Gap Analysis of EHCC Hospital as Per the NABH Standards

Internship Training
at
Eternal Heart Care Centre (EHCC) Hospital, Jaipur

By

Surbhi Deo Gupta

Under the guidance of
Brig. (Dr.) S.K. Puri

Post Graduate Diploma in Hospital & Health Management
2012–14

Institute of Health Management Research
Jaipur
2014

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TO WHOMSOEVER MAY CONCERN

This is to certify that **Surbhi Deo Gupta**, student of Post Graduate Diploma in Hospital and Health Management (PGDHM) from Institute of Health Management Research, Jaipur has undergone dissertation at Eternal Heart Care Centre from February 2014 to April 2014.

The candidate has successfully carried out the study designated to her during dissertation and her approach to the study has been sincere, scientific and analytical.

The internship is in fulfillment of the course requirements.

I wish her all success in all her future endeavors.

Dr. Ashok Kaushik
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May 17th, 2014

TO WHOMSOEVER IT MAY CONCERN

This is to certify that Dr. Surbhi Deo Gupta, student of Institute of Health Management Research (IIHMR), Jaipur has successfully completed her internship from February, 2014 to April, 2014 in the department of Quality Management of Eternal Heart Care Centre (EHCC), Jaipur, under the able guidance of Dr.Vikram Singh Chouhan (Head- Medical Operations) & Dr. Swati Guglani (Deputy Medical Superintendent).

Apart from the general understanding of the hospital, she has worked on the following aspects of the hospital:

1. Documentation of Hospital Policies & SOP formulation
2. Facilitating the NABH application procedure
3. Designing packages for orthopedic joint replacement procedures

During this period, she was found to be a hardworking, pleasant, & sincere student. She has completed her project entirely to the satisfaction of the hospital's management.

We wish her all the best for her future endeavors.

Eternal Heartcare Centre & Research Institute JAIPUR

Amitav Naresh
Head -HR

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CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **'Gap analysis as per NABH Standards" for EHCC Hospital-** submitted by '**Surbhi Deo Gupta**". Under the supervision of **Brig. (Dr.) S. K. Puri** for award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the period from February 2014 to 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

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ACKNOWLEDGEMENT

The success of any task would be incomplete without the expression of appreciation of gratitude to the people who made it possible .Though words fall short to express the sincere gratitude towards everyone who helped directly or indirectly in my endeavor. It is a pleasant aspect that I now have the opportunity to express my gratitude for all of them. This is a humble attempt in this regard. I would like to render my sincere thanks to **Eternal Heart Care Centre (EHCC) Hospital**, Jaipur for providing me with such unique learning experience.

I convey my deep and sincere thanks to **Dr. Ashok Kaushik** (Dean Academic and Student Affairs) and My Mentor, **Brig. (Dr.) S. K. Puri** for being helpful, supportive and receptive.

Most importantly I would like to thank my Hospital mentor **Dr. Vikram Singh Chouhan**, (Head- Medical Operations) for his advice and encouragement, to question and take responsibilities, for his precious time and instructions support, guidance and motivation throughout the study period. I would also like to extent my sincere thanks to **Dr. Avinash Mishra**, Medical Director for his constant motivation and appreciation throughout the study period.

I am highly grateful to the departmental head of Orthopedics **Dr. Aditya Soral**, and Billing Incharge **Mr. A.K.Jain** for giving me valuable insights for understanding and designing the orthopedic packages.

My earnest thanks to **Dr. Swati Guglani**, Deputy Medical Superintendant, under whose constant support and guidance this project was carried out. Her zealous approach towards the profession would inspire me for times to come. It would not have been possible to understand the quality aspects of the hospital & the NABH accreditation procedure to the extent as I have now. It has been my privilege to work under her dynamic supervision in the hospital. Without her co-operation and warm attitude this project would have been a distant dream.

ABBREVIATIONS

NABH - National Accreditation Board for Hospitals and Healthcare Providers

EHCC – Eternal Heart Care Center

SWOT – Strength Weakness Opportunity & Threats

AAC – Access, Assessment and Continuity of Care

COP – Care of Patients

MOM – Management of Medication

PRE – Patient Rights and Responsibility

HIC – Hospital Infection Control

CQI – Continuous Quality Improvement

ROM – Responsibility of Management

FMS – Facility Management and Safety

HRM – Human Resource Management

IMS – Information Management System

SOPs – Standard Operating Procedures

LIST OF FIGURES

DISSERTATION REPORT

EXECUTIVE SUMMARY:

The budding healthcare sector is progressing towards a full bloom in the wake of the rising demand for its services. With numerous small and large scale healthcare delivery systems coming up, a major concern for the quality of the services delivered has arisen. Owing to increased preference for quality services the hospitals are forced to scale up the quality of the facilities provided.

Quality is the key determinant of success of an organization as it wins credibility, enhances customer satisfaction and last but not least decreases the overall operational costs in the long term. The step towards this quality achievement is accreditation.

Accreditation is soon becoming a necessity with the central and state governments taking a lot of interest in quality of care and delivering uniformity in the healthcare delivery channels. A few factors which have made it compulsory are as follows:

- Present day need for quality in a hospital due to dependency on insurance
- Compulsion from government to be recognized by NABH to be a part of CGHS program
- More and more amount of educated population demanding quality healthcare
- Physicians mind set to work in an organized sector.

Although EHCC is a newly commissioned oraganisation, it decided to walk the road to accreditation keeping in mind the above enlisted factors. EHCC is a 225 bedded hospital with state of art facilities and a pioneer cardiac team. The first step towards this is the gap analysis as per the NABH standards. This gap analysis was done from Feb 2014 to April 2014.

Gap analysis refers to a study where hospital compares the present policy, procedure, documentation as per the defined laid down standards of the accreditation body.

The gap analysis was done using following tools and techniques:

- Personal observation.
- Interviews of the staff and authorities (like nursing staff, hospital administrator, medical director etc) with the help of a Questionnaire.
- Self assessment toolkit as given by NABH.
- Review of Hospital registers & records and NABH document for hospital standards.

The compliances, partial compliances and non compliances were recorded as per the given standards. The major non – compliance as observed was due to lack of documented policies and procedures and lack of apex and departmental manuals. A major gap regarding training and orientation of the staff was observed. Partial compliances for signage standards and legal compliances were also an observation.

It was thus suggested that the partial compliance be converted to compliance and various clinical and non – clinical departments enumerate their policy, procedures, SOPs and training requirements. The hospital must formulate the apex manual and approve the departmental manuals and put in force as soon as possible.

INTRODUCTION:

The budding healthcare sector is progressing towards a full bloom in the wake of the rising demand for its services. With numerous small and large scale healthcare delivery systems coming up, a major concern for the quality of the services delivered has arisen. The consumers of these services are becoming increasingly aware and quality oriented and do not hesitate to pay a little extra for better facilities offered. Owing to their increased preference for quality services the hospitals are forced to scale up the quality of the facilities provided. In order to achieve a standard delivery of care throughout the healthcare delivery institutions for the benefit of the patients, a quality council of India was established in 2006. It is set up to establish and operate accreditation program for healthcare organizations. The board while being supported by all stakeholders including industry, consumers, government and has a fully functional autonomy in its operation.

ACCREDITATION:

Accreditation is a process by which professionals establish criteria and supply them to the institutions under considerations so as to provide assurance that these institutions are meeting their goals and objectives in the interest of the society which they serve. In health services, accreditation is defined as "a system which encourages professional participation from within the institution but is subject to external and objective control". It eventually means professional and national recognition reserved for facilities that provide high quality healthcare. Generally, accreditation is a form of review which meets two conditions: the measuring of performance against external standards; that this is undertaken on a voluntary basis.

In majority of the countries, quality of care provided by the health care delivery system has become the focus. Since quality is a crucial factor in health care, initiatives to address quality of health care have become world-wide phenomena. Many countries are exploring various means & methods to improve the quality of health care services.

HOSPITAL ACCREDITATION:

Hospital Accreditation is a public recognition by a National Healthcare Accreditation Body, of the achievement of accreditation standards by a Healthcare Organization, demonstrated through an independent external peer assessment of that organization's level of performance in relation to the standards.

In India, Health System currently operates within an environment of rapid social, economical and technical changes. Such changes raise the concern for the quality of health care. Hospital is an integral part of health care system. Accreditation would be the single most important approach for improving the quality of hospitals. Accreditation is an incentive to improve capacity of national hospitals to provide quality of care. National accreditation system for hospitals ensures that hospitals, whether public or private, national or expatriate, play their expected roles in national health system. Confidence in accreditation is obtained by a

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

NATIONAL ACCREDITATION BOARD FOR HOSPITAL

National Accreditation Board for Hospital & Healthcare Providers (NABH) is a constituent board of Quality Council of India set up to establish and operate accreditation program for healthcare organizations. The board is structured to cater to much desired needs of the consumers and to set benchmarks for progress of health industry. The board while being supported by all stakeholders including industry, consumers, government, has full functional autonomy in its operation.

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BENEFITS OF NABH ACCREDITATION:

NABH accreditation benefits all key stakeholders.

It benefits patients by ensuring:

- High quality of care and safety
- Services by credential staff
- Rights of patients are respected and protected
- Regular evaluation of patient satisfaction

It ensures staff satisfaction by:

- Providing continuous learning
- Good working environment
- Providing ownership of clinical processes
- Good leadership

It also enables hospital:

- In demonstrating commitment towards quality of care
- In enhancing community confidence in the services provided by the hospital
- An opportunity to benchmark with the best

It also provides:

- Access to reliable and certified information on facilities, infrastructure and level of care
- An improvement in risk management and risk reduction
- Recognition from insurers and other third parties
- Reduction in liability insurance costs by enhancing risk management efforts

NABH ASSESSMENT METHOD: NABH has on its panel, qualified and trained personnel as assessors for objective evaluation of hospitals. The assessment is usually a two step procedure which includes:

- Pre – assessment or the initial assessment
- Final assessment

Pre-Assessment:
NABH appoints a Principal Assessor/ Assessment Team who is responsible for pre assessment of healthcare organization. NABH forwards the application form, documents, procedures, Self assessment toolkit to the Principal Assessor/ Assessment Team.

- **Objective of Pre-assessment:**
  - Check the preparedness of the hospital for final assessment
  - Review the scope of accreditation and ascertain the requirement of the number of assessors and the duration of the accreditation
  - Review of the documentation system of the hospital
  - Explain the methodology to be adopted for assessment.
  -

The Principal assessor shall submit a pre-assessment report in the format specified in the document 'Pre-Assessment Guidelines & Forms'. Copy of the report is handed over to the organization after the assessment and original sent to NABH Secretariat.
The hospital shall be required to pay the requisite Annual fee before the final assessment.

Final Assessment:
The hospital is required to take necessary corrective action to the nonconformities pointed out during the pre-assessment. The final assessment involves comprehensive review of hospital functions and services. NABH shall appoint an assessment team. The team shall include Principal assessor (already appointed) and the assessors. The total number of assessors appointed shall depend on the number of beds and services provided. The date of final assessment shall be agreed upon by the hospital management and assessors. Assessment shall be conducted on hospital's department and services. Based on the assessment by the assessors, the assessment report is prepared by the Principal assessor in a format prescribed by NABH. The report is taken to the accreditation committee. Depending on the score and compliance to standards it would decided the award of accreditation

Ten steps to NABH Accreditation:

1. Obtaining a copy of NABH Standards
2. Carrying out self assessment on status of compliance with the NABH standards
3. Identifying the gap areas and bridging the gaps by the help of a proper action plan
4. Ensuring implementation and integration of NABH standards with the hospital functioning
5. Submission of application form for assessment

6. Payment o accreditation fees
7. Receiving the assessment programme including dates and names of the assessors
8. Facilitating the assessment
9. Receiving recommendations on accreditation
10. Maintaining quality improvement programme based on continuous monitoring of patient care services

REVIEW OF LITERATURE:

The Indian healthcare landscape is rapidly changing as it is gradually moving from a non – systematic to highly systematized healthcare delivery channels where utmost importance is given to the quality of care and safety of the patients. Concerns about how to improve health care quality have been frequently raised by the general public and a wide variety of stakeholders, including government, professional associations, private providers and agencies financing health care. Their attempts to establish systems and process ensure quality of care by the health providers. Many state governments are in the process or have drafted legislations that incorporate standards for private institutional healthcare providers.

The patients, to whom this huge market caters, are becoming more and more aware of the quality issues related to care and have grown increasingly demanding in terms of quality of services rendered to them. Here we observe a paradigm shift in the healthcare industry as the hospitals as opposed to their previous orthodox views, strive to satisfy their customers in all possible ways and regularly find ways to delight them. They have started following the footsteps of other markets and have now come to accept that it is better and cheaper to retain an old customer rather than getting new customers all the time.

