Gap Analysis of District Hospital Bulandshahr (UP) as per NABH Norms

Internship Training
at
Octavo Solutions Pvt. Ltd., New Delhi
(3rd February - 30th April 2014)

By
Kaushalendra Singh

Under the guidance of
Col. (Dr.) Ashok Kaushik

Post Graduate Diploma in Hospital & Health Management
2012–14

Institute of Health Management Research
Jaipur
2014

INSTITUTE OF HEALTH MANAGEMENT RESEARCH
1, Prabhu Dayal Marg
Sanganer Airport, JAIPUR - 302 029, INDIA
Tel. : 3924700, 2791431-32
Fax : 91-141-3924738
E-mail : iihmr@iihmr.org
URL : http://www.iihmr.org
Gram : HEALTHINST

TO WHOMSOEVER MAY CONCERN

This is to certify that Dr.Kaushalendra Pratap Singh student of Post Graduate Diploma in Health and Hospital Management (PGDHM) from Institute of Health Management Research, Jaipur has undergone internship training from 3rd February 2014 to 30th April 2014.

The Candidate has successfully carried out the study designated to his during internship training and his approach to the study has been sincere, scientific and analytical.

The Internship is in fulfillment of the course requirements.

I wish his all success in all her future endeavors.

Dr Ashok Kaushik
Dean, Academics and Student Affairs
IIHMR Jaipur

Dr.Ashok Kaushik
Dean, Academics and Students Affairs
IIHMR Jaipur

OCTAVO
SOLUTIONS PVT. LTD.
The Health & Hospital Consultants

Registered with NABET NC07 01

SE Asia Partners for ACHSI

The certificate is awarded to

Dr KAUSHALENDRA PRATAP SINGH

In recognition of having successfully completed his

Internship in OCTAVO SOLUTIONS PVT. LTD.

And has successfully completed his Project on

"GAP ANALYSIS OF DISTRICT HOSPITAL, BULANDSHAHAR AS PER NABH STANDARDS"

Date: 30th April, 2014

Organisation: OCTAVO SOLUTIONS PVT. LTD.

He comes across as a committed, sincere & diligent person who has a strong drive & zeal for learning

We wish him all the best for future endeavours.

Vice President

Octavo Solutions P Ltd.

INSTITUTE OF HEALTH MANAGEMENT RESEARCH
1, Prabhu Dayal Marg
Sanganer Airport, JAIPUR - 302 011, INDIA
Tel. : 3924700, 2791431-32
Fax : 91-141-3924738
E-mail : iihmr@iihmr.org
URL : http://www.iihmr.org
Gram : HEALTHINST

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled "**Gap Analysis of District Hospital Bulandshahr as per NABH norms**" in UP, submitted by Dr.Kaushalendra Pratap Singh, Enrollment No. IIHMR/PGDHM/2012-14/17-1323 under the supervision of Dr.Ashok Kaushik (Dean Academics and Students Affairs, IHMR Jaipur) for award of Postgraduate Diploma in Health and Hospital Management of the Institute carried out during the period from 3rd February 2014 to 30th April 2014 embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.

Signature

Acknowledgement

I believe, nothing really can be accomplished alone. It's the direction, guidance, involvement, Support and prayers of more than one people around you those results into realization.

My Institute - **Institute of Health Management Research (IHMR), Jaipur** deserves the foremost appreciation for providing me the opportunities to understand my capabilities. I would like to thank one and all in the IIHMR team for providing me a platform for my professional career as well as for helping me boosting up all my capabilities and making me confident enough to work for health care organisations. I would like to thank **Dr. S.D. Gupta** (Director IIHMR, Jaipur) and

Dr. Ashok Kaushik (Dean IIHMR, Jaipur) for their continuous support.

I acknowledge the tremendous contribution of my guide **Dr. Ashok Kaushik in** completion of the project right from the word go.

I would like to render my sincere thanks to **Octavo Solutions Private Limited**, New Delhi for providing me the opportunity to complete my dissertation.

I convey my deep and sincere thanks to **Dr.Bidhan Das**, Director, Octavo Solutions Private Limited New Delhi for giving me the opportunity to work under his guidance.

I extend my words of thanks to **Dr. Kriti Yadav,** Assistant Consultant octavo solutions for being so cooperative, facilitating and guiding.

I am sincerely thankful to **Dr. Satya Singh**, Medical Superintendent, – B.B.D. District Hospital Bulandshahr for his continual support in successful completion of the gap analysis study.

Thanking you

Dr.Kaushalendra Singh

CONTENTS:-

Abbreviations

1.	AAC	Access, assessment and continuity of care
2.	AC	Air conditioning
3.	ACLS	Advanced cardiac life support
4.	AERB	Atomic Energy Regulatory Board
5.	AHU	Air handling unit
6.	AMC	Annual Maintenance Contract
7.	BARC	Bhabha Atomic Research Centre
8.	BLS	Basic life support
9.	BMW	Bio Medical Waste Management
10.	CCTV	Close Circuit Television
11.	CCU	Critical Care Unit
12.	COP	Care Of Patients
13.	CPR	Cardio Pulmonary Resuscitation
14.	CQI	Continuous Quality Improvement
15.	CSSD	Central Sterile and Supply Department
16.	EOQ	Economic Oder Quantity
17.	FMS	Facility Management System
18.	HDU	High Dependency Unit
19.	HIC	Hospital Infection Control

20.	HMIS	Hospital Management Information System
21.	HRM	Human Resource Management
22.	ICU	Intensive Care Unit
23.	IMS	Information Management System
24.	IPD	In Patient department
25.	LAMA	Leave against Medical Advice
26.	MOM	Management Of Medication
27.	MRD	Medical Records Department
28.	MRI	Magnetic Resonance Imaging
29.	NABH	National Accreditation Board for Hospitals and Healthcare Providers
30.	OPD	Out Patient Department
31.	OSPL	Octavo Solutions Pvt. Ltd.
32.	OT	Operation Theatre
33.	PM	Preventive Maintenance
34.	PPE	Personal Protective Equipment
35.	PRE	Patient Right and Education
36.	QA	Quality Assurance
37.	QCI	Quality Council of India
38.	ROM	Responsibilities Of Management

39.	SOP	Standard Operating Procedure
40.	TQM	Total Quality Management
41.	UTI	Urinary Tract Infection

Dissertation on “Gap Analysis of District Hospital, Bulandshahr, Uttar Pradesh as per NABH norms”

Executive Summary :-

The gap analysis as per NABH norms was done so as to assess the existing status of the hospital and prepare it for NABH accreditation. The gap analysis was done with the help of Gap analysis check list. For getting the required data the various activities in the hospital were observed, policy manuals and records were referred and patients and hospital staff were interviewed. According to the toolkit the documentation and implementation of each objective element was checked and scores were given accordingly. After this the average scores for the standards and chapters were calculated. Then these were checked against the evaluation criteria. It was found that the analysis results did not match the required criteria and there were several gaps. Gaps were in all chapters of management of medication, quality management and information management system etc. Therefore, great effort and focus is required for fulfilling the gaps found and preparing the hospital for accreditation.

Introduction :-

Government of Uttar Pradesh has adopted several strategies for sensitization towards importance of quality health services. One of the strategies is to get NABH accreditation of public hospitals.

Assistant Consultants have been appointed in all the district hospitals to coordinate the NABH related gap analysis. So, a gap analysis report as per NABH norms was required to be prepared for analysis of gaps and progress in accreditation preparedness activities.

NABH

National Accreditation Board for Hospitals & Healthcare Providers (NABH) is a constituent board of Quality Council of India, set up to establish and operate accreditation programme for healthcare organizations. The board while being supported by all stakeholders including industry, consumers, government, has fully functional autonomy in its operation.

Accreditation

A public recognition of the achievement of accreditation standards by a healthcare organization, demonstrated through an independent external peer assessment of that organization's level of performance in relation to the standards.

Benefits of accreditation

Accreditation benefits all Stake Holders. **Patients** are the biggest beneficiaries. Accreditation results in high quality of care and patient safety. The patients get services by credential medical staff. Rights of patients are respected and protected. Patient satisfaction is regularly evaluated.

Accreditation to a **Hospital** stimulates continuous improvement. It enables hospital in demonstrating commitment to quality care. It raises community confidence in the services provided by the hospital. It also provides opportunity to healthcare unit to benchmark with the best.

The **Staff** in an accredited hospital are satisfied lot as it provides for continuous learning, good working environment, leadership and above all ownership of clinical processes. It improves overall professional development of Clinicians and Paramedical staff and provides leadership for quality improvement within medicine and nursing. Accreditation provides an objective system of empanelment by insurance and other **Third Parties** . Accreditation provides access to reliable and certified information on facilities, infrastructure and level of care.

Problem statement:-

Uttar Pradesh is the highest populated state of the country and the health parameters are very poor. It is a major contributor to the poor health status of the country. The quality of health system in terms of structure, manpower, equipments etc, is not having compliance with the requirements. To improve the quality of healthcare facilities NABH accreditation is in the process.

Justification :-

A checklist is a document, which evolves as per circumstantial requirement of the organization to know scope of activities required to meet standards to achieve project goal i.e. NABH accreditation status.

There is a requirement of measuring the performance of hospital. The performance can be measured once the standards or benchmarks for the same are available. The accreditation of healthcare facilities is concerned with assessing the quality of organizational process and performance using agreed upon standards. The purpose of accreditation is to establish and encourage best practices, in the organization. It is based on the premises that there are certain actions which should be undertaken to create a good healthcare organization. Accreditation is a process by which an authoritative body gives a formal recognition that an organization is competent to carry out specific tasks.

Objective of study :-

1. To assess the existing service delivery status of the district hospital in U.P.
2. To identify the gaps as per NABH guidelines.
3. To give suggestions so as to meet the requirements.

Review of literature :-

K. Francis Sudhakar, M. Kameshwar Rao, T.Rahul (1Jan 2012) in a study on **"Gaps in quality of expected and perceived health services in public hospitals"** was found that as regards tangibles in public hospitals services, there was a wide gap by 3 counts which was statistically significant. With regard to reliability, by 3 counts there is the gap. Such gap or difference in the quality scores was statistically significant. As regards responsiveness it was found that the gap found between them was by 3.0 units. Such gap was statistically significant. With regard to assurance, it was found that the gap was 3.0 units. Such gap was statistically significant. Lastly, with regard to empathy, it was found that the gap was found to be 3.0 units. Such gap was statistically significant.

Di Mclntyre and Laura Anselmi, Health Economics Unit, School of Public Health and Family, Medicine, University of Cape Town Paper provides an overview of the methods used to promote an equitable distribution of healthcare resources. It highlights that resource allocations is extremely valuable in efficient budgeting. It also highlights the successful implementation of resource distribution can be facilitated by undertaking a detailed gap analysis. Gap analysis will provide basis for developing service development plans. There is also need to strengthen capacity for planning, budgeting and implementing plans to ensure use of limited healthcare resources. Monitoring and evaluation of these entire can enhance effective redistribution of resources to promote healthcare services.

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

Infrastructure related gaps

Process related gaps

Infrastructure related gaps are insufficient space, make shift buildings, improper signage, poor fire safety measure and disaster plan, piped medical gases not available, shortage of equipment and instruments, old and out of order equipments and instruments, lack of biomedical equipment

engineering cell. Most of the gaps related to infrastructure related need, external support from the ministry and bilateral donor agencies.

Most of the process related gaps can be worked out at the hospital level with proper training and hand holding. Process gaps related gaps were lack of mission/vision and patient charters, lack of training in hospital operations, lack of control over resources (such as funds, drugs and consumables, equipments, ordnance/general stores). Only few hospitals have quality control department however medical and nursing audits are not done. Equipments did not have AMC/CMC, utilization audit of equipment is not done, proper BMW Management system did not exist, and security was not organized in three tier manners (outer ring, middle ring, and inner ring).

Research methodology:

Study Design:-

The study will be non – experimental evidence based in nature. The study will be based on observation made. It will be done broadly in the 2 parts.

1. Present status of the departments.
2. Comparison/ compliance with NABH Standards.

Data collection tools:-

- Interview and discussions with head of the departments.
- Checklists
- Observation
- Using available information

Study time

Study time was of six weeks which included preparing checklist, filling of checklist compiling data, Gap analysis and final report compilation.

Study Methodology:-

In this study the important identified Gaps of the hospital have been mentioned and discussed. Available facilities of hospital compared against the set standards and scoring was done on a scale of 1to 10 to know the compliance, partial compliance and non compliance. For compliance I have given score 10 which means the parameters present in the checklist fully comply with the services present in the hospital. Similarly if the parameters mentioned in the checklist are not completely met by the services present inside the hospital the score is 5 as partial compliance. If not present at all then, its non compliance and score is 0. Scoring was done to measure the scope of improvement.

Study Data:

Primary data:- To study the present status and functioning of departments, each section of the department will be studied individually by observing the set of activities performed by doctors, technicians, paramedical staff and clerical staff.

Secondary data:- Records of various departments.

GAP ANALYSIS

SIGNAGE SYSTEM :-

Signage's	Displayed (Yes / No / NA)	Bilingual (Yes / No / NA)	Pictorial (Yes / No / NA)	Remarks (if any)
Citizen Charter	Yes	Yes	No	Not displayed in one single board
Mission	No	No	No	
Vision	No	No	No	
Patients Rights & Responsibilities	No	No	No	
Scope of Services	Yes	Yes		
Tariff List	Yes	Yes		
Doctors list along with their Specialities and Qualifications	Yes	Yes		Partially
OPD Schedule of Doctors (Speciality, Timings and Day of Availability)	Yes	No	No	Outside the consultation rooms
Biohazard Symbols	Yes	NA	Yes	
Fire Exit Plan	No	No	No	
Floor Directory	No	No	No	
Wash Rooms (Differently Able)	No	No	No	
Toilets	Yes	Yes	Yes	
Ambulance Parking Area	No	No	No	
Drinking Water	Yes	Yes	No	
Health Education Related Signage (HIV & Immunization)	Yes	Yes	Yes	Counselling room for HIV and Leprosy patients

STATUTORY REQUIREMENTS :-

Licenses	Status *(A / NA)	Available YES/NO
Building Occupancy/Completion Certificate	A	No
Fire License	A	No
License under Bio- medical Management and handling Rules, 1998.	A	No (in process)
NOC for Air & Water from State Pollution Control Board	A	No
Excise permit to store Spirit.	A	No
Permit to operate lifts under the Lifts and escalators Act.	NA	
Narcotics and Psychotropic substances Act and License.	NA	
Vehicle registration certificates for Ambulances.	A	Yes
Retail drug license (Pharmacy)	A	No
PNDT Certificate	A	No (In process)
Site & Type Approval for X-Ray from AERB	A	No
License for Blood Bank	A	Yes
Noise & Air pollution certificate for Diesel Generators	A	No

A = Applicable **NA** = Not Applicable

MANPOWER

Sl. No	Designations	Sanctioned	NABH Norms	Actual	Vacant/ Surplus (Sanction - Actual)	Vacant (NABH)
DOCTORS						
1	Chief Medical Superintendent/ Equivalent	1	1	1	0	0
2	Medical Specialist (General Medicine)	2	3	2	0	1
3	General Surgery Specialists	2	2	1	1(V)	1
4	Dermatologist /Venereologist)	1		1	0	
5	Paediatrician	2	3	3	1(S)	0
6	Anaesthesiologist	2	2	0	2(V)	2
7	ENT Surgeon	1	1	0	1	1
8	Ophthalmologist	2	1	2	1(S)	0
9	Orthopedician	2	2	2	0	0
10	Radiologist	2	1	2	0	0
11	Pathologist & Blood Bank In-charge	2	2	1	1(V)	1
12	Medical Officer	4	14	4	0	10
13	Dental Surgeon	1		1	0	
SUB TOTAL		**24**	**31**	**20**	**7**	**16**
NURSING STAFF						
1	Matron/Nursing Superintendent	1	1	1	0	0
2	Nursing In-charge	10	9	7	3	2
3	Staff Nurse	18	113	6	12	107

4	Infection Control Nurse	0	1	0	0	1
SUB TOTAL		**29**	**124**	**14**	**16**	**109**
PARAMEDICAL STAFF						
1	Dental Hygienist	1		1	0	
2	OT Technician	0	6	0	0	6
3	Lab Supervisor	0	1	0	0	1
4	Laboratory Technician (Lab +BB)	2	7	1 (M.Sc. Micro)	1	6
5	Radiographer	1	3	1	0	2
6	Dark Room Assistant	0	3	0	0	3
7	ECG Technician	1	1	1	0	0
8	Optometrist	1	2	1	0	1
9	Physiotherapist	0	1	0	0	1
10	CSSD Technician	0	1	0	0	1
SUB TOTAL		**6**	**25**	**5**	**1**	**21**
PHARMACIST						
1	Pharmacy I/C	1	7	1	0	0
2	Chief Pharmacist	4		2	2	
3	Pharmacist	3		5	2(S)	2
SUB TOTAL		**8**	**7**	**8**	**4**	**2**
ADMINISTRATIVE						
1	Bio Medical Engineer	0	1	0	0	1
2	Junior Engineer	0	1	0	0	1
3	Office Superintendent	0	1	0	0	1
4	Accountant/Asst. Accountant	0	1	0	0	1

5	Head Clerk	1	0	0	0	0
6	Senior Clerk	1	3	1	0	1
7	Junior Clerk	1		1	0	
8	Registration Clerk	0	6	0	0	6
9	Store keeper	1	2	1	0	1
10	Medical Records Clerk	0	2	0	0	2
11	Mortuary Attendant	0	1	0	0	1
12	Electrician	1	1	1	0	0
13	Plumber	0	1	0	0	1
14	Sr. Assistants	1		0	0	
SUB TOTAL		**6**	**22**	**4**	**0**	**16**
CLASS 4						
1	Mali	2		0	2	
2	Ward Boy	28		26	2(V)	
3	Ward Aaya	2		4	2(S)	
4	Chaprasi	1		1	0	
5	Kahar	5		2	3(V)	
6	Cook	5		2	3(V)	
7	Bhisti	1		1	0	
8	Choukidar	2		1	1	
9	Dhobi	2		2	0	
10	Cleaner	1		0	1	
11	Housekeeping Staff	17	7	12	5(V)	0
12	Driver	1		1	0	
13	Security	0	5	0	0	5
SUB TOTAL		**25**	**12**	**17**	**8**	**5**
TOTAL		**98**	**221**	**68**	**36**	**169**

OUT PATIENT DEPARTMENT:-

OPD is the first point of contact between the hospital and the community, and very commonly called "show window" of hospital. A well planned OPD plays an important role in building up the image of the hospital. A properly planned building with pleasant ambience makes the patient and their relative comfortable who are in search of solace and comfort for mitigating their suffering.

