A STUDY TO ASSESS MAINTENANCE OF NABH STANDARDS IN A TERTIARY CARE TEACHING HOSPITAL IN JAMMU

Dissertation Submitted to

The IIHMR University, Jaipur

For the partial fulfillment for the award of the degree

of Master of Business Administration (MBA)

In

Hospital and Health Management

By

Dr Sarbpriay Jamwal

Under the Supervision and Guidance of

Dr Kanika Jindal

2022

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DECLARATION BY STUDENT

I hereby declare that this dissertation titled“Study toAccess maintance of NABH standards in a tertiary care teaching hospital in Jammu”is the bonafide record of my original research work. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published work of others has been duly acknowledged in the text.

Signature

Dr Sarbpriay Jamwal

Date-25th June 2022

CERTIFICATE

This is to certify that Dr Sarbpriay Jamwal impartial fulfillment of the requirements for the award of the degree of MBA (Hospital and Health Management) from the IIHMR University; Jaipur has successfully completed his internship at Shri Mata Vashino Devi Narayana Super specialty Hospital Kakryal Katra, Jammu during March 28, 2022 to June 25, 2022

Place: Jammu (J&K,UT)
Date: 25th June 2022

Head of the Organization
Mr. Muthu Mathavan
Facility Director
Department of Administration
SMVDN Super specialty Hospital
Kakryal, Katra, Jammu

CERTIFICATE

This is to certify that dissertation titled “Study to acess maintance of NABH standards in a tertiary care teaching hospital in Jammu” is a record of the research Work undertaken by Dr Sarbpriay Jamwal impartial fulfillment of the requirements for the award of the degree of MBA (Hospital and Health Management) from the IIHMR University, Jaipur under my guidance and supervision and his/her approach to the research study has been sincere, scientific, and analytical.

Faculty Guide	School Dean
Dr Kanika Jindal	Dr. (Col.) Mahender
Assistant Professor	Kumar
IIHMR University, Jaipur	Dean, IIHMR University, Jaipur
Date	Date

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LIST OF ABBREVIATIONS

SMVDNSH	Shri Mata Vaishno Devi Narayana Superspeciality Hospital
JCAHO	Joint Commission on Accreditation of Health Care Organization
JCI	Joint Commission International
QCI	Quality Council of India
ICU	Intensive Care Unit
SOP	Standard Operating Procedures
AAC	Access, Assessment and Continuity of Care
COP	Care of Patients
MOM	Management of Patients
PRE	Patient Rights and responsibilities
HIC	Hospital Infection Control
CQI	Continuous Quality Improvement
ROM	Responsibilities of Management
FMS	Facility Management System
HRM	Human Resource Management
IMS	Information management System
OPD	Out Patient Department
KASH	Kerala Accreditation Standards for Hospitals
IPD	Inpatient Department
MRD	Medical Record Department

WHO	World Health Organization
CAPA	Corrective and Preventive Action
MOT	Major Operation Theatre
STEEP	Safe, Timely, Effective, Efficient, Equitable, Patient centered
ISQua	International Society for Quality in health care
SPSS	Statistical Package for the Social Sciences
HOD	Head of the Department
CSSD	Central Sterile and Supply Department

Chapter: 1

INTRODUCTION

Around the USA, certification first gained popularity in 1910 as a way to measure the effectiveness of medical care. The American College of Surgeons was founded in 1919 as a result of the hospital regularity program. The Joint Commission on Accreditation of Health Care Organization (JCAHO), now known as Joint Commission International, was founded in 1953 (JCI). A division of the Quality Council of India (QCI), the National Accreditation Board for Hospitals and Health Care Providers (NABH) was established to create and manage an accreditation program for healthcare institutions. The company must conduct a self-evaluation of its level of conformity with NABH criteria in order to receive NABH accreditation. The NABH, which is part of the national certification agency of India, is the premier accreditation body, which constitutes the board of the quality council of India. The design and management of an accreditation program for healthcare institutions is the primary goal of the National Accreditation Board for Hospitals & Healthcare Providers (NABH), a constituent board of the Quality Council of India. The board's goals are to satisfy customers' top priorities while setting standards for the growth of the health sector. The board has full operational authority and is supported by all parties, including business, consumers, and the government. Through the accreditation process, it is possible to evaluate the current setup, procedures, and activities in order to transform them into process maps, standard operating procedures (SOPs), standards, and norms as specified by various accreditation authorities. A foundation for measuring hospital care quality is provided through accreditation. Accreditation establishes a standard that the organization must adhere to. In recent years, there has been a lot of interest in accreditation as a complete strategy to raise and maintain the standard of healthcare. Accreditation is a learning and continual quality improvement process. But little is understood about how accreditation affects the standard of patient care and safety.. The accreditation board does not tolerate performance that falls short of that criterion. It provides a list of objectives and goals that aid the organization in providing high-quality treatment, and if they are not met, the accreditation may be revoked..

The post-certification era is particularly important because the organization should not let the goals it worked so hard to achieve during the accreditation process be in vain. Following the creation of the fundamental structure, the completion of functions, and optimization of activities, the culture of the company should embrace ongoing quality improvement. The quality of treatment will decline and the license may be revoked by the certification body if the standards are not upheld as they were at the time of accreditation. Accreditation alone is insufficient for upholding standards at all times after accreditation; additional efforts are required. We will check the compliance rate of the NABH standards in the organization according to NABH 5th edition post accreditation and key causes of non- compliance in NABH standards as per the NABH 5th edition. The NABH 5th edition has 10 chapters, 651 Objectives elements, of which 102 are in the core category and must be evaluated as part of each assessment, 459 are in the commitment category and will be evaluated as part of the final assessment, 60 are in the achievement category, and 30 are in the excellence category. The NABH accreditation process is ongoing, and the accreditation is not cumulative. It is a continuous process instead. The hospital is in charge of constantly upholding standards and regulating policies. Once a hospital receives accreditation, the accreditation is good for a specific amount of time and is subject to revision based on ongoing monitoring. Regular surveillance of the accredited organization is carried out by NABH. Once the specified time of accreditation has passed, the accreditation will need to be renewed. For a list of recognized and applicant organizations under various programs, consult the "Accredited Register." Hospital accreditation guidelines aid in concentrating on patient safety and enhancing the caliber of medical procedures and services. One of the most popular methods for externally evaluating the effectiveness and performance of healthcare institutions is accreditation. The NABH standards in the current situation are the best benchmark for the quality care. The NABH accreditation primarily benefits patients by ensuring high standards of care and their safety. A technique for evaluating the caliber of healthcare institutions uses published standards and outside surveyors. It is commonly contrasted with internal review procedures, in which team members create their own criteria and metrics for evaluating quality. There isn't much data to back up which of these two review types has an effect on patient care and clinical results. A higher emphasis is placed on risk management and patient safety during the certification process than it was

during prior testing to gauge standard compliance.. Different accreditation organizations were founded all around the world to help enhance the quality of treatment offered. These certification bodies provided a set of standards, which not only assist one to understand where a company sits in terms of quality but also aid in maintaining and improving the standards. Different accreditation institutions that work with non-governmental, nonprofit groups are operating now in India. The NABH is one of the crucial organizations among them. The maintenance and enhancement of quality depend on accreditation. Accreditation alone is not sufficient; quality must be upheld and ongoing development is required. A study was conducted to see whether accreditation was a continuing procedure for an organization or if it was merely a one-time event. The post-accreditation era is particularly important since everything the organization worked so hard to achieve during the accreditation process shouldn't be in vain. Following the creation of the fundamental structure, the completion of functions, and optimization of activities, the culture of the company should embrace ongoing quality improvement. The quality of treatment will decrease if the requirements are not upheld as they were at the time of certification, and the accreditation agency may revoke the license. Accreditation is not sufficient; additional efforts must be made to uphold the standards.

Accreditation and quality management systems are flexible tools for ensuring healthcare services are equitable and that people's growing demands are met. The establishment of a quality management system with an emphasis on conformity with NABH and similar agencies' accreditation criteria can help to bring about this ideal state of affairs. An organization can use gap analysis as a technique to evaluate its current performance to that of the future.

The Aim of the study is to assess maintenance of NABH standards in a Tertiary Care NABH Accredited Teaching Hospital at Jammu.

The study was carried out in a corporate hospital in Jammu with NABH accreditation. Various accreditation agencies are formed in order to raise the standard of treatment given. Accreditation is not a onetime process. It is an integral part of quality. This study aims to find gaps in standards during the post accreditation process and also check whether an

organization was able to maintain standards. Also suggest recommendations for streamlining the processes.

Chapter: 2

REVIEW OF LITERATURE

NABH accreditation and maintenance of these standards directly effects the patient satisfaction. It is important to educate the staff of these standards to maintain the quality of hospital and patient satisfaction. The results of the patient satisfaction survey will also indicated that the patients are dissatisfied with the provided services if staff is not aware of general standards. [1]

Health care accreditation is a way to evaluate the calibre of healthcare organisations utilising outside surveyors and published standards in the post-accreditation phase patient safety culture. The KAUH nursing staffs were regularly contrasted with internal evaluation procedures, in which team members create their own metrics for evaluating performance. In an effort to gauge how the nursing staff at KAUH felt about the patient safety culture following the adoption of the Canadian certification procedure, a survey of the staff was conducted. The survey findings were compared to the global benchmarks from the Hospital Survey on Patient Safety Culture. The significance of any discrepancies was recognised after statistical analysis of the data using the z test. The study's findings were displayed, with each displaying the scores of responses to the questions included in the questionnaire. The observer discovered that the reported KAUH values were either higher or lower than the international benchmarks, despite the observed agreement between nearly all of the various aspects of patient safety culture and the corresponding international benchmarks, as determined by the answers to nearly all of the questioned items. [2]

In many government hospitals in Kerala received accreditation through national-level (National Accreditation Board for Hospitals & Healthcare Providers [NABH]) and state-level (Kerala Accreditation Standards for Hospitals [KASH]) accreditation programmes. Accreditation has become a crucial benchmark for healthcare organizations as compared to non-accredited hospitals, the study looked at how well public healthcare was delivered in these accredited hospitals. According to the survey, patient satisfaction was the same in hospitals that were accredited and those that weren't. Patient satisfaction in hospitals with NABH accreditation was lower than in hospitals with KASH accreditation. In comparison

to NABH recognized hospitals, KASH accredited hospitals had a higher mean score on six components of quality healthcare delivery. This proved that study that while certification improves some aspects of healthcare delivery, it does not result in a systemic transformation. Hence, interpersonal and infrastructural aspects of healthcare delivery must be included if accreditation is to signify quality healthcare delivery. [3]

In the current economic climate, ensuring patient happiness globally requires careful consideration on how to continuously improve the quality of healthcare services. 51 freshly hired staff nurses at Krishna Hospital participated in the study. A survey of evaluators was taken into consideration. The goal was to evaluate newly hired staff nurses' knowledge of and adherence to NABH recommendations and to see whether there was any correlation between that knowledge and adherence between the PTP program's pre-test and post-test. One group underwent a pre- and post-test as part of the study's design. The technique of purposeful sampling was adopted. 51 freshly hired staff nurses at Krishna Hospital participated in the study. A survey of evaluators was taken into consideration. The study found that the majority of newly hired nursing staff had average awareness of NABH guidelines—19.38 percent—and average practice—17.85 percent. There was a substantial difference in newly hired nursing staff's knowledge and practice scores between the pre-test and post-test. [4]

Also by comparing the hospitals with and without NABH accreditation can clarify whether or not NABH accreditation aids hospitals in enhancing their performance. Data for the comparison came from primary and secondary sources.. The percentage, ratio, and z-test are used to assess the data that has been gathered. shows that one doctor is available for ten patients in non-NABH accredited hospitals, but only five patients in NABH accredited ones. Similarly, in non-NABH accredited hospitals, there is one nurse available for every 20 patients. However, one nurse can care for 10 patients in NABH-accredited facilities. The standard minimum stay in non-NABH recognised hospitals is five days, while the standard minimum stay in NABH accredited hospitals is seven days. Additionally, the ratio of patients who received treatment while being admitted and those who did not is 1:10 in NABH-accredited hospitals against 1:10 in non-NABH-accredited hospitals. It is abundantly obvious that high rates of bed occupancy and turnover occur in hospitals that

are not NABH recognised. Patients are therefore released early in the healing process, as opposed to NABH recognised facilities where patients are released a few days into the healing process. They remain longer because of it. Additionally, the SERVQUAL's five characteristics of Tangible, Reliability, Responsiveness, Assurance, and Empathy are used to evaluate the non-clinical outcome. According to the non-clinical results displayed in the table below, NABH accredited hospitals are more real, trustworthy, responsive, confident, and full of empathy than non-NABH accredited hospitals.. [5]

Now, let’s discuss an example of one of the chapter under NABH 5th Edition guidelines i.e Management of Medication (MOM) in Hospitals. The third chapter of the NABH guidelines for hospitals, MOM-Management of Medication, provides information on how pharmaceuticals should be managed in any hospital or healthcare facility. There are 68 objective elements and 11 Standards. The first standard discusses prescription drug use and pharmacy services. Implementing pharmacy services and using medications should follow a documented guideline for smooth process operation. The second standard concerns the use of hospital formularies. A multidisciplinary committee should create a list of pharmaceuticals that are appropriate for the patients and in line with the therapeutic requirements of the organisation. The third standard talks about the proper handling and prompt delivery of medications. Medication should be stored according to the manufacturer's recommendations in a clean, secure, and safe location. Additionally, regular audits are used to protect the drug from theft and loss. The fourth standard deals with the logical and secure prescription of medications. Guidelines for excellent practise and guidelines for the rational prescription of medications are followed while writing prescriptions for medications. To prevent any untoward incident, drug allergies and prior drug responses are determined before prescribing. Medication writing in a consistent manner is standard 5. Only a designated person may write orders. Medication orders, which include the patient's name and unique identification number, are consistently written in the medical records. The dates, times, and signatures on medication orders are legible. It is important to give emphasis to the identity of the individual writing the prescription, including name and employee code. [6]

We can also understand the single department medical record keeping in accordance with NABH standards. According to the National Accreditation Board of Hospitals Information Management System (NABH.IMS) and Patient Rights and Education (NABH.PRE) guidelines, the investigation was carried out in a South Indian cancer hospital and research facility. The investigation was split into two stages: In Phase 1, policies and practises relating to medical documentation were observed in accordance with the NABH.IMS and NABH.PRE Standards. The compliance of current policies and procedures with regard to medical documentation in practise was assessed using a standard checklist based on the objective NABH.IMS standards (NABH.IMS 1, 2, 4g, 5, 6, and 7). Phase 2's investigation of 520 records of cancer patients who had been discharged included 325 records for head and neck cancer, 130 records for breast cancer, and 65 records for cervical cancer. Using a 1:2:5 proportionate stratified random selection approach, the records were chosen. For the study, records that were both active and expired were used. The observations' compliance and non-compliance with each other were recorded down. The data was gathered using a verified and pre-tested checklist based on the NABH.IMS Standards (IMS 3, 4, except 4g) and NABH.PRE Standards (PRE-3 a, d, e except 3c). Ten different forms—including the Admission Record Form, the Consent of Procedure and Operation Form, the CT Simulation Form, the History and Physical Examination, the Radiotherapy Chart, the Discharge Summary, the Anesthesia Report, the Operation Chart, the Progress Note, and the Nurses Records—were all taken into consideration and their accuracy and completeness were assessed. Except for NABH.IMS.5c, where inadequate precautions were taken to preserve patient records from disaster or destruction, the existing policies and procedures were judged to be in compliance with NABH standards. The periodic evaluation of medical records, which is required by law but is not documented yet is practised in hospitals, was also found to be out of compliance (NABH.IMS.7). When a patient first enters the facility, there is no general consent for treatment protocol in place (NABH.PRE.3). The study's findings are reported in terms of the existence of different features in various formats that are used to record the specifics of cancer patients' medical care. The outcomes are calculated using percentages. The outcomes of the examination and inspection of medical records revealed that, with few exceptions or noncompliance, the medical documentation used in the hospital complies with the standards established by NABH. Breast and head and

neck malignancies had the lowest compliance rates, but radiation for cervical cancer had the highest. On 139 radiotherapy charts for head and neck cancer and 51 radiotherapy charts for breast cancer, the main non-compliance was related to the existence of form, details, age, gender, diagnosis, consultant name and unit, physicians order with date, and doctors signature. The phrase "witness whose memory never feeds" is often used to describe medical records, however this only applies when they are well-maintained and controlled. The hospital is able to comply with regulatory and accrediting standards because to the methodical approach in which the necessary data, information, and other pertinent papers are recorded and stored with the intention of easy availability and accessibility.. According to the findings of this research, hospital medical record management and documentation correspond to the most stringent criteria established by NABS.IMS. The highest levels of satisfaction with regard to medical documentation were found to be in the nurse's record, the doctor's order, the anaesthetic reports in cases of breast and head and neck cancer, the radiotherapy charts in cases of cervical cancer, and the doctor's order. The bulk of entries—including the patient's or a relative's signature, a witness's signature along with their name and address, and the time the consent was obtained—were found to be missing on the General Consent Form and Procedure Consent Form, which were the most flagged as non-compliant. NABH standards found the overall documentation to be adequate. [7]

It is also important to understand the care of patient and patient satisfaction. The majority of patients have faith and confidence in the medical professionals who are treating them. The main problem patient faces while complaining is the lack of a patient grievance cell that can be used to file complaints and address patient grievances. Half of the patients are generally unaware of whether nurses cleaned/washed their hands after touching them. Right to Privacy is practice effectively. Only in few cases it hard to follow, particularly in general wards, where privacy is occasionally attainable but not always. Most of the issues about privacy came from general ward. The hospital must make sure that the patient's privacy is protected throughout the procedure or consultation. The investigation found that current procedures regarding patient education and rights are not up to mark of NABH standards. [8]

Also it is important to understanding the Hazard Profile and Levels of Disaster Preparedness of NABH Accredited Hospitals. Despite structural differences and institutional age, there should be substantial level of catastrophe readiness among recognised hospitals. [9]

Also in Major Operation Theatre Complex the NABH Accreditation Standard in place are very important. Physical facilities and safety precautions are insufficient without following NABH standards. Though, the equipment facilities and staffing structure were satisfactory. But lack of compliance with necessary documentation for NABH accreditation is a primary cause of the discrepancy with staff opinion. Also the knowledge of quality management concepts and accreditation standards is beneficial for enhancing the performance of hospital. [10]

National accreditation also involves how patients experience ambulance services. In India NABH has affected patients' experiences and the experiences of their families who have used hospital ambulance services. Prior to accreditation, it was found that patients and families who used hospital ambulance services had a worse patient experience rate, which had an impact on the hospital's business. It was found that the patients and families that utilized the ambulance services benefited from the national accreditation NABH. [11]

While it is important to get NABH accreditation to enhance the performance of hospital, hospital Staff Awareness of NABH Standards of Human Resource Management is also very important. Timely upgrading current procedures and putting in place mechanisms of action to ensure strict adherence to the NABH standards for human resource management are both required. Training in human resource management standards is required because there aree numerous Standards that the personnel did not know about. A suitable communication system had to be constructed. It is important to schedule training sessions so that staff employees could participate. Additionally, training with accurate and sufficient knowledge on the standards is required. [12]

For the present generation of healthcare professionals, quality has emerged as a key keyword. The majority of hospitals and healthcare organisations are categorised and assessed based on the effectiveness of their organisations. An integral board of the Quality

