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NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

ASSESSOR'S GUIDEBOOK FOR NATIONAL QUALITY ASSURANCE STANDARDS IN DISTRICT HOSPITALS

2020

VOLUME - I

Ministry of Health and Family Welfare
Government of India

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DISCLAIMER

The checklists given in Volume I , II & III have been developed after review Indian Public Health Standards (IPHS), Guidelines of Ministry of Health & Family Welfare, National Health Programmes, Standard Text Books, Journals & Periodicals, etc. The checklists are to be used as tools for the Quality Improvement. While taking patient and clinical care related decisions these checklists may not be used.

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PREFACE

The National Rural Health Mission (NRHM) Strives to Provide Quality Health Care to all citizens of the country in an equitable manner. The 12th Five Year Plan has re-affirmed Government of India's commitment – *"All government and publicly financed private health care facilities would to expected to achieve and maintain Quality Standards. An in-house quality management system will be built into the design of each facility, which will regularly measure its quality achievements."*

Indian Public Health Standards (IPHS) developed during 11th Five Year Plan describe norms for health facilities at different levels of the Public Health System. However, It has been observed that while implementing these Standards, the focus of the states has been mostly on creating IPHS specified infrastructure and deploying recommended Human Resources. The requirement of national programmes for ensuring quality of the services and more importantly user's perspective are often overlooked.

The need is to create an inbuilt and sustainable quality for Public Health Facilities which not only delivers good quality but is also so perceived by the clients. The guidelines have been prepared with this perspective defining relevant quality standards, a robust system of measuring these standards and institutional framework for its implementation.

These operational guidelines and accompanying compendium of cheklists are intended to support the efforts of states in ensuring a credible quality system at Public Health Facilities. I do hope states would take benefit of this painstaking work.

(Keshav Desiraju)

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FOREWORD

The successful implementation of NRHM since its launch is 2005 is clearly evident by the many fold increase in OPD, IPD and other relevant services being delivered in the Public Health Institutions, however, the quality of services being delivered still remains an issue. The offered services should not only be judged by its technical quality but also from the perspective of service seekers. An ambient and bright environment where the patients are received with dignity and respect along with prompt care are some of the important factors of judging quality from the clients' perspective.

Till now most of the States' approach toward the quality is based on accreditation of Public Health Facilities by external organizations which at times is hard to sustain over a period of time after that support is withdrawn. Quality can only be sustained, if there is an inbuilt system within the institution along with ownership by the providers working in the facility As Aristotle said "Quality is not an act but a habit".

Quality Assurance (QA) is cyclical process which needs to be continuously monitored against defined standards and measurable elements. Regular assessment of health facilities by their own staff and state and 'action-planning' for traversing the observed gaps is the only way in having a viable quality assurance programme in Public Health. Therefore, the Ministry of Health and Family Welfare (MoHFW) has prepared a comprehensive system of the quality assurance which can be operationalized through the institutional mechanism and platforms of NRHM.

I deeply appreciate the initiative taken by Maternal Health Division and NHSRC of this Ministry in preparing these guidelines after a wide range of consultations. It is hoped that States' Mission Directors and Programme Officers will take advantage of these guidelines and initiate quick and time bound actions as per the road map placed in the guidelines.

(Anuradha Gupta)

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FOREWORD

The National Rural Health Mission (NRHM) was launched in the year 2005 with aim to provide affordable and equitable access to public health facilities. Since then Mission has led to considerable expansion of the health services through rapid expansion of infrastructure, increased availability of skilled human resources; greater local level flexibility in operations, increased budgetary allocation and improved financial management. However, improvement in Quality of health services at every location is still not perceived, generally.

Perceptions of poor quality of health care, in fact, dissuade patients from using the available services because health issues are among the most salient of human concerns. Ensuring quality of the services will result in improved patient/client level outcomes at the facility level.

Ministry of Health and Family Welfare, Government of India is committed to support and facilitate a Quality Assurance Programme, which meets the need of Public Health System in the country which is sustainable. The present guidelines on Quality Assurance has been prepared with a focus on both the technical and perception of service delivery by the clients. This would enhance satisfaction level among users of the Government Health Facilities and reposing trust in the Public Health System.

The Operational guidelines along-with standards and checklist are expected to facilitate the states in improving and sustaining quality services beginning with RMNCH-A services at our Health facilities so as to bring about a visible change in the services rendered by them. The guideline is broad based and has a scope for extending the quality assurance in disease control and other national programme. It is believed that states will adopt it comprehensively and extend in phases for bringing all services under its umbrella. Feedback from the patients about our services is single-most important parameter to assess the success of our endeavour.

I acknowledge and appreciate the contribution given by NRHM division and NHSRC to RCH division of this Ministry in preparing and finalizing the guidelines. I especially acknowledge proactive role and initiative taken by Dr. Himanshu Bhushan, Deputy Commissioner and I/C of Maternal Health Division, Dr. S.K. Sikdar Deputy Commissioner and I/C of Family Planning Division and Dr. J.N. Srivastava of NHSRC in framing these guidelines.

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ACKNOWLEDGEMENT

The Operational Guidelines for Quality Assurance have been developed by the Ministry of Health and Family Welfare GoI, under the guidance and support of Shri Keshav Desiraju, Secretary, Health & Family Welfare, GoI. The contribution and insightful inputs given by Ms. Anuradha Gupta, Additional Secretary & Mission Director NRHM helped in firming up the guidelines within a set time period.

I must appreciate the efforts and initiatives of the entire team of Maternal Health, Family Planning & Child health Divisions, especially Dr. Himanshu Bhushan (DC MH I/C), Dr. S.K. Sikdar (DC FP I/C), and Dr. P.K. Prabhakar DC (CH), who have coordinated the process of developing these Operational Guidelines besides making substantial technical contributions in it.

The technical contribution by Dr. J.N. Srivastava, Head of QI Division and their team members Dr. Nikhil Prakash and Dr. Deepika Sharma of NHSRC need a special mention for their robust and sound contribution and collating all available information.

I would like to express my sincere gratitude to Mr. Vikas Kharge, Mission Director & Dr. Satish Pawar, DG (Health), Govt. of Maharashtra for their inputs and continued support. I would also like to place on record the contribution of development partners like WHO, UNICEF, UNFPA particularly Dr. Arvind Mathur, Dr. Malalay, Dr. Ritu Agarwal and Dr. Dinesh Agarwal.

I would like to convey my special thanks to all the experts, particularly Dr. Poonam Shivkumar from MGIMS, Wardha, Dr. Neerja Bhatla from AIIMS, Dr. R. Rajendran, Institute of OBGYN, Chennai, Dr. R.P. Sridhar from MCH Gujart Dr. P. Padmanaban and Mr. Prashanth from NHSRC, MH Division Consultants Dr. Pushkar Kumar, Mr. Nikhil Herur, Dr. Rajeev Agarwal and Dr. Anil Kashyap for putting their best efforts in preparing several drafts and final guidelines. Since it is difficult to acknowledge all those who contributed a list of contributors is attached in the guidelines.

I hope these Operational Guidelines and accompanying compendium of checklists facilitate to build a sound and credible quality system at Public Health facilities at-least in provision of RMNCH-A services to start with.

(Dr. Rakesh Kumar)

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Date: 24th October, 2013

Program Officer's Message

'Quality' is the core and most important aspect of services being rendered at any health facility. The Clinicians at the health facility particularly public health facilities mostly deliver their services based on their clinical knowledge. Mostly client's expectations goes beyond only cure & includes courtesy, behavior of the staff, cleanliness of the facility & delivery of prompt & respectful service. Few of these clinician's also take care of clients perspective however in many cases, it is overlooked. Those who can afford, can go to a private facility but the large mass particularly the poor and those living in rural areas do not have such means neither they have the voices which can be heard.

Government System particularly the policy makers, planners and programme officers have this responsibility to act upon the needs of the people, who cannot raise voice but need equal opportunity, at par with those who can afford. Fulfilling the needs of sick and ailing is the responsibility of public health service provider.

We have several stand alone guidelines from IPHS to Technical aspects of service delivery but there is no standard guidelines defining quality assurance and its different parameters. The present set of guidelines have been prepared comprehensively beginning with areas of concerns, defining its standards, measurable elements and checkpoints both from service provider and service seekers aspect. There is a prudent mix of technical, infrastructural and clients perspective while framing these guidelines.

The programme divisions of RCH, NRHM, NHSRC and other experts along with team from Govt. of Maharashtra, representative from Govt. of Karnataka, Gujarat, Tamil Nadu and Bihar along with institutional experts had extensive deliberations before firming up each and every aspects of these guidelines.

It is an earnest request to all the States and District Programme Officers to utilize these guidelines for placing the services as per the expectations of those who do not have means to afford treatment and services from a private health facility. Protecting the dignity and rendering timely services with competency to the clients is our moral duty but we also need to assess the quality of services sitting on the opposite side of the chair. Implementing these guidelines in letter and spirit will help us in achieving our desired outcomes.

Ensuring standard practices and adherence to the technical protocols, changing behavior and attitude of a staff is not an easy task. It needs rigorous monitoring, continuous support and encouragement by the supervisors and most importantly the ownership of the staff working at the facility for implementation and sustainability of quality efforts. The guidelines are only a tool and its success will depend upon actions envisaged under these guidelines.

(Dr. Himanshu Bhushan)

BACKGROUND

The Assessor's Guidebook for District Hospitals was launched in 2013. Subsequently, 2nd edition was published in 2018. Now, the 3rd edition is an update as per National Quality Assurance Standards 2020, with the primary focus being incorporating the latest National Health Programmes. The revised Assessors' Guidebook serves as a comprehensive tool, to assess the quality of healthcare services in district hospitals aligning with current national health initiatives, scientific knowledge & evidence. Assessors' Guidebook for Quality Assurance for District Hospitals 2018 has two volumes (Volume I & II) while in the revised guidebook, the checklists have been divided into three volumes (Volume I, II, & III).

There is addition of new standards like Standard G10 about clinical governance, Standard E24 about Haemodialysis services and the new National Health Programme like National Viral Hepatitis programme etc. Also, standards about clinical assessment (E2), rational prescribing (E6) & management of Death (E16) are further strengthened.

The revised guidebook reinforces the commitment to continual quality improvement and sustenance of healthcare services nationwide

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PART-A

GUIDELINES FOR ASSESSMENT

I INTRODUCTION TO QUALITY MEASUREMENT SYSTEM

Often, measuring the quality in health facilities has never been easy, more so, in Public Health Facilities. We have quality frame-work and Quality Standards & linked measurement system, globally and as well as in India. The proposed system has incorporated best practices from the contemporary systems, and contextualized them for meeting the needs of Public Health System in the country.

The system draws considerably from various guidelines, Standards and Texts on the Quality in Healthcare and Public health system, which ranges from ISO 9001 based system to healthcare specific standards such as JCI, IPHS, etc. Operational and technical Guidelines for National Health Programmes and schemes have also been consulted.

We do realise that there would always be some kind of 'trade-off', when measuring the quality. One may have short and simple tools, but that may not capture all micro details. Alternatively one may devise all-inclusive detailed tools, encompassing the micro-details, but the system may become highly complex and difficult to apply across Public Health Facilities in the country.

Another issue needs to be addressed having some kind of universal applicability of the quality measurement tools, which are relevant and practical across the states. Therefore, proposed system has flexibility to cater for differential baselines and priorities of the states.

Following are salient features of the proposed quality system:

1. **Comprehensiveness –** The proposed system is all inclusive and captures all aspects of quality of care within the eight areas of concern. The twenty one departmental checklists transposed within seventy five standards, and commensurate measurable elements provide an exhaustive matrix to capture all aspects of quality of care at the Public Health Facilities.

2. **Contextual –** The proposed system has been developed primarily for meeting the requirements of the Public Health Facilities; since Public Hospitals have their own processes, responsibilities and peculiarities, which varies from 'for-profit' sector. For instance, there are standards for providing free drugs, diagnostics, services ensuring availability of clean linen, etc. which may not be relevant for other hospitals.

3. **Contemporary –** Contemporary Quality standards such as NABH, ISO and JCI, and Quality improvement tools such as Six Sigma, Lean and CQI have been consulted and their relevant practices have been incorporated.

4. **User Friendly –** The Public Health System requires a credible Quality system. It has been endeavour of the team to avoid complex language and jargon. So that the system remains user-friendly and enable easy understanding and implementation by the service providers. Checklists have been designed to be user-friendly with guidance for each checkpoint. Scoring system has been made simple with uniform scoring rules and weightage. Additionally, a formula fitted excel sheet tool has been provided for the convenience, and to avoid calculation errors.

5. **Evidence Based –** The Standards have been developed after consulting vast knowledge resource available on the quality. All respective operational and technical guidelines related to RMNCHAN and National Health Programmes have been factored in.

6. **Objectivity –** Ensuring objectivity in measurement of the Quality has always been a challenge. Therefore in the proposed quality system, each Standard is accompanied with measurable elements & Checkpoints to measure compliance to the standards. Checklists have been developed for various departments, which also captures inter- departmental variability for the standards. At the end of assessment, there would be numeric scores, bringing out the quality of care in a snap-shot, which can be used for monitoring, as well as for inter-hospital/inter-state(s) comparison.

7. **Flexibility –** The proposed system has been designed in such a way that states and Health Facilities can adapt the system according to their priorities and requirements. State or facilities may pick some of the departments or group of services in the initial phase for Quality improvement. As baseline differs from state to state, checkpoints may either be made essential or desirable, as per availability of resources. Desirable checkpoints will be counted in arriving at the score, but this may not withhold its certification, if compliance is still not there. In this way the proposed system provides flexibility, as well as 'road-map'.

8. **Balanced –** All three components of Quality – Structure, process & outcome, have been given due weightage.

9. **Transparency –** All efforts have been made to ensure that the measurement system remains transparent, so that assessee and assessors have similar interpretation of each checkpoint.

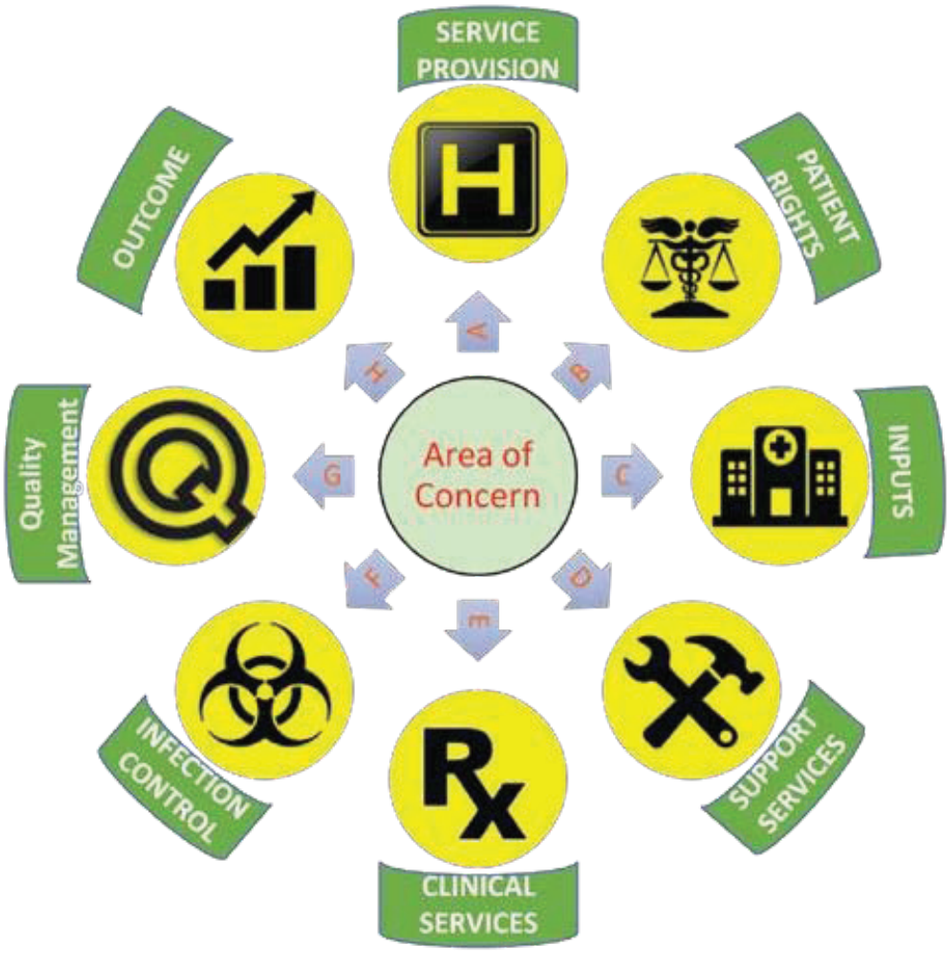
10. **Enabler –** Though standards and checklists are primarily meant for the assessment, it can also be used as a 'road- map' for improvement.

II COMPONENTS OF QUALITY MEASUREMENT SYSTEM AND THEIR INTENT

The main pillars of Quality Measurement Systems are Quality Standards. There are **seventy five standards,** defined under the proposed quality measurement system. The standards have been grouped within the eight **areas of concern**. Each Standard further has specific measurable elements. These standards and measurable elements are checked in each department of a health facility through department specific **checkpoints.** All Checkpoints for a department are collated, and together they form assessment tool called **'Checklist'**. Scored/ filled-in Checklists would generate scorecards.

Following are the area of concern in a health facility:

a. Service Provision
b. Patient Rights
c. Inputs
d. Support Services
e. Clinical Services
f. Infection Control
g. Quality Management
h. Outcome



Categorization of standards within the eight areas of concern is in line with the Quality of Care model - Structure, Process and Outcome.

Currently National Quality Assurance Standards for following level of facilities are available:

1. District Hospital
2. Community Health Centre
3. Primary Health Centre (24x7)
4. Urban Primary Health Centre
5. Health & Welness Centre – Sub Centre

Following is the summary of Standard, Measurable Element, Check Point & Departmental thematic Checklist for various level of Facilities:

MEASUREMENT SYSTEM FOR VARIOUS LEVELS FOR FACILITIES

Component	DH	CHC	PHC	UPHC	HWC-SC
Area of Concern	8	8	8	8	8
Standards	75	65	50	35	50
Measurable Elements	380	297	250	200	129
Checklists	21	12	6	12	1

Intent of Area of Concerns and Standards for District Hospitals is given under Chapter V.

Compiled description of Standards and Measurable Elements (facility wise and specific programme wise) is given in Chapter VI of this Assessors' Guidebook.

III HOW TO USE ASSESSOR'S GUIDEBOOK

Assessor's Guidebook contains tools for Internal and External Assessment of a District Hospital (and equivalent health facility). This Guidebook has three Volumes, Volume I, II, & III. Details of the departments as per voulmes are given in table below. Soft copy of the assessment tools that is formula fitted MS Excel sheets are given at NHSRC website. To access the assessment tools, QR code is given at the end of the book. State has customized checklists and updated copy of these customized checklists are available in the Gunak App. The following web links may be used to access the Gunak App for iOS and android devices respectively

1. iOS Link: https://apps.apple.com/in/app/gunak/id1354891968
2. Android Link: https://play.google.com/store/apps/details?id=com.facilitiesassessment&pcampaignid

List of checklists given in Assessor's Guidebook is given below:

	Volume I		Volume II		Volume III
1	Accident & Emergency Department	8	Labour Room (LaQshya)	16	Radiology
2	Out Patient Department	9	Maternity Operation Theatre (LaQshya)	17	Pharmacy
3	Operation Theatre	10	Maternity Ward	18	Auxiliary Services
4	Intensive Care Unit (ICU)	11	Paediatric Out Patient Department (MusQan)	19	Mortuary
5	Indoor Patient Department	12	Paediatric Ward (MusQan)	20	Haemodialysis
6	Blood Bank	13	Sick Newborn Care Unit (SNCU) (MusQan)	21	General Administration
7	Laboratory Services	14	Nutritional Rehabilitation Center (NRC) (MusQan)		
		15	Post Partum Unit		

IV NATIONAL QUALITY ASSURANCE STANDARDS FOR DISTRICT HOSPITAL

AREA OF CONCERN – A : SERVICE PROVISION	
Standard A1	The facility provides Curative services
Standard A2	The facility provides RMNCHA services
Standard A3	The facility provides Diagnostic services
Standard A4	The facility provides services as mandated in National Health Programmes/State Scheme
Standard A5	The facility provides Support services
Standard A6	Health services provided at the facility are appropriate to community needs
AREA OF CONCERN – B : PATIENT RIGHTS	
Standard B1	The facility provides the information to care seekers, attendants & community about the available services and their modalities
Standard B2	Services are delivered in a manner that is sensitive to gender, religious and cultural needs, and there are no barriers on account of physical, economic, cultural or social reasons
Standard B3	The facility maintains the privacy, confidentiality & dignity of patient, and has a system for guarding patient related information
Standard B4	The facility has defined and established procedures for informing patients about the medical condition, and involving them in treatment planning, and facilitates informed decision making
Standard B5	The facility ensures that there are no financial barriers to access, and that there is financial protection given from the cost of hospital services
Standard B6	The facility has defined framework for ethical management including dilemmas confronted during delivery of services at public health facilities
AREA OF CONCERN – C : INPUTS	
Standard C1	The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms
Standard C2	The facility ensures the physical safety of the infrastructure
Standard C3	The facility has established Programme for fire safety and other disasters
Standard C4	The facility has adequate qualified and trained staff, required for providing the assured services to the current case load
Standard C5	The facility provides drugs and consumables required for assured list of services
Standard C6	The facility has equipment & instruments required for assured list of services
Standard C7	The facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff
AREA OF CONCERN – D : SUPPORT SERVICES	
Standard D1	The facility has established programme for inspection, testing and maintenance and calibration of equipment
Standard D2	The facility has defined procedures for storage, inventory management and dispensing of medicines and consumables in pharmacy and patient care areas
Standard D3	The facility provides safe, secure and comfortable environment to staff, patients and visitors

Standard D4	The facility has established Programme for maintenance and upkeep of the facility
Standard D5	The facility ensures 24x7 water and power backup as per requirement of service delivery, and support services norms
Standard D6	Dietary services are available as per service provision and nutritional requirement of the patients
Standard D7	The facility ensures clean linen to the patients
Standard D8	The facility has defined and established procedures for promoting public participation in management of hospital transparency and accountability
Standard D9	Hospital has defined and established procedures for Financial Management
Standard D10	The facility is compliant with all statutory and regulatory requirement imposed by local, state or central government
Standard D11	Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standard operating procedures
Standard D12	The facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations
AREA OF CONCERN – E : CLINICAL SERVICES	
Standard E1	The facility has defined procedures for registration, consultation and admission of patients
Standard E2	The facility has defined and established procedures for clinical assessment reassessment and preparation of the treatment plan.
Standard E3	The facility has defined and established procedures for continuity of care of patient and referral
Standard E4	The facility has defined and established procedures for nursing care
Standard E5	The facility has a procedure to identify high risk and vulnerable patients
Standard E6	Facility ensures rationale precribing and use medicines.
Standard E7	The facility has defined procedures for safe drug administration
Standard E8	The facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage
Standard E9	The facility has defined and established procedures for discharge of patient
Standard E10	The facility has defined and established procedures for intensive care
Standard E11	The facility has defined and established procedures for Emergency Services and Disaster Management
Standard E12	The facility has defined and established procedures of Diagnostic services
Standard E13	The facility has defined and established procedures for Blood Bank/Storage Management and Transfusion
Standard E14	The facility has established procedures for Anaesthetic Services
Standard E15	The facility has defined and established procedures of Operation Theatre services
Standard E16	The facility has defined and established procedures for the management of death & bodies of deceased patients
MATERNAL & CHILD HEALTH SERVICES	
Standard E17	The facility has established procedures for Antenatal care as per guidelines
Standard E18	The facility has established procedures for Intranatal care as per guidelines
Standard E19	The facility has established procedures for Postnatal care as per guidelines
Standard E20	The facility has established procedures for care of new born, infant and child, as per guidelines
Standard E21	The facility has established procedures for abortion and family planning, as per government guidelines and law

Standard E22	The facility provides Adolescent Reproductive and Sexual Health services as per guidelines.
NATIONAL HEALTH PROGRAMMES	
Standard E23	The facility provides National health Programme as per Operational/Clinical Strategies
Standard E24	The facility has defined and established procedure for Haemodialysis Services
AREA OF CONCERN – F : INFECTION CONTROL	
Standard F1	The facility has infection control programme and procedures in place for prevention and measurement of hospital associated infection
Standard F2	The facility has defined and implemented procedures for ensuring hand hygiene practices and antisepsis
Standard F3	The facility ensures standard practices and materials for Personal protection
Standard F4	The facility has standard procedures for processing of equipment and instruments
Standard F5	Physical layout and environmental control of the patient care areas ensures infection prevention
Standard F6	The facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste
AREA OF CONCERN – G : QUALITY MANAGEMENT	
Standard G1	The facility has established organizational framework for quality improvement
Standard G2	The facility has established system for patient and employee satisfaction
Standard G3	The facility has established internal and external quality assurance programs wherever it is critical to quality
Standard G4	The facility has established, documented, implemented and maintained Standard Operating procedures for all key processes and support services
Standard G5	The facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages
Standard G6	The facility has defined Mission, Values, Quality policy and Objectives, and prepares a strategic plan to achieve them
Standard G7	The facility seeks continually improvement by practicing Quality methods and tools
Standard G8	The facility has defined, approved and communicated Risk Management framework for existing and potential risks
Standard G9	The facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan
Standard G10	The facility has established Clinical Governance Framework to improve quality and safety of clinical care processes
AREA OF CONCERN – H : OUTCOME	
Standard H1	The facility measures Productivity Indicators and ensures compliance with State/National Benchmarks
Standard H2	The facility measures Efficiency Indicators and ensure to reach State/National Benchmark
Standard H3	The facility measures Clinical Care & Safety Indicators and tries to reach State/National Benchmark
Standard H4	The facility measures Service Quality Indicators and endeavours to reach State/National Benchmark

V INTENT OF STANDARDS FOR DISTRICT HOSPITAL

Area of Concern - A : Service Provision

Overview

Apart from the curative services that district hospitals provide, public hospitals are also mandated to provide preventive and promotive services. Reproductive and Child Health services are now grouped as RMNCHA, which are major chunk of the services. These services are also priority for the government, so as to have direct impact on the key indicators such as MMR and IMR.

