures also address managing patients during non-availability of beds.	0
	f	The staff is aware of these processes.	0
		AVERAGE SCORE	0.8
AAC.3: There is an appropriate mechanism for transfer (in and out) or referral of patients.			
	a	Documented policies and procedures guide the transfer-in of patients to the organization.	0
	b	Documented policies and procedures guide the transfer-out/referral of unstable patients to another facility in an appropriate manner.	0
	c	Documented policies and procedures guide the transfer-out/referral of stable patients to another facility in an appropriate manner.	0
	d	The documented procedures identify staff responsible during transfer/referral	5
	e	The organization gives a summary of patient's condition and the treatment given	5
		AVERAGE SCORE	2
AAC.4: Patients cared for by the organization undergo an established initial assessment.			
	a	The organization defines and documents the content of the initial assessment for the out–patients, in-patients and emergency patients	0
	b	The organization determines who can perform the initial assessment.	5
	c	The organization defines the time frame within which the initial assessment is completed based on patient's needs	5
	d	The initial assessment for in-patients is documented within 24 hours or earlier as per the patient's condition as defined in the organization's policy	0
	e	Initial assessment of in-patients includes nursing assessment which is done at the time of admission and documented.	5
	f	Initial assessment includes screening for nutritional needs	0
	g	The initial assessment results in a documented plan of care	0
	h	The plan of care also includes preventive aspects of the care where appropriate	0
	i	The plan of care is countersigned by the clinician in-charge of the patient within 24 hours.	0
	j	The plan of care includes goals or desired results of the treatment, care or service	0

		AVERAGE SCORE	1.5
AAC.5: Patients cared for by the organization undergo a regular reassessment			
	a	Patients are reassessed at appropriate intervals.	5
	b	Out-patients are informed of their next follow up where appropriate.	0
	c	For in-patients during reassessment the plan of care is monitored and modified where found necessary.	5
	d	Staff involved in direct clinical care document reassessments.	5
	e	Patients are reassessed to determine their response to treatment and to plan further treatment or discharge.	5
		AVERAGE SCORE	4
AAC.6: Laboratory services are provided as per the scope of services of the organization.			
	a	Scope of the laboratory services are commensurate to the services provided by the organization.	5
	b	The infrastructure (physical and manpower) is adequate to provide for its defined scope of services.	5
	c	Adequately qualified and trained personnel perform, supervise and interpret the investigations.	5
	d	Documented procedures guide ordering of tests, collection, identification, handling, safe transportation, processing and disposal of specimens.	0
	e	Laboratory results are available within a defined time frame.	0
	f	Critical results are intimated immediately to the concerned personnel.	0
	g	Results are reported in a standardized manner.	5
	h	Laboratory tests not available in the organization are outsourced to organization(s) based on their quality assurance system.	0
		AVERAGE SCORE	2.5
AAC.7:There is an established laboratory quality assurance programme			
	a	The laboratory quality assurance programme is documented.	0
	b	The programme addresses verification and/or validation of test methods.	0
	c	The programme addresses surveillance of test results.	0

	d	The programme includes periodic calibration and maintenance of all equipment.	0
	e	The programme includes the documentation of corrective and preventive actions.	0
		AVERAGE SCORE	0
AAC.8:There is an established laboratory safety programme			
	a	The laboratory safety programme is documented.	0
	b	This programme is aligned with the organization's safety programme.	0
	c	Written procedures guide the handling and disposal of infectious and hazardous materials.	0
	d	Laboratory personnel are appropriately trained in safe practices.	5
	e	Laboratory personnel are provided with appropriate safety equipment / devices.	5
		AVERAGE SCORE	2
AAC.9: Imaging services are provided as per the scope of services of the organization.			
	a	Imaging services comply with legal and other requirements.	5
	b	Scope of the imaging services are commensurate to the services provided by the organization.	5
	c	The infrastructure (physical and manpower) is adequate to provide for its defined scope of services.	5
	d	Adequately qualified and trained personnel perform, supervise and interpret the investigations.	5
	e	Documented policies and procedures guide identification and safe transportation of patients to imaging services.	0
	f	Imaging results are available within a defined time frame.	5
	g	Critical results are intimated immediately to the concerned personnel.	0
	h	Results are reported in a standardized manner.	0
	i	Imaging tests not available in the organization are outsourced to organization(s) based on their quality assurance system.	0
		AVERAGE SCORE	2.8
AAC.10: There is an established Quality assurance programme for imaging services.			
	a	The quality assurance programme for imaging services is documented.	0

	b	The programme addresses verification and/or validation of imaging methods.	0
	c	The programme addresses surveillance of imaging results.	0
	d	The programme includes periodic calibration and maintenance of all equipment.	0
	e	The programme includes the documentation of corrective and preventive actions.	0
		AVERAGE SCORE	0
AAC.11:There is an established radiation safety programme.			
	a	The radiation safety programme is documented.	0
	b	This programme is aligned with the organization's safety programme.	0
	c	Handling, usage and disposal of radio-active and hazardous materialsis as per statutory requirements.	5
	d	Imaging personnel are provided with appropriate radiation safety devices.	5
	e	Radiation safety devices are periodically tested and results documented.	5
	f	Imaging personnel are trained in radiation safety measures.	0
	g	Imaging signageare prominently displayed in all appropriate locations.	5
		AVERAGE SCORE	2.8
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 organization.	0
	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.	5
	f	The patient's record (s) is available to the authorized care providers to facilitate the exchange of information.	10
	g	Documented procedures guide the referral of patients to other departments/ specialities.	0
		AVERAGE SCORE	4.2

AAC.13:The organization has a documented discharge process.			
	a	The patient's discharge process is planned in consultation with the patient and/or family.	0
	b	Documented procedures exist for coordination of various departments and agencies involved in the discharge process (including medico-legal and absconded cases).	0
	c	Documented policies and procedures are in place for patients leaving against medical advice and patients being discharged on request	0
	d	A discharge summary is given to all the patients leaving the organization (including patients leaving against medical advice and on request).	5
		AVERAGE SCORE	1.2
AAC.14: Organization defines the content of the discharge summary.			
	a	Discharge summary is provided to the patients at the time of discharge.	5
	b	Discharge summary contains the patient's name, unique identification number, date of admission and date of discharge.	5
	c	Discharge summary contains the reasons for admission, significant findings and diagnosis and the patient's condition at the time of discharge.	5
	d	Discharge summary contains information regarding investigation results, any procedure performed, medication administered and other treatment given.	5
	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
		AVERAGE SCORE	5.7
		AVERAGE SCORE OF CHAPTER	**2.3**
Chapter 2: CARE OF PATIENTS (COP)			
COP.1: Uniform care to patients is provided in all settings of the organization and is guided by the applicable laws, regulations and guidelines.			
	a	Care delivery is uniform for a given health problem when similar care is provided in more than one setting.	5
	b	Uniform care is guided by documented policies and procedures	0

	c	These reflect applicable laws, regulations and guidelines	5
	d	The organization adapts evidence based medicine and clinical practice guidelines to guide uniform patient care.	5
		AVERAGE SCORE	3.8
COP.2: Emergency services are guided by documented policies, procedures, applicable laws and regulations.			
	a	Policies and procedures for emergency care are documented and are in consonance with statutory requirements.	0
	b	This also addresses handling of medico-legal cases.	0
	c	The patients receive care in consonance with the policies.	0
	d	Documented policies and procedures guide the triage of patients for initiation of appropriate care	0
	e	Staff are familiar with the policies and trained on the procedures for care of emergency patients.	0
	f	Admission or discharge to home or transfer to another organization is also documented.	5
	g	In case of discharge to home or transfer to another organization a discharge note shall be given to the patient.	0
		AVERAGE SCORE	0.7
COP.3: The ambulance services are commensurate with the scope of the services provided by the organization.			
	a	There is adequate access and space for the ambulance(s).	10
	b	The ambulance adheres to statutory requirements.	5
	c	Ambulance(s) is appropriately equipped.	5
	d	Ambulance(s) is manned by trained personnel.	5
	e	Ambulance (s) is checked on a daily basis.	5
	f	Equipment are checked on a daily basis using a checklist.	0
	g	Emergency medications are checked daily and prior to dispatch using a checklist.	5
	h	The ambulance(s) has a proper communication system.	5
		AVERAGE SCORE	5
COP.4: 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 organization	0
	b	Staff providing direct patient care are trained and periodically updated in cardio pulmonary resuscitation.	0
	c	The events during a cardio-pulmonary resuscitation are recorded.	0
	d	A post-event analysis of all cardio-pulmonary resuscitations is done by a multidisciplinary committee.	0
	e	Corrective and preventive measures are taken based on the post-event analysis.	0
		AVERAGE SCORE	0
COP.5: Documented policies and procedures guide nursing care.			
	a	There are documented policies and procedures for all activities of the Nursing Services.	0
	b	These reflect current standards of nursing services and practice, relevant regulations and the purposes of the services.	0
	c	Assignment of patient care is done as per current good practice guidelines.	5
	d	Nursing care is aligned and integrated with overall patient care.	5
	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 timely care of patients.	5
		AVERAGE SCORE	3.5
COP.6: Documented procedures guide the performance of various procedures.			
	a	Documented procedures are used to guide the performance of various clinical procedures.	0
	b	Only qualified personnel order, plan, perform and assist in performing procedures.	5
	c	Documented procedures exist to prevent adverse events like wrong site, wrong patient and wrong procedure.	0
	d	Informed consent is taken by the personnel performing the procedure where applicable.	10
	e	Adherence to standard precautions and asepsis is adhered to during the conduct of the procedure.	5
	f	Patients are appropriately monitored during and after the procedure.	5

	g	Procedures are documented accurately in the patient record.	5
		AVERAGE SCORE	4.2
COP.7: Documented policies and procedures define rational use of blood and blood products.			
	a	Documented policies and procedures are used to guide rational use of blood and blood products.	0
	b	Documented procedures govern transfusion of blood and blood products.	0
	c	The transfusion services are governed by the applicable laws and regulations.	5
	d	Informed consent is obtained for donation and transfusion of blood and blood products.	10
	e	Informed consent also includes patient and family education about donation.	5
	f	The organization defines the process for availability and transfusion of blood/blood components for use in emergency.	0
	g	Post transfusion form is collected; reactions if any identified and are analyzed for preventive and corrective actions.	0
	h	Staff is trained to implement the policies.	5
		AVERAGE SCORE	3.1
COP.8: Documented policies and procedures guide the care of patients in the Intensive care and high dependency units.			
	a	Documented policies and procedures are used to guide the care of patients in the Intensive care and high dependency units.	0
	b	The organization has documented admission and discharge criteria for its intensive care and high dependency units.	0
	c	Staff is trained to apply these criteria.	0
	d	Adequate staff and equipment are available.	0
	e	Defined procedures for situation of bed shortages are followed.	0
	f	Infection control practices are documented and followed.	0
	g	A quality assurance programme is documented and implemented.	0
		AVERAGE SCORE	0