Council of India, the National Accreditation Board for Hospitals and Healthcare Providers (NABH) was created to run an accreditation programme for healthcare organisations and institutions. Healthcare organisations that meet the NABH standards are given accreditation through an impartial, external assessment carried out by a skilled team of assessors. For good reason, the word "quality" has emerged as a key watchword in the healthcare sector. But quality might imply different things to various organisations and service providers. A hospital's quality should embrace all it does, including how it treats its patients, ensures the health and safety of all of its clients and staff, and enhances the general health and wellbeing of its communities. NABH is a corporate member of the ISQua's Accreditation Council. ISQua has accredited and given its approval to the standards established by NABH. As a result, NABH standards are in line with the international standards established by ISQua. As a result, the hospitals that have received NABH accreditation are recognised internationally. Also it benefits all the stakeholders in one way or another .[13]

To gauge and keep track of the level of patient care delivered, quality and safety indicators are utilised. It promotes a culture of consistent, long-lasting quality. For example, the United States Joint Commission on Hospital Accreditation created the first set of clinical indicators for anaesthesia. The third edition of NABH's CQI.3 standards and COP 13 and COP 14 includes anaesthesia quality standard. Following the standards there were no anesthesia-related death and less than 1% of anesthesia plans were modified, unplanned breathing continued after anesthesia, and adverse anesthetic events occurred. No instances of improper surgery. [14]

The quality and effectiveness of patient care during hospitalisation and in subsequent follow-up visits are largely dependent on the thoroughness and accuracy of the medical records, which are provided by NABH accreditation and maintained standards. [15]

The investigation into Internal Assessment Gap Analysis Against NABH Standards for Hospitals & Healthcare Providers Accreditation and quality management systems are flexible tools for ensuring healthcare services are equitable and that people's growing demands are met. An organisation can use gap analysis as a method to compare its actual performance to established expectations and standards. Gap analysis is a research in which a hospital compares its current policies, practises, SOPs, and infrastructure to the

requirements established by the National Accreditation Board for Hospitals & Healthcare Providers, an accreditation agenc. Findings like verbal order given which can cause medication errors. Junior Resident present in the department was not Basic Life Support (BLS) trained, Expired patient medication was found in the Refrigerator of Admixing Lab. Records of Discarded Lead Aprons in all departments were not available with the Radiation Safety Officer (RSO).In Out Patient Department Display for the following was missing: Scope of Services of Hospital, Scope of Services for pediatric patients, Scope of High Risk Obstetric Patients, Vision, Mission and Values of Hospital, Hospital Directory needs to be updated, Nutritional Screening was not done for OPD patients. Patients were not transported safely in OPD, as many patients were transported without safety belt. In radiology department Expired ETO (ethyline oxide) Biopsy Gun was found in Ultrasound Room. There were no proper records for testing the lead aprons and of discarded aprons. These were the basic findings. The hospital leadership should ensure that all deficiencies are addressed on priority. The VP Operations, Medical Superintendent, Quality Manager and Departmental Heads must ensure that they were familiar with the NABH & Hospital Medical Quality standards and the same should be thoroughly implemented. All employees should have training in both Basic life support (BLS) and Advanced cardiac life support (ACLS). Place essential posters, such as the Material Safety Data Sheet (MSDS), in the proper locations. Signage should be placed appropriately. Doctors need to be made more aware of the importance of fully filling out informed consents. Mandatory pain assessments require training for the nursing field. Nursing training should be improved to include labeling files during the management of vulnerable patients. The monitoring system should be properly documented, and doctors and nurses should attend special training sessions to learn the significance of thorough documentation. The Quality Manager should collaborate closely with all the departments to make sure they receive the necessary training, as well as direction and assistance. [16]

In the field of surgical sciences, the ideas of quality assurance and quality control are quickly gaining ground. The quality of anaesthetic services is now primarily monitored by quality indicators, as was correctly expected, and a significant transformation is occurring in anaesthesia practise. Anesthesia manual for all types of anaesthesia, pre-induction

assessment record, informed consent, anaesthesia record, record of post-anesthesia monitoring, policy on criteria to shift patient from recovery area, record of criteria to shift patient from recovery area, infection control policy, and record of intra-operative adverse anaesthesia events are among the minimum list of documents required for implementation of OEs related to anaesthesia. Therefore, the effectiveness of NABH accreditation depends greatly on the medical staff having solid knowledge of and a good attitude toward it. It makes things easier for the anesthesiologist who is just embracing NABH standards if they have past experience working in NABH accredited hospitals, have prior training and awareness of NABH standards, and have access to the NABH manual in the department.. [17]

The staff's knowledge of NABH standards is also crucial. It highlights areas that can be improved, including lab quality assurance, cardiopulmonary resuscitation, pain evaluation, medication error recognition and reporting, readdress mechanisms, and efficient patient safety and quality improvement programme implementation. This outlines how the opportunities can be fulfilled based on how the staff interprets the standards. [18]

If the NABH requirements were divided into categories relating to customers, processes, support workers, and organisations, the standards that lower the likelihood of error and lower the rate of infection should be required. Encouragement of sanitary practises and support for patient- and process-focused care could be another area of emphasis for NABH. NABH must sustain the standards that help offer quality and timely care while also enhancing system equity. It is possible to achieve this balance between the various performance measurements in phases. [19]

Additionally, the whole paperwork should meet the NABH criteria. The hospital's medical documentation will be more accurate and thorough if care is taken to compulsorily record patient clinical data in the appropriate forms. [20]

NABH Accreditation Standard also used to Enhance Staff Nurses Documentation Performance in hospitals. Accreditation is an accurate self-assessment and external peer assessment process for health care organizations performance against established standards, and implemented continuously for improvement. It is seen that levels of staff nurses'

knowledge about accreditation standards for patient care documentation pre and post program enhanced. Auditing helps to identify discrepancies between what is done and what should be done. [21]

Leadership and governance are also crucial for the appropriate maintenance of NABH standards. Lack of competent governance with provisions for legal authority and accountability, disproportionate budgetary allocations, an ineffective work environment, a lack of committed leadership, and insufficient strategic planning are among the problems. While enhancing the standard of healthcare services provided in Indian healthcare settings, these difficulties should be taken into account. The authorities should also implement the proper measures to raise the standard of healthcare in India. [22]

Chapter: 3

Methodology

1. Aim of the Study

To assess the maintenance of NABH standards in a Tertiary Care NABH Accredited Teaching Hospital at Jammu

2. Research Design

Descriptive and Observational study was carried out.

3. Study Setting

The respondents were from different departments i.e. Doctors, Nurses, HODs, Other health professionals (labs, Radiology, pharmacy, Management and Administration). This was conducted in four steps. First and foremost Self-assessment tool kit of NABH 5th edition according to chapter was taken. In Second step, the Audits were conducted according to the areas in the Hospital (Intensive Care Unit, Out Patient Department, Emergency Department, In-Patient Department, Operation Theatres, and Support Service Areas - Labs & Blood Bank, Radio-diagnostics, Physiotherapy, CSSD, Laundry, Kitchen & Medical Record Department). Then gap analysis was performed to check the gaps, non-compliances. This helped to find issues and communicate them moving forward, and find shortcomings if any to overcome them and help in making improvements. Interventions were given. Internal Audit was also carried out by the researcher and the quality department. It was the source of Secondary data

4. Sampling Technique

Convienence Sampling was done

5. Study Tool

Self-Assessment Audit tool kit (Checklist will be prepared according to the 10 chapters of the NABH 5th Edition).Self-Assessment tool kit report in the form of tool kit was used. The entries are all correctly completed. The following factors would be relevant for scoring.

Criteria	SCORE
Compliance	10
Partial Compliance	5
Non Compliance	0

Also an Internal Audit checklist was carried out by the researcher.

6. Statistical And Qualitative

Information from both primary and secondary sources was acquired. The tool set was used to carry out the essential information. The Secondary information was collected from Internal Audit, Quality department, Review of literature, Books, journals, various publications related to NABH standards etc.

Statistical Analysis: Percentage analysis was used to measure the compliances. The following work was completed in order to facilitate data Analysis.

1. Graphical representation of data analysis.
2. Variables were represented in columns and rows.
3. Implicit interpretation of graphical representation.
4. Bar charts were prepared to represent the data.

7. Study Duration:

Study duration was three months. Data was collected for three months and then on the month of June, data was analyze

Chapter-4

Results

Accreditation and quality management systems are flexible tools for ensuring healthcare services are equitable and that people's growing demands are met. The establishment of a quality management system with an emphasis on conformity with NABH and similar agencies' accreditation criteria can help to bring about this ideal state of affairs.

NABH self-assessment tool kit is shown in annexure with proper scoring and also the tables of other observations like Signagepresent , statutory requirements, Commities and quality indicators as per the NABH standards.

1. ACCESS, ASSESS & CONTINUITY OF CARE (AAC)

The hospital's services and the need to give patients ongoing care are covered in this chapter. The standards describe the organization's responsibilities in providing patients with the highest calibre care and enhancing patient satisfaction. The patients are aware of the whole range of services that the organisation offers. In the organisation, only patients who can be treated are admitted. After receiving life-stabilizing care, emergency patients are either admitted (if resources are available) or moved to a facility with the capacity to care for them. Patients who are admitted utilising a certain procedure and who meet the organization's resource requirements go through an initial assessment that is predetermined as well as frequent and routine reassessments. Planning for laboratory and imaging services is a part of assessments. These evaluations lead to the creation of a detailed care plan. Multidisciplinary approaches to patient care provide continuity of care through clearly defined transfer and discharge protocols. These protocols call for sharing relevant information with patients.

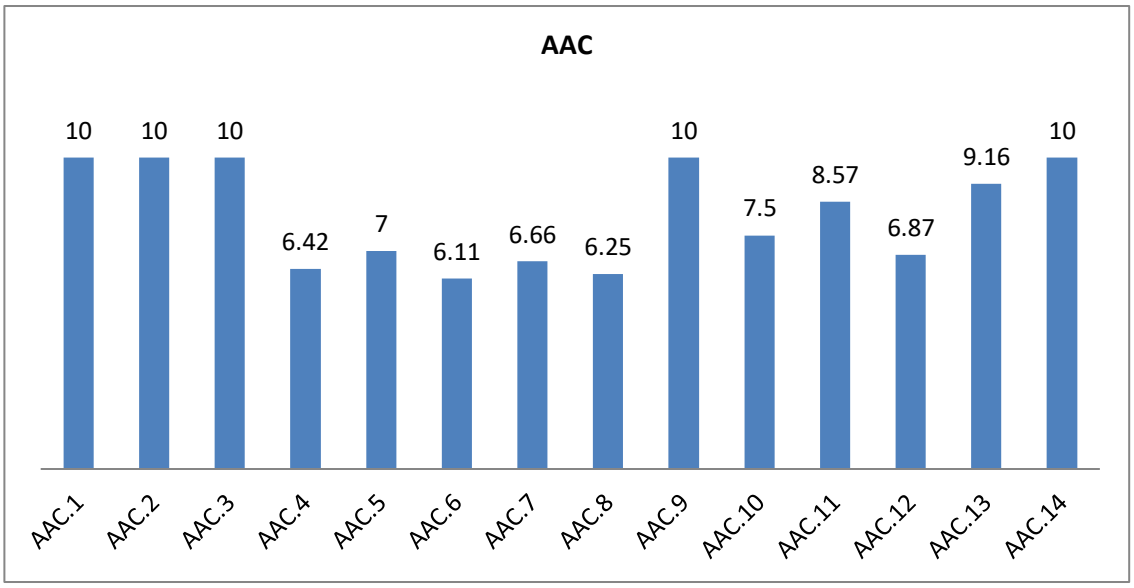

Fig.1-Score of AAC Standards

INTERPRETATION: On analyzing it was found that the least score 6.11 which were seen in AAC.6 stated that policies regarding requisition for tests, collection, identification and mechanism to address the recall/amendment of reports were not found.

The highest score was found in AAC.2, AAC.1, AAC.9, AAC.3 and AAC.14 which mainly follows all the parameters. For detailed scoring and interpretation refer to annexure Table 6 (Page 54-68)

2. CARE OF PATIENTS (COP)

This chapter addresses providing consistent care to all patients in various contexts. Care is given in a variety of locations, such as outpatient units, various ward types, intensive care units, critical care sections, procedure rooms, and operating rooms. Care delivery is uniform when it occurs in each of these many situations. Emergency and ambulance services, cardiopulmonary resuscitation, the use of blood and blood components, and the care of patients in critical care and high dependency units are all governed by policies, procedures, applicable laws, and regulations. The care of vulnerable patients (elderly, physically or mentally

challenged children, pediatric patients, patients undergoing moderate sedation, anesthesia administration, patients undergoing surgical procedures, patients "under restraints," research activities, and end-of-life care) is also governed by policies, procedures, applicable laws, and regulations. In order to provide comprehensive healthcare, pain management, nutritional therapy, and rehabilitation therapies are also addressed.

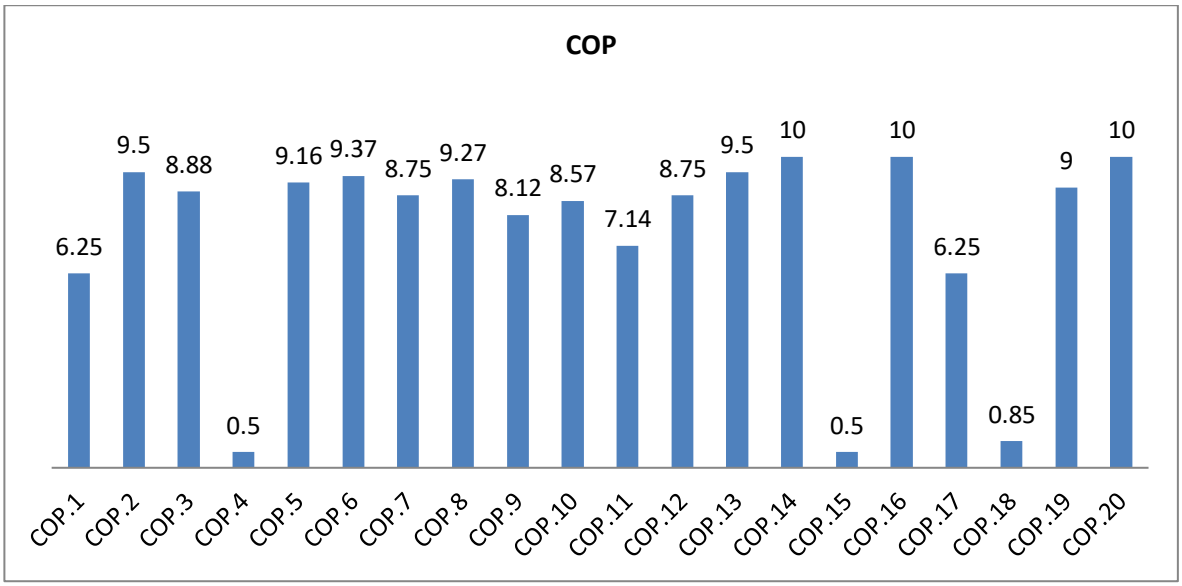

Fig.2-Graph showing the average score of Care of Patients

INTERPRETATION: In COP.1 major non compliance was inability of organization to provide uniform patient care and there were no clinical pathways in place, also no policy related to the telemedicine.The lowest score was found was 0.5 in COP.4 & Cop15 .In COP.4 the major non compliance were organization lacks the policy for community emergenceis, epidemics and other disasters. In COP.15 there is no policy related to the organ donation. Only pamphlets were made, neither awareness nor counseling of patients was done.COP.17 score of 6 due to partial compliance by the organization in pain management of patient. For detailed scoring and interpretation refer to annexure Table 6 (Page 68-87)

3. MANAGEMENT OF MEDICATIONS(MOM)

The pharmacy services offered to outpatient, inpatient, and emergency patients are the subject of this chapter. The company has policies and processes that govern storage safety and availability. The standards promote pharmacy integration into routine hospital operations and patient care. The pharmacy is responsible for overseeing any pharmaceuticals stocked outside of the pharmacy as well as for directing and auditing medication processes. Correct storage (light, temperature, lookalike, sound alike, etc.), expiration dates, and paperwork upkeep should all be guaranteed by the pharmacy. The accessibility of emergency medications needs to be emphasized. The company should have a system in place to guarantee that emergency pharmaceuticals are uniformly distributed throughout the company, easily accessible, and promptly supplied. A monitoring system should be in place to guarantee that the necessary medications are constantly available. Every order for a high-risk medication should be checked by a qualified individual to ensure that the dosage, frequency, and route of administration are accurate. A clinical pharmacist, registered nurse, or another doctor could be the "suitable person." Policies and procedures help ensure the safe use of high-risk medications like opioids, chemotherapy drugs, and radioactive isotopes. The protocol also includes steps for reporting and analyzing pharmaceutical errors, as well as monitoring patients following administration. Both Patients and family members are informed about appropriate medicine & interactions between edibles and drugs. Blood, implants, and gadgets are also considered to be medicines.

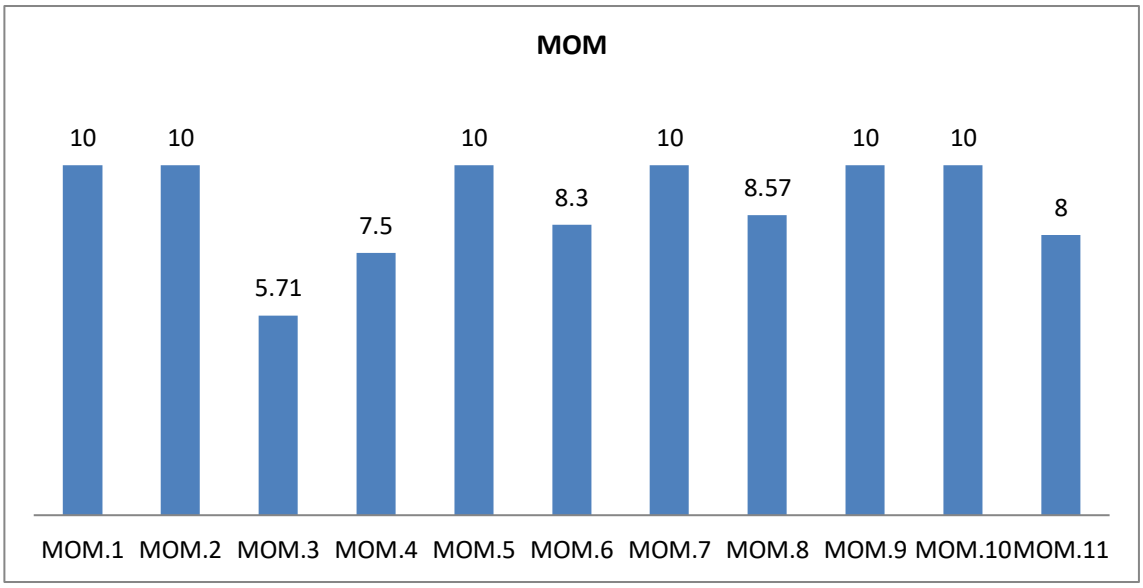

Fig.3-Graph showing average score of Management of Medications

INTERPRETATION: MOM.1, MOM.2, MOM5, MOM.7, MOM.9 & MOM.10 shows full compliance with NABH standards. MOM.3 shows non compliance to NABH requirements in which sound inventory control practices storage of medication and high risk medications were not stored in the respective areas. MOM.4 shows score of 7.5 due to lack of policies related to rational prescription of medication. MOM.6 shows non compliance in realtion with lack of policy related to handeling of medication which are near expiry date. In MOM.11 scores 8 due to lack in policy related to acquisition of medical supplies and consumables. For detailed scoring and interpretation refer to annexure Table 6 (Page 68-98)

4. PATIENT RIGHTS ANDEDUCATION(PRE)

This chapter focuses on advising patients and their families about their rights and obligations and giving them the best treatment possible. The rights and obligations of the patient and family are set forth by the institution. The staff members are trained to uphold these rights and are aware of them. At the time of admission, patients are instructed on their obligations and informed of their rights. They participate in decision-making and are informed about the illness and its potential consequences. The patient and/or family members are given a thorough explanation of the charges. "Patients are informed about the channels open for resolving complaints. There is a formalized procedure for getting patients' and/or families' consent to make decisions concerning their care. Patients and their families are

entitled to information about their healthcare requirements in a language and manner that they can understand.