In today's world of excellence maintaining the quality of the health services delivered and their continuous quality improvement is the key to retain the patients. Here steps in the accreditation. The standardization of the healthcare services is thus the first step towards this journey. More and more hospitals have come forward with a lot of interest and eagerness to adapt to the standardization framework. The industry has welcomed this change for a better scenario in the future. It is now become statement of fact and accepted by the industry as well as the society that a hospital that has gone through NABH evaluation shows an extraordinary commitment to provide safe, high quality care and a willingness to be measured against the highest standards of performance.

It has been substantiated by numerous studies that standardization and accreditation leads to better quality patient focused healthcare delivery.

In a study "**The Private Health Sector in India: A Framework for Improving the Quality of Care",** by P H Rao 1
– "The technical quality of care depends on the competence of the personnel involved and adherence to clinical protocols and standard treatment guidelines. While the

accredited hospitals ensure both, in the case of non-accredited private hospitals, technical quality of care is suspect."

"The Value and Impact of Health Care Accreditation: A Literature Review" by Wendy Nicklin2 -
"Accreditation can serve as a risk mitigation strategy, and it can also measure performance; it provides key stakeholders with an unbiased, objective, and third-party review. Accreditation organizations are uniquely positioned to provide a comprehensive look at the challenges and successes of health care organizations, and to identify themes and trends in the delivery of health care services. This performance measure contributes to the sustainability of the health care system"
According to a study by **Chen, Rathore, Radford & Krumholz3, 2003** - the accredited hospitals performed better on a range of quality indicators than did non-accredited hospitals, albeit that there was considerable variation of performance within the accredited hospitals. It stimulates sustainable quality improvement efforts and continuously raises the bar with regard to quality improvement initiatives, policies, and processes.
According to **Karen H Timmons**[4], accreditation is recognised as a framework to integrate a quality management system while reducing risk, and requires a systematic assessment of hospitals against explicit standards

In her study **Joint Commission Accreditation and the Quality of Patient Care in Hospitals,** Entinger Melisa A5, stated that "accredited hospitals significantly improved their performance more than non-accredited hospitals did for 13 of the 16 processes of care that they focused on."

A systematic review **Advantages and Disadvantages of Health Care Accreditation Models** by
Jafar S. Tabrizi, Farid Gharibi, Andrew J. Wilson6 was done in order to recommend the best model for accreditation based on the attributes of accreditation for the hospitals. These attributes were: quality improvement, patient and staff safety, improving health services integration, public's confidence, effectiveness and efficiency of health services, innovation, influence global standards, information management, breadth of activity, history, effective relationship with stakeholders. This gives a clear picture of the parameters that hold a direct relationship to the quality of healthcare delivered.
Accreditation is soon becoming a necessity with the central and state governments taking a lot of interest in quality of care and delivering uniformity in the healthcare delivery channels. A few factors which have made it compulsory are as follows:

- Present day need for quality in a hospital due to dependency on insurance
- Compulsion from government to be recognized by NABH to be a part of CGHS program
- More and more amount of educated population demanding quality healthcare
- Physicians mind set to work in an organized sector

The healthcare industry has responded positively to these cues by voluntarily participating in the accreditation program. As a result of which the present status is as follows: -

The Indian scenario:

- 209 NABH accredited hospitals (both government as well as private)
- > 500 hospitals have applied for NABH

The scenario of Rajasthan has:

- 7 NABH accredited hospitals
- 10 have applied for NABH

The Jaipur scenario has:

- 6 NABH accredited
- 6 have applied for NABH

Various huge brands are lined up for their projects to be started in Jaipur in the near future. Soon Jaipur will be transformed into a medical hub. Standardization is thus the only way to make a mark for these upcoming organizations.

NEED FOR THE STUDY:

Hospitals form a vital part of the society and the responsibility of the care rendered by them to the society is heavy. With numerous small and large facilities coming up, the quality of services seems to be in jeopardy. The only solution out seems to be standardization of the services in order to provide similar care to all the patients as per their treatment needs and laid down guidelines. This will not only ensure better quality patient care but also reduce burden on the facilities and personnel as well. The cases of mortality and morbidity are often a result of lack of practice of standardized procedure of care delivery. The number of such events is lower in the hospitals with a well laid quality control mechanism. This increased morbidity and mortality harms the patient as well as the hospital in terms of the cost associated with the prolonged average length of stay. It is thus important to evaluate and scale up the quality standards for a larger good.

OBJECTIVES OF THE STUDY:

- To assess the hospital's existing set up & procedures as per NABH standards
- To understand the major non-compliances for first internal assessment
- To establish action plan based on the gap report

METHODOLOGY:

Study area: Eternal heart care centre, Jaipur

Study design: analytical cross – sectional study

Approach:

The approach to the project was as follows:

1. Prepared checklist was used – for this, NABH self assessment toolkit was used.
2. Interviews of staff were carried out based on the NABH standards for hospitals
3. Records review – list of legal documents, their validity and renewal were assessed as per NABH required legal compliance.

- Primary sources of data:
    - Personal observation.
    - Interviews of the staff and authorities (like nursing staff, hospital administrator, medical director etc) with the help of a Questionnaire.
    - Self assessment toolkit as per NABH.
- Secondary sources data:
    - Hospital registers & records.
    - NABH document for hospital standards
    - Studies available on the internet regarding accreditation

Scoring Technique:

The scores will be imparted as per the NABH assessment i.e.

- ✓ 0 for non compliance (NC)
- ✓ 5 for partial compliance (PC)
- ✓ 10 for full compliance (FC)

In the end the scores of all the standards are summed up and divided by the total number of standards and after completion of scores for each of the 10 chapters of standards all the scores are added and then divided by 10 (the total no. of chapters) to obtain a final score.

Evaluation Criteria during final assessment:

- No individual standard should have more than one zero to qualify. However, no zero is accepted in the regulatory/ legal requirements.
- The average score for individual standard 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.

SWOT analysis of the organization to assess its preparedness to go for NABH Accreditation:

Strengths	**Weaknesses**
• Leadership of the organization envisions exceptional quality as a part of their work culture and daily activities. • The leadership enjoys an international fame and accountability owing to its internationally acclaimed founder. • The top and middle level managers are well versed with the significance and process of accreditation. • All HODs (clinical & non – clinical departments) have either been the part of accreditation process or worked in accredited organizations previously. • The organization is newly commissioned and has new staff.	• As it is a new organization it does hold a strong market footing. • It is still undergoing construction • Systems are not well defined and in place
Opportunities	**Threats**
• The top management and leadership supports the staff technically and financially towards the process o accreditation • Able and well qualified team	• Job responsibilities are not clearly defined which causes a state of confusion. • Employee satisfaction is on the lower side due to lack of proper

drivers for the process. • It is easier to train the new staff and develop a quality driven work culture right from the beginning to make it a way of life. • Also lower resistance from the staff to adapt to change	systems in place. • Financial implication of accreditation should also be taken into account owing to the present situation of the organization.

The above factors point in the favorable direction towards the accreditation. Though there are certain weaknesses and threats but they can be converted to our opportunities by –

- Construction activities will facilitate any infrastructural discrepancies to be corrected right away.
- Once policies and SOPs are implemented, staff satisfaction will be improved
- Market value enhancement will take place once the accreditation process has been ensued.

RESULTS AND FINDINGS:

Signage system

There are a number of signage showing the various departments and utilities like drinking water, toilets, different OPDs etc at appropriate places but they are only in English.

Signage's	Displayed	Bilingual	Pictorial
Mission	NO	NO	NO
Vision	NO	NO	NO
Core Values	NO	NO	NO
Patients Rights And Responsibilities	NO	NO	NO
Scope Of Services	NO	NO	NO
Complaint Redressal Box	NO	NO	NO

Tariff List	NO	NO	NO
Doctors List Along With Their Specialties And Qualifications	NO	NO	NO
OPD Schedule Of Doctors (Specialty, Timings And Days Of Availability)	NO	NO	NO
Biohazard Symbols	YES	NO	NO
Fire Exit Plan	NO	NO	NO
Floor Directory	NO	NO	NO
Floor Plan	NO	NO	NO
Departmental Signages	YES	NO	NO
Wash Rooms(Handicap)	NO	NO	NO
Ambulance Parking Area	YES	NO	NO
Drinking Water	YES	NO	NO
Health Education Related Signages	NO	NO	NO
Hand Hygiene Signage	YES	NO	NO

STATUTORY REQUIREMENTS:

Sr No.	Description of License/Registration	AVAILABLE
1	NOC Fire (pre & post)	**YES**
	VAT	YES
2	Income Tax PAN Number	YES
3	Certificate of Importer-Exporter Code(IEC) under Customs Act, 1962	YES
4	Vehicle Registration Certificate	YES
5	Vehicles' PUC Certificate	NA till 1st 6 months
6	Authorization under Bio-medical Management and handling Rules, 1998	NO
7	License for installation of Explosives	NO

8	Excise permit to store Spirit	NA
9	Building Permit (from the Municipality)	NO
10	Pharmacy Registration under Central Sales Tax Act, 1956	YES
11	License to sale stock, or exhibit for sale or distribute by wholesale and Retail drugs under Drugs & Cosmetic Act 1940 and Rules 1945	YES
12	Pharmacists' Registration under Pharmacy Act, 1948	YES
13	License under NDPS Act, 1985	YES
14	Licenses under Electricity Act, 1998 and Rules, 1956	YES
15	Certificate of Registration under PNDT Act, 1994	YES
16	License for the blood bank (Storage)	YES
17	Agreement with BMW Disposal and treatment Facility Instromedix (India) Pvt. Ltd.	**YES**
18	Explosives Diesel/petroleum storage	NO
19	Electrical installations	YES
20	Sanction of lifts	NA
21	Project site lease deed	YES
22	Buidling plan approval from JDA	YES
23	Concession agreement between govt and hospital (if land or some funding was done)	YES
24	Registration of Doctors with MCI/RMC	YES
25	Registration of Nurses with NCI	YES
26	Employees Provident Fund Act, 1996	YES
27	Employees State Insurance Act , 1948	YES
28	Renewal-CONSENT TO OPERATE under section 21 of the AIR	NO

29	Renewal-CONSENT TO OPERATE under section 25/26 of the WATER	NO
30	License for Nuclear Medicine	YES
31	Pharmacy-wholesale-inpatient(IP)	YES
32	Pharmacy-retail-inpatient(IP)	YES
33	Pharmacy-retail-outpatient(OP)	YES
34	Ambulance registration	YES
35	Building completion certificate	YES
36	Registration with Central Excise Dept	YES
37	Shop & Establishment Act	YES
38	Fire Door Rating	NO

CHAPTER WISE SCORES:

1. **AAC**

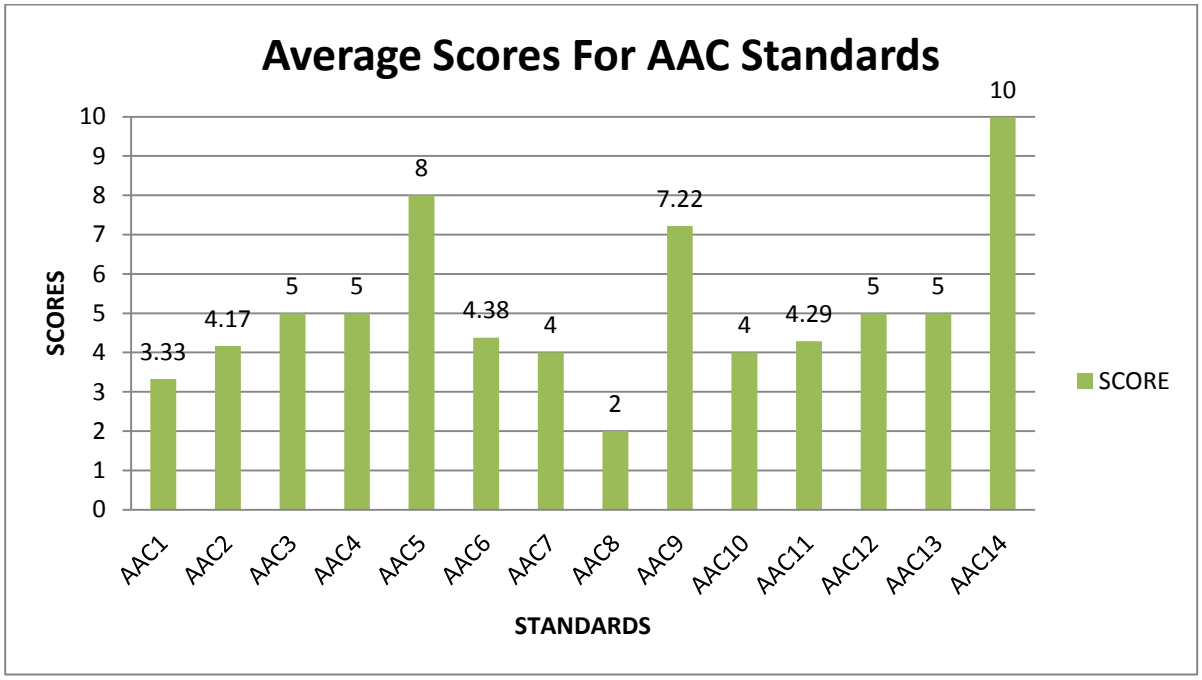

Fig 1. Average scores for Chapter 1 - AAC

INTERPRETATIONS:

AAC.1: The services being provided by the hospital are clearly defined and in consonance with the needs of the community but not displayed in the common patient areas and the staff is not properly oriented about services.