COP.9: Documented policies and procedures guide the care of vulnerable patients (elderly, children, physically and/or mentally challenged).			
	a	Policies and procedures are documented and are in accordance with the prevailing laws and the national and international guidelines.	0
	b	Care is organized and delivered in accordance with the policies and procedures.	0
	c	The organization provides for a safe and secure environment for this vulnerable group.	5
	d	A documented procedure exists for obtaining informed consent from the appropriate legal representative.	0
	e	Staff is trained to care for this vulnerable group.	0
		AVERAGE SCORE	1
COP.10: Documented policies and procedures guide obstetric care.			
	a	There is a documented policy and procedure for obstetric services.	0
	b	The organization defines and displays whether high risk obstetric cases can be cared for or not.	0
	c	Persons caring for high risk obstetric cases are competent.	10
	d	Documented procedures guide provision of ante-natal services.	0
	e	Obstetric patient's assessment also includes maternal nutrition.	5
	f	Appropriate pre-natal, peri-natal and post-natal monitoring is performed and documented.	5
	g	The organization caring for high risk obstetric cases has the facilities to take care of neonates of such cases.	5
		AVERAGE SCORE	3.5
COP.11: Documented policies and procedures guide pediatric services.			
	a	There is a documented policy and procedure for pediatric services.	0
	b	The organization defines and displays the scope of its pediatric services.	0
	c	The policy for care of neonatal patients is in consonance with the national/ international guidelines.	0
	d	Those who care for children have age specific competency.	0

	e	Provisions are made for special care of children.	0
	f	Patient assessment includes detailed nutritional, growth, psychosocial and immunization assessment.	5
	g	Documented policies and procedures prevent child/neonate abduction and abuse.	0
	h	The children's family members are educated about nutrition, immunization and safe parenting and this is documented in the medical record.	0
		AVERAGE SCORE	0.6
COP.12: Documented policies and procedures guide the care of patients undergoing moderate sedation.			
	a	Documented procedures guide the administration of moderate sedation.	0
	b	Informed consent for administration of moderate sedation is obtained.	5
	c	Competent and trained persons perform sedation.	5
	d	The person administering and monitoring sedation is different from the person performing the procedure.	5
	e	Intra-procedure monitoring includes at a minimum the heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation, and level of sedation.	5
	f	Patients are monitored after sedation and the same documented.	0
	g	Criteria are used to determine appropriateness of discharge from the recovery area.	0
	h	Equipment and manpower are available to manage patients who have gone into a deeper level of sedation than initially intended.	0
		AVERAGE SCORE	2.5
COP.13: Documented policies and procedures guide the administration of anaesthesia.			
	a	There is a documented policy and procedure for the administration of anaesthesia.	0
	b	Patients for anaesthesia have a pre-anaesthesia assessment by a qualified anaesthesiologist.	5
	c	The pre-anaesthesia assessment results in formulation of an anaesthesia plan which is documented	0
	d	An immediate pre-operative re-evaluation is performed and documented.	0

	e	Informed consent for administration of anaesthesia is obtained by the anaesthesiologist.	0
	f	During anaesthesia monitoring includes regular recording of temperature, heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation and end tidal carbon dioxide.	5
	g	Patient's post-anaesthesia status is monitored and documented.	0
	h	The anaesthesiologist applies defined criteria to transfer the patient from the recovery area.	0
	i	The type of anaesthesia and anaesthetic medications used are documented in the patient record.	5
	j	Procedures shall comply with infection control guidelines to prevent cross infection between patients.	5
	k	Adverse anaesthesia events are recorded and monitored.	0
		AVERAGE SCORE	1.8
COP.14: Documented policies and procedures guide the care of patients undergoing surgical procedures.			
	a	The policies and procedures are documented.	0
	b	Surgical patients have a preoperative assessment and a provisional diagnosis documented prior to surgery.	5
	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.	0
	g	The operating surgeon documents the post-operative plan of care.	10
	h	Patient, personnel and material flow conforms 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.	0
	k	The quality assurance programme includes surveillance of the operation theatre environment.	0
		AVERAGE SCORE	4

COP.15: Documented policies and procedures guide the care of patients under restraints (physical and / or chemical).			
	a	Documented policies and procedures guide the care of patients under restraints.	0
	b	These include both physical and chemical restraint measures.	0
	c	These include documentation of reasons for restraints.	0
	d	These patients are more frequently monitored.	5
	e	Staff receives training and periodic updating in control and restraint techniques.	0
		AVERAGE SCORE	1
COP.16: Documented policies and procedures guide appropriate pain management.			
	a	Documented policies and procedures guide the management of pain.	0
	b	All patients are screened for pain.	0
	c	Patients with pain undergo detailed assessment and periodic re-assessment.	0
	d	The organization respects and supports management of pain for such patients.	0
	e	Patient and family are educated on various pain management techniques where appropriate.	0
		AVERAGE SCORE	0
COP.17: Documented policies and procedures guide appropriate rehabilitative services.			
	a	Documented policies and procedures guide the provision of rehabilitative services.	0
	b	These services are commensurate with the organizational requirements.	5
	c	Care is guided by functional assessment and periodic re-assessment which is done and documented by qualified individual (s).	5
	d	Care is provided adhering to infection control and safe practices.	5
	e	Rehabilitative services are provided by a multidisciplinary team.	5
	f	There is adequate space and equipment to perform these activities.	5

		AVERAGE SCORE	4.1
COP.18: Documented policies and procedures guide all research activities.			
	a	Documented policies and procedures guide all research activities in compliance with national and international guidelines.	0
	b	The organization has an ethics committee to oversee all research activities.	0
	c	The committee has the powers to discontinue a research trial when risks outweigh the potential benefits.	0
	d	Patient's informed consent is obtained before entering them in research protocols.	0
	e	Patients are informed of their right to withdraw from the research at any stage and also of the consequences (if any) of such withdrawal.	0
	f	Patients are assured that their refusal to participate or withdrawal from participation will not compromise their access to the organization's services.	0
		AVERAGE SCORE	0
COP.19: Documented policies and procedures guide nutritional therapy.			
	a	Documented policies and procedures guide nutritional assessment and reassessment.	0
	b	Patients receive food according to their clinical needs.	0
	c	There is a written order for the diet.	0
	d	Nutritional therapy is planned and provided in a collaborative manner.	0
	e	When families provide food, they are educated about the patient's diet limitations.	0
	f	Food is prepared, handled, stored and distributed in a safe manner.	0
		AVERAGE SCORE	0
COP.20: Documented policies and procedures guide the end of life care.			
	a	Documented policies and procedures guide the end of life care.	0
	b	These policies and procedures are in consonance with the legal requirements.	0

	c	These also address the identification of the unique needs of such patient and family.	0
	d	Symptomatic treatment is provided and where appropriate measures are taken for alleviation of pain.	0
	e	Staff are educated and trained in end of life care.	0
		AVERAGE SCORE	0
		AVERAGE SCORE OF CHAPTER	1.9
Chapter 3: Management of Medication (MOM)			
MOM.1: Documented policies and procedures guide the organization of pharmacy services and usage of medication.			
	a	There is a documented policy and procedure for pharmacy services and medication usage.	0
	b	These comply with the applicable laws and regulations.	0
	c	A multidisciplinary committee guides the formulation and implementation of these policies and procedures.	0
	d	There is a procedure to obtain medication when the pharmacy is closed.*	0
		AVERAGE SCORE	0
MOM.2. There is a hospital formulary.			
	a	A list of medications appropriate for the patients and as per the scope of the organization's clinical services is developed.	10
	b	The list is developed and updated collaboratively by the multidisciplinary committee.	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.	10
		AVERAGE SCORE	9
MOM.3: Documented policies and procedures guide the storage of medication			
	a	Documented policies and procedures exist for storage of medication	0

	b	Medications are stored in a clean; safe and secure environment; and incorporating manufacturer's recommendation (s).	5
	c	Sound inventory control practices guide storage of the medications.	0
	d	Sound alike and look alike medications are identified and stored separately.*	0
	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
		AVERAGE SCORE	2.8
MOM.4: Documented policies and procedures guide the safe and rational prescription of medications			
	a	Documented policies and procedures exist for prescription of medications.	0
	b	These incorporate inclusion of good practices/guidelines for rational prescription of medications.	0
	c	The organization determines the minimum requirements of a prescription.	0
	d	Known drug allergies are ascertained before prescribing.	0
	e	The organization determines who can write orders.*	10
	f	Orders are written in a uniform location in the medical records.	0
	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.	0
	j	The organization defines a list of high risk medication (s).	0
	k	Audit of medication orders/prescription is carried out to check for safe and rational prescription of medications.	0
	l	Corrective and/or preventive action (s) is taken based on the analysis where appropriate.	0
		AVERAGE SCORE	1.6

MOM.5: Documented policies and procedures guide the safe dispensing of medications.			
	a	Documented policies and procedures guide the safe dispensing of medications	0
	b	The procedure addresses medication recall.	0
	c	Expiry dates are checked prior to dispensing.	5
	d	There is a procedure for near expiry medications.	0
	e	Labeling requirements are documented and implemented by the organization.	0
	f	High risk medication orders are verified prior to dispensing.	0
		AVERAGE SCORE	0.8
MOM.6: There are documented policies and procedures for medication management.			
	A	Medications are administered by those who are permitted by law to do so.	5
	B	Prepared medication is labeled prior to preparation of a second drug.	0
	C	Patient is identified prior to administration.	0
	D	Medication is verified from the order prior to administration.	5
	E	Dosage is verified from the order prior to administration.	5
	F	Route is verified from the order prior to administration.	5
	G	Timing is verified from the order prior to administration.	5
	H	Medication administration is documented.	0
	I	Documented policies and procedures govern patient's self-administration of medications.	0
	J	Documented policies and procedures govern patient's medications brought from outside the organization.*	0
		AVERAGE SCORE	2.5
MOM.7: Patients are monitored after medication administration.			