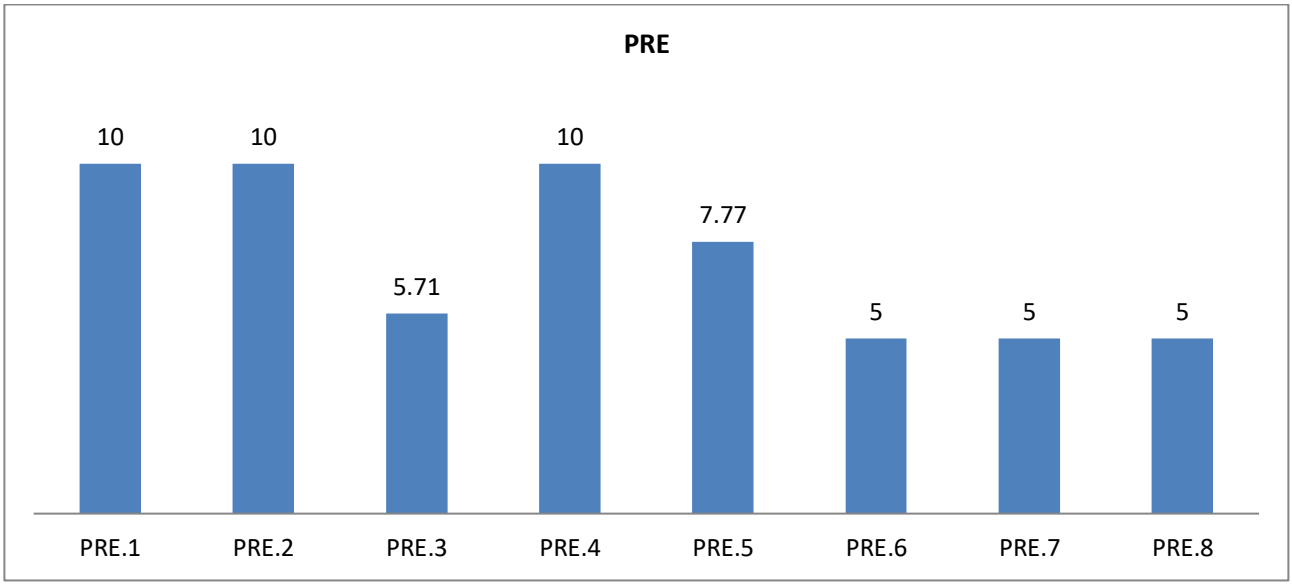

Fig.4-Graph showing average score of Patient Rights and Education

INTERPRETATION: The lowest score was of PRE.6, PRE.7, and PRE.8 which meant no corrective and preventive actions were taken based on analysis. Also, the organization was having no system to monitor and review the implementation of effective communication. In PRE.3 & PRE.5 the low score is due lack of counseling of patient / family memeber in decision making and understanding the care plan. For detailed scoring and interpretation refer to annexure Table 6 (Page 98-107)

5. HOSPITAL INFECTION CONTROL (HIC):

This chapter discusses infection control procedures that safeguard patients, guests, and employees by preventing infections. The hospital offers an efficient infection control programme inside the company. The organization's implementation of a successful healthcare-associated infection prevention and control programme is guided by the standards. The programme is well-documented and attempts to lower or eliminate infection risks for patients, guests, and healthcare professionals. The

company monitors the risk of Healthcare Associated Infection (HAI) in patients and staff members and takes appropriate steps to avoid or lower it. It offers appropriate resources and facilities to support the infection control programme. Through a constantly updated antibiotic policy based on local data and monitoring its application, the organization has an efficient antimicrobial management programme. The programme also monitors how antimicrobials are used within the company. The programme includes activities for cleaning up after spills, sterilizing equipment, managing biomedical waste (BMW), and informing staff members about employee health.

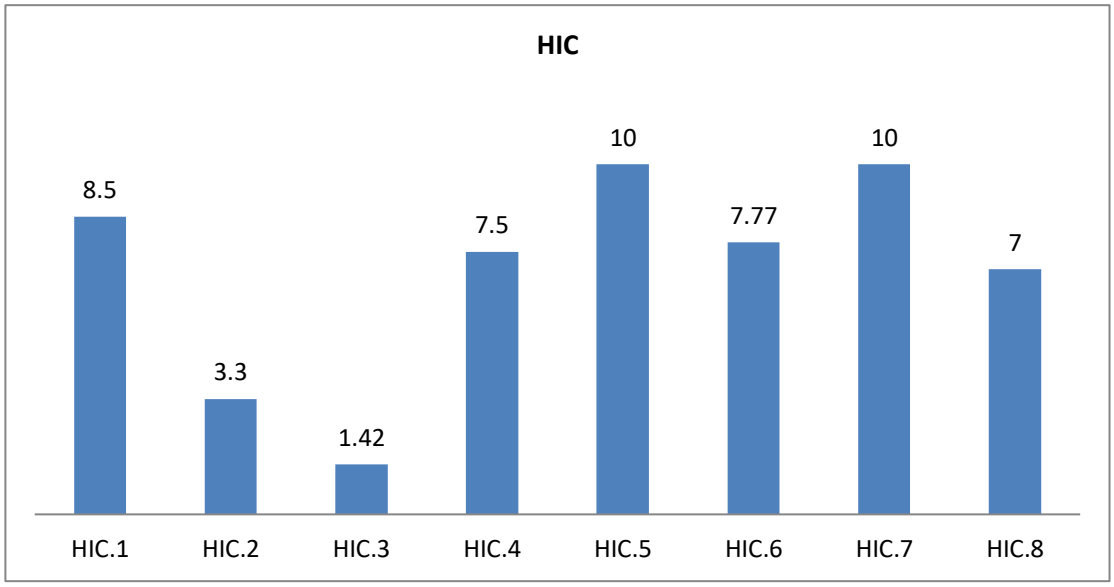

Fig.5 - Graph showing the average score for Hospital Infection Control

INTERPRETATION: In HIC.1 score of 8.5 is due to partial compliance in community awarness about infection control by the hospital. In HIC.2 there was no isolation nursing facilities avalilabe. Partial compliance in avalibility of proper hand hygine facilities in patient care area for healthcare staff. The lowest score was found in HIC. 3 was 1.42. The reason behind non compliances was that there were no policies related to infection control. In HIC.4 the low score was due to lack of policy related to appropriate engineering contriols to prevent infections .In HIC.6

there was partial complaince in surveillance of infection control and prevention data.

The highest score was seen in HIC.5 and HIC.7. For detailed scoring and interpretation refer to annexure Table 6 (Page 107-115)

6. PATIENT SAFETY AND QUALITY IMPROVEMENT (PSQ)

Patient safety and quality enhancement are topics covered by PSQ. The requirement promotes a culture of patient safety and continuous increase in the quality. All areas of the hospital and all employees should be involved in the patient and quality improvement, which should be documented. Goals for national and international patient safety should be applied in a hospital. Particularly in areas of high-risk situations, the organization should gather data on structure, process, and outcome. This data should then be compiled, analyzed, and used to inform future improvements. Activities involving quality improvement should be carried out using appropriate, high-quality equipment. The use of clinical audit as a technique should be encouraged to raise the standard of patient care. The development need to continue. Improvements in patient safety and quality should have management's backing.

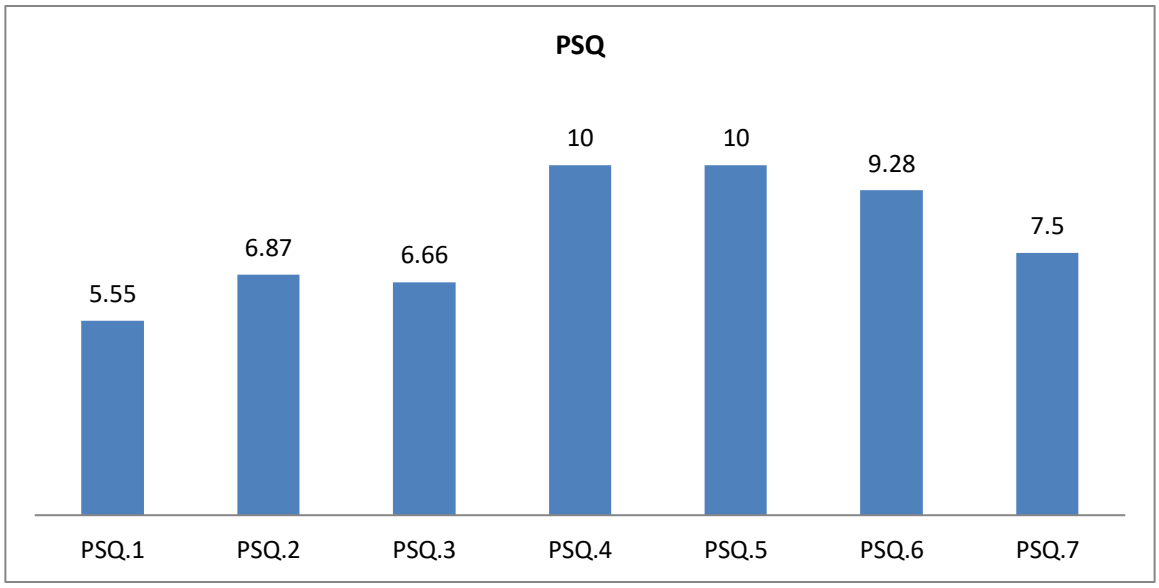

Fig.6- Graph depicting the average score for Patient Safety and Quality Improvement

INTERPRETATION: On analyzing it was found that PSQ.1 lowest score was 5.55. The reason behind this was that the organization does not perform proactive analysis of patient risks and improvements accordingly. In PSQ.2 score of 6.87 is due to lack in policies related to quality improvement programme & partial compliance in efficiency of quality improvement programme. In PSQ.3 partial compliance was seen in continual improvement process of organization. In PQS.6 score of 9.28 is due to partial involvement of departemental leaders in quality improvement. In PQS7 there was partial compliance in incident collection and analysis to ensure continual quality improvement. For detailed scoring and interpretation refer to annexure Table 6 (Page 115-122)

7. RESPONSIBILTY OF MANAGEMENT(ROM):

All of the important elements of governance are known to and managed by the health organization's management. The standard promotes professional and moral organization governance. The duties of management are specified. All levels of leadership are assigned certain duties. The management carries out its obligation to adhere to all relevant laws.

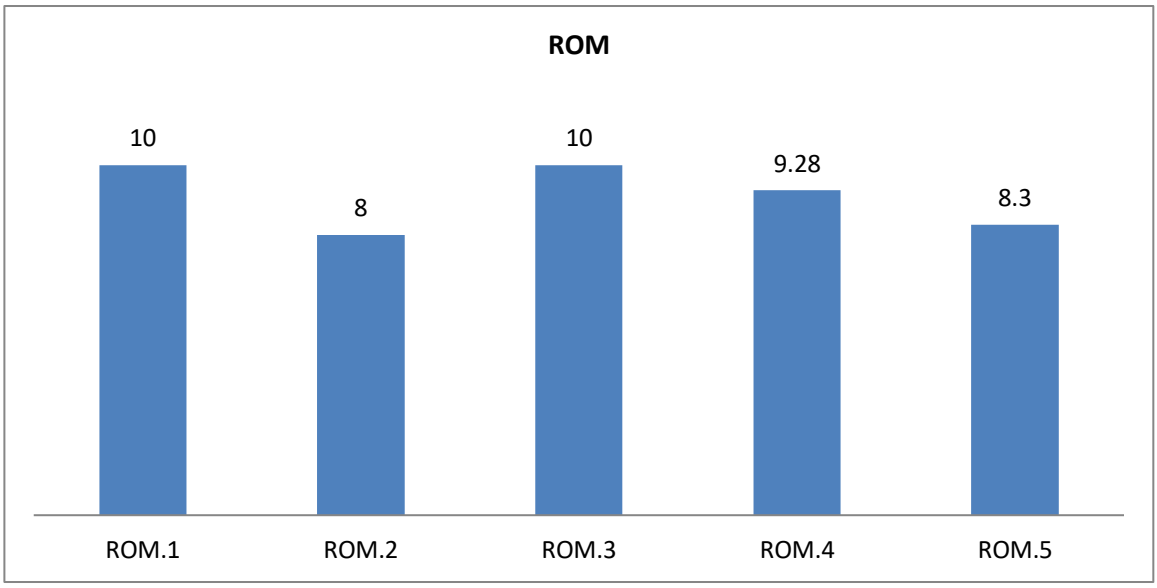

Fig.7- Graph depicting the average score for Responsibility of Management

INTERPRETATION: On analyzing the graph it was found that the lowest score was seen in ROM. 2 which was 8. The reason was that the policy regarding leaders establishes the organization's ethical management framework was not seen. In ROM.4 score of 9.24 due to partial compliance in annualbudget allocation by the organization.Also in ROM.5 there was no policy related to the risk management across the organization. For detailed scoring and interpretation refer to annexure Table 6 (Page 123-128)

8. FACILITY MANAGEMENT SYSTEM (FMS)

The provision of a safe and secure environment for patients, their families, staff, and visitors is governed by this chapter. By regularly resolving any issues that may occur from the facility, equipment, and internal physical environment, the organization works to improve patient safety and the standard of services. The organization accomplishes this through proactive risk assessments, personnel training on safety enhancements, and catastrophe management. The firm carries out routine facility inspection rounds and takes the necessary safety precautions to make sure of this.

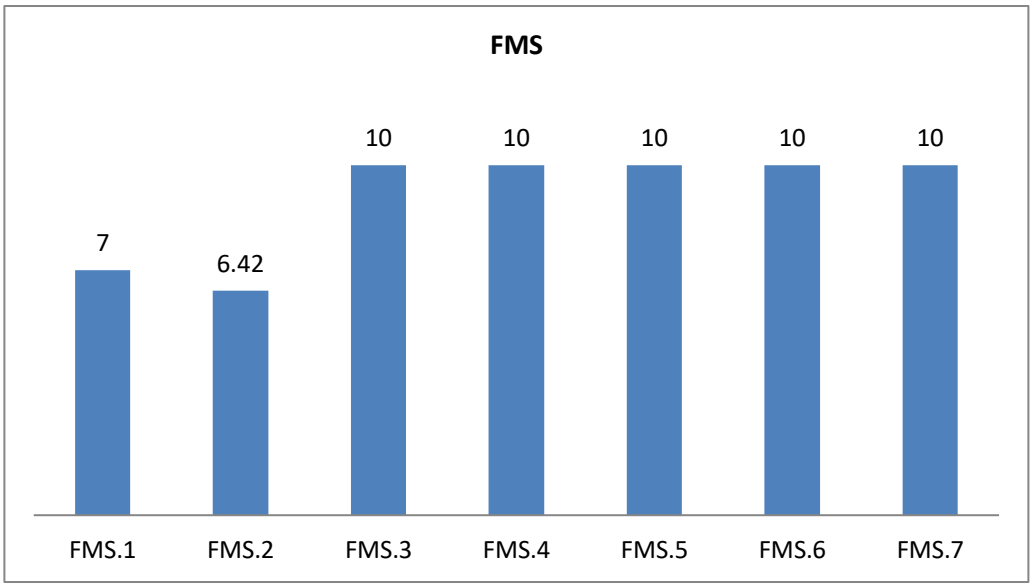

Fig.8- Graph depicting the average score for Facility Management System

INTERPRETATION: FMS shows non compliances to NABH requirements in FMS.1 & FMS.2. In FMS.1 score of 7 is due to partial compliance in inspection rounds according to NABH i.e there is avalibility of facility inspections quaterley not monthly in organization, also non compliance was see in preventive and corrective measures taken after facility inspection (ligts and doors were not repaired).In FMS.2 shares the lowest score of 6.42, reason being portable water and electricity was not available round the clock. And also on some areas there were no bilingual sign postings for the patients, families and community. Rest all chapters are in accordance with the NABH standards. For detailed scoring and interpretation refer to annexure Table 6 (Page 128-135)

9. HUMAN RESOURCE MANAGEMENT(HRM)

The organization's human resource is its most valuable resource. Any organization's ability to function effectively and efficiently depends on its human resources. The management intends to determine the precise quantity and combination of skills of personnel needed to provide patients with safe care. Both the organization's environment and the precise tasks and duties associated with each employee's position must be explained to the workforce. The company should have a plan in place for ongoing professional development in order to continuously improve the staff's competencies and skills. The company supports the staff's physical and

mental health. A disciplinary process and system for managing grievances should be in place.

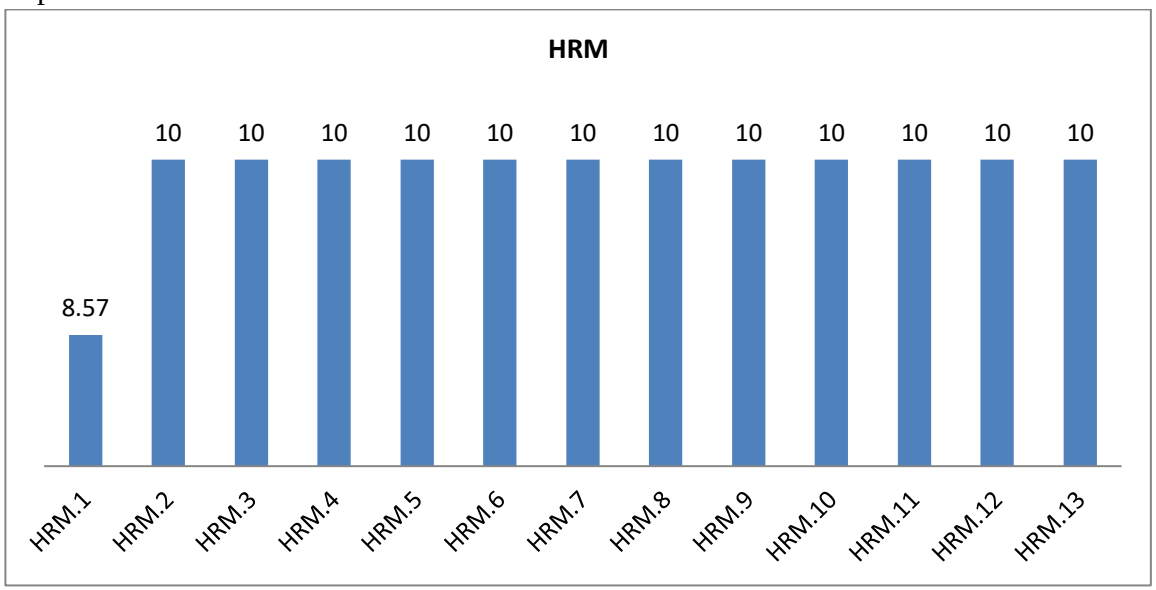

Fig.9- Graph depicting the average score for Human Resource Management

INTERPRETATION: On depicting the average score on graph it was found that human resource departement of the organization lacks only in HRM.1 (8.57) i.e the policy of organization lacks the job role and job specification for each category of employees. For detailed scoring and interpretation refer to annexure Table 6 (Page 135-146)

10. INFORMATION MANAGEMENT SYSTEM (IMS)

Making sure that the appropriate information is available to the appropriate person at the appropriate time is the aim of an organization's information management system. Management of the hospital's information system and methods for disseminating information to the staff, patients, guests, and community at large are both included in information management. The management of data and information must be focused on serving the needs of the organisation and assisting in the provision of high-quality patient care. At the appropriate time and location, the requested information is delivered in an accurate, secure, and authenticated manner.