AAC.2: the organization implements a clear procedure for registration and bed management but the documentation and a policy regarding the same is missing. The staff is also not uniformly oriented on the same.

AAC.3: the organization follows a transfer but there is a lack of documentation and well defined policies.

AAC.4: the organization is practicing these processes but the key personnel is not been identified due lack of the policy in black and white.

AAC.5: the organization practices the required procedure but no defined policy to substantiate the process is available

AAC.6: the scope of laboratory services is not displayed at the entrance. Processes of collection, identification, handling, safe transportation, processing and disposal of specimens are carried out but the policy and guideline in documented form are lacking

AAC.7: Laboratory Quality assurance program is being implemented but is not supported by documented guidelines. The periodic maintenance is said to be non applicable as the first calibration after installation will be carried out after 1 year which is not yet complete.

AAC.8: laboratory safety program is practiced as per the knowledge of the staff. No guidelines are available for its substantiation. The staff has also not been trained.

AAC.9: The scope of radiology & imaging services is not displayed at the entrance. The critical results are being intimated and turnaround time is being monitored but there is no laid down guidelines for the same.

AAC.10: the Quality assurance program is being implemented but is not supported by documented guidelines. The periodic maintenance is said to be non applicable as the first calibration after installation will be carried out after 1 year which is not yet complete.

AAC.11: the radiation safety measures are being followed by the organization but it lacks a safety manual as per the hospital policy. Also the staff training regarding the same is not formally organized.

AAC.12: the referral system is already functional but it is not supported by any written guidelines and SOPs

AAC. 13: the discharges are coordinated by the staff themselves as there is no documented plan for discharge.

AAC.14: discharge summary is being issued for every patient as per the standard format of the industry but hospital policy has not documented it.

2. COP

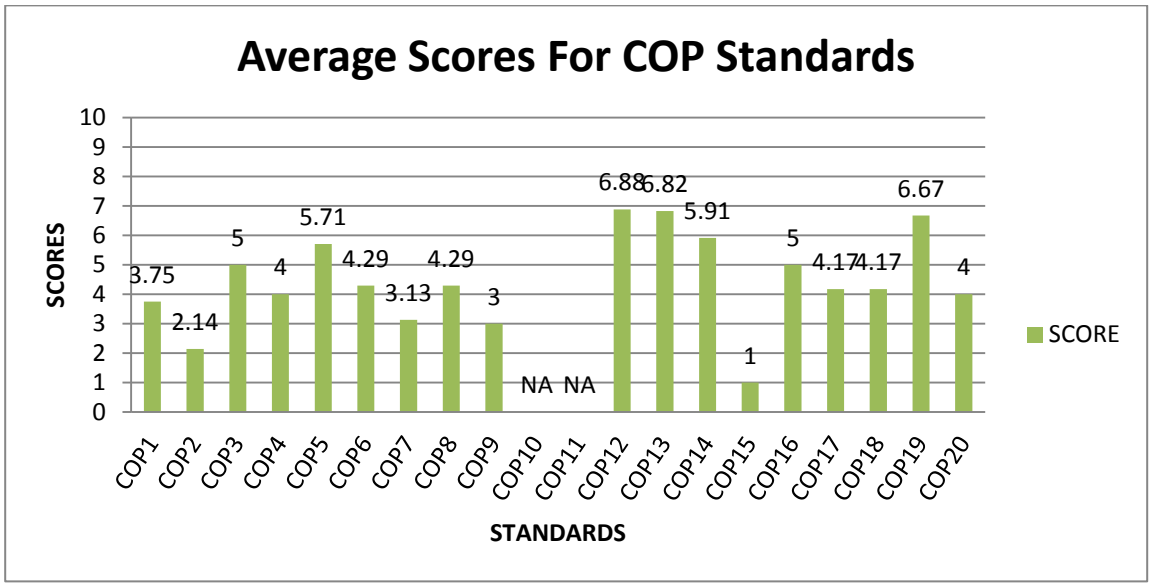

Fig 2 : average scores for chapter 2 - COP

INTERPRETATION

COP.1: Uniform care is being provided as per the applicable law but the policy and procedure regarding the same is not yet formulated.

COP.2: Emergency services provided by the hospital are according to the standard emergency guidelines but these are still not approved by the top level management.

COP.3: The in house ambulance services are yet to become functional.

COP.4: Policies and guidelines for cardiac resuscitation are not documented but the staff carries out these functions on their own. The code blue is not defined and partial post event analysis is carried out.

COP.5: A nursing manual is maintained by the nursing superintendent, which is still not approved by the top management. Most of the nursing services are provided as per this manual only, but as it is not yet approved and signed the documentation part cannot be taken as positive.

COP.6: The qualified personnel assist the procedure but no guideline supports it.

COP.7: the use of blood and blood products are carried out as per the blood bank document maintained by the staff themselves. This document has not been formally approved by the authorities.

COP.8: the nursing manual deals with this aspect but it cannot be considered as a formal documented policy of the hospital

COP.9: done according to the nursing manual which is not yet formalized in the form of hospital policies and SOPs

COP.10: the organization does not offer this service

COP.11: the organization does not offer this service

COP.12: done as per the nursing manual which is not been approved formally

COP.13: the anesthesia practices are according to the standard practice guidelines, but a well defined policy and SOPs are not available for the same.

COP.14: standard practice guidelines are followed for the same but no documented policies define its scope.

COP.15: done as per the nursing manual. The staff training is also looked after by the nursing superintendent himself but there is no coordination with the HR department for the same

COP.16: as per the nursing manual. The medical records contain the evidence of its implementation. The only missing part is the SOPs regarding the same.

COP.17: the rehab services are practiced as per standard industry norms as no guidlin is available from the hospitals side

COP.18: research activities are still not started.

COP.19: the nutrition services are practiced as per the norms but lack a documented procedure to support it.

COP.20: the end of life care is given as per the nursing manual which is not approved yet. The staff is not much trained for the same

3. MOM

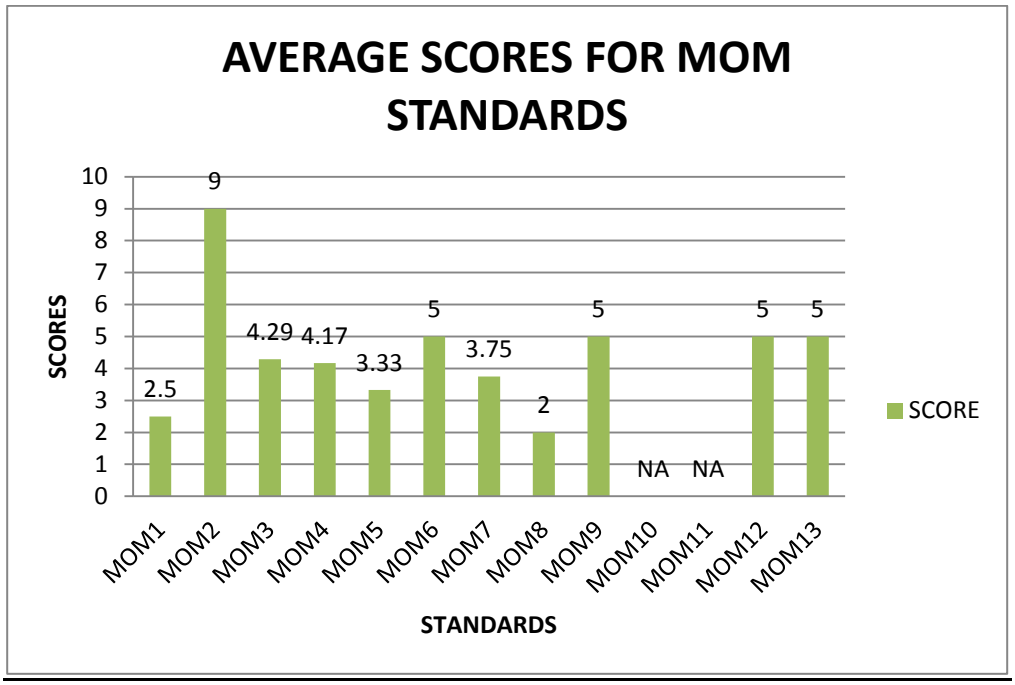

FIG. 3: average scores for chapter 3 – MOM

INTERPRETATION:

MOM.1: the processes are carried out but there is no documentary evidence for the same.

MOM.2: the hospital formulary exists which develops the list of medications, but a well defined process is not available for the procurement of the drugs excluded from their list.

MOM.3: there is no documented hospital policy specified for the storage of medications. But the processes are carried out as per best practices

MOM.4: the medication orders are clear and recorded in the medical record but the SOPs regarding the same are not documented.

MOM.5: dispensing occurs as per the standard practices but there are no documented SOPs regarding the same

MOM.6: safe dispensing of medication and their administration is done as per the nursing manual which still awaits its approval. The medical record contains complete details of the administered medications during patient care.

MOM.7: monitoring of patients is done as per the nursing care guidelines in the nursing manual. The hospital has not provided any SOPs regarding the same.

MOM.8: the events are being recorded and analysed at a non formal platform and no laid guidelines are available to define this process,

MOM.9: narcotics are handled as per the standard practices but no documented SOPs are available for the same.

MOM.10: chemotherapeutic agents are not used in the organization

MOM.11: Radioactive drugs are not used in the organization

MOM.12: implants are procured, stocked and used as per the standard practices but no documented SOPs are available for the same.

MOM.13: processes exist in practice but the hospital policy is not documented to substantiate it.

4. PRE

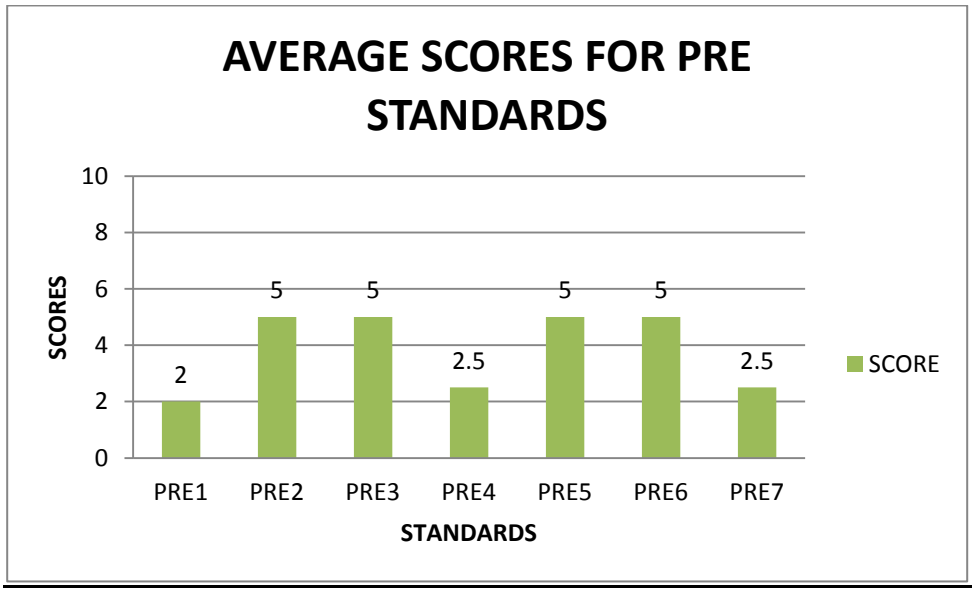

FIG 4: average score for chapter 4: PRE

INTERPRETATION:

PRE.1: there is no documentation of patient and family rights and responsibilities. They are not been displayed and the staff is not uniformly aware of their responsibility in protecting the rights of the patients.