There is centralized outpatient department which is located in front of Emergency department. OPD block is well visible from the entrance. Drinking water facilities are available in the OPD area. There is not a sufficient waiting area for the patients in OPD block. The doctors' name, their specialty, qualifications, time and day of OPD are not displayed outside the OPD.

IDENTIFIED GAPS

STRUCTURAL	1. Citizen charter and patient charter is not displayed. 2. List of doctors along with OPD timing is not displayed. 3. No calibration of equipments is done.
PROCESS	4. UHID is not generated for all patients. 5. Separate registration is not done for old and new patients.
OUTCOME	Following indicators were not captured properly 6. Patient satisfaction 7. Waiting time of OPD patients.

Outcome

MONTH	TOTAL	AVERAGE OPD/MONTH
August, 2013	31815	33436
September, 2013	39407	
October, 2013	26147	
November, 2013	45312	
December, 2013	31629	
January, 2014	26308	
February,2014	33436	
Total	**2,34,054**	

AMBULANCE SERVICES:-

The ambulance is defined as a vehicle used for emergency medical care that provides:-

There is not adequate system for communication in Ambulance.Required equipments (stetho, sphygno, suction app, defib, monitor, oxygen cylinder) are not available in the ambulance. Required medicines are not available in the ambulance. Maintenance of the medical gas (oxygen) to 90% of the total capacity is not done. Calibration of Equipments is not done. Medication and equipment checklist is not maintained.

EMERGENCY DEPARTMENT:-

The emergency departments of most hospitals operate 24 hours a day, although staffing levels may be varied in an attempt to mirror patient volume.Due to the unplanned nature of patient attendance, the department must provide initial treatment for a broad spectrum of illnesses and injuries, some of which may be life-threatening and require immediate attention.

IDENTIFIED GAPS

STRUCTURAL	• Triage area is not marked separately. • Emergency signage is not visible from road. • There is no nurse round the clock for emergency care of patients. • An appropriately qualified staff member is not scheduled to manage triage activities. • Oral Airways of various sizes is not present in the emergency. • Laryngoscope with various blades is not there. • Endo-tracheal tubes of various sizes are not there.
PROCESS	• Security staffs are not immediately available when required in the emergency room. • BMW is not segregated and handled properly. • Triaging of the patients is not done. • Staff is not trained in BLS/ACLS.
OUTCOME	• Time for initial assessment of nurses and doctors in the casualty department are not monitored.

LABORATORY:-

Laboratory services are an integral and indispensible part of disease diagnosis, treatment, monitoring response to treatment, disease surveillance programs and clinical research.

- ❑ It is place of work for testing patient's sample- for results, in favor of diagnosis and treatment.
- ❑ According to NABL, the following classification can be used:
  - Small Laboratory: A laboratory receiving up to 100 patients per day
  - Medium Laboratory: A laboratory receiving up to 101-400 patients per day
  - Large Laboratory: A laboratory receiving above 400 patients per day

The main laboratory in this hospital is located at the back side area of the main building. The sample collection area is not near to the laboratory.

IDENTIFIED GAPS

STRUCTURAL	No change
PROCESS	• Scope of services is not defined. • Critical results are not defined, reported, and documented. • Surveillance for lab test is not being carried out. • EQAS is not being monitored. • Turnaround time for lab reports is not being monitored. • MOU is not available for outsourced tests.
OUTCOME	Following need to be monitored • No. of reporting errors/1000 investigations, • Percentage of Re-do's • Percentage of reports correlating with clinical diagnosis • Percentage of employees adhering to safety precautions working in diagnostics

RADIOLOGY AND IMAGING DEPARTMENT

The main objectives of the radiology department are:

a) To provide comprehension high quality imaging service

b) Establishment and confirmation of clinical diagnosis

c) Providing high quality therapeutic radiology

d) Commitment to training and research

e) Aiding in the effective implementation of therapeutic procedures

f) The radiology department of the hospital is located in a separate building which is not easily accessible from OPD and Emergency department. Services provided by the radiology department are X-RAY and USG

IDENTIFIED GAPS

STRUCTURAL	• Unit has no AERB (SITE/TYPE approval) • There is no change room available for patients. • TLD badges are not available. • Gonad shield is not available. • Thyroid shield is not available. • Critical results are not defined, reported, and documented.
PROCESS	• Maintenance of radiology equipments is not done. • Radiology equipments are not calibrated. • Radiology staff is not taking safety measures. • Quality Assurance program is not followed. • Radiology test requisition form is not signed by doctor. • Radiology reports are not signed by Radiologist. • Time frame is not defined for dispatching reports. • Turnaround time for reports is not monitored.
OUTCOME	• No monitoring of quality indicators like number of reporting errors/1000 investigations, percentage of re-dos, percentage of reports correlating with clinical diagnosis, percentage of employees adhering to safety precautions, percentage of contrast related reactions.

WARDS:-

An inpatient area is that part of the hospital which includes the nursing station, the beds it serves, storage and public areas needed to carry out nursing care. Since it is a home away from home for a patient, it requires holistic planning and designing to suit the requirements of seekers and providers of patient care. The hospital has wards categorized as Female ward, Male ward, private rooms, Medical ward, Surgical ward.

IDENTIFIED GAPS

STRUCTURAL	• Crash cart is not maintained as per the standard checklist. • There is not adequate number of nurses in each shift.
PROCESS	• BMW is not segregated at the point of generation. • Nurses are not trained in BLS(CPR).

Intensive Care Unit:-

The ICU is highly specified and sophisticated area of a hospital which is specifically designed, staffed, located, furnished and equipped, dedicated to management of critically ill patients, injuries or complications.ICU can be classified as

- **Level I** – 6-8 beds, District Hospital. Referred as high dependency area where close monitoring, immediate resuscitation, and **short term ventilation <24hrs** has to be performed.
- **Level II** – 6-12 beds, General Hospital. undertake more **prolonged ventilation**. Must have resident doctors, nurses, access to pathology, radiology, etc.
- **Level III –** 10-16 beds, Tertiary Hospital. It should provide all aspects of intensive care required with ventilation for indefinite period. All complex procedures should be undertaken. Specialist, intensivist, critical care fellows, nurses, therapists, support of complex investigations and specialists from other disciplines to be available at all times.

The ICU is 6 bedded which is located at the ground floor nearby cardiologist OPD.

IDENTIFIED GAPS

STRCTURAL	• The required equipments are not available (Crash cart, Defibrillator, oxygen cylinder, multi para monitors, central line connection, ventilator, pulse oximetre, oxygen concentrator). • Qualified and trained nurses are not available. • HVAC is not available. • Fowler's bed is not available.

PROCESS	• The admission and discharge criteria for ICCU and high dependency units is not defined. • The infection control practices are not documented and followed. • The quality assurance programme is not documented and implemented. • The policies and procedures does not guide the care of patients under restraints. • The patient under restrain is not frequently monitored. • The staff is not aware about the end of life care policy. • The policy for initial assessment and re-assessment of patient is not documented and present. • The staff is not trained on resuscitation. • The documented policies and procedures on uniform use of resuscitation present. • Documented policies and procedures for rational use of blood and blood products is not available. • The informed consent is not obtained before donation and transfusion of blood and blood products. • The post transfusion reaction is not monitored and analyzed for preventive and corrective actions. • Scope of pediatric services is not defined and displayed. • Nutritional therapy is not planned and provided in a collaborative manner. • Emergency medications are not available all the time and replenished in a timely manner when used. • Medication orders are not written in a uniform location and are not clear, legible, dated, timed, named and signed. • Written orders for high risk medication are not done. • Policies and procedures are not there for monitoring of patients after medication administration. • No knowledge to pick adverse drug events and reporting of the same. • There is no policy and procedure to guide the use of narcotic drugs and psychotropic substances. • Narcotic drugs are not stored in a safe manner. • Proper record is not kept for the usage, administration and disposal of narcotic drugs.

PROCESS	• Antibiotic policy is not adhered and followed by the staff. • Infection control data is not collected and HAI rates not monitored. • The layout of beds, its spacing, and visual privacy is not appropriate. • All the equipments are not periodically inspected and calibrated. • Information is not exchanged and documented during transfers between units/departments. • Documented procedures do not guide the referral of patients to other departments/ specialties. • There is no policy in place for LAMA patients and patients being discharged on request. • Policy for care of vulnerable patients is not available. • The organization does not provide a safe and secure environment for the vulnerable patients. • Instructions for proper hand washing are not displayed and followed by the staff. • Adequate PPE like gloves, masks are not available and used by the staff. • Isolation /Barrier nursing facility is not available. • Policy for obtaining consent is not present.
OUTCOME	Following rates are not monitored • Re intubation rate. • ICU utilization.

OPERATION THEATRE:-

Operation theater (OT) is a specialized facility of the hospital where life saving or life improving procedures are carried out on human body, under strict aseptic conditions in a controlled environment by specially trained personnel to promote the healing and cure with maximum safety and comfort. Operation theater must be designed scientifically to ensure sterility, easy maintenance and effective utilization of resources and manpower. The main Operation theatre of this hospital is located at the ground floor. OT is nearby surgical ward.

IDENTIFIED GAPS

STRUCTURAL	• HVAC System is not present inside OT. • Proper Zoning concept is not followed (Clean zone, Protective zone, Sterile zone, and disposal zone). • There is no crash cart in OT.
PROCESS	• No documented SOP for the Operation theatre, Informed consent, Anaesthesia, Sedation, Restraints, Pain Management, Wrong Patient & Wrong Site Surgery And Surgical Services. • Surgical safety checklist is not available. • OT list was not prepared. • OT booking is not being done.
OUTCOME	• Rescheduling of procedures is not monitored. • No monitoring of anaesthesia related events like percentage of modification of anaesthesia plan, percentage of unplanned ventilation following anaesthesia, anaesthesia related adverse events and anaesthesia related mortality rate. • Percentage of surgical site infections. • Re Exploration rate is not monitored.

BLOOD BANK:-

Blood bank is the important department in case of emergency situations. Blood is stored in freezers and given to patients as and when required and prescribed by doctors.

IDENTIFIED GAPS

STRUCTURAL	• Nurse is not present in blood bank. • All sections do not have bilingual signage. • Separate counseling section is not present.

PROCESS	• Bilingual consent form for blood donation is not available. • Patients are not educated and given counseling. • List of all department staff does not exist and displayed. • Policies and procedures for blood bank is not available. • Blood transfusion committee does not exist. • Register of all recipient adverse reactions to blood and blood products is not maintained. • Data is not collected regarding recipient adverse reactions and analyzed and reported to the blood transfusion committee. • Work instructions are not visibly displayed and prominent.
OUTCOME	Following rates are not monitored • % of transfusion reactions. • % of blood and blood products wastage. • % of component usage. • Turnaround time for issue of blood and blood products.

PHARMACY

The pharmacy is located back side to the main building of the Hospital. The department is manned by qualified pharmacists for round the clock.

IDENTIFIED GAPS

STRUCTURAL	• There is not adequate ventilation and lighting in the department. • There is no security system available at the department. • No receiving area; segregation and storing area. • Refrigerator for storing medicines (2-8 degree C) is not available. • Provision for storage of narcotic drugs is not there. (double lock and key system).

PROCESS	• The items are not labeled & arranged as per alphabetical order. • Pest/rodent control measures are not regularly under taken. • Sound Inventory control practices are not followed (ABC, VED, FSN,FIFO) • There is no Drugs and therapeutics committee in the hospital. • Adverse drug reactions are not analyzed.
OUTCOME	Following need to be monitored • Percentage of stock out including emergency drugs, • Percentage of local purchase, • Incidence of variation from the procurement process • Percentage of goods rejected before preparation of GRN.

BIO-MEDICAL WASTE MANAGEMENT:-

The biomedical waste management facility is outsourced. The hospital has a temporary storage room behind the hospital building. The biomedical waste management practices in the hospital needs to be strengthened.

IDENTIFIED GAPS

STRUCTURAL	• Color coded Foot operated Bins at point of BMW generation are not available. • Display of work instructions at the point of segregation is not there. • Availability of PPE (Personal Protective Equipments) with biomedical waste handlers is not there. • Availability of safe mode of transportation is not there.
PROCESS	• Segregation of BMW at point of generation is not done. • There is no provision of regular health checkup for staff of this unit. • Usage of PPE by staff is not being practiced. • Annual report is not submitted to UP PCB.

HOSPITAL INFECTION CONTROL:-

There is no hospital infection control committee to oversee the infection control practices.

IDENTIFIED GAPS

STRUCTURAL	• A designated and qualified infection control nurse(s) is not present. • Adequate and appropriate facilities for hand hygiene in all patient care areas is not Provided. • Adequate and appropriate personal protective equipment, soaps, and disinfectants are not available. • A designated infection control officer is not present.

PROCESS	There are no policies and/or procedures to prevent infection in hospital. • Equipment cleaning, disinfection and sterilization practices are not followed. • An appropriate antibiotic policy is not established and implemented. • Hospital does not adhere to laundry and linen management processes. • Hospital does not adhere to kitchen sanitation and food handling issues. • Infection prevention and control programme is not updated at least once in a year. • HIC surveillance data is not collected regularly. • Verification of data is not done on a regular basis by the infection control team. • In cases of notifiable diseases, information (in relevant format) is not sent to appropriate authorities. • Tracking and analyzing of infection risks, rates and trends is not done. • Surveillance activities do not include monitoring of the effectiveness of housekeeping services. • HAI rates are not monitored. • Hospital infection control committee and team are not formed. • PPPEs (personal protective equipment) are not used correctly by the staff. • Compliance with hand hygiene guidelines is not monitored. • Documented procedure is not there to guide the cleaning, packing, disinfection and/or sterilization, storing and issue of items. • Isolation / barrier nursing facilities are not available. • Appropriate personal protective equipment are not used by the BMW handlers. • Hospital does not make available resources required for the infection control programme. • Hospital does not earmark adequate funds from its annual budget for infection control activities. • Appropriate "in-service" training sessions for all staff at least once in a year are not conducted. • Appropriate pre and post exposure prophylaxis is not provided to all concerned staff members.

OUTCOME	• Infection rates like UTI, VAP, CRBSI, SSI are not being monitored.

TSSU:-

A theater sterile supply unit TTSU is a hospital support service which is entrusted with processing and issue of supplies including sterile instruments and equipment used in OT department of the hospital. It receives stores, sterilizes and distributes. The TSSU department of this hospital is located in the OT block itself.

IDENTIFIED GAPS

STRUCTURAL	• Sufficient space for sterilisation activities is not available. • Layout does not follow the functional flow: Receiving, Washing, decontamination, drying, packing, loading, unloading, storing and issuing. • Calibration of pressure meter of autoclave is not done. • Racks are not present in the department. • Technician is not present in TSSU. • Transport trolley is not present for items.
PROCESS	• TSSU sterilization register is not present. (receipt/Issue) • Labeling of drums in TSSU does not take place. • Chemical, biological and bowie-dick test is not performed. • Recall system of items is not followed. • Reuse policy for items is not available.

ENGINEERING AND MAITENANCE:-

There is no one available in the facility to look after the facility management. There are separate DG sets for both the buildings. The hospital has its own transformer. The water is supplied from bore well. Parking space is available in the hospital premises.

IDENTIFIED GAPS

STRUCTURAL	• Various statutory requirements are not fulfilled- Fire Diesel storage Liquid oxygen and storage of medical cylinders. Boiler Lift Water(ETP/STP) Air (DG sets) • Up to date drawing, layout, escape route is not present and displayed. • Designated individual for maintenance is not present. • Staff is not present round the clock for emergency repairs. • There is no alternative source of water and electricity. • Availability of (personnel) safety devices is not there. • Safety devices (Fire extinguishers, smoke detectors, sprinklers, grab bars, side rails, nurse CCTV, ALARMS ETC) are not available.
PROCESS	• There is no mechanism for renewing licenses. • Preventive and break down maintenance plan is not implemented. • Alternate sources and their checking is not done. • Response time is not monitored. • Water quality reports are not monitored. • There is no safety committee in hospital. • Staff is not trained for disaster management and fire management. • Mock drills are not conducted at periodic intervals and documented.
OUTCOME	• Number of variations is not observed during mock drills.

STORE:-

No separate/centralized store is present in the Hospital.

MEDICAL RECORD DEPARTMENT:-

Medical Record Department of a hospital is dedicated for storing all the medical records of patients. A medical record could be defined as a clinical, scientific, administrative and legal document relating to patient care in which are recorded sufficient data written in the sequence of events to justify diagnosis and warrant treatment and end result. The medical record department of this hospital is not properly structured and maintained.