This area of concern measures availability of services. "Availability" of functional services means service is available to end- users because mere availability of infrastructure or human resources does not always ensure availability of the services. For example, a facility may have functional OT, Blood Bank, and availability of Obstetrician and Anaesthetist, but it may not be providing CEmONC services on 24x7 basis. The facility may have functional Dental Clinic, but if there are hardly any procedures undertaken at the clinic, it may be assumed that the services are either not available or non-accessible to users. Compliance to these standards and measurable elements should be checked, preferably by observing delivery of the services, review of records and checking utilisation of the services.

Compliance to following standards ensures that the health facility is addressing this area of concern:

STANDARD A1 THE FACILITY PROVIDES CURATIVE SERVICES	This standard would include availability of OPD consultation, Indoor services and Surgical procedures, Intensive care, Emergency Care and dialysis services under different specialities e. g. Medicine, Surgery, Orthopaedics, Paediatrics etc. Each measurable element under this standard measures one speciality across the departments. For example, ME A1.2 measures availability of emergency surgical procedures in Accident & Emergency department, availability of General surgery clinic at OPD, Availability of surgical procedures in Operation theatre and availability of indoors services for surgery patients in wards.
STANDARD A2 THE FACILITY PROVIDES RMNCHA SERVICES	This standard measures availability of Reproductive, Maternal, Newborn, Child and Adolescent services in different departments of the hospital. Each aspect of RMNCHA services is covered by one measurable element of this standard.
STANDARD A3 THE FACILITY PROVIDES DIAGNOSTIC SERVICES	This standard covers availability of Laboratory, Radiology and other diagnostics services viz ultrasound in the respective departments.
STANDARD A4 THE FACILITY PROVIDES SERVICES AS MANDATED IN NATIONAL HEALTH PROGRAMMES/ STATE SCHEME	This standard measures availability of the services at health facility under different National Health Programmes such as NTEP, NVBDCP, PMNDP, Viral Hepatitis, National programme for palliative care etc. One measurable element has been assigned to each National Health Programme.
STANDARD A5 THE FACILITY PROVIDES SUPPORT SERVICES	This standard measures availability of support services like dietary, laundry and housekeeping services at the facility.
STANDARD A6 HEALTH SERVICES PROVIDED AT THE FACILITY ARE APPROPRIATE TO COMMUNITY NEEDS	This standard mandates availability of the services according to specific local health needs. Different geographical area may have certain health problems, which are prevalent locally.

Area of Concern - B : Patient Rights

Overview

Mere availability of services does not serve the purpose until the services are accessible to the users, and are provided with dignity and confidentiality. Access includes physical access as well as financial access. The Government has launched many schemes, such as JSSK, RBSK and PMJAY, for ensuring that the service packages are available cashless to different targeted groups. There are evidences to suggest that patient's experience and outcome improves, when they are involved in the care. So availability of information is critical for access as well as enhancing patient's satisfaction. Patient's rights also include that health services give due consideration to patient's cultural and religious preferences.

Brief description of the standards under this area of concern are given below:

STANDARD B1 THE FACILITY PROVIDES THE INFORMATION TO CARE SEEKERS, ATTENDANTS & COMMUNITY ABOUT THE AVAILABLE SERVICES AND THEIR MODALITIES	Standard B1 measures availability of the information about services and their modalities to patients and visitors. Measurable elements under this standard check for availability of user-friendly signages, display of services available and user charges, citizen charter, enquiry desk and access to patient's clinical records.
STANDARD B2 SERVICES ARE DELIVERED IN A MANNER THAT IS SENSITIVE TO GENDER, RELIGIOUS AND CULTURAL NEEDS, AND THERE ARE NO BARRIERS ON ACCOUNT OF PHYSICAL, ECONOMIC, CULTURAL OR SOCIAL REASONS	Standard B2 ensures that the services are sensitive to gender, cultural and religious needs. This standard also measures the physical access, and speciallyabled friendliness of the services, such as availability of ramps and speciallyabled friendly toilets. The standard mandates for provision for affirmative action for vulnerable and marginalized patients like orphans, destitute, terminally ill patients, victims of rape and domestic violence and ensure everyone can avail health care services with dignity and confidence at public health facilites.
STANDARD B3 THE FACILITY MAINTAINS PRIVACY, CONFIDENTIALITY & DIGNITY OF PATIENT, AND HAS A SYSTEM FOR GUARDING PATIENT RELATED INFORMATION	Standard B3 measures the patient friendliness of the services in terms of privacy, confidentiality and dignity. Measurable elements under this standard check for provision of screens and curtains, confidentiality of patient's clinical information, behaviour of service providers, and also ensuring specific precautions to be taken, while providing care to patients with HIV infection, abortion, teenage pregnancy, etc.
STANDARD B4 THE FACILITY HAS DEFINED AND ESTABLISHED PROCEDURES FOR INFORMING PATIENTS ABOUT THE MEDICAL CONDITION, AND INVOLVING THEM IN TREATMENT PLANNING, AND FACILITATES INFORMED DECISION MAKING	Standard B4 mandates that health facility has procedures of informing patients about their rights, and actively involves them in the decision-making about their treatment. Measurable elements in this standard look for practices such as informed consent, dissemination of patient rights and communication to patients about their clinical conditions and options available. Standard also focus on grievance redressal and its compliance to that can be checked through review of records for consent, interviewing staff about their awareness of patient's rights, interviewing patients whether they had been informed of the treatment plan available options & prognosis.
STANDARD B5 THE FACILITY ENSURES THAT THERE IS NO FINANCIAL BARRIER TO ACCESS, AND THAT THERE IS FINANCIAL PROTECTION GIVEN FROM THE COST OF HOSPITAL SERVICES	Standard B5 majorly checks that there are no financial barriers to the services. Measurable elements under this standard check for availability free drugs, diagnostic consulation, procedure and transport under different schemes, and timely payment of the entitlements under JSY and family planning incentives. This standard also ensures the implementation of health insurance scheme like PMJAY.

STANDARD B6 THE FACILITY HAS DEFINED FRAMEWORK FOR ETHICAL MANAGEMENT INCLUDING DILEMMAS CONFRONTED DURING DELIVERY OF SERVICES AT PUBLIC HEALTH FACILITIES	Public Health facilities have been instituted for providing health care services for the larger good and welfare of community. Apart from providing health care services, the public health facilities have a statutory obligation to conduct medico-legal examinations, post-mortems, facilitate justice dispensation as required by the law, issuing medical certificates and implement government health policies. It is of utmost importance that public health facilities portray highest standards for ethical practices in clinical care and governance. This standard requires the facility to adhere to Ethical norms, and a pre-defined code of conduct is followed by its staff. The standard ensures the identification, reporting & resolution of ethical dilemmas faced by health professionals while delivering the service. The standard mandates compliance with code of conduct by health professionals. Preferably code of conducts should be communicated to the staff in form of written instructions. This may include do's and don'ts while performing their duties. These norms should broadly encompass provider's duty to sick, doing 'no-harm', keeping privacy, confidentiality and autonomy of patients, non-discrimination and equity. Ethical norms should be in consonance with Code of Medical Ethics and Code of Nursing Ethics released by the Indian Medical Council and Indian Nursing Council respectively. While providing the services, the providers may confront ethical dilemmas. These may arise from patient's refusal to receive treatment, withdrawal of life support, prescribing drugs that doctor found more effective but are not part of essential drug list, entertaining representatives of pharmaceutical companies at workplace, sharing data with research purposes where consent has not been taken from patients, etc. to address these ethical dilemmas effectively and within the legal parameters, the health facility should develop and implement a framework to address ethical dilemmas. The facility need mechanism in place to identify the situations, where ethical dilemma usually arise or have potential to arise. Futher, the facility should appoint a person or group that will address such issues of ethical dilemma, and will endeavour to timely resolve it. There is formal for referral of such issues to appointed person on group. All the decisions mechanism pertaining to dilemmas are effectively communicated to concerned staff. These standards are targeted for secondary and public hospital; those are usually not involved in research activities. However, if any health care facility is involved in clinical or public health research activity, (like DNB courses, MPH and other students degree or professions), should have mechanism to formal approval from research ethics committee.

AREA OF CONCERN - C : INPUT

Overview

This area of concern predominantly covers the structural part of the facility. Indian Public Health Standards (IPHS) defines infrastructure, human resources, drugs and equipment requirements for different level of health facilities. Quality standards given in this area of concern take into cognizance of the IPHS requirement. However, focus of the standards is to ensure compliance to minimum level of inputs, which are required for ensuring delivery of committed level of the services. The words like 'adequate' and 'as per load' has been given in the requirements of standards & measurable elements, as it would be hard to set structural norms for every level of the facility that commensurate with patient load. For example, a 100-bedded hospital having 40% bed occupancy may not have same requirements as the similar hospital having 100% occupancy. So structural requirement should be based more on the utilization, than fixing the criteria like beds available. Assessor should use his/her discretion to arrive at a decision, whether available structural component is adequate for committed service delivery or not.

Following are the standards under this area of concern:

STANDARD C1 THE FACILITY HAS INFRASTRUCTURE FOR DELIVERY OF ASSURED SERVICES, AND AVAILABLE INFRASTRUCTURE MEETS THE PREVALENT NORMS	Standard C1 measures adequacy of infrastructure in terms space, layouts, circulation area, communication facilities, service counters, patient amenities, communication facilities, etc. It also looks into the functional aspect of the structure, whether it commensurates with the process flow of the facility or not. Minimum requirement for space, layout and patient amenities are given in some of departments, but assessors should use his discretion to see whether space available is adequate for the given work load. Compliance to most of the measurable elements can be assessed by direct observation except for checking functional adequacy, where discussion with staff and hospital administration may be required to know the process flow between the departments, and also within a department.
STANDARD C2 THE FACILITY ENSURES THE PHYSICAL SAFETY OF THE INFRASTRUCTURE	Standard C2 deals with physical safety of the infrastructure. It includes seismic safety, safety of lifts, electrical safety, physical condition of hospital infrastructure.
STANDARD C3 THE FACILITY HAS ESTABLISHED PROGRAMME FOR FIRE SAFETY AND OTHER DISASTERS	Standard C3 is concerned with fire safety of the facility. Measurable elements in this standard look for implementation of fire prevention, availability of adequate number of fire fighting equipment and preparedness of the facility for fire and other disaster in terms of mock drill and staff awarness & training.
STANDARD C4 THE FACILITY HAS ADEQUATE QUALIFIED AND TRAINED STAFF, REQUIRED FOR PROVIDING THE ASSURED SERVICES TO THE CURRENT CASE LOAD	Standard C4 measures the numerical adequacy and skill sets of the staff. It includes availability of doctors, nurses, paramedics and support staff. There are two components while assessing the staff adequacy - first is the numeric adequacy, which can be checked by interaction with hospital administration and review of records. Second is the availability of human resources within the department. For instance, a hospital may have 20 security guards, but if none of them is posted at the labour room, then the intent of standard is not being complied with.
STANDARD C5 THE FACILITY PROVIDES DRUGS AND CONSUMABLES REQUIRED FOR ASSURED SERVICES	Standard C5 measures availability of drugs and consumables in user departments. Assessor may check availability of drugs under the broad group such as antibiotics, analytic IV fluids, dressing material, and make an assessment that majority of normal patients and critically ill patients are getting treated at the health facility.
STANDARD C6 THE FACILITY HAS EQUIPMENT & INSTRUMENTS REQUIRED FOR ASSURED LIST OF SERVICES	Standard C6 is also concerned with availability of equipment & instruments in various departments and service delivery points. Equipment and instruments have been categorized into sub groups as per their use, and measurable elements have been assigned to each sub group, such as examination and monitoring, clinical procedures, diagnostic equipment, resuscitation equipment, storage equipment and equipment used for non clinical support services. Some representative equipment could be used as tracers and checked in each category.

STANDARD C7 FACILITY HAS A DEFINED AND ESTABLISHED PROCEDURE FOR EFFECTIVE UTILIZATION, EVALUATION AND AUGMENTATION OF COMPETENCE AND PERFORMANCE OF STAFF	Human resources are the most critical asset of a healthcare organization. Public health facilities serve volumes of patients and sometime feel constrained by limited human resources. For being a facility providing quality and safe healthcare services, it is indispensable to ensure that the staff engaged in patient care and auxiliary activities have requisite knowledge and skills to accomplish their task in the expected manner. It is also important to ensure that workforce is working at optimal level and their performance is evaluated periodically. This standard and related measurable elements require that public health facility should have defined staff's competency and have a system for assessing. It periodically at pre-defined interval, and takes actions for maintaining it. These criteria should be based on job description as defined in Standard D-11. These defined criteria can be converted into simple checklist that can work as tools for the competency assessment e.g. Checklist for competency assessment of Labour room nurse, Lab technician, Security guard, Hospital manager, etc. The Ministry of Health & Family Welfare, Government of India also has prepared checklist for competence assessment. (Eg: OSCE is available for the competence assessment for labour room, etc) In addition there are explicit requirement spelled by the professional bodies such as National Medical Commission, Nursing Council of India, Dental Council of India, etc. These requirements can be used to ensure that the staff have been trained as per their job description and responsibilities.These can also be used after local customization This standard also requires that performance evaluation criteria should also be defined for each cadre of staff. These criteria may have some indicators measuring productivity and efficiency of the staff as well. Based on these defined criteria, the competence and performance of staff should be evaluated at least once in a year though it may be more frequent ongoing activity. Competence assessment program and performance evaluation program should include contractual staff, staff working in hospital premises through outsourced agencies, empanelled doctors providing services for specific duration. Based on these assessment and evaluation, the training needs of each staff are identified and training plan is prepared. Staff should be trained according to the training plan. Facility should also ensure that skills gained through training are retained and utilized and feedback is given to individual staff on their competence and performance.

AREA OF CONCERN - D : SUPPORT SERVICES

Overview

Support services are backbone of every health care facility. The expected clinical outcome cannot be envisaged in absence of sturdy support services. This area of concern includes equipment maintenance, calibration, drug storage and inventory management, security, facility management, water supply, power backup, dietary services and laundry. Administrative processes like RKS, financial management, legal compliances, staff deputation and contract management have also been included in this area of concern.

Brief description of the standards under this area of concern are given below:

STANDARD D1 THE FACILITY HAS ESTABLISHED PROGRAMME FOR INSPECTION, TESTING AND MAINTENANCE AND CALIBRATION OF EQUIPMENT	Standard D1 is concerned with equipment maintenance processes, such as AMC, daily and breakdown maintenance processes, calibration and availability of operating instructions. Equipment records should be reviewed to ensure that valid AMC is available for critical equipment and preventive/corrective maintenance is done timely. Calibration records and label of measuring equipment should be reviewed to confirm that the calibration has been done. Operating instructions should be displayed or should be readily available with the users.
STANDARD D2 THE FACILITY HAS DEFINED PROCEDURES FOR STORAGE, INVENTORY MANAGEMENT AND DISPENSING OF MEDICINES IN PHARMACY AND PATIENT CARE AREAS	Standard D2 is concerned with safe storage of medicines and scientific management of the inventory, so drugs and consumables are available in adequate quantity in patient care area. Measurable elements of this standard look into processes of indenting, procurement, storage, expired medicines management, inventory management, stock management at patient care areas, including storage at optimum temperature. While assessing drug management system, these practices should be looked into each clinical department, especially at the nursing stations and its complementary process at drug stores/Pharmacy.
STANDARD D3 THE FACILITY PROVIDES SAFE, SECURE AND COMFORTABLE ENVIRONMENT TO STAFF, PATIENTS AND VISITORS	Standard D3 is concerned with providing safe, secure and comfortable environment to patients as well as to service providers. The measurable elements under this standard have two aspects, provision of comfortable work environment in terms of illumination and temperature control in patient care areas & work stations, and arrangement for security of patients and staff. Availability of environment control arrangements should be looked into. Security arrangements at patient area should be observed for restriction of visitors and crowd management.
STANDARD D4 THE FACILITY HAS ESTABLISHED PROGRAMME FOR MAINTENANCE AND UPKEEP OF THE FACILITY	Standard D4 is concerned with adequacy of facility management processes. This includes appearance of facility, cleaning processes, infrastructure maintenance, removal of junk and condemned items and control of stray animals and pests at the facility.
STANDARD D5 THE FACILITY ENSURES 24x7 WATER AND POWER BACKUP AS PER REQUIREMENT OF SERVICE DELIVERY, AND SUPPORT SERVICES NORMS	Standard D5 covers processes to ensure water supply (quantity & quality), power back-up and medical gas supply. All departments should be assessed for availability of water and power back-up. Some critical area like OT and ICU may require two-tire power backup in terms of UPS. Availability of central oxygen and vacuum supply should especially be assessed in critical area OT, ICU & IPD.
STANDARD D6 DIETARY SERVICES ARE AVAILABLE AS PER SERVICE PROVISION AND NUTRITIONAL REQUIREMENT OF THE PATIENTS	Standard D6 is concerned with processes ensuring timely and hygienic diet to the patient as per their nutritional services. It includes nutritional assessment of patients, availability of different types of diet as per the diseases condition. It is also includes procedures for preparation and distribution of food, including hygiene & sanitation in the kitchen. Patients / staff may be interacted for knowing their perception about quality and quantity of the food.

STANDARD D7 THE FACILITY ENSURES CLEAN LINEN TO THE PATIENTS	Standard D7 is concerned with the laundry processes. It includes availability of adequate quantity of clean & usable linen, process of providing and changing bed sheets in patient care area and process of collection, washing and distributing the linen. Besides direct observation, staff interaction may help in knowing availability of adequate linen and work practices. An assessment of segregation and disinfection of soiled laundry should be undertaken. Observation should be recorded if laundry is being washed at some public water body like pond or river.
STANDARD D8 THE FACILITY HAS DEFINED AND ESTABLISHED PROCEDURES FOR PROMOTING PUBLIC PARTICIPATION IN MANAGEMENT OF HOSPITAL TRANSPARENCY AND ACCOUNTABILITY	Standard D8 measures processes related to functioning of Rogi Kalyan Samiti (RKS; equivalent to Hospital Management Society) and community participation in Hospital Management. RKS records should be reviewed to assess frequency of the meetings, and issues discussed in RKS meeting. Participation of non-official members like community/NGO representatives in such meetings should be checked.
STANDARD D9 HOSPITAL HAS DEFINED AND ESTABLISHED PROCEDURES FOR FINANCIAL MANAGEMENT	Standard D9 is concerned with the financial management of the funds/grants, received from different sources including NHM. Assessment of financial anagement processes by no means should be equated with financial or accounts audit. Hospital administration and accounts department can be interacted to know process of utilization of funds, timely payment of salaries, entitlements and incentives to different stakeholders and process of receiving funds and submitting utilization certificates. An assessment of resource utilisation and prioritisation should be undertaken.
STANDARD D10 THE FACILITY IS COMPLIANT WITH ALL STATUTORY AND REGULATORY REQUIREMENT IMPOSED BY LOCAL, STATE OR CENTRAL GOVERNMENT	Standard D10 is concerned with compliances to statutary and regulatory requirements. It includes availability of requisite licenses, updated copies of acts and rules, and adherence to the legal requirements as applicable to Public Health Facilities.
STANDARD D11 ROLES & RESPONSIBILITIES OF ADMINISTRATIVE AND CLINICAL STAFF ARE DETERMINED AS PER GOVT. REGULATIONS AND STANDARD OPERATING PROCEDURES	Standard D11 is concerned with processes regarding staff management and their deployment in the departments of a facility. This includes availability of job descriptions for different cadre, processes regarding preparation of duty rosters and staff discipline. The staff can be interviewed to assess about their awareness about own job description. It should be assessed by observation and review of the records. Adherence to dress-code should be observed during the assessment.
STANDARD D12 THE FACILITY HAS ESTABLISHED PROCEDURE FOR MONITORING THE QUALITY OF OUTSOURCED SERVICES AND ADHERES TO CONTRACTUAL OBLIGATIONS	Standard D12 measures the processes related to outsourcing and contract management. This includes monitoring of outsourced services, adequacy of contract documents and tendering system, timely payment for the availed services and provision for action in case of inadequate/ poor quality of services. Assessor should review the contract records related to outsourced services, and interview hospital administration about the management of outsourced services.