PRE.2: processes are carried out in accordance with the standards but no documented SOPs and policies are available to the departmental staff

PRE.3: the patients and their families are educated but there is no documented plan and guideline fotr the same.

PRE.4: consent of the patient is taken as per the standard protocol but the SOPs regarding the same is not defined. Also the general consent of the patient is not taken and the staff is not uniformly aware of the same.

PRE.5:the patients and their family members are educated about the medication use but there is no standard protocol documented for the same

PRE.6: the patient and their family members are educated uniformly about the estimated costs of treatment but no SOPs define the strict protocol to be followed for the same.

PRE.7: the organization lacks a proper redressal system but still the complaints are addressed and analysed

5. HIC

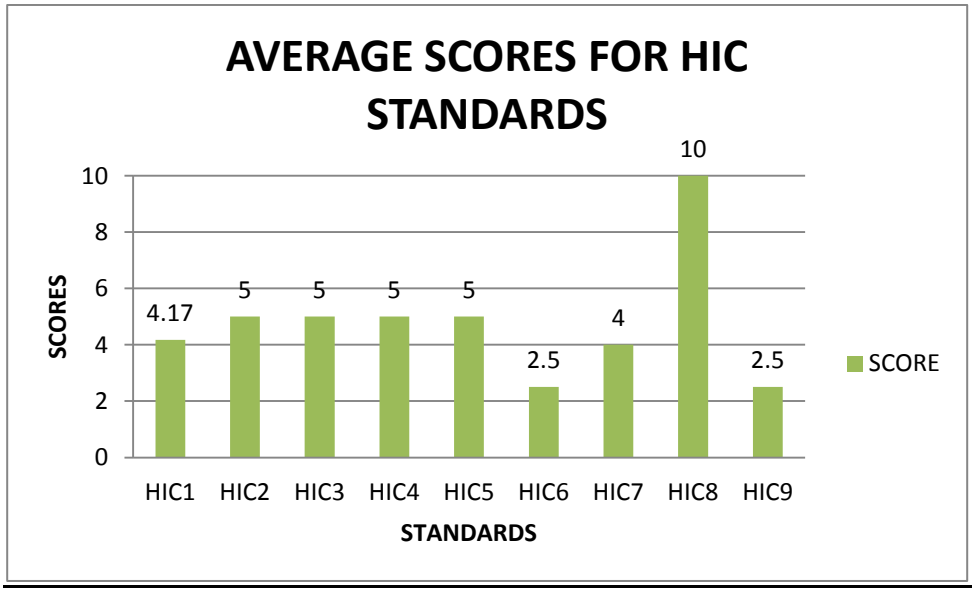

FIG 5. Average scores for chapter 5 - HIC

INTERPRETATION:

HIC.1: the organization has an already functional infection control in practice and data is being collected and analysed. The SOPs regarding these is missing.

HIC.2: processes are being carried out as per the standard protocols but infection control manual is not present to substantiate it

HIC.3: surveillance is done on timely basis and record is maintained, but proper documented guidelines for the same is required

HIC.4: the organization takes action to prevent or reduce the risk of different HAI in patients and employees but these policies are not documented.

HIC.5: facilities and resources are available but the documented SOPs and guidelines to support the infection control program are not present.

HIC.6: outbreaks are recorded and followed up and their root cause analysis is done but written policies to substantiate these measures is not present.

HIC.7: adequate space and sterilization practices are there with regular validation tests as a part of the routine. Recall process however is not established. Lack of SOPs for the process.

HIC.8: proper segregation of the BMW is done with proper documentation in the form of log books. Staff is provided with the personal protective equipments for handling of BMW.

HIC.9: infection control program is supported by the management and is being implemented. The infection control manual is not present, as a result of which it does not have a documentary support. Training of the staff is not carried out

6. CQI

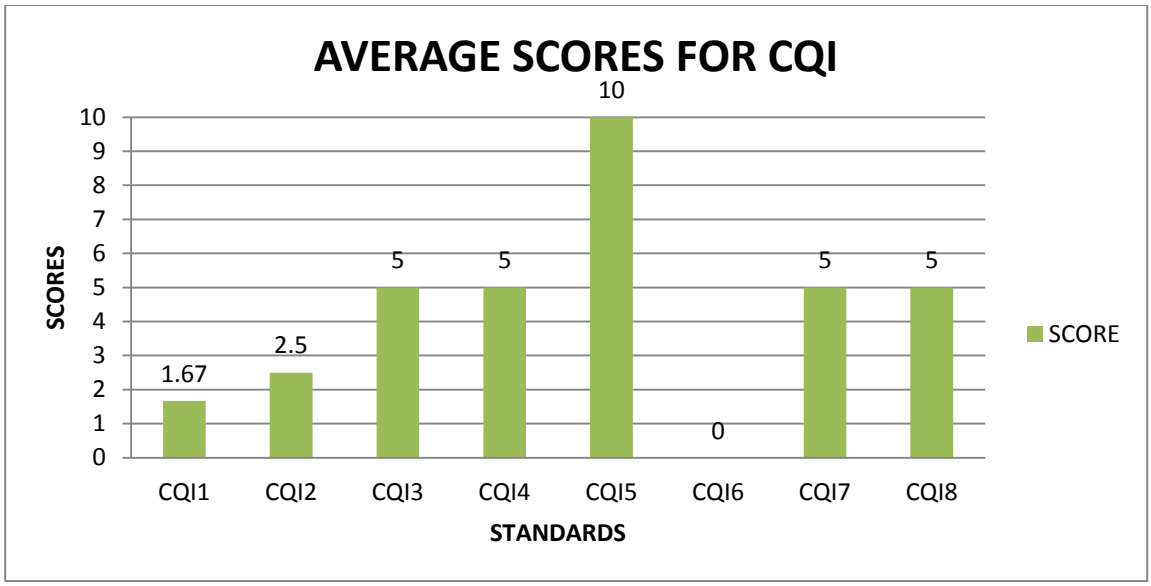

FIG6: average scores for chapter 6 – CQI

INTERPRETATION:

CQI.1: the quality is being monitored and the key person is identified for the same but the programme has not been shared with the staff oragnisation wide. Also the audits and updations are not applicable as of now as the organization is still in its 1st year of commissioning. Also the quality manual has not been formulated.

CQI.2: no documentation of the patient safety program. The organization uses two identifiers to identify the patients across the organization. Updation is not applicable as of now.

CQI.3: monitoring of the patients is done as a part of the clinical protocol. There is no quality manual which defines the guidelines for such a process.

CQI.4: key indicators are are being used as tools for continuous quality improvement but no documented guidelines are present to support it.

CQI.5: the management fully supports the continuous quality improvement undertakings

CQI.6: as the clinical audit is carried out annually it is thus not applicable to this organization as of now as it is in its 1st year of commissioning. Also there is no documented policy regarding the same for future.

CQI.7: the incidents are analysed and feedbacks evaluated as per the standard practices but no documentary policies regarding the same are available.

CQI.8: sentinel events are defined and analysed but it does not have any documentary support

7. ROM

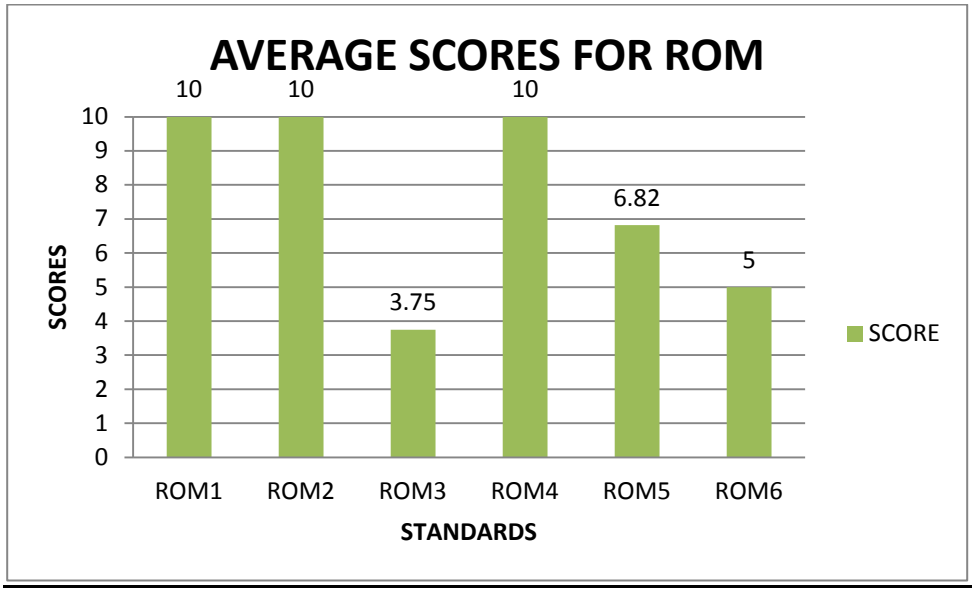

FIG 7: average scores for chapter 7 - ROM

INTERPRETATION:

ROM.1: responsibilities of the management are defined with a well established organogram

ROM.2: the organistion complies with the laid down applicable laws and regulations and has a well defined mechanism to regularly update the licenses/registrations/certificates.

ROM.3: scope of services is defined but not documented. Leadership is active but the documentation is lacking

ROM.4: organization is being managed in an ethical manner

ROM.5: a suitably qualified leadership is present. All types of documentation is lacking but the organization keeps a check on the quality of the outsourced services.

ROM.6: the processes are carried out as per the best practices but the hospital policy to guide these protocols is absent.

8. FMS

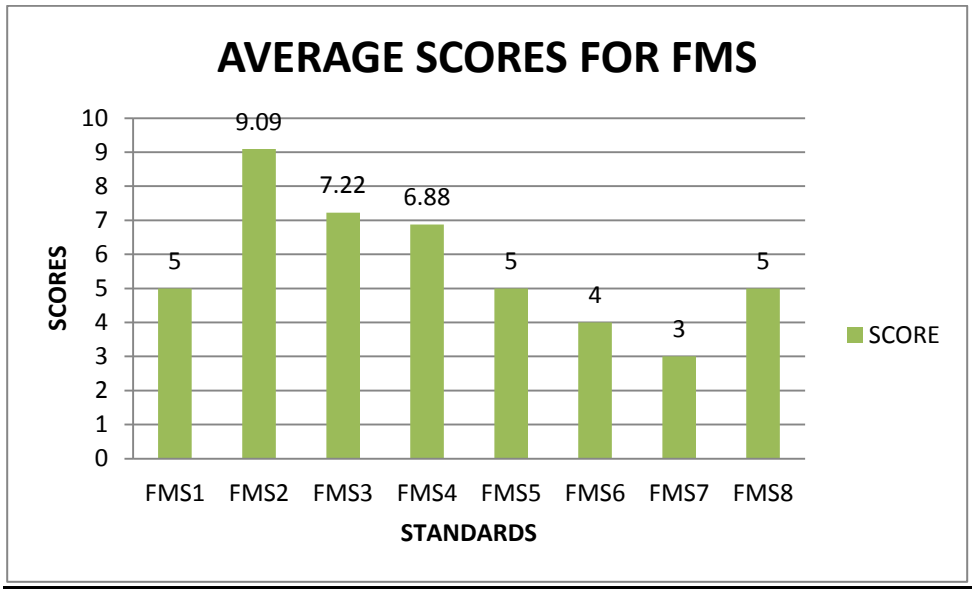

FIG 8: average scores for chapter 8 - FMS

INTERPRETATION:

FMS.1: the organization has a system in place to provide a safe and secure environment. A safety program for all the staff exists but is not documented.

FMS.2: a safe environment for patients and their families is provided. The signages are only in English and should be atleast bilingual. The response time to breakdown is defined in the engineering manual which is being maintained at the departmental level only and is still not approved by the top management.

FMS.3: engineering support services are available and the preventive and maintenance plan is as per the departmental manual. The manual still needs to be approved by the higher authorities.

FMS.4: a program as per the departmental manual (not approved) is present. Calibration is not applicable as of now.

FMS.5: as per the policy in the departmental manual. But it requires approval

FMS.6: A fire safety plan is available in the departmental manual but the staff is not trained for the same and the mock drills are not organized

FMS.7: a disaster management plan is formulated but it is not been approved by the top management. The staff is not trained and plan has not been tested yet.

FMS.8: hazardous material is defined but the staff is not uniformly trained. There are no documented protocols regarding the same.