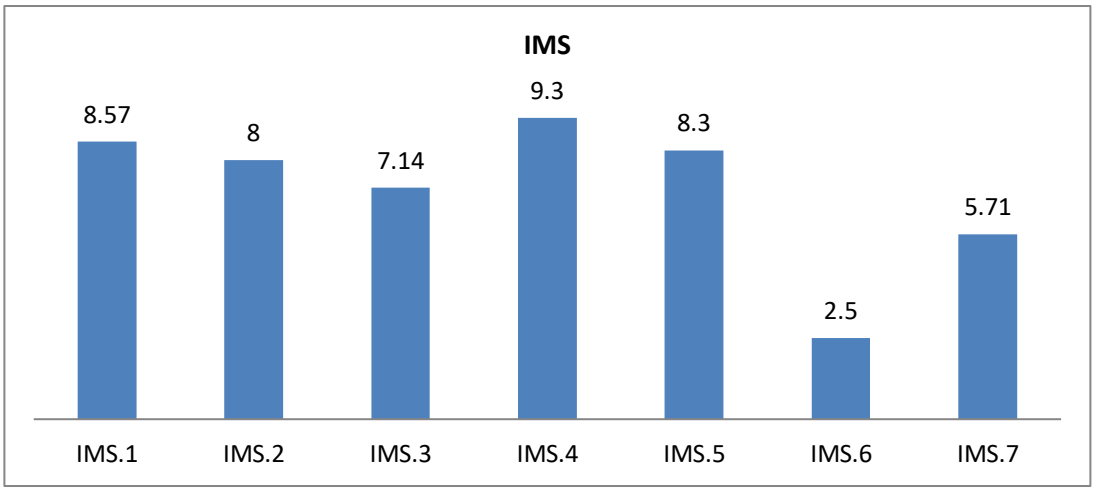

Fig.10- Graph depicting the average score for Information Management System

INTERPRETATION: As per the graph IMS.1 scores 8.57, the non complianc was seen in the lack of policy related to the identification of information needs of the patient, vistor, staff, management external agencies and community. In IMS.2 score 8/10 due to non compliance in avalibility of policy related to data retrival in organization according to needs. In IMS.3 the non compliance was related to entry in medical record. In IMS.4 there was partial non compliance due to lack of operation notes in some medical records making its score 8.3. In IMS.5 there wa non compliance related to lack of policy related to acess of medical record information by other public agencies. The least score was 2.5 of IMS.6. There was no policy regarding document control clinical records, data and information etc.In IMS7 score of 7.07 due to non compliance seen in medical records review system. For detailed scoring and interpretation refer to annexure Table 6 (Page 147-153)

AVERAGE SCORE OF NABH CHAPTERS:

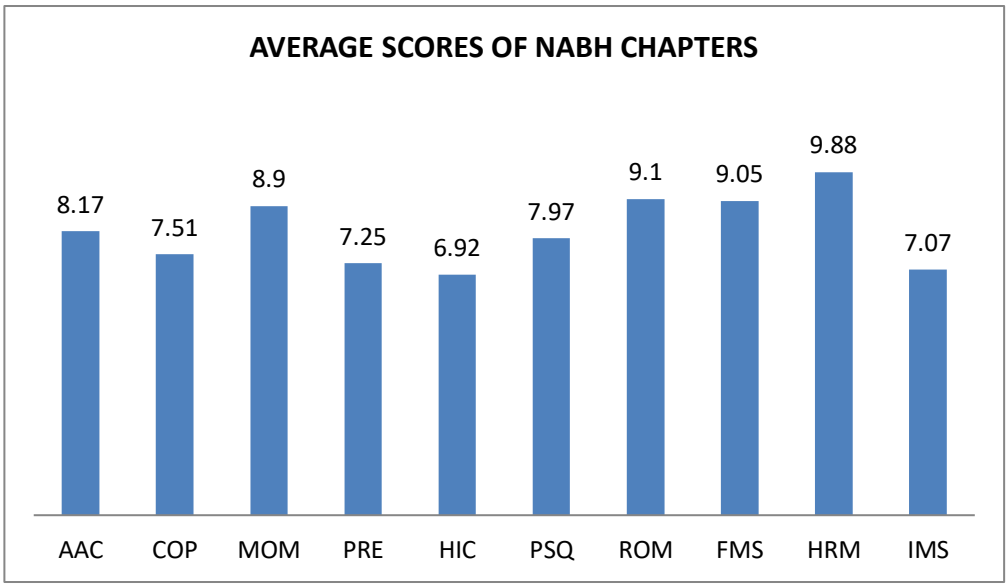

Fig.11-Average score of NABH Chapters

INTERPRETATION: The fact that all of the chapters had average scores of at least 5 indicates that there were few NABH regulations that weren't followed. The hospital has demonstrated the highest level of compliance with NABH Chapters 8 and 9 on Facility Management and Safety & Human Resource Management respectively.

INTERNAL AUDITFINDINGS:

GAPS IDENTIFIED:

HOUSEKEEPING DEPARTMENT
Chemical spill kit was not maintained properly.
According to the plan cleaning checklist was not filled completely (Sign, Name ,Date and Time)
Hazardous material was not placed below the knee.
Lids of the containers are not properly closed
Continuous & Regular training to be done for all the staff members

GAPS IDENTIFIED:

PHARMACY
No document in place to show how pharmacy communicates medication shortage including stock outs.
Current formulary is there but clinicians are not aware how to access it
Mechanism to assist Clinicians in prescribing appropriate medication to identify drug interactions, Food-drug interaction, therapeutic duplication was not evidenced
Recall SOP is there but not document showing recent recall done effectively
No document shown for return of medication to the pharmacy
There was no information displayed about precautions to take to prevent catheter and tubing misconnections when administering medicine.
No SOP shown on policy of self-administration of medication
No SOP shown on measures to govern patients medication brought from outside the organization
No documentation regarding the safe handling of medical equipment and implantable prostheses was displayed.

GAPS IDENTIFIED:

1st FLOOR WARD
Staff not aware about the Recall & Reuse policy
Staff not aware about high risk medication & Narcotic policy

Staff Not aware about the restraint policy
Staff not aware about the Medication Rights
Medical officer Handover register was not completely filled.

GAPS IDENTIFIED:

3RD FLOOR WARD
BMW bins bags were not appropriately colour coded
Critical value register was not documented for the month of May-22
Medical officer Handover register was not completely filled
Shift in-charge was not aware about the IPSG goals
Staff was not aware about the Recall & Reuse policy
Staff was not aware about high risk medication & Narcotic policy
Medical officer was not aware about the cross referral policy
Staff was not aware about the restraint policy

GAPS IDENTIFIED:

Terrace
RO terrace cleaning checklist not properly maintained.
Signage as per installation and drawing not properly maintained.

Heater Controller signage mark on the wooden box cover need to check

GAPS IDENTIFIED:

Basement
Motor electric wires were not properly connected.
RO Tanks were not cleaned properly
Electrical panels found rusty.
Minor leakage in UV system.
Leakage was also found in the raw water tank.
Electric panels were not covered with proper rain waterproof covers.

GAPS IDENTIFIED:

OUTPATIENT DEPARTMENT
The shown signs were not bilingual.
Hand washing facilities was absent in certain cabins.
Complete data not recorded in the hospital's HMIS
Patients at Camp were not getting registered separately
Low patient contentment
Long waiting time of OPD Patient

GAPS IDENTIFIED:

HUMAN RESOURCE DEPARTMENT
Regular health checks of the employees were not carried out.

No documented Policies for Manpower planning (), Recruitment and selection, job descriptions, performance appraisal grievance Readdress training & Development etc**.**
Training on Occupational safety to be conducted
File separators to be labeled
Complete closure of any grievance record to be checked and maintained.

GAPS IDENTIFIED:

MEDICAL RECORD DEPARTMENT
Abbreviation policy incomplete
Admission order instructions incomplete
Record of people entering and going out of MRD not there.
Mortuary consent form not in format- was on plain paper

GAPS IDENTIFIED:

MORTUARY
Cleaning/ disinfection protocol of Mortuary cabinet/trolley/ room to be made, implemented and to be displayed.
Temperature monitoring register not properly maintained, date and signs missing
Collection of water on mortuary tray, any defect needs to be rectified so that no water collection is there.
No hand wash area is available near the Mortuary. Small wash basin to be provided.
Disinfectant/ chemical can was not labeled
Checklist of cleaning of mortuary to be maintained

GAPS IDENTIFIED:

GENERAL STORE

Cardboard boxes were found in the floor and near expiry sections
Entrance door to be locked
Teaching training to be done for codes, rights and responsibilities.

GAPS IDENTIFIED:

IPD PHARMACY
Hospital formulary to be revised
LASA medicine is not arranged appropriately.
LASA sticker is not applied on medicines.
Fridge temperature monitoring not being done for two fridges and checklist to be maintained.
Medicines being stored in cardboard boxes. To be done in cleanable plastic boxes.
Double verification of high alert drugs to be done
High risk medicines not matched with quantity

GAPS IDENTIFIED:

MRI/CT
Medicine cart in the store room had mix of LASA and High alert medicines. Labeling of look alike drug is done as "LASA". To be rectified
Store room where Medicine Cart is kept has seepage and multiple items are lying in cardboard boxes. To be rectified and items to be stored in plastic cleanable boxes
To ensure BLS training of all staff
TAT for reporting for both OPD & IPD is not defined.
Staff is not aware of hand hygiene steps
Segregation of biomedical waste was not done properly
Recall procedures to be framed

GAPS IDENTIFIED:

CSSD
Water spillage in RO plant room.
RO plant monitoring sheet not being maintained.
LT panel checklist not being maintained.

GAPS IDENTIFIED:

PHSIOTHERAPY
Consent forms were found incomplete
Pain assessment done on physiotherapy assessment form, pain assessment form to be use for pain assessment
Training calendar needs to be made, teaching training to be done and training records to be maintained
Extra set of BMW bins required.
Cleaning protocols of physiotherapy machines to be available
Patient and family education forms not properly filled.

GAPS IDENTIFIED:

LAUNDRY
Signage of laundry not displayed
Fire safety training to be done
MSDS sheet to be displayed
Cupboards to be labeled and segregation of linen to be done

GAPS IDENTIFIED:

CHEMO DAYCARE
Staffs were not aware of the CSSD shelf life.
Covers / boxes of chemo medicines were kept in big Card board box**.** Cleanable plastic boxes to be provided for such storage.
LASA cupboard labeling was to be done appropriately according to rack position.
Staffs were not aware of safe injection & infusion practices.

CHAPTER-5

Discussion

The study's goal was to identify any gaps in the criteria throughout the post-accreditation phase. As the observations indicate the least score was found in the HIC and the score was 6.92. The organization didn't develop any program for community education, information sharing, or infection control activities, and no suitable hand sanitizers were available in any patient care locations. This was the main cause. Also, isolation / barrier nursing facilities were not available in wards. There was no gauze present for monitoring positive and negative pressure in dialysis ward. The organization also lacks with the policy of hospital infection control for e.g. the hospital follows industry standards and procedures at all times, including hand hygiene recommendations and transmission-based safety measures.

The highest score was found in chapter-9 human Resource management this chapter showed very less non compliances to NABH requirements. The second highest score was found in FMS (Facility management and safety system) the non-compliances showed to NABH requirements were facility rounds were not conducted every month. There were no documented inspection reports or facility tours, and no corrective or proactive measures were prescribed. Facility round was only conducted quarterly. There was no policy found regarding initiatives to wards and energy, efficient and environmentally friendly hospital. ROM Responsibility of management lies third number with 9.1 score where non compliances were mainly seen in policies of an organization which were not updated.

The next chapter AAC scored 8.17 the non-compliances to this chapter were that imaging personnel were not seen using appropriate radiation safety and monitoring devices. There was no periodic internal/ external peer review of imaging. Patient transfer within the organization was not done safely in a good manner. Because sometime safety belts were not worn by patients on wheel chairs and side railings of beds were also not maintained. The critical value alert register of radiology department was missing and there was miscommunication between the employees of department.

The chapter COP scored 7.51 the non-compliances related this chapter was absence of policy on telemedicine facility, patient waiting in emergency were not reassessed as appropriate. Informed consent was not taken by the person performing procedure.

Procedures were also not properly documented in patient record. Sometimes abbreviation of various procedures was used. No counseling of patient and family was done periodically. Chapter PRE received a 7.25. Patients and families were not informed about the planned treatment's dangers, alternatives, and advantages, which was a violation of this chapter. They were not even fully counseled about complication related to procedure. There were no identified or met special educational needs. The next chapter patient safety and quality improvement, the noncompliance observed during post assessment of NABH were the organization uses no mechanism to capture patient reported outcome measures. No forms regarding this were implemented. No departmental leaders were visible participating in the process of enhancing patient safety and quality.

The chapter hospital infection control scored 6.92 the non-compliances in this chapter seen were the biomedical waste handling was not done appropriately and safely. The person carrying biomedical waste was not seen wearing gumboots and PPE. The infection control staff did not consistently verify data. The chapter MOM scored 8.9. The non-compliances to NABH requirements were no document in place to show how pharmacy communicates medication shortage including stock outs. No SOP was shown on policy of self-administration of medication, no document shown on recall of properly handled medical equipment and implantable prosthetics.

The next goal was to suggest recommendations for streaming the process.

In light of the shortcomings in adherence to NABH standards, the following recommendations were made.

- One of the most prevalent findings for the majority of the department was staff training. The interviewees' employees had no knowledge of the emergency codes, vision, mission, or hand hygiene protocol, for example.
- The workers must receive training on how to flee in an emergency and find the nearest fire exit.
- The chemical skill kit to be maintained properly in housekeeping department.
- Cleaning checklist of housekeeping department need to be filled properly with sign, date and time.
- Training to staff should be provided for proper handling of hazardous material.

- Policies needed to be updated again. Training should be provided to the staff regarding policies.
- All nursing directors have been told to enforce the practise of the nursing staff maintaining their files in appropriate locations to prevent clutter.
- Proper training to be provided to medical officers for proper documentation of records of patient. Many deficiencies were seen in patient files.
- Documentation of pharmacy should be checked again how they communicate medication shortage including stock out.
- Nursing barrier rooms need proper check. No gauze was there to monitor positive or negative pressure in dialyses ward.
- A daily inventory of the drugs and equipment for the ambulance should be kept and checked.
- Critical alert results should be announced with specifics to prevent any misunderstandings with various departments.
- Audits to be strengthened and real time correction to be done. In IPD first floor medical officers needs to be trained for completely filling the handover registers.
- In IPD third floor, supervisors round to be improved for checking the biomedical waste bins which were not appropriately colour coded.
- Proper training should be provided to nursing staff about updated version of forms.
- Medical record department needs special attention. The process of MRD needs to be checked by proper qualified personnel according to NABH requirements.
- Nursing training matrix should be removed from emergency departments and latest updated version should be kept.
- LASA and high alert drugs should be separately placed in emergency department
- Staff should be instructed to take consents properly, completely by patients after awaking them about alternatives and complication of procedure

CHAPTER-6

Conclusion

According to NABH rules, gaps were found during the project. However, with a little management and employee effort, these gaps can be closed. The majority of the organizational holes should be filled by providing regular training to the workforce. An issue that needs to be fixed is noncompliance with NABH Standards, as highlighted by the gap analysis. In conclusion, the steps that need to be taken in order to comply with NABH accreditation standards are likely to have a positive impact on the delivery of public health services, guaranteeing quality services, economical outcomes with efficient outcomes, risk management with respect to patient, staff, and visitor safety, and most importantly, equity in healthcare services for the people.

As all the deficiencies have been clearly revealed by this study, it is indicated that it requires a special orientation and approach to comply with applicable requirements, should the hospital decide to pursue accreditation. Based on an assessment of the standards, the study outlines how the opportunities identified can be fulfilled. The hospital leadership should ensure that all deficiencies are addressed on priority. The Operations, Quality and Departmental Heads must ensure that they are familiar with the NABH & Hospital Medical Quality standards and the same should be thoroughly implemented. Signage should be placed appropriately. Doctors need to be made more aware of the importance of fully filling out informed consents. Mandatory pain assessments require training for the nursing field. Nursing education needs to be improved in order to manage vulnerable patients and mark files. The monitoring system should be properly documented, and doctors and nurses should attend special training sessions to learn the significance of thorough documentation. In order to ensure that all the departments receive direction and support, including trainings as needed, the Quality team should collaborate closely with each department.

After data analysis, the test's findings showed that there was noncompliance with NABH Standards, which needed to be remedied. It is advised that the hospital make an effort to close the gaps that have been found in accordance with the planned course of action. In conclusion, the procedures required to comply with NABH and SMVDNSH certification requirements are anticipated to have a good impact on the provision of public health

services, ensuring quality services, effective outcomes with economy, risk management with regard to patient, worker, and visitor safety, and, most importantly, equity in healthcare for the people.