	A	Documented policies and procedures guide the monitoring of patients after medication administration.	0
	B	The organization defines those situations where close monitoring is required.	0
	C	Monitoring is done in a collaborative manner.	5
	D	Medications are changed where appropriate based on the monitoring.	5
		AVERAGE SCORE	2.5
MOM.8: Near misses, medication errors and adverse drug events are reported and analysed.			
	A	Documented procedure exists to capture near miss, medication error and adverse drug event.	0
	B	Near miss, medication error and adverse drug event are defined.	0
	C	These are reported within a specified time frame.	0
	D	They are collected and analyzed.	0
	E	Corrective and/or preventive action (s) is taken based on the analysis where appropriate.	0
		AVERAGE SCORE	0
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.	0
	B	These drugs are stored in a secure manner.	0
	C	A proper record is kept of the usage, administration and disposal of these drugs.	0
	D	These drugs are handled by appropriate personnel in accordance with the documented procedure.	0
		AVERAGE SCORE	0
MOM.10: Documented policies and procedures guide the usage of chemotherapeutic agents.			
	A	Documented policies and procedures guide the usage of chemotherapeutic agents.	NA
	B	Chemotherapy is prescribed by those who have the knowledge to monitor and treat the adverse effect of chemotherapy.	NA

	C	Chemotherapy is prepared in a proper and safe manner and administered by qualified personnel.	NA
	D	Chemotherapy drugs are disposed off in accordance with legal requirements.	NA
		AVERAGE SCORE	0
MOM.11: Documented policies and procedures govern usage of radioactive drugs.			
	A	Documented policies and procedures govern usage of radioactive drugs.	0
	B	These policies and procedures are in consonance with laws and regulations.	0
	C	The policies and procedures include the safe storage, preparation, handling, distribution and disposal of radioactive drugs.	0
	D	Staff, patients and visitors are educated on safety precautions.	0
		AVERAGE SCORE	0
MOM.12: Documented policies and procedures guide the use of implantable prosthesis and medical devices.			
	A	Usage of implantable prosthesis and medical devices is guided by scientific criteria for each individual item and national / international recognized guidelines / approvals for such specific item(s).	0
	B	Documented policies and procedures govern procurement, storage / stocking, issuance and usage of implantable prosthesis and medical devices incorporating manufacturer's recommendation(s).*	0
	C	Patient and his / her family are counselled for the usage of implantable prosthesis and medical device including precautions, if any.	5
	D	The batch and serial number of the implantable prosthesis and medical devices are recorded in the patient's medical record and the master logbook.	0
		AVERAGE SCORE	1.2
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.	5
	B	Medical supplies and consumables are used in a safe manner where appropriate.	5

	C	Medical supplies and consumables are stored in a clean; safe and secure environment; and incorporating manufacturer's recommendation (s).	5
	D	Sound inventory control practices guide storage of medical supplies and consumables.	0
		AVERAGE SCORE	3.8
		AVERAGE SCORE OF CHAPTER	1.9
Chapter 4: Patient Rights and Education (PRE)			
PRE.1. The organization protects patient and family rights and informs them about their responsibilities during care.			
	A	Patient and family rights and responsibilities are documented and displayed.	0
	B	Patients and families are informed of their rights and responsibilities in a format and language that they can understand.	0
	C	The organization's leaders protect patient and family rights.	10
	D	Staff is aware of their responsibility in protecting patient and family rights.	5
	E	Violation of patient and family rights is recorded, reviewed and corrective / preventive measures taken.	5
		AVERAGE SCORE	4
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.	5
	B	Patient and family rights include respect for personal dignity and privacy during examination, procedures and treatment.	5
	C	Patient and family rights include protection from physical abuse or neglect.	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 rights include informed consent before transfusion of blood and blood products, anaesthesia, surgery, initiation of any research protocol and any other invasive / high risk procedures / treatment.	5
	G	Patient and family rights include right to complain and information on how to voice a complaint.	5

	H	Patient and family rights include information on the expected cost of the treatment.	5
	I	Patient and family rights include access to his / her clinical records.	10
	J	Patient and family rights include information on plan of care, progress and information on their health care needs.	5
		AVERAGE SCORE	6
PRE.3: The patient and/ or family members are educated to make informed decisions and are involved in the care planning and delivery process.			
	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.	5
	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.	0
	E	The care plan respects and where possible incorporates patient and/or family concerns and requests.	5
	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.	10
		AVERAGE SCORE	5.8
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.	0
	B	General consent for treatment is obtained when the patient enters the organization.	0
	C	Patient and/or his family members are informed of the scope of such general consent.	0
	D	Informed consent includes information regarding the procedure, risks, benefits, alternatives and as to who will perform the requisite procedure in a language that they can understand.	0
	E	The procedure describes who can give consent when patient is incapable of independent decision making.	0
	F	Informed consent is taken by the person performing the procedure.	0

	G	Informed consent process adheres to statutory norms.	0
	H	Staff is aware of the informed consent procedure.	5
		AVERAGE SCORE	0.6
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.	0
	B	Patient and/or family are educated about food-drug interactions.	0
	C	Patient and/or family are educated about diet and nutrition.	5
	D	Patient and/or family are educated about immunizations.	5
	E	Patient and/or family are educated about organ donation, when appropriate.	0
	F	Patient and/or family are educated about their specific disease process, complications and prevention strategies.	5
	G	Patient and/or family are educated about preventing healthcare associated infections.	0
	H	Patient and/or family are educated in a language and format that they can understand.	10
		AVERAGE SCORE	3.1
PRE.6: Patient and families have a right to information on expected costs.			
	A	There is uniform pricing policy in a given setting (out-patient and ward category).	10
	B	The 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.	5
		AVERAGE SCORE	7.5
PRE.7: Organization has a complaint redressal procedure.			
	A	The organization has a documented complaint redressal procedure.	0
	B	Patient and/or family members are made aware of the procedure for lodging complaints.	0

	C	All complaints are analyzed.	5
	D	Corrective and/or preventive action (s) is taken based on the analysis where appropriate.	5
		AVERAGE SCORE	2.5
		AVERAGE SCORE OF CHAPTER	4.2
Chapter 5: Hospital Infection Control (HIC)			
HIC.1: The organization has a well-designed, comprehensive and coordinated Hospital Infection Prevention and Control (HIC) programme aimed at reducing/ eliminating risks to patients, visitors and providers of care.			
	A	The hospital infection prevention and control programme is documented which aims at preventing and reducing risk of healthcare associated infections.	0
	B	The infection prevention and control programme is a continuous process and updated at least once in a year.	0
	C	The hospital has a multi-disciplinary infection control committee which co-ordinates all infection prevention and control activities.	0
	D	The hospital has an infection control team which co-ordinates implementation of all infection prevention and control activities.	0
	E	The hospital has designated infection control officer as part of the infection control team.	0
	F	The hospital has designated infection control nurse(s) as part of the infection control team.	0
		AVERAGE SCORE	0
HIC.2: The organization implements the policies and procedures laid down in the Infection Control Manual.			
	A	The organization identifies the various high-risk areas and procedures and implements policies and/or procedures to prevent infection in these areas	0
	B	The organization adheres to standard precautions at all times.	0
	C	The organization adheres to hand hygiene guidelines.	5
	D	The organization adheres to safe injection and infusion practices.	5
	E	The organization adheres to transmission based precautions at all times.	0
	F	The organization adheres to cleaning, disinfection and sterilization practices	5

	G	An appropriate antibiotic policy is established and implemented.	0
	H	The organization adheres to laundry and linen management processes.	5
	I	The organization adheres to kitchen sanitation and food handling issues.	0
	J	The organization has appropriate engineering controls to prevent infections.	0
	K	The organization adheres to housekeeping procedures.	5
		AVERAGE SCORE	2.2
HIC.3: The organization performs surveillance activities to capture and monitor infection prevention and control data.			
	A	Surveillance activities are appropriately directed towards the identified high-risk areas and procedures.	0
	B	Collection of surveillance data is an on-going process.	0
	C	Verification of data is done on a regular basis by the infection control team.	0
	D	Scope of surveillance activities incorporates tracking and analysing of infection risks, rates and trends.	0
	E	Surveillance activities include monitoring the compliance with hand hygiene guidelines.	0
	F	Surveillance activities include monitoring the effectiveness of housekeeping services.	0
	G	Appropriate feedback regarding HAI rates are provided on a regular basis to appropriate personnel.	0
	H	In cases of notifiable diseases, information (in relevant format) is sent to appropriate authorities.	0
		AVERAGE SCORE	0
HIC.4: The organization takes actions to prevent and control Healthcare Associated Infections (HAI) in patients.			
	A	The organization takes action to prevent urinary tract infections.	0
	B	The organization takes action to prevent respiratory tract infections.	0
	C	The organization takes action to prevent intra-vascular device infections.	0
	D	The organization takes action to prevent surgical site infections.	0
		AVERAGE SCORE	0

HIC.5: The organization provides adequate and appropriate resources for prevention and control of Healthcare Associated Infections (HAI).			
	A	Adequate and appropriate personal protective equipment, soaps, and disinfectants are available and used correctly.	5
	B	Adequate and appropriate facilities for hand hygiene in all patient care areas are accessible to health care providers.	0
	C	Isolation / barrier nursing facilities are available.	5
	D	Appropriate pre and post exposure prophylaxis is provided to all concerned staff members.	0
		AVERAGE SCORE	2.5
HIC.6: The organization identifies and takes appropriate action to control outbreaks of infections.			
	A	Organization has a documented procedure for identifying an outbreak.	0
	B	Organization has a documented procedure for handling such outbreaks.	0
	C	This procedure is implemented during outbreaks.	0
	D	After the outbreak is over appropriate corrective actions are taken to prevent recurrence.	0
		AVERAGE SCORE	0
HIC.7: There are documented policies and procedures for sterilization activities in the organization.			
	A	The organization provides adequate space and appropriate zoning for sterilization activities.	5
	B	Documented procedure guides the cleaning, packing, disinfection and/or sterilization, storing and issue of items.	0
	C	Reprocessing of instruments and equipment are covered.	0
	D	Regular validation tests for sterilization are carried out and documented.	5
	E	There is an established recall procedure when breakdown in the sterilization system is identified.	0
		AVERAGE SCORE	2
HIC.8: Biomedical waste (BMW) is handled in an appropriate and safe manner.			
	A	The organization adheres to statutory provisions with regard to biomedical waste.	5

	B	Proper segregation and collection of biomedical waste from all patient care areas of the hospital is implemented and monitored.	5
	C	The organization ensures that biomedical waste is stored and transported to the site of treatment and disposal in proper covered vehicles within stipulated time limits in a secure manner.	0
	D	Biomedical waste treatment facility is managed as per statutory provisions (if in-house) or outsourced to authorised contractor(s).	0
	E	Appropriate personal protective measures are used by all categories of staff handling biomedical waste.	5
		AVERAGE SCORE	3
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.	0
	B	The organization earmarks adequate funds from its annual budget in this regard.	0
	C	The organization conducts induction training for all staff.	0
	D	The organization conducts appropriate "in-service" training sessions for all staff at least once in a year.	0
		AVERAGE SCORE	0
		AVERAGE SCORE OF CHAPTER	1.1
Chapter 6: Continual Quality Improvement (CQI)			
CQI.1: There is a structured quality improvement and continuous monitoring programme in the organization.			
	A	The quality improvement programme is developed, implemented and maintained by a multi-disciplinary committee.	0
	B	The quality improvement programme is documented.	0
	C	There is a designated individual for coordinating and implementing the quality improvement programme.	0
	D	The quality improvement programme is comprehensive and covers all the major elements related to quality assurance and supports innovation.	0
	E	The designated programme is communicated and coordinated amongst all the staff of the organization through appropriate training mechanism.	0
	F	The quality improvement programme identifies opportunities for improvement based on review at pre-defined intervals.	0