AREA OF CONCERN - E : CLINICAL CARE

Overview

The ultimate purpose of existence of a hospital is to provide clinical care. Therefore, clinical processes are the most critical and important in the hospitals. These are the processes that define directly the outcome of services and quality of care. The Standards under this area of concern could be grouped into three categories. First, nine standards (E1-E9) are concerned with those clinical processes that ensure adequate care to the patients. It includes processes such as registration, admission, consultation, clinical assessment, continuity of care, nursing care, identification of high risk and vulnerable patients, prescription practices, safe drug administration, maintenance of clinical records and discharge from the hospital.

Second set of next seven standards (E10-E16)) are concerned with specific clinical and therapeutic processes including intensive care, emergency care, diagnostic services, transfusion services, anaesthesia, surgical services and handling of death conduct of post-mortem etc.

The third set of eight standards (E17-E24) are concerned with specific clinical processes for Maternal, Newborn, Child, Adolescent & Family Planning services, National Health Programmes and specific schemes like PMNDP. These standards are based on the technical guidelines published by the Government of India on respective programmes and processes.

It may be difficult to assess clinical processes, as direct observation as clinical procedure may not always be possible at time of assessment. Therefore, assessment of these standards would largely depend upon review of the clinical records and interaction with the staff to know their skill level and how they practice clinical care (Competence testing) would also be helpful. Assessment of these standard would require thorough domain knowledge.

Following is the brief description of standards under this area of concern:

STANDARD E1 THE FACILITY HAS DEFINED PROCEDURES FOR REGISTRATION, CONSULTATION AND ADMISSION OF PATIENTS	Standard E1 is concerned with the registration and admission processes in hospitals. It also covers OPD consultation processes. The assessor should review the records to verify that details of patients have been recorded, and patients have been given unique identification number. OPD consultation may be directly observed, followed by review of OPD tickets to ensure that patient history, examination details, provisional & confirmed diagnosis etc. have been recorded on the OPD ticket. Staff should be interviewed to know, whether there is any fixed admission criteria especially in critical care department.
STANDARD E2 THE FACILITY HAS DEFINED AND ESTABLISHED PROCEDURES FOR CLINICAL ASSESSMENT, REASSESSMENT AND PREPARATION OF TREATMENT PLANS	Standard E2 pertains to clinical assessment of the patients. It includes initial assessment and reassessment of admitted patients at defined interval depending on the disease condition Care planning is done for the individual case as per assessment and investigation findings (wherever applicable). It also ensures that care or treatment is provided as per standard treatment guidelines/ available clinical evidence.
STANDARD E3 THE FACILITY HAS DEFINED AND ESTABLISHED PROCEDURES FOR CONTINUITY OF CARE OF PATIENT AND REFERRAL	Standard E3 is concerned with continuity of care for the patient's ailment. It includes process of inter-departmental transfer, referral to another facility, care, and linkages with higher institutions. Staff should be interviewed to know the referral linkages, how they inform the referral hospital about the referred patients and arrangement for the vehicles and follow-up care. Records should be reviewed for confirming that referral slips have been provided to the referred patients.
STANDARD E4 THE FACILITY HAS DEFINED AND ESTABLISHED PROCEDURES FOR NURSING CARE	Standard E4 measures adequacy and quality of nursing care for the patients. It includes processes for identification of patients, timely and accurate implementation of treatment plan, nurses' handover processes, maintenance of nursing records and monitoring of the patients. Staff should be interviewed and patient's records should be reviewed for assessing how drugs distribution/administration endorsement and other procedures like sample collection and dressing have been done on time as per treatment plan. Handing-over of patients is a critical process and should be assessed adequately Review BHT for patient monitoring & nursing notes should be done.

STANDARD E5 THE FACILITY HAS A PROCEDURE TO IDENTIFY HIGH RISK AND VULNERABLE PATIENTS	Standard E5 is concerned with identification of vulnerable and high-risk patients. Review of records and staff interaction would be helpful in assessing how High- risk patients are given due attention and treatment.
STANDARD E6 THE FACILITY FOLLOWS STANDARD TREATMENT GUIDELINES DEFINED BY STATE/ CENTRAL GOVERNMENT FOR PRESCRIBING THE GENERIC DRUGS & THEIR RATIONAL USE	Standard E6 is concerned with assessing that patients are prescribed drugs according to standard treatment guidelines and protocols. Patient records are assessed to ascertain that prescriptions are written in generic name only. Hospital drug forulary is avaible and followed. For all cases, medicine review and otimization are done.
STANDARD E7 THE FACILITY HAS DEFINED PROCEDURES FOR SAFE DRUG ADMINISTRATION	Standard E7 concerns with the safety of drug administration. It includes administration of high alert medicines, legibility of medical orders, process for checking medicines before administration and processes related to self medication. Patient's records should be reviewed for legibility of the writing and recording of date and time of orders. Safe injection practices like use of separate needle for multi-dose vial should be observed.
STANDARD E8 THE FACILITY HAS DEFINED AND ESTABLISHED PROCEDURES FOR MAINTAINING, UPDATING OF PATIENT'S CLINICAL RECORDS AND THEIR STORAGE	Standard E8 is concerned with the processes of maintaining clinical records systematically and adequately. Compliance to this standard can be assessed by comprehensive review of the patient's records. If the records are maintained in e-version, the security & safety of clinical standards need to be ensured.
STANDARD E9 THE FACILITY HAS DEFINED AND ESTABLISHED PROCEDURES FOR DISCHARGE OF PATIENT	Standard E9 measures adequacy of the discharge process. It includes pre-discharge assessment, adequacy of discharge summary, pre-discharge counselling and adherence to standard procedures, if a patient is found absconding. Patient's record should be reviewed for adequacy of the discharge summary.
STANDARD E10 THE FACILITY HAS DEFINED AND ESTABLISHED PROCEDURES FOR INTENSIVE CARE	Standard E10 is concerned with processes related to intensive care treatment of patients, availability and adherence to protocols related to pain management, sedation, intubation, newborn resuscitation, ETAT etc.
STANDARD E11 THE FACILITY HAS DEFINED AND ESTABLISHED PROCEDURES FOR EMERGENCY SERVICES AND DISASTER MANAGEMENT	Standard E11 is concerned with emergency clinical processes and procedures. It includes triage, adherence to emergency clinical protocols, disaster management, processes related to ambulance services, handling of medico-legal cases, etc. Availability of the buffer stock for medicines and other supplies for disaster and mass casualty needs to be found out. Interaction with staff and hospital administration should be done to asses overall disaster preparedness of the health facility.
STANDARD E12 THE FACILITY HAS DEFINED AND ESTABLISHED PROCEDURES OF DIAGNOSTIC SERVICES	Standard E12 deals with the procedures related to diagnostic services. The standard is majorly applicable for laboratory and radiology services, ultrasound and other, diagnostic services if provoided by the facility. It includes pre-testing, testing and post-testing procedures. It needs to be observed that samples in the laboratory are properly labelled, and instructions for handling sample are available. The process for storage and transportation of samples needs to be ensured. Availability & use of critical values and biological references should also be checked.
STANDARD E13 THE FACILITY HAS DEFINED AND ESTABLISHED PROCEDURES FOR BLOOD BANK/STORAGE MANAGEMENT AND TRANSFUSION	Standard E13 is concerned with functioning of blood bank and transfusion services. The measurable elements under this standard are processes for donor selection, collection of blood, testing procedures, preparation of blood components, labelling and storage of blood bags, compatibility testing, issuing, transfusion and monitoring of transfusion reaction. The assessor should observe the functioning, and interact with the staff to know regarding the adherence to standard procedures for blood collection and testing, including preparation of blood components, storage practices, as per National Guidelines protocols. Record of temperature maintained in different storage units should be checked. The staff should also be interacted to know how they manage if certain blood is not available at the blood bank. Records should be reviewed for assessing processes of monitoring transfusion reactions and ensures the availability of services.

STANDARD E14 THE FACILITY HAS ESTABLISHED PROCEDURES FOR ANAESTHETIC SERVICES	Standard E14 is concerned with the processes related to safe anaesthesia practices. It includes pre-anaesthesia, monitoring and post-anaesthesia processes. Records should be reviewed to assess how Pre-anaesthesia check-up is done and records are maintained. Interact with Anaesthetists and OT technician/Nurse for adherence to protocols in respect of anaesthesia safety, monitoring, recording & reporting of adverse events, maintenance of anaesthesia notes, etc.
STANDARD E15 THE FACILITY HAS DEFINED AND ESTABLISHED PROCEDURES OF OPERATION THEATRE SERVICES	Standard E15 is concerned with processes related with Operation Theatre. It includes processes for OT scheduling, pre-operative, post-operative practices of surgical safety. Interaction with the surgeon(s) and OT staff should be done to assess processes - preoperative medication, part preparation and evaluation of patient before surgery, identification of surgical site, etc. Review of records for usage of surgical safety checklist & protocol for instrument count, suture material, etc may be undertaken.
ST STANDARD E16 THE FACILITY HAS DEFINED AND ESTABLISHED PROCEDURES FOR MANAGEMENT OF DEATH & BODIES OF DECEASED PATIENTS.	Standard E16 concerns with end of life care and management of death. Records should be reviewed for knowing adequacy of the notes. Interact with the facility staff to know how news of death is communicated to relatives, and kind of support available to family members. This standard also covers procedures for post-mortem, its recording and handling over body to relatives/kin etc.
STANDARD E17 THE FACILITY HAS ESTABLISHED PROCEDURES FOR ANTENATAL CARE AS PER GUIDELINES	Standard E17 is concerned with processes ensuring that adequate and quality antenatal care is provided at the facility. It includes measurable elements for ANC registration, processes during check-up, identification of High Risk pregnancy, management of severe anaemia and counselling services. Staff at ANC clinic should be interviewed and records should be reviewed for maintenance of MCP cards and registration of pregnant women. For assessing quality and adequacy of ANC check-up, direct observation may be undertaken after obtaining requisite permission. ANC records can be reviewed to see findings of examination and diagnostic tests are recorded. Review the line listing of anaemia cases and how they are followed. Client and staff can be interacted for counselling on the nutrition, birth preparedness, family planning as per National Guidelines etc.
STANDARD E18 THE FACILITY HAS ESTABLISHED PROCEDURES FOR INTRANATAL CARE AS PER GUIDELINES	Standard E18 measures the quality of intra-natal care. It includes clinical process for normal delivery as well as management of complications and C-Section surgeries. Staff can be interviewed to know their skill and practices regarding management of different stages of labour, especially Active Management of Third stage of labour. Staff may be interacted for demonstration of resuscitation and essential newborn care. Competency of the staff for managing obstetric emergencies, interpretation of partograph, should also be assessed. The standard is applicable to Labour Room and Maternity Operation Theatre in LaQshya.
STANDARD E19 THE FACILITY HAS ESTABLISHED PROCEDURES FOR POSTNATAL CARE, AS PER GUIDELINES	Standard E19 is concerned with adherence to post-natal care of mother and newborn within the hospital. Observe that postnatal protocols of prevention of hypothermia and breastfeeding are adhered to. Mother may be interviewed to know that proper counselling has been provided to manage the post-natal complications of mother & newborn.
STANDARD E20 THE FACILITY HAS ESTABLISHED PROCEDURES FOR CARE OF NEW BORN, INFANT AND CHILD, AS PER GUIDELINES	Standards E20 is concerned with adherence to clinical protocols for newborn and child health. It covers immunization, emergency triage, management of newborn and childhood illnesses like neonatal asphyxia, low birth weight, neo-natal jaundice, sepsis, malnutrition and diarrhoea. Immunization services are majorly assessed at immunization clinic. Staff interview and observation should be done to assess availability of diluents, adherence to protocols of reconstitution of vaccine, storage of VVM labels and shake test. Adherence to clinical protocols for management of different illnesses in newborn and child should be done through interaction with the doctors and nursing staff.

STANDARD E21 THE FACILITY HAS ESTABLISHED PROCEDURES FOR ABORTION AND FAMILY PLANNING, AS PER GOVERNMENT GUIDELINES AND LAW	Standard 21 is concerned with providing safe and quality family planning and abortion services. This includes standard practices and procedures for family planning counselling, spacing methods, family planning surgeries and counselling and procedures for abortion. Quality and adequacy of counselling services can be assessed by exit interview with the clients. Staff at family planning clinic may be interacted to assess adherence to the protocols for IUD insertion, precaution & contraindication for oral pills, use of injectables, family planning surgery, etc.
STANDARD E22 THE FACILITY PROVIDES ADOLESCENT REPRODUCTIVE AND SEXUAL HEALTH SERVICES, AS PER GUIDELINES	Standard E22 is concerned with services related to Adolescent Friendly Health Clinics service (AFHCS) guidelines. It includes promotive, preventive, curative and referral services under the AFHCS. Staff should be interviewed, and records should be reviewed.
STANDARD E23 THE FACILITY PROVIDES NATIONAL HEALTH PROGRAMME AS PER OPERATIONAL/CLINICAL GUIDELINES	Standard E23 pertains to adherence for clinical guidelines under the National Health Programmes. For each national health programme, quality of curative & followup services as per respective Nationa guidelines should be assessed
STANDARD E24 THE FACILITY HAS DEFINED AND ESTABLISHED PROCEDURE FOR HAEMODIALYSIS SERVICES	Standard E24 is concerned with procedures related to Haemodialysis services. It includes processes for pre-haemodialysis assessment like complete patient assessment performed before dialysis, predialysis testing, etc. It also includes processes during and after haemodialysis, post-dialysis samples is being taken and observations are recorded. It includes the management of the Quality of services provided in Haemodialysis unit.

AREA OF CONCERN - F : INFECTION CONTROL

Overview

The first principle of health care is "to do no harm". As Public Hospitals usually have high occupancy, the Infection control practices become more critical to avoid cross-infection and its spread. This area of concern covers Infection control practices, hand-hygiene, antisepsis, personal protection, processing of equipment, environment control, and Biomedical Waste Management.

Following is the brief description of the Standards within this area of concern:

STANDARD F1 THE FACILITY HAS INFECTION CONTROL PROGRAMME AND PROCEDURES IN PLACE FOR PREVENTION AND MEASUREMENT OF HOSPITAL ASSOCIATED INFECTION	Standard F1 is concerned with the implementation of Infection control programme at the facility. It includes existence of functional infection control committee, microbiological surveillance, measurement of hospital acquired infection rates, periodic medical check-up and immunization of staff and monitoring of infection control practices. Hospital administration should be interacted to assess the functioning of infection control committee. Records should be reviewed for confirming the culture surveillance practices, monitoring of hospital acquired infection, status of staff immunization, etc. Implementation of antibiotic policy can be assessed through staff interview, perusal of patient record and usage pattern of antibiotics.
STANDARD F2 THE FACILITY HAS DEFINED AND IMPLEMENTED PROCEDURES FOR ENSURING HAND HYGIENE PRACTICES AND ANTISEPSIS	Standard F2 is concerned with practices of hand-washing and antisepsis. Availability of hand washing facilities with soap and running water should be observed at the point of use. Technique of hand-washing for assessing the practices, and effectiveness of training may be observed.
STANDARD F3 THE FACILITY ENSURES STANDARD PRACTICES AND MATERIALS FOR PERSONAL PROTECTION	Standard F3 is concerned with usage of Personal Protection Equipment (PPE) such as gloves, mask, apron, etc. Interaction with staff may reveal the adequacy of supply of PPE.
STANDARD F4 THE FACILITY HAS STANDARD PROCEDURES FOR PROCESSING OF EQUIPMENT AND INSTRUMENTS	Standard F4 is concerned with standard procedures, related to processing of equipment and instruments. It includes adequate decontamination, cleaning, disinfection and sterilization of equipment and instruments. These practices should be observed and staff should be interviewed for compliance to certain standard procedures.
STANDARD F5 PHYSICAL LAYOUT AND ENVIRONMENTAL CONTROL OF THE PATIENT CARE AREAS ENSURES INFECTION PREVENTION	Standard F5 pertains to environment cleaning. It assesses whether lay out and arrangement of processes are conducive for the infection control or not. Environment cleaning processes like mopping, especially in critical areas like OT and ICU should be observed for the adequacy and technique.
STANDARD F6 THE FACILITY HAS DEFINED AND ESTABLISHED PROCEDURES FOR SEGREGATION, COLLECTION, TREATMENT AND DISPOSAL OF BIO MEDICAL AND HAZARDOUS WASTE	Standard F6 is concerned with Biomedical waste management including its segregation, transportation, disposal and management of sharps. Availability of equipment and practices of segregation can be directly observed. Staff should be interviewed about the procedure for management of the needle stick injuries. Storage and transportation of waste should be observed and records are verified.

AREA OF CONCERN - G : QUALITY MANAGEMENT

Overview

Quality management requires a set of interrelated activities that assure quality of services according to set standards and strive to improve upon it through a systematic planning, implementation, checking and acting upon the compliances. The standards in this area of concern are the opportunities for improvement to enhance quality of services and patient satisfaction by using various Quality tools & methods. These standards are in synchronization with facility based quality improvement activities given in 'Operational Guidelines'.

Following are the Standards under this area of Concern:

STANDARD G1 THE FACILITY HAS ESTABLISHED ORGANIZATIONAL FRAMEWORK FOR QUALITY IMPROVEMENT	Standard G1 is concerned with creating a Quality Team at the facility and making it functional. Assessor may review the document and interact with Quality team members to know how frequently they meet and responsibilities have been delegated to them. Quality team meeting records may be reviewed at periodic intervals. At department level eg: labour room and maternity operation theatre small quality circle may be constituted to coordinate & continuously improve the system. As quality circles are the informal teams. The quality circle at each department is supposed to interlink their activity with the overall hospital's quality objectives & quality team.
STANDARD G2 THE FACILITY HAS ESTABLISHED SYSTEM FOR PATIENT AND EMPLOYEE SATISFACTION	Standard G2 is concerned with having a system of measurement of patient and employee satisfaction. This includes periodic patient's satisfaction survey, analysis of the feedback and preparing action plan. Assessors should review the records pertaining to patient satisfaction and employee satisfaction survey to ascertain that Patient feedback is taken at prescribed intervals and sample size is adequate.
STANDARD G3 THE FACILITY HAS ESTABLISHED INTERNAL AND EXTERNAL QUALITY ASSURANCE PROGRAMMES WHEREVER IT IS CRITICAL TO QUALITY	Standard G3 is concerned with implementation of internal quality assurance programmes within departments such as EQAS of diagnostic services, daily round and use of departmental checklists, EQAS records at laboratory, etc. Interview with Matron, Hospital Managers etc may give information about how they conduct daily round of departments and usage of checklists.
STANDARD G4 THE FACILITY HAS ESTABLISHED, DOCUMENTED IMPLEMENTED AND MAINTAINED STANDARD OPERATING PROCEDURES FOR ALL KEY PROCESSES AND SUPPORT SERVICES	Standard G4 is concerned with availability and adequacy of Standard operating procedures and work instructions with the respective process owners. Display of work instructions and clinical protocols should be observed during the assessment.
STANDARD G5 THE FACILITY MAPS ITS KEY PROCESSES AND SEEKS TO MAKE THEM MORE EFFICIENT BY REDUCING NON VALUE ADDING ACTIVITIES AND WASTAGES	Standard G5 is concerned the efforts made for the mapping and improving processes. Records should be checked to ensure that the critical processes have been mapped, wastes have been identified and efforts are made to remove them to make processes more efficient.
STANDARD G6 FACILITY HAS DEFINED MISSION, VALUES, QUALITY POLICY AND OBJECTIVES, AND PREPARES A STRATEGIC PLAN TO ACHIEVE THEM	Every organization has a purpose for its existence and what it wants to be achieve in future. Public health facilities have been created not only to provide curative services, but also support health promotion in their target community and disease prevention. Therefore, public hospitals not only cater needs of sick and those in need of medical care, but also provide holistic care, which includes preventive & promotive care. With this positioning it is very important that health facilities should clearly articulate their mission statement in consultation withinternal and external stakeholders and disseminate it effectively amongst staff, visitors& community. The Mission statement may incorporate 'what is the purpose of existence',' who are our users' and 'what do we intend to do by operating this facility'. Mission statement should be pragmatic and simple so it can be easily understood by target audiences and they can relate it with their work.

	As the public health facility is part of larger public health system governed by State Health Department, it is recommended that the facility's mission statement should be in congruence with mission of the State's Health department. Mission statement should be approved and endorsed by administration of facility and effectively communicated in local language through display. Caution should also be taken to keep the language simple and easily understandable. This standard also requires health facilities to define core value that should be part of all policies & procedures, and are always considered while realizing the services to the patients and community. Being public hospital, facility should have core values of Honesty, transparency, Non–discrimination, ethical practices, Competence, empathy and goodwill towards community. It is also of utmost importance that how hospital administration plan and promote that these values amongst its staff so it becomes part of their attitude and work culture. Quality policy is overall intension and direction of an organization related to quality as formally expressed by hospital administration. Hospital should define what they intend to achieve in terms of quality, safety and patient satisfaction. Quality Policy is should be aligned with the mission statement to achieve overall aim of the facility. To achieve the mission and quality policy, the facility should define commensurate objectives. Objectives are more tangible and short-term goals, with each objective targeting one specific issue or aspiration of organization. Objectives should be Specific, Measurable, Attainable, Relevant/ realistic and Time-bound (SMART). Though Mission and Quality Policy are framed at the organizational level, objectives can be at departmental or activity level. Quality Policy and objectives should also be disseminated effectively to staff and other relevant stakeholders. It is equally important that hospital administration prepares a time bound plan to achieve these objectives and provide adequate resources to achieve them. Assessment of this standard and related measurable elements can be done by reviewing the records pertaining to mission, quality policy and objectives. Assessors may also interview some of the staff about their awareness of Mission, Values, Quality Policy and objectives.
STANDARD G7 THE FACILITY SEEKS CONTINUALLY IMPROVEMENT BY PRACTICING QUALITY METHOD AND TOOLS	Standard G7 is concerned with the practice of using Quality tools and methods like control charts, 5-'S', etc. The Assessor should look for any specific methods and tools practiced for quality improvement.
STANDARD G8 FACILITY HAS DEFINED, APPROVED AND COMMUNICATED RISK MANAGEMENT FRAMEWORK FOR EXISTING AND POTENTIAL RISKS	Healthcare facilities of all level are exposed to risks from Internal and External sources, which may put attainment of Quality objective at a risk. In Public hospitals these risks may be patient's safety issues, shortage of supplies, fall in allocation of resources, man-made or natural disaster, failure to comply with statutary & legal requirements, Violence towards service providers or even risk of getting outdated or becoming obsolete. Hospitals are complex organizations and just reacting on occurred threats may not be helpful alone. This standard requires healthcare facilities to develop, implement and continuously improve a risk management framework considering both internal and external threats. Risk Management framework should not be isolated exercise. It should be integrated with facility's objectives and intended Quality Management System (QMS). In this direction, the initial step is to define scope of risk management and objectives of the framework keeping in mind the context and environment. The hospital administration should prepare a comprehensive list of current and perceived risks. It is also important to define the responsibility and process of reporting and managing risks. Facility should also have provision for training of staff on risk management framework. Assessors may verify documents that defines facilities risk management system. Assessors should verify that potential risks has been identified in framework keeping in accordance to context of. Assessors can also interview hospital administration and staff for their knowledge and practice of risk management framework.