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Annexure

SIGNAGE SYSTEM

Signage's	Displayed (Yes/No/ NA)	Bilingual (Yes/No/ NA)
Services available in the hospital(prominent board near the entry to the hospital)	Yes	Yes
Mission &Vision	Yes	Yes
Quality Policy	No	No
Patients Rights and Responsibilities	Yes	Yes
Complaint Re addressal box, whom to contact and how to lodge a Complain	Yes	Yes
Doctors list along with their Specialties and Qualifications	Yes	Yes
OPD Schedule of Doctors (Speciality,Timings and Day of Availability)	No	No
Radiation Hazard Symbols at respective functional areas	Yes	Yes
Fire Exit Plan(on every floor	Yes	Yes
Floor Directory	Yes	Yes
Departmental Signages	Yes	Yes
Wash Rooms (Handicap)	Yes	No
Ambulance Parking Area	Yes	Yes
Drinking Water	Yes	Yes
Health Education Related Signage's (Maternal health, HIV,	No	No

Prevention of infections, Immunization programme, etc)		

STATUTORY REQUIREMENTS

Licences	Applicable/Not Applicable	Available
No objection certificate from the Chief Fire officer.	Yes	Yes
License under Bio- medical Management and handling Rules, 1998.	Yes	Yes
No objection certificate under Pollution Control Act.	Yes	Yes
Permit to operate lifts under the Lifts and escalators Act.	Yes	Yes
Income tax PAN.	Yes	Yes
Narcotics and Psychotropic substances Act and License.	Yes	Yes
Sales Tax Registration certificate.	Yes	Yes
Vehicle registration certificates for Ambulances.	Yes	Yes
Retail drug license (Pharmacy).	Yes	Yes
Air (prevention and control of pollution) Act, 1981andLicense	Yes	Yes
PNDT Certificate	Yes	Yes
Atomic Energy Regulatory Body approvals	Yes	Yes
License for Blood Bank	Yes	Yes
ACT	Applicable/Not Applicable	Available
Biomedical waste management handling rules 1998.	Yes	Yes

Central sales tax Act, 1956	Yes	Yes
Consumer protection Act, 1986.	Yes	Yes
Contract Act, 1982.	Yes	Yes
Dentist regulations, 1976.	Yes	Yes
Drugs & cosmetics Act, 1940.	NA	No
Employees provident fund Act, 1952	Yes	Yes
Environment protection Act, 1986.	Yes	Yes
Equal remuneration Act, 1976.	Yes	Yes
Explosives Act, 1884.	Yes	Yes
Income Tax Act, 1961.	Yes	Yes
Indian medical council Act and code of medical ethics, 1956	Yes	Yes
Nurses and Midwives Act, 1953	Yes	Yes
Indian Nursing council Act 1947	Yes	Yes
Indian penal code, 1860	Yes	Yes
Maternity benefits Act, 1961.	Yes	Yes
MTP Act, 1971.	Yes	Yes
Minimum wages Act, 1948.	Yes	Yes
National building code.	Yes	Yes
Negotiable instruments Act, 1881	No	No
Payment of bonus Act, 1965.	No	No
Payment of gratuity Act, 1972.	Yes	Yes
Payment of wages Act, 1936.	Yes	Yes
Persons with disability Act, 1995.	Yes	Yes
Pharmacy Act, 1948.	Yes	Yes
PNDT Act, 1996.	Yes	Yes
BARC, Act.	Yes	Yes
Registration of births and deaths Act, 1969	Yes	Yes
Workers compensation Act, 1923	Yes	Yes

Indian Trade Union Act, 1926	Yes	Yes
TAX Deducted at source Act	Yes	Yes
Transplantation of Human Organ Act,1994	NA	No
Water Prevention and control of Pollution Act	Yes	Yes

COMMITTES

Committees	(Yes/No/ NA)	MEETING FREQUENCY
Quality Assurance Committee	Yes	Quarterly
Hospital Infection Control Committee	Yes	Once in 2 Month
Pharmaceutical And Therapeutic Committee	Yes	Quarterly
Condemnation Committee	Yes	Quarterly
Condemnation Committee	Yes	Quarterly
CPR Committee	Yes	Quarterly
FMS Committee	Yes	Quarterly
OT Committee	Yes	Quarterly
Lab And Diagnostic	Yes	Quarterly

Committee		
IMS Committee	Yes	Once in 2 Month
Transfusion Committee	Yes	Quarterly
Clinical Audit And Peer Review Committee	Yes	Once in 2 Month
Ethics Committee	Yes	Quarterly
Academic and CME Committee	Yes	Quarterly
Incident Management Committee	Yes	Monthly
Hospital Advisory Management Review Committee	Yes	Quarterly
Standing Committee for Radiation Safety	Yes	Annually
POSH Committee	Yes	Monthly
Privileging and Credentialing Committee	Yes	Quarterly

Grievance Committee	Yes	Monthly

QUALITYINDICATORS

Particulars	Quality Indicators	Monitored(Yes/No)
Patient Assessment	Time for initial assessment of indoor and emergency patients.	No
	Percentage of cases wherein care plan is documented and counter-signed by the clinician.	No
	Percentage of cases wherein screening for nutritional needs has been done.	No
	Percentage of cases wherein the pre-defined initial nursing assessment is completed within 30 minutes.	Yes
Invasive Procedures	Re-exploration rate	Yes
	Percentage of accidental removal of tubes and	Yes

	catheters.	
	Incidence of hematoma at puncture site.	Yes
	Percentage of re-scheduling of procedures	Yes
	Incidences when Consent for invasive procedure is missed.	Yes
Anesthesia Use	Percentage of modification of anesthesia plan.	Yes
	Percentage of unplanned ventilation following anesthesia.	Yes
	Percentage of adverse anesthesia events.	Yes
	Anesthesia related mortality rate.	Yes
Blood and Blood products use	Percentage of transfusion reactions	Yes
	Percentage of wastage of blood and blood products.	Yes
	Percentage of blood component usage.	Yes
	Turnaround time for issue of blood and blood components.	Yes
Infection Control	Urinary tract infection rate	Yes
	Respiratory infection rate.	Yes
	Intra-vascular device infection rate.	Yes
	Surgical site infection rate.	Yes
Adverse Drug Events	Percentage of medication	Yes

	errors.	
	Incidence of adverse drug reactions.	Yes
	Percentage of medication charts with illegible writing over a given period.	Yes
	Percentage of contrast related reactions	Yes
Clinical Research	Number of research activities being carried out.	Yes
	Percentage of patients withdrawing from the study.	Yes
	Percentage of protocol violations/deviations reported.	Yes
	Percentage of serious adverse events (which have occurred in the HCO) reported to the ethics committee within the defined time frame	Yes
Management	Bed occupancy rate and average length of stay.	Yes
	OT and ICU utilization rate.	Yes
	Equipment down time.	Yes
	Nurse-patient ratio	Yes
Patient Satisfaction	Out patient satisfaction index.	Yes
	In patient satisfaction index.	Yes
	Waiting time for services including diagnostics and outpatient.	Yes

	Time taken for discharge.	Yes
Employee Satisfaction	Employee satisfaction index.	Yes
	Employee attrition rate.	Yes
	Employee absenteeism rate.	Yes
	Percentage of employees who are aware of employee rights, responsibilities and welfare schemes.	Yes
Diagnostic Services	Number of reporting errors/1000investigations.	Yes
	Percentage of re-dos.	Yes
	Percentage of reports co-relating with clinical diagnosis.	Yes
	Percentage of adherence to safety precautions by employees working in diagnostics.	Yes
	Report timeliness for the report dispatch.	Yes
Medical Records	Percentage of medical records not having discharge summary.	Yes
	Percentage of medical records not having initial assessment and the plan of care.	Yes
	Percentage of medical records having incomplete and/or improper consent.	Yes
	Percentage of missing	Yes

	records.	
Adverse Events and Near Misses	Number of sentinel events.	Yes
	Percentage of near misses analyzed.	Yes
	Number of security related incidents including thefts.	Yes
	Incidence of needle sticks injuries.	Yes
Risk Management	Number of variations observed in mock drills.	Yes
	Incidence of falls.	Yes
	Incidence of bed sores after admission.	Yes
	Percentage of employees provided pre-exposure prophylaxis.	Yes
Reporting of Activities as required by Laws and Regulations	Number of births and deaths	Yes
	Number of Notifiable diseases	Yes
	Submission of report/ data/form pertaining to bio-medical waste, PNDT act and radiation safety within the defined timeframe.	Yes
	Submission of tax returns and deduction of taxes at the specified time frame.	Yes
Pharmacy	Percentage of drugs procured by local purchase.	Yes
	Percentage of stock outs	Yes

	including emergency drugs.	
	Percentage of consumables rejected before preparation of Goods Receipt Note.	Yes
	Incidence of variations from the procurement process.	Yes
	Bounced Prescriptions	Yes
Biomedical Engineering	Turn Around time for Complaints	Yes

SELF ASSESSMENT TOOL KIT				
ELEMENTS				
Chapter1:ACCESS, ASSESSMENT AND CONTINUITY OF CARE(AAC)		Score		
AAC.1: The organization defines and displays the healthcare services that it provides.		0/5/10		
AAC.1. a.	The Service being provided is clearly defined.	10		0=Non Compliance

AAC.1.b.	Each defined healthcare service should have diagnostic and treatment services with suitably qualified personnel who provide out-patient, in-patient and emergency cover.	10		5=Partial Compliance
AAC.1.c.	Scope of the healthcare services of each department is defined. *	10		10=Compliance
AAC.1.d.	d. The organization's defined healthcare services are prominently displayed.	10		
	Average Score	10		
AAC.2: The organization has a well-defined registration and admission process.				
AAC.2.a.	The organization uses written guidance for registering and admitting patients. *	10		
AAC.2.b.	A unique identification number is generated at the end of the registration.	10		
AAC.2.c.	Patients are accepted only if the organization can provide the required service.	10		
AAC.2.d.	The written guidance also addresses managing patients during non-availability	10		

	of beds. *			
AAC.2.e.	Access to the healthcare services in the organization is prioritized according to the clinical needs of the patient. *	10		
	Average Score	10		
AAC.3: There is an appropriate mechanism for transfer (in and out) or referral of patients.				
AAC.3.a.	Transfer-in of patients to the organization is done appropriately. *	10		
AAC.3.b.	Transfer- out/referral of patients to another facility is done appropriately. *	10		
AAC.3.c.	During transfer or referral, accompanying staff are appropriate to the clinical condition of the patient.	10		
AAC.3.d.	The organization gives a summary of the patient's condition and the treatment given.	10		
	Average Score	10		
AAC.4: Patients cared for by the organization undergo an established initial assessment.				

AAC.4.a.	The initial assessment of the outpatients, day-care, in-patients and emergency patients is done. *	10		
AAC.4.b	The initial assessment is performed by qualified personnel.	5		
AAC.4.c.	The initial assessment is performed within a time frame based on the needs of the patient. *	10		
AAC.4.d.	Initial assessment of day-care and in-patients includes nursing assessment, which is done at the time of admission and documented.	5		
AAC.4.e.	The initial assessment for in-patients results in a documented care plan.	5		
AAC.4.f.	The care plan is countersigned by the clinician-in-charge of the patient within 24 hours.	0		
AAC.4.g.	The care plan includes the identification of special needs regarding care following discharge.	10		
	Average Score	6.42		
AAC.5:Patients cared for by the organization undergo a regular reassessment				

AAC.5.a.	Patients are reassessed at appropriate intervals to determine their response to treatment and to plan further treatment or discharge.	5		
AAC.5.b.	Out-patients are informed of their next follow-up, where appropriate.	10		
AAC.5.c.	For in-patients during reassessment, the care plan is monitored and modified, where found necessary.	10		
AAC.5.d.	Staff involved in direct clinical care document reassessments.	10		
AAC.5.e.	The organization lays down guidelines and implements processes to identify early warning signs of change or deterioration in clinical conditions for initiating prompt intervention.	0		
	Average Score	7		
AAC.6: Laboratory services are provided as per the scope of services of the organization.				
AAC.6.a.	Scope of the laboratory services is commensurate to the services provided by the organization.	10		
AAC.6.b.	The infrastructure (physical and equipment) is adequate to	10		

	provide the defined scope of services.			
AAC.6.c.	Human resource is adequate to provide the defined scope of services.	5		
AAC.6.d.	Qualified and trained personnel perform and supervise the investigations and report the results.	10		
AAC.6.e.	Requisition for tests, collection, identification, handling, safe transportation, processing and disposal of a specimen is performed according to written guidance. *	0		
AAC.6.f.	Laboratory results are available within a defined time frame. *	10		
AAC.6.g.	Critical results are intimated to the person concerned at the earliest. *	0		
AAC.6.h.	Results are reported in a standardized manner.	10		
AAC.6.i.	There is a mechanism to address the recall / amendment of reports whenever applicable. *	0		
AAC.6.j.	Laboratory tests not available in the organization are outsourced to the	NA		

	organization(s) based on their quality assurance system. *			
	Average Score	6.11		
AAC.7: There is an established laboratory quality assurance programme.				
AAC.7.a.	The laboratory quality assurance programme is implemented. *	10		
AAC.7.b.	The programme addresses verification and/or validation of test methods. *	10		
AAC.7.c.	The programme ensures the quality of test results. *	10		
AAC.7.d.	The programme includes periodic calibration and maintenance of all equipment*	0		
AAC.7.e.	The programme includes the documentation of corrective and preventive actions.*	0		
AAC.7.f.	The programme addresses clinic pathological meeting(s).	10		
	Average Score	6.66		
AAC.8: There is an established laboratory safety programme.				
AAC.8.a.	The laboratory safety programme is implemented. *	10		
AAC.8.b.	This programme is aligned with the organization's safety	10		

	programme.			
AAC.8.c.	Laboratory personnel are appropriately trained in safe practices.	0		
AAC.8.d.	Laboratory personnel are provided with appropriate safety measures.	5		
	Average Score	6.25		
AAC.9: Imaging services are provided as per the scope of services of the organization.				
AAC.9.a.	Imaging services comply with legal and other requirements.	10		
AAC.9.b.	Scope of the imaging services is commensurate to the services provided by the organization.	10		
AAC.9.c.	The infrastructure (physical and equipment) and human resources are adequate to provide for its defined scope of services.	10		
AAC.9.d.	Qualified and trained personnel perform, supervise and interpret the investigations.	10		
AAC.9.e.	Patients are transported in a safe and timely manner to and from the imaging services *	10		
AAC.9.f.	Imaging results are available within a defined time frame. *	10		

AAC.9.g.	Critical results are intimated immediately to the personnel concerned. *	10		
AAC.9.h.	Results are reported in a standardized manner.	10		
AAC.9.i.	There is a mechanism to address the recall / amendment of reports whenever applicable. *	10		
AAC.9.j.	Imaging tests not available in the organization are outsourced to the organization(s) based on their quality assurance system. *	10		
	Average Score	10		
AAC.10: There is an established quality assurance programme for imaging services.				
AAC.10.a.	The quality assurance programme for imaging services is implemented. *	10		
AAC.10.b.	Quality assurance programme includes tests for imaging equipment.	10		
AAC.10.c.	Quality assurance programme includes the review of imaging protocols.	10		
AAC.10.d.	A system is in place to ensure the appropriateness of the investigations and procedures for the clinical	10		

	indication.			
AAC.10.e.	The programme addresses periodic internal/external peer review of imaging results using appropriate sampling.	0		
AAC.10.f.	The programme addresses the clinic-radiological meeting(s).	0		
AAC.10.g.	The programme includes periodic calibration and maintenance of all equipment. *	10		
AAC.10.h.	The programme includes the documentation of corrective and preventive actions. *	10		
	Average Score	7.5		
AAC.11: There is an established safety programme in imaging services.				
AAC.11.a	The radiation-safety programme is implemented. *	10		
AAC.11.b.	This programme is aligned with the organization's safety programme.	10		
AAC.11.c.	Patients are appropriately screened for safety/risk before imaging.	10		

AAC.11.d.	Imaging personnel and patients use appropriate radiation safety and monitoring devices where applicable.	5		
AAC.11.e.	Radiation-safety and monitoring devices are periodically tested, and results are documented. *	10		
AAC.11.f.	Imaging and ancillary personnel are trained in imaging safety practices and radiation-safety measures.	5		
AAC.11.g.	Imaging signage is prominently displayed in all appropriate locations.	10		
	Average Score	8.57		
AAC.12: Patient care is continuous and multidisciplinary.				
AAC.12.a.	During all phases of care, there is a qualified individual identified as responsible for the patient's care.	10		
AAC.12.b.	Patient care is co - coordinate in all care settings within the organization.	5		
AAC.12.c.	Information about the patient's care and response to treatment is shared among medical, nursing and other care	10		

	-providers.			
AAC.12.d.	The Organization implements standardized hand-over communication during each staffing shift, between shifts and during transfers between units/ departments.	10		
AAC.12.e.	Patient transfer within the organization is done safely in a safe manner.	5		
AAC.12.f.	Referral of patients to other departments/ specialties follows written guidance.	5		
AAC.12.g.	The organization ensures predictable service delivery by adhering to defined timelines and informs the patient/family and/ or caregiver whenever there is a change in schedule.	10		
AAC.12.h.	The organization has a mechanism in place to monitor whether adequate clinical intervention has taken place in response to a critical value alert.	0		
	Average Score	6.87		

AAC.13: The organization has an established discharge process.				
AAC.13.a.	The patient's discharge process is planned in consultation with the patient and/or family.	10		
AAC.13.b.	The discharge process is coordinated among various departments and agencies involved (including medico-legal and absconded cases). *	10		
AAC.13.c.	Written guidance governs the discharge of patients leaving against medical advice. *	10		
AAC.13.d.	A discharge summary is given to all the patients leaving the organization (including patients leaving against medical advice).	10		
AAC.13.e.	The organization adheres to planned discharge.	5		
AAC.13.f.	The organization conforms to the defined timeframe for discharge and makes continual improvement.	10		
	Average Score	9.16		
AAC.14: The organization defines the content of the discharge summary.				
AAC.14.a.	A discharge summary is provided to the patients at the	10		

	time of discharge.			
AAC.14.b.	Discharge summary contains the patient's name, unique identification number, name of the treating doctor, date of admission and date of discharge.	10		
AAC.14.c.	Discharge summary contains the reasons for admission, significant findings and diagnosis and the patient's condition at the time of discharge.	10		
AAC.14.d.	Discharge summary contains information regarding investigation results, any procedure performed, medication administered, and other treatment given.	10		
AAC.14.e.	Discharge summary contains follow-up advice, medication and other instructions in an understandable manner.	10		
AAC.14.f.	Discharge summary incorporates instructions about when and how to obtain urgent care.	10		
AAC.14.g.	In case of death, the summary of the case also includes the	10		

	cause of death.			
	Average Score	10		
	Average Score of Chapter	8.17		
Chapter2:CARE OF PATIENTS(COP)				
COP.1: Uniform care to patients is provided in all settings of the organization and is guided by written guidance, and the applicable laws and regulations.				
COP.1.a.	Uniform care is provided following written guidance. *	10		
COP.1.b.	The organization has a uniform process for identification of patients and at a minimum, uses two identifiers.	10		
COP.1.c.	Care shall be provided in consonance with applicable laws and regulations.	10		
COP.1.d.	The organization adapts evidence-based clinical practice guidelines and/or clinical protocols to guide uniform patient care.	0		
COP.1.e.	Clinical care pathways are developed, consistently followed across all settings of care, and reviewed periodically.	0		

COP.1.f.	Care delivery is uniform for a given clinical condition when similar care is provided in more than one setting. *	10		
COP.1.g.	Multi-disciplinary and multi-specialty care, where appropriate, is planned based on best clinical practices/clinical practice guidelines and delivered in a uniform manner across the organization.	10		
COP.1.h.	Telemedicine facility is provided safely and securely based on written guidance. *	0		
	Average Score	6.25		
COP.2: Emergency services are provided in accordance with written guidance, applicable laws and regulations.				
COP.2.a.	There shall be an identified area in the organization which is easily accessible to receive and manage emergency patients, with adequate and appropriate resources.	10		
COP.2.b.	Prevention of patient over-crowding is planned, and crowd management measures are implemented.	10		

COP.2.c.	Emergency care is provided in consonance with statutory requirements and in accordance with the written guidance. *	10		
COP.2.d.	The organization manages medico-legal cases in accordance with statutory requirements. *	10		
COP.2.e.	Initiation of appropriate care is guided by a system of triage. *	10		
COP.2.f.	Patients waiting in the emergency are reassessed as appropriate for change in status.	5		
COP.2.g.	Admission, discharge to home, or transfer to another organization is documented.	10		
COP.2.h.	In case of discharge to home or transfer to another organization, a discharge/ transfer note shall be given to the patient.	10		
COP.2.i.	The organization shall implement a quality assurance programme. *	10		
COP.2.j.	The organization has systems in place for the management of patients found dead on arrival and patients	10		

	who die within a few minutes of arrival *			
	Average Score	9.5		
COP.3:Ambulance services ensure safe patient transportation with appropriate care				
COP.3.a.	The organization has access to ambulance services commensurate with the scope of the services provided by it.	10		
COP.3.b.	There are adequate access and space for the ambulance(s).	5		
COP.3.c.	The ambulance(s) is fit for purpose and is appropriately equipped.	10		
COP.3.d.	The ambulance(s) is operated by trained personnel.	10		
COP.3.e.	The ambulance(s) is checked daily.	5		
COP.3.f.	Equipment is checked daily using a checklist. *	10		
COP.3.g.	A mechanism is in place to ensure that emergency medications are available in the ambulance.	10		
COP.3.h.	The ambulance(s) has a proper communication system.*	10		

COP.3.i.	The emergency department identifies opportunities to initiate treatment at the earliest when the patient is in transit to the organization.	10		
	Average Score	8.88		
COP.4: The organization plans and implements mechanisms for the care of patients during community emergencies, epidemics and other disasters.				
COP.4.a.	The organization identifies potential community emergencies, epidemics and other disasters.*	0		
COP.4.b.	The organization manages community emergencies, epidemics and other disasters as per a documented plan.*	0		
COP.4.c.	Provision is made for availability of medical supplies, equipment and materials during such emergencies.	10		
COP.4.d.	The plan is tested at least twice a year.	10		
	Average Score	0.5		
COP.5: Cardio-pulmonary resuscitation services are provided uniformly across the organization.				