	G	The quality improvement programme is a continuous process and updated at least once in a year.	0
	H	Audits are conducted at regular intervals as a means of continuous monitoring.	0
	I	There is an established process in the organization to monitor and improve quality of nursing and complete patient care.	0
		AVERAGE SCORE	0
CQI.2: There is a structured patient safety programme in the organization.			
	A	The patient safety programme is developed, implemented and maintained by a multi-disciplinary committee.	0
	B	The patient safety programme is documented.	0
	C	The patient safety programme is comprehensive and covers all the major elements related to patient safety and risk management.	0
	D	The scope of the programme is defined to include adverse events ranging from “no harm” to “sentinel events”.	0
	E	There is a designated individual for coordinating and implementing the patient safety programme.	0
	F	The designated programme is communicated and coordinated amongst all the staff of the organization through appropriate training mechanism.	0
	G	The patient safety programme identifies opportunities for improvement based on review at pre-defined intervals.	0
	H	The patient safety programme is a continuous process and updated at least once in a year.	0
	I	The organization adapts and implements national/international patient safety goals/solutions.	0
	J	The organization uses at least two identifiers to identify patients across the organization.	0
		AVERAGE SCORE	0
CQI.3: The organization identifies key indicators to monitor the clinical structures, processes and outcomes which are used as tools for continual improvement.			
	A	Monitoring includes appropriate patient assessment.	0
	B	Monitoring includes safety and quality control programmes of all the diagnostic services.	0
	C	Monitoring includes medication management.	0

	D	Monitoring includes use of anaesthesia.	0
	E	Monitoring includes surgical services.	0
	F	Monitoring includes use of blood and blood products.	5
	G	Monitoring includes infection control activities.	0
	H	Monitoring includes review of mortality and morbidity indicators.	5
	I	Monitoring includes clinical research.	0
	J	Monitoring includes data collection to support further improvements.	0
	K	Monitoring includes data collection to support evaluation of these improvements.	0
		AVERAGE SCORE	0.9
CQI.4: The organization identifies key indicators to monitor the managerial structures, processes and outcomes which are used as tools for continual improvement.			
	A	Monitoring includes procurement of medication essential to meet patient needs.	5
	B	Monitoring includes risk management.	0
	C	Monitoring includes utilisation of space, manpower and equipment.	5
	D	Monitoring includes patient satisfaction which also incorporates waiting time for services.	0
	E	Monitoring includes employee satisfaction.	0
	F	Monitoring includes adverse events and near misses.	0
	G	Monitoring includes availability and content of medical records.	0
	H	Monitoring includes data collection to support further improvements.	0
	I	Monitoring includes data collection to support evaluation of these improvements.	0
		AVERAGE SCORE	1.1
CQI.5: The quality improvement programme is supported by the management.			
	A	The management makes available adequate resources required for quality improvement programme.	0

	B	Organization earmarks adequate funds from its annual budget in this regard.	0
	C	The management identifies organizational performance improvement targets.	0
	D	The management supports and implements use of appropriate quality improvement, statistical and management tools in its quality improvement programme.	0
		AVERAGE SCORE	0
CQI.6: There is an established system for clinical audit.			
	A	Medical and nursing staff participates in this system.	0
	B	The parameters to be audited are defined by the organization.	0
	C	Patient and staff anonymity is maintained.	0
	D	All audits are documented.	0
	E	Remedial measures are implemented.	0
		AVERAGE SCORE	0
CQI.7: Incidents, complaints and feedback are collected and analysed to ensure continual quality improvement.			
	A	The organization has an incident reporting system.	0
	B	The organization has a process to collect feedback and receive complaints.	0
	C	The organization has established processes for analysis of incidents, feedbacks and complaints.	5
	D	Corrective and preventive actions are taken based on the findings of such analysis.	5
	E	Feedback about care and service is communicated to staff.	5
		AVERAGE SCORE	3
CQI.8: Sentinel events are intensively analysed.			
	A	The organization has defined sentinel events.	0

	B	The organization has established processes for intense analysis of such events.	0
	C	Sentinel events are intensively analysed when they occur.	5
	D	Corrective and Preventive Actions are taken based on the findings of such analysis.	5
		AVERAGE SCORE	2.5
		AVERAGE SCORE OF CHAPTER	0.9
Chapter 7: Responsibilities of Management (ROM)			
ROM.1: The responsibilities of those responsible for governance are defined.			
	A	Those responsible for governance lay down the organization's vision, mission and values.	0
	B	Those responsible for governance approve the strategic and operational plans and organization's budget.	0
	C	Those responsible for governance monitor and measure the performance of the organization against the stated mission.	0
	D	Those responsible for governance establish the organization's organogram.	0
	E	Those responsible for governance appoint the senior leaders in the organization.	5
	F	Those responsible for governance support safety initiatives and quality improvement plans.	5
	G	Those responsible for governance support research activities.	0
	H	Those responsible for governance address the organization's social responsibility.	5
	I	Those responsible for governance inform the public of the quality and performance of services.	0
		AVERAGE SCORE	1.7
ROM.2: The organization complies with the laid down and applicable legislations and regulations.			
	A	The management is conversant with the laws and regulations and knows their applicability to the organization.	5
	B	The management ensures implementation of these requirements.	5
	C	Management regularly updates any amendments in the prevailing laws of the land.	0
	D	There is a mechanism to regularly update licenses/ registrations/certifications.	0
		AVERAGE SCORE	2.5

ROM.3: The services provided by each department are documented.			
	A	Scope of services of each department is defined	0
	B	Administrative policies and procedures for each department are maintained.	0
	C	Each organizational programme, service, site or department has effective leadership.	0
	D	Departmental leaders are involved in quality improvement.	5
		AVERAGE SCORE	1.2
ROM.4: The organization is managed by the leaders in an ethical manner.			
	A	The leaders make public the vision, mission and values of the organization.	0
	B	The leaders establish the organization's ethical management.	0
	C	The organization discloses its ownership.	0
	D	The organization honestly portrays the services which it can and cannot provide.	0
	E	The organization honestly portrays its affiliations and accreditations.	0
	F	The organization accurately bills for its services based upon a standard billing tariff.	10
		AVERAGE SCORE	1.7
ROM.5: The organization displays professionalism in management of affairs.			
	A	The person heading the organization has requisite and appropriate administrative qualifications.	5
	B	The person heading the organizationhas requisite and appropriate administrative experience.	10
	C	The organization prepares the strategic and operational plans including long term and short term goals commensurate to the organization's vision, mission and values in consultation with the various stake holders.	0
	D	d. The organization coordinates the functioning with departments and external agencies, and monitors the progress in achieving the defined goals and objectives.	0
	E	The organization plans and budgets for its activities annually.	5
	F	The performance of the senior leaders is reviewed for their effectiveness.	0
	G	The functioning of committees is reviewed for their effectiveness.	0

	H	The organization documents employee rights and responsibilities.	0
	I	The organization documents the service standards.	0
	J	The organization has a formal documented agreement for all outsourced services.	0
	K	The organization monitors the quality of the outsourced services.	0
		AVERAGE SCORE	1.8
ROM.6: Management ensures that patient safety aspects and risk management issues are an integral part of patient care and hospital management.			
	A	Management ensures proactive risk management across the organization.	0
	B	Management provides resources for proactive risk assessment and risk reduction activities.	0
	C	Management ensures implementation of systems for internal and external reporting of system and process failures.	0
	D	Management ensures that appropriate corrective and preventive action is taken to address safety related incidents.	0
		AVERAGE SCORE	0
		AVERAGE SCORE OF CHAPTER	1.5
Chapter 8:Facility Management and Safety (FMS)			
FMS.1: The organization has a system in place to provide a safe and secure environment.			
	A	Safety committee coordinates development, implementation, and monitoring of the safety plan and policies	0
	B	Patient safety devices are installed across the organization and inspected periodically.	0
	C	The organization is a non-smoking area.	0
	D	Facility inspection rounds to ensure safety are conducted at least twice in a year in patient care areas and at least once in a year in non-patient care areas.	0
	E	Inspection reports are documented and corrective and preventive measures are undertaken.	5
	F	There is a safety education programme for staff.	0
		AVERAGE SCORE	0.8
FMS.2: The organization's environment and facilities operate to ensure safety of patients, their families, staff and visitors.			

	A	Facilities are appropriate to the scope of services of the organization.	0
	B	Up-to-date drawings are maintained which detail the site layout, floor plans and fire escape routes.	0
	C	There is internal and external sign posting in the organization in a language understood by patient, families and community.	5
	D	The provision of space shall be in accordance with the available literature on good practices (Indian or International Standards) and directives from government agencies.	0
	E	Potable water and electricity are available round the clock.	0
	F	Alternate sources for electricity and water are provided as backup for any failure / shortage.	0
	G	The organization regularly tests these alternate sources.	0
	H	There are designated individuals responsible for the maintenance of all the facilities.	10
	I	There is a documented operational and maintenance (preventive and breakdown) plan.	0
	J	Maintenance staff is contactable round the clock for emergency repairs.	5
	K	Response times are monitored from reporting to inspection and implementation of corrective actions.	0
		AVERAGE SCORE	1.8
FMS.3: The organization has a programme for engineering support services.			
	A	The organization plans for equipment in accordance with its services and strategic plan.	0
	B	Equipment are selected, rented, updated or upgraded by a collaborative process.	5
	C	Equipments are inventoried and proper logs are maintained as required.	5
	D	Qualified and trained personnel operate and maintain equipment and utility systems.	5
	E	There is a documented operational and maintenance (preventive and breakdown) plan.	0
	F	There is a maintenance plan for water management.	0
	G	There is a maintenance plan for electrical systems.	0
	H	There is a maintenance plan for heating, ventilation and air-conditioning.	0
	I	There is a documented procedure for equipment replacement and disposal.	0