STANDARD G9 THE FACILITY HAS ESTABLISHED PROCEDURES FOR ASSESSING, REPORTING, EVALUATING AND MANAGING RISK AS PER RISK MANAGEMENT PLAN	To implement risk management framework facility should prepare a risk management plan. The plan will delineate responsibilities and timelines for risk management activities such as assessment and risk treatment. All staff and external stakeholders should be made aware of the plan in general and their roles & responsibilities in particular. Facility should define the criteria for identifying the risk and finalize its assessment tools. These tools may be a simple checklist, reporting format or work instruction for identifying risks. It may be checklist for fire safety preparedness, infection control audit, electrical safety audit or even an open ended questionnaire for staff on what potential threats they feel on their security at workplace. Once risks are identified, they should be analyzed and evaluated for their impact. Based on their impact the risk should be graded - severe, moderate and low. Accordingly actions are taken to mitigate prevent or eliminate the risks. Actions may need to be prioritized in term of potential impact a rick may have. Facility should also establish a risk register. This register will record the identified or reported risk, their severity and actions to be taken. Assessors should review relevant records for verify availability of a valid plan for risk management and whether risk management activities have been conducted as per plan. Assessors should also review risk register to see how facility has graded their risks and prioritized them for action. Assessors may verify documents that defines facilities risk management system. Assessors should verify that potential risks has been identified in framework keeping in accordance to context of. Assessors can also interview hospital administration and staff for their knowledge and practice of risk management framework.
STANDARD G10 THE FACILITY HAS ESTABLISHED CLINICAL GOVERNANCE FRAMEWORK TO IMPROVE THE QUALITY AND SAFETY OF CLINICAL CARE PROCESSES	Clinical Governance has broad 7 elements viz. Education & training, clinical audits, clinical effectiveness, research and development, openness, information management and risk management. Under NQAS structure, most of the elements are covered in their respective area of concerns. This Standard requires healthcare facilities to develop, implement and improve clinical Governance framework. Framework should cover policy formulation, Clinical Governance has broad 7 elements viz. Education & training, clinical audits, clinical effectiveness, research and development, openness, information management and risk management. Under NQAS structure, most of the elements are covered in their respective area of concerns. This Standard requires healthcare facilities to develop, implement and improve clinical Governance framework. Framework should cover policy formulation, constitution of Apex Committee for clinical governance, defined roles and responsibilities of its members and ensuring regular discussions & monitoring on clinical cases. In this direction, the first step should be reviewing the functioning of existing clinical committee viz. Drug and therapeutic committee, Medical, death and prescription audit committee etc by the Apex committee. Committee should ensure the use of evidence-based practices and Standard treatment guideline for all the clinical treatment provided to the patient. Assessor will verify the clinical governance policy, ensuring apex committee is meeting at regular intervals, data or information is analysed pertaining to clinical & administrative process and presented during the meeting. The steps are taken to improve the processes further using PDCA approach. Assessor may verify the transparency in the processes while respecting the confidentiality of patient and service providers.

AREA OF CONCERN - H : OUTCOME

Overview

Measurement of the quality is critical to improvement of processes and outcomes. This area of concern has four standard measures for quality- Productivity, Efficiency, Clinical Care & Safety and Service quality in terms of measurable indicators. Every standard under this area has two aspects – Firstly, there is a system of measurement of indicators at the health facility; and secondly, how the hospital meets the benchmark. It is realized that at the beginning many indicators given in these standards may not be getting measured across all facilities, and therefore it would be difficult to set benchmark beforehand. However, the state can set their benchmarks, and evaluate performance of health facilities against the set benchmarks. In LaQshya (LR & MOT) and MusQan (SNCU/NBSU, Paed. OPD, Paed. ward & NRC), the benchmarks/ targets for achievment is given in Annexure 'C' & Annexure 'A' respectively

Following is the brief description of the Standards in this area of concern:

STANDARD H1 THE FACILITY MEASURES PRODUCTIVITY INDICATORS AND ENSURES COMPLIANCE WITH STATE/NATIONAL BENCHMARKS	Standard H1 is concerned with the measurement of productivity indicators and meeting the benchmarks. This includes utilization indicators like bed occupancy rate and C-Section rate. Assessor should review these records to ensure that these indicators are getting measured at the health facility.
STANDARD H2 THE FACILITY MEASURES EFFICIENCY INDICATORS AND ENSURE TO REACH STATE/ NATIONAL BENCHMARK	Standard H2 pertains to measurement of efficiency indicators and meeting the benchmarks. This standard contains indicators that measure efficiency of processes, such as turnaround time, and efficiency of human resource like number of surgeries per surgeon, lab test done per technician. Review of records should be done to assess that these indicators have been measured correctly.
STANDARD H3 THE FACILITY MEASURES CLINICAL CARE & SAFETY INDICATORS AND TRIES TO REACH STATE/NATIONAL BENCHMARK	Standard H3 is concerned with the indicators of clinical quality & safty, such as average length of stay, death rates, HAI rates etc. Record review should be done to see the measurement of these indicators.
STANDARD H4 THE FACILITY MEASURES SERVICE QUALITY INDICATORS AND ENDEAVOURS TO REACH STATE/ NATIONAL BENCHMARK	Standard H4 is concerned with indicators measuring service quality patient satisfaction scores, waiting time and LAMA rates.

VI MEASURABLE ELEMENTS

AREA OF CONCERN A- SERVICE PROVISION	
Standard A1	**Facility Provides Curative Services**
ME A1.1	The facility provides General Medicine services
ME A1.2	The facility provides General Surgery services
ME A1.3	The facility provides Obstetrics & Gynaecology Services
ME A1.4	The facility provides paediateric services
ME A1.5	The facility provides Ophthalmology Services
ME A1.6	The facility provides ENT Services
ME A1.7	The facility provides Orthopaedics Services
ME A1.8	The facility provides Skin & VD Services
ME A1.9	The facility provides Psychiatry Services
ME A1.10	The facility provides Dental Treatment Services
ME A1.11	The facility provides AYUSH Services
ME A1.12	The facility provides Physiotherapy Services
ME A1.13	The facility provides services for OPD procedures
ME A1.14	Services are available for the time period as mandated
ME A1.15	The facility provides services for Super specialties, as mandated
ME A1.16	The facility provides Accident & Emergency Services
ME A1.17	The facility provides Intensive care Services
ME A1.18	The facility provides Blood bank & transfusion services
ME A1.19	The facility provides the dialysis services
Standard A2	**Facility provides RMNCHA Services**
ME A2.1	The facility provides Reproductive health Services
ME A2.2	The facility provides Maternal health Services
ME A2.3	The facility provides Newborn health Services
ME A2.4	The facility provides Child health Services
ME A2.5	The facility provides Adolescent health Services
Standard A3	**Facility Provides diagnostic Services**
ME A3.1	The facility provides Radiology Services
ME A3.2	The facility Provides Laboratory Services
ME A3.3.	The facility provides other diagnostic services, as mandated
Standard A4	**Facility provides services as mandated in National Health Programmes/ State Scheme**
ME A4.1	The facility provides services under National Vector Borne Disease Control Programme as per guidelines
ME A4.2	The facility provides services under national tuberculosis elimination programme as per guidelines.
ME A4.3	The facility provides services under National Leprosy Eradication Programme as per guidelines
ME A4.4	The facility provides services under National AIDS Control Programme as per guidelines
ME A4.5	The facility provides services under National Programme for Prevention and control of Blindness as per guidelines
ME A4.6	The facility provides services under Mental Health Programme as per guidelines
ME A4.7	The facility provides services under National Programme for the health care of the elderly as per guidelines
ME A4.8	The facility provides services under National Programme for Prevention and control of Cancer, Diabetes, Cardiovascular diseases & Stroke (NPCDCS) as per guidelines
ME A4.9	The facility Provides services under Integrated Disease Surveillance Programme as per Guidelines

ME A4.10	The facility provide services under National health Programme for deafness
ME A4.11	The facility provides services as per State specific health programmes
ME A 4.12	The facility provided services as per Rashtriya bal swasthya Karykram
ME A4.13	The facility provides services as PMNDP
ME A4.14	The facility provides services as per National Viral Hepatitis Program
ME A4.15	The facility provide services under National Programme for pallative care
Standard A5	**Facility provides support services**
ME A5.1	The facility provides dietary services
ME A5.2	The facility provides laundry services
ME A5.3.	The facility provides security services
ME A5.4	The facility provides housekeeping services
ME A5.5	The facility ensures maintenance services
ME A5.6	The facility provides pharmacy services
ME A5.7	The facility has services of medical record department
ME A5.8	The facility provides mortuary services
Standard A6	**Health services provided at the facility are appropriate to community needs.**
ME A6.1	The facility provides curatives & preventive services for the health problems and diseases, prevalent locally.
ME A6.2	There is process for consulting community/ or their representatives when planning or revising scope of services of the facility
	AREA OF CONCERN B- PATIENT RIGHTS
Standard B1	**Facility provides the information to care seekers, attendants & community about the available services and their modalities**
ME B1.1	The facility has uniform and user-friendly signage system
ME B1.2	The facility displays the services and entitlements available in its departments
ME B1.3	The facility has established citizen charter, which is followed at all levels
ME B1.4	User charges are displayed and communicated to patients effectively
ME B1.5	Patients & visitors are sensitised and educated through appropriate IEC / BCC approaches
ME B1.6	Information is available in local language and easy to understand
ME B1.7	The facility provides information to patients and visitor through an exclusive set-up.
ME B1.8	The facility ensures access to clinical records of patients to entitled personnel
Standard B2	**Services are delivered in a manner that is sensitive to gender, religious, and cultural needs, and there are no barrier on account of physical economic, cultural or social reasons.**
ME B2.1	Services are provided in manner that are sensitive to gender
ME B2.2	Religious and cultural preferences of patients and attendants are taken into consideration while delivering services
ME B2.3	Access to facility is provided without any physical barrier & and friendly to people with disabilities
ME B2.4	There is no discrimination on basis of social and economic status of the patients
ME B2.5	There is affirmative actions to ensure that vulnerable sections can access services
Standard B3	**Facility maintains the privacy, confidentiality & Dignity of patient, and has a system for guarding patients related information**
ME B3.1	Adequate visual privacy is provided at every point of care
ME B3.2	Confidentiality of patients records and clinical information is maintained
ME B3.3	The facility ensures the behaviours of staff is dignified and respectful, while delivering the services
ME B3.4	The facility ensures privacy and confidentiality to every patient, especially of those conditions having social stigma, and also safeguards vulnerable groups

Standard B4	**Facility has defined and established procedures for informing patients about the medical condition,and involving them in treatment planning, and facilitate informed decision making patient.**
ME B4.1	There is established procedures for taking informed consent before treatment and procedures
ME B4.2	Patient is informed about his/her rights and responsibilities
ME B4.3	Staff are aware of Patients rights responsibilities
ME B4.4	Information about the treatment is shared with patients or attendants, regularly
ME B4.5	The facility has defined and established grievance redressal system in place
Standard B5	**Facility ensures that there are no financial barrier to access and that there is financial protection given from cost of hospital services.**
ME B5.1	The facility provides cashless services to pregnant women, mothers and neonates as per prevalent government schemes
ME B5.2	The facility ensures that drugs prescribed are available at Pharmacy and wards
ME B5.3	It is ensured that facilities for the prescribed investigations are available at the facility
ME B5.4	The facility provide free of cost treatment to Below poverty line patients without administrative hassles
ME B5.5	The facility ensures timely reimbursement of financial entitlements and reimbursement to the patients
ME B5.6	The facility ensure implementation of health insurance schemes as per National /state scheme
Standard B6	**Facility has defined framework for ethical management including dilemmas confronted during delivery of services at public health facilities**
ME B6.1	Ethical norms and code of conduct for medical and paramedical staff have been established.
ME B6.2	The Facility staff is aware of code of conduct established
ME B6.3	The Facility has an established procedure for entertaining representatives of drug companies and suppliers
ME B6.4	The Facility has an established procedure for medical examination and treatment of individual under judicial or police detention as per prevalent law and government directions
ME B6.5	There is an established procedure for sharing of hospital/patient data with individuals and external agencies including non governmental organization
ME B6.6	There is an established procedure for 'end-of-life' care
ME B 6.7	There is an established procedure for patients who wish to leave hospital against medical advice or refuse to receive specific c treatment
ME B6.8	There is an established procedure for obtaining informed consent from the patients in case facility is participating in any clinical or public health research
ME B6.9	There is an established procedure to issue of medical certificates and other certificates
ME B6.10	There is an established procedure to ensure medical services during strikes or any other mass protest leading to dysfunctional medical services
ME B6.11	An updated copy of code of ethics under Indian Medical council act is available with the facility
ME B6.12	Facility has established a framework for identifying, receiving, and resolving ethical dilemmas' in a time-bound manner through ethical committee
AREA OF CONCERN C - INPUTS	
Standard C1	**The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms**
ME C1.1	Departments have adequate space as per patient or work load
ME C1.2	Patient amenities are provide as per patient load
ME C1.3	Departments have layout and demarcated areas as per functions
ME C1.4	The facility has adequate circulation area and open spaces according to need and local law
ME C1.5	The facility has infrastructure for intramural and extramural communication
ME C1.6	Service counters are available as per patient load

ME C1.7	The facility and departments are planned to ensure structure follows the function/processes (Structure commensurate with the function of the hospital)
Standard C2	**The facility ensures the physical safety of the infrastructure.**
ME C2.1	The facility ensures the seismic safety of the infrastructure
ME C2.2	The facility ensures safety of lifts and lifts have required certificate from the designated bodies/ board
ME C2.3	The facility ensures safety of electrical establishment
ME C2.4	Physical condition of buildings are safe for providing patient care
Standard C3	**The facility has established Programme for fire safety and other disaster**
ME C3.1	The facility has plan for prevention of fire
ME C3.2	The facility has adequate fire fighting Equipment
ME C3.3	The facility has a system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation
Standard C4	**The facility has adequate qualified and trained staff, required for providing the assured services to the current case load**
ME C4.1	The facility has adequate specialist doctors as per service provision
ME C4.2	The facility has adequate general duty doctors as per service provision and work load
ME C4.3	The facility has adequate nursing staff as per service provision and work load
ME C4.4	The facility has adequate technicians/paramedics as per requirement
ME C4.5	The facility has adequate support / general staff
Standard C5	**Facility provides drugs and consumables required for assured list of services.**
ME C5.1	The departments have availability of adequate drugs at point of use
ME C5.2	The departments have adequate consumables at point of use
ME C5.3	Emergency drug trays are maintained at every point of care, where ever it may be needed
Standard C6	**The facility has equipment & instruments required for assured list of services.**
ME C6.1	Availability of equipment & instruments for examination & monitoring of patients
ME C6.2	Availability of equipment & instruments for treatment procedures, being undertaken in the facility
ME C6.3	Availability of equipment & instruments for diagnostic procedures being undertaken in the facility
ME C6.4	Availability of equipment and instruments for resuscitation of patients and for providing intensive and critical care to patients
ME C6.5	Availability of Equipment for Storage
ME C6.6	Availability of functional equipment and instruments for support services
ME C6.7	Departments have patient furniture and fixtures as per load and service provision
Standard C7	**Facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff**
ME C7.1	Criteria for Competence assessment are defined for clinical and Para clinical staff
ME C7.2	Competence assessment of Clinical and Para clinical staff is done on predefined criteria at least once in a year
ME C7.3	Criteria for performance evaluation clinical and Para clinical staff are defined
ME C7.4	Performance evaluation of clinical and para clinical staff is done on predefined criteria at least once in a year
ME C7.5	Criteria for performance evaluation of support and administrative staff are defined
ME C7.6	Performance evaluation of support and administration staff is done on predefined criteria at least once in a year
ME C7.7	Competence assessment and performance assessment includes contractual, empanelled, and outsourced staff
ME C7.8	Training needs are identified based on competence assessment and performance evaluation and facility prepares the training plan

ME C7.9	The Staff is provided training as per defined core competencies and training plan
ME C7.10	There is established procedure for utilization of skills gained thought trainings by on -job supportive supervision
ME C7.11	Feedback is provided to the staff on their competence assessment and performance evaluation
AREA OF CONCERN D - SUPPORT SERVICES	
Standard D1	**The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.**
ME D1.1	The facility has established system for maintenance of critical Equipment
ME D1.2	The facility has established procedure for internal and external calibration of measuring Equipment
ME D1.3	Operating and maintenance instructions are available with the users of equipment
Standard D2	**The facility has defined procedures for storage, inventory management and dispensing of medicines and consumables in pharmacy and patient care areas**
ME D2.1	There is established procedure for forecasting and indenting drugs and consumables
ME D2.2	The facility has establish procedure for procurement of drugs
ME D2.3	The facility ensures proper storage of drugs and consumables
ME D2.4.	The facility ensures management of expiry and near expiry drugs
ME D2.5	The facility has established procedure for inventory management techniques
ME D2.6	There is a procedure for periodically replenishing the drugs in patient care areas
ME D2.7	There is process for storage of vaccines and other drugs, requiring controlled temperature
ME D2.8	There is a procedure for secure storage of narcotic and psychotropic drugs
Standard D3	**The facility provides safe, secure and comfortable environment to staff, patients and visitors.**
ME D3.1	The facility provides adequate illumination level at patient care areas
ME D3.2	The facility has provision of restriction of visitors in patient areas
ME D3.3	The facility ensures safe and comfortable environment for patients and service providers
ME D3.4	The facility has security system in place at patient care areas
ME D3.5	The facility has established measure for safety and security of female staff
Standard D4	**The facility has established Programme for maintenance and upkeep of the facility**
ME D4.1	Exterior of the facility building is maintained appropriately
ME D4.2	Patient care areas are clean and hygienic
ME D4.3	Hospital infrastructure is adequately maintained
ME D4.4	Hospital maintains the open area and landscaping of them
ME D4.5	The facility has policy of removal of condemned junk material
ME D4.6	The facility has established procedures for pest, rodent and animal control
Standard D5	**The facility ensures 24X7 water and power backup as per requirement of service delivery, and support services norms**
ME D5.1	The facility has adequate arrangement storage and supply for portable water in all functional areas
ME D5.2	The facility ensures adequate power backup in all patient care areas as per load
ME D5.3	Critical areas of the facility ensures availability of oxygen, medical gases and vacuum supply
ME D5.4	The facility has adeqaute arrangement for uninterrupted supply of RO water for dialysis unit
Standard D6	**Dietary services are available as per service provision and nutritional requirement of the patients.**
ME D6.1	The facility has provision of nutritional assessment of the patients
ME D6.2	The facility provides diets according to nutritional requirements of the patients
ME D6.3	Hospital has standard procedures for preparation, handling, storage and distribution of diets, as per requirement of patients

Standard D7	The facility ensures clean linen to the patients
ME D7.1	The facility has adequate availability of linen for meting its need.
ME D7.2	The facility has established procedures for changing of linen in patient care areas
ME D7.3	The facility has standard procedures for handling , collection, transportation and washing of linen
Standard D8	**The facility has defined and established procedures for promoting public participation in management of hospital transparency and accountability.**
ME D8.1	The facility has established procures for management of activities of Rogi Kalyan Samitis
ME D8.2	The facility has established procedures for community based monitoring of its services
Standard D9	**Hospital has defined and established procedures for Financial Management**
ME D9.1	The facility ensures the proper utilization of fund provided to it
ME D9.2	The facility ensures proper planning and requisition of resources based on its need
Standard D10	**Facility is compliant with all statutory and regulatory requirement imposed by local, state or central government**
ME D10.1	The facility has requisite licences and certificates for operation of hospital and different activities
ME D10.2	Updated copies of relevant laws, regulations and government orders are available at the facility
ME D10.3	The facility ensure relevant processes are in compliance with statutory requirement
Standard D11	**Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.**
ME D11.1	The facility has established job description as per govt guidelines
ME D11.2	The facility has a established procedure for duty roster and deputation to different departments
ME D11.3	The facility ensures the adherence to dress code as mandated by its administration / the health department
Standard D12	**Facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations**
ME D12.1	There is established system for contract management for out sourced services
ME D12.2	There is a system of periodic review of quality of out sourced services
AREA OF CONCERN E - CLINICAL SERVICES	
Standard E1	**The facility has defined procedures for registration, consultation and admission of patients.**
ME E1.1	The facility has established procedure for registration of patients
ME E1.2	The facility has a established procedure for OPD consultation
ME E1.3	There is established procedure for admission of patients
ME E1.4	There is established procedure for managing patients, in case beds are not available at the facility
Standard E2	**The facility has defined and established procedures for clinical assessment, reassessment and preparation of the treatment plan.**
ME E2.1	There is established procedure for initial assessment of patients
ME E2.2	There is established procedure for follow-up/ reassessment of Patients
ME E2.3	There is established procedure to plan and deliver appropriate treatment or care to individual as per the needs to achieve best possible results
Standard E3	**Facility has defined and established procedures for continuity of care of patient and referral**
ME E3.1	Facility has established procedure for continuity of care during interdepartmental transfer
ME E3.2	Facility provides appropriate referral linkages to the patients/Services for transfer to other/higher facilities to assure their continuity of care.
ME E3.3	A person is identified for care during all steps of care
ME E3.4	Facility is connected to medical colleges through telemedicine services

Standard E4	The facility has defined and established procedures for nursing care
ME E4.1	Procedure for identification of patients is established at the facility
ME E4.2	Procedure for ensuring timely and accurate nursing care as per treatment plan is established at the facility
ME E4.3	There is established procedure of patient hand over, whenever staff duty change happens
ME E4.4	Nursing records are maintained
ME E4.5	There is procedure for periodic monitoring of patients
Standard E5	**Facility has a procedure to identify high risk and vulnerable patients.**
ME E5.1	The facility identifies vulnerable patients and ensure their safe care
ME E5.2	The facility identifies high risk patients and ensure their care, as per their need
Standard E6	**Facility ensures rationale prescribing and use of medicines**
ME E6.1	Facility ensured that drugs are prescribed in generic name only
ME E6.2	There is procedure of rational use of drugs
ME E6.3	There are procedures defined for medication review and optimization
Standard E7	**Facility has defined procedures for safe drug administration**
ME E7.1	There is process for identifying and cautious administration of high alert drugs
ME E7.2	Medication orders are written legibly and adequately
ME E7.3	There is a procedure to check drug before administration/ dispensing
ME E7.4	There is a system to ensure right medicine is given to right patient
ME E7.5	Patient is counselled for self drug administration
Standard E8	**Facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage**
ME E8.1	All the assessments, re-assessment and investigations are recorded and updated
ME E8.2	All treatment plan prescription/orders are recorded in the patient records.
ME E8.3	Care provided to each patient is recorded in the patient records
ME E8.4	Procedures performed are written on patients records
ME E8.5	Adequate form and formats are available at point of use
ME E8.6	Register/records are maintained as per guidelines
ME E8.7	The facility ensures safe and adequate storage and retrieval of medical records
Standard E9	**The facility has defined and established procedures for discharge of patient.**
ME E9.1	Discharge is done after assessing patient readiness
ME E9.2	Case summary and follow-up instructions are provided at the discharge
ME E9.3	Counselling services are provided as during discharges wherever required
Standard E10	**The facility has defined and established procedures for intensive care.**
ME E10.1	The facility has established procedure for shifting the patient to step-down/ward based on explicit assessment criteria
ME E10.2	The facility has defined and established procedure for intensive care
ME E10.3	The facility has explicit clinical criteria for providing intubation & extubation, and care of patients on ventilation and subsequently on its removal
Standard E11	**The facility has defined and established procedures for Emergency Services and Disaster Management**
ME E11.1	There is procedure for Receiving and triage of patients
ME E11.2	Emergency protocols are defined and implemented
ME E11.3	The facility has disaster management plan in place
ME E11.4	The facility ensures adequate and timely availability of ambulances services and mobilisation of resources, as per requirement
ME E11.5	There is procedure for handling medico legal cases
Standard E12	**The facility has defined and established procedures of diagnostic services**
ME E12.1	There are established procedures for Pre-testing Activities