COP.5.a.	Resuscitation services are available to patients at all times.	10		
COP.5.b.	During cardio-pulmonary resuscitation, assigned roles and responsibilities are complied with.	10		
COP.5.c.	Equipment and medications for use during cardio-pulmonary resuscitation are available in various areas of the organization.	10		
COP.5.d.	The events during cardio-pulmonary resuscitation are recorded.	10		
COP.5.e.	A multidisciplinary committee does a post-event analysis of cardiopulmonary resuscitations.	5		
COP.5.f.	Corrective and preventive measures are taken based on the post-event analysis.	10		
	Average Score	9.16		
COP.6: Nursing care is provided to patients in the organization in consonance with clinical protocols.				
COP.6.a.	Nursing care is provided to patients in accordance with written guidance. *	10		

COP.6.b.	The organization develops and implements nursing clinical practice guidelines reflecting current standards of practice. *	10		
COP.6.c.	Assignment of patient care is done as per current good clinical/ nursing practice guidelines.	10		
COP.6.d.	The organization implements acuity-based staffing to improve patient outcomes.	5		
COP.6.e.	Nursing care is aligned and integrated with overall patient care.	10		
COP.6.f.	Care provided by nurses is documented in the patient record.	10		
COP.6.g.	Nurses are provided with appropriate and adequate equipment for providing safe and efficient nursing care.	10		
COP.6.h.	Nurses are empowered to make patient care decisions within their scope of practice.	10		
	Average Score	9.37		
COP.7: Clinical procedures are performed in a safe manner.				
COP.7.a.	Procedures are performed based on the clinical needs of the patient.	10		

COP.7.b.	Performance of various clinical procedures is based on written guidance. *	10		
COP.7.c.	Qualified personnel order, plan, perform and assist in performing procedures.	10		
COP.7.d.	Care is taken to prevent adverse events like a wrong patient, wrong procedure and wrong site. *	10		
COP.7.e.	Informed consent is taken by the personnel performing the procedure, where applicable.	5		
COP.7.f.	The procedure is done adhering to standard precautions.	10		
COP.7.g.	Patients are appropriately monitored during and after the procedure.	10		
COP.7.h.	Procedures are documented accurately in the patient record.	5		
	Average Score	8.75		
COP.8: Transfusion services are provided as per the scope of services of the organization, safely.				
COP.8.a.	Scope of transfusion services is commensurate with the services provided by the organization.	10		
COP.8.b.	Transfusion of blood and blood components is done safely. *	10		

COP.8.c.	Blood and blood components are used rationally. *	10		
COP.8.d.	Informed consent is obtained for transfusion of blood and blood components.	10		
COP.8.e.	Informed consent also includes patient and family education about the donation.	5		
COP.8.f.	Blood/blood components are available for use in emergency situations within a defined time-frame. *	10		
COP.8.g.	Post-transfusion form is collected, reactions if any identified and are analyzed for preventive and corrective actions.	10		
COP.8.h.	The organization shall implement a quality assurance programme. *	10		
	Average Score	9.37		
COP.9: The organization provides care in intensive care and high dependency units in a systematic manner.				
COP.9.a.	Care of patients in intensive care and high dependency units is provided based on written guidance. *	10		

COP.9.b.	The defined admission and discharge criteria for intensive care and high dependency units are implemented. *	10		
COP.9.c.	Adequate staff and equipment are available.	5		
COP.9.d.	The organization endeavors to upgrade its physical infrastructure to meet national and international guidelines.	10		
COP.9.e.	Defined procedures for the situation of bed shortages are followed. *	10		
COP.9.f.	Infection control practices are followed. *	10		
COP.9.g.	The organization shall implement a quality assurance programme. *	10		
COP.9.h.	The organization has a mechanism to counsel the patient and/or family periodically.	5		
	Average Score	8.12		
COP.10: Organization provides safe obstetric care.				
COP.10.a.	Obstetric services are organized and provided safely. *	0		

COP.10.b.	The organization identifies and, provides care to high-risk obstetric cases, and where needed, refers them to another appropriate centre.	10		
COP.10.c.	Persons caring for high-risk obstetric cases are competent.	10		
COP.10.d.	Ante-natal services are provided. *	10		
COP.10.e.	Obstetric patient's assessment also includes maternal nutrition.	10		
COP.10.f.	Appropriate peri-natal and post-natal monitoring is performed.	10		
COP.10.g.	The organization caring for high-risk obstetric cases has the facilities to take care of neonates of such cases.	10		
	Average Score	8.57		
COP.11Organization provides safe pediatric services.				
COP.11.a.	Paediatric services are organized and provided safely. *	10		
COP.11.b.	Neonatal care is in consonance with the national/ international guidelines. *	10		
COP.11.c.	Those who care for children have age-specific competency.	10		

COP.11.d.	Provisions are made for special care of children.	10		
COP.11.e.	Paediatric assessment includes growth, developmental and immunization assessment.	10		
COP.11.f.	The organization has measures in place to prevent child/neonate abduction and abuse. *	0		
COP.11.g.	The child's family members are educated about nutrition, immunization and safe parenting.	0		
	Average Score	7.14		
COP.12: Procedural sedation is provided in a consistent and safe manner.				
COP.12.a.	Procedural sedation is administered in a consistent manner *	10		
COP.12.b.	Informed consent for administration of procedural sedation is obtained.	10		
COP.12.c.	Competent and trained persons administer sedation.	10		
COP.12.d.	The person monitoring sedation is different from the person performing the procedure.	0		

COP.12.e.	Intra-procedure monitoring includes at a minimum the heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation, and level of sedation.	10		
COP.12.f.	Patients are monitored after sedation, and the same is documented.	10		
COP.12.g.	Criteria are used to determine the appropriateness of discharge from the observation/recovery area. *	10		
COP.12.h.	Equipment and workforce are available to manage patients who have gone into a deeper level of sedation than initially intended.	10		
	Average Score	8.75		
COP.13: Anesthesia services are provided in a consistent and safe manner.				
COP.13.a.	Anesthesia services are provided in a consistent manner*	10		
COP.13.b.	The pre-anesthesia assessment results in the formulation of an anesthesia plan which is documented.	10		
COP.13.c.	A pre-induction assessment is	5		

	performed and documented.			
COP.13.d.	The anesthesiologist obtains informed consent for administration of anesthesia.	10		
COP.13.e.	During anesthesia, monitoring includes regular recording of temperature, heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation and end-tidal carbon dioxide.	10		
COP.13.f.	Patient's post-anesthesia status is monitored and documented.	10		
COP.13.g.	The anesthesiologist applies defined criteria to transfer the patient from the recovery area. *	10		
COP.13.h.	The type of anesthesia and anesthetic medications used are documented in the patient record.	10		
COP.13.i.	Procedures shall comply with infection control guidelines to prevent cross-infection between patients.	10		
COP.13.j.	Intraoperative adverse anesthesia events are recorded and monitored.	10		

	Average Score	9.5		
COP.14: Surgical services are provided in a consistent and safe manner.				
COP.14.a.	Surgical services are provided in a consistent and safe manner. *	10		
COP.14.b.	Surgical patients have a preoperative assessment, a documented pre-operative diagnosis, and pre-operative instructions are provided before surgery.	10		
COP.14.c.	Informed consent is obtained by a surgeon before the procedure.	10		
COP.14.d.	Care is taken to prevent adverse events like the wrong site, wrong patient and wrong surgery. *	10		
COP.14.e.	An operative note is documented before transfer out of patient from recovery.	10		
COP.14.f.	Postoperative care is guided by a documented plan.	10		
COP.14.g.	Patient, personnel and material flow conform to infection control practices.	10		
COP.14.h.	Appropriate facilities, equipment, instruments and supplies are available in the	10		

	operating theatre.			
COP.14.i.	The organization shall implement a quality assurance programme. *	10		
COP.14.j.	The quality assurance programme includes surveillance of the operation theatre environment. *	10		
	Average Score	10		
COP.15: The organ transplant programme is carried out safely.				
COP.15.a.	The organ transplant program shall be in consonance with the legal requirements and shall be conducted ethically.	NA		
COP.15.b.	Care of transplant patients is guided by clinical practice guidelines. *	NA		
COP.15.c.	The organization ensures education and counseling of recipient and donor through trained/qualified counselors before organ transplantation.	NA		

COP.15.d.	The organization shall take measures to create awareness regarding organ donation.	5		
	Average Score	0.5		
COP.16: The organization identifies and manages patients who are at higher risk of morbidity/ mortality.				
COP.16.a.	The organization identifies and manages vulnerable patients. *	10		
COP.16.b.	The organization provides for a safe and secure environment for the vulnerable patient.	10		
COP.16.c.	The organization identifies and manages patients who are at a risk of fall.*	10		
COP.16.d.	The organization identifies and manages patients who are at risk of developing/worsening of pressure ulcers.*	10		
COP.16.e.	The organization identifies and manages patients who are at risk of developing deep vein thrombosis.*	10		
COP.16.f.	The organization identifies and manages patients who need restraints. *	10		
	Average Score	10		

COP.17: Pain management for patients is done in a consistent manner.				
COP.17.a.	Patients in pain are effectively managed. *	10		
COP.17.b.	Patients are screened for pain.	5		
COP.17.c.	Patients with pain undergo detailed assessment and periodic reassessment.	5		
COP.17.d.	Pain alleviation measures or medications are initiated and titrated according to the patient's need and response.	5		
	Average Score	6.25		
COP.18: Rehabilitation services are provided to the patients in a safe, collaborative and consistent manner.				
COP.18.a.	Scope of the rehabilitation services at a minimum is commensurate to the services provided by the organization.	10		
COP.18.b.	Rehabilitation services are provided in a consistent manner.	10		
COP.18.c.	Care providers collaboratively plan rehabilitation services.	10		
COP.18.d.	There are adequate space and equipment to provide rehabilitation.	10		

COP.18.e.	Care is guided by functional assessment and periodic re-assessments which are done and documented.	10		
COP.18.f.	Care is provided adhering to infection control and safety practices.	10		
COP.18.g.	Care pathways are developed, implemented, and reviewed periodically.	0		
	Average Score	0.85		
COP.19: Nutritional therapy is provided to patients consistently and collaboratively.				
COP.19.a.	Patients admitted to the organization are screened for nutritional risk. *	10		
COP.19.b.	Nutritional assessment is done for patients found at risk during nutritional screening.	10		
COP.19.c.	The therapeutic diet is planned and provided collaboratively.	10		
COP.19.d.	Patients receive food according to the written order for the diet.	5		
COP.19.e.	When family provides food, they are educated about the patient's diet limitations.	10		
	Average Score	9		

COP.20: End-of-life-care is provided in a compassionate and considerate manner.				
COP.20.a.	End-of-life care is provided in a consistent manner in the organization. *	10		
COP.20.b.	A multi-professional approach is used to provide end-of-life care.	10		
COP.20.c.	End-of-life care is in consonance with the legal requirements.	10		
COP.20.d.	End of life care also addresses the identification of the unique needs of such patient and family.	10		
COP.20.e.	Symptomatic treatment is provided and where appropriate measures are taken for the alleviation of pain.	10		
	Average Score	10		
	Average Score of Chapter	7.51		
Chapter3:Management of Medication(MOM)				
MOM.1: Pharmacy services and usage of medication is done safely.				
MOM.1.a.	Pharmacy services and medication usage are implemented following written	10		

	guidance. *			
MOM.1.b.	A multidisciplinary committee guides the formulation and implementation of pharmacy services and medication usage.	10		
MOM.1.c.	There is a mechanism in place to facilitate the multidisciplinary committee to monitor literature reviews and best practice information on medication management and use the information to update medication management processes.	10		
MOM.1.d.	There is a procedure to obtain medication when the pharmacy is closed. *	10		
MOM.1.e.	The organization has a mechanism to inform relevant staff of key changes in pharmacy services and medication usage to ensure uninterrupted and safe care.	10		
	Average Score	10		

MOM.2.The organization develops updates and implements a hospital formulary.				
MOM.2.a.	A list of medications appropriate for the patients and as per the scope of the organization's clinical services is developed collaboratively by the multidisciplinary committee.	10		
MOM.2.b.	The list is reviewed and updated collaboratively by the multidisciplinary committee at least annually.	10		
MOM.2.c.	The current formulary is available for clinicians to refer to.	10		
MOM.2.d.	The clinicians adhere to the current formulary.	10		
MOM.2.e.	The organization adheres to the procedure for the acquisition of formulary medications. *	10		
MOM.2.f.	The organization adheres to the procedure to obtain medications not listed in the formulary. *	10		
	Average Score	10		
MOM.3: Medications are stored appropriately				

and are available where required.				
MOM.3.a.	Medications are stored in a clean, safe and secure environment; and incorporating the manufacturer's recommendation(s).	10		
MOM.3.b.	Sound inventory control practices guide storage of the medications throughout the organization.	0		
MOM.3.c.	The organization defines a list of high-risk medication(s). *	10		
MOM.3.d.	High-risk medications are stored in areas of the organization where it is clinically necessary.	0		
MOM.3.e.	High-risk medications including look-alike, sound-alike medications and different concentrations of the same medication are stored physically apart from each other. *	0		
MOM.3.f.	The list of emergency medications is defined and is stored uniformly. *	10		
MOM.3.g.	Emergency medications are available all the time and are	10		

	replenished promptly when used.			
	Average Score	5.71		
MOM.4: Medications are prescribed safely and rationally.				
MOM.4.a.	Medication prescription is in consonance with good practices/guidelines for the rational prescription of medications. *	0		
MOM.4.b.	The organization adheres to the determined minimum requirements of a prescription. *	10		
MOM.4.c.	Drug allergies and previous adverse drug reactions are ascertained before prescribing.	10		
MOM.4.d.	The organization has a mechanism to assist the clinician in prescribing appropriate medication.	0		
MOM.4.e.	Implementation of verbal orders ensures safe medication management practices. *	10		
MOM.4.f.	Audit of medication orders/prescription is carried out to check for safe and rational prescription of	10		

	medications.			
MOM.4.g.	Corrective and/or preventive action(s) is taken based on the audit, where appropriate.	10		
MOM.4.h.	Reconciliation of medications occurs at transition points of patient care.	10		
	Average Score	7.5		
MOM.5: Medications orders are written in a uniform manner.				
MOM.5.a.	The organization ensures that only authorized personnel write orders. *	10		
MOM.5.b.	Medication orders are written in a uniform location in the medical records, which also reflects the patient's name and unique identification number.	10		
MOM.5.c.	Medication orders are legible, dated, timed and signed.	10		
MOM.5.d.	Medication orders contain the name of the medicine, route of administration, strength to be administered and frequency/time of administration.	10		

	Average Score	10		
MOM.6: Medications are dispensed in a safe manner.		10		
MOM.6.a.	Dispensing of medications is done safely. *	10		
MOM.6.b.	Medication recalls are handled effectively. *	10		
MOM.6.c.	Near-expiry medications are handled effectively. *	0		
MOM.6.d.	Dispensed medications are labeled. *	10		
MOM.6.e.	High-risk medication orders are verified before dispensing.	10		
MOM.6.f.	Return of medications to the pharmacy is addressed. *	10		
	Average Score	8.3		
MOM.7: Medications are administered safely.				
MOM.7.a.	Medications are administered by those who are permitted by law to do so.	10		
MOM.7.b.	Prepared medication is labeled before preparation of a second drug.	10		
MOM.7.c.	The patient is identified before administration.	10		
MOM.7.d.	Medication is verified from the medication order and physically inspected before	10		

	administration.			
MOM.7.e.	Strength is verified from the order before administration.	10		
MOM.7.f.	The route is verified from the order before administration.	10		
MOM.7.g.	Timing is verified from the order before administration.	10		
MOM.7.h.	Measures to avoid catheter and tubing mis-connections during medication administration are implemented. *	10		
MOM.7.i.	Medication administration is documented.	10		
MOM.7.j.	Measures to govern patient's self-administration of medications are implemented. *	10		
MOM.7.k.	Measures to govern patient's medications brought from outside the organization are implemented. *	10		
	Average Score	10		
MOM.8: Patients are monitored after medication administration.		0		
MOM.8.a.	Patients are monitored after medication administration. *	10		
MOM.8.b.	Medications are changed where	10		

	appropriate based on the monitoring.			
MOM.8.c.	The organization captures near miss, medication error and adverse drug reaction. *	10		
MOM.8.d.	Near miss, medication error and adverse drug reaction are reported within a specified time frame. *	10		
MOM.8.e.	Near miss, medication error and adverse drug reaction are collected and analyzed.	10		
MOM.8.f.	Corrective and/or preventive action(s) are taken based on the analysis.	10		
	Average Score	8.57		
MOM.9: Narcotic drugs and psychotropic substances, chemotherapeutic agents and radioactive agents are used in a safe manner.				
MOM.9.a.	Narcotic drugs and psychotropic substances, chemotherapeutic agents and radioactive agents are used safely. *	10		
MOM.9.b.	Narcotic drugs and psychotropic substances, chemotherapeutic agents and radioactive agents are prescribed by appropriate	10		

	caregivers.			
MOM.9.c.	Narcotic drugs and psychotropic substances, chemotherapeutic agents and radioactive agents drugs are stored securely.	10		
MOM.9.d.	Chemotherapy and radioactive agents are prepared properly and safely and administered by qualified personnel.	10		
MOM.9.e.	A proper record is kept of the usage, administration and disposal of narcotic drugs and psychotropic substances, chemotherapeutic agents and radioactive agents.	10		
	Average Score	10		
MOM.10: Implantable prosthesis and medical devices are used in accordance with laid down criteria.				
MOM.10.a.	Usage of the implantable prosthesis and medical devices is guided by scientific criteria for each item and national/international	10		

	recognized guidelines/ approvals for such specific item(s).			
MOM.10.b.	The organization implements a mechanism for the usage of the implantable prosthesis and medical devices. *	10		
MOM.10.c.	Patient and his/her family are counselled for the usage of the implantable prosthesis and medical device, including precautions if any.	10		
MOM.10.d.	The batch and the serial number of the implantable prosthesis and medical devices are recorded in the patient's medical record, the master logbook and the discharge summary.	10		
MOM.10.e.	Recall of implantable prosthesis and medical devices are handled effectively. *	10		
	Average Score	10		
MOM.11: Medical supplies and consumables are stored appropriately and are available where required.				