		AVERAGE SCORE	1.7
FMS.4: The organization has a programme for bio-medical equipment management.			
	A	The organization plans for equipment in accordance with its services and strategic plan.	0
	B	Equipment are selected, rented, updated or upgraded by a collaborative process.	0
	C	Equipment are inventoried and proper logs are maintained as required.	0
	D	Qualified and trained personnel operate and maintain the medical equipment.	0
	E	Equipment are periodically inspected and calibrated for their proper functioning.	0
	F	There is a documented operational and maintenance (preventive and breakdown) plan.	0
	G	There is a documented procedure for equipment replacement and disposal.*	0
		AVERAGE SCORE	0
FMS.5: The organization has a programme for medical gases, vacuum and compressed air.			
	A	Documented procedures govern procurement, handling, storage, distribution, usage and replenishment of medical gases.	0
	B	Medical gases are handled, stored, distributed and used in a safe manner.	0
	C	The procedures for medical gases address the safety issues at all levels.	0
	D	Alternate sources for medical gases, vacuum and compressed air are provided for, in case of failure.	0
	E	The organization regularly tests these alternate sources.	0
	F	There is an operational and maintenance plan for piped medical gas, compressed air and vacuum installation.*	0
		AVERAGE SCORE	0
FMS.6: The organization has plans for fire and non-fire emergencies within the facilities.			
	A	The organization has plans and provisions for early detection, abatement and containment of fire and non-fire emergencies.	0
	B	The organization has a documented safe exit plan in case of fire and non-fire emergencies.	0
	C	Staff are trained for their role in case of such emergencies	0

	D	Mock drills are held at least twice in a year.	0
	E	There is a maintenance plan for fire related equipment.	0
		AVERAGE SCORE	0
FMS.7: The organization plans for handling community emergencies, epidemics and other disasters.			
	A	The organization identifies potential emergencies.	0
	B	The organization has a documented disaster management plan.	0
	C	Provision is made for availability of medical supplies, equipment and materials during such emergencies.	0
	D	Staff are trained in the hospital's disaster management plan.	0
	E	The plan is tested at least twice in a year.	0
		AVERAGE SCORE	0
FMS.8: The organization has a plan for management of hazardous materials.			
	A	Hazardous materials are identified within the organization.	0
	B	The organization implements processes for sorting, labelling, handling, storage, transporting and disposal of hazardous material.	0
	C	Requisite regulatory requirements are met in respect of radioactive materials.	0
	D	There is a plan for managing spills of hazardous materials.	0
	E	Staff are educated and trained for handling such materials.	0
		AVERAGE SCORE	0
		AVERAGE SCORE OF CHAPTER	0.5
Chapter 9: Human Resource Management (HRM)			
HRM.1. The organization has a documented system of human resource planning.			
	A	Human resource planning supports the organization's current and future ability to meet the care, treatment and service needs of the patient.	0

	B	The organization maintains an adequate number and mix of staff to meet the care, treatment and service needs of the patient.	0
	C	The required job specification and job description are well defined for each category of staff.	0
	D	The organization verifies the antecedents of the potential employee with regards to criminal/negligence background.	0
		AVERAGE SCORE	0
HRM.2. The organization has a documented procedure for recruiting staff and orienting them to the organization's environment.			
	A	There is a documented procedure for recruitment.	0
	B	Recruitment is based on pre-defined criteria	5
	C	Every staff member entering the organization is provided induction training	0
	D	The induction training includes orientation to the organization's vision, mission and values.	0
	E	The induction training includes awareness on employee rights and responsibilities.	0
	F	The induction training includes awareness on patient's rights and responsibilities.	0
	G	The induction training includes orientation to the service standards of the organization.	0
	H	Every staff member is made aware of organization wide policies and procedures as well as relevant department / unit / service / programme's policies and procedures.	0
		AVERAGE SCORE	0.6
HRM.3. There is an on-going programme for professional training and development of the staff.			
	A	A documented training and development policy exists for the staff.	0
	B	The organization maintains the training record.	0
	C	Training also occurs when job responsibilities change/ new equipment is introduced.	0
	D	Feedback mechanisms for assessment of training and development programme exist and the feedback is used to improve the training programme.	0
		AVERAGE SCORE	0

HRM.4. Staff are adequately trained on various safety related aspects.			
	A	Staff is trained on the risks within the organization's environment.	0
	B	Staff members can demonstrate and take actions to report, eliminate / minimize risks.	0
	C	Staff members are made aware of procedures to follow in the event of an incident.	0
	D	Staff is trained on occupational safety aspects.	0
		AVERAGE SCORE	0
HRM.5. An appraisal system for evaluating the performance of an employee exists as an integral part of the human resource management process.			
	A	A documented performance appraisal system exists in the organization.*	0
	B	The employees are made aware of the system of appraisal at the time of induction.	0
	C	Performance is evaluated based on the pre-determined criteria.	0
	D	The appraisal system is used as a tool for further development.	0
	E	Performance appraisal is carried out at pre-defined intervals and is documented.	0
		AVERAGE SCORE	0
HRM.6. The organization has documented disciplinary and grievance handling policies and procedures.			
	A	Documented policies and procedures exist.	0
	B	The policies and procedures are known to all categories of staff of the organization.	0
	C	The disciplinary policy and procedure is based on the principles of natural justice.	0
	D	The disciplinary procedure is in consonance with the prevailing laws.	0
	E	There is a provision for appeals in all disciplinary cases.	0
	F	The redress procedure addresses the grievance.	0

	G	Actions are taken to redress the grievance.	0
		AVERAGE SCORE	0
HRM.7. The organization addresses the health needs of the employees.			
	A	A pre-employment medical examination is conducted on all the employees.	10
	B	Health problems of the employees are taken care of in accordance with the organization's policy.	0
	C	Regular health checks of staff dealing with direct patient care are done at-least once a year and the findings/ results are documented.	0
	D	Occupational health hazards are adequately addressed.	0
		AVERAGE SCORE	2.5
HRM.8. There is documented personal information for each staff member.			
	A	Personal files are maintained in respect of all staff.	5
	B	The personal files contain personal information regarding the staff's qualification, disciplinary background and health status.	5
	C	All records of in-service training and education are contained in the personal files.	0
	D	Personal files contain results of all evaluations.	0
		AVERAGE SCORE	2.5
HRM.9. There is a process for credentialing and privileging of medical professionals, permitted to provide patient care without supervision.			
	A	Medical professionals permitted by law, regulation and the organization to provide patient care without supervision is identified.	5
	B	The education, registration, training and experience of the identified medical professionals is documented and updated periodically.	0
	C	All such information pertaining to the medical professionals is appropriately verified when possible.	0
	D	Medical professionals are granted privileges to admit and care for patients in consonance with their qualification, training, experience and registration.	0
	E	The requisite services to be provided by the medical professionals are known to them as well as the various departments / units of the organization.	5

	F	Medical professionals admit and care for patients as per their privileging.	0
		AVERAGE SCORE	1.7
HRM.10. There is a process for credentialing and privileging of nursing professionals, permitted to provide patient care without supervision.			
	A	Nursing staff permitted by law, regulation and the organization to provide patient care without supervision are identified.	5
	B	The education, registration, training and experience of nursing staff is documented and updated periodically.	0
	C	All such information pertaining to the nursing staff is appropriately verified when possible.	0
	D	Nursing staff are granted privileges in consonance with their qualification, training, experience and registration.	5
	E	The requisite services to be provided by the nursing staff are known to them as well as the various departments / units of the organization.	0
	F	Nursing professionals care for patients as per their privileging.	0
		AVERAGE SCORE	1.7
		AVERAGE SCORE OF CHAPTER	0.9
Chapter 10: Information Management System (IMS)			
IMS.1. Documented policies and procedures exist to meet the information needs of the care providers, management of the organization as well as other agencies that require data and information from the organization.			
	A	The information needs of the organization are identified and are appropriate to the scope of the services being provided by the organization.	0
	B	Documented policies and procedures to meet the information needs exist.	0
	C	These policies and procedures are in compliance with the prevailing laws and regulations.	0
	D	All information management and technology acquisitions are in accordance with the documented policies and procedures.	0
	E	The organization contributes to external databases in accordance with the law and regulations.	0
		AVERAGE SCORE	0
IMS.2. The organization has processes in place for effective management of data.			

	A	Formats for data collection are standardized.	5
	B	Necessary resources are available for analysing data.	0
	C	Documented procedures are laid down for timely and accurate dissemination of data.	0
	D	Documented procedures exist for storing and retrieving data.	0
	E	Appropriate clinical and managerial staff participates in selecting, integrating and using data.	0
		AVERAGE SCORE	1
IMS.3. The organization has a complete and accurate medical record for every patient.			
	A	Every medical record has a unique identifier.	5
	B	Organization policy identifies those authorized to make entries in medical record.	5
	C	Entry in the medical record is named, signed, dated and timed.	0
	D	The author of the entry can be identified.	0
	E	The contents of medical record are identified and documented.	5
	F	The record provides a complete, up-to-date and chronological account of patient care.	5
	G	Provision is made for 24-hour availability of the patient's record to healthcare providers to ensure continuity of care.	5
		AVERAGE SCORE	3.5
IMS.4. The medical record reflects continuity of care.			
	A	The medical record contains information regarding reasons for admission, diagnosis and plan of care.	0
	B	The medical record contains the results of tests carried out and the care provided.	0
	C	Operative and other procedures performed are incorporated in the medical record.	0
	D	When patient is transferred to another hospital, the medical record contains the date of transfer, the reason for the transfer and the name of the receiving hospital.	0
	E	The medical record contains a copy of the discharge summary duly signed by appropriate and qualified personnel.	5
	F	In case of death, the medical record contains a copy of the cause of death certificate.	0

	G	Whenever a clinical autopsy is carried out, the medical record contains a copy of the report of the same.	5
	H	Care providers have access to current and past medical record.	5
		AVERAGE SCORE	1.9
IMS.5. Documented policies and procedures are in place for maintaining confidentiality, integrity and security of records, data and information.			
	a	Documented policies and procedures exist for maintaining confidentiality, security and integrity of records, data and information.	0
	B	Documented policies and procedures are in consonance with the applicable laws.	0
	C	The policies and procedure (s) incorporate safeguarding of data/ record against loss, destruction and tampering.	0
	D	The organization has an effective process of monitoring compliance of the laid down policy and procedure.	0
	E	The organization uses developments in appropriate technology for improving confidentiality, integrity and security.	0
	F	Privileged health information is used for the purposes identified or as required by law and not disclosed without the patient's authorization.	0
	G	A documented procedure exists on how to respond to patients / physicians and other public agencies requests for access to information in the medical record in accordance with the local and national law.*	0
		AVERAGE SCORE	0
IMS.6. Documented policies and procedures exist for retention time of records, data and information.			
	A	Documented policies and procedures are in place on retaining the patient's clinical records, data and information.	0
	B	The policies and procedures are in consonance with the local and national laws and regulations.	0
	C	The retention process provides expected confidentiality and security.	0
	D	The destruction of medical records, data and information is in accordance with the laid down policy.	0
		AVERAGE SCORE	0
IMS.7. The organization regularly carries out review of medical records.			