ME E12.2	There are established procedures for testing Activities
ME E12.3	There are established procedures for Post-testing Activities
Standard E13	**The facility has defined and established procedures for Blood Bank/Storage Management and Transfusion.**
ME E13.1	Blood bank has defined and implemented donor selection criteria
ME E13.2	There is established procedure for the collection of blood
ME E13.3	There is established procedure for the testing of blood
ME E13.4	There is established procedure for preparation of blood component
ME E13.5	There is establish procedure for labelling and identification of blood and its product
ME E13.6	There is established procedure for storage of blood
ME E13.7	There is established the compatibility testing
ME E13.8	There is established procedure for issuing blood
ME E13.9	There is established procedure for transfusion of blood
ME E13.10	There is a established procedure for monitoring and reporting Transfusion complication
Standard E14	**Facility has established procedures for Anaesthetic Services**
ME E14.1	Facility has established procedures for Pre Anaesthetic Check up and medical records
ME E14.2	Facility has established procedures for monitoring during anaesthesia and maintenance of records
ME E14.3	Facility has established procedures for Post Anaesthesia care
Standard E15	**Facility has defined and established procedures of Operation theatre services**
ME E15.1.	Facility has established procedures OT Scheduling
ME E15.2	Facility has established procedures for Preoperative care
ME E15.3	Facility has established procedures for Surgical Safety
ME E15.4	Facility has established procedures for Post operative care
Standard E16	**The facility has defined and established procedures for the management of death & bodies of deceased patients**
ME E16.1	Death of admitted patient is adequately recorded and communicated
ME E16.2	The facility has standard procedures for handling the death in the hospital
ME E16.3	The facility has standard procedures for conducting post-mortem, its recording and meeting its obligation under the law
Standard E17	**Facility has established procedures for Antenatal care as per guidelines**
ME E17.1	There is an established procedure for Registration and follow up of pregnant women.
ME E17.2	There is an established procedure for History taking, Physical examination, and counselling for each antenatal visit.
ME E17.3	Facility ensures availability of diagnostic and drugs during antenatal care of pregnant women
ME E17.4	There is an established procedure for identification of High risk pregnancy and appropriate treatment/referral as per scope of services.
ME E17.5	There is an established procedure for identification and management of moderate and severe anaemia
ME E17.6	Counselling of pregnant women is done as per standard protocol and gestational age
Standard E18	**Facility has established procedures for Intranatal care as per guidelines**
ME E18.1	Facility staff adheres to standard procedures for management of second stage of labour.
ME E18.2	Facility staff adheres to standard procedure for active management of third stage of labour
ME E18.3	Facility staff adheres to standard procedures for routine care of new-born immediately after birth
ME E18.4	There is an established procedure for assisted and C-section deliveries per scope of services.
ME E18.5	Facility staff adheres to standard protocols for identification and management of Pre Eclampsia / Eclampsia
ME E18.6	Facility staff adheres to standard protocols for identification and management of PPH.

ME E18.7	Facility staff adheres to standard protocols for Management of HIV in Pregnant Woman & Newborn
ME E18.8	Facility staff adheres to standard protocol for identification and management of preterm delivery.
ME E18.9	Staff identifies and manages infection in pregnant woman
ME E18.10	There is Established protocol for newborn resuscitation is followed at the facility.
ME E18.11	Facility ensures Physical and emotional support to the pregnant women means of birth companion of her choice
Standard E19	**Facility has established procedures for postnatal care as per guidelines**
ME E19.1	Facility staff adheres to protocol for assessment of condition of mother and baby and providing adequate postpartum care
ME E19.2	Facility staff adheres to protocol for counselling on danger signs, post-partum family planning and exclusive breast feeding
ME E19.3	Facility staff adheres to protocol for ensuring care of newborns with small size at birth
ME E 19.4	The facility has established procedures for stabilization/treatment/referral of post natal complications
ME E19.5	The facility ensure adequate stay of mother and new born in a safe environoment as per standard protocols
ME E19.6	There is established procedure for discharge and follow up of mother and newborn.
Standard E20	**The facility has established procedures for care of new born, infant and child as per guidelines**
ME E20.1	The facility provides immunization services as per guidelines
ME E20.2	Triage, Assessment & Management of newborns having emergency signs are done as per guidelines
ME E20.3	Management of Low birth weight newborns is done as per guidelines
ME E20.4	Management of neonatal asphyxia is done as per guidelines
ME E20.5	Management of neonatal sepsis is done as per guidelines
ME E20.6	Management of children with Jaundice is done as per guidelines
ME E20.7	Management of children presenting with fever, cough/ breathlessness is done as per guidelines
ME E20.8	Management of children with severe acutue malnutrition is done as per guideline
ME E20.9	Management of children presenting diarrhoea is done per guidelines
ME 20.10	The facility ensures optimal breast feedingpractices for new born & infants as per guidelines
ME E20.11	The facility provide services under Rashtriya Bal Swasthya Karyakram (RBSK)
Standard E21	**Facility has established procedures for abortion and family planning as per government guidelines and law**
ME E21.1	Family planning counselling services provided as per guidelines
ME E21.2	Facility provides spacing method of family planning as per guideline
ME E21.3	Facility provides limiting method of family planning as per guideline
ME E21.4	Facility provide counselling services for abortion as per guideline
ME E21.5	Facility provide abortion services for 1st trimester as per guideline
ME E21.6	Facility provide abortion services for 2nd trimester as per guideline
Standard E22	**Facility provides Adolescent Reproductive and Sexual Health services as per guidelines**
ME E22.1	Facility provides Promotive ARSH Services
ME E22.2	Facility provides Preventive ARSH Services
ME E22.3	Facility Provides Curative ARSH Services
ME E22.4	Facility Provides Referral Services for ARSH
Standard E23	**Facility provides National health program as per operational/Clinical Guidelines**
ME E23.1	Facility provides service under National Vector Borne Disease Control Program as per guidelines

ME E23.2	Facility provides service under National TB Elmination Program as per guidelines
ME E23.3	Facility provides service under National Leprosy Eradication Program as per guidelines
ME E23.4	Facility provides service under National AIDS Control program as per guidelines
ME E23.5	Facility provides service under National program for control of Blindness as per guidelines
ME E23.6	Facility provides service under Mental Health Program as per guidelines
ME E23.7	Facility provides service under National programme for the health care of the elderly as per guidelines
ME E23.8	Facility provides service under National Programme for Prevention and Control of cancer, diabetes, cardiovascular diseases & stroke (NPCDCS) as per guidelines
ME E23.9	Facility provide service for Integrated disease surveillance program
ME E23.10	Facility provide services under National program for prevention and control of deafness
ME E 23.11	The facility provide services under National viral Hepatitis Control Programme
ME E23.12	Facility provide services under National program for pallative care
Standard E24	**The facility has defined and established procedure for Haemodialysis Services**
ME E 24.1	The facility has defined and establised procedure for Pre Haemodialysis assessment
ME E 24.2	The facility has defined and establised procedure for care during Haemodialysis
ME E 24.3	The facility has defined and established procedure for care after completion of Haemodialysis
AREA OF CONCERN F - INFECTION CONTROL	
Standard F1	**Facility has infection control program and procedures in place for prevention and measurement of hospital associated infection**
ME F1.1	Facility has functional infection control committee
ME F1.2	Facility has provision for Passive and active culture surveillance of critical & high risk areas
ME F1.3	Facility measures hospital associated infection rates
ME F1.4	There is Provision of Periodic Medical Checkups and immunization of staff
ME F1.5	Facility has established procedures for regular monitoring of infection control practices
ME F1.6	Facility has defined and established antibiotic policy
Standard F2	**Facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis**
ME F2.1	Hand washing facilities are provided at point of use
ME F2.2	Staff is trained and adhere to standard hand washing practices
ME F2.3	Facility ensures standard practices and materials for antisepsis
Standard F3	**Facility ensures standard practices and materials for Personal protection**
ME F3.1	Facility ensures adequate personal protection equipments as per requirements
ME F3.2	Staff is adhere to standard personal protection practices
Standard F4	**Facility has standard Procedures for processing of equipments and instruments**
ME F4.1	Facility ensures standard practices and materials for decontamination and clean ing of instruments and procedures areas
ME F4.2	Facility ensures standard practices and materials for disinfection and sterilization of instruments and equipments
Standard F5	**Physical layout and environmental control of the patient care areas ensures infection prevention**
ME F5.1	Layout of the department is conducive for the infection control practices
ME F5.2	Facility ensures availability of standard materials for cleaning and disinfection of patient care areas
ME F5.3	Facility ensures standard practices followed for cleaning and disinfection of patient care areas
ME F5.4	Facility ensures segregation infectious patients
ME F5.5	Facility ensures air quality of high risk area

Standard F6	**Facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.**
ME F6.1	Facility Ensures segregation of Bio Medical Waste as per guidelines and on-site management of waste is carried out as per guidelines
ME F6.2	Facility ensures management of sharps as per guidelines
ME F6.3	Facility ensures transportation and disposal of waste as per guidelines
AREA OF CONCERN G - QUALITY CONTROL	
Standard G1	**The facility has established organizational framework for quality improvement**
ME G1.1	The facility has a quality team in place
ME G1.2	The facility reviews quality of its services at periodic intervals
Standard G2	**Facility has established system for patient and employee satisfaction**
ME G2.1	Patient Satisfaction surveys are conducted at periodic intervals
ME G2.2	Facility analyses the patient feed back and do root cause analysis
ME G2.3	Facility prepares the action plans for the areas, contributing to low satisfaction of patients
Standard G3	**Facility have established internal and external quality assurance programs wherever it is critical to quality.**
ME G3.1	Facility has established internal quality assurance program at relevant departments
ME G3.2	Facility has established external assurance programs at relevant departments
ME G3.3	Facility has established system for use of check lists in different departments and services
ME G3.4	Actions are planned to address gaps observed during quality assurance process
ME G3.5	Planned actions are implemented through Quality Improvement Cycles (PDCA)
Standard G4	**Facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.**
ME G4.1	Departmental standard operating procedures are available
ME G4.2	Standard Operating Procedures adequately describes process and procedures
ME G4.3	Staff is trained and aware of the standard procedures written in SOPs
ME G4.4	The facility ensures documented policies and procedures are appropriately approved and controlled
Standard G5	**Facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages**
ME G5.1	Facility maps its critical processes
ME G5.2	Facility identifies non value adding activities / waste / redundant activities
ME G5.3	Facility takes corrective action to improve the processes
Standard G6	**The facility has defined Mission, values, Quality policy and objectives, and prepares a strategic plan to achieve them**
ME G6.1	Facility has defined mission statement
ME G6.2	Facility has defined core values of the organization
ME G6.3	Facility has defined Quality policy, which is in congruency with the mission of facility
ME G6.4	Facility has de defined quality objectives to achieve mission and quality policy
ME G6.5	Mission, Values, Quality policy and objectives are effectively communicated to staff and users of services
ME G6.6	Facility prepares strategic plan to achieve mission, quality policy and objectives
ME G6.7	Facility periodically reviews the progress of strategic plan towards mission, policy and objectives
Standard G7	**Facility seeks continually improvement by practicing Quality method and tools.**
ME G7.	Facility uses method for quality improvement in services
ME G7.2	Facility uses tools for quality improvement in services

Standard G8	**Facility has de defined, approved and communicated Risk Management framework for existing and potential risks.**
ME G8.1	Risk Management framework has been defined including context, scope, objectives and criteria
ME G8.2	Risk Management framework defines the responsibilities for identifying and managing risk at each level of functions
ME G8.3	Risk Management Framework includes process of reporting incidents and potential risk to all stakeholders
ME G8.4	A compressive list of current and potential risk including potential strategic, regulatory, operational, financial, environmental risks has been prepared
ME G8.5	Modality for staff training on risk management is defined
ME G8.6	Risk Management Framework is reviewed periodically
Standard G9	**Facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan**
ME G9.1	Risk management plan has been prepared and approved by the designated authority and there is a system of its updating at least once in a year
ME G9.2	Risk Management Plan has been effectively communicated to all the staff, and as well as relevant external stakeholders
ME G9.3	Risk assessment criteria and checklist for assessment have been defined and communicated to relevant stakeholders
ME G9.4	Periodic assessment for Physical and Electrical risks is done as per defined criteria
ME G9.5	Periodic assessment for potential disasters including re is done as per de defined criteria
ME G9.6	Periodic assessment for Medication and Patient care safety risks is done as per defined criteria.
ME G9.7	Periodic assessment for potential risk regarding safety and security of staff including violence against service providers is done as per defined criteria
ME G9.8	Risks identified are analyzed evaluated and rated for severity
ME G9.9	Identifed risks are treated based on severity and resources available
ME G9.10	A risk register is maintained and updated regularly to risk records identify ed risks, there severity and action to be taken
Standard G10	**The facility has established clinical Governance framework to improve quality and safety of clinical care processes**
ME G10.1	The facility has defined clinical governance framework
ME G10.2	Clinical Governance framework has been effectively communicated to all staff
ME G10.3	Clinical care assessment criteria have been defined and communicated
ME G10.4	Facility conducts the periodic clinical audits including prescription, medical and death audits
ME G10.5	Clinical care audits data is analysed, and actions are taken to close the gaps identified during the audit process
ME G10.6	Governing body of healthcare facilities ensures accountability for clinical care provided
ME G10.7	Facility ensures easy access and use of standard treatment guidelines & implementation tools at point of care
AREA OF CONCERN H - OUTCOME	
Standard H1	**The facility measures Productivity Indicators and ensures compliance with State/National benchmarks**
ME H1.1	Facility measures productivity Indicators on monthly basis
ME H1.2	Facility endavours to improve its productivity indicators to meet benchmarks
Standard H2	**The facility measures Efficiency Indicators and ensure to reach State/National Benchmark**
ME H2.1	Facility measures efficiency Indicators on monthly basis
ME H2.2	Facility endavours to improve its efficiency indicators to meet benchmarks

Standard H3	The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark
ME H3.1	Facility measures Clinical Care & Safety Indicators on monthly basis
ME H3.2	Facility endavours to improve its clincal & safety indicators to meet benchmarks
Standard H4	**The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark**
ME H4.1	Facility measures Service Quality Indicators on monthly basis
ME H4.2	Facility endavours to improve its service Quality indicators to meet benchmarks

VII INTRODUCTION TO DEPARTMENT CHECKLIST - TOOL FOR ASSESSMENT

As we discussed earlier, Checklist are the tools for measuring compliance to the Standards. We may also recall that "standards are statement of requirements that are critical for delivery of quality services".

These are cross sectional themes that may apply to all or some of the departments. Assessing every standard independently in each department may take lot of time and hence not practicable. Therefore for the convenience sake, all the applicable standards and measurable elements for one department have been collated in the checklists. It enables measurement of all aspect of quality of care in a department in one go. After assessing the departments on the checklist, their scores can be calculated to see compliance to different standards in the department.

There are twnety one checklists given District Hospital or equivalent Assessors Guidebooks (Volume I, II & III). Following is a brief description of checklists:

1. **Accident & Emergency Department** – This checklist is applicable to Accident & Emergency department of a hospital. The checklist has been designed to assess all aspects of dedicated emergency department. If emergency department is shared with OPD infrastructure then two checklists should be used independently.

2. **Out Patient Department** – This checklist is applicable to outdoor department of a hospital. It includes all clinics and support areas like immunization room, dressing room, waiting area and laboratory's sample collection centre, located there, except for Family planning Clinic (if co-located in OPD), which has been included in the post partum unit. Similarly dispensary has been included in the Pharmacy check list. This checklist also includes ICTC and ANC clinics. It may be possible that OPD services are dispersed geographically, for example ANC Clinic may not be located in the main OPD complex. Therefore, all such facilities should be visited.

3. **Operation Theatre –** This checklist is applicable for OT complex including General OT, Obstetrics & Gynaecology OT, Orthopaedics OT, Ophthalmic OT and any other facility for undertaking the surgeries (if available). Family planning/Postpartum OT is excluded from this checklist, which will be assessed through postpartum checklist. This checklist also includes CSSD /TSSU, either co-located within the OT complex or located separately.

4. **Intensive Care Unit –** This checklist is meant for assessing level II ICUs, which are recommended for District Hospitals. The ICU should have ventilators.

5. **Indoor Patient Department –** This is a common checklist for other indoors wards including Medical, Surgical, Orthopaedics, etc. In subsequent years, separate checklist for each ward may be included. However, as of now, this checklist should be used for all such departments.

6. **Blood Bank –** This checklist is applicable to Blood bank available within the premises of the hospital. This checklist covers the blood component services. This checklist is not meant for blood storage unit.

7. **Laboratory** – This checklist is meant for main clinical laboratory of the hospital and also includes the laboratory for testing TB and malaria cases under respective National Health programme. This does not include ICTC lab for HIV testing which is part of OPD checklist

8. **Labour Room (LaQshya)** – This checklist is applicable to the labour room(s) and its auxiliary area like nursing station, waiting area and recovery area. The checklist is focussed on improvement of care during delivery and immediate post-partum. The checklist would be used for LaQshya Assessment as well.

9. **Maternity Operation Theatre (LaQshya) –** This checklist is applicable to the Maternity Operation Theatre of the hospital. It focuses on the management of obstetric emergency services, improvement in Quality of Care during elective C-section. It also gives emphasis on safe anaesthetic and surgical procedures. If the hospital is providing services of general and obstetric cases in same OT, the Maternity Operation Theatre checklist will be applicable separately. It includes management of complications viz APH, PPH, pre-term, pre-eclampsia, eclampsia, obstructed labour etc. The checklist promotes use of safe birth checklist and also respectful maternal care to all pregnant women visiting the health care facilities.

10. **Maternity Ward** – This checklist is meant for assessment of indoor obstetric department including wards for Antenatal care, and Post-partum wards (including C-Section). The auxiliary area for these wards like nursing station, toilets and department sub stores are also included in this check-list. However, general female wards or family planning ward are not covered within the purview of maternity ward.

11. **Pediatric Out patient Department (MusQan)** – This checklist is applicable to dedicated Pediatric Outdoor department. Common childhood ailments' are identified, treated and managed. For specific childhood illness cases alike Opthalmology, ENT, Orthopaedics etc the hospital specific clinics should be visited. The emphasis is given on paediatric ambience, children friendly environment also services in Paediatric OPD should be co-located

12. **Paediatric Ward (MusQan) –** This checklist meant for a dedicated paediatric ward. If, there is no such ward in the hospital and paediatric patients are treated in other wards, then this checklist is not applicable at such health facilities.

13. **Sick Newborn Care Unit (MusQan) –** This checklist is applicable to a functional Level II SNCU, located in the Hospital. It includes auxiliary area like waiting area for relatives, side laboratory and duty rooms for the staff. This checklist is not meant for lower level of facilities like Newborn Stabilization units and Newborn corner.

14. **Nutritional Rehabilitation Centre (MusQan) –** This checklist is applicable to NRC functioning within the health facility. However, it may not be relevant, if management of malnourished patients is done in the paediatric wards.

15. **Post Partum Unit –** This checklist is applicable to Family Planning clinic, separate OT used for Family planning surgeries & abortion cases and separate indoor ward available to admit any such cases. Assessment of Post partum unit would be undertaken through this checklist.

16. **Radiology –** This checklist is applicable on X-ray and Ultrasound departments. This checklist does not cover technical checkpoints for CT Scan and MRI.

17. **Pharmacy –** This checklist is applicable on Drug store, Cold Chain storage and Drug dispensing counter. General store and Drug warehouse are not covered within ambit of this checklist.

18. **Auxiliary Services –** This checklist covers Laundry, Dietary and medical record department. If these departments are outsourced and even located outside the premises, then also this checklist can be used. Washing hospital linen in public water body like river or pond or food supplied by charitable/religious institutions does not constitute having Hospital laundry / kitchen per se.

19. **Mortuary –** This checklist is applicable to Mortuary and post-mortem room located at the hospital

20. **Haemodialysis centre** – This checklist is applicable to the haemodialysis centre. The haemodialysis centre could be a standalone centre with the diagnostic and other support within centre or linkage with the main hospital. This checklist is applicable to dialysis set-up provided by the government, PPP or mixed

21. **General Hospital Administration** – This checklist covers medical superintendent (equivalent) and hospital manager offices and processes related to their functioning. This also covers hospital policy level issues and hospital wide cross cutting processes. This checklist is complimentary to all other checklist. So if a hospital wants to choose only of some of the department for quality assurance initially, then this check list should always be included in the assessment programme.

A. General Principles

Assessment of the Quality at Public Health Facilities is based on general principles of integrity, confidentiality, objectivity and replicability:

1. **Integrity -** Assessors and persons managing assessment programmes should:
   - Perform their work with honesty, diligence and responsibility
   - Demonstrate their competence while performing assessment
   - Performance assessment in an impartial manner
   - Remain fair and unbiased in their findings
2. **Fair Presentation -** Assessment findings should represent the assessment activities truthfully and accurately. Any unresolved diverging opinion between assessors and assesses should be reported.
3. **Confidentiality -** Assessors should ensure that information acquired by them during the course of assessment is not shared with any authorised person including media. The information should not be used for personal gain.
4. **Independence -** Assessors should be independent to the activity that they are assessing and should act in a manner that is free from bias and conflict of interest. For internal assessment, the assessor should not assess his or her own department and process. After the assessment, assessor should handhold to guide the service providers for closing the gap and improving the services.
5. **Evidence based approach -** Conclusions should be arrived based on evidences, which are objective, verifiable and reproducible.

B. Planning Assessment Activities

Following assessment activities are undertaken at different level:

1. Internal Assessment at the facility level – A continuous process of assessment within the facility by internal assessors.
2. Assessment by District and State Quality Assurance Units
3. External assessment – Assessment by national assessors for the purpose for certification/ accreditation.