9. HRM

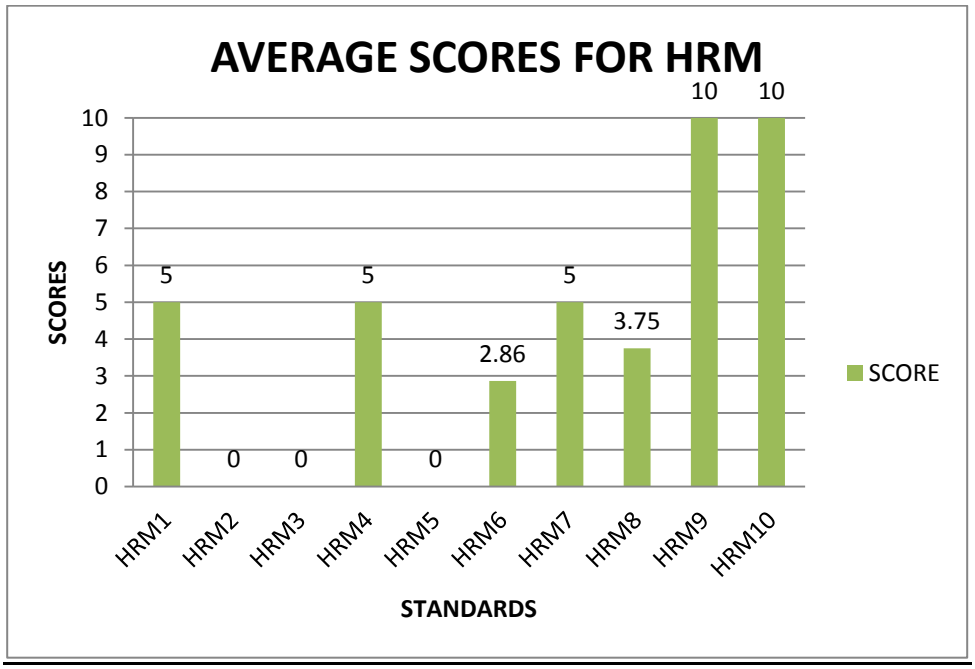

FIG 9: average scores for chapter 9 - HRM

INTERPRETATION:

HRM.1: the organization does not have a documented plan for human resource planning.

HRM.2: employee rights and responsibilities are not defined and documented. The staff is not uniformly made aware of their rights and responsibilities. Patient rights and responsibilities are not defined to the employees.

HRM.3: No training and development program is being carried out for the staff

HRM.4: the staff is trained on the job by their senior members. No formal training sessions are conducted.

HRM.5: no appraisal of the staff is done as of now. Also there is no documented policy for performance appraisal.

HRM.6: grievances are handled and actions are taken, but there is no documented procedure for the same

HRM.7: health needs are being addressed as and when the need arises but a documented protocol for the same is not available for its support.

HRM.8: every employee's personal records are maintained but the training and evaluation part is lacking.

HRM.9: a system of credentialing and privileging of the medical professionals is done with utmost care. Again this is done as per the standard industry practices as no document defining the SOPs for the same is available.

HRM.10: a system of credentialing and privileging of the nursing professionals is done with utmost care. The guidelines for this and their training and evaluation are available in the nursing manual and is looked after by the NS himself.

10. IMS

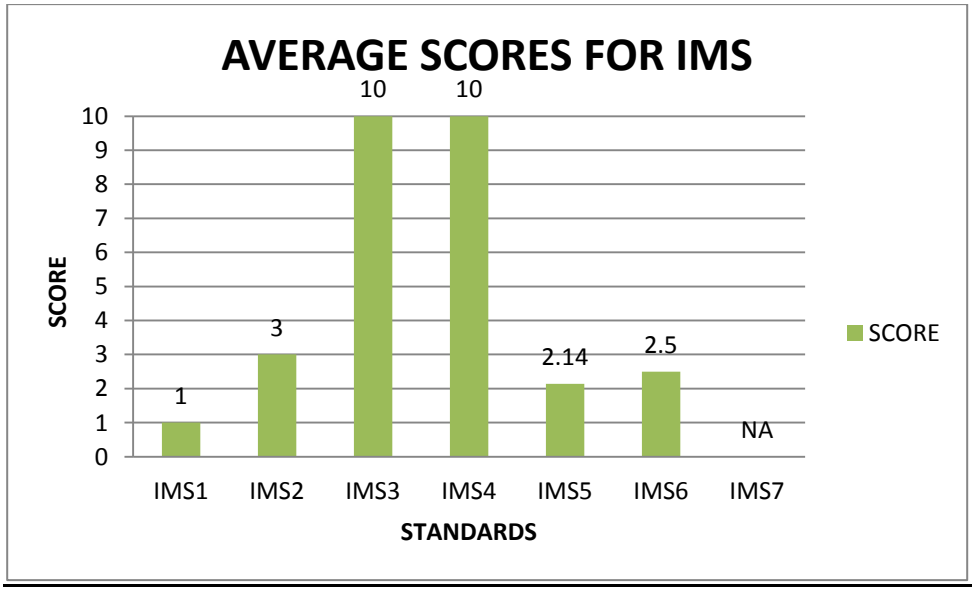

FIG 10: average scores for chapter 10 - IMS

INTERPRETATION:

IMS.1: the information needs of the organization are identified but no documented policies and procedures are available.

IMS.2: the processes are carried out as per the standard practices but the documented SOPs are not present.

IMS.3: a complete medical record is being maintained which is available to the patient and the clinician as and when required.

IMS.4: a complete medical record is being maintained which is available to the patient and the clinician as and when required

IMS.5: the organization maintains the confidentiality of the records but lacks a documented policy for the same.

IMS.6: a retention process for the records is followed as per the standards but no documented policies support this.

IMS.7: a medical record audit has not been carried out yet and no policy is available to define this protocol.

Total average scores for all the chapters are as depicted by this figure

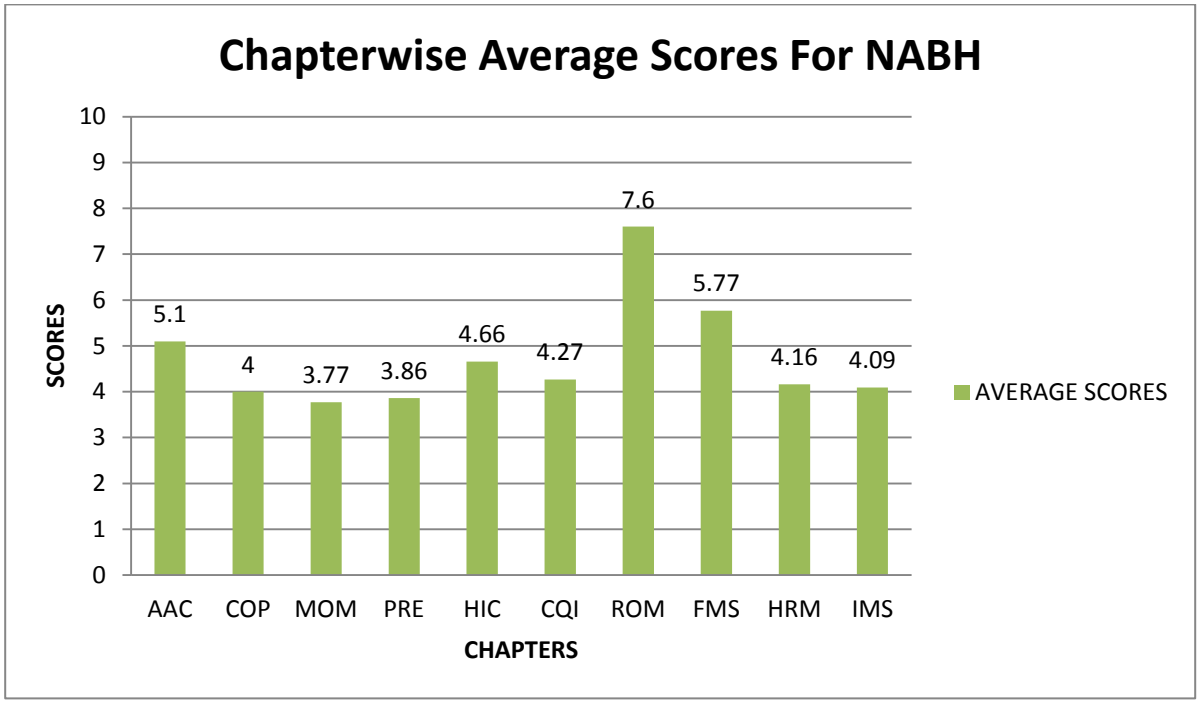

Fig 11: Chapter wise average scores

It is thus clearly evident that the score are quite low. This is mainly due to lack of documents and manuals. If this gap is bridged, the scores would improve considerably.

RECOMMENDATIONS:

For proper documentation:

- Formulation of apex manual - including
  - Introduction of the organization
  - Ownership, Vision, Mission, Ethical Management
  - Quality policy
  - Scope of services
  - Composition and role of different committees
  - Organogram
  - Statutory & regulatory requirements
  - Department wise brief policy
- Formulation of departmental manual – detailed SOPs for the department (in this case many departmental manuals are already present, so they can be evaluated, compiled, edited if need may be and be sent for approval to the top management.)
- Formulation of the safety manual – includes lab & radiation safety
- General consent forms, cpr reporting formats, standardized initial assessment formats, training calendars, event register to be designed and finalized.
- The absent signages need to be displayed and the existing to be changed to bilingual (atleast Hindi & English)
- The deficient statutory requirements to be fulfilled.
- Induction program for the staff to be introduced
- Training evaluation records to be maintained.
- Mock drills to be organized and a record maintained for the same

CONCLUSION:

Quality is omnipresent and all pervasive. NABH accreditation program has been widely accepted as a credible mark of excellence in delivery of quality healthcare. The journey of NABH is a long way to go. GAP analysis is the initial and one of the most critical exercises in the process. It helps us to revisit the existing system with an eye to find facts instead of faults. Traditionally existing system has some lacunae which create a stumbling block to improve quality. The analysis has divulged various quality related issues in various clinical & non – clinical departments at eternal heart care centre & research institute. It will take about 6 months to get all the policies implemented and get the system running in full swing. If they apply for NABH immediately, they would receive a preparation time of 6 months before the pre-assessment visit by the assessors. In the meantime, formulation and implementation of the policies and SOPs can be easily carried out given the presence of the highly qualified and knowledgeable leadership in all clinical as well as non clinical departments. The commitment to strive

for accreditation from all the areas of the organization will help it to achieve the NABH accreditation

LIMITATIONS OF THE STUDY:

- The data obtained is based on the existing set-up, which prevails in the hospital at the time of the system study
- The study being subjective, is based on the perception of the employees working in the hospital and may be biased
- The time frame as a period of only 3 months could be a limitation

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6. Jafar S. Tabrizi, Farid Gharibi, Andrew J. Wilson, A systematic review **Advantages and Disadvantages of Health Care Accreditation Models**
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ANNEXURES:

Self assessment toolkit:

		Elements	Scores (0/ 5/ 10)
Chapter 1: ACCESS, ASSESSMENT AND CONTINUITY OF CARE (AAC)			
AAC.1: The organisation 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 display.	0
	c	The staff is oriented to these services.	5
AAC.2: The organisation has a well defined registration and admission process.			
	a.	Documented policies and procedures are used for registering and admitting patients.	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.	10
	d.	Patients are accepted only if the organization can provide the required service.	5
	e.	The documented policies and procedures also address managing patients during non availability of beds.	5
	f.	The staff is aware of these processes.	5

AAC.3 There is an appropriate mechanism for transfer or referral of patients			
	a.	Documented policies and procedures guide the transfer-in of patients to the organization	5
	b.	Documented policies and procedures guide the transfer-out/referral of unstable patients to another facility in an appropriate manner.	5
	c.	Documented policies and procedures guide the transfer-out/referral of stable patients to another facility in an appropriate manner.	5
	d.	The documented procedures identify staff responsible during transfer/referral.	5
	e.	The organization gives a summary of patient's condition and the treatment given.	5
AAC.4 Patients cared for by the organisation undergo an established initial assessment.			
	a.	The organisation defines and documents the content of the initial assessment for the out-patients, in-patients and emergency patients.	5
	b.	The organisation determines who can perform the initial assessment.	5
	c.	The organisation defines the time frame within which the initial assessment is completed based on patient's needs.	5
	d.	The initial assessment for in-patients is documented within 24 hours or earlier as per the patient's condition as defined in the organization's policy.	5
	e.	Initial assessment of in-patients includes nursing assessment which is done at the time of admission and documented.	5
	f.	Initial assessment includes screening for nutritional needs.	5
	g.	The initial assessment results in a documented plan of care.	5
	h.	The plan of care also includes preventive aspects of the care where appropriate.	5