A	The medical records are reviewed periodically.	0
B	The review uses a representative sample based on statistical principles.	0
C	The review is conducted by identified care providers.	0
D	The review focuses on the timeliness, legibility and completeness of the medical records.	0
E	The review process includes records of both active and discharged patients.	0
F	The review points out and documents any deficiencies in records.	0
G	Appropriate corrective and preventive measures are undertaken within a defined period of time and are documented.	0
	AVERAGE SCORE	0
	AVERAGE SCORE OF CHAPTER	0.9

7 ANALYSIS

1. ACCESS, ASSESS & CONTINUITY OF CARE

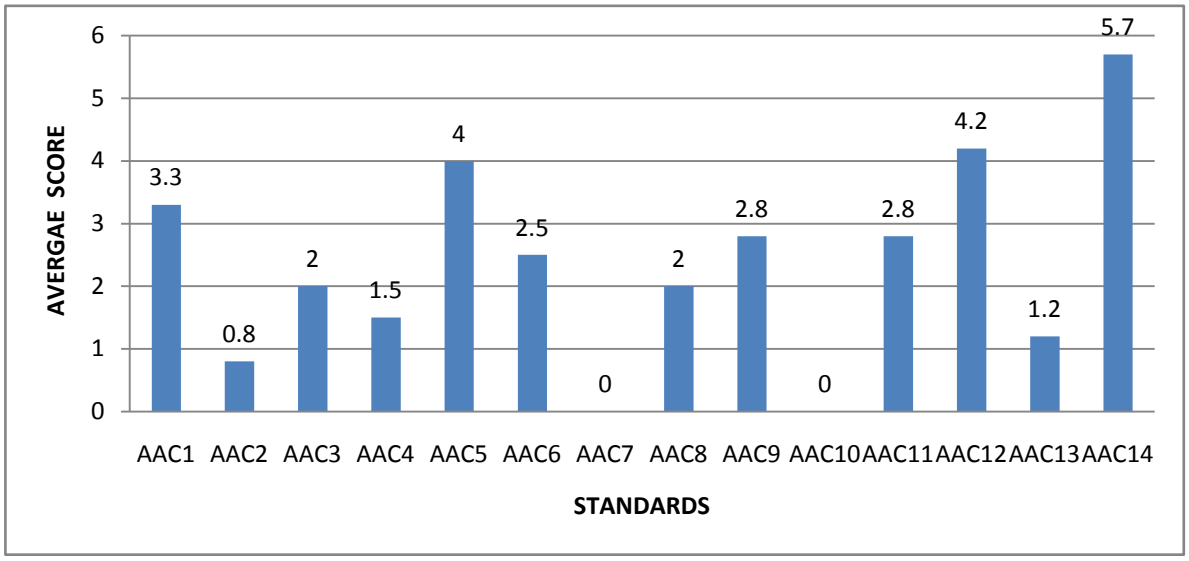

Fig.1-Score of AAC Standards

INTERPRETATION

The highest score in this chapter is AAC 14 which shows that hospital has defined the extent of discharge summary partially.

Two standards,AAC 7 and AAC 10 show no compliance to the NABH requirements.

2. CARE OF PATIENTS

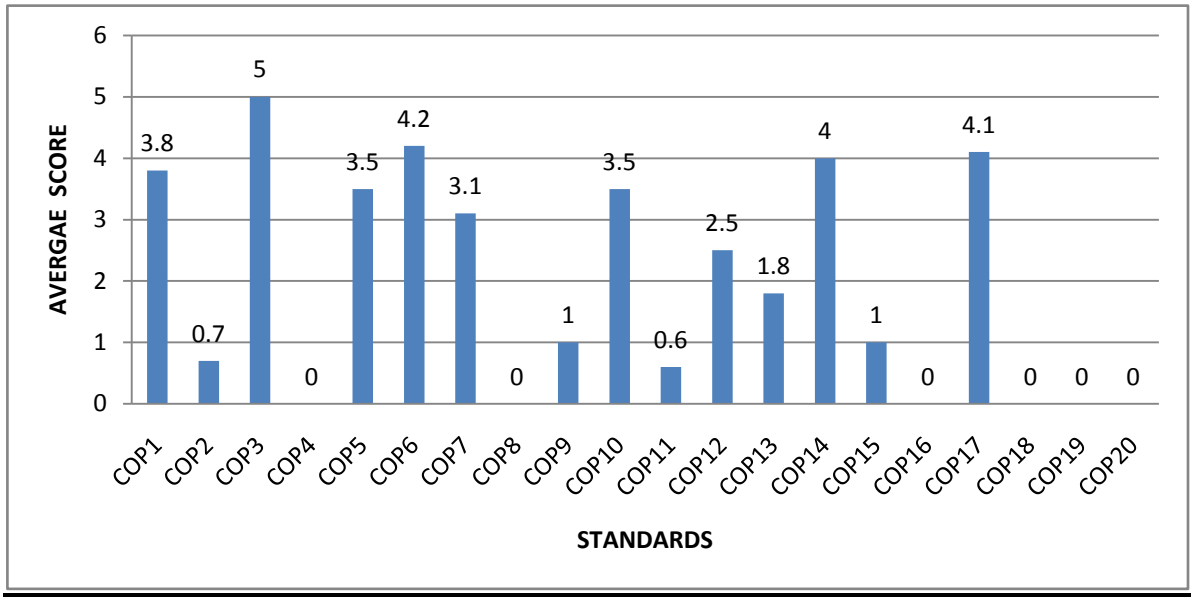

Fig.2-Score of COP Standards

INTERPRETATION

COP 3 scored 5 which mean ambulance services show partial compliance in commensurating with scope of services provided by the hospital.

There are 7 standards namely COP4,COP8,COP 16 ,COP18,COP19,COP20 which are non Compliant to NABH requirements.

3. MANAGEMENT OF MEDICATION

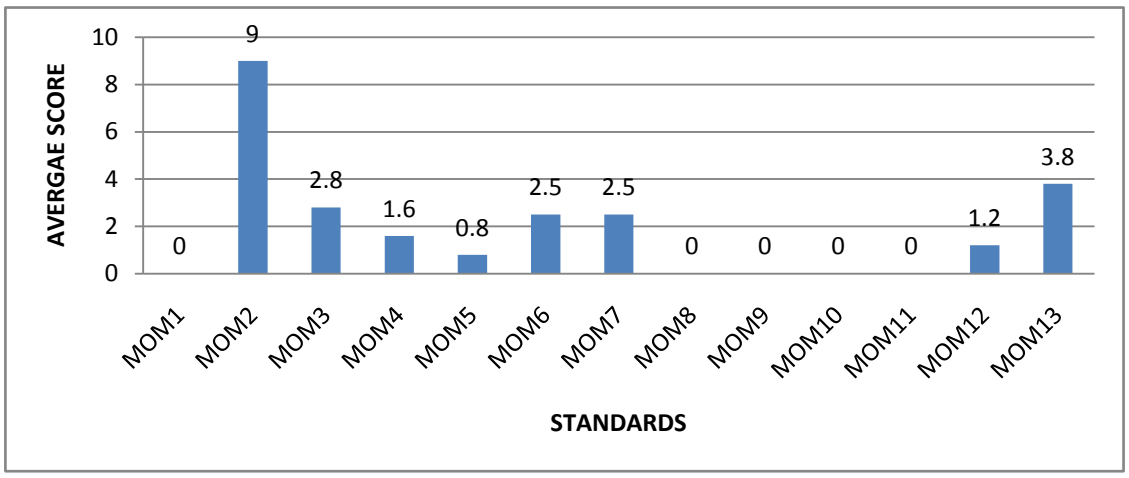

Fig.3-Score of MOM Standards

INTERPRETATION

The highest score is of standard MOM 2 which means there is near compliance to the requirement. A hospital formulary and a defined procedure for the acquisition of these medicines are present.

MOM 1, MOM 8, MOM 9, MOM 10, MOM 11 shows no compliance to NABH requirements.

4. PATIENTS RIGHTS & EDUCATION

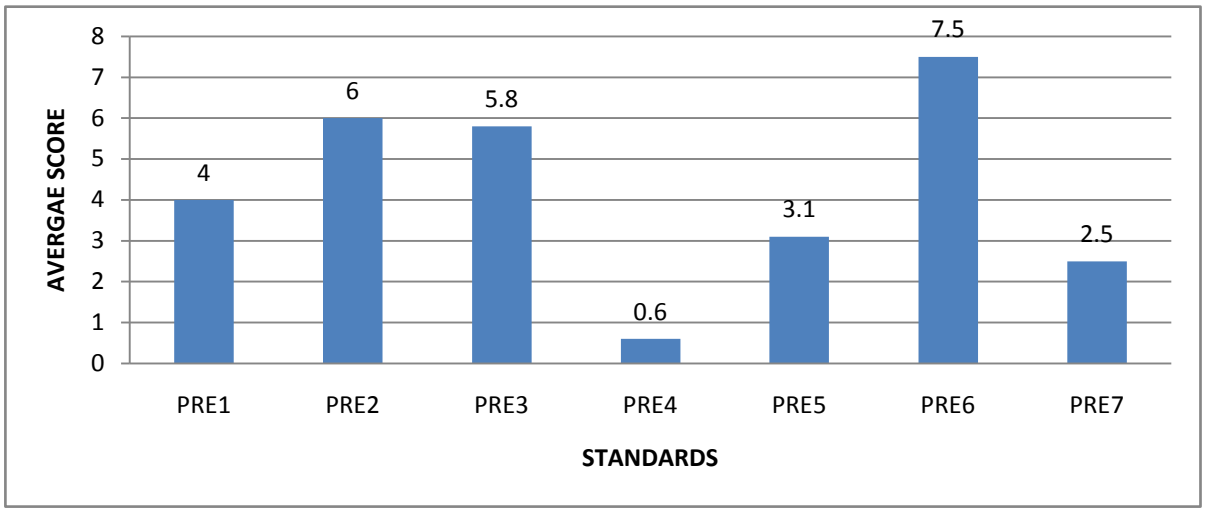

Fig.4-Score of PRE Standards

INTERPRETATION

PRE 6 has score of 6.5 which means the patients and families have right to information on expected costs in the hospital.

Lowest score of PRE 4 in this chapter shows negligible compliance in obtaining informed consent from patient/patient's relatives in decision making about care provided to them.