IDENTIFIED GAPS

STRUCTURAL	• Sufficient space for medical record department is not available. • Proper ventilation is not present in the department. • Fire fighting system is not available in the unit. • A qualified and trained MRD technician is not available in the department. • Table and chairs are not provided to the department. • Adequate number of racks is not available for the storage of records.
PROCESS	• The functional flow at MRD is not present: Receiving, assembling, deficiency check, coding, indexing, filing, issuing. • ICD coding method is not used for complete and incomplete files. • The retrieval of the records is not easy. • MRD Committee is not available. • MRD audits is not being conducted. • Records are not kept under lock. • Hospital has no retention policy for documents. • Forms and formats are not standardized. • Destruction policy for records is not available. • Pest control is not done on a regular basis.
OUTCOME	Following are not monitored • percentage of medical records not having discharge summary, • percentage of medical records having incomplete and/or improper consent • Percentage of missing records. • Percentage of records with ICD codification done.

HOUSEKEEPING DEPARTMENT:-

The Hospital does not have a specified place for Housekeeping Department.

IDENTIFIED GAPS

STRUCTURAL	• Housekeeping staffs are not provided with PPE like heavy duty rubber gloves, shoes, mask & caps. • Housekeeping staff is not being trained in the infection control practices. • Pest control methods are not being practiced. • Medical examination of staff is not being done periodically.

MORTUARY:-

Mortuary services are available in hospital and post-mortems are done.

IDENTIFIED GAPS

STRUCTURAL	• Freezer is not available for dead bodies. • Cold storage and back-up power is not available. • Measures for fire detection/fire fighting are not installed in this unit.
PROCESS	• There is no process of infection control followed.

Score Analysis:-

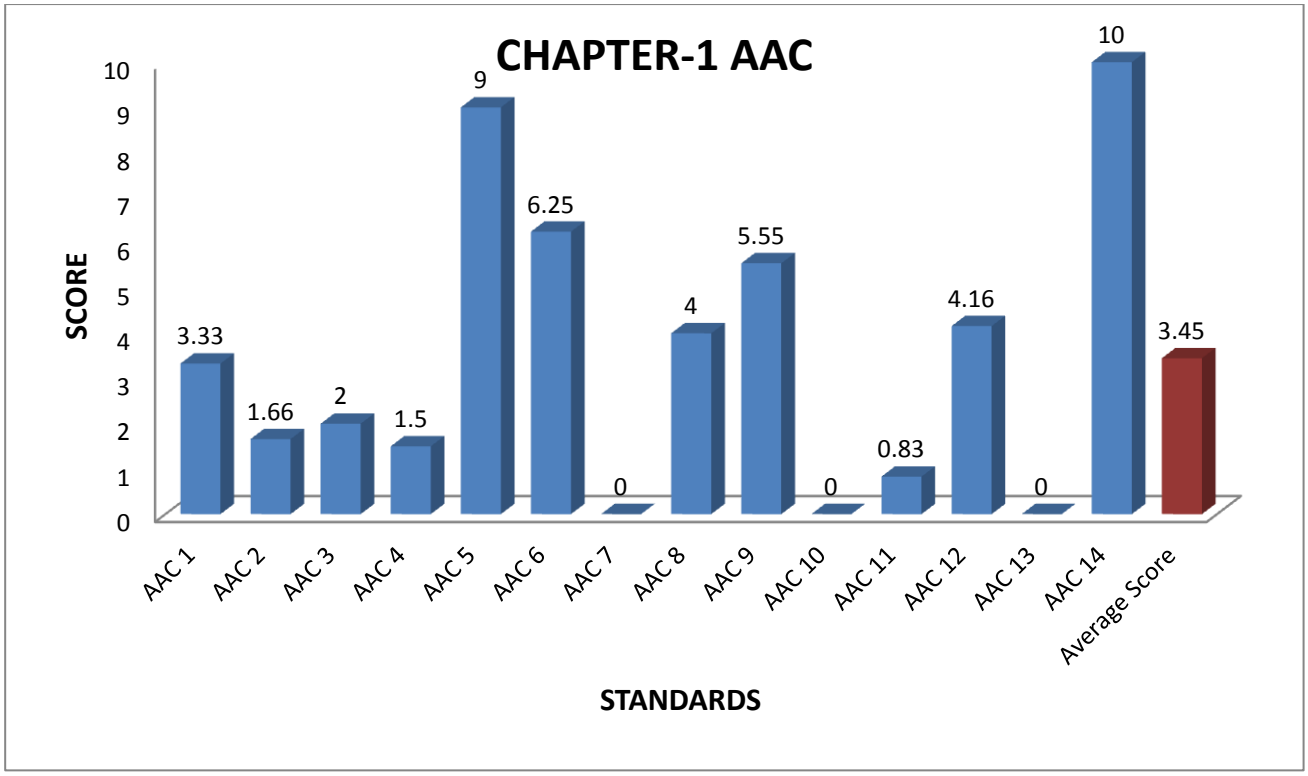
Findings:

After filling up of the NABH self- assessment toolkit the following scores were calculated:

1. The average score of each individual standard
2. The average score of each chapter
3. The average score of all standards.

These scores and the findings of each chapter are being provided below:

Chapter 1: ACCESS, ASSESSMENT AND CONTINUITY OF CARE (AAC)	
AAC 1	3.33
AAC 2	1.66
AAC 3	2
AAC 4	1.5
AAC 5	9
AAC 6	6.25
AAC 7	0
AAC 8	4
AAC 9	5.55
AAC 10	0
AAC 11	.83
AAC 12	4.16
AAC 13	0
AAC 14	10
Chapter average	3.45



INTERPRETATION

AAC 1. - The services being provided are not clearly defined and are not in consonance with the needs of the community but some services are displayed properly and staff is not properly oriented about services .

AAC 2. The organization has not well defined documentation and polices and procedures for registration of patients. The documented procedures do not address out- patients, in-patients and emergency patients. A unique identification number is not generated at the end of registration.It does not have policies & procedures for managing patients during non availability of beds. The staff are not uniformly oriented on the same.

AAC 3.. Documented policies and procedures are not there to guide the transfer-in and transfer-out of patients to the organization. The organization does not have appropriate mechanism for transfer or referral of unstable & stable patients. It does not address the staffs that are responsible during transfer.

AAC 4. The organization does not define and not documented the time frame within which the initial assessment is completed based on patient's needs. Documentation has not been done about initial assessment and plan of care, implementation is also required. Initial assessment does not include nutritional needs, nursing assessment. The plan of care does not include preventive aspects, goals of treatment.

AAC 5.Patient reassessed at regular intervals and documentation are also maintained but implementation is required.

AAC 6. The scope of laboratory services is displayed at the entrance. There are not documented policies and procedures for collection, identification, handling, safe transportation, processing and disposal of specimens and not implemented. The outsourced tests are not done on organization's quality assurance system.

AAC 7.laboratory quality assurance programme has not been documented and implemented. Validation has not been done till date. Surveillance of test results is not being documented and implemented. It also does not address periodic calibration and maintenance of all equipments and documentation of corrective and preventive actions.

AAC 8. Laboratory Safety programme has not been documented and implemented and aligned with organization's safety programme. Written procedures do not guide the handling and disposal of infectious and hazardous materials.

AAC 9. Imaging services do not comply with legal and other requirements. There are not documented policies and procedures for identification and safe transportation of patients to imaging services but not implemented. Imaging results are not available within a defined time frame and out sourced tests are not done in organizations based on quality assurance system.

AAC 10. The quality assurance programme is not documented implemented. It does not address validation of imaging methods and surveillance of imaging results. It also does not address periodic calibration and maintenance of all equipments and corrective and preventive actions.

AAC 11 The radiation safety programme has not been documented and implemented. signage are properly displayed in all appropriate location .The staff are not trained on the same. Adequate number of safety devices (TLD batches) is not provided to the staffs

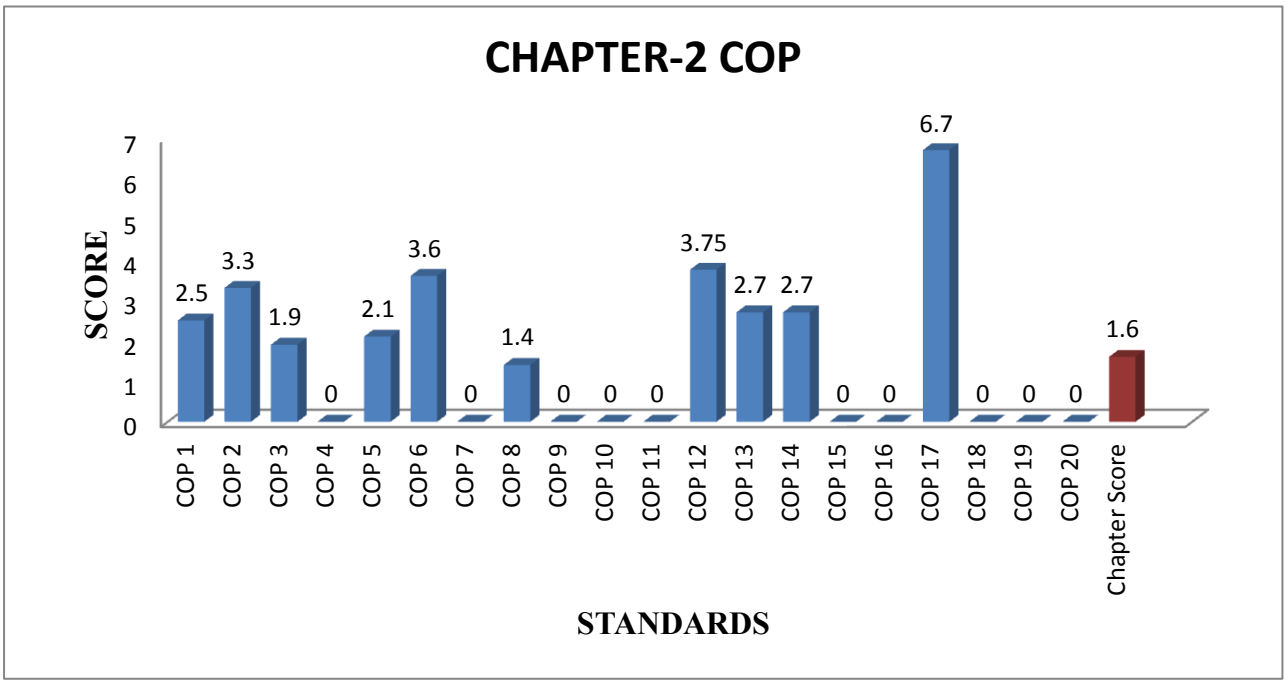
AAC 12. Procedure has not been documented about information sharing about care of patients, but implementation has not been done. There are not documented policies and procedures to guide the referral of patients to other departments/specialities and not implemented.

AAC 13 The hospital discharge process and procedure for coordination of various departments has not been documented and implemented. Documented policies and procedures are not in place for patients leaving against medical advice and patients being discharged on request and discharge summary is not given to all patients.

AAC 14. The hospital has defined and documented the content of discharge summary.

Chapter 2: CARE OF PATIENTS (COP)	
COP 1	2.5
COP 2	3.3
COP 3	1.9
COP 4	0
COP 5	2.1
COP 6	3.6
COP 7	0
COP 8	1.4
COP 9	0
COP 10	0
COP 11	0
COP 12	3.75
COP 13	2.7
COP 14	2.7
COP 15	0
COP 16	0
COP 17	6.7
COP 18	NA

COP 19	0
COP 20	0
Chapter average	1.6



INTERPRITATION

COP-1.Documentation of policy and procedures for uniform care of patients in all setting of the hospital and guided by applicable law, regulation and guideline has done as per NABH standard it is documented well but implementation has not done as per NABH standard.

COP-2. Policies and procedures for emergency care are not documented and are not in consonance with statutory requirements. Documented policies and procedures are not there to guide the triage of patients for initiation of appropriate care. Admission or discharge to home or transfer to another organization is not documented and implemented.

COP-3. Ambulance Services provided by the hospital need to be improved a lot. Ambulances are not well equipped and manned by a trained personnel.

COP- 4. Policies and procedures to guide the care of patients requiring cardio-pulmonary resuscitation are not available. Staffs are not trained uniformly and periodically updated in CPR. The

events during a CPR are not recorded and hence post event analysis is not carried out by multidisciplinary committee. Corrective and preventive measures are not taken based on the post-event analysis.

COP-5.Some of policy and procedure of guide nursing care has been documented but not implemented.

COP-6. Polices to guide the performance of various procedures is available but not implemented but only Patients are appropriately monitored during and after the procedure. Documented procedures do not exist to prevent adverse events like wrong site, wrong patient and wrong procedure.

COP -7 There are neither documented policies and procedures for rational use of blood and blood components nor implemented. Staffs are not trained to implement the polices. The transfusion reactions are not analysed for preventive and corrective actions.

COP- 8. The organization has not a documented admission and discharge criteria for intensive care unit. For Intensive Care Unit and High Dependency Unit adequate staff and equipments are there Staff is not trained to apply these criteria. Infection control practices are not followed uniformly. Quality assurance programme for the ICCU is not documented and implemented.

COP- 9. There are no documented policies and procedures to guide the care of vulnerable patients (elderly, children, physically and/or mentally challenged) not implemented. Staffs are not trained uniformly to care for this vulnerable group.

COP-10 Obstetric care is not present in the hospital.

COP-11. There is not a documented policy and procedure for paediatric services. The organisation has not defined and displayed the scope of paediatric services. The staffs those care for children are not trained for age specific competency. The children's family members are not uniformly educated about nutrition, immunization and safe parenting.

COP -12. There are not documented policies and procedures to guide the care of patients undergoing moderate sedation and not implemented in every case. Patients are not monitored after sedation and not documented. Equipment and manpower are not available to manage patients who have gone into a deeper level of sedation than initially intended.

COP- 13 There are not documented policies and procedures for guiding the administration of anaesthesia. An immediate preoperative re-evaluation is not done and documented. Adverse anaesthesia events are not recorded and monitored. Patient's post-anaesthesia status is not monitored and documented. The anaesthesiologist does not apply defined criteria to transfer the patient from the recovery area. Procedures are not complying with infection control guidelines to prevent cross infection between patients.

COP- 14 Policies and procedures are not documented for the care of patients undergoing surgical procedures not implemented also the quality assurance programme for the operation is not followed. A brief of note that should be documented prior to transfer out of patient from recovery area is not documented. The operating surgeon does not document the post-operative plan of care.

COP-15 Policies and procedures for the care of patients under restraints (physical and/ or chemical) are not documented but training policy programme not as per NABH Standards and these are not implemented. Staffs are not trained to control and restraint techniques.

COP-16. The policy and procedure guiding the management of pain has not been documented and implemented Patient and family members are not educated uniformly on various pain management techniques. The organization does not respects and supports management of pain for such patients.

COP- 17 The hospital does not provide documented policies and procedures to guide appropriate rehabilitative services but These services are not commensurate with the organizational requirements.

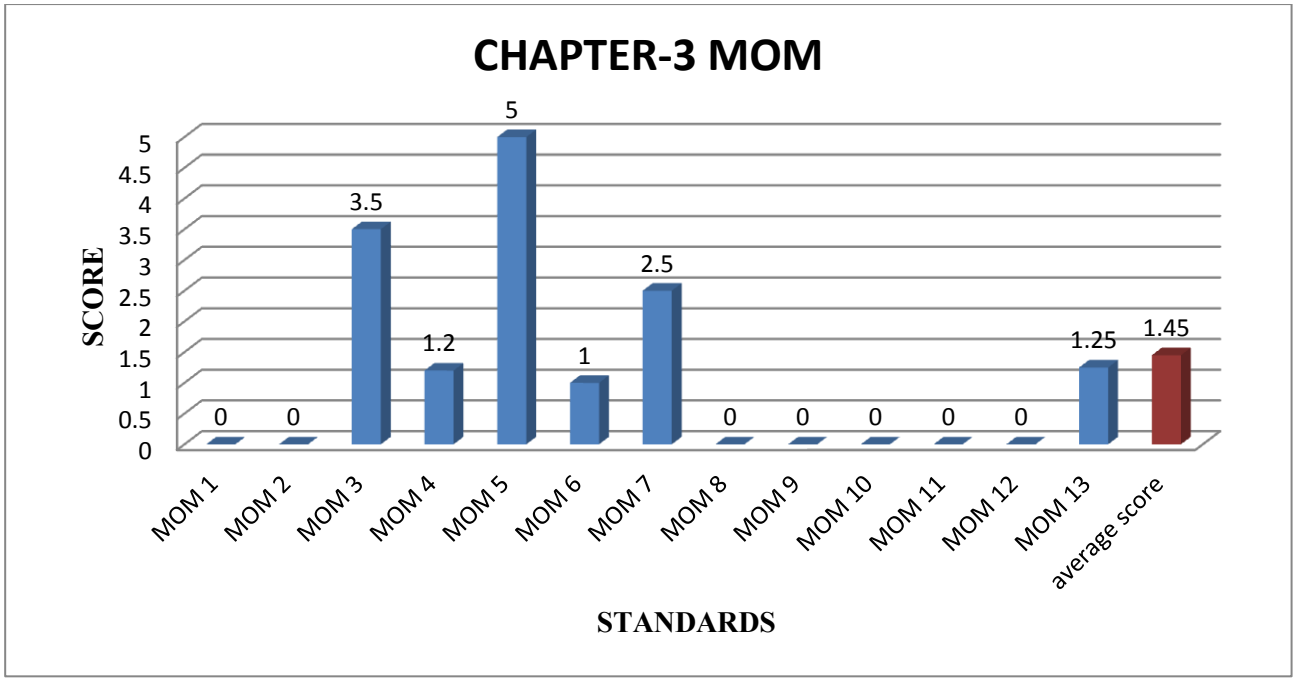
COP -18 Research activities are not carried out in the hospital.