	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.	5
AAC.5 Patients cared for by the organisation undergo a regular reassessment.			
	a.	Patients are reassessed at appropriate intervals.	5
	b.	Out-patients are informed of their next follow-up, where appropriate.	5
	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.	10
	e.	Patients are reassessed to determine their response to treatment and to plan further treatment or discharge.	10
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 organisation.	5
	b.	The infrastructure (physical and manpower) is adequate to provide for its defined scope of services.	5
	c.	Adequately qualified and trained personnel perform, supervise and interpret the investigations.	5
	d.	Documented procedures guide ordering of tests, collection, identification, handling, safe transportation, processing and disposal of specimens.	0
	e.	Laboratory results are available within a defined time frame.	5
	f.	Critical results are intimated immediately to the personnel concerned.	5

	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.	5
AAC.7 There is an established laboratory quality assurance programme.			
	a.	The laboratory quality assurance programme is documented.	0
	b.	The programme addresses verification and/or validation of test methods.	5
	c.	The programme addresses surveillance of test results.	5
	d.	The programme includes periodic calibration and maintenance of all equipment.	5
	e.	The programme includes the documentation of corrective and preventive actions.	5
AAC.8 There is an established laboratory-safety programme.			
	a.	The laboratory safety programme is documented.	0
	b.	This programme is aligned with the organisation's safety programme.	0
	c.	Written procedures guide the handling and disposal of infectious and hazardous materials.	0
	d.	Laboratory personnel are appropriately trained in safe practices.	5
	e.	Laboratory personnel are provided with appropriate safety equipment/ devices.	5
AAC.9 Imaging services are provided as per the scope of services of the organization.			

a.	Imaging services comply with the legal and other requirements.	10
b.	Scope of the imaging services is commensurate to the services provided by the organisation.	10
c.	The infrastructure (physical and 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.	5
g.	Critical results are intimated immediately to the personnel concerned.	5
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	5
AAC.10 There is an established quality assurance programme for imaging services.		
a.	The quality assurance program for imaging services is documented.	0
b.	The programme addresses verification and/or validation of imaging methods.	5
c.	The programme addresses surveillance of imaging results.	5
d.	The programme includes periodic calibration and maintenance of all equipment.	5
e.	The programme includes the documentation of corrective and preventive actions.	5

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 are as per statutory requirements.	5
	d.	Imaging personnel are provided with appropriate radiation safety devices.	10
	e.	Radiation safety devices are periodically tested and results documented.	5
	f.	Imaging personnel are trained in radiation safety measures.	5
	g.	Imaging signage are prominently displayed in all appropriate locations.	5
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 setting within the organisation.	5
	c.	Information about the patient's care and response to treatment is shared among medical, nursing and other care providers.	5
	d.	Information is exchanged and documented during each staffing shift, between shifts, and during transfers between units/ departments.	10
	e.	Transfers between departments/units are done in a safe manner.	5
	f.	The patient's record(s) is available to the authorized care providers to facilitate the exchange of information.	5

	g.	Documented procedures guide the referral of patients to other departments/ specialities.	0
AAC.13 The organisation has a documented discharge process.			
	a.	The patient's discharge process is planned in consultation with the patient and/ or family.	10
	b.	Documented procedures exist for coordination of various departments and agencies involved in the discharge process (including medico-legal and abandoned cases)	5
	c.	Documented policies and procedures are in place for patients leaving against medical advice and patients being discharged on request.	0
	d.	A discharge summary is given to all the patients leaving the organization (including patients leaving against medical advice and on request).	5
AAC.14 Organisation define 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
Chapter 2: CARE OF PATIENTS (COP)			

COP.1: Uniform care of 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 adopts evidence-based medicine and clinical practice guidelines to guide uniform patient care.	5
COP.2: Emergency services are guided by documented policies, procedures and applicable laws and regulations.			
	a	Policies and procedure for emergency care are documented and are in consonance with statutory requirements.	0
	b	This also addresses handling of medico-legal cases.	0
	c	The patients receive care in consonance with the policies.	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 organisation is also documented.	0
	g	In case of discharge to home or transfer to another organization a discharge note shall be given to patient.	5
COP.3: The ambulance services are commensurate with the scope of the services provided by the organisation.			

	a	There is adequate access and space for the ambulance(s).	5
	b	The ambulance adheres to statutory requirements.	5
	c	Ambulance(s) is appropriately equipped.	5
	d	Ambulance(s) is manned by the trained personnel.	5
	e	Ambulance(s) is checked on a daily basis.	5
	f	Equipment are checked on a daily basis using a checklist.	5
	g	Emergency medications are checked daily and prior to dispatch using a checklist.	5
	h	The ambulance(s) has a proper communication system.	5
COP.4: Documented policies and procedures guide the care of patients requiring cardio-pulmonary resuscitation.			
	a	Documented policies and procedures guide the uniform use of resuscitation throughout the organisation.	0
	b	Staff providing direct patient care are trained and periodically updated in cardio pulmonary resuscitation.	5
	c	The events during a cardio pulmonary resuscitation are recorded.	5
	d	A post-event analysis of all cardio-pulmonary resuscitations is done by a multidisciplinary committee.	5
	e	Corrective and preventive measures are taken based on the post-event analysis.	5
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 purposes of the services.	5
	c	Assignment of patient care is done as per current good practice guidelines.	5
	d	Nursing care is aligned and integrated with overall patient care.	5
	e	Care provided by nurses is documented in the patient record.	10
	f	Nurses are provided with adequate equipment for providing safe and efficient nursing services.	10
	g	Nurses are empowered to take nursing-related decisions to ensure timely care of patients.	5
COP.6: Documented procedures guide the performance of various procedures.			
	a	Documented procedures are used to guide the performance of various clinical procedures.	0
	b	Only qualified personnel order, plan, perform and assist in performing procedures.	5
	c	Documented procedures exist to prevent adverse events like wrong site, wrong patient and wrong procedure.	0
	d	Informed consent is taken by the personnel performing the procedure, where applicable.	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.	5
	g	Procedures are documented accurately in the patient record.	10

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 guide transfusion of blood and blood products.	0
	c	The transfusion services are governed by the applicable laws and regulations.	5
	d	Informed consent is obtained for donation and transfusion of blood and blood products.	5
	e	Informed consent also includes patient and family education about donation.	5
	f	The organization defines the process for availability and transfusion of blood/blood components for use in emergency.	5
	g	Post-transfusion form is collected, reactions if any identified and are analyzed for preventive and corrective actions.	5
	h	Staff are trained to implement the policies.	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 organisation has documented admission and discharge criteria for its intensive care and high dependency units.	0
	c	Staff are trained to apply these criteria.	5
	d	Adequate staff and equipment are available.	10
	e	Defined procedures for situation of bed shortages are followed.	5

	f	Infection control practices are documented and followed.	5
	g	A quality assurance programme is documented and implemented.	5
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 organised and delivered in accordance with the policies and procedures.	5
	c	The organisation provides for a safe and secure environment for this vulnerable group.	5
	d	A documented procedure exists for obtaining informed consent from the appropriate legal representative.	0
	e	Staff are trained to care for this vulnerable group.	5
COP.10: Documented policies and procedures guide obstetric care.			NA
	a	There is a documented policy and procedure for obstetric services.	NA
	b	The organisation defines and displays whether high-risk obstetric cases be cared for or not.	NA
	c	Persons caring for high-risk obstetric cases are competent.	NA
	d	Documented procedures guide provision for ante-natal services.	NA
	e	Obstetric patient's assessment also includes maternal nutrition.	NA

	f	Appropriate pre-natal, peri-natal and post-natal monitoring is performed and documented.	NA
	g	The organization caring for high-risk obstetric cases has the facilities to take care of neonates of such cases.	NA
COP.11: Documented policies and procedures guide paediatric services.			NA
	a	There is a documented policy and procedure for paediatric services.	NA
	b	The organisation defines and displays the scope of its paediatric services.	NA
	c	The policy for care of neonatal patients is in consonance with the national/ international guidelines.	NA
	d	Those who care for children have age specific competency.	NA
	e	Provisions are made for special care of children.	NA
	f	Patient assessment includes detailed nutritional, growth, psychosocial and immunization assessment.	NA
	g	Documented policies and procedures prevent child/ neonate abduction and abuse.	NA
	h	The children's family members are educated about nutrition, immunization and safe parenting and this is documented in the medical record.	NA
COP.12: Documented policies and procedures guide the care of patients undergoing moderate sedation.			
	a	Documented procedures guide the administration of moderate sedation.	0
	b	Informed consent for administration of moderate sedation is obtained.	5
	c	Competent and trained persons perform sedation.	10

d	The person administering and monitoring sedation is different from the person performing the procedure.	10
e	Intra – procedure monitoring includes at a minimum the heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation and level of sedation.	10
f	Patients are monitored after sedation and the same is documented.	10
g	Criteria are used to determine appropriateness of discharge from the recovery area.	5
h	Equipment and manpower are available to manage patients who have gone into a deeper level of sedation than that intended.	5
COP.13: Documented policies and procedures guide the administration of anesthesia.		
a	There is a documented policy and procedure for the administration of anesthesia.	0
b	Patients for anesthesia have a pre-anesthesia assessment by a qualified anaesthesiologist.	10
c	The pre-anesthesia assessment results in formulation of an anesthesia plan which is documented.	10
d	An immediate preoperative re-evaluation is performed and documented.	5
e	Informed consent for administration of anesthesia is obtained by the anesthesiologist.	5
f	During anesthesia 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-anesthesia status is monitored and documented.	10
h	The anaesthesiologist applies defined criteria to transfer the patient from the recovery area.	5
i	The type of anaesthesia and anaesthetic medications used is documented in the patient record.	10

	j	Procedures shall comply with infection control guidelines to prevent cross-infection between patients.	5
	k	Adverse anesthesia events are recorded and monitored.	5
COP.14: Documented policies and procedures guide the care of patients undergoing surgical procedures.			
	a	The policies and procedures are documented.	0
	b	Surgical patients have a preoperative assessment and a provisional diagnosis documented prior to surgery.	5
	c	An informed consent is obtained by a surgeon prior to the procedure.	5
	d	Documented policies and procedure exist to prevent adverse events like wrong site, wrong patients and wrong surgery.	0
	e	Persons qualified by law are permitted to perform the procedures that they are entitled to perform.	10
	f	A brief operative note is documented prior to transfer out of patient from recovery area.	10
	g	The operating surgeons documents the post operative plan of care.	10
	h	Patient, personnel and material flow conforms to infection control practices.	5
	i	Appropriate facilities and equipment/appliances/instrumentation are available in the operating theatre.	10
	j	A quality assurance programme is followed for the surgical services.	5
	k	The quality assurance program includes surveillance of the operation theatre environment.	5
COP.15: Documented policies and procedures guide the care of patients under restraints (physical and/ or chemical).			

	a	Documented policies and procedures guide the care of patients under restraints.	0
	b	These include both physical and chemical restraint measures.	0
	c	These include documentation of reasons for restraints.	0
	d	These patients are more frequently monitored.	5
	e	Staff receive training and periodic updating in control and restraint techniques.	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.	5
	c	Patients with pain undergo detailed assessment and periodic re-assessment	10
	d	The organization respects and supports management of pain for such patients.	5
	e	Patient and family are educated on various pain management techniques, where appropriate.	5
COP.17: Documented policies and procedures guide appropriate rehabilitative services.			
	a	Documented policies and procedures guide the provision of rehabilitative services.	0
	b	These services are commensurate with the organizational requirements.	5
	c	Care is guided by functional assessment and periodic re-assessment which is done and documented by qualified individual(s).	5

	d	Care is provided adhering to infection control and safe practices.	5
	e	Rehabilitative services are provided by a multidisciplinary team.	5
	f	There is adequate space and equipment to perform these activities.	5
COP.18: Documented policies and procedures guide all research activities.			
	a	Documented policies and procedures guide all research activities in compliance with national and international guidelines.	0
	b	The organization has an ethics committee to oversee all research activities.	5
	c	The committee has the powers to discontinue a research trial when risks outweigh the potential benefits.	5
	d	Patient's informed consent is obtained before entering them in research protocols.	5
	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.	5
	f	Patients are assured that their refusal to participate or withdrawal from participation will not compromise their access to the organization's services.	5
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.	10
	c	There is a written order for the diet.	10
	d	Nutritional therapy is planned and provided in a collaborative manner.	10

	e	When families provide food, they are educated about the patients diet limitations.	5
	f	Food is prepared, handled, stored and distributed in a safe manner.	5
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.	5
	c	These also address the identification of the unique needs of such patient and family.	5
	d	Symptomatic treatment is provided and where appropriate measures are taken for alleviation of pain.	5
	e	Staff is educated and trained in end of life care.	5
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.	5
	c	A multidisciplinary committee guides the formulation and implementation of these policies and procedures.	5
	d	There is a procedure to obtain medication when the pharmacy is closed.	0
MOM.2: There is a hospital formulary.			