5. HOSPITAL INFECTION CONTROL

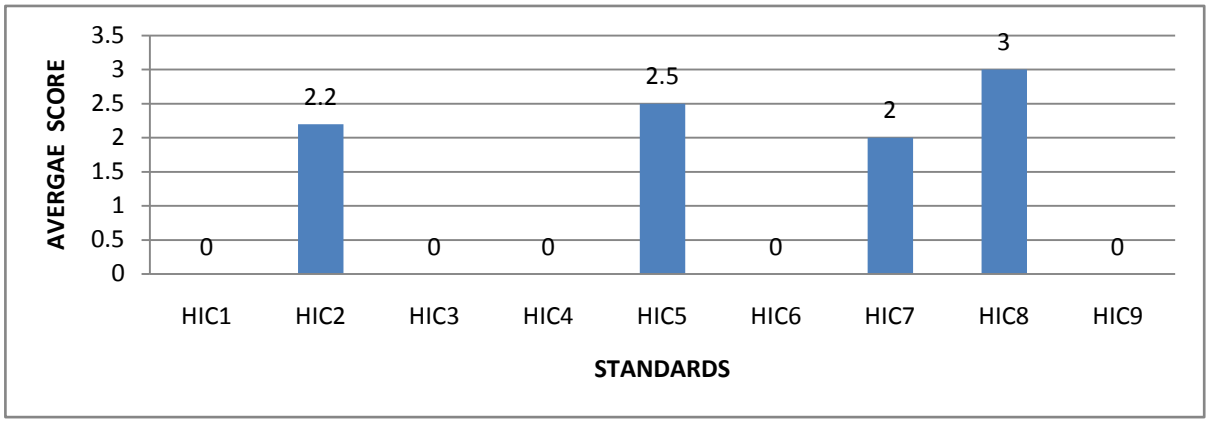

Fig.5-Score of HIC Standards

INTERPRETATION

All Hospital Infection Control standards have scored below 5 which signify a poor state of infection control in hospital.

HIC1, HIC 3, HIC 4, HIC 6, HIC 9 show no compliance to NABH requirements.

6. CONTINOUS QUALITY IMPROVEMENT

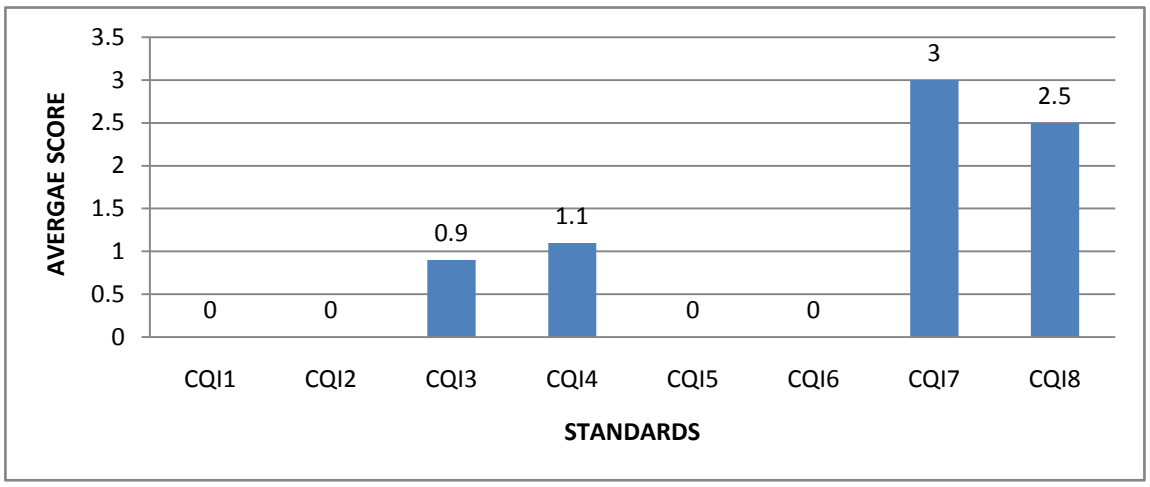

Fig.6-Score of CQI Standards

INTERPRETATION

All Continuous Quality Improvement Standards have a score less than 5 which signifies absence of quality improvement, patient safety and monitoring of performance indicators in hospital.

7. RESPONSIBILTY OF MANAGEMENT

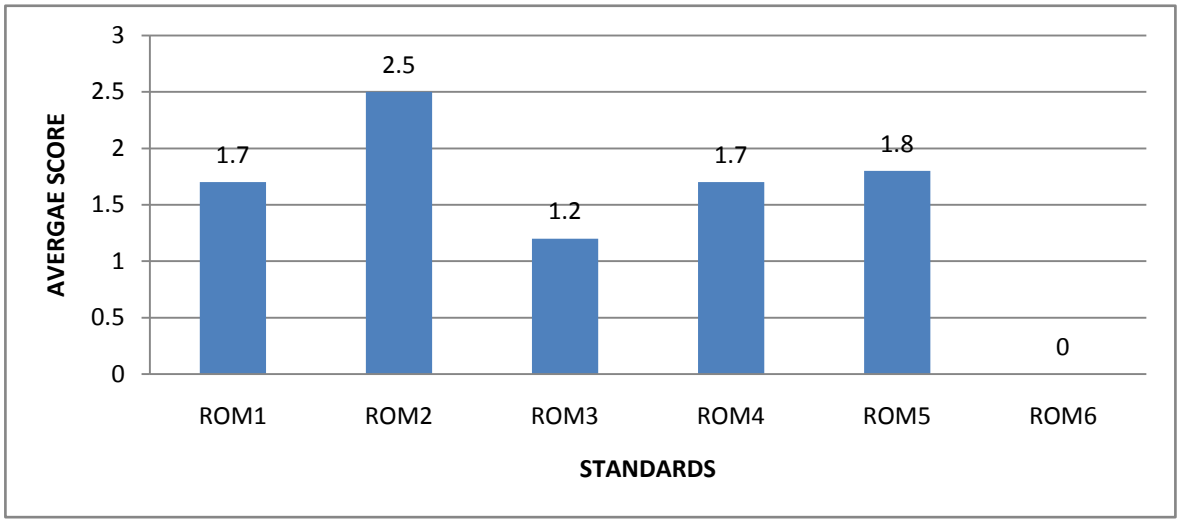

Fig.7-Score of ROM Standards

INTERPRETATION

All the ROM standards have scored below 5 which means the hospital does not comply with the laid down legislations and regulations

Hospital shows non compliance in terms of patient safety aspects and risk management issues.

8. FACILITY MANAGEMENT & SAFETY

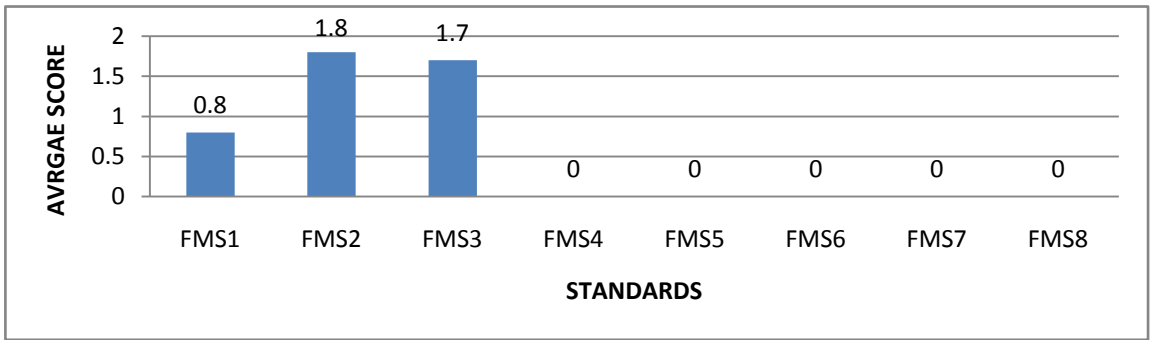

Fig.8-Score of FMS Standards

INTERPRETATION

All standards in this chapter have average score below 5.

Fire and non fire emergencies, biomedical equipment management, disaster management needs focus.

9. HUMAN RESOURCE MANAGEMENT

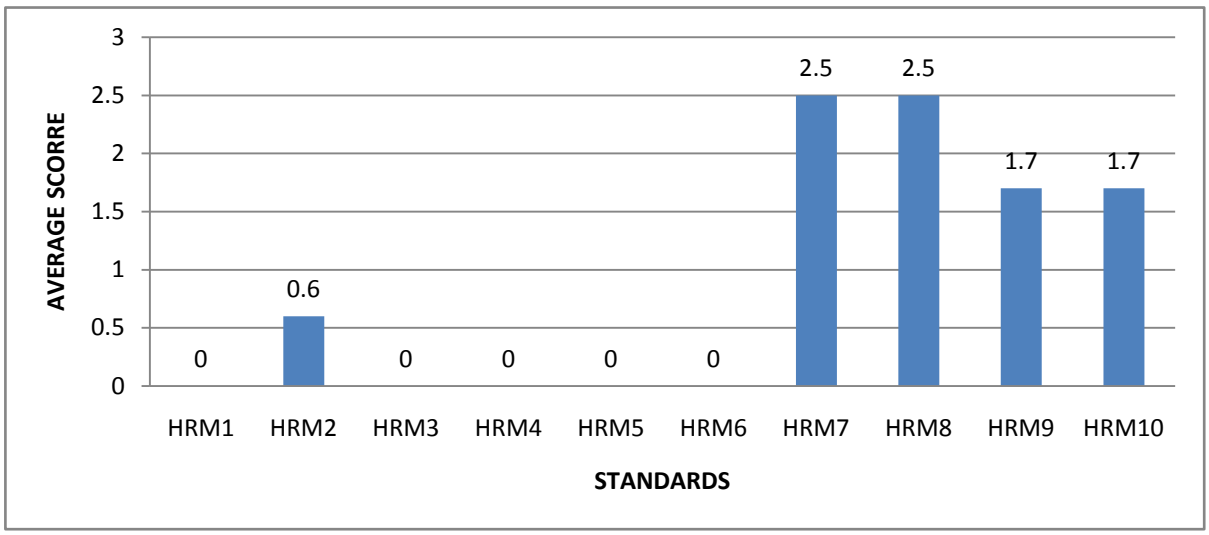

Fig.9-Score of HRM Standards

INTERPRETATION

All standards have average score below 5. There is no mechanism for staff training and development, appraisal system and grievance handling.

HRM1, HRM3, HRM4, HRM5, HRM6 show no compliance to NABH standards.

10. INFORMATION MANAGEMENT SYSYTEM

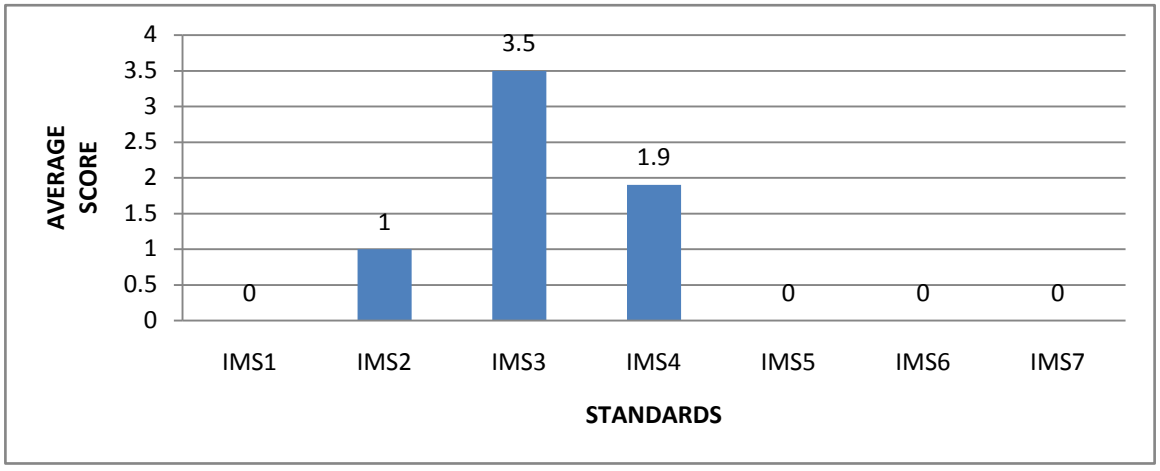

Fig.10-Score of IMS Standards

INTERPRETATION

All the standards in this chapter have score below 5. There are no documented policies and procedures for retention, review or maintaining confidentiality of medical records.