COP-19 The hospital does not has documented policies and procedures for nutritional therapy and not implemented.

COP- 20. Policies for End of Life Care have not been documented, and hospital does not provide any specific facility for such care and the staffs are not trained on the same.

Chapter 3: MANAGEMENT OF MEDICATION (MOM)	
MOM 1	0
MOM 2	0
MOM 3	3.5
MOM 4	1.2
MOM 5	5
MOM 6	1
MOM 7	2.5
MOM 8	0

MOM 9	NA
MOM 10	NA
MOM 11	NA
MOM 12	0
MOM 13	1.25
Chapter average	1.45



INTERPRETATION

MOM-1. Documentation and implementation has not been done regarding pharmacy services and usage of medication. There is no multidisciplinary committee to guide the formulation and implementation of these policies and procedures.

MOM-2. Hospital formulary has not been developed and requires implementation to define process for acquisition of the medication. There is a process to obtain medications not listed in the formulary.

MOM-3. There is no documented policy and procedures for storage of medications and not implemented. Sound alike and Look alike medications are not stored separately. Every medicine is not stored according to the manufacturer's recommendations. Sound inventory control practices do not guide storage of the medications.

MOM-4. The organisation does not has documented policies and procedures for prescription of medications and for high risk medications and need to be implemented and organisation does not determine who can write the prescription. Known drug allergies are not ascertained before prescribing.

The organization does not determines who can write orders. Medication orders are not clear, legible, dated, timed, named and signed. Documented policy and procedure on verbal orders is not implemented. The organization does not define a list of high risk medication (s). Audit of medication orders/prescription is not carried out to check for safe and rational prescription of medications.

MOM-5. Documentation and implementation has not been done for safe dispensing of medications

MOM-6. Prepared medication is not labelled prior to preparation of a second drug. Patient is not identified prior to administration. Medication, dosage, route, and timing is not verified from the order prior to administration. Medication administration by self and medication brought from outside is not documented and implemented.

MOM-7. Documentation policies and procedure to guide the monitoring of patients after medication administration has not been done and polices require to be implemented. Organisation does not define those situations where close monitoring is required.

MOM-8. Documented procedure does not exist to capture near miss, medication error and adverse drug event and not implemented. Adverse drugs events are not reported within a specified time frame. They are also not collected and analysed by multidisciplinary committee.

MOM-9. Narcotics are not used in hospital.

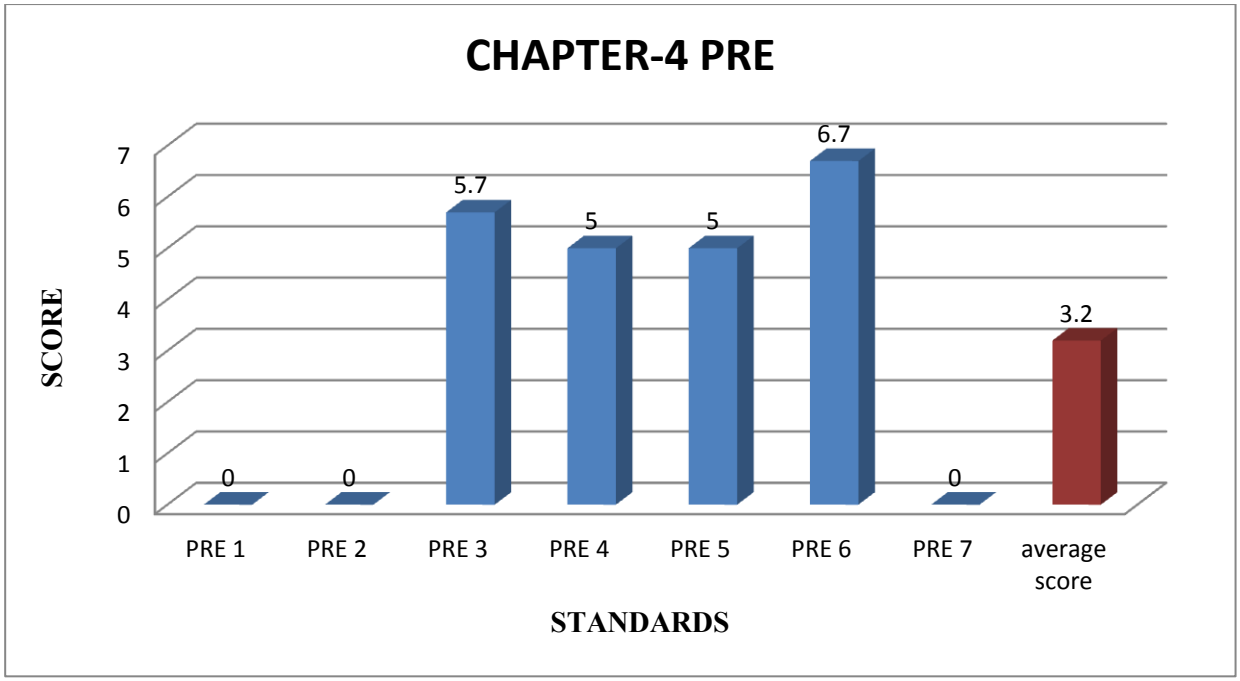
MOM-10: Chemotherapeutic agents are not used in the hospital.

MOM- 11: Radioactive drugs are not used in the hospital.

MOM-12: Implantable prosthesis are not used in the hospital.

MOM- 13: There are no documented policies and procedures for use of medical gases and not implemented. Medical supplies and consumables are kept in clean and safety environment. Medical supplies and consumables are not used in a safe manner where appropriate.

Chapter 4: PATIENT RIGHT AND EDUCATION (PRE)	
PRE 1	0
PRE 2	0
PRE 3	5.7
PRE 4	5
PRE 5	5
PRE 6	6.7
PRE 7	0
Chapter average	3.2



INTERPRETATION

PRE -1. Documentation of patient and family rights and responsibilities has not been done and displayed, Staffs are not uniformly aware of their responsibility in protecting patient's rights. Violation of patient and family rights is not recorded, reviewed and corrective / preventive measures are not taken.

PRE-2 There is no policy in which patients rights and responsibility has been described and it does not include respecting spiritual and cultural needs and many other policies which are not documented and implemented.

PRE-3. There are documented policies to educate family members about expected results and possible complications but these are no implemented. The patient and/or family members are not explained about the expected results. The care plan is not prepared and modified in consultation with patient and/or family members.

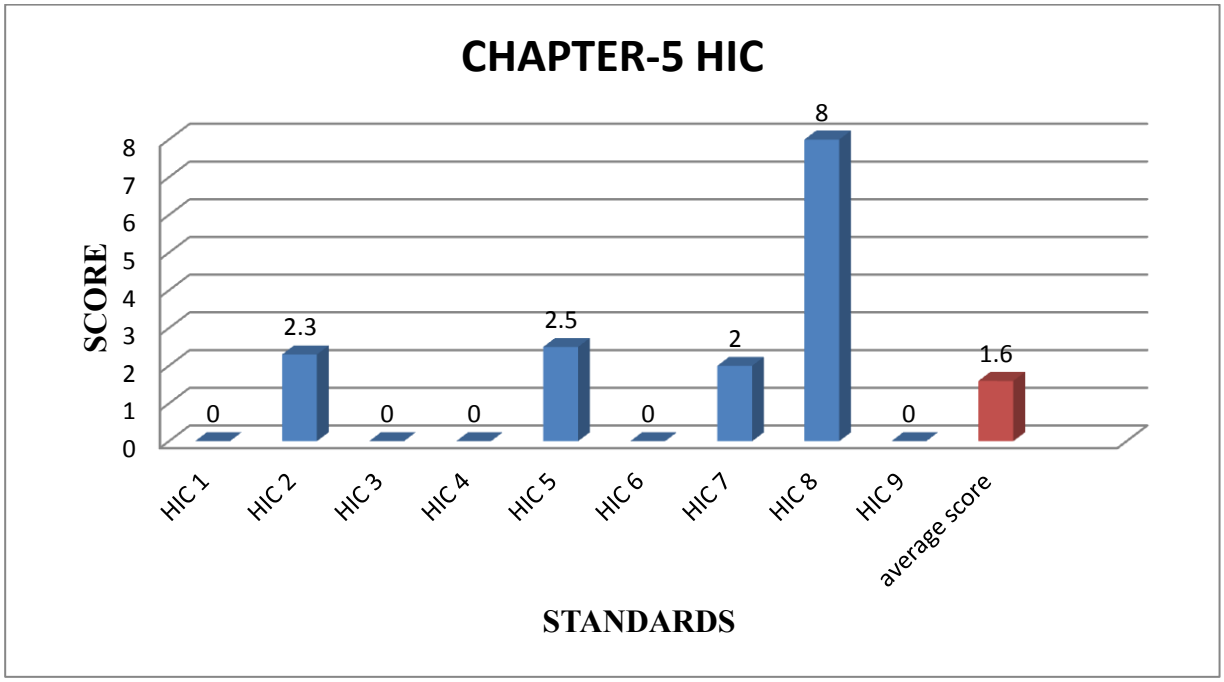
PRE -4.Informed consent policy is not documented and implemented but staff is not uniformly aware about these policies. General consent for treatment is not obtained and family members are not informed when the patient enters the organization.

PRE-5. The patient and their family members are not educated about the food drug interactions, diet and nutrition, organ donation and about preventing healthcare associated infections.

PRE-6. This objective is not applicable because it is a govt. Hospital.

PRE-7. The documentation of organization redressed procedure has not been done and implemented. Complaints are not analysed.

Chapter 5: HOSPITAL INFECTION CONTROL (HIC)	
HIC 1	0
HIC 2	2.3
HIC 3	0
HIC 4	0
HIC 5	2.5
HIC 6	0
HIC 7	2
HIC 8	8
HIC 9	0
Chapter average	1.6



INTERPRETATION

HIC-1. The hospital infection prevention and control programme is not documented and implemented which aims at preventing and reducing risk of healthcare associated infections. Hospital does not have infection control committee, infection control team, officer and nurse.

HIC-2.Infection Control manual has not been documented and implemented. The organization is not adhere to standard precautions at all times. Linen and laundry management is improper and antibiotic policy, kitchen sanitation and food handling issues need to be documented and implemented. There are not engineering controls to prevent infections.

HIC-3.Survillance is not done and record is not maintained, proper documentation and implementation is required.

HIC-4.The organization does not take actions to prevent or reduce the different risk of Hospital Associated Infections (HAI) in patients and employees.

HIC-5.Facilities and resources provided to support the infection control programme are inadequate. Barrier nursing facility is not available. Appropriate pre and post exposure prophylaxis is not provided to all concerned staff members.

HIC-6. Outbreaks of infections are not documented and implemented.

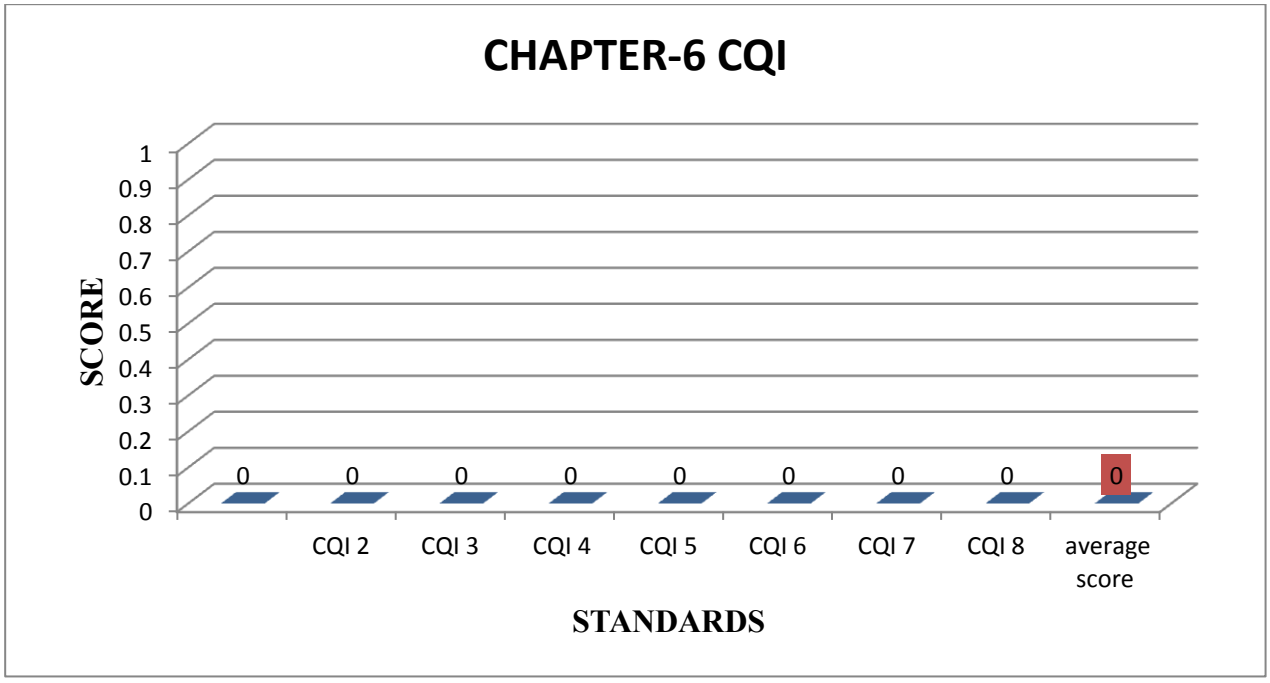
HIC-7. Documentation and implementation has not been done for procedures for sterilisation activities in the organisation. There is no adequate space for sterilization activities. Regular validation tests for sterilization (bowie dick tape test and leak rate test) are not carried out No established recall procedure for sterile and non sterile items.

HIC-8. There is no proper segregation and collection of BMW uniformly from all patient care areas of the hospital. The hospital monitor that the BMW is transported safely within the time frame. Staffs are not provided with appropriate Personal Protective Equipments (PPE) for handling of BMW.

HIC-9. Infection control programme is not supported by the management. Policy of annual budget for HIC is not being followed and staff is not being trained for infection control practices.

Chapter 6: CONTINUOUS QUALITY IMPROVEMENT (CQI)	
CQI 1	0
CQI 2	0

CQI 3	0
CQI 4	0
CQI 5	0
CQI 6	0
CQI 7	0
CQI 8	0
Chapter average	0



INTERPRETATION

CQI-1. Structured quality improvement and continuous monitoring programme in the organization is not documented and implementation.

CQI-2. There is not a structured patient safety programme in the organization.

CQI-3. Safety and quality control programmes of the diagnostics services, invasive procedures, anaesthesia, and infection control have not been documented and implemented there is no proper monitoring of use of blood and blood products. The organization does not identify key indicators to

monitor the clinical structures, processes and outcomes which are used as tools for continual improvement have been documented but not implemented.

CQI-4. Key indicators to monitor the managerial structures, processes and outcomes which are used as tools for continual improvement have not been documented and implemented.

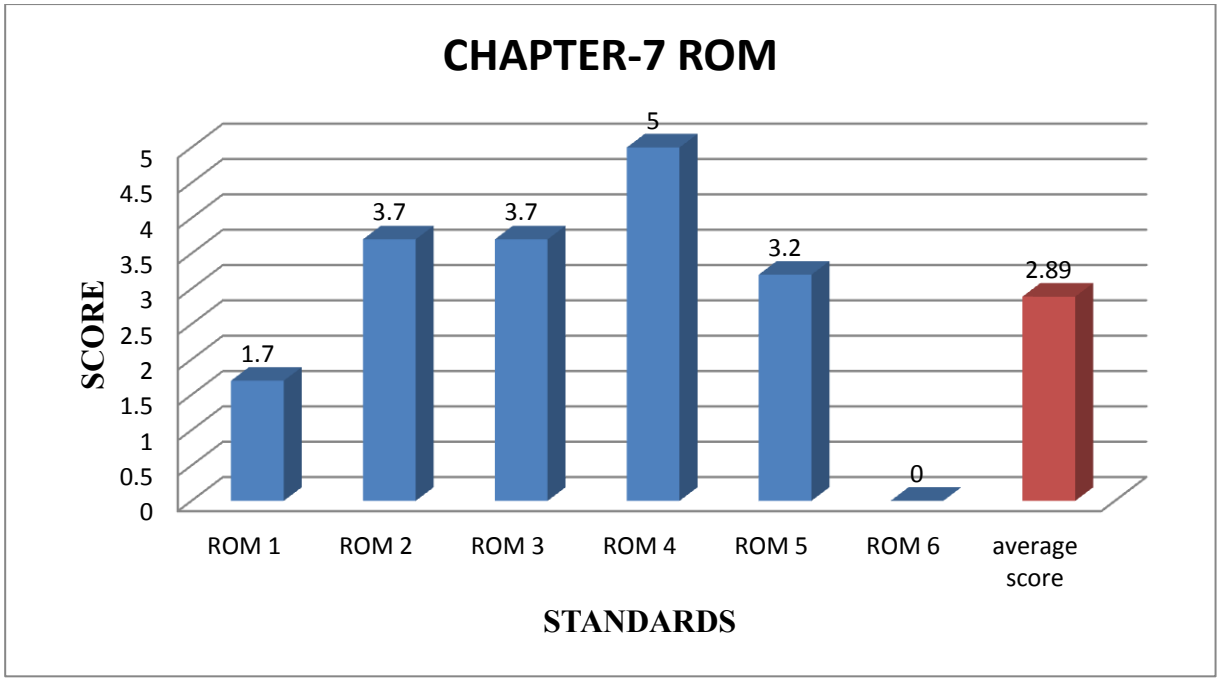
CQI-5. There is no quality improvement programme as such and not supported by management.