a	A list of medications appropriate for the patients and as per the scope of the organization's clinical services is developed.	10
b	The list is developed and updated collaboratively by the multidisciplinary committee.	10
c	The formulary is available for clinicians to refer and adhere to.	10
d	There is a defined process for acquisition of these medications.	10
e	There is a process to obtain medications not listed in the formulary.	5
MOM.3: Documented policies and procedures guide the storage of medication.		
a	Documented policies and procedures exist for storage of medication.	0
b	Medications are stored in a clean, safe and secure environment; and incorporating manufacturer's recommendation(s).	5
c	Sound inventory control practices guide storage of the medications.	5
d	Sound alike and look alike medications are identified and stored separately.	5
e	The list of emergency medications is defined and is stored in a uniform manner.	5
f	Emergency medications are available all the time.	5
g	Emergency medications are replenished in a timely manner when used.	5
MOM.4: Documented policies and procedures guide the safe and rational prescription of medications.		
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.	5
d	Known drug allergies are ascertained before prescribing.	5
e	The organization determines who can write orders.	5
f	Orders are written in a uniform location in the medical records.	5
g	Medication orders are clear, legible, dated, timed, named and signed.	10
h	Medication orders contain the name of the medicine, route of administration, dose to be administered and frequency/time of administration.	10
i	Documented policy and procedure on verbal orders is implemented.	0
j	The organization defines a list of high-risk medication(s).	5
k	Audit of medication orders/prescription is carried out to check for the safe and rational prescription of medications.	0
l	Corrective and/or preventive action(s) is taken based on the analysis, where appropriate.	5
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.	5
c	Expiry dates are checked prior to dispensing.	5

	d	There is a procedure for near expiry medications.	5
	e	Labeling requirements are documented and implemented by the organization.	0
	f	High-risk medication orders are verified prior to dispensing.	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 labeled prior to preparation of a second drug.	5
	c	Patient is identified prior to administration.	5
	d	Medication is verified from the order prior to administration.	5
	e	Dosage is verified from the order prior to administration.	5
	f	Route is verified from the order prior to administration.	5
	g	Timing is verified from the order prior to administration.	5
	h	Medication administration is documented.	10
	i	Documented polices and procedures govern patient's self administration of medications.	0
	j	Documented polices and procedures govern patient's medications brought from outside the organization.	0
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 defined those situation where close monitoring is required.	5
	c	Monitoring is done in a collaborative manner.	5
	d	Medications are changed where appropriate based on the monitoring.	5
MOM.8: Near misses, medication errors and adverse drug events are reported and analyzed.			
	a	Documented procedures exist to capture near miss, medication error and adverse drug event.	0
	b	Near miss, medication error and adverse drug events are defined.	0
	c	These are reported within a specified time frame.	5
	d	They are collected and analysed.	0
	e	Corrective and/or preventive action(s) are taken based on the analysis where appropriate.	5
MOM.9: Documented procedures guide the use of narcotic drugs and psychotropic substances.			
	a	Documented procedures guide the use of narcotic drugs and psychotropic substances which are in consonance with local and national regulations.	0
	b	These drugs are stored in a secure manner.	5
	c	A proper record is kept of the usage, administration and disposal of these drugs.	10
	d	These drugs are handled by appropriate personnel in accordance with the documented procedure.	5

MOM.10: Documented policies and procedures guide the usage of chemotherapeutic agents.			
	a	Documented policies and procedures guide the usage of chemotherapeutic agents.	NA
	b	Chemotherapy is prescribed by those who have the knowledge to monitor and treat the adverse effect of chemotherapy.	NA
	c	Chemotherapy is prepared in a proper and safe manner and administered by qualified personnel.	NA
	d	Chemotherapy drugs are disposed off in accordance with legal requirements.	NA
MOM.11: Documented policies and procedures govern usage of radioactive drugs.			NA
	a	Documented policies and procedures govern usage of radioactive drugs.	NA
	b	These policies and procedures are in consonance with laws and regulations.	NA
	c	The policies and procedures include the safe storage, preparation, handling, distribution, and disposal of radioactive drugs.	NA
	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).	5
	b	Documented policies and procedures govern procurement, storage/stocking, issuance and usage of implantable prosthesis and medical devices incorporating manufacturer's recommendation(s).	0
	c	Patient and his/her family are counselled for the usage of implantable prosthesis and medical device including precautions, if any.	5
	d	The batch and serial number of the implantable prosthesis and medical devices are recorded in the patient’s medical record and the master logbook.	10

MOM.13: Documented policies and procedures guide the use of medical supplies and consumables.			
	a	There is a defined process for acquisition of medical supplies and consumables.	5
	b	Medical supplies and consumables are used in a safe manner, where appropriate.	5
	c	Medical supplies and consumables are stored in a clean, safe and secure environment; and incorporating manufacturer's recommendation(s).	5
	d	Sound inventory control practices guide storage of medical supplies and consumables.	5
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's and family rights.	5
	d	Staff is aware of its responsibility in protecting patients and family rights.	5
	e	Violation of patient and family rights is recorded, reviewed and corrective/ preventive measures taken.	0
PRE.2: Patient and family rights support individual beliefs, values and involve the patient and family in decision-making processes.			
	a	Patient and family rights include respecting any special preferences, spiritual and cultural needs.	5
	b	Patient and family rights include respect for personal dignity and privacy during examination, procedures and treatment.	5

	c	Patient and family rights include protection from physical abuse and neglect.	5
	d	Patient and family rights include treating patient information as confidential.	5
	e	Patient and family rights include refusal of treatment.	5
	f	Patient and family rights include informed consent before transfusion of blood and blood products, anaesthesia, surgery, initiation of any research protocol and any other invasive/ high-risk procedures/ treatment.	5
	g	Patient and family rights include right to complain and information on how to voice a complaint.	5
	h	Patient and family rights include information on the expected cost of the treatment.	5
	i	Patient and family rights include access to his/ her clinical records.	5
	j	Patient and family rights include information on plan of care, progress and information on their health care needs.	5
PRE.3: The patient nd/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 includinng the risks, alternatives and benefits.	5
	b	The patient and/or family members are explained about the expected results.	5
	c	The patient and/or family members are explained about the possible complications.	5
	d	The care plan is prepared and modified in consultation with patient and/or family members.	5
	e	The care plan respects and where possible incorporates patient and/or family concerns and requests.	5
	f	The patient and/or family members are informed about the results of diagnostic tests and the diagnosis.	5

	g	The patient and/or family members are explained about any change in the patient's condition.	5
PRE.4: A documented procedure for obtaining patient and/ or family's consent exists for informed decision making about their care.			
	a	Documented procedure incorporates the list of situations where informed consent is required and the process for taking informed consent.	0
	b	General consent for treatment is obtained when the patient enters the organisation.	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.	5
	e	The procedure describes who can give consent when patient is incapable of independent decision making.	0
	f	Informed consent is taken by the person performing the procedure.	5
	g	Informed consent process adheres to statutory norms.	5
	h	Staff are aware of the informed consent procedures.	5
PRE.5: Patient and families have a right to information and education about their health care needs.			
	a	Patient and/or family are educated about the safe and effective use of medication and the potential side effects of the medication, when appropriate.	5
	b	Patient and/or family are educated about food-drug interactions.	5
	c	Patient and/or family are educated about diet and nutrition	5

	d	Patient and/or family are educated about immunisations.	5
	e	Patient and/or family are educated about organ donation, when appropriate.	5
	f	Patient and/or family are educated about their specific disease process, complications and prevention strategies.	5
	g	Patient and/or family are educated about preventing healthcare associated infections.	5
	h	Patient and/or family are educated in a language and format that they can understand.	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).	5
	b	The tariff list is available to patients.	5
	c	The patient and/or family are explained about the expected costs.	5
	d	Patient and/or family are informed about the financial implications when there is a change in the patient condition or treatment setting.	5
PRE.7: Organization has a complaint redressal procedure.			
	a	The organization has a documented complaint redressal procured.	0
	b	Patient and/or family members are made aware of the procedures for lodging complaints.	0
	c	All complaints are analysed.	5
	d	Corrective and/or preventive action(s) are taken based on the analysis where appropriate.	5

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.	5
	c	The hospital has a multi-disciplinary infection control committee, which coordinates all infection prevention and control activities.	5
	d	The hospital has an infection control team, which coordinates implementation of all infection prevention and control activities.	5
	e	The hospital has designated infection control officer as part of the infection control team.	5
	f	The hospital has designated infection control nurse(s) as part of the infection control team.	5
HIC.2: The organisation 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.	5
	b	The organization adheres to standard precautions at all times.	5
	c	The organization adheres to hand-hygiene guidelines.	10
	d	The organization adhere 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 sterilisation practices.	5
	g	An appropriate antibiotic policy is established and implemented.	0
	h	The organization adheres to laundry and linen management processes.	5
	i	The organization adheres to kitchen sanitation and food handling issues.	5
	j	The organization has appropriate engineering controls to prevent infections.	5
	k	The organization adheres to housekeeping procedures.	5
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.	5
	b	Collection of surveillance data is an on-going process.	5
	c	Verification of data is done on regular basis by the infection control team.	5
	d	Scope of surveillance activities incorporates tracking and analyzing of infection risks, rates and trends.	5
	e	Surveillance activities include monitoring the compliance with hand-hygiene guidelines.	5
	f	Surveillance activities include monitoring the effectiveness of housekeeping services.	5
	g	Appropriate feedback regarding HAI rates are provided on a regular basis to appropriate personnel.	5
	h	In cases of notifiable diseases, information (in relevant format) is sent to appropriate authorities.	5

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.	5
	b	The organization takes action to prevent respiratory tract infections.	5
	c	The organization takes action to prevent intra-vascular device infections.	5
	d	The organization takes action to prevent surgical site infections.	5
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 healthcare providers.	5
	c	Isolation/ barrier nursing facilities are available.	5
	d	Appropriate pre- and post-exposure prophylaxis is provided to all staff members concerned.	5
HIC.6: The organisation identifies and takes appropriate action to control outbreaks of infections.			
	a	Organization has a documented procedure for identifying an outbreak.	0
	b	The organization has a documented procedure for handling such outbreaks.	0
	c	This procedure is implemented during outbreaks.	5

	d	After the outbreak is over appropriate corrective actions are taken to prevent recurrence.	5
HIC.7: There are documented policies and procedures for sterilisation activities in the organisation.			
	a	The organization provides adequate space and appopriate zoning for sterilization activities.	10
	b	Documented procedure guides the cleaning, packing, disinfection and/or sterlization, storing and issue of items.	0
	c	Reprocessing of instruments and equipment are covered.	0
	d	Regular validation tests for sterilisation are carried out and documented.	10
	e	There is an established recall procedure when breakdown in the sterilisation system is identified.	0
HIC.8: Bio-medical Waste (BMW) is handled in an appropriate and safe manner.			
	a	The organization adheres to statutory provisions with regard to biomedical waste.	10
	b	Proper segregation and collection of Bio-medical Waste from all patient care areas of the hospital is implemented and monitored.	10
	c	The organization ensures that Bio-medical 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	Bio-medical 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 Bio-medical Waste.	10
HIC.9: The infection control programme is supported by the management and includes training of staff.			
	a	The management makes available resources required for the infection control programme.	10

	b	The 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
Chapter 6: CONTINUOUS 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.	5
	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 predefined intervals.	5
	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.	5
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.	5
d	The scope of the programme is defined to include adverse events ranging from "no harm" to "sentinel events".	5
e	There is a designated individual for coordinating and implementing the patient-safety programme.	5
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-safey goals/solutions.	5
j	The organization uses at least two identifiers to identify patients across the organization.	5
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.	5
b	Monitoring includes safety and quality control programmes of the diagnostics services.	5
c	Monitoring includes medication management.	5

	d	Monitoring includes use of anaesthesia.	5
	e	Monitoring includes surgical services.	5
	f	Monitoring includes use of blood and blood products.	5
	g	Monitoring includes infection control activities.	5
	h	Monitoring includes review of mortality and morbidity indicators.	5
	i	Monitoring includes clinical research.	5
	j	Monitoring includes data collection to support further improvements.	5
	k	Monitoring includes data collection to support evaluation of these improvements.	5
CQI.4: The organization identifies key indicators to monitor the managerial structures, processes and outcomes which are used as tools for continual improvement.			
	a	Monitoring includes procurement of medication essential to meet patient needs.	5
	b	Monitoring includes risk management.	5
	c	Monitoring includes utilisation of space, manpower and equipment.	5
	d	Monitoring includes patient satisfaction which also incorporates waiting time for services.	5
	e	Monitoring includes employee satisfaction.	5

	f	Monitoring includes adverse events and near misses.	5
	g	Monitoring includes availability and content of medical records.	5
	h	Monitoring includes data collection to support further study for improvements.	5
	i	Monitoring includes data collection to support evaluation of these improvements.	5
CQI.5: The quality improvement programme is supported by the management.			
	a	The management makes available adequate resources required for quality improvement programme.	10
	b	Organization earmarks adequate funds from its annual budget in this regard.	10
	c	The management identifies organizational performance improvement targets.	10
	d	The management supports and implements use of appropriate quality improvement, statistical and management tools in its quality improvement programme.	10
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 organisation.	0
	c	Patient and staff anonymity is maintained.	0
	d	All audits are documented.	0
	e	Remedial measures are implemented.	0