IMS1, IMS5, IMS6, IM7 show no compliance to NABH requirements.

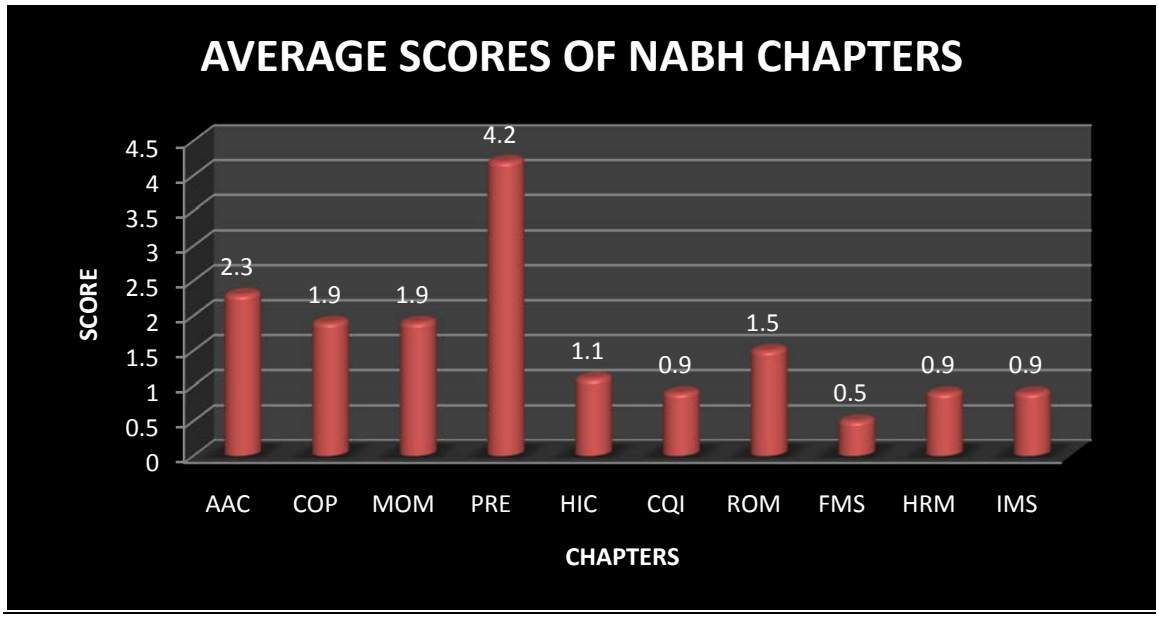

Fig.11-Average score of NABH Chapters

INTERPRETATION

All the chapters have average score below 5, which shows that they are non-compliant to NABH requirements. Hospital has shown maximum compliance in NABH chapter no.4 Patient Rights and Education and least compliance to Chapter No.8, Facility management and safety .

8 STUDY FINDINGS

The major findings of the study are as:

1. Non-availability of the display of scope of services.
2. Non-compliance to the mandatory legal approvals by the Imaging Department.
3. Essential equipments such as crash cart, defibrillator, etc are not available in patients care areas.

4. Maintenance of the building is not being carried out properly. There is a huge problem of seepage in the various areas in the hospital building.

5. The knowledge and practices about BMW management are rudimentary and need repeated training and monitoring. The hospital does not have licence for BMWM.

6. No infection Control programme and practice in the hospital.

7. The Operation Theatres in the Old Building needs certain renovation. Central AC and HEPA filter are not installed.

8. There is no system of allotting Unique ID numbers for each patient at the time of OPD Registration. The patients are registered and the Registration number changes every re-visit.

9. Dietary services are not being provided in the Hospital as there is no Kitchen/dietary department.

10. Laundry services are provided in-house but the segregation and disinfection of the soiled linen is not done.

11. The maintenance of the hospital building, premises and equipments is not being done periodically and hence are in dilapidated condition.

12. Fire safety issues are not addressed.

13. Safety and security issues for patients are not in place. The security guards have not been placed in many areas like paediatric ward

14. There is an acute shortage of nurses as per the bed strength and national standards, which leads to suffer the patient care services.

15. All the sanctioned posts are not filled up.

16. Documentation of the patient care services are at poor state. Forms and formats are not defined at many areas.

17. There are no documented policies and procedures available in the hospital.

9 RECOMMENDATIONS

SIGNAGES

- The floor directory should be created for each floor and be displayed at exit points from lift/ staircase on respective floor.
- Signage's should be bilingual (English/ Hindi or English/ Punjabi) and symbolic/ pictorial.

LICENSES

- The Licences and Acts should be available with the responsible authority (MS/SMO/HA) at the hospital level.

FRONT OFFICE

- The person sitting at front office should have fully aware on the scope of services provided by the organization.

OUTPATIENT DEPARTMENT

- The OPD slip is generated in duplicate and one copy is retained by the hospital which is stored in the MRD. These need be stored in a proper manner.

AMBULANCES

- The emergency staff including doctors and Nursing staff and driver should be BLS trained. ACLS training should be given to CMO and few of the nursing staff.

- Checklist of drugs and equipments for ambulances should be maintained which should be checked daily in each shift.

EMERGENCY DEPTT

- Fully equipped crash carts in the department are required
- Designated trolley and wheel chair bay is required for this department
- Triaging area should be earmarked (displayed) in the department.

LABORATORY

- Well documented procedure & procedure manual should be developed for the Lab department.
- The intimation of the critical results shall be documented with the details of date, time person intimated to and by, etc
- Biohazard cabinet for Microbiology needs to be provided in the department.

BLOOD BANK

- Dedicated refreshment room needs to be demarcated.
- Data capturing of adverse blood transfusion reaction needs to be made compulsory by insisting on return of Transfusion reaction form to Blood bank from each unit issued.
- Blood bank safety programme to be made and integrated to the hospital safety manual.
- Immunization should be carried out for all the staff.

IMAGING DEPARTMENT

- The required AERB approvals should be obtained.
- Well documented procedure & procedure manual should be developed for the Radiology department.

- The intimation of the critical results shall be documented with the details of date, time person intimated to and by, etc
- Internal & External quality assurance should be carried out.
- The radiology staffs needs to be trained on necessary safety precautions required in the department.

OPERATION THEATRES

- Plumbing work and fixtures need immediate replacement and repair.
- Zoning facility shall be strictly followed by the clinical staff.
- Centrally air conditioning with HEPA Filters is required in the operating room.

WARDS

- Janitor closet should be there with every ward.
- Side rails for the beds should be provided which are must for patient safety.
- Civil works needs to be carried out immediately to replace/ repair the broken fittings and furniture.

ICU

- Adequate number of nurses need to be allotted as per the Standard National Norms.
- Personnel protective wears as per Universal Precautions must be provided for the staff during working hours.
- Attendee counseling area need to be demarcated.
- A separate area for the patient attendees should be provided.

PAEDIATRICS WARD& NICU

- Infection Control measures should be followed in NICU

MEDICAL RECORDS DEPARTMENT

- A well documented Medical records policy & procedure manual needs to be preapared.
- It is recommended to label the shelves with IP number or UHID number which will result in efficient retrieval of files.
- It is recommended to have compactors because the store area is very less as compared to the number of patients being treated here.
- A security guard should be appointed in the MRD section for safety of MLC files
- Medical record audits are not carried out periodically to assess the completeness and continuity of care.

C.S.S.D

- Zoning should be done in the CSSD department(receipt, washing, assembling and checking for breakages, sterilization, labelling, storage, and issue area)

PHARMACY STORE/MEDICAL STORE

- In the medical store it is suggested to have double locking system for psychotropic drug and narcotic drugs. Two different keys of the double lock will remain with two different authorised person like one with head of the department and other with medical store in charge.
- ABC, VED, analysis should be done in the medical store department

REHABILITATION SERVICES

- Quality manual of Physiotherapy department needs to be documented.

KITCHEN

- Patients & families needs to be educated on diet limitation when the food is brought from home.

LAUNDRY

- One sluicing machine and calendaring machine are required in department.
- It is recommended to have separate clean area where the cleaned linen will be kept and dirty area for the soiled and infected linen.
- Linen collection and Transportation trolleys for dirty linen and clean linen should be provided.

SECURITY AND SAFETY

- There are huge amount of crowd and parking of vehicles in the hospital campus, which needs an effective control.
- Training on safety and security measures needs to be imparted to all the security staff at regular intervals.

BIOMEDICAL WASTE MANAGEMENT

- The organization must apply and receive the license for Bio-medical waste mgmt.
- Staff including the housekeeping staff, shall be provided the required number of personal protective devices.
- The staff needs an exhaustive training on Bio-medical waste management.

MORTUARY SERVICES

- The organization needs to place some security provision in this area.
- The cold drawers need periodical maintenance and temperature monitoring, which should be documented.
- The infection control measures needs a focus in this area.
- Documented Policy needs to be framed

BIOMEDICAL ENGINEERING

- Break-down, corrective and preventive plan needs to be formed and documented.

- AMC and Calibration of the equipments shall be done and the documentation of the same to be maintained.

- Since there is no Bio-Medical Engineer the equipments are not maintained as per the requirements. A full time technical staff should be there in the hospital.

HUMAN RESOURCE DEPARTMENT

- The organization should have a well documented manpower plan and job specification and descriptions.
- Well documented policies should be finalized on Performance appraisal, grievance redressal, training & Development, etc.

Other Recommendations

- Formation of committees involving some of the stake holders who would be committed to bring about the requisite changes.
- Monitoring of Performance Indicators

10 CONCLUSION

The gap analysis has revealed non compliance as per NABH Standards which need to be addressed. As per the scheduled plan of action it is recommended that the hospital will attempt to fill the identified gaps. To conclude, the actions to be taken for compliance with accreditation standards of NABH at Civil Hospital, Jalandhar are likely to impact the delivery of public health services positively, ensuring quality services, efficient outcomes with economy, risk management with patients, staff, and visitors safety, and above all equity in healthcare services for the citizens.

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