CQI-6. There is not an established system for clinical audit**.**

CQI-7 Incidents, complaints and feedback are not collected and analysed to ensure continual quality improvement**.**

CQI-8. The organization has not defined sentinel events and there is no established process for analysis of sentinel events.

Chapter 7: RESPONSIBILITIES OF MANAGEMENT (ROM)	
ROM 1	1.7
ROM 2	3.7
ROM 3	3.7
ROM 4	5
ROM 5	3.2
ROM 6	0
Chapter average	2.89



INTERPRETATION

ROM-1. Some of responsibilities of Management are defined but not all. Organogram of the hospital is not available. Those responsible for governance do not approve the strategic and operational plans and organization's budget and does not appoint senior leaders.

ROM-2. The management is not conversant with the laws and regulations and knows their applicability to the organization and does not ensure implementation of these requirements. The policy and procedure of the organization complies with the laid down and applicable legislations.

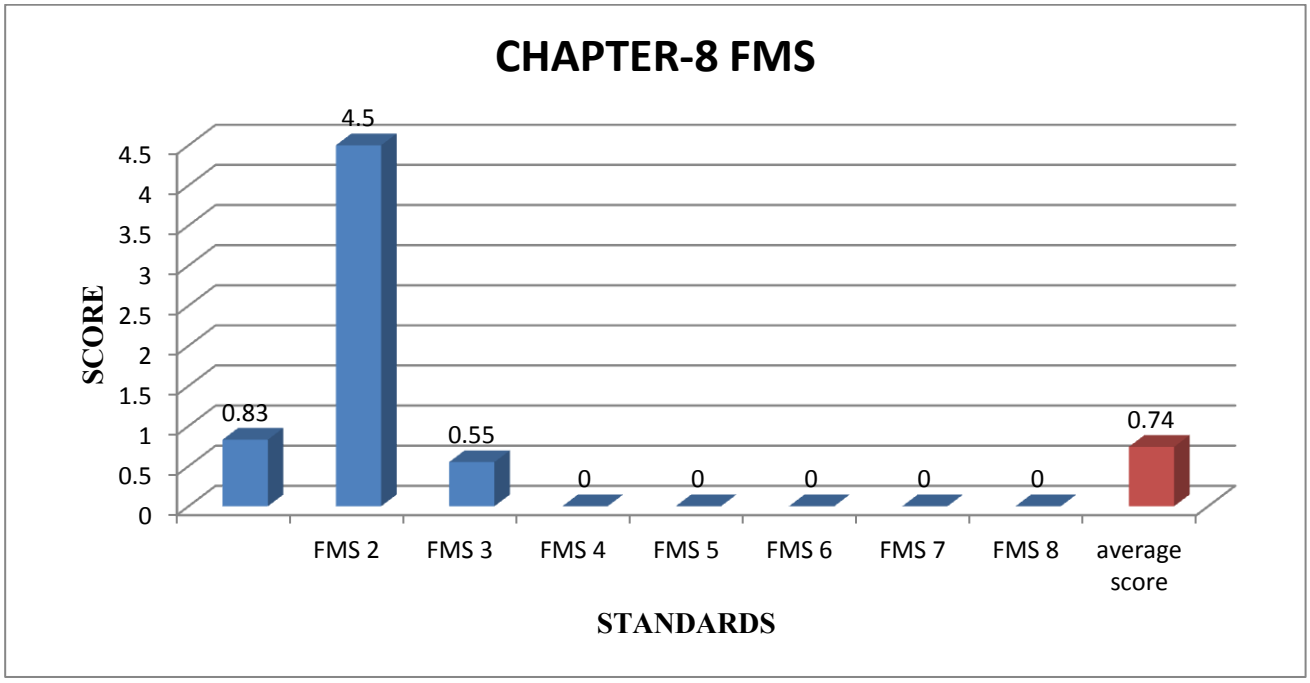
ROM-3. Services provided by each department are documented but not displayed and staff is not oriented. Administrative policies and procedures for each department are not maintained.

ROM-4. Organization's Ethical Management needs to be improved.

ROM-5. A suitably qualified and experienced individual managerial heads the organization. The organization coordinates the functioning with departments and external agencies, and monitors the progress in achieving the defined goals and objectives. The performance of the senior leaders and committees is reviewed for their effectiveness. The organization documents employee rights and responsibilities and service standards.

ROM-6. Management does not ensure and provide resources for proactive risk management across the organization. Management does not ensure that appropriate corrective and preventive action is taken to address safety related incidents.

Chapter 8: FACILITY MANAGEMENT AND SAFETY (FMS)	
FMS 1	.83
FMS 2	4.5
FMS 3	.55
FMS 4	0
FMS 5	0
FMS 6	0
FMS 7	0
FMS 8	0
Chapter average	.74



INTERPRETATION

FMS-1. There is no safety committee. The management is conversant with the laws and regulations and knows their applicability to the organization, but updating of amendments is required. The organization is not a non-smoking area. Safety education programme for staff is not there.

FMS-2. Documentation and implementation has not been done on the aspects to ensure safety of patients, their families, staff and visitors, but implementation is required. Facilities are not appropriate to the scope of services of the organization. There is not a documented operational and maintenance (preventive and breakdown) plan. Response times are not monitored from reporting to inspection and implementation of corrective actions.

FMS-3. The organization has no documented program for clinical and support service equipment management, and implementation is also not done. Response times are not monitored for all the complaints received. Equipment are not selected, rented, updated or upgraded by a collaborative process. There is not a documented operational and maintenance (preventive and breakdown) plan for water management, electrical systems and HVAC system.

FMS-4. The organization has not a programme for bio medical equipment management. The organization does not plan for equipment in accordance with its services and strategic plan. Qualified and trained personnel do not operate and maintain the medical equipment.

FMS-5. The organization has not a programme for medical gases, vacuum and compressed air. Medical gases are not handled, stored, distributed and used in a safe manner. The procedures for medical gases do not address the safety issues at all levels.

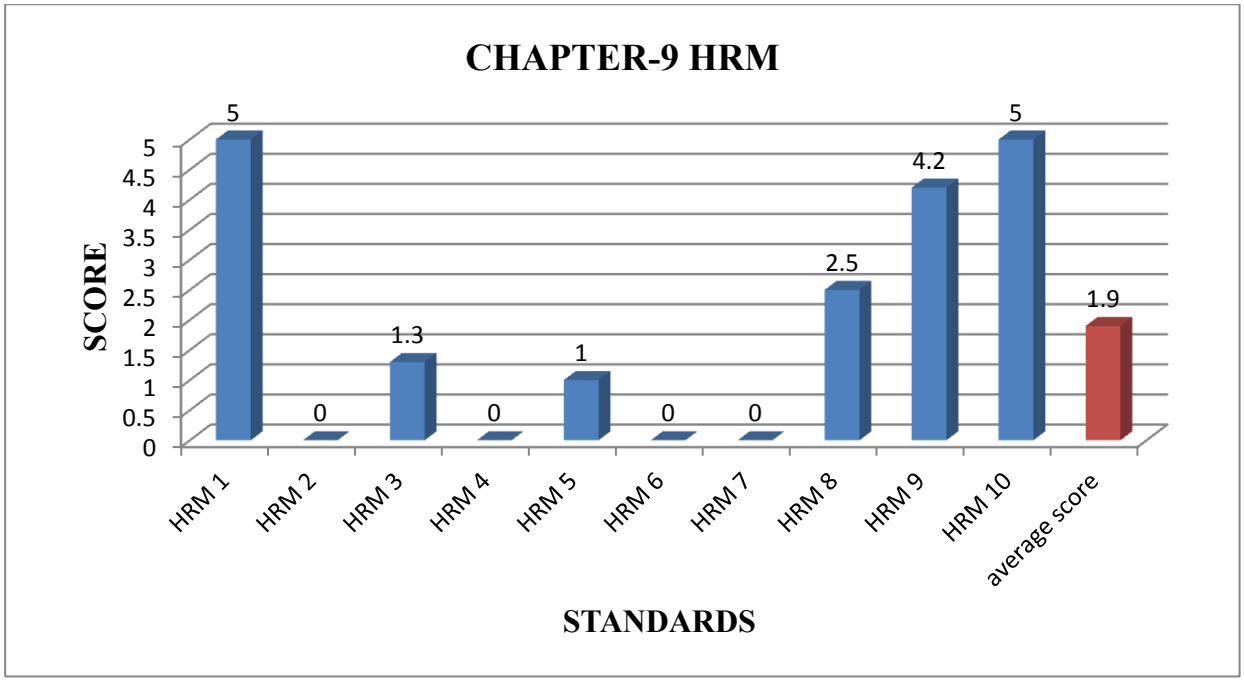
FMS-6. The organization has no plan for fire and for non-fire emergencies within the facilities. Staff are not trained for their role in case of such emergencies. Mock drills are not held.

FMS-7. Provision is not made for availability of medical supplies, equipment and materials during emergencies. Documented disaster management plan is not available, and staff is not trained.

FMS-8. Plan for management of hazardous materials is not there. Staff are not educated and trained for handling such materials.

Chapter 9: HUMAN RESOURCE MANAGEMENT (HRM)	
HRM 1	5.0
HRM 2	0
HRM 3	1.25

HRM 4	0
HRM 5	1
HRM 6	0
HRM 7	0
HRM 8	2.5
HRM 9	4.16
HRM 10	5
Chapter average	1.89



INTERPRETATION

HRM-1 The organization has a documented system of human resource planning but it is not implemented.

HRM-2. Employee rights and responsibilities are not defined and implemented. Staffs are not made aware of his/her rights and responsibilities. Patient rights and responsibilities are not defined to the employees. Induction training is not given to employees.

HRM-3. The organization has not a documented professional training and development programme for the staff. Training record is not maintained properly. There is not a feedback mechanism for assessment of training programme.

HRM-4. Staff members are not trained on specific job duties or responsibilities related to safety .Staffs are not trained on risks within the hospital environment and to take actions to report, eliminate/minimize risks. Reporting processes for common problems, failures and user error does not exists.

HRM-5. An appraisal system for evaluating the performance of an employee is not implemented. Performance is not evaluated on the basis of pre determined criteria. The appraisal system is not used as a tool for further development.

HRM-6. The organization has not documented and implemented disciplinary and grievance handling policies. The policies and procedures are not known to all categories of staff of the organization.

HRM-7. The hospital does not address the health needs of employees. Documentation has not been done for regular health checkups of staff and addressing of occupational hazards but not implemented.

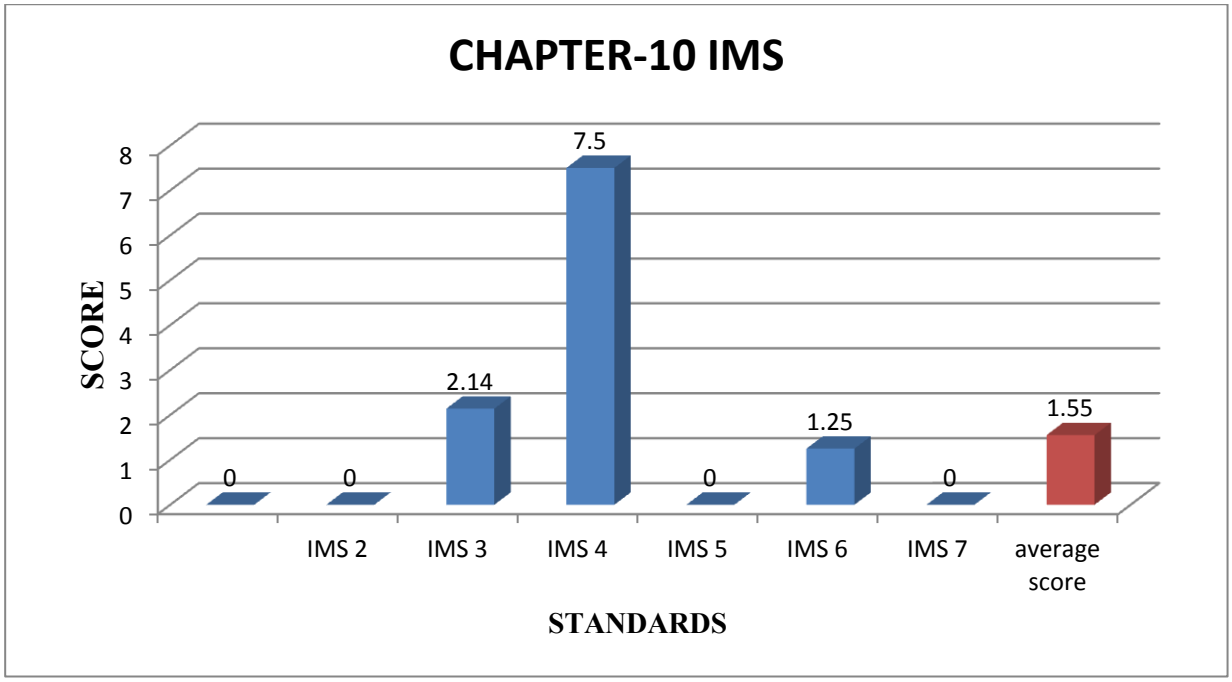
HRM-8. Documented personal record for each staff member is maintained but not updated uniformly. All records of in-service training and education are not contained in the personal files. Personal files do not contain results of all evaluations.

HRM-9. There is a process for collecting, verifying and evaluating the credentials (education, registration, training and experience) of medical professionals permitted to provide patient care without supervision. Documentation has been done for the process for authorising all medical professionals to admit and treat patients and provide other clinical services commensurate with their qualifications but implementation is still require.

HRM-10. There is a process for collecting, verifying and evaluating the credentials (education, registration, training and experience) of nursing staff. There is a process to identify job responsibilities and make clinical work assignments to all nursing staff members commensurate with their qualifications and any other regulatory requirements.

Chapter 10: INFORMATION MANAGEMENT SYSTEM (IMS)	
IMS 1	0
IMS 2	0

IMS 3	2.14
IMS 4	7.5
IMS 5	0
IMS 6	1.25
IMS 7	0
Chapter average	1.55



INTERPRETATION

IMS-1. Policies and procedures are not documented and implemented 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.

IMS-2. Documentation and implementation is not done for processes for effective management of data. Formats for data collection are not standardized and necessary resources are not available for analysing data. Documented procedures exist for storing and retrieving data.

IMS-3. The hospital has not a complete document of accurate medical record for every patient. Every medical record has not a unique identifier. Entry in the medical record is named, signed, dated

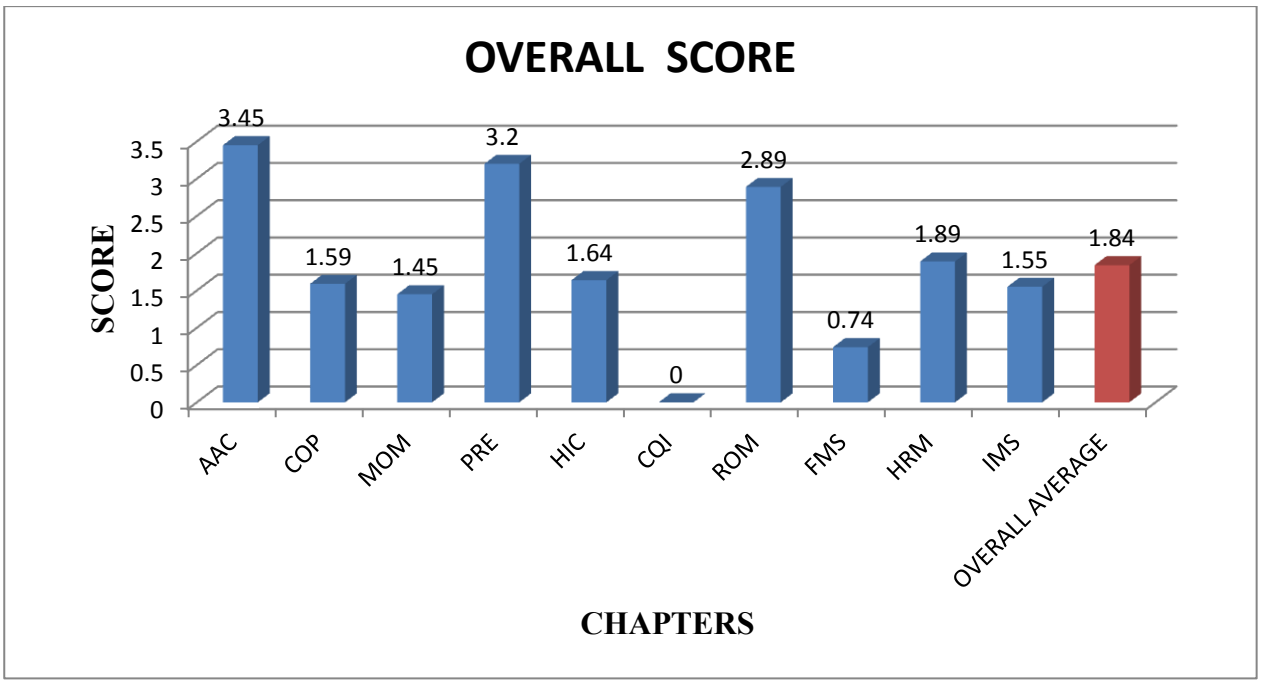
and timed. The author and contents of entry cannot be identified. Provision for 24 hours availability of patient record is maintained.