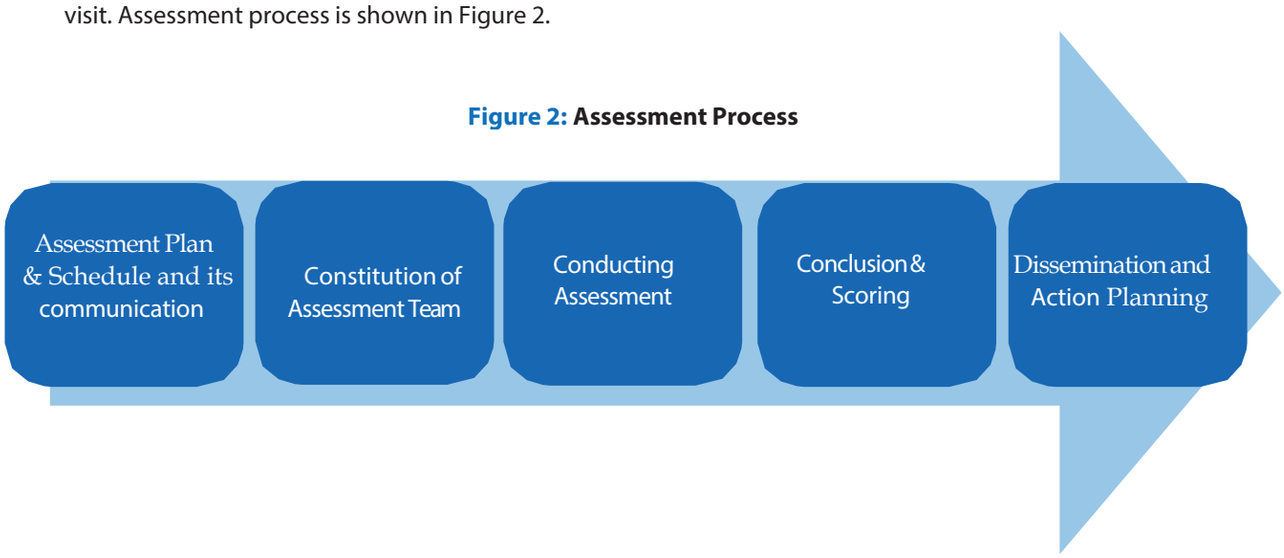
1. **Internal Assessment -** Internal assessment is a continuous process and integral part of facility based Quality assurance program. Assessing all departments in a health facility every month may not be possible. The hospital should prepare a quarterly assessment schedule. It needs to be ensured that every department would be assessed and scored at least once in a quarter. This plan should be prepared in consultation with respective departments. Quality team at the facility can also prioritize certain departments, where quality of services has been a cause of concern.

For internal assessment, the Hospital Quality Team should appoint a coordinator, preferably the hospital manager or quality manager, whose main responsibilities are given below:

1. Preparing assessment plan and schedule
2. Constitute an assessment team for internal assessment
3. Arrange stationary (forms & formats) for internal assessment
4. Maintenance of assessment records
5. Communicating and coordinating with departments
6. Monitor & review the internal assessment programme
7. Disseminate the findings of internal assessment
8. Preparation of action plan in coordination with quality team and respective departments.

2. **Assessment by DQAU/SQAU -** DQAU and SQAU are also responsible for undertaking an independent quality assessment of a health facility. Facilities having poor quality indicators would be at priority in the assessment programme. Visit for the assessment should also be utilized for building facility level capacity of quality assurance and hand holding. Efforts should be made to ensure that all departments of the hospital have been assessed during one visit. Assessment process is shown in Figure 2.

Figure 2: Assessment Process



3. **External Assessment -** When the health facility attains an overall score of 70 percent and above in the State Assessment, it is eligible to apply for the National Quality Assessment by duly filling the application performa (copy of the application format may be referred from the Operational Guidelines for improving quality in Public Health Facilities, 2021, Annexure L, page 130). The External Assessment is conducted by NHSRC through certified External Assessors empanelled with the Ministry of Health and Family Welfare.

C. Constituting Assessment Team

Assessment team should be constituted according to the scope of assessment i.e. departments to be assessed. Team assessing clinical department should have at least one person from clinical domain preferably a doctor, assessing patient care departments. Indoor departments should also have one nursing staff in the team. It would be preferable to have a multidisciplinary team having at least one doctor and one nurse during the external assessment. As DQAU/SQAU may not have their own capacity for arranging all team members internally, a person from another hospital may be nominated to be part of the assessment team. However, it needs to be ensured that person should not assess his/her own department and there is no conflict of interest. For external assessment, the team members should have undergone the assessors' training.

D. Preparing Assessment Schedule

Assessment schedule is a micro-plan for conducting assessment. It constitutes of details regarding departments, date, timing, etc. Assessment schedule should be prepared beforehand and shared with respective departments.

E. Performing Assessment

i. Pre-assessment preparation – Team leader of the assessment team should ensure that assessment schedule has been communicated to respective departments. Team leader should assign the area of responsibility to each team member, according to the schedule and competency of the members.

ii. Opening meeting – A short opening meeting with the assessee's department or hospital should be conducted for introduction, aims & objective of the assessment and role clarity.

iii. Reviewing documents – The available records and documents such as SOPs, BHT, Registers, etc should be reviewed.

F. Communication During Assessment

Behaviours and communication of the assessors should be polite and empathetic. Assessment should be fact finding exercise and not a fault finding exercise. Conflicts should be avoided.

G. Using Checklists

Checklists are the main tools for the assessment. Hence, familiarity with the tools would be important.

Figure 3: Sample checklist*

Checklist for Accident and Emergency						
Reference No.	**Measurable Element**	**Checkpoint**	**Compli-ance**	**Assess-ment Method**	**Means of Verification**	**Rem-arks**
Area of Concern - A Service Provision						
Standard A1	**Facility Provides Curative Services**					
ME A1.1	The facility provides General Medicine services	Availability of functional General Medicine Clinic		SI/OB	Dedicated General speciality Medicine Clinic	
ME A1.2	The facility provides General Surgery services	ailability of functional eneral Surgery Clinic		SI/OB	Dedicated General speciality Surgical Clinic	
ME A1.3	The facility provides Obstetrics & Gynaecology Services	Availability of Functional Obstetrics & Gynaecology Clinic		SI/OB	(a) Dedicated speciality Obstetrics & Gynaecology Clinic. (b) High-risk pregnancy cases are referred from the ANC clinic and consulted.	
ME A1.4	The facility provides Paediatric Services	Availability of Paediatric Clinic		SI/OB	Dedicated Paediatric speciality Clinic	

* ME denotes measurable elements of a standard, for which details have been provided in the Annexure 'A'.

a) Header of the checklist denotes the name of department for which checklist is intended.

b) The horizontal bar in grey colour contains the name of the Area of concern for which the underlying standards belong.

c) Extreme left column of checklist in blue colour contain the reference no. of Standard and Measurable Elements, which can used for the identification and traceability of the standard. When reporting or quoting, reference no of the standard and measurable element should also be mentioned.

d) Yellow horizontal bar contains the statement of standard which is being measured. There are a total of seventy five standards, but all standards may not be applicable to every department, so only relevant standards are given in yellow bars in the checklists.

e) Second column contains text of the measurable element for the respective standard. Only applicable measurable elements of a standard are shown in the checklists. Therefore, all measurable elements under a standard are not there in the departmental checklists. They have been excluded because they are not relevant to that department.

f) Next right to measurable elements are given the check points to measure the compliance to respective measurable element and the standard. It is the basic unit of measurement, against which compliance is checked and the score is awarded.

g) Right next to Checkpoint is a blank column for noting the findings of assessment, in term of Compliance:

- Full Compliance - 2
- Partial Compliance - 1
- Non Compliance - 0

h) Next to compliance column is the assessment method column. This denotes the 'HOW' to gather the information. Generally, there are four primary methods for assessment:

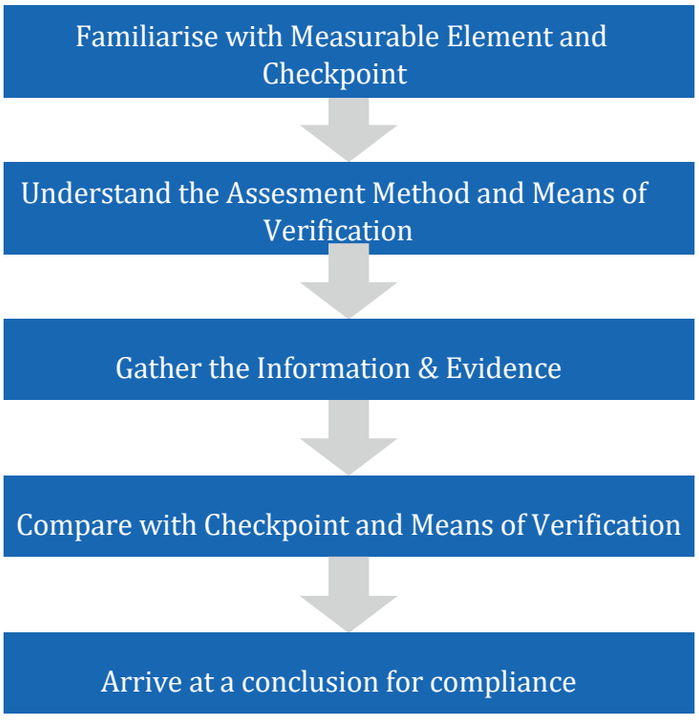
- SI: means Staff Interview
- OB: means Observation
- RR: means Record Review
- PI: means Patient Interview

i) Column next to assessment method contains means of verification. It denotes what to see at a Checkpoint. It may be a list of equipment or procedures to be observed, or question you have to ask or some benchmark, which could be used for comparison, or reference to some other guideline or legal document. It has been left blank, as the check point is self-explanatory.

j) The last column next to means of verification contains remarks. The assessors can provide their remarks based on their assessment against that particular checkpoint. The remarks could be helpful to understand the compliance given against that checkpoint. Please note, remark coulmn is intentionally not kept in the assessors' guidebook to manage the spacing of the assessors' guidebook

Assessor may use one of these methods to asses certain measurable element. Suggestive methods have been given in the Assessment method column against each checkpoint Means of verification has been given against each checkpoint. Normal flow of gathering information assessment would be as given in Figure 4:

Figure 4: Flow of Information



H. Assessment Methods

1. **Observation (OB):** Compliance against many of the measurable elements can be assessed by directly observing the articles, processes and surrounding environment. Few examples are given below:
   a) Enumeration of articles like equipment, drugs, etc.
   b) Displays of signages, work instructions, important information
   c) Facilities - patient amenities, ramps, complaint-box, etc.
   d) Environment – cleanliness, loose-wires, seepage, overcrowding, temperature control, drains, etc.
   e) Procedures like measuring BP, counseling, segregation of biomedical waste.

2. **Record Review (RR):** It may not be possible to observe all clinical procedures. Records also generate objective evidences, which need to be triangulated with finding of the observation. For example on the day of assessment, drug tray in the labour room may have adequate quantity of Oxytocin, but if review of the drug expenditure register reveals poor consumption pattern of Oxytocin, then more enquiries would be required to ascertain on the adherence to protocols in the labour room. Examples of the record review are:

a) Review of clinical records - delivery note, anaesthesia note, maintenance of treatment chart, operation notes, etc.

b) Review of department registers like admission registers, handover registers, expenditure registers, etc.

c) Review of licenses, formats for legal compliances like Blood bank license and Form 'F' for PNDT

d) Review of SOPs for adequacy and process

e) Review of monitoring records – TPR chart, Input/output chart, culture surveillance report, calibration records, etc.

f) Review of department data and indicators

3. **Staff Interview (SI):** Interaction with the staff helps in assessing the knowledge and skill level, required for performing job functions

   Examples include:

   a) Competency testing – Quizzing the staff on knowledge related to their job

   b) Demonstration – Asking staff to demonstrate certain activities like hand-washing technique, new born resuscitation, etc.

   c) Awareness - Asking staff about awareness of patient's right, quality policy, handling of high alerts drugs, etc.

   d) Attitude about patient's dignity and gender issues.

   e) Feedback about adequacy of supplies, problems in performing work, safety issues, etc.

4. **Patient Interview (PI):** Interaction with patients/clients may be useful in getting information about quality of services and their experience in the hospital. It gives us users' perspective. It should include:

   a) Feedback on quality of services staff behaviour, food quality, waiting times, etc.

   b) Out of pocket expenditure incurred during the hospitalization

   c) Effective communication like counseling services and self-drug administration

I. Assessment conclusion

After gathering information and evidence for measurable elements, assessors should arrive at a conclusion for extent of compliance - full, partial or non-compliance for each of the checkpoints. If the information and evidence collected gives an impression of not fully meeting the requirements, it could be given 'Partial compliance', provided there some evidences pointing towards the compliance. Non-compliance should be given of none or very few of the requirements are being met.

After arriving on conclusion, assessor should mark '2' for full compliance, '1' for partial compliance and '0' for non-compliance in Compliance column.

IX SCORING SYSTEM

If you can't measure something, you can't understand it. If you can't understand it, you can't control it. If you can't control it, you can't improve it. Therefore, measuring quality of care forms the path for its improvement. Following the same approach, National Quality Assurance Standards are constituted of the following four parameters:

1. **Area of Concern:** They are broad area/ themes for assessing different aspects for quality like Service provision, Patient Rights, Infection Control etc.
2. **Standards:** They are statements of requirement for particular aspects of quality.
3. **Measurable Element:** These are specific attributes of a standard which should be looked into for assessing the degree of compliance to a particular standard.
4. **Checkpoint:** Tangible measurable checkpoints are those, which can be objectively observed and scored.

Ammalgamation of all these four parameters in a systemic manner constitute a checklist, which may be departmental or thematic.

For Example:

S. No.	Parameter	Example
1	Area of Concern	Area of Concern F: Infection Control
2	Standard	Standard F2: Facility has defined and implemented procedures for ensuring hand hygiene practices and antisepsis
3	Measurable Element	ME F2.1: Hand washing facilities are provided at point of use
4	Checkpoint	Facility ensures uninterrupted and adequate supply of antiseptic soap and alcohol hand rub in all departments

After assessing all the measurable elements and checkpoints and marking compliance, scores of the department/facility can be calculated

Rules of Scoring

Measure of Compliance	Marks to be given	Attributes
• Full compliance	2	• All Requirements in Checkpoint are Meeting • All Tracers given in Means of verification are available • Intent of Measurable Element is meeting
• Partial compliance	1	• Some of the requirements in checkpoints are meeting • At Least 50-99% of tracers in Means of verification are available • Intent of Measurable Element is partially meeting
• Non-compliance	0	• Most of the requirements are not meeting • Less than 50% of tracers in Means of verification are available • Intent of Measurable Element is not meeting

All checkpoints have equal weightage to keep scoring simple

Once scores have been assigned to each checkpoint, department wise scores can be calculated for the departments, and also for standards by adding the individual scores for the checkpoints

The final score should be given in percentage, so it can be compared with other groups and department Calculation of percentage is as follows:

$$\frac{\text{Score obtained X 100}}{\text{No. of checkpoint in checklist X 2}}$$

Scores can be calculated manually or scores can be entered into excel sheet given in the accompanying soft copy to get score card. All scores should be in percentages to have uniform unit for inter-departmental and inter-hospital comparison.

The assessment scores can be presented in three ways:

1. **Departmental Scorecard:** This score-card presents the Quality scores of a department. It shows the overall quality score of the department as well as the area of concern wise score in term of percentages. This score card can be generated by two way:

   a. If calculations are done manually departmental score can be calculated by simple formula given above, and filled-in score card format given at the top of checklist

   b. If using excel tool given with this guide book, the scorecard will be generated automatically after filling a score for all checkpoints

   Figure 5 is an example of a filled in score-card after assigning and calculating scores. Score given in the yellow box denotes the overall quality score of the department in percentage.

   Scores given in blue label are area of concern wise scores of the department in percentage.

Figure 5: Sample of filled-in Score card for Outdoor Patient Department

OPD Score Card			
Area of Concern wise Score			OPD Score
A	Service Provision	95%	80%
B	Patient Rights	83%	
C	Inputs	84%	
D	Support Services	73%	
E	Clinical Services	79%	
F	Infection Control	62%	
G	Quality Management	83%	
H	Outcome	82%	

2. **Hospital Quality Scorecard**

   This scorecard depicts departmental and overall quality score of hospital in a snapshot. Another variant depicts area of Concern wise scores of the Hospital.

   Figure 6 is an example of hospital score card generated after calculation of scores for all departments in the hospital. Yellow label depicts the overall score of the hospital in percentage by taking average of departmental scores. Rest of the boxes in blue label shows individual scores of the departments.

Figure 6: **Sample Score card of a Hospital with Departmental Score**

<table>
<tr><th colspan="7">Hospital Score Card (Department wise)</th></tr>
<tr><td>Accident & Emergency
64%</td><td>OPD
72%</td><td>Labour Room
88%</td><td>Maternity Ward
82%</td><td>Paediateric OPD
88%</td><td colspan="2" rowspan="2">Hospital Score
76%</td></tr>
<tr><td>Paediateric Ward
86%</td><td>SNCU
73%</td><td>NRC
57%</td><td>OT
79%</td><td>M- OT
85%</td></tr>
<tr><td>PP Unit
77%</td><td>ICU
67%</td><td>IPD
73%</td><td>Blood Bank
74%</td><td>Laboratory
78%</td><td>LaQshya Score</td><td>MusQan Score</td></tr>
<tr><td>Radiology
71%</td><td>Pharmacy
71%</td><td>Auxillary
73%</td><td>Mortuary
72%</td><td>Haemodialysis Centre
78%</td><td rowspan="2">87%</td><td rowspan="2">76%</td></tr>
<tr><td colspan="5">General Administration
80%</td></tr>
</table>

3. **Area of concern wise Scorecard:** Figure 7 gives a sample score card for each of eight areas of concern. These have been calculated by taking average of area of concern score of all departments. Yellow label shows the overall score of Hospital.

Figure 7: **Sample Scorecard of a Hospital with Area of Concern Score**

<table>
<tr><th colspan="4">HOSPITAL QUALITY SCORE CARD AREA OF CONCERN WISE</th></tr>
<tr><td>Service Provision
72%</td><td>Patient Rights
66%</td><td>Inputs
78%</td><td>Support Services
59%</td></tr>
<tr><td colspan="4">Hospital Score</td></tr>
<tr><td colspan="4">70%</td></tr>
<tr><td>Clinical Services
85%</td><td>Infection Control
75%</td><td>Quality Management
70%</td><td>Outcome
55%</td></tr>
</table>

4. **Standard-wise Scorecard:** Apart from these scorecards, the tool provided in the accompanying QR code for DH Checklist (given at the end of the book) provides flexibility to present scores according to your choice. You can choose some of the area and themes like RMNCHA, Patient Safety, etc, as per requirement.

   There are endless possibilities the way you can represent your quality scores.

Figure 8 depicts a sample scorecard with the Standards under various Area of Concern. Yellow label shows the standards. The calculated score of each standard against NQAS is visible in grey label, while the score against LaQshya is visible in blue label and the score against the MusQan is visible in green label.

Figure 8: Sample Scorecard of a Hospital with Standard-wise Score

Reference No	Area of Concern & Standards	NQAS Score	LaQshya Score	MusQan Score
Area of Concern A- Service Provision				
Standard A1	Facility Provides Curative Services	100%	100%	100%
Standard A2	Facility provides RMNCHA Services	100%	100%	100%
Standard A3	Facility Provides diagnostic Services	100%	100%	100%
Standard A4	Facility provides services as mandated in national Health Programs/ state scheme	100%	NA	100%
Standard A5	Facility provides support services	100%	NA	100%
Standard A6	Health services provided at the facility are appropriate to community needs.	100%	NA	100%
Area of Concern B- Patient Rights				
Standard B1	Facility provides the information to care seekers, attendants & community about the available services and their modalities	100%	100%	100%
Standard B2	Services are delivered in a manner that is sensitive to gender, religious, and cultural needs, and there are no barrier on account of physical economic, cultural or social reasons.	100%	100%	100%
Standard B3	Facility maintains the privacy, confidentiality & Dignity of patient and related information.	100%	100%	100%
Standard B4	Facility has defined and established procedures for informing and involving patient and their families about treatment and obtaining informed consent wherever it is required.	100%	100%	100%
Standard B5	Facility ensures that there are no financial barrier to access and that there is financial protection given from cost of care.	100%	100%	100%
Standard B6	Facility has defined framework for ethical management including dilemmas confronted during delivery of services at public health facilities	100%	NA	100%

सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

PART-B

DEPARTMENTAL CHECKLISTS

सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

CHECKLIST-1

ACCIDENT & EMERGENCY DEPARTMENT

CHECKLIST FOR ACCIDENT & EMERGENCY DEPARTMENT

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
AREA OF CONCERN - A SERVICE PROVISION					
Standard A1	**Facility Provides Curative Services**				
ME A1.1	The facility provides General Medicine services	Availability of Emergency Medical Procedures		SI/OB	Poisoning, Snake Bite, CVA, Acute MI, ARF, Hypovolemic Shock , Dyspnoea, Unconscious Patients
ME A1.2	The facility provides General Surgery services	Availability of Emergency Surgical Procedures		SI/OB	Appendicitis, Rupture spleen, Intestinal Obstruction, Assault Injuries, perforation, Burns
ME A1.4	The facility provides paediatrics services	Availability of emergency Paediatric procedures		SI/OB	ARI, Diarrhoeal diseases, Hypothermia, PEM,resustication
ME A1.5	The facility provides Ophthalmology Services	Availability of Emergency Ophthalmology procedures		SI/OB	Foreign body and injuries
ME A1.6	The facility provides ENT Services	Availability of Emergency ENT procedures		SI/OB	Epitasis, foreign body
ME A1.7	The facility provides Orthopaedics Services	Availability of Emergency Orthopaedic procedures		SI/OB	Fracture, RTA, Poly trauma
ME A1.9	The facility provides Psychiatry Services	Availability of Emergency Psychiatric procedures		SI/OB	Conversion Reactions, other Psychiatric emergencies Hysteria, mania, psychosis
ME A1.13	The facility provides services for OPD procedures	Availability of Dressing room facility		SI/OB	Drainage, dressing, suturing
		Availability of injection room facilities		SI/OB	Injection room facility with ARV, ASV and emergency drugs
ME A1.14	Services are available for the time period as mandated	24X7 availability of dedicated emergency Services		SI/RR	
ME A1.16.	The facility provides Accident & Emergency Services	Availability of Emergency procedures		SI/OB	Defibrillation, CPR, Mobilization, Chest Tube, Intubations, Tracheotomy, Mechanical Ventilation
Standard A2	**Facility provides RMNCHA Services**				
ME A2.2	The facility provides Maternal health Services	Availability of Emergency Gynaecology procedure		SI/OB	(a) Primary management of Severe pelvic pain, severe vaginal bleeding, vulvar abscesses & toxic shock syndrome etc.