MOM.11.a.	The organization adheres to the defined process for the acquisition of medical supplies and consumables. *	0		
MOM.11.b.	Medical supplies and consumables are used in a safe manner, where appropriate.	10		
MOM.11.c.	Medical supplies and consumables are stored in a clean, safe and secure environment; and incorporating the manufacturer's recommendation(s).	10		
MOM.11.d.	Sound inventory control practices guide storage of medical supplies and consumables	10		
MOM.11.e.	There is a mechanism in place to verify the condition of medical supplies and consumables	10		
	Average Score	8		
	Average Score of Chapter	8.9		
Chapter4:Patient Rights and Education(PRE)				
PRE.1.The organization protects and promotes patient and family rights and informs them about their responsibilities during care.				

PRE.1.a.	Patient and family rights and responsibilities are documented, displayed and they are made aware of the same. *	10		
PRE.1.b.	Patient and family rights and responsibilities are actively promoted. *	10		
PRE.1.c.	The organization protects patient and family rights.	10		
PRE.1.d.	The organization has a mechanism to report a violation of patient and family rights.	10		
PRE.1.e.	Violation of patient and family rights are monitored, analyzed, and corrective/preventive action taken by the top leadership of the organization.	10		
	Average Score	10		
PRE.2: Patient and family rights support individual beliefs, values and involve the patient and family in decision-making processes.				
PRE.2.a.	Patients and family rights include respecting values and beliefs, any special preferences, cultural needs, and responding to requests for spiritual needs.	10		

PRE.2.b.	Patient and family rights include respect for personal dignity and privacy during examination, procedures and treatment.	10		
PRE.2.c.	Patient and family rights include protection from neglect or abuse.	10		
PRE.2.d.	Patient and family rights include treating patient information as confidential.	10		
PRE.2.e.	Patient and family rights include the refusal of treatment.	10		
PRE.2.f.	Patient and family rights include a right to seek an additional opinion regarding clinical care.	10		
PRE.2.g.	Patient and family rights include informed consent before the transfusion of blood and blood components, anesthesia, surgery, initiation of any research protocol and any other invasive/high-risk procedures/treatment.	10		
PRE.2.h.	Patient and family rights include a right to complain and information on how to voice a complaint.	10		

PRE.2.i.	Patient and family rights include information on the expected cost of the treatment.	10		
PRE.2.j.	Patient and family rights include access to their clinical records.	10		
PRE.2.k.	Patient and family rights include information on the name of the treating doctor, care plan, progress and information on their health care needs.	10		
PRE.2.l.	Patient rights include determining what information regarding their care would be provided to self and family.	10		
	Average Score	10		
PRE.3: The patient and/or family members are educated to make informed decisions and are involved in the care planning and delivery process.				
PRE.3.a.	The Patient and/or family members are explained about the proposed care, including the risks, alternatives and benefits.	5		
PRE.3.b.	The patient and/or family members are explained about the expected results.	5		

PRE.3.c.	The patient and/or family members are explained about the possible complications.	5		
PRE.3.d.	The care plan is prepared and modified in consultation with the patient and/or family members.	5		
PRE.3.e.	The patient and/or family members are informed about the results of diagnostic tests and the diagnosis.	5		
PRE.3.f.	The patient and/or family members are explained about any change in the patient's condition in a timely manner.	10		
PRE.3.g.	The patient and/or family members are provided multi-disciplinary counselling when appropriate.	5		
	Average Score	5.71		
PRE.4: Informed consent is obtained from the patient or family about their care.				
PRE.4.a.	The organization obtains informed consent from the patient or family for situations where informed consent is required. *	10		
PRE.4.b.	Informed consent process	10		

	adheres to statutory norms.			
PRE.4.c.	Informed consent includes information regarding the procedure; it's risks, benefits, alternatives and as to who will perform the procedure in a language that they can understand.	10		
PRE.4.d.	The organization describes who can give consent when a patient is incapable of independent decision making and implements the same. *	10		
PRE.4.e.	Informed consent is taken by the person performing the procedure.	10		
	Average Score	10		
PRE.5: Patient and families have a right to information and education about their healthcare needs.				
PRE.5.a.	Patient and/or family are educated in a language and format that they can understand.	10		
PRE.5.b.	Patient and/or family are educated about the safe and effective use of medication and the potential side effects of	10		

	the medication, when appropriate.			
PRE.5.c.	Patient and/or family are educated about food-drug interaction.	10		
PRE.5.d.	Patient and/or family are educated about diet and nutrition.	10		
PRE.5.e.	Patient and/or family are educated about immunizations.	10		
PRE.5.f.	Patient and/or family are educated on various pain management techniques when appropriate.	5		
PRE.5.g.	Patient and/or family are educated about their specific disease process, complications and prevention strategies.	5		
PRE.5.h.	Patient and/or family are educated about preventing healthcare associated infections.	5		
PRE.5.i.	The patients and/or family members' special educational needs are identified and addressed.	5		
	Average Score	7.77		

PRE.6: Patients and families have a right to information on expected costs.				
PRE.6.a.	The patient and/or family members are made aware of the pricing policy in different settings (out-patient, emergency, ICU and inpatient).	5		
PRE.6.b.	The relevant tariff list is available to patients.	5		
PRE.6.c.	The patient and/or family members are explained about the expected costs.	5		
PRE.6.d.	Patient and/or family are informed about the financial implications when there is a change in the care plan.	5		
	Average Score	5		
PRE.7: The organization has a mechanism to capture patient's feedback and to redress complaints.				
PRE.7.a.	The organization has a mechanism to capture feedback from patients, which includes patient satisfaction.	5		
PRE.7.b.	The organization has a mechanism to capture patient experience.	5		
PRE.7.c.	The organization redresses patient complaints as per the	5		

	defined mechanism. *			
PRE.7.d.	Patient and/or family members are made aware of the procedure for giving feedback and/or lodging complaints.	5		
PRE.7.e.	Feedback and complaints are reviewed and/or analyzed within a defined time frame.	0		
PRE.7.f.	Corrective and/or preventive action(s) are taken based on the analysis where appropriate.	0		
	Average Score	5		
PRE.8: The organization has a system for effective communication with patients and/or families.				
PRE.8.a.	Communication with the patients and/or families is done effectively. *	10		
PRE.8.b.	The organization shall identify special situations where enhanced communication with patients and/or families would be required. *	5		
PRE.8.c.	Enhanced communication with the patients and/or families is	10		

	done effectively. *			
PRE.8.d.	The organization ensures that there is no unacceptable communication.	0		
PRE.8.e.	The organization has a system to monitor and review the implementation of effective communication.	0		
	Average Score	5		
	Average Score of Chapter	7.25		
Chapter5:Hospital Infection Control(HIC)				
HIC.1: The organization has a comprehensive and coordinated Hospital Infection Prevention and Control (HIC) programme aimed at reducing/ eliminating risks to patients, visitors, providers of care and community.				
HIC.1.a.	The hospital infection prevention and control programme is documented, which aims at preventing and reducing the risk of healthcare associated infections in the hospital. *	10		

HIC.1.b.	The hospital infection prevention and control programme identifies high-risk activities, and has written guidance to prevent and manage infections for these activities.*	10		
HIC.1.c.	The infection prevention and control programme is reviewed and updated at least once a year.	10		
HIC.1.d.	The infection prevention and control programme is reviewed based on infection control assessment tool.	5		
HIC.1.e.	The organization has a multi-disciplinary infection control committee, which coordinates all infection prevention and control activities. *	10		
HIC.1.f.	The organization has an infection control team, which coordinates the implementation of all infection prevention and control activities. *	10		
HIC.1.g.	The organization has designated infection control officer as part of the infection control team. *	10		

HIC.1.h.	The organization has designated infection control nurse(s) as part of the infection control team. *	10		
HIC.1.i.	The organization implements information, education and communication programme for infection prevention and control activities for the community.	5		
HIC.1.j.	The organization participates in managing community outbreaks.	5		
	Average Score	8.5		
HIC.2: The organization provides adequate and appropriate resources for infection prevention and control.		5		
HIC.2.a.	The management makes available resources required for the infection control programme.	5		
HIC.2.b.	The organization earmarks adequate funds from its annual budget in this regard.	0		
HIC.2.c.	Adequate and appropriate personal protective equipment, soaps, and disinfectants are available and used correctly.	5		

HIC.2.d.	Adequate and appropriate facilities for hand hygiene in all patient-care areas are accessible to healthcare providers.	5		
HIC.2.e.	Isolation/barrier nursing facilities are available.	0		
	Average Score	3.3		
HIC.3: The organization implements the infection prevention and control programme in clinical areas.				
HIC.3.a.	The organization adheres to standard precautions at all times. *	0		
HIC.3.b.	The organization adheres to hand-hygiene guidelines. *	0		
HIC.3.c.	The organization adheres to transmission-based precautions. *	0		
HIC.3.d.	The organization adheres to safe injection and infusion practices. *	0		
HIC.3.e.	Appropriate antimicrobial usage policy is established and documented *	10		
HIC.3.f.	The organization implements the antimicrobial usage policy and monitors the rational use of antimicrobial agents.	0		

HIC.3.g.	The organization implements an antibiotic stewardship programme. *	0		
	Average Score	1.42		
HIC.4: The organization implements the infection prevention and control programme in support services.				
HIC.4.a.	The organization has appropriate engineering controls to prevent infections. *	0		
HIC.4.b.	The organization designs and implements a plan to reduce the risk of infection during construction and renovation. *	10		
HIC.4.c.	The organization adheres to housekeeping procedures. *	10		
HIC.4.d.	Biomedical waste (BMW) is handled appropriately and safely.	5		
HIC.4.e.	The organization adheres to laundry and linen management processes. *	10		
HIC.4.f.	The organization adheres to kitchen sanitation and food-handling issues. *	10		
	Average Score	7.5		
HIC.5: The organization takes actions to prevent healthcare associated infections (HAI)				

in patients.				
HIC.5.a.	The organization takes action to prevent catheter-associated urinary tract Infections.	10		
HIC.5.b.	The organization takes action to prevent infection-related ventilator associated complication/ventilator-associated pneumonia.	10		
HIC.5.c.	The organization takes action to prevent catheter linked blood stream infections.	10		
HIC.5.d.	The organization takes action to prevent surgical site infections.	10		
	Average Score	10		
HIC.6: The organization performs surveillance to capture and monitor infection prevention and control data.				
HIC.6.a.	The scope of surveillance incorporates tracking and analyzing of infection risks, rates and trends.	5		
HIC.6.b.	Verification of data is done regularly by the infection control team.	5		
HIC.6.c	Surveillance is directed	5		

	towards the identified high-risk activities.			
HIC.6.d.	Surveillance includes monitoring compliance with hand-hygiene guidelines.	10		
HIC.6.e.	Surveillance includes mechanisms to capture the occurrence of multi-drug resistant organisms and highly virulent infections.	10		
HIC.6.f.	Surveillance includes monitoring the effectiveness of housekeeping services.	10		
HIC.6.g.	Feedback regarding surveillance data is provided regularly to the appropriate health care provider.	10		
HIC.6.h.	The organization identifies and takes appropriate action to control outbreaks of infections.	10		
HIC.6.I.	Surveillance data is analyzed, and appropriate corrective and preventive actions are taken.	5		
	Average Score	7.77		
HIC.7: Infection prevention measures include sterilization and/or disinfection of				

instruments, equipment and devices.				
HIC.7.a.	The organization provides adequate space and appropriate zoning for sterilization activities.	10		
HIC.7.b.	Cleaning, packing, disinfection and/or sterilization, storing and the issue of items is done as per the written guidance. *	10		
HIC.7.c.	Reprocessing of single-use instruments, equipment and devices are done as per written guidance. *	10		
HIC.7.d.	Regular validation tests for sterilization are carried out and documented. *	10		
HIC.7.e.	The established recall procedure is implemented when a breakdown in the sterilization system is identified. *	10		
	Average Score	10		
HIC.8: The organization takes action to prevent or reduce healthcare associated infections in its staff.				
HIC.8.a.	The organization implements occupational health and safety practices to reduce the risk of transmitting microorganisms	5		

	among health care providers.			
HIC.8.b.	The organization implements an immunization policy for its staff. *	10		
HIC.8.c.	The organization implements work restrictions for health care providers with transmissible infections.	5		
HIC.8.d.	The organization implements measures for blood and body fluid exposure prevention.	5		
HIC.8.e.	Appropriate post-exposure prophylaxis is provided to all staff members concerned. *	10		
	Average Score	7		
	Average Score of Chapter	6.92		
Chapter6: Patient Safety and Quality Improvement (PSQ)				
PSQ.1. The organization implements a structured patient-safety programme.				
PSQ.1.a.	The patient-safety programme is developed, implemented and maintained by a multi-disciplinary safety committee.	5		

	*			
PSQ.1.b.	The patient-safety programme is comprehensive and covers all the major elements related to patient safety.	5		
PSQ.1.c.	The programme covers incidents ranging from "no harm" to "sentinel events".	5		
PSQ.1.d.	Designated patient safety officer(s) coordinates implementation of the patient safety programme.	5		
PSQ.1.e.	Designated clinical safety officer(s) coordinates implementation of the clinical aspects of the patient-safety programme.	5		
PSQ.1.f.	The patient-safety programme identifies opportunities for improvement based on the review at pre-defined intervals.	5		
PSQ.1.g.	The organization performs proactive analysis of patient safety risks and makes improvements accordingly.	5		
PSQ.1.h.	The patient-safety programme is reviewed and updated at least	5		

	once a year.			
PSQ.1.i.	The organization adapts and implements national/international patient-safety goals/solutions.	10		
	Average Score	5.55		
PSQ.2.The organization implements a structured quality improvement and continuous monitoring programme.				
PSQ.2.a.	The quality improvement programme is developed, implemented and maintained by a multi-disciplinary committee.*	0		
PSQ.2.b.	The quality improvement programme is comprehensive and covers all the major elements related to quality assurance.*	0		
PSQ.2.c.	The quality improvement programme improves process efficiency and effectiveness.	5		
PSQ.2.d.	There is a designated individual for coordinating and implementing the quality improvement programme.*	10		

PSQ.2.e.	The quality improvement programme identifies opportunities for improvement based on the review at pre-defined intervals.*	10		
PSQ.2.f.	The quality improvement programme is reviewed and updated at least once a year.	10		
PSQ.2.g.	Audits are conducted at regular intervals as a means of continuous monitoring.*	10		
PSQ.2.h.	There is an established process in the organization to monitor and improve the quality of nursing care.*	10		
	Average Score	6.87		
PSQ.3.The organization identifies key indicators to monitor the structures, processes and outcomes, which are used as tools for continual improvement.				
PSQ.3.a.	The organization identifies and monitors key indicators to oversee the clinical structures, processes and outcomes.	10		
PSQ.3.b.	The organization identifies and monitors the key indicators to oversee infection control activities.	10		

PSQ.3.c.	The organization identifies and monitors key indicators to oversee the managerial structures, processes and outcomes.	5		
PSQ.3.d.	The organization identifies and monitors key indicators to oversee patient safety activities.	5		
PSQ.3.e.	The organization has a mechanism to capture patient reported outcome measures.	0		
PSQ.3.f.	Verification of data is done regularly by the quality team.	10		
PSQ.3.g.	There is a mechanism for analysis of data which results in identifying opportunities for improvement.	10		
PSQ.3.h.	The improvements are implemented and evaluated.	5		
PSQ.3.i.	Feedback about care and service is communicated to staff.	5		
	Average Score	6.66		
PSQ.4.The organization uses appropriate quality improvement tools for its quality improvement activities.				
PSQ.4.a.	The organization undertakes quality improvement projects.	10		

PSQ.4.b.	The organization uses appropriate analytical tools for its quality improvement activities.	10		
PSQ.4.c.	The organization uses appropriate statistical tools for its quality improvement activities.	10		
PSQ.4.d.	The organization uses appropriate managerial tools for its quality improvement activities.	10		
	Average Score	10		
PSQ.5.There is an established system for clinical audit.				
PSQ.5.a.	Clinical audits are performed to improve the quality of patient care.	10		
PSQ.5.b.	The parameters to be audited are defined by the organization.	10		
PSQ.5.c.	Medical and nursing staff participates in clinical audit.	10		
PSQ.5.d.	Patient and staff anonymity are maintained.	10		
PSQ.5.e.	Clinical audits are documented.	10		
PSQ.5.f.	Remedial measures are implemented.	10		
	Average Score	10		

PSQ.6.The patient safety and quality improvement programme are supported by the management.				
PSQ.6.a.	The management creates a culture of safety.	10		
PSQ.6.b.	The leaders at all levels in the organization are aware of the intent of the patient safety and quality improvement programme and the approach to its implementation.	10		
PSQ.6.c.	Departmental leaders are involved in patient safety and quality improvement.	5		
PSQ.6.d.	The management makes available adequate resources required for patient safety and quality improvement programme.	10		
PSQ.6.e.	Organization earmarks adequate funds from its annual budget in this regard.	10		
PSQ.6.f.	The management identifies organizational performance improvement targets.	10		
PSQ.6.g.	The management uses the feedback obtained from the workforce to improve patient safety and quality	10		

	improvement programme.			
	Average Score	9.28		
PSQ.7.Incidents are collected and analyzed to ensure continual quality improvement.				
PSQ.7.a.	The organization implements an incident management system.*	10		
PSQ.7.b.	The organization has a mechanism to identify sentinel events.*	10		
PSQ.7.c.	The organization has established processes for analysis of incidents.	10		
PSQ.7.d.	Corrective and preventive actions are taken based on the findings of such analysis.	5		
PSQ.7.e.	The organization incorporates risks identified in the analysis of incidents into the risk management system.	5		
PSQ.7.f.	The organization shall have a process for informing various stakeholders in case of a near miss/adverse event/sentinel event.	5		
	Average Score	7.5		
	Average Score of Chapter	7.97		

Chapter7:Responsibilities of Management(ROM)				
ROM.1: The organization identifies those responsible for governance and their roles are defined.				
ROM.1.a.	Those responsible for governance are identified, and their roles and responsibilities are defined and documented. *	10		
ROM.1.b.	Those responsible for governance lay down the organization's vision, mission and values.*	10		
ROM.1.c.	Those responsible for governance approve the strategic and operational plans and the organization's annual budget.	10		
ROM.1.d.	Those responsible for governance monitor and measure the performance of the organization against the stated mission.	10		
ROM.1.e.	Those responsible for governance appoint the senior leaders in the organization.	10		
ROM.1.f.	Those responsible for governance support safety	10		

	initiatives and quality improvement plans.			
ROM.1.g.	Those responsible for governance support the ethical management framework of the organization.	10		
ROM.1.h.	Those responsible for governance inform the public of the quality and performance of services.	10		
	Average Score	10		
ROM.2: The leaders manage the organization in an ethical manner.				
ROM.2.a.	The leaders make public the vision, mission and values of the organization.	10		
ROM.2.b.	The leaders establish the organization's ethical management framework. *	0		
ROM.2.c.	The ethical management framework includes processes for managing issues with ethical implications, dilemmas and concerns.	10		
ROM.2.d.	The organization discloses its ownership.	10		
ROM.2.e.	The organization honestly portrays its affiliations and accreditations.	10		

	Average Score	8		
ROM.3: The organization is headed by a leader who shall be responsible for operating the organization on a day-to-day basis.				
ROM.3.a.	The person heading the organization has requisite and appropriate administrative qualifications.	10		
ROM.3.b.	The person heading the organization has requisite and appropriate administrative experience.	10		
ROM.3.c.	The leader is responsible for and complies with the laid-down and applicable legislations, regulations and notifications.	10		
ROM.3.d.	The leader appoints/participates in the recruitment of senior leadership of the organization who will assist in the day-to-day functioning of the organization.	10		
ROM.3.e.	The leader ensures that each organizational programme, service, site or department has effective leadership.	10		