IMS-4. The medical record contains a copy of the discharge summary duly signed by appropriate and qualified personnel and the medical record reflects continuity of care

IMS-5. Policies, procedures and implementation are not in place for maintaining confidentiality, integrity and security of information.

IMS-6. Documented policies and procedures do not exist for retention time of records, data and information. The retention process does not provide expected confidentiality and security.

IMS-7.. The organization does not regularly carry out review of medical records to find out the timeliness, legibility and completeness of medical records and appropriate corrective and preventive measures are not undertaken.



Analysis

Pre-accreditation entry level:

Conditions for qualifying to this award are as below:

• All the regulatory legal requirements should be fully met.

• No individual standard should have more than two zeros.

• The average score for individual standard must not be less than 5.

• The average score for individual chapter must be more than 5.

• The overall average score for all standards must exceed 5.

The validity period for pre-accreditation entry level stage is from a minimum 6 months to a maximum of 18 months. It means that a hospital placed under this award cannot apply for assessment before 6 months.

Pre-accreditation progressive level:

Conditions for qualifying to this award are as below:

• All the regulatory legal requirements should be fully met.

• No individual standard should have more than two zeros.

• The average score for individual standard must not be less than 5.

• The average score for individual chapter must be more than 6.

• The overall average score for all standards must exceed 6.

The validity period for pre-accreditation progressive level stage is from a minimum 3 months to a maximum of 12 months. It means that a hospital placed under this award cannot apply for assessment before 3 months.

Accredited:

Conditions for qualifying for accreditation are as below:

• All the regulatory legal requirements should be fully met.

• No individual standard should have more than one zero to qualify.

• The average score for individual standards must not be less than 5.

• The average score for individual chapter must not be less than 7.

• The overall average score for all standards must exceed 7.

The validity period for accreditation is 3 years subject to terms and conditions.

ON COMPARING THE HOSPITAL PRESENT STATUS WITH CRITERIA OF NABH PRE ACCREDITATION ENTRY LEVEL WE FIND:

1) There are many individual standards with more than two zero.
2) There are many standards having average score less than 5.
3) There are many individual chapters having average score less than 5.
4) The overall average of all the standards does not meet the criteria as it is greater than 5.

With the above analysis it is clear that the hospital is not fulfilling the pre-accreditation entry level criteria.

RECOMMENDATIONS:-

1. Documented policy and Procedures are needed to be developed & followed.
2. Emergency Department is required to be **well equipped to deal acute Emergency**. **Triaging of emergency patients is required to be established**. Training is required to be given to the Emergency staff with regard to the **Emergency practices** (BLS, Head injury management, Shock management, poly trauma management etc.
3. **Essential equipments & Accessories such as** crash cart, Ventilators, Suction Apparatus trolley, Monitors, Intubation Set, Emergency tray are required to be made available in most of the patient care areas.
4. **Parking** facility is required to be organised. There should be a designated parking space with parking lot facility for the Patients, Staff, and Visitors.
5. **The knowledge and practices about BMW management** is required to be strengthened and needs repeated training and monitoring of the staff. Bins in used needed to be cleaned and disinfected at regular intervals.
6. **There has to be a system of allotting Unique ID numbers** for each patient at the time of OPD Registration.
7. Relevant licenses and statutory requirements are to be obtained Viz- NOC fire safety, No objection from PCB, AERB approval, BMW license etc.
8. The maintenance of the hospital building, premises and equipments is to be done periodically and hence are in decaying condition. None of the equipments have calibration details except Pathology Department' equipment; AMC details and history cards are not being maintained.
9. There has to be a system of auditing of patient care services through a structured tool. **Medical audit, clinical audit, and nursing audit, death audit is to be regularly carried out.**
10. There has to be a system of **External Quality Assurance for** diagnostic services.
11. **Medical Records Department is to be well established** and hence essential statistical information is not captured. Standard form & formats are not being used.
12. Record management for decision making was not evidenced. Clinical as well managerial data are to be maintained by the medical record department. **There is no Trained and Qualified MRO available**.
13. **Microbiology department not available**. Surveillance programme in high risk area is to be initiated and feedback regarding growth, infection rates, and trends are to be provided to respective units.

14. There is no dedicated sterilization unit for the equipments/accessories. A **dedicated Centralized** sterilization unit is recommended for better infection control practices.
15. There has to be documented disaster management plan for the hospital. Since plan is not available hence no awareness of key staff for their roles and responsibility during the disaster situations.
16. There is no arrangement for treatment of infected liquid waste. There is no Sewage treatment plant available for managing body fluids, infected liquid wastes.
17. **Key result area of hospital key staff** has not been defined. Hence there is no monitoring of performance of staff based on their Key result area.
18. The Surgical suites needs to be planned with due consideration of **four well defined zones of varying degree of cleanliness.** Zoning of OT was not done with four distinct zone i.e., Protective, Clean, Sterile and disposal zones. There was no **HVAC system** in the OT.
19. Important forms and formats are not available in the medical records. (Preoperative checklist, post operative checklist, Consent forms for anesthesia and surgery, Blood transfusion consent, TPR chart)
20. Area for **Intensive Care unit** is designated but is not functional.

CONCLUSION:-

The analysis shows that there are lots of gaps in the hospital as per NABH norms. Documentation and implementation is required. As the hospital wishes for NABH accreditation so it must be prepared according to the evaluation criteria for assessment. There are different stages of accreditation which needs to be fulfilled by the organization. As of now the hospital does not fulfil the criteria for entry level according to which no standard must not have more than two zero and the average score of individual standard must not less than 5 and the average score for individual chapter must be more than 5.we conducted gap analysis to analyze the present status of the hospital and concluded that the hospital is not at the entry level as there are many standards having less than 5 score therefore these all are the areas which require greatest attention.

REFERENCES:-

1. NABH 3rd edition.
2. Self assessment toolkit of NABH. www.scribd.com/doc/100389593/**Self-Assessment-Toolkit-NABH**. Date :10-03-2014
3. IPHS Guidelines for District Hospitals, 2012. health.bih.nic.in/Docs/**Guidelines**/**Guidelines-District-Hospitals-2012**.pdf . Date :21-03-2014.
4. Medical Equipment & Hospital Planning - BIS (Bureau of Indian standards) www.bis.org.in sf pow M DPO .pdf Date:15-03-2014.
5. National Accreditation Board for Hospitals & Healthcare providers www.nabh.co Date:11-03-2014.
6. Quality Council of India: www.**qci**n.org Date:23-03-2014.
7. Shielding and Layout Guidelines **(AERB).** www.aerb.gov.in AE Po rtal pages English t ... layout guidelines.pdf

ANNEXURE

CHECKLIST

EMERGENCY

Checklist for Emergency				
S. No.		Yes	No	Remarks
STRUCTURE				
1.	Whether the triage area is marked separately		√	
2.	Does the Emergency department have a separate entrance?	√		
3.	Is the Emergency signage visible from the road with proper lighting and signs?		√	
4.	Is the doctor available round the clock for emergency care of patients?	√		
5.	Is there a nurse available round the clock for emergency care of patients?		√	Nursing assessment is done by the pharmacist appointed in the Departmen t
6.	Does the number of trolleys and wheelchairs commensurate to the needs?	√		
7.	Does the emergency room retain a list of all staff that contains Name, Contact details, Designation?	√		
8.	Is Doctor's name and contact number kept posted at all times in the emergency room?	√		
9.	Is there an appropriate waiting area for the relatives of the patient?	√		
10.	An appropriately qualified staff member is scheduled to manage triage activities.		√	
11.	Is Emergency Crash Cart available?	√		

12.	Defibrillator	√		
13.	Cardiac Monitor	√		
14.	Emergency drugs	√		
15.	Resuscitation bags (i.e. AMBU) of various sizes	√		
16.	Oral Airways of various sizes		√	
17.	Laryngoscope with various blades		√	
18.	Laryngoscope replacement batteries and bulbs.		√	
19.	Endotracheal tubes of various sizes.		√	
PROCESS				
20.	Is there a system to review all imaging by a radiologist within 24 hours	√		
21.	Ability to perform acute blood test and receive results within one hour for Arterial blood gases, Full blood picture, urea and electrolytes, plasma, glucose, Blood levels for common overdose medication/agents, Coagulation studies.	√		
22.	Security staffs are immediately available when required in the emergency room.		√	
23.	Electrical equipment (e.g. defibrillator) is charged at all times.	√		
24.	Is Crash cart checked daily regarding regular testing?	√		
25.	The documentation from a medico-legal and treatment view point is detailed, professional and accurate.	√		Policy is defined but not documented
26.	Are the separate registers maintained for medico legal cases, discharge, admissions to ward?	√		
27.	Is BMW segregated and handled properly.		√	

28.	Is Triaging of the patients done?		√	
29.	Does the initial assessment of the patient take place?	√		
30.	Are the patients attended by attendants when they come or when they are transferred to wards?	√		
31.	Is staff trained in BLS/ACLS		√	
OUTCOME				
32.	Time for initial assessment of emergency patient		√	

AMBULANCE

Checklist for Ambulance				
Sl. No.	**Check points**	**Yes**	**No**	**Remarks**
STRUCTURE				
1	Adequate communication system exists in ambulance		√	Done by EMO through personal phone
2	Required equipments (stetho, sphygno, suction app, defib, monitor, oxygen cylinder) are available in the ambulance.		√	Only oxygen cylinder is present
3	Required medicines are available in the ambulance.		√	
4	Is Vehicle license available?	√		ospit al's ambulance is condemned;1 Ambulance is provided by NRHM
5	Is driver license (HMV Registered) present?	√		

6	Maintenance of the medical gas (oxygen) to 90% of the total capacity.		√	
7	Calibration of Equipments present		√	
PROCESS				
8	Is staff trained in BLS	√		Partially; certificates not present
9	Is Medication and equipment checklist maintained		√	
10	Is infection control practices followed	√		Improper

OPD

Checklist for OPD				
Sl. No.	**Check Points**	**Yes**	**No**	**Remarks**
STRUCTURE				
1	Availability of enquiry counter			
2	Availability of registration counter	√		
3	Availability of separate queue for Differently able.		√	
4	Availability of designated waiting area with adequate sitting arrangement	√		
5	Availability of drinking water facility	√		
6	Availability of separate and functional toilet for differently able.		√	
7	Availability of fan & lights in waiting area	√		
8	Is the Scope of services displayed?	√		
9	Is citizen charter and Patient charter displayed		√	
10	Is list of doctors along with OPD Timings displayed		√	

11	Are the different OPD rooms numbered	√		
12	Is there provision of patient privacy in the consultation room	√		
13	Is BP apparatus with stethoscope present	√		
14	Is weighing machine present	√		
15	Is thermometer present	√		
16	Is calibration of BP apparatus, weighing machine and thermometer		√	
MANPOWER				
17	Availability of dedicated registration clerk	√		
18	Availability of nurse to direct patients to specific OPDs		√	
PROCESS				
19	Is UHID generated for all patients		√	
20	Is separate registration done for old and new OPD patients		√	
21	Is the tariff rates defined and made aware to the patients/ attendant	√		
22	Is patient privacy maintained during consultation time	√		
23	Is the staff aware of all the information like Doctors OPD timings, charges etc	√		
OUTCOME				
24	Monitoring of waiting time		√	
25	OPD patient satisfaction survey		√	

LABORATORY

Checklist for Laboratory

Sl. NO	Check points	Yes	No	Remarks
	STRUCTURE			
1	Is laboratory present in hospital? (In house/ outsourced)	√		
2	Specify the functional units of laboratories present in the hospital	√		
3	Is there continuous water supply to this unit?	√		
4	Is adequate drainage system present in this unit?	√		
5	Is there provision for hand washing facility in this unit?	√		
6	Is there provision of personal protective devices for staff?(if yes mention the name)	√		
7	Is the staff licensed and competent in knowledge and skill?	√		
8	Is there separate area available for sample collection?	√		
9	Is pathologist available?	√		
10	Are BMW bins are present in the department?	√		
11	Is there power back up facility available	√		
	PROCESS			
12	Is the scope of services defined		√	
13	Is maintenance of laboratory equipments done?	√		
14	Are laboratory equipments calibrated?	√		
15	Is laboratory staff aware about the safety precautions while handling samples?	√		

16	Is laboratory staff taking necessary precautions while handling samples?	√		
17	Is BMW segregation done as per BMW guidelines?	√		
18	Is critical results defined, reported, and documented.		√	
19	Is surveillance for lab test being carried out		√	
20	Is EQAS being monitored		√	
21	Laboratory reports are signed by Pathologist.	√		
22	Is labeling of sample done?	√		
23	Is time frame defined for dispatching lab reports?	√		Inpatient: till 2 pm Outpatient: next day from 8 am to 5 pm
24	Is turnaround time for lab reports monitored?		√	
25	Is MOU available for outsourced tests		√	
26	Is temperature monitoring of refrigerator is done?	√		
OUTCOME				
27	Number of reporting errors per 1000 investigations		√	
28	% of reports having clinical correlation with provisional diagnosis		√	
29	% of adherence to safety precautions		√	

30	% of redo's		√	

RADIOLOGY & IMAGING

Checklist for Radiology & Imaging				
S. No.	**Check points**	**Yes**	**No**	**Remarks**
	STRUCTURE			
1	Is this unit has AERB (SITE/TYPE approval)		√	
2	Are basic facilities for staff present? (toilet/drinking water/change room)	√		
3	Is the staff licensed and competent in knowledge and skill?	√		
4	Is there a change room available for patients?		√	
5	TLD badges available (Are they sufficient in number)		√	
6	Lead glass available (Are they sufficient in number)	√		
7	Lead apron available (Are they sufficient in number)	√		
8	Gonad shield available (Are they sufficient in number)		√	
9	Thyroid shield available (Are they sufficient in number)		√	
10	Is radiologist available?	√		
11	Is critical results defined, reported, and documented.		√	
12	Radiation hazard symbol is present	√		Not properly visible from the main door as it is too small
13	PNDT license is available	√		
	PROCESS			

14	Is maintenance of radiology equipments done?		√	
15	Are radiology equipments calibrated?		√	
16	Is radiology staff aware about the safety precautions?	√		
17	Is radiology staff taking safety measures?		√	
18	Quality Assurance program is followed or not		√	
19	Radiology test requisition form is signed by doctor.		√	
20	Radiology reports are signed by Radiologist.		√	
21	Is time frame defined for dispatching reports?		√	
22	Is turnaround time for reports monitored?		√	
OUTCOME				
23	Number of reporting errors per 1000 investigations		√	
24	% of reports having clinical correlation with provisional diagnosis		√	
25	% of adherence to safety precautions		√	
26	% of redo's		√	

WARDS

Checklist for Ward Management				
SL.NO	**Check points**	**Yes**	**No**	**Remarks**
STRUCTURE				
1	Is Medical Gas Facility available in the ward?	√		
2	Are basic facilities for staffs present (toilet/ drinking water)?	√		
3	Is needle cutter present in each ward?	√		

4	Emergency crash cart is present in the ward?		√	
5	Color coded BMW bins are present in each ward?	√		
6	Is there a nursing station in the ward?	√		
7	Is there adequate number of nurses in each shift?		√	
8	Racks are present to store linen?	√		
9	Wash basin is present in each ward.	√		
10	PPE is provided in each ward?	√		
PROCESS				
11	Is staff aware of the admission process?	√		
12	Does the cleaning of the department take place?	√		
13	Are the vitals of the patient checked every day?	√		
14	Administration of medication is done by qualified nurse?	√		
15	Indent of medicines and other items is placed by nurses regularly?	√		
16	PPE is used by the nurses?	√		

17	Are the BMW segregated at the point of generation?		√	
18	Does the nurse on duty record the details of the patient in the BHT on a daily basis?	√		
19	Are the nurses trained in BLS(CPR)		√	
20	Is infection control practices being followed	√		
21	Is bio medical waste management practice followed	√		
22	Is the staff aware about transfer IN/OUT system	√		
23	Is cost estimate for treatment provided to the patient/attendant			Treatment are provided free of cost
24	Is discharge process defined and documented?	√		Defined but not documented

LABOUR ROOM

Not applicable (Service not being provided by the hospital)

ICCU

Intensive Cardiac Care Unit				
Sr. No		**Yes**	**No**	**Remarks**
STRUCTURE				
1	Is the required equipments available (Crash cart, Defibrillator, oxygen cylinder, multi para monitors, central line connection, ventilator, pulse oximetre, oxygen concentrator)		√	3 monitors are present those are not sufficient for no. of available beds in ICCU

2	Qualified and trained nurses available		√	
3	Is air condition available		√	
4	Is fowler's bed available		√	
PROCESS				
5	Are the admission and discharge criteria for ICCU and high dependency units defined?		√	
6	Is the staff trained to apply these criteria?		√	
7	Are the infection control practices documented and followed?		√	
8	Is the quality assurance programme documented and implemented?		√	
9	Procedures for situation of bed shortages are defined and followed?		√	
10	Do the policies and procedures guide the care of patients under restraints?		√	
11	Are the reasons for restraints documented?		√	
12	Is the patient under restrain frequently monitored?			
13	Is the staff aware about the end of life care policy?		√	
14	Are the policy for initial assessment and re-assessment of patient documented and present?		√	

15	Does the Initial assessment include screening for nutritional needs?		√	
16	Is the time frame for doing and documenting initial assessment defined?		√	
17	Is the frequency of reassessment defined and followed by the staff?		√	
18	Does the documented policies and procedures on uniform use of resuscitation present?		√	
19	Is the staff trained on resuscitation?		√	
20	Are the documented policies and procedures for rational use of blood and blood products available?		√	
21	Is the informed consent obtained before donation and transfusion of blood and blood products?		√	Only before donation of blood
22	Are the patient and family educated about donation?		√	
23	Are the post transfusion reaction monitored and analyzed for preventive and corrective actions?		√	
24	Is the scope of pediatric services defined and displayed?		√	
25	Does who care for children have age specific competency?		√	
26	Is there a written order for the diet?		√	
27	Is the nutritional therapy planned and provided in a collaborative manner?		√	