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
					(b) Emergency laparotomy - Due to uterine perforation, septic abortion, pelvic abscess, ectopic pregnancy
ME A2.4	The facility provides Child health Services	Triage and emergency management of paediatric cases		SI/OB	
Standard A3	**Facility Provides diagnostic Services**				
ME A3.1	The facility provides Radiology Services	Availability / Linkage to X-ray & USG services		SI/OB	
		Radiology Services are functional 24X7		SI/OB	Check services are functional at night
ME A3.2	The facility Provides Laboratory Services	Availability of Emergency diagnostic tests 24x7		SI/OB	HB%, CPC, Blood Sugar, RDK, Urine Protein, Electrolyte (Na+K)
ME A3.3	The facility provides other diagnostic services, as mandated	Availability of Functional ECG Services		SI/OB	
Standard A4	**facility provides services as mandated in national health programs/state scheme**				
ME A4.8	The facility provides services under National Programme for Prevention and control of Cancer, Diabetes, Cardiovascular diseases & Stroke (NPCDCS) as per guidelines	Availability emergency services cardiovascular diseases & cerebro vascular attack		SI/OB	Acute chest pain, Acute / chronic hypertension, pulmonary oedema, congestive cardiac failure & acute arrhythmias
Standard A5	**Facility provides support services**				
ME A5.3	The facility provides security services	Availability of Police post		SI/OB	
ME A5.7	The facility has services of medical record department	Availability of Medico-legal record services		SI/OB	
Standard A6	**Health services provided at the facility are appropriate to community needs.**				
ME A6.1	The facility provides curatives & preventive services for the health problems and diseases, prevalent locally.	Availability of specific procedures for local prevalent emergencies		SI/OB	Ask for the specific local health frequent emergencies. See if emergency is ready for it or not.
AREA OF CONCERN - B PATIENT RIGHTS					
Standard B1	**Facility provides the information to care seekers, attendants & community about the available services and their modalities**				
ME B1.1	The facility has uniform and user-friendly signage system	Availability departmental signages.		OB	Emergency department board is prominently displayed with facility of illumination in night.
		Availability of Directional Signages.		OB	Direction is displayed from main gate to direct.

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME B1.2	The facility displays the services and entitlements available in its departments	List of services including emergencies that are managed at the facility		OB	
		Names of doctor and nursing staff on duty are displayed and updated		OB	
		List of drugs available are displayed		OB	
		Important numbers including ambulance, blood bank , police and referral centres displayed		OB	
ME B1.6	Information is available in local language and easy to understand	Signage's and information are available in local language		OB	
ME B1.7	The facility provides information to patients and visitor through an exclusive set-up.	Enquiry services are available 24X7.		OB	Enquiry services may be provided by registration clerk/Nurse in a small set up. For large and busy emergency departments there should be dedicated enquiry counter
ME B1.8	The facility ensures access to clinical records of patients to entitled personnel	Treatment note/ discharge note is given to patient		RR/OB	
Standard B2	**Services are delivered in a manner that is sensitive to gender, religious, and cultural needs, and there are no barrier on account of physical economic, cultural or social reasons.**				
ME B2.1	Services are provided in manner that are sensitive to gender	Separate room for examination of rape victims		OB	
		Availability of sexual assault forensic evidence kit		OB	
		Availability of protocols / guidelines for collection of forensic evidence in case of rape victim		OB /RR	
		Counselling services are available for rape victim and domestic violence		OB/RR	
		Availability of female staff if a male doctor examine a female patients		OB/SI	
		Separate toilets for male and females		SI/OB	
		Demarcated male and female observation areas		OB	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME B2.3	Access to facility is provided without any physical barrier & and friendly to people with disabilities	Availability of Wheel chair/ stretcher for emergency		OB	
		Emergency is located at ground floor with availability of ramp and railing		OB	At least 120 cm width, gradient not steeper than 1:12
		Ambulance has direct access to the receiving/ triage area of the emergency.		OB	No vehicle parked on the way /in front of emergency entrance. Access road to emergency is wide enough for streamline moment of emergency
		Availability of specially abled friendly toilet		OB	
Standard B3	**Facility maintains the privacy, confidentiality & Dignity of patient, and has a system for guarding patients related information**				
ME B3.1	Adequate visual privacy is provided at every point of care	Screens provided at emergency		OB	At the examination and procedure area.
ME B3.2	Confidentiality of patients records and clinical information is maintained	Confidentiality of patient record maintained		SI/OB	1. No information regarding patient / parent identity is displayed 2. Records are not shared with anybody without written permission of parents & appropriate hospital authorities
		MLC cases are kept in secure place beyond access of general public		SI/OB	
ME B3.3	The facility ensures the behaviours of staff is dignified and respectful, while delivering the services	Behaviour of staff is empathetic and courteous		OB/PI	
ME B3.4	The facility ensures privacy and confidentiality to every patient, especially of those conditions having social stigma, and also safeguards vulnerable groups	Privacy and confidentiality of HIV, Rape, suicidal cases, domestic violence and psychotic cases		SI/OB	
Standard B4	**Facility has defined and established procedures for informing patients about the medical condition, and involving them in treatment planning, and facilitate informed decision making patient.**				
ME B4.1	There is established procedures for taking informed consent before treatment and procedures	Consent is taken for invasive emergency procedures		SI/RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME B4.2	Patient is informed about his/her rights and responsibilities	Display of patient rights and responsibilities.		OB	
ME B4.3	Staff are aware of Patients rights responsibilities	Staff is aware about patient rights and responsibilities		SI	
ME B4.4	Information about the treatment is shared with patients or attendants, regularly	Patient is informed about her clinical condition and treatment been provided		PI	Ask patients about what they have been communicated about the treatment plan
ME B4.5	The facility has defined and established grievance redressal system in place	Availability of complaint box and display of process for grievance redressal and whom to contact is displayed		OB	
Standard B5	**Facility ensures that there are no financial barrier to access and that there is financial protection given from cost of hospital services.**				
ME B5.1	The facility provides cashless services to pregnant women, mothers and neonates as per prevalent government schemes	Emergency services are free for all including pregnant woman, neonate and children		PI/SI	
ME B5.2	The facility ensures that drugs prescribed are available at Pharmacy and wards	Check that patient party has not spent on purchasing drugs or consumables from outside.		PI/SI	
ME B5.3	It is ensured that facilities for the prescribed investigations are available at the facility	Check that patient party has not spent on diagnostics from outside.		PI/SI	
ME B5.4	The facility provide free of cost treatment to Below poverty line patients without administrative hassles	Free Emergency Consultation for BPL patients		PI/SI/RR	
Standard B6	**Facility has defined framework for ethical management including dilemmas confronted during delivery of services at public health facilities**				
ME B6.6	There is an established procedure for 'end-of-life' care	End of life policy & procedure are available and followed		SI/RR	The policy clearly defines the procedures for managing critical cases in the ward, HDU/ICU, brain-dead patients, conscious patients with serious diseases like motor neurons and brought-in dead cases. It also includes: (a) Patient and family have the right to be informed about their condition and make choices about the treatment (b) Withhold or withdraw life-sustaining treatment (c) Organ donation as per NOTTO &India's Governing organ donation law

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
					(d) All the decisions should be transparent and documented
		Staff is educated & trained for end of life care		SI/RR	
		The patient's Relatives informed clearly about the deterioration in the health condition of Patient.		SI/RR	Periodic update on the patient's condition is given to the family.
		Hospital has documented policy for pain management		SI/OB	
		Screening of the patient for pain		SI/RR	Symptomatic treatment is given to the patient to prevent complications to extent possible
		Pain alleviation measures or medication is initiated & titrated as per need and response		SI/RR	
ME B 6.7	There is an established procedure for patients who wish to leave hospital against medical advice or refuse to receive specific c treatment	Declaration is taken from the LAMA patient		RR/SI	Consequences of LAMA are explained to patient/ relative
AREA OF CONCERN - C INPUTS					
Standard C1	**The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms**				
ME C1.1	Departments have adequate space as per patient or work load	Adequate space for accommodating emergency load		OB	1000 square meters per 100 patient daily loads
		Availability of adequate waiting area		OB	
ME C1.2	Patient amenities are provide as per patient load	Availability of seating arrangement in the waiting area		OB	
		Availability of cold Drinking water		OB	
		Availability of functional toilets		OB	
ME C1.3	Departments have layout and demarcated areas as per functions	Demarcated trolley bay		OB	
		Demarcated receiving / triage areas		OB	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Demarcated Nursing station		OB	
		Demarcated duty room for doctor /nurse		OB	
		Demarcated resuscitation area		OB	
		Demarcated observation area/beds		OB	
		Demarcated dressing area /room		OB	
		Demarcated injection room		OB	
		Demarcated area for keeping serious patient for intensive monitoring		OB	
		Demarcated areas for keeping dead bodies.		OB	Separate room or linkage with mortuary/ Post mortem room
		Lay out is flexible		OB	All the fixture and furniture are movable to rearrange the different areas in case of mass casualty
		Dedicated Minor OT		OB	
		Shaded porch for ambulance		OB	
		availability of clean and dirty utility room		OB	
ME C1.4	The facility has adequate circulation area and open spaces according to need and local law	Corridors at Emergency are broad enough for easy moment of stretcher and trolley		OB	2-3 meter
ME C1.5	The facility has infrastructure for intramural and extramural communication	Availability of functional telephone and Intercom Services		OB	
		The ambulance(s) has a proper communication system(at least cell phone)		OB	
ME C1.6	Service counters are available as per patient load	Availability of emergency beds as per load		OB	5% of the total beds
		Availability of buffer beds for handling mass causality and disaster			

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME C1.7.	The facility and departments are planned to ensure structure follows the function/ processes (Structure commensurate with the function of the hospital)	Unidirectional flow of services.		OB	Receiving/Triage-Resuscitation-observation beds- Procedures area. There is no crises cross
		Separate entrance for emergency department		OB	Entrance of Emergency should not be shared with OPD and IPD
		Emergency has functional linkage with Major OT , ICU and labour room , Indoors and laboratories		OB/SI	
		Emergency is located near to the entry of the hospital		OB	
Standard C2.	**The facility ensures the physical safety of the infrastructure.**				
ME C2.1	The facility ensures the seismic safety of the infrastructure	Non structural components are properly secured		OB	Check for fixtures and furniture like cupboards, cabinets, and heavy equipment , hanging objects are properly fastened and secured
ME C2.3	The facility ensures safety of electrical establishment	Emergency department does not have temporary connections and loosely hanging wires		OB	
ME C2.4	Physical condition of buildings are safe for providing patient care	Floors of the Emergency are non slippery and even		OB	
		Windows have grills and wire meshwork		OB	
Standard C3	**The facility has established Programme for fire safety and other disaster**				
ME C3.1	The facility has plan for prevention of fire	Emergency has sufficient fire exit to permit safe escape to its occupant at time of fire		OB/SI	
		Check the fire exits are clearly visible and routes to reach exit are clearly marked.		OB	
ME C3.2	The facility has adequate fire fighting Equipment	Emergency has installed fire Extinguisher that is Class A , Class B, C type or ABC type		OB	
		Check the expiry date for fire extinguishers are displayed on each extinguisher as well as due date for next refilling is clearly mentioned		OB/RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME C3.3	The facility has a system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation	Check for staff competencies for operating fire extinguisher and what to do in case of fire		SI/RR	
Standard C4	**The facility has adequate qualified and trained staff, required for providing the assured services to the current case load**				
ME C4.1	The facility has adequate specialist doctors as per service provision	Availability of specialist Doctor		OB/RR	Check for specialist on call/ full time
ME C4.2	The facility has adequate general duty doctors as per service provision and work load	Availability of emergency medical officer		OB/RR	
ME C4.3	The facility has adequate nursing staff as per service provision and work load	Availability of Nursing staff		OB/RR/SI	At least 2 in day and 1 in night
ME C4.4	The facility has adequate technicians/ paramedics as per requirement	Availability of dresser / paramedic		OB/SI	
ME C4.5	The facility has adequate support / general staff	Dedicated 24X7 house keeping staff		SI/RR	
		availability of dedicated security guards 24X7		SI/RR	
		Availability of registration clerk		SI/RR	
		Availability of Drivers for Ambulance 24X7		SI/RR	103/108/State specific ambulance services
Standard C5	**Facility provides drugs and consumables required for assured list of services.**				
ME C5.1	The departments have availability of adequate drugs at point of use	Availability of Analgesics/ Antipyretics/Anti Inflammatory		OB/RR	Tracers as per State's EML
		Availability of Anti-Infective/Antibiotics		OB/RR	Tracers as per State's EML
		Availability of Solutions Correcting Water, Electrolyte Disturbances and Acid-Base Disturbances		OB/RR	Tracers as per State's EML
		Availability of Drugs acting on Cardiovascular System		OB/RR	Tracers as per State's EML

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Availability of drugs action on Central nervous system and peripheral nervous system		OB/RR	Tracers as per State's EML
		Availability of dressing material and antiseptics		OB/RR	Tracers as per State's EML
		Availability of drugs for Respiratory System		OB/RR	Tracers as per State's EML
		Availability of Hormonal Preparation		OB/RR	Tracers as per State's EML
		Availability of emergency drugs in ambulance		OB/RR	Tracers as per State's EML
		Availability of drugs for obstetric emergencies		OB/RR	Magnesium sulphate, Oxytocin, Plasma Expanders
		Availability of Medical gases		OB/RR	Availability of Oxygen Cylinders
		Availability of Immunological/vaccines		OB/RR	Polyvalent Anti snake Venom, Anti tetanus Human Immunoglobin
		Availability of Antidotes and Other Substances used in Poisoning		OB/RR	Activated charcoal, Anti-snake venom
ME C5.2	The departments have adequate consumables at point of use	Resuscitation Consumables / Tubes		OB/RR	Masks, Ryles tubes, Catheters, Chest Tube, ET tubes etc
		Availability of disposables at dressing room		OB/RR	
		Availability of consumables in ambulance		OB/RR	Dressing material / Suture material
ME C5.3	Emergency drug trays are maintained at every point of care, where ever it may be needed	Emergency Drug Tray/ Crash Cart is maintained at emergency		OB/RR	
Standard C6	**The facility has equipment & instruments required for assured list of services.**				
ME C6.1	Availability of equipment & instruments for examination & monitoring of patients	Availability of functional Equipment &Instruments for examination & Monitoring		OB	BP apparatus, Multiparameter Torch, hammer , Spot Light
		Availability of Monitoring equipment in ambulance		OB	
ME C6.2	Availability of equipment & instruments for treatment procedures, being undertaken in the facility	Availability of dressing tray for Emergency procedures		OB	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Dressing tray are in adequate numbers as per load		OB	
		Availability of instruments for emergency Gynae procedure		OB	
ME C6.3	Availability of equipment & instruments for diagnostic procedures being undertaken in the facility	Availability of Point of care diagnostic devices		OB	Glucometer, ECG and HIV rapid diagnostic kit
ME C6.4	Availability of equipment and instruments for resuscitation of patients and for providing intensive and critical care to patients	Availability of functional Instruments for Resuscitation.		OB	Ambu bag, defibrillator, layrngo scope, nebulizer, suction apparatus , LMA
		Availability of resuscitation equipment in ambulance		OB	
ME C6.5	Availability of Equipment for Storage	Availability of equipment for storage for drugs		OB	Refrigerator, Crash cart/ Drug trolley, instrument trolley, dressing trolley
ME C6.6	Availability of functional equipment and instruments for support services	Availability of equipment for cleaning and sterilization		OB	Buckets for mopping, mops, duster, waste trolley, Deck brush, Boiler
ME C6.7	Departments have patient furniture and fixtures as per load and service provision	Availability of patient beds with prop up facility, attachments and accessories		OB	Hospital graded Mattress, IV stand, bed rails, Bed pan
		Availability of fixtures		OB	Spot light, electrical fixture for equipment like suction, monitor and defibrillator, X ray view box
		Availability of furniture at emergency		OB	Doctors Chair, Patient Stool, Examination Table, Chair, Table, Footstep, cupboard
Standard C7	**Facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff**				
ME C7.1	Criteria for Competence assessment are defined for clinical and Para clinical staff	Check parameters for assessing skills and proficiency of clinical staff has been defined		SI/RR	Check objective checklist has been prepared for assessing competence of doctors, nurses and paramedical staff based on job description defined for each cadre of staff. Dakshta checklist issued by MoHFW can be used for this purpose.

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME C7.2	Competence assessment of Clinical and Para clinical staff is done on predefined criteria at least once in a year	Check for competence assessment is done at least once in a year		SI/RR	Check for records of competence assessment including filled checklist, scoring and grading . Verify with staff for actual competence assessment done
ME C7.9	The Staff is provided training as per defined core competencies and training plan	Triage and Mass Casualty Management		SI/RR	
		Basic life support (BLS)/ Advance life support (ALS)		SI/RR	
		Infection control & prevention training		SI/RR	Bio medical Waste Management including Hand Hygiene
		Training on Quality Management System			
		Patient Safety			
ME C7.10	There is established procedure for utilization of skills gained thought trainings by on -job supportive supervision	Staff is skilled for emergency procedures		SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps
		Staff is skilled for resuscitation and use defibrillator		SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps
		Staff is skilled for maintaining clinical records		SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps
AREA OF CONCERN - D SUPPORT SERVICES					
Standard D1	**The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.**				
ME D1.1	The facility has established system for maintenance of critical Equipment	All equipment are covered under AMC including preventive maintenance		SI/RR	1. Check with AMC records/ Warranty documents 2. Staff is aware of the list of equipment covered under AMC.

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		There is system of timely corrective break down maintenance of the equipment		SI/RR	1.Check for breakdown & Maintenance record in the log book 2. Staff is aware of contact details of the agency/person in case of breakdown.
		There has system to label Defective/Out of order equipment and stored appropriately until it has been repaired		OB/RR	
		Staff is skilled for trouble shooting in case equipment malfunction		SI/RR	(1) Staff is trained for use, preventive maintenance and trouble shooting of equipment such as radiant warmers, infusion pump, oxygen concentrator, bag &mask, weighting machine, phototherapy unit. (2) There is procedure to check timely replacement of lights in Phototherapy unit.
ME D1.2	The facility has established procedure for internal and external calibration of measuring Equipment	All the measuring equipment/ instrument are calibrated		OB/ RR	
ME D1.3	Operating and maintenance instructions are available with the users of equipment	Operating instructions for critical equipment are available		OB/SI	
Standard D2	**The facility has defined procedures for storage, inventory management and dispensing of medicines and consumables in pharmacy and patient care areas**				
ME D2.1	There is established procedure for forecasting and indenting drugs and consumables	There is established system of timely indenting of consumables and drugs		SI/RR	Stock level are daily updated Indents are timely placed
ME D2.3	The facility ensures proper storage of drugs and consumables	Drugs are stored in containers/tray/crash cart and are labelled		OB	Labelled with drug name, drug strength and expiry date
		Empty and filled cylinders are labelled		OB	
ME D2.4	The facility ensures management of expiry and near expiry drugs	Drugs expiry dates' are maintained at emergency drug tray		OB/RR	
		No expired drug found		OB/RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Records for expiry and near expiry drugs are maintained for drug stored at department		RR	Check register/DVDMS/ other supply chain software for record of stock of expired and near expiry drugs
ME D2.5	The facility has established procedure for inventory management techniques	There is practice of calculating and maintaining buffer stock in Emergency		SI/RR	
		Department maintained stock register of drugs and consumables in Emergency		RR/SI	Record of drug received, issued and balance stock of drug in hand
		There is practice of calculating and maintaining buffer stock in ambulance		SI/RR	
		Department maintained stock register of drugs and consumables in ambulance		RR/SI	Check record of drug received, issued and balance stock in hand
ME D2.6	There is a procedure for periodically replenishing the drugs in patient care areas	There is established procedure for replenishing drug tray emergency crash cart		SI/RR	
		There is established procedure for replenishing drug tray emergency crash cart in ambulance		OB/SI	
		There is no stock out of drugs		SI/RR	Random stock check of some essential medicines. E.g. Paracetamol, Atenolol, Amlodipine, Azithromycin, etc.
ME D2.7	There is process for storage of vaccines and other drugs, requiring controlled temperature	Temperature of refrigerators are kept as per storage requirement and records twice a day and are maintained		OB/RR	Check for refrigerator/ ILR temperature charts. Charts are maintained and updated twice a day
ME D2.8	There is a procedure for secure storage of narcotic and psychotropic drugs	Narcotics and psychotropic drugs are kept separately in lock and key		OB/SI	
Standard D3	**The facility provides safe, secure and comfortable environment to staff, patients and visitors.**				
ME D3.1	The facility provides adequate illumination level at patient care areas	Adequate illumination at procedure area		OB	Resuscitation area, dressing room and examination area
		Adequate illumination at receiving and triage area		OB	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME D3.2	The facility has provision of restriction of visitors in patient areas	Visitors are restricted at resuscitation and procedure area		OB/SI	
ME D3.3	The facility ensures safe and comfortable environment for patients and service providers	Temperature control and ventilation in patient care area		PI/OB	Fans/ Air conditioning/ Heating/Exhaust/ Ventilators as per environment condition and requirement
		Temperature control and ventilation in nursing station/duty room		SI/OB	Fans/ Air conditioning/ Heating/Exhaust/ Ventilators as per environment condition and requirement
ME D3.4	The facility has security system in place at patient care areas	There are set procedures for handling mass situation and violence in emergency		SI/OB	See for linkage to police, self protection form staff
		Hospital has sound security system to manage overcrowding in emergency		OB/SI	
ME D3.5	The facility has established measure for safety and security of female staff	Ask female staff whether they feel secure at work place		SI	
Standard D4	**The facility has established Programme for maintenance and upkeep of the facility**				
ME D4.1	Exterior of the facility building is maintained appropriately	Building is painted/ whitewashed in uniform colour		OB	
		Interior of patient care areas are plastered & painted		OB	
ME D4.2	Patient care areas are clean and hygienic	Floors, walls, roof, roof topes, sinks patient care and circulation areas are Clean		OB	All area are clean with no dirt,grease,littering and cobwebs
		Surface of furniture and fixtures are clean		OB	
		Toilets are clean with functional flush and running water		OB	
ME D4.3	Hospital infrastructure is adequately maintained	Check for there is no seepage , Cracks, chipping of plaster		OB	
		Window panes , doors and other fixtures are intact		OB	
		Patients beds are intact and painted		OB	Mattresses are intact and clean