ROM.3.f.	The performance of the organization's leader is reviewed for effectiveness.	10		
	Average Score	10		
ROM.4: The organization displays professionalism in its functioning.				
ROM.4.a.	The organization has 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		
ROM.4.b.	The organization coordinates the functioning with departments and external agencies and monitors the progress in achieving the defined goals and objectives.	10		
ROM.4.c.	The organization plans and budgets for its activities annually.	5		
ROM.4.d.	The functioning of committees is reviewed for their effectiveness.	10		
ROM.4.e.	The organization documents staff rights and responsibilities. *	10		

ROM.4.f.	The organization documents the service standards that are measurable and monitors them.*	10		
ROM.4.g.	Systems and processes are in place for change management.	10		
	Average Score	9.28		
ROM.5: Management ensures that patient-safety aspects and risk-management issues are an integral part of patient care and hospital management.				
ROM.5.a.	Management ensures proactive risk management across the organisation.*	0		
ROM.5.b.	Management provides resources for proactive risk assessment and risk reduction activities.	10		
ROM.5.c.	Management ensures integration between quality improvement, risk management and strategic planning within the organization.	10		
ROM.5.d.	Management ensures implementation of systems for internal and external reporting of system and process failures.*	10		

ROM.5.e.	Management ensures that it has a documented agreement for all outsourced services that include service parameters.	10		
ROM.5.f.	Management monitors the quality of the outsourced services and improvements are made as required.	10		
	Average Score	8.3		
	Average Score of Chapter	9.1		
Chapter8:Facility Management and Safety(FMS)				
FMS.1: The organization has a system in place to provide a safe and secure environment.				
FMS.1.a.	Patient-safety devices and infrastructure are installed across the organization and inspected periodically.	10		
FMS.1.b.	The organization has facilities for the differently-abled.	10		
FMS.1.c.	Facility inspection rounds to ensure safety are conducted at least once a month.	5		Quarterly
FMS.1.d.	Inspection reports of facility rounds are documented, and corrective and preventive measures are	0	No repair Occur(Lights,	

	undertaken.		doors)	
FMS.1.e.	Before construction, renovation and expansion of existing hospital, risk assessment are carried out.	10	Form is availabl e.	
	Average Score	7		
FMS.2: The organization's environment and facilities operate in a planned manner and promotes environment-friendly measures.				
FMS.2.a.	Facilities and space provisions are appropriate to the scope of services.	10		
FMS.2.b.	As-built and updated drawings are maintained as per statutory requirements.	10		
FMS.2.c.	There are internal and external sign postings in the organization in a manner understood by the patient, families and community.	5	No Bilingu al signs.	
FMS.2.d.	Potable water and electricity are available round the clock.	0		
FMS.2.e.	Alternate sources for electricity and water are provided as a backup for any failure/shortage.	10		

FMS.2.f.	The organization tests the functioning of these alternate sources at a predefined frequency.	10		
FMS.2.g.	The organization takes initiatives towards an energy-efficient and environmentally friendly hospital.*	0		
	Average Score	6.42		
FMS.3: The organization's environment and facilities operate to ensure the safety of patients, their families, staff and visitors.				
FMS.3.a.	Patient safety aspects in terms of structural safety of hospitals especially of critical areas are considered while planning, design and construction of new hospitals and re-planning, assessment, and retrofitting of existing hospitals.	10		
FMS.3.b.	Operational planning identifies areas which need to have extra security and describes access to different areas in the hospital by staff, patients, and visitors.	10		
FMS.3.c.	The organization conducts electrical safety audits for the facility.	10		

FMS.3.d.	There is a procedure which addresses the identification and disposal of material(s) not in use in the organization. *	10		
FMS.3.e.	Hazardous materials are identified and used safely within the organisation.*	10		
FMS.3.f.	The plan for managing spills of hazardous materials is implemented. *	10		
	Average Score	10		
FMS.4:The organisation has a programme for the facility, engineering support services and utility system.				
FMS.4.a.	The organization plans for utility and engineering equipment in accordance with its services and strategic plan.	10		
FMS.4.b.	Equipment is inventoried, and proper logs are maintained as required.	10		
FMS.4.c.	The documented operational and maintenance (preventive and breakdown) plan is implemented. *	10		
FMS.4.d.	Utility equipment, are periodically inspected and calibrated (wherever applicable) for their proper	10		

	functioning.			
FMS.4.e.	Competent personnel operate, inspect, test and maintain equipment and utility systems.	10		
FMS.4.f.	Maintenance staff is contactable round the clock for emergency repairs.	10		
FMS.4.g.	Downtime for critical equipment breakdowns is monitored from reporting to inspection and implementation of corrective actions.	10		
FMS.4.h.	Written guidance supports equipment replacement, identification of unwanted material and disposal. *	10		
	Average Score	10		
FMS.5: The organization has a programme for medical equipment management.				
FMS.5.a.	The organization plans for medical equipment in accordance with its services and strategic plan.	10		
FMS.5.b.	Medical equipment is inventoried, and proper logs are maintained as required.	10		

FMS.5.c.	The documented operational and maintenance (preventive and breakdown) plan for medical equipment is implemented. *	10		
FMS.5.d.	Medical equipment is periodically inspected and calibrated for their proper functioning.	10		
FMS.5.e.	Qualified and trained personnel operate and maintain medical equipment.	10		
FMS.5.f.	Written guidance supports medical equipment replacement and disposal. *	10		
FMS.5.g.	There is a monitoring of medical equipment and medical devices related to adverse events, and compliance hazard notices on recalls. *	10		
FMS.5.h.	Downtime for critical equipment breakdown is monitored from reporting to inspection and implementation of corrective actions.	10		
	Average Score	10		
FMS.6: The organization has a programme for medical gases, vacuum and compressed air.				

FMS.6.a.	Written guidance governs the implementation of procurement, handling, storage, distribution, usage and replenishment of medical gases. *	10		
FMS.6.b.	Medical gases are handled, stored, distributed and used in a safe manner.	10		
FMS.6.c.	The procedures for medical gases address the safety issues at all levels.	10		
FMS.6.d.	Alternate sources for medical gases, vacuum and compressed air are provided for, in case of failure.	10		
FMS.6.e.	The organization regularly tests the functioning of these alternate sources.	10		
FMS.6.f.	There is an operational, inspection, testing and maintenance plan for piped medical gas, compressed air and vacuum installation. *	10		
	Average Score	10		
FMS.7: The organization has plans for fire and non-fire emergencies within the facilities.				
FMS.7.a.	The organization has plans and provisions for early detection, abatement and containment of	10		

	the fire, and non-fire emergencies. *			
FMS.7.b.	The organization has a documented and displayed exit plan in case of fire and non-fire emergencies.	10		
FMS.7.c.	Mock drills are held at least twice a year.	10		
FMS.7.d.	There is a maintenance plan for fire-related equipment and infrastructure *	10		
FMS.7.e.	The organization has a service continuity plan in case of fire and non-fire emergencies	10		
	Average Score	10		
	Average Score of Chapter	9.05		
HRM.1. The organization has a documented system of human resource planning.				
HRM.1.a.	Human resource planning supports the organization's current and future ability to meet the care, treatment and service needs of the patient.	10		
HRM.1.b.	The organization maintains an adequate number and mix of staff to meet the care, treatment and service needs of the patient.	10		

HRM.1.c.	The organization has contingency plans to manage long- and short-term workforce shortages, including unplanned shortages.	10		
HRM.1.d.	The job specification and job description are defined for each category of staff. *	10		
HRM.1.e.	The organization performs a background check of new staff.	10		
HRM.1.f.	Reporting relationships are defined for each category of staff. *	10		
HRM.1.g.	Exit interviews are conducted and used as a tool to improve human resource practices.	0		
	Average Score	8.57		
HRM.2.The organization implements a defined process for staff recruitment.				
HRM.2.a.	Written guidance governs the process of recruitment. *	10		
HRM.2.b.	A pre-employment medical examination is conducted on the staff.	10		
HRM.2.c.	The organization defines and implements a code of conduct for its staff.	10		

HRM.2.d.	Administrative procedures for human resource management are documented.*	10		
	Average Score	10		
HRM.3.Staff is provided induction training at the time of joining the organization.				
HRM.3.a.	Staff is provided with induction training.	10		
HRM.3.b.	The induction training includes orientation to the organization's vision, mission and values.	10		
HRM.3.c.	The induction training includes awareness on staff rights and responsibilities and patient rights and responsibilities.	10		
HRM.3.d.	The induction training includes training on safety.	10		
HRM.3.e.	The induction training includes training on cardio-pulmonary resuscitation for staff providing direct patient care.	10		
HRM.3.f.	The induction training includes training in hospital infection prevention and control.	10		

HRM.3.g.	The induction training includes orientation to the service standards of the organization.	10		
HRM.3.h.	The induction training includes an orientation on administrative procedures.	10		
HRM.3.i.	The induction training includes an orientation on relevant department/unit/ service/programmer's policies and procedures.	10		
	Average Score	10		
HRM.4.There is an on-going programme for professional training and development of the staff.				
HRM.4.a.	Written guidance governs training and development policy for the staff.*	10		
HRM.4.b.	The organization maintains the training record.	10		
HRM.4.c.	Training also occurs when job responsibilities change/new equipment is introduced.	10		
HRM.4.d.	Feedback mechanisms are in place for improvement of training and development programme.	10		
HRM.4.e.	Evaluation of training	10		

	effectiveness is done by the organization.			
HRM.4.f.	The organization supports continuing professional development and learning.	10		
	Average Score	10		
HRM.5.Staff is appropriately trained based on their specific job description.				
HRM.5.a.	Staff involved in blood transfusion services is trained on the handling of blood and blood products.	10		
HRM.5.b.	Staff is trained in handling vulnerable patients.	10		
HRM.5.c	Staff is trained in control and restraint techniques.	10		
HRM.5.d.	Staff is trained in healthcare communication techniques.	10		
HRM.5.e.	Staff involved in direct patient care is provided training on cardiopulmonary resuscitation periodically.	10		
HRM.5.f.	Staff is provided training on infection prevention and control.	10		
	Average Score	10		
HRM.6.Staff is trained in safety and quality-related aspects.				

HRM.6.a.	Staff is trained on the organization's safety programme.	10		
HRM.6.b.	Staff is provided training on the detection, handling, minimization and elimination of identified risks within the organization's environment.	10		
HRM.6.c.	Staff members are made aware of procedures to follow in the event of an incident.	10		
HRM.6.d.	Staff is trained in occupational safety aspects.	10		
HRM.6.e.	Staff is trained in the organization's disaster management plan.	10		
HRM.6.f.	Staff is trained in handling fire and non-fire emergencies.	10		
HRM.6.g.	Staff are trained on the organization's quality improvement programme	10		
	Average Score	10		
HRM.7.An appraisal system for evaluating the performance of staff exists as an integral part of the human resource management process.				
HRM.7.a.	Performance appraisal is done for staff within the	10		

	organisation.*			
HRM.7.b.	The staff is made aware of the system of appraisal at the time of induction.	10		
HRM.7.c.	Performance is evaluated based on the pre-determined criteria.	10		
HRM.7.d.	The appraisal system is used as a tool for further development.	10		
HRM.7.e.	Performance appraisal is carried out at defined intervals and is documented.	10		
	Average Score	10		
HRM.8.Process for disciplinary and grievance handling is defined and implemented in the organization.				
HRM.8.a.	Written guidance governs disciplinary and grievance handling mechanisms.*	10		
HRM.8.b.	The disciplinary and grievance handling mechanism is known to all categories of staff of the organization.	10		
HRM.8.c.	The disciplinary policy and procedure are based on the principles of natural justice.	10		
HRM.8.d.	The disciplinary and grievance procedure is in consonance	10		

	with the prevailing laws.			
HRM.8.e.	There is a provision for appeals in all disciplinary cases.	10		
HRM.8.f.	Actions are taken to redress the grievance.	10		
	Average Score	10		
HRM.9.The organization promotes staff well-being and addresses their health and safety needs.				
HRM.9.a.	Staff well-being is promoted.	10		
HRM.9.b.	Health problems of the staff, including occupational health hazards, are taken care of in accordance with the organization's policy.	10		
HRM.9.c.	Health checks of staff dealing with direct patient care are done at least once a year and the findings/results are documented.	10		
HRM.9.d.	Organization provides treatment to staff who sustains workplace-related injuries.	10		
HRM.9.e.	The organization has measures in place for prevention and handling workplace violence.	10		

	Average Score	10		
HRM.10.There is documented personal information for each staff member.				
HRM.10.a.	Personal files are maintained with respect to all staff, and their confidentiality is ensured	10		
HRM.10.b.	The personal files contain personal information regarding the staff's qualification, job description, verification of credentials and health status.	10		
HRM.10.c.	Records of in-service training and education are contained in the personal files.	10		
HRM.10.d.	Personal files contain results of all evaluations and remarks.	10		
	Average Score	10		
HRM.11.There is a process for credentialing and privileging of medical professionals, permitted to provide patient care without supervision.				
HRM.11.a.	Medical professionals permitted by law, regulation and the organization to provide patient care without supervision is identified.	10		

HRM.11.b.	The education, registration, training and experience of the identified medical professionals are documented and updated periodically.	10		
HRM.11.c.	The information about medical professionals is appropriately verified when possible.	10		
HRM.11.d.	Medical professionals are granted privileges to admit and care for patients in consonance with their qualification, training, experience and registration.	10		
HRM.11.e.	The requisite services to be provided by the medical professionals are known to them as well as the various departments/units of the organization.	10		
HRM.11.f.	Medical professionals admit and care for patients as per their privileging.	10		
	Average Score	10		
HRM.12.There is a process for credentialing and privileging of nursing professionals, permitted to provide patient care without supervision				

HRM.12.a.	Nursing staff permitted by law, regulation and the organization to provide patient care without supervision are identified.	10		
HRM.12.b.	The education, registration, training and experience of nursing staff are appropriately verified, documented and updated periodically.	10		
HRM.12.c.	The information about the nursing staff is appropriately verified when possible.	10		
HRM.12.d.	Nursing staff are granted privileges in consonance with their qualification, training, experience and registration.	10		
HRM.12.e.	The requisite services to be provided by the nursing staff are known to them as well as the various departments/units of the organization.	10		
HRM.12.f.	Nursing professionals care for patients as per their privileging.	10		
	Average Score	10		
HRM.13.There is a process for credentialing				

and privileging of Para-clinical professionals, permitted to provide patient care without supervision.				
HRM.13.a.	Para-clinical professionals permitted by law, regulation and the organization to provide patient care without supervision is identified.	10		
HRM.13.b.	The education, registration, training and experience of Para clinical professionals are appropriately verified, documented and updated periodically.	10		
HRM.13.c.	Para-clinical professionals are granted privileges in consonance with their qualification, training, experience and registration.	10		
HRM.13.d.	The requisite services to be provided by the Para-clinical professionals are known to them as well as the various departments/units of the organization.	10		
HRM.13.e.	Para-clinical professionals care for patients as per their privileging.	10		
	Average Score	10		

	Average Score of Chapter	9.88		
Chapter10:Information Management System(IMS)				
IMS.1.Information needs of the patients, visitors, staff, and management and external agencies are met.				
IMS.1.a.	The organization identifies the information needs of the patients, visitors, staff, management external agencies and community. *	0		
IMS.1.b.	Identified information needs are captured and/or disseminated.	10		
IMS.1.c.	Information management and technology acquisitions are commensurate with the identified information needs.	10		
IMS.1.d.	A maintenance plan for information technology and communication network is implemented.	10		
IMS.1.e.	Contingency plan ensures continuity of information capture, integration and dissemination.	10		
IMS.1.f.	The organization ensures that information resources are accurate and meet	10		

	stakeholder requirements.			
IMS.1.g.	The organization contributes to external databases in accordance with the law and regulations.	10		
	Average Score	8.57		
IMS.2.The organization has processes in place for management and control of data and information.				
IMS.2.a.	Processes for data collection are standardized.	10		
IMS.2.b.	Data is analyzed to meet the information needs.	10		
IMS.2.c.	The organization disseminates the information in a timely and accurate manner.	10		
IMS.2.d.	The organization stores and retrieves data according to its information needs. *	0		
IMS.2.e.	Clinical and managerial staff participates in selecting, integrating and using data for meeting the information needs.	10		
	Average Score	8		
IMS.3.The patients cared for by the organization has a complete and accurate medical record.				

IMS.3.a.	The unique identifier is assigned to the medical record.	10		
IMS.3.b.	The contents of the medical record are identified and documented. *	10		
IMS.3.c.	The medical record provides a complete, up-to-date and chronological account of patient care.	10		
IMS.3.d.	Authorized staff makes the entry in the medical record. *	10		
IMS.3.e.	Entry in the medical record is signed, dated and timed.	0		
IMS.3.f.	The author of the entry can be identified.	0		
IMS.3.g.	The medical record has only authorized abbreviations.	10		
	Average Score	7.14		
IMS.4.The medical record reflects the continuity of care.				
IMS.4.a.	The medical record contains information regarding reasons for admission, diagnosis and care plan.	10		
IMS.4.b.	The medical record contains the details of assessments, re-assessments and consultations.	10		

IMS.4.c.	The medical record contains the results of investigations and the details of the care provided.	10		
IMS.4.d.	Operative and other procedures performed are incorporated in the medical record.	5		
IMS.4.e.	When a patient is transferred to another organization, the medical record contains the details of the transfer.	10		
IMS.4.f.	The medical record contains a copy of the discharge summary.	10		
IMS.4.g.	In case of death, the medical record contains a copy of the cause of death report.	10		
IMS.4.h.	Care providers have access to current and past medical record.	10		
	Average Score	9.37		
IMS.5.The organization maintains confidentiality, integrity and security of records, data and information.				
IMS.5.a.	The organization maintains the confidentiality of records, data and information.*	10		
IMS.5.b.	The organization maintains the	10		

	integrity of records, data and information. *			
IMS.5.c.	The organization maintains the security of records, data and information.*	10		
IMS.5.d.	The organization uses developments in appropriate technology for improving confidentiality, integrity and security.	10		
IMS.5.e.	The organization discloses privileged health information as authorized by the patient and/or as required by law.	10		
IMS.5.f.	Request for access to information in the medical records by patients/physicians and other public agencies are addressed consistently.*	0		
	Average Score	8.3		
IMS.6.The organization ensures availability of current and relevant documents, records, data and information and provides for retention of the same.				
IMS.6.a.	The organization has an effective process for document control. *	0		
IMS.6.b.	The organization retains patient's clinical records, data	0		

	and information according to its requirements. *			
IMS.6.c.	The retention process provides expected confidentiality and security.	10		
IMS.6.d.	The destruction of medical records, data and information are in accordance with the written guidance.*	0		
	Average Score	2.5		
IMS.7.The organization carries out a review of medical records.				
IMS.7.a.	The medical records are reviewed periodically.	0		
IMS.7.b.	The review uses a representative sample based on statistical principles.	0		
IMS.7.c.	The review is conducted by identified individuals.	10		
IMS.7.d.	The review of records is based on identified parameters.	10		
IMS.7.e.	The review process includes records of both active and discharged patients.	10		
IMS.7.f.	The review points out and documents any deficiencies in records.	10		
IMS.7.g.	Appropriate corrective and preventive measures are undertaken.	0		

	Average Score	5.71		
	Average Score of Chapter	7.07		