28	Are emergency medications available all the time and replenished in a timely manner when used?		√	
29	Are the medication orders written in a uniform location and are clear, legible, dated, timed, named and signed?		√	
30	Is a written order for high risk medication done?		√	
31	Do the policies and procedures guide the monitoring of patients after medication administration?		√	
32	Is the medication administration documented?		√	
33	Is the policy for patient's medications brought from outside the organization available?		√	
34	Knowledge to pick adverse drug events and reporting of the same?		√	
35	Does the policy and procedure guide the use of narcotic drugs and psychotropic substances?		√	
36	Are the narcotic drugs stored in a safe manner?		√	
37	Is a proper record kept for the usage, administration and disposal of narcotic drugs?		√	
38	Is the antibiotic policy adhered and followed by the staff?		√	
39	Is the infection control data collected?		√	
40	Availability of various HAI rates of that area and		√	

	action taken report?			
41	Is the layout of beds, its spacing, and visual privacy appropriate?		√	
42	Are all the equipments periodically inspected and calibrated?		√	
43	Service labels on Equipment and calibration records present?		√	
44	Is the Information exchanged and documented during transfers between units/departments?		√	
45	Documented procedures guide the referral of patients to other departments/ specialties?		√	
46	Qualified individual identified as responsible for the patient's care?		√	
47	Is a policy in place for LAMA patients and patients being discharged on request?		√	
48	Is the policy for care of vulnerable patients available?		√	
49	Does the organization provide a safe and secure environment for the vulnerable patients?		√	
50	Is the informed consent obtained by a surgeon prior to the procedure?	√		
51	Are the instructions for proper hand washing displayed and followed by the staff?		√	
52	Are the adequate PPE like gloves, masks available and used by the staff?		√	
53	Isolation /Barrier nursing facility available?		√	

54	Is the Segregation of bio-medical waste done as per the guidelines?	√		
55	Is the policy for obtaining consent present?		√	
56	Does the procedure describe who can give consent when patient is incapable of independent decision making?		√	
OUTCOME				
1	Re intubation rate		√	
2	ICCU utilization		√	

OT

Checklist for Operation Theatre				
S. No.		**Yes**	**No**	**Remarks**
STRUCTURE				
1	Is HVAC System present inside OT		√	
2	Is proper Zoning concept followed(Clean zone, protective zone, sterile zone, and disposal zone)		√	
3	Is the number of OT tables present in the hospital appropriate for the daily load	√		4 OT tables
4	If any OT has got more than one OT table		√	
5	Does the OT have a hand washing facility	√		
6	Is the fire fighting system available in the unit			2 fire extinguishers

		√		
7	Is continuous water available for the unit?	√		
8	Is the changing room available for the doctors and nurses	√		
9	Is there a continuous power back up for OT	√		
10	Does the OT have a crash cart		√	
11	Does the OT have defibrillator	√		
12	Does the OT have an ECG monitor	√		
13	Does the OT have oxygen supply	√		
14	Does the OT have shadow less OT light	√		
15	Is the staff provided with the personnel protective devices	√		
16	Is scrubbing area present for the OT staff	√		
PROCESS				
17	Is the consent for the surgery and anesthesia taken from the patient	√		
18	Is the OT list prepared		√	
19	Is the OT booking being done		√	
20	Is the preparation of patient done before the operation	√		
21	Does the nurse enter the patient details in the OT register	√		
22	Are the number of OT instruments counted before and after operation	√		
23	Is OT disinfection done after every procedure	√		
24	Is the pre anesthesia check up done by the anesthetists	√		
25	Is pre, intra, post operative notes are documented	√		
26	Is infection control practices being followed in OT	√		

27	Is pre operative checklist being followed		√	
28	Is bio medical waste management practices being followed	√		
OUTCOME				
29	Is % of anesthesia related adverse events being monitored		√	
30	% of anesthesia related mortality		√	
31	% of modification in plan of anesthesia		√	
32	% of unplanned ventilation following anesthesia		√	
33	Is % of Surgical site infection rate monitored		√	
34	Re Exploration rate		√	
35	Re scheduling of surgeries		√	

BLOOD BANK

Checklist for Blood Bank				
Si. No	**Description**	**Yes**	**No**	**Remarks**
STRUCTURE				
1	Is the required layout available: (Reception, examination room, bleeding room, refreshment room, blood separation and storage area and doctors room?)	√		
2	Is power back up available	√		
3	A full time qualified Blood Bank In-charge manages the blood collection/distribution department.	√		
4	A couch/cot is provided during venipuncture & the correct equipment for blood agitation/ volume measurement is present	√		

5	Refrigerators, insulated carrier boxes with ice pack, warmers, Bio mixers, Tube scale, Component separator if applicable, Thawing bath, Centrifuge and freezers are in adequate quantity	√		
6	Blood bank signage and schedule of charges are displayed	√		
7	Blood Bank Technician is present	√		
8	Nurse is present		√	
9	All sections have bilingual signage		√	
10	Separate counseling section is present		√	
PROCESS				
11	Is bilingual consent for blood donation available		√	
12	If patients are educated and given counseling.		√	
13	Donors are appropriately screened prior to blood donation.	√		A proper blood donation form with consent is followed
14	Evidence is present that blood is cross matched, labeled, recipient identified, compatibility level noted, units dispensed.	√		
15	Refrigerators, warmers and freezers must have temperature monitoring devices which are monitored daily	√		
16	A list of all department staff exist and is prominently displayed		√	
17	Is Policies and procedures for blood bank available		√	
18	Appropriate disposal of blood and blood products are done as per BMW management rules	√		
19	A blood collection/issue register exists.	√		

20	Is blood transfusion committee in existence		√	
21	Donated blood is labeled appropriately with adhesive labels.	√		
22	Register of all recipient adverse reactions to blood and blood products are maintained		√	
23	Data collected regarding recipient adverse reactions is collated, analyzed and reported to the blood transfusion committee.		√	
24	Work instructions are visibly displayed and prominent		√	
OUTCOME				
25	% of transfusion reactions		√	
26	% of blood and blood products wastage		√	Roughly Monitored in discard register
27	% of component usage		√	
28	Turnaround time for issue of blood and blood products.		√	Monitored but not calculated on monthly basis

PHARMACY

Checklist for Pharmacy				
Si. No	**Description**	**Yes**	**No**	**Remarks**
STRUCTURE				
1	The racks are available in sufficient number to store the items	√		
2	There is adequate ventilation and lighting in the department		√	

3	There is a security system available at the department		√	
4	Fire detecting & fire fighting systems are available at department	√		
5	There is no water seepage/ dampness	√		
6	All items storage areas are marked and labeled	√		
7	There is a receiving area; segregation and storing area		√	
8	Is refrigerator for storing medicines (2-8 degree C) available		√	Temperature monitor is not available
9	Is qualified and trained staff available	√		
10	Provision for storage of narcotic drugs (double lock and key system)		√	NA as Narcotic drugs are not being purchased/stored
PROCESS				
11	The items are labeled & arranged as per alphabetical order.		√	
12	Pest/rodent control measures are regularly under taken		√	
13	Is stock register maintained properly	√		
14	Verification of stock is done every six months.	√		Every month verification of stock is done
15	Is sound Inventory control practices followed (ABC, VED, FSN,FIFO)		√	
16	General items required by the hospital are purchased from vendors registered by management	√		

17	Is there a Drugs and therapeutics committee in the hospital?		√	
18	Is hospital drug formulary available	√		
19	Is adverse drug reactions are analyzed		√	
OUTCOME				
20	% of local purchase		√	
21	% of stock outs		√	
22	% of variation from the procurement process		√	Roughly monitored by CMS
23	% of goods rejected before GRN		√	

BIOMEDICAL WASTE MANAGEMENT

Checklist for Biomedical Waste Management				
Sl. No	**Check Points**	**Yes**	**No**	**Remarks**
STRUCTURE				
1	Availability of colour coded Foot operated Bins at point of BMW generation		√	Foot operated bins are not present
2	Availability of coloured plastic bags	√		
3	Display of work instructions at the point of segregation		√	
4	Is needle destroyer present	√		
5	Availability of PPE(Personal Protective Equipments) with biomedical waste handlers		√	
6	Availability of sodium hypochlorite solution and puncture proof boxes	√		
7	Availability of safe mode of transportation		√	
8	Is Temporary storage area available	√		

PROCESS				
9	Is segregation of BMW at point of generation		√	
10	Is the route for transportation of waste separate from the general traffic area	√		
11	Is there provision of regular health checkup for staff of this unit?		√	
12	Usage of PPE by staff is being practiced		√	
13	Is Annual report submitted to UP PCB		√	
14	Is monitoring done for the amount of BMW generated	√		

HOSPITAL INFECTION CONTROL

Checklist for HIC				
Sl. No.		**Yes**	**No**	**Remarks**
INFRASTRUCTURE				
1	A designated and qualified infection control nurse(s) is present?		√	
2	Adequate and appropriate facilities for hand hygiene in all patient care areas Provided?		√	
3	Are adequate and appropriate personal protective equipment, soaps, and disinfectants available?		√	
4	A designated infection control officer is present?		√	
PROCESS				
5	Does the hospital implements policies and/or procedures to prevent infection in these areas?		√	
6	Does the organization adhere to standard precautions at all times?		√	
7	Equipment cleaning, disinfection and sterilization practices as polices?		√	

8	An appropriate antibiotic policy is established and implemented?		√	
9	Hospital adheres to laundry and linen management processes?		√	
10	Hospital adheres to kitchen sanitation and food handling issues?		√	
11	Does the hospital have appropriate engineering controls to prevent infections?		√	
12	Does the hospital adhere to mortuary practices?		√	
13	Is the infection prevention and control programme updated at least once in a year?		√	
14	Is the HIC surveillance data collected regularly?		√	
15	Is the Verification of data done on a regular basis by the infection control team?		√	
16	In cases of notifiable diseases, information (in relevant format) is sent to appropriate authorities?		√	
17	Tracking and analyzing of infection risks, rates and trends		√	
18	Do the surveillance activities include monitoring of the effectiveness of housekeeping services?		√	
19	HAI rates monitored?		√	
20	Appropriate feedback regarding HAI rates provided on a regular basis to appropriate personnel?		√	
21	A hospital infection control committee and team are formed?		√	
22	Are the personal protective equipment used correctly by the staff?		√	
23	Compliance with hand hygiene guidelines monitored?		√	
24	Documented procedure for identifying an outbreak present?		√	
25	Implementation of laid down procedure done?		√	

26	Documented procedure guides the cleaning, packing, disinfection and/or sterilization, storing and issue of items?		√	
27	Isolation / barrier nursing facilities are available?		√	
28	Appropriate personal protective equipment used by the BMW handlers?		√	
29	Visit by the hospital authorities to the disposal site done and documented?	√		Not documented
30	Does the hospital makes available resources required for the infection control programme		√	
31	Does the organization earmarks adequate funds from its annual budget for infection control activities?		√	
32	Appropriate "in-service" training sessions for all staff at least once in a year conducted?		√	
33	Appropriate pre and post exposure prophylaxis is provided to all concerned staff members?		√	
OUTCOME				
34	UTI rate		√	
35	VAP rate		√	
36	SSI rate		√	
37	Central line associated blood stream infection rate		√	

TSSU

Checklist for TSSU				
SL.NO	**CHECK POINTS**	**Yes**	**No**	**Remarks**
STRUCTURE				
1	Is sufficient space available(0.75sq mts/bed)		√	
2	Does the layout follow the functional flow: Receiving, Washing, decontamination, drying, packing, loading, unloading, storing and issuing?		√	

3	Autoclaves are present?	√		Only one autoclave is functional in TSSU
4	Calibration of pressure meter of autoclave is done?		√	
5	Racks are present in the department?		√	
6	Technician is present in TSSU?		√	
7	Sterilizer drums are present?	√		
8	Is decontamination solution present?	√		
9	Transport trolley present for items?		√	
PROCES				
10	TSSU sterilization register present? (receipt/Issue)		√	
11	Labeling of drums in CSSD takes place?		√	
12	Is chemical, biological and bowie-dick test performed		√	
13	If recall system of items followed		√	
14	If reuse policy for items available		√	

BIOMEDICAL ENGINEERING

Audit Checklist for Biomedical Equipment Management: **Equipment, Medical Gases, Vacuum System etc.**				
Sl. No		**Yes**	**No**	**Remarks**
INFRASTRUCTURE				
1	Does bio medical engineering department exist		√	

2	Does the department is managed by a qualified person		√	
3	Is Central supply system for bio medical gases exist		√	
4	Is Safety devices available		√	
5	Is the department manned by 24 hours		√	
PROCESS				
6	Preventive maintenance and calibration		√	Calibration of Pathology Department's equipment is done
7	Review of Preventive Maintenance record as per checklist like Anesthesia ventilator, IABP etc.		√	
8	Traceability of calibration report		√	
9	Is there a documented procedure for equipment replacement and disposal?		√	
10	Equipments are inventoried and proper logs are maintained as required.		√	
11	Training of staff when new equipment is installed (HRM 3b)		√	
12	Documented Preventive and breakdown maintenance plans			
13	Color coding of pipelines		√	NA as Medical gas pipeline system is not present
OUTCOME				
14	% of downtime of critical equipments		√	

ENGINEERING AND MAINTENANCE

Checklist for Facility Management: Engineering and Maintenance				
SR. No	**Check points**	**Yes**	**No**	**Remarks**
	STRUCTURE			
1	Various statutory requirements		√	
	o Fire			
	o Diesel storage			
	o Liquid oxygen and storage of medical cylinders.			
	o Boiler			
	o Lift			
	o Water (ETP/STP)			
	o Air (DG sets)			
2	Up to date drawing, layout, escape route present and displayed?		√	
3	Various required signage's displayed?	√		Non sufficient
4	Designated individual for maintenance present?		√	
5	Presence of staff round the clock for emergency repairs		√	
6	Alternative source of water and electricity		√	
7	Availability of (personnel) safety devices		√	
8	Availability of safety devices (Fire extinguishers, smoke detectors, sprinklers, grab bars, side rails, nurse CCTV, ALARMS ETC)		√	Fire extinguishers present in some

				areas; cost estimation for implementation of new fire extinguishers is done
PROCESS				
9	Mechanism for renewing licenses		√	
10	Preventive and break down maintenance plan implemented?		√	
11	Alternate sources and their checking done?		√	
12	Response time monitored?			
13	Water quality reports		√	
14	Are staff using safety devices	√		Not in all the areas
15	Facility inspection rounds twice a year in patient care areas and once in non-patient care areas		√	
16	Documentation of facility inspection report		√	
17	Safety education program for all staff	√		On yearly basis by the State Government
18	Is safety committee present		√	
19	Is staff trained for disaster management and fire management		√	

20	Are the mock drills conducted at periodic intervals and documented		√	
OUTCOME				
21	Number of variations observed during mock drills		√	

STORE

No separate/centralized store is present in the Hospital

HUMAN RESOURCE

Not Applicable (There is no such dedicated department present in the Hospital)

MEDICAL RECORDS DEPARTMENT

CHECKLIST FOR MEDICAL RECORDS DEPARTMENT				
S. No.	**Check Points**	**Yes**	**No**	**Remarks**
STRUCTURE				
1	Is the sufficient space for medical record department available		√	
2	Is proper ventilation present in the department		√	
3	Is the fire fighting system available in the unit		√	
4	Is qualified and trained MRD technician available in the department		√	
5	Is table and chair provided to the MRD technician		√	
6	Is adequate number of racks available for the storage of records		√	

PROCESS				
7	Is the functional flow at MRD : Receiving, assembling, deficiency check, coding, indexing , filing, issuing		√	
8	Is ICD coding method used for complete and incomplete files		√	
9	Are the MLC cases/dead cases stored separately under lock and key	√		Not kept under lock and key
10	Is the retrieval of the records easy			
11	Is deficiency checklist is followed		√	
12	Is MRD Committee available?		√	
13	MRD audits is being conducted		√	
14	Are the records kept under lock		√	
15	If the hospital has retention policy for documents		√	
16	Are the forms and formats standardized		√	
17	Is the destruction policy for records available		√	
18	Is pest control done on a regular basis		√	
OUTCOME				
19	Is number of births/deaths monitored	√		

20	Is number of diseases notified to the local authority		√	
21	% of missing records		√	
22	% of records with ICD codification done		√	
23	Percentage of medical records not having discharge summary		√	
24	Percentage of medical records not having consent form		√	

HOUSEKEEPING

Checklist for Housekeeping Department				
Name of the Hospital:				
S. No.	**Check Points**	**Yes**	**No**	**Remarks**
	STRUCTURE			
1	Does the housekeeping being provided with the personal protective equipment(dedicated gown/slippers/masks/gloves/head cover)		√	Slippers, masks and gloves only and not in adequate amount
2	Does the housekeeping staff have basic facilities like (toilet/drinking water/change room)	√		Change room is not available
3	Are the hand washing and floor washing agent being used?	√		Soap is used for hand washing
4	Is the house keeping staff being trained in the infection control practices		√	
5	Is staff using PPE	√		Partially
6	Is daily cleaning schedule available	√		3 times a day

7	Are the staff aware about the preparation of cleaning solutions	√		
8	Is the pest control methods being practiced		√	
9	Is the medical examination of staff being done periodically		√	

SECURITY

Security Services is not available in the Hospital which is required to be outsourced