CQI.7: Incidents, complaints and feedback are collected and analyzed to ensure continual improvement.			
	a	The organization has an incident reporting system.	5
	b	The organization has a process to collect feedback and receive complaints.	5
	c	The organization has established processes for analysis of incidents, feedbacks and complaints.	5
	d	Corrective and preventive actions are taken based on the findings of such analysis.	5
	e	Feedback about care and service is communicated to staff.	5
CQI.8: Sentinel events are intensively analysed.			
	a	The organisation has defined sentinel events.	5
	b	The organisation has established processes for intense analysis of such events.	5
	c	Sentinel events are intensively analysed when they occur.	5
	d	Corrective and preventive Actions are taken based on the findings of such analysis.	5
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 vission, mission and values.	10
	b	Those responsible for governance approve the strategic and operational plans and organization's budget.	10

	c	Those responsible for governance monitor and measure the performance of the organization against the stated mission.	10
	d	Those responsible for governance establish the organization's organogram.	10
	e	Those responsible for governance appoint the senior leaders in the organization.	10
	f	Those responsible for governance support safety initiatives and quality-improvement plans.	10
	g	Those responsible for governance support research activities.	10
	h	Those responsible for governance address the organization's social responsibility.	10
	i	Those responsible for governance inform the public of the quality and performance of services.	10
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.	10
	b	The management ensures implementation of these requirements.	10
	c	Management regularly updates any amendments in the prevailing laws of the land.	10
	d	There is a mechanism to regularly update licenses/ registrations/certifications.	10
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 is maintained.	0

	c	Each organizational program, service, site or department has effective leadership.	5
	d	Departmental leaders are involved in quality improvement.	5
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.	10
	b	The leaders establish the organization's ethical management.	10
	c	The organization discloses its ownership.	10
	d	The organization honestly portrays the services which it can and cannot provide.	10
	e	The organization honestly portrays its affiliations and accreditations.	10
	f	The organization accurately bills for it's services based upon a standard billing tariff.	10
ROM.5: The organisation displays professionalism in management of affairs.			
	a	The person heading the organization has requisite and appropriate administrative qualifications.	10
	b	The person heading the organization has 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 stakeholders.	10
	d	The organization coordinates the functioning with departments and external agencies and monitors the progress in achieving the defined goals and objectives.	10
	e	The organization plans and budgets for its activities annually.	10

	f	The performance of the senior leaders is reviewed for their effectiveness.	10
	g	The functioning of committees is reviewed for their effectiveness.	5
	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
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.	5
	b	Management provides resources for proactive risk assessment and risk reduction activities.	5
	c	Management ensures implementation of systems for internal and external reporting of system and process failures.	5
	d	Management ensures that appropriate corrective and preventive actions are taken to address safety-related incidents.	5
Chapter 8: FACILITY MANAGEMENT AND SAFETY (FMS)			
FMS.1: The organisation 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.	5

b	Patient safety devices are installed across the organization and inspected periodically.	5
c	The organization is a non-smoking area.	5
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.	5
e	Inspection reports are documented and corrective and preventive measures are undertaken.	5
f	There is a safety education programme for all staff.	5
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.	10
b	Up-to-date drawings are maintained which detail the site layout, floor plans and fire escape routes.	10
c	There is internal and external sign postings in the organisation 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.	10
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 organisation regularly tests the alternate sources.	10
h	There are designated individuals responsible for the maintenance of all the facilities.	10
i	There is a documented operational and maintenance (preventive and breakdown) plan.	5

	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.	10
FMS.3: The organization has a program for engineering support services.			
	a	The organization plans for equipment in accordance with its services and strategic plan.	10
	b	Equipments are selected, rented, updated or upgraded by a collaborative process.	10
	c	Equipments are inventoried and proper logs are maintained as required.	10
	d	Qualified and trained personnel operate and maintain equipment and utility systems.	10
	e	There is a documented operational and maintenance (preventive and breakdown) plan.	5
	f	There is a maintenance plan for water management.	5
	g	There is a maintenance plan for electrical systems.	5
	h	There is a maintenance plan for heating, ventilation and air-conditioning.	5
	i	There is a documented procedure for equipment replacement and disposal.	5
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.	10
	b	Equipment are selected, rented, updated or upgraded by a collaborative process.	10

	c	Equipment are inventoried and proper logs are maintained as required.	10
	d	Qualified and traned personnel operate and maintain the medical equipment.	10
	e	Equipment are periodically inspected and calibrated for their proper functioning.	5
	f	There is a documented operational and maintenance (preventive and breakdown) plan.	5
	g	There is a documented procedure for equipment replacement and disposal.	5
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.	5
	b	Medical gases are handled, stored, distributed and used in a safe manner.	5
	c	The procedures for medical gases address the safety issues at all levels.	5
	d	Alternate sources for medical gases, vacuum and compressed air are provided for, in case of failure.	5
	e	The organization regularly tests these alternate sources.	5
	f	There is a maintenance plan for piped medical gas, compressed air and vacuum installation.	5
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.	5
	b	The organization has a documented safe exit plan in case of fire and non-fire emergencies.	5

	c	Staff is trained for its 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.	5
FMS.7: The organization plans for handling community emergencies, epidemics and other disasters.			
	a	The organization identifies potential emergencies.	5
	b	The organization has a documented disaster management plan.	5
	c	Provision is made for availability of medical supplies, equipment and materials during such emergencies.	5
	d	Staff are trained in the hospital's disaster management plan.	0
	e	The plan is tested at least twice in a year.	0
FMS.8: The organization has a plan for management of hazardous materials.			
	a	Hazardous materials are identified within the organization.	5
	b	The hospital implements processes for sorting, labelling, handling, storage, transporting and disposal of hazardous material.	5
	c	Requisite regulatory requirements are met in respect of radioactive materials.	5
	d	There is a plan for managing spills of hazardous materials.	5
	e	Staff are educated and trained for handling such materials.	5

Chapter 9: HUMAN RESOURCE MANAGEMENT (HRM)			
HRM.1: The organization has a documented system of human resource planning.			
	a	Human resource planning supports the organization's current and future ability to meet the care, treatment and service needs of the patient.	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 specifications 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
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 patients’ rights and responsibilities.	0
	g	The induction training includes orientation to the service standards of the organisation.	0
	h	Each staff member is made aware of organization wide policies and procedures as well as relevant department / unit / service / programme’s policies and procedures.	0

HRM.3: There is an ongoing programme for professional training and development of the staff.			
	a	A documented training and development policy exists for the staff.	0
	b	The organization maintains the training record.	0
	c	Training also occurs when job responsibilities change/ new equipment is introduced.	0
	d	Feedback mechanisms for assessment of training and development programme exist and the feedback is used to improve the training programme.	0
HRM.4: Staff are adequately trained on various safety-related aspects.			
	a	Staff are trained on the risks within the organization's environment.	5
	b	Staff members can demonstrate and take actions to report, eliminate / minimize risks.	5
	c	Staff members are made aware of procedures to follow in the event of an incident.	5
	d	Staff are trained on occupational safety aspects.	5
HRM.5: An appraisal system for evaluating the performance of an employee exists as an integral part of the human resource management process.			
	a	A documented performance appraisal system exists in the organization.	0
	b	The employees are made aware of the system of appraisal at the time of induction.	0
	c	Performance is evaluated based on the pre-determined criteria.	0

	d	The appraisal system is used as a tool for further development.	0
	e	Performance appraisal is carried out at pre defined intervals and is documented.	0
HRM.6: The organization has documented disciplinary and grievance-handling policies and procedures.			
	a	Documented policies and procedures exist.	0
	b	The policy and procedure 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.	5
	d	The disciplinary procedure is in consonance with the prevailing laws.	5
	e	There is a provision for appeals in all-disciplinary cases.	5
	f	The redress procedure addresses the grievance.	0
	g	Actions are taken to redress the grievance.	5
HRM.7: The organization addresses the health needs of the employees.			
	a	A pre-employment medical examination is conducted on all the employees.	5
	b	Health problems of the employees are taken care of in accordance with the organization's policy.	5
	c	Regular health checks of staff dealing with direct patient care are done at-least once a year and the findings/ results are documented.	5
	d	Occupational health hazards are adequately addressed.	5

HRM.8: There is a documented personal record for each staff member.			
	a	Personal files are maintained in respect of all employees.	10
	b	The personal files contain personal information regarding the employees 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 result of all evalutions.	0
HRM.9: There is a process for credentialing and privileging of medical professionals permitted to provide patient care without supervision.			
	a	Medical professionals permitted by law, regulation and the organization to provide patient care without supervision is identified.	10
	b	The education, registration, training and experience of the identified medical professionals is documented and updated periodically.	10
	c	All such information pertaining to the medical professionals is appropriately verified when possible.	10
	d	Medical professionals are granted priviledges to admit and care for patients in consonance with their qualification, training, experience and registration.	10
	e	The requisite services to be provided by the medical professionals are known to them as well as the various departments/ units of the hospital.	10
	f	Medical professionals admit and care for patients as per their priviledging.	10
HRM.10: There is a process for credentializing and priviledging 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.	10

	b	The education, registration, training and experience of nursing staff is documented and updated periodically.	10
	c	All such information pertaining to the nursing staff is appropriately verified when possible.	10
	d	Nursing staff are granted privileges in consonance with their qualification, training, experience and registration.	10
	e	The requisite services to be provided by the nursing staff are known to them as well as the various departments / units of the hospital.	10
	f	Nursing professionals care for patients as per their priviledging.	10
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.	5
	b	Documented policies and procedures to meet the information needs are documented.	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
IMS.2: The organization has processes in place for effective management of data.			
	a	Formats for data collection are standardized	5

	b	Necessary resources are available for analyzing data.	5
	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.	5
IMS.3: The organization has a complete and accurate medical record for every patient.			
	a	Every medical record has a unique identifier.	10
	b	Organisation policy identifies those authorized to make entries in medical record.	10
	c	Entry in the medical record is named, signed, dated and timed.	10
	d	The author of the entry can be identified.	10
	e	The contents of medical record are identified and documented.	10
	f	The record provides a complete, up-to-date and chronological account of patient care.	10
	g	Provision is made for 24-hour availability of the patient's record to healthcare providers to ensure continuity of care.	10
IMS.4: The medical record reflects continuity of care.			
	a	The medical record contains information regarding reasons for admission, diagnosis and plan of care.	10
	b	The medical record contains the result 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.	10
	e	The medical record contains a copy of the discharge summary duly signed by appropriate and qualified personnel.	10
	f	In case of death, the medical record contains a copy of the 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
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 procedures 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.	5
	e	The organization uses developments in appropriate technology for improving confidentiality, integrity and security.	5
	f	Privileged health information is used for the purposes identified or as required by law and not disclosed without the patient's authorization.	5
	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

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.	5
	d	The destruction of medical records, data and information is in accordance with the laid down policy.	5
IMS.7: The organization regularly carries out review of medical records.			
	a	The medical records are reviewed periodically.	NA
	b	The review uses a representative sample based on statistical principles.	NA
	c	The review is conducted by identified care providers.	NA
	d	The review focuses on the timeliness, legibility and completeness of the medical records.	NA
	e	The review process includes records of both active and discharged patients.	NA
	f	The review points out and documents any deficiencies in records.	NA
	g	Appropriate corrective and preventive measures are undertaken within a defined period of time and are documented.	NA