MORTUARY

Checklist for Mortuary				
Sl. No.	**Check Points**	**Yes**	**No**	**Remarks**
STRUCTURE				
1	Is this unit present in the hospital?	√		
2	Is freezer available for dead bodies		√	
3	Is calibration and maintenance is done regularly		√	NA as no any machine/s is/are not kept in the department
4	Cold storage and back-up power available?		√	
5	Are measures for fire detection/fire fighting installed in this unit?		√	
PROCESS				
6	Is temperature being regularly monitored		√	NA as no any machine/s is/are not kept in the department

7	Is there any process of infection control followed		√	

SCORE SHEET

SELF ASSESSMENT TOOLKIT					
Elements					**Scores**
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
					3.33
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.			10
	e	The documented policies andprocedures also address managing patients during non-availability of beds.			0
	f	The staff is aware of these processes.			0
					1.66
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	0
	e	The organization gives a summary of patient's condition and the treatment given	10
			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	5
	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	0
	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.	0
	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.	5
	j	The plan of care includes goals or desired results of the treatment, care or service	0
			1.5
AAC.5: Patients cared for by the organization undergo a regular reassessment			
	a	Patients are reassessed at appropriate intervals.	10
	b	Out-patients are informed of their next follow up where appropriate.	10
	c	For in-patients during reassessment the plan of care is monitored and modified where found necessary.	10
	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.	10
			9

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.	10
	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.	10
	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.	10
	f	Critical results are intimated immediately to the concerned personnel.	10
	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
			6.25
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
			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.	10
	e	Laboratory personnel are provided with appropriate safety equipment / devices.	10

					4
AAC.9: Imaging services are provided as per the scope of services of the organization.					
	a	Imaging services comply with legal and other requirements.			0
	b	Scope of the imaging services are commensurate to the services provided by the organization.			10
	c	The infrastructure (physical and manpower) is adequate to provide for its defined scope of services.			10
	d	Adequately qualified and trained personnel perform, supervise and interpret the investigations.			10
	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.			0
	g	Critical results are intimated immediately to the concerned personnel.			10
	h	Results are reported in a standardized manner.			10
	i	Imaging tests not available in the organization are outsourced to organization(s) based on their quality assurance system.			0
					5.55
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
					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 materials is as per statutory requirements.			NA
	d	Imaging personnel are provided with appropriate radiation safety devices.			0

	e	Radiation safety devices are periodically tested and results documented.			0
	f	Imaging personnel are trained in radiation safety measures.			0
	g	Imaging signage are prominently displayed in all appropriate locations.			5
					0.83
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.			
	C	Information about the patient's care and response to treatment is shared among medical, nursing and other care providers.			0
	D	Information is exchanged and documented during each staffing shift, between shifts, and during transfers between units/departments.			0
	E	Transfers between departments/units are done in a safe manner.			10
	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
					4.16
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.			
	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).			0
					0
AAC.14: Organization defines the content of the discharge summary.					
	a	Discharge summary is provided to the patients at the time of discharge.			10
	b	Discharge summary contains the patient's name, unique identification number, date of admission and date of discharge.			10
	c	Discharge summary contains the reasons for admission, significant findings and diagnosis and the patient's condition at the time of discharge.			10

	d	Discharge summary contains information regarding investigation results, any procedure performed, medication administered and other treatment given.			10
	e	Discharge summary contains follow up advice, medication and other instructions in an understandable manner.			10
	f	Discharge summary incorporates instructions about when and how to obtain urgent care.			10
	g	In case of death, the summary of the case also includes the cause of death.			10
					10
	SCORE OF CHAPTER - 01				3.45
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.			0
					2.5
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.			
	c	The patients receive care in consonance with the policies.			5
	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.			5
	f	Admission or discharge to home or transfer to another organization is also documented.			0
	g	In case of discharge to home or transfer to another organization a discharge note shall be given to the patient.			10
					3.33

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).			0
	b	The ambulance adheres to statutory requirements.			5
	c	Ambulance(s) is appropriately equipped.			5
	d	Ambulance(s) is manned by trained personnel.			0
	e	Ambulance (s) is checked on a daily basis.			0
	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.			0
	h	The ambulance(s) has a proper communication system.			5
					1.87
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 careare 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 doneby a multidisciplinary committee.			0
	e	Corrective and preventive measures are taken based on the post-event analysis.			0
					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.			0
	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.			0
					2.14
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.			5
	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.			10
	g	Procedures are documented accurately in the patient record.			0
					3.57
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.			0
	d	Informed consent is obtained for donation and transfusion of blood and blood products.			0
	e	Informed consent also includes patient and family education about donation.			0
	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 analysed for preventive and corrective actions.			0
	h	Staff are trained to implement the policies.			0
					0
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 are trained to apply these criteria.			0
	d	Adequate staff and equipment are available.			10
	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
					1.42
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.			0
	d	A documented procedure exists for obtaining informed consent from the appropriate legal representative.			0
	e	Staff are trained to care for this vulnerable group.			0
					0
COP.10: Documented policies and procedures guide obstetric care.					NA
	a	There is a documented policy and procedure for obstetric services.			
	b	The organization defines and displays whether high risk obstetric cases can be cared for or not.			
	c	Persons caring for high risk obstetric cases are competent.			
	d	Documented procedures guide provision of ante-natal services.			0
	e	Obstetric patient's assessment also includes maternal nutrition.			
	f	Appropriate pre-natal, peri-natal and post-natal monitoring is performed and documented.			
	g	The organization caring for high risk obstetric cases has the facilities to take care of neonates of such cases.			

					0
COP.11: Documented policies and procedures guide paediatric services.					
	a	There is a documented policy and procedure for paediatric services.			0
	b	The organization defines and displays the scope of its paediatric 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.			0
	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
					0
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.			10
	c	Competent and trained persons perform sedation.			10
	d	The person administering and monitoring sedation is different from the person performing the procedure.			10
	e	Intra-procedure monitoring includes at a minimum the heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation, and level of sedation.			0
	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 managepatients who have gone intoa deeper level of sedation than initially intended.			0
					3.75

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.	10
	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.	10
	f	During anaesthesia monitoring includes regular recording of temperature, heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation and end tidal carbon dioxide.	10
	g	Patient's post-anaesthesia status is monitored and documented.	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.	0
	j	Procedures shall comply with infection control guidelines to prevent cross infection between patients.	0
	k	Adverse anaesthesia events are recorded and monitored.	0
			2.72
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.	0
	c	An informed consent is obtained by a surgeon prior to the procedure.	0
	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.	5
	g	The operating surgeon documents the post-operative plan of care.	0

	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
					2.27
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.			0
	e	Staff receive training and periodic updating in control and restraint techniques.			0
					0
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
					0
COP.17: Documented policies andprocedures guideappropriate rehabilitative services.					
	a	Documented policies and procedures guide the provision of rehabilitative services.			0
	b	These services are commensurate with the organizational requirements.			10

	c	Care is guided by functional assessment and periodic re-assessment which is done and documented by qualified individual (s).			0
	d	Care is provided adhering to infection control and safe practices.			10
	e	Rehabilitative services are provided by a multidisciplinary team.			10
	f	There is adequate space and equipment to perform these activities.			10
					6.66
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.			NA
	b	The organization has an ethics committee to oversee all research activities.			NA
	c	The committee has the powers to discontinue a research trial when risks outweigh the potential benefits.			NA
	d	Patient's informed consent is obtained before entering them in research protocols.			NA
	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.			NA
	f	Patients are assured that their refusal to participate or withdrawal from participation will not compromise their access to the organization's services.			NA
					NA
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	hen 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
					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
					0
	SCORE OF CHAPTER - 02				1.59
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
					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.			0
	b	The list is developed and updated collaboratively by the multidisciplinary committee.			0
	c	The formulary is available for clinicians to refer and adhere to.			0
	d	There is a defined process for acquisition of these medications			0
	e	There is a process to obtain medications not listed in the formulary.			0
					0

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).			0
	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.			10
	g	Emergency medications are replenished in a timely manner when used.			10
					3.57
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.*			0
	f	Orders are written in a uniform location in the medical records.			10
	g	Medication orders are clear, legible, dated, timed, named and signed.			0
	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
					1.25
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.			10
	d	There is a procedure for near expiry medications.			5
	e	Labelling requirements are documented and implemented by the organization.			5
	f	High risk medication orders are verified prior to dispensing.			10
					5
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.			10
	b	Prepared medication is labelled 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.			0
	e	Dosage is verified from the order prior to administration.			0
	f	Route is verified from the order prior to administration.			0
	g	Timing is verified from the order prior to administration.			0
	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
					1

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
					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 analysed.			0
	e	Corrective and/or preventive action (s) is taken based on the analysis where appropriate.			0
					0
MOM.9: Documented procedures guide the use of narcotic drugs and psychotropic substances.					NA
	a	Documented procedures guide the use of narcotic drugs and psychotropic substances which are in consonance with local and national regulations.			
	b	These drugs are stored in a secure manner.			
	c	A proper record is kept of the usage, administration and disposal of these drugs.			
	d	These drugs are handled by appropriate personnel in accordance with the documented procedure.			
					NA
MOM.10: Documented policies and procedures guide the usage of chemotherapeutic agents.					NA
	a	Documented policies and procedures guide the usage of chemotherapeutic agents.			

	b	Chemotherapy is prescribed by those who have the knowledge to monitor and treat the adverse effect of chemotherapy.			
	c	Chemotherapy is prepared in a proper and safe manner and administered by qualified personnel.			
	d	Chemotherapy drugs are disposed off in accordance with legal requirements.			
					NA
MOM.11: Documented policies and procedures govern usage of radioactive drugs.					NA
	a	Documented policies and procedures govern usage of radioactive drugs.			
	b	These policies and procedures are in consonance with laws and regulations.			
	c	The policies and procedures include the safe storage, preparation, handling, distribution and disposal of radioactive drugs.			
	d	Staff, patients and visitors are educated on safety precautions.			
					NA
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.			0
	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
					0
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.			0
	b	Medical supplies and consumables are used in a safe manner where appropriate.			0
	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
			1.25
	SCORE OF CHAPTER - 03		1.45
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.	0
	d	Staff is aware of their responsibility in protecting patient and family rights.	0
	e	Violation of patient and family rights is recorded, reviewed and corrective / preventive measures taken.	0
			0
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.	0
	b	Patient and family rights include respect for personal dignity and privacy during examination, procedures and treatment.	0
	c	Patient and family rights include protection from physical abuse or neglect.	0
	d	Patient and family rights include treating patient information as confidential.	0
	e	Patient and family rights include refusal of treatment.	0
	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.	0
	g	Patient and family rights include right to complain and information on how to voice a complaint.	0
	h	Patient and family rights include information on the expected cost of the treatment.	0
	i	Patient and family rights include access to his / her clinical records.	0

	j	Patient and family rights include information on plan of care, progress and information on their health care needs.			0
					0
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.			0
	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.			10
	f	The patient and/or family members are informed about the results of diagnostic tests and the diagnosis			10
	g	g. The patient and/or family members are explained about any change in the patient's condition.			10
					5.71
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.			10
	e	The procedure describes who can give consent when patient is incapable of independent decision making.			10
	f	Informed consent is taken by the person performing the procedure.			10
	g	Informed consent process adheres to statutory norms.			0
	h	Staff are aware of the informed consent procedure.			10
					5

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.			10
	b	Patient and/or family are educated about food-drug interactions.			0
	c	Patient and/or family are educated about diet and nutrition.			0
	d	Patient and/or family are educated about immunizations.			10
	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.			10
	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
					5
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).			NA
	b	The tariff list is available to patients.			10
	c	The patient and/or family members are explained about the expected costs.			10
	d	Patient and/or family are informed about the financial implications when there is a change in the patient condition or treatment setting.			0
					6.66
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 analysed.			0
	d	Corrective and/or preventive action (s) is taken based on the analysis where appropriate.			0
					0
	SCORE OF CHAPTER - 04				3.2

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
					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.			5
	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.			0
	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
					2.27

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
					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
					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.			5
	c	Isolation / barrier nursing facilities are available.			0
	d	Appropriate pre and post exposure prophylaxis is provided to all concerned staff members.			0
					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
			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.	0
	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.	10
	d	Regular validation tests for sterilizationare carried out and documented.	0
	e	There is an established recall procedure when breakdown in the sterilization system is identified.	0
			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.	10
	d	Biomedical waste treatment facility is managed as per statutory provisions (if in-house) or outsourced to authorised contractor(s).	10
	e	Appropriate personal protective measures are used by all categories of staff handling biomedical waste.	10
			8
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
			0
	SCORE OF CHAPTER - 05		1.64
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
			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
			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.	0
	g	Monitoring includes infection control activities.	0
	h	Monitoring includes review of mortality and morbidity indicators.	0
	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
			0
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.	0
	b	Monitoring includes risk management.	0
	c	Monitoring includes utilisation of space, manpower and equipment.	0
	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
			0
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
			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
			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.	0
	d	Corrective and preventive actions are taken based on the findings of such analysis.	0
	e	Feedback about care and service is communicated to staff.	0
			0
CQI.8: Sentinel events areintensively 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.	0
	d	Corrective and Preventive Actions are taken based on the findings of such analysis.	0
			0
	SCORE OF CHAPTER - 06		0
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.	5
	e	Those responsible for governance appoint the senior leaders in the organization.	0
	f	Those responsible for governance support safety initiatives and quality improvement plans.	0
	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.			5
					1.66
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.			0
	b	The management ensures implementation of these requirements.			0
	c	Management regularly updates any amendments in the prevailing laws of the land.			5
	d	There is a mechanism to regularly update licenses/ registrations/certifications.			10
					3.75
ROM.3: The services provided by each department are documented.					
	a	Scope of services of each department is defined			5
	b	Administrative policies and procedures for each department are maintained.			0
	c	Each organizational programme, service, site or department has effective leadership.			5
	d	Departmental leaders are involved in quality improvement.			5
					3.75
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.			5
	c	The organization discloses its ownership.			5
	d	The organization honestly portrays the services which it can and cannot provide.			5
	e	The organization honestly portrays its affiliations and accreditations.			5
	f	The organization accurately bills for its services based upon a standard billing tariff.			10
					5
ROM.5: The organization displays professionalism in management of affairs.					

	a	The person heading the organization has requisite and appropriate administrative qualifications.	10
	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.	5
	k	The organization monitors the quality of the outsourced services.	5
			3.18
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
			0
	SCORE OF CHAPTER - 07		2.89
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.			5
	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.			0
	f	There is a safety education programme for staff.			0
					0.83
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.			5
	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.			10
	f	Alternate sources for electricity and water are provided as backup for any failure / shortage.			10
	g	The organization regularly tests these alternate sources.			0
	h	There are designated individuals responsible for the maintenance of all the facilities.			10
	i	iThere is a documented operational and maintenance (preventive and breakdown) plan.			0
	j	Maintenance staff is contactable round the clock for emergency repairs.			10
	k	Response times are monitored from reporting to inspection and implementation of corrective actions.			0
					4.54
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.			0

	c	Equipment are inventoried and proper logs are maintained as required.	0
	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
			0.55
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
			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
					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
					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
					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
					0

	SCORE OF CHAPTER - 08		0.74
Chapter 9: Human Resource Management (HRM)			
HRM.1. The organization has a documented system of human resource planning.			
	a	uma n resource planning supports the organization's current and future ability to meet the care, treatment and service needs of the patient.	5
	b	The organization maintains an adequate number and mix of staff to meet the care, treatment and service needs of the patient.	5
	c	The required job specification and job description are well defined for each category of staff.	5
	d	The organization verifies the antecedents of the potential employee with regards to criminal/negligence background.	5
			5
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	0
	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
			0
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.			5
	d	Feedback mechanisms for assessment of training and development programme exist and the feedback is used to improve the training programme.			0
					1.25
HRM.4. Staff are adequately trained on various safety related aspects.					
	a	Staff are 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 are trained on occupational safety aspects.			0
					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.			5
	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
					1
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
			0
HRM.7. The organization addresses the health needs of the employees.			
	a	A pre-employment medical examination is conducted on all the employees.	0
	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
			0
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
			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 are identified.	0
	b	The education, registration, training and experience of the identified medical professionals is documented and updated periodically.	5
	c	All such information pertaining to the medical professionals is appropriately verified when possible.	5
	d	Medical professionals are granted privileges to admit and care for patients in consonance with their qualification, training, experience and registration.	5
	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.			5
					4.16
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.			5
	c	All such information pertaining to the nursing staff is appropriately verified when possible.			5
	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.			5
	f	Nursing professionals care for patients as per their privileging.			5
					5
	SCORE OF CHAPTER - 09				1.89
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
					0
IMS.2. The organization has processes in place for effective management of data.					
	a	Formats for data collection are standardized.			0

	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
			0
IMS.3. The organization has a complete and accurate medical record for every patient.			
	a	Every medical record has a unique identifier.	0
	b	Organization policy identifies those authorized to make entries in medical record.	0
	c	Entry in the medical record is named, signed, dated and timed.	5
	d	The author of the entry can be identified.	0
	e	The contents of medical record are identified and documented.	0
	f	The record provides a complete, up-to-date and chronological account of patient care.	0
	g	Provision is made for 24-hour availability of the patient's record to healthcare providers to ensure continuity of care.	10
			2.14
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.	10
	c	Operative and other procedures performed are incorporated in the medical record.	10
	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.	5
	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.	10
	g	Whenever a clinical autopsy is carried out, the medical record contains a copy of the report of the same.	10
	h	Care providers have access to current and past medical record.	10

					7.5
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
					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.			5
					1.25
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
			0
		SCORE OF CHAPTER - 10	1.55
		TOTAL SCORE OF ALL CHAPTERS	1.84