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME D4.5	The facility has policy of removal of condemned junk material	No condemned/ Junk material in the Emergency		OB	
ME D4.6	The facility has established procedures for pest, rodent and animal control	No stray animal/rodent/ birds		OB	
Standard D5	**The facility ensures 24X7 water and power backup as per requirement of service delivery, and support services norms**				
ME D5.1	The facility has adequate arrangement storage and supply for portable water in all functional areas	Availability of 24x7 running and potable water		OB/SI	
ME D5.2	The facility ensures adequate power backup in all patient care areas as per load	Availability of power back in Emergency		OB/SI	
		Availability of UPS		OB/SI	
		Availability of Emergency light		OB/SI	
ME D5.3	Critical areas of the facility ensures availability of oxygen, medical gases and vacuum supply	Availability of Centralized /local piped Oxygen and vacuum supply		OB	
Standard D7	**The facility ensures clean linen to the patients**				
ME D7.1	The facility has adequate availability of linen for meting its need.	Clean Linens are provided at observation beds		OB/RR	
ME D7.2	The facility has established procedures for changing of linen in patient care areas	Linen are changed after change shift of each patient or whenever it get soiled		OB/RR	
ME D7.3	The facility has standard procedures for handling , collection, transportation and washing of linen	There is system to check the cleanliness and Quantity of the linen received from laundry		SI/RR	
Standard D10.	**Facility is compliant with all statutory and regulatory requirement imposed by local, state or central government**				
ME D10.1	The facility has requisite licences and certificates for operation of hospital and different activities	Valid licences for ambulances are available		RR/SI	
ME D10.3	The facility ensure relevant processes are in compliance with statutory requirement	Staff is aware of requirements of medico legal cases		SI	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard D11	**Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.**				
ME D11.1	The facility has established job description as per govt guidelines	Staff is aware of their role and responsibilities		SI	
ME D11.2	The facility has a established procedure for duty roster and deputation to different departments	There is procedure to ensure that staff is available on duty as per duty roster		RR/SI	Check for system for recording time of reporting and relieving (Attendance register/ Biometrics etc)
		There is designated in charge for department		SI	
ME D11.3	The facility ensures the adherence to dress code as mandated by its administration / the health department	Doctor, nursing staff and support staff adhere to their respective dress code		OB	
Standard D12	**Facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations**				
ME D12.1	There is established system for contract management for out sourced services	There is procedure to monitor the quality and adequacy of outsourced services on regular basis		SI/RR	Verification of outsourced services (cleaning/ Dietary/Laundry/Security/ Maintenance) provided are done by designated in-house staff
AREA OF CONCERN - E CLINICAL SERVICES					
Standard E1	**The facility has defined procedures for registration, consultation and admission of patients.**				
ME E1.1	The facility has established procedure for registration of patients	Unique identification number is given to each patient during process of registration		RR	
		Patient demographic details are recorded in admission records		RR	Check for that patient demographics like Name, age, Sex, Address, Chief complaint, etc.
ME E1.3	There is established procedure for admission of patients	There is established criteria for admission through emergency department		SI/RR	
		There is establish procedure for admission of MLC cases as per prevalent laws		SI/RR	
		There is establish procedure for prisoners as per prevalent local laws		SI/RR	
		Admission is done by written order of a qualified doctor		SI/RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		There is no delay in treatment because of admission process		SI/RR	
		Time of admission is recorded in patient record		RR	
		There is no delay in transfer of patient to respective department once admission is confirmed		SI/RR	
		Emergency department is aware of admission criteria to critical care units		SI/RR	Like ICU, SNCU, Burn cases
		Staff is aware of cases that can not be admitted at the facility due to constraint in scope of services		SI	
ME E1.4	There is established procedure for managing patients, in case beds are not available at the facility	The is provision of extra beds, trolley beds in case of high occupancy or mass casualty		OB/SI	
Standard E2	**The facility has defined and established procedures for clinical assessment, reassessment and treatment plan preparation.**				
ME E2.1	There is established procedure for initial assessment of patients	Assessment criteria of different kind of medical emergencies is defined and practiced		SI/RR	Use of standard criteria of assessment like Glasgow comma scale, Poly trauma, MI, burn patient, paediatric patient, pain assessment criteria etc.
		Initial assessment and treatment is provided immediately		OB/RR	
		Initial assessment is documented preferably within 2 hours		RR	
ME E2.2	There is established procedure for follow-up/ reassessment of Patients	There is fixed schedule for reassessment of patient under observation		RR/SI	
		There is system in place to identify and manage the changes in Patient's health status		SI/RR	Criteria is defined for identification, and management of high risk patients/ patient whose condition is deteriorating
		Check the treatment or care plan is modified as per re assessment results		SI/RR	Check the re assessment sheets/ Case sheets modified treatment plan or care plan is documented

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME E2.3	There is established procedure to plan and deliver appropriate treatment or care to individual as per the needs to achieve best possible results	Check healthcare needs of all hospitalised patients are identified through assessment process		SI/RR	Assessment includes physical assessment, history, details of existing disease condition (if any) for which regular medication is taken as well as evaluate psychological ,cultural, social factors
		Check treatment/care plan is prepared as per patient's need		RR	(a) According to assessment and investigation findings (wherever applicable). (b) Check inputs are taken from patient or relevant care provider while preparing the care plan.
		Check treatment / care plan is documented		RR	Care plan include:, investigation to be conducted, intervention to be provided, goals to achieve, timeframe, patient education, , discharge plan etc
		Check care is delivered by competent multidisciplinary team		SI/RR	Check care plan is prepared and delivered as per direction of qualified physician
Standard E3	**Facility has defined and established procedures for continuity of care of patient and referral**				
ME E3.1	Facility has established procedure for continuity of care during interdepartmental transfer	There is procedure for hand over for patient transfer from emergency to IPD /OT		SI/RR	Check for how hand over is given from emergency to ward, ICU, SNCU etc.
		There is a procedure consultation of the patient to other specialist with in the hospital		SI/RR	
ME E3.2	Facility provides appropriate referral linkages to the patients/Services for transfer to other/higher facilities to assure their continuity of care.	Patient referred with referral slip		SI/RR	
		Availability of referral linkages to higher centres.		SI/RR	Check how patient are referred if services are not available
		Advance communication is done with higher centre		SI/RR	
		Referral vehicle is being arranged		SI/RR	
		Referral in or referral out register is maintained		RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Facility has functional referral linkages to lower facilities		SI/RR	
		Check for if there is any system of follow up		RR	1. Check referral out record is maintained 2. Check randomly with the referred cases (contact them) for completion of treatment or follow up.
ME E3.3	A person is identified for care during all steps of care	Doctor and nurse is designated for each patient admitted to emergency ward		SI/RR	
Standard E4	**The facility has defined and established procedures for nursing care**				
ME E4.1	Procedure for identification of patients is established at the facility	There is a process for ensuring the identification before any clinical procedure		OB/SI	Patient id band/ verbal confirmation/Bed no. etc.
ME E4.2	Procedure for ensuring timely and accurate nursing care as per treatment plan is established at the facility	Treatment chart are maintained		RR	Check for treatment chart are updated and drugs given are marked. Co relate it with drugs and doses prescribed.
		There is a process to ensure the accuracy of verbal/telephonic orders		SI/RR	(1) Check system is in place to give telephonic orders & practised (2) Verbal orders are verified by the ordering physician within defined time period
ME E4.3	There is established procedure of patient hand over, whenever staff duty change happens	Patient hand over is given during the change in the shift		SI/RR	
		Nursing Handover register is maintained		RR	
		Hand over is given bed side		OB/SI	
ME E4.4	Nursing records are maintained	Nursing notes are maintained adequately		RR/SI	Check for nursing note register. Notes are adequately written
ME E4.5	There is procedure for periodic monitoring of patients	Patient Vitals are monitored and recorded periodically		RR/SI	Check for TPR chart, IO chart, any other vital required is monitored
		Critical patients are monitored continually		RR/OB	Check for use of cardiac monitor/multi parameter
Standard E5	**Facility has a procedure to identify high risk and vulnerable patients.**				
ME E5.1	The facility identifies vulnerable patients and ensure their safe care	Vulnerable patients are identified and measures are taken to protect them from any harm		OB/SI	Unstable, irritable, unconscious. Psychotic and serious patients are identified

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME E5.2	The facility identifies high risk patients and ensure their care, as per their need	High risk medical emergencies are identified and treatment given on priority		OB/SI	
Standard E6	**Facility ensures rationale prescribing and use of medicines**				
ME E6.1	Facility ensured that drugs are prescribed in generic name only	Check for BHT if drugs are prescribed under generic name only		RR	Check for: 1. No. of medicines prescribed 2. High-end antibiotics are not prescribed 3. polypharmacy 4. Medicines are prescribed from EML
ME E6.2	There is procedure of rational use of drugs	Check for that relevant Standard treatment guideline are available at point of use		RR	
		Check staff is aware of the drug regime and doses as per STG		SI/RR	Check BHT that drugs are prescribed as per STG
		Availability of drug formulary at emergency		SI/OB	
ME E6.3	There are procedures defined for medication review and optimization	Complete medication history is documented for each patient		RR/OB	Check complete medication history including over-the-counter medicines is taken and documented
Standard E7	**Facility has defined procedures for safe drug administration**				
ME E7.1	There is process for identifying and cautious administration of high alert drugs	High alert drugs available in department are identified		SI/OB	Electrolytes like Potassium chloride,opiods, Neuro muscular blocking agent, Anti thrombolytic agent, insulin, warfarin, Heparin, Adrenergic agonist etc.
		Maximum dose of high alert drugs are defined and communicated		SI/RR	Value for maximum doses as per age, weight and diagnosis are available with nursing station and doctor
		There is process to ensure that right doses of high alert drugs are only given		SI/RR	A system of independent double check before administration, Error prone medical abbreviations are avoided
ME E7.2	Medication orders are written legibly and adequately	Every Medical advice and procedure is accompanied with date , time and signature		RR	
		Check for the writing, It comprehendible by the clinical staff		RR/SI	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME E7.3	There is a procedure to check drug before administration/ dispensing	Drugs are checked for expiry and other inconsistency before administration		OB/SI	
		Check single dose vial are not used for more than one dose		OB	Check for any open single dose vial with left over content indented to be used later on
		Check for separate sterile needle is used every time for multiple dose vial		OB	In multi dose vial needle is not left in the septum
		Any adverse drug reaction is recorded and reported		RR/SI	Adverse drug event trigger tool is used to report the events
ME E7.4	There is a system to ensure right medicine is given to right patient	Administration of medicines done after ensuring right patient, right drugs , right route, right time		SI/OB	
ME E7.5	Patient is counselled for self drug administration	Patient is advice by doctor/ Pharmacist / nurse about the dosages and timings .		SI/PI	
Standard E8	**Facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage**				
ME E8.1	All the assessments, re-assessment and investigations are recorded and updated	Assessment findings are written on BHT		RR	Day to day progress of patient is recorded in BHT (Manually/e-records)
ME E8.2	All treatment plan prescription/orders are recorded in the patient records.	Treatment plan, first orders are written on BHT		RR	Treatment prescribed in nursing records
ME E8.3	Care provided to each patient is recorded in the patient records	Maintenance of treatment chart/ treatment registers		RR	Treatment given is recorded in treatment chat
ME E8.4	Procedures performed are written on patients records	Any procedure performed written on BHT		RR	CPR, Dressing, mobilization etc
ME E8.5	Adequate form and formats are available at point of use	Availability of form formats for emergency		OB/SI	MLC,PIB, Lab /X-ray requisition, death certificate, Initial assessment format, referral slip etc.
ME E8.6	Register/records are maintained as per guidelines	Emergency Records are maintained		OB/RR	Emergency register, death register, MLC register, are maintained
		All register/records are identified and numbered		OB/RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME E8.7	The facility ensures safe and adequate storage and retrieval of medical records	Safe keeping of MLC records		OB/SI	
Standard E9	**The facility has defined and established procedures for discharge of patient.**				
ME E9.1	Discharge is done after assessing patient readiness	Assessment is done before discharging patient from emergency		SI/RR	See if there is any procedure/protocol for discharging the patient if the condition of patient improves in emergency itself. What is the procedure for discharge for short stay / day care patients
		Discharge is done by a responsible and qualified doctor		SI/RR	
		Patient / attendants are consulted before discharge		PI	
		Treating doctor is consulted/ informed before discharge of patients		SI/RR	
ME E9.2	Case summary and follow-up instructions are provided at the discharge	Discharge summary is provided		RR/PI	See for discharge summary, referral slip provided.
		Discharge summary adequately mentions patients clinical condition, treatment given and follow up		RR	
		Discharge summary is give to patients going in LAMA/Referral		SI/RR	
ME E9.3	Counselling services are provided as during discharges wherever required	Counselling services are provided wherever it is required		SI/PI	
Standard E11	**The facility has defined and established procedures for Emergency Services and Disaster Management**				
ME E11.1	There is procedure for Receiving and triage of patients	Emergency has a implemented system of sorting the patients		SI/OB	As care provider how they triage patient- immediate, delayed, expectant, minimal, dead
		Triage area is marked		OB/SI	
		Triage protocols are displayed		OB	
		Responsibility of receiving and shifting the patient from vehicle is defined		SI	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME E11.2	Emergency protocols are defined and implemented	Emergency protocols are available at point of use		OB	See for protocols of head injury, snake bite, poisoning, drawing etc.
		Staff is aware of Clinical protocols		SI/RR	
		There is procedure for CPR		SI/RR	
ME E11.3	The facility has disaster management plan in place	Lines of authority is defined		SI/RR	
		Procedure for internal communication defined		SI/RR	
		There is procedure for setting up control room		SI/RR	
		Disaster buffer stock of medicines and other supplies maintained		SI/RR	
		Role and responsibilities of staff in disaster is defined		SI/RR	
		Staff is aware of disaster plan		SI/RR	
ME E11.4	The facility ensures adequate and timely availability of ambulances services and mobilisation of resources, as per requirement	Check for how ambulances are called and patient is shifted		SI/RR	
		Ambulances are equipped		OB	
		If the patient is stable then he is transferred in ambulance with the trained driver and one staff from hospital.		SI/RR	
		If the patient is serious (as decided by the Doctor), then trained driver and one paramedical staff is mandatory to accompany him.		SI/RR	
		The Patient's rights are respected during transport.		SI/RR	
		Ambulance appropriately equipped for BLS with trained personnel		OB/RR	
		There is a daily checklist of all equipment and emergency medications		RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Ambulance has a log book for the maintenance of vehicle and daily vehicle checklist		RR	
		Transfer register is maintained to record the detail of the referred patient		RR	
ME E11.5	There is procedure for handling medico legal cases	Medico legal cases are identified by on patient records		RR/SI	
		MLC cases are not delayed because of police proceedings		SI/OB/RR	
		There is procedure for informing police		SI/RR	Discharge is not done before police consent
		Emergency has criteria for defining medico legal cases		SI/RR	Criteria is defined based on cases and when to do MLC
Standard E12	**The facility has defined and established procedures of diagnostic services**				
ME E12.1	There are established procedures for Pre-testing Activities	Container is labelled properly after the sample collection		OB	
ME E12.3	There are established procedures for Post-testing Activities	Nursing station is provided with the critical value of different tests		SI/RR	
Standard E13.	**The facility has defined and established procedures for Blood Bank/Storage Management and Transfusion.**				
ME E13.8	There is established procedure for issuing blood	There is a procedure for issuing the blood promptly for life saving measures		RR/SI	
ME E13.9	There is established procedure for transfusion of blood	Consent is taken before transfusion		RR	
		Patient's identification is verified before transfusion		SI/OB	
		Blood is kept on optimum temperature before transfusion		RR	
		Blood transfusion is monitored and regulated by qualified person		SI/RR	
		Blood transfusion note is written in patient record		RR	
ME E13.10	There is a established procedure for monitoring and reporting Transfusion complication	Any major or minor transfusion reaction is recorded and reported to responsible person		RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard E15.	**Facility has defined and established procedures of Operation Theatre Services**				
ME E15.1	Facility has established procedures OT Scheduling	There is procedure for emergency surgeries		SI/RR	See surgeon is available on call/on duty
		Procedure for arranging logistics		SI	Responsibilities are defined and patient is shifted promptly
Standard E16	**The facility has defined and established procedures for the management of death & bodies of deceased patients**				
ME E16.1	Death of admitted patient is adequately recorded and communicated	Facility has a standard procedure to decent communicate death to relatives		SI	
		Death note is written on patient record		RR	
ME E16.2	The facility has standard procedures for handling the death in the hospital	Past history and sign of any medico legal cause is looked for		RR	Check what is policy for registering brought in dead, death cases as MLC
		There is criteria for declaring death		SI/RR	ask form how death is declared - Physical examination or ECG is done
		Procedure for handing over the dead body		SI	
		Death certificate is issued		SI/RR	
AREA OF CONCERN - F INFECTION CONTROL					
Standard F1	**Facility has infection control program and procedures in place for prevention and measurement of hospital associated infection**				
ME F1.2	Facility has provision for Passive and active culture surveillance of critical & high risk areas	Surface and environment samples are taken for microbiological surveillance		SI/RR	Swab are taken from infection prone surfaces
ME F1.4	There is Provision of Periodic Medical Check-ups and immunization of staff	There is procedure for immunization of the staff		SI/RR	Hepatitis B, Tetanus Toxic etc
		Periodic medical check-ups of the staff		SI/RR	
ME F1.5	Facility has established procedures for regular monitoring of infection control practices	Regular monitoring of infection control practices		SI/RR	Hand washing and infection control audits done at periodic intervals
ME F1.6	Facility has defined and established antibiotic policy	Check for Doctors are aware of Hospital Antibiotic Policy		SI/RR	
Standard F2	**Facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis**				
ME F2.1	Hand washing facilities are provided at point of use	Availability of hand washing Facility at Point of Use		OB	Check for availability of wash basin, elbow operated tap near the point of use

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Availability of running Water		OB/SI	Ask to Open the tap. Ask Staff water supply is regular
		Availability of antiseptic soap with soap dish/ liquid antiseptic with dispenser.		OB/SI	Check for availability/ Ask staff if the supply is adequate and uninterrupted
		Availability of Alcohol based Hand rub		OB/SI	Check for availability/ Ask staff for regular supply.
		Display of Hand washing Instruction at Point of Use		OB	Prominently displayed above the hand washing facility , preferably in Local language
ME F2.2	Staff is trained and adhere to standard hand washing practices	Adherence to 6 steps of Hand washing		SI/OB	Ask of demonstration
		Staff aware of when to hand wash		SI	
ME F2.3	Facility ensures standard practices and materials for antisepsis	Availability of Antiseptic Solutions		OB	
		Proper cleaning of procedure site with antisepsis		OB/SI	like before giving IM/IV injection, drawing blood, putting Intravenous and urinary catheter
Standard F3	**Facility ensures standard practices and materials for Personal protection**				
ME F3.1	Facility ensures adequate personal protection equipment as per requirements	Clean gloves are available at point of use		OB/SI	
		Availability of Masks		OB/SI	
		Personal protective kit for infectious patients		OB/SI	
ME F3.2	Staff is adhere to standard personal protection practices	No reuse of disposable gloves, Masks, caps and aprons.		OB/SI	
		Compliance to correct method of wearing and removing the PPE		SI	Gloves, Masks, Cap, Aprons etc
Standard F4	**Facility has standard Procedures for processing of equipment and instruments**				
ME F4.1	Facility ensures standard practices and materials for decontamination and cleaning of instruments and procedures areas	Decontamination of operating & Procedure surfaces		SI/OB	Ask staff about how they decontaminate the procedure surface like Examination table , dressing table, Stretcher/ Trolleys etc. (Wiping with 0.5% Chlorine solution

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Decontamination of instruments after use		SI/OB	Ask staff how they decontaminate the instruments like ambubag, suction cannula, Airways, Face Masks, Surgical Instruments (Soaking in 0.5% Chlorine Solution, Wiping with 0.5% Chlorine Solution or 70% Alcohol as applicable
		Contact time for decontamination is adequate		SI/OB	10 minutes
		Cleaning of instruments after decontamination		SI/OB	Cleaning is done with detergent and running water after decontamination
		Proper handling of Soiled and infected linen		SI/OB	No sorting ,Rinsing or sluicing at Point of use/ Patient care area
		Staff know how to make chlorine solution		SI/OB	
ME F4.2	Facility ensures standard practices and materials for disinfection and sterilization of instruments and equipment's	Equipment and instruments are sterilized after each use as per requirement		OB/SI	Autoclaving/HLD/Chemical Sterilization
		High level Disinfection of instruments/equipment is done as per protocol		OB/SI	Ask staff about method and time required for boiling
		Chemical sterilization of instruments/equipment is done as per protocols		OB/SI	Ask staff about method, concentration and contact time required for chemical sterilization
		Autoclaved dressing material is used		OB/SI	
Standard F5	**Physical layout and environmental control of the patient care areas ensures infection prevention**				
ME F5.1	Layout of the department is conducive for the infection control practices	Facility layout ensures separation of general traffic from patient traffic		OB	
ME F5.2	Facility ensures availability of standard materials for cleaning and disinfection of patient care areas	Availability of disinfectant as per requirement		OB/SI	Chlorine solution, Glutaraldehyde, carbolic acid
		Availability of cleaning agent as per requirement		OB/SI	Hospital grade phenyl, disinfectant detergent solution

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME F5.3	Facility ensures standard practices followed for cleaning and disinfection of patient care areas	Staff is trained for spill management		SI/RR	
		Cleaning of patient care area with disinfectant detergent solution		SI/RR	
		Staff is trained for preparing cleaning solution as per standard procedure		SI/RR	
		Standard practice of mopping and scrubbing are followed		OB/SI	Unidirectional mopping from inside out
		Cleaning equipment like broom are not used in patient care areas		OB/SI	Any cleaning equipment leading to dispersion of dust particles in air should be avoided
ME F5.4	Facility ensures segregation infectious patients	Emergency department define list of infectious diseases require special precaution and barrier nursing		OB/SI	
		Staff is trained for barrier nursing		OB/SI	
Standard F6	**Facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.**				
ME F6.1	Facility Ensures segregation of Bio Medical Waste as per guidelines and on-site management of waste is carried out as per guidelines	Availability of colour coded bins at point of waste generation		OB	Adequate number. Covered. Foot operated.
		Availability of colour coded non chlorinated plastic bags		OB	
		Segregation of Anatomical and soiled waste in Yellow Bin		OB/SI	Human Anatomical waste, Items contaminated with blood, body fluids, dressings, plaster casts, cotton swabs and bags containing residual or discarded blood and blood components.
		Segregation of infected plastic waste in red bin		OB	Items such as tubing, bottles, intravenous tubes and sets, catheters, urine bags, syringes (without needles and fixed needle syringes) and vacutainer's with their needles cut) and gloves
		Display of work instructions for segregation and handling of Biomedical waste		OB	Pictorial and in local language

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		There is no mixing of infectious and general waste			
ME F6.2	Facility ensures management of sharps as per guidelines	Availability of functional needle cutters		OB	See if it has been used or just lying idle
		Segregation of sharps waste including Metals in white (translucent) Puncture proof, Leak proof, tamper proof containers		OB	Should be available nears the point of generation. Needles, syringes with fixed needles, needles from needle tip cutter or burner, scalpels, blades, or any other contaminated sharp object that may cause puncture and cuts. This includes both used, discarded and contaminated metal sharps
		Availability of post exposure prophylaxis		SI/OB	Ask if available. Where it is stored and who is in charge of that.
		Staff knows what to do in condition of needle stick injury		SI	Staff knows what to do in case of shape injury. Whom to report. See if any reporting has been done
		Contaminated and broken Glass are disposed in puncture proof and leak proof box/ container with Blue colour marking		OB	Vials, slides and other broken infected glass
ME F6.3	Facility ensures transportation and disposal of waste as per guidelines	Check bins are not overfilled		SI	
		Disinfection of liquid waste before disposal		SI/OB	
		Transportation of bio medical waste is done in close container/trolley		SI/OB	
		Staff is aware of mercury spill management		SI/RR	Check for: 1. Spill area evacuation 2. Removal of Jewellery 3. Wear PPE 4. Use of flashlight to locate mercury beads 5. Use syringe without a needle/eyedropper and sticky tape to suck the beads 6. Collection of beads in leak-proof bag or container 7. Sprinkle sulphur or zinc powder to remove any remaining mercury

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
					8. All the mercury spill surfaces should be decontaminated with 10% sodium thiosulfate solution 9. All the bags or containers containing items contaminated with mercury should be marked as "Hazardous Waste, Handle with Care" 10. Collected mercury waste should be handed over to the CBMWTF
AREA OF CONCERN - G QUALITY MANAGEMENT					
Standard G1	**The facility has established organizational framework for quality improvement**				
ME G1.1	The facility has a quality team in place	Quality circle has been formed in the Emergency		SI/RR	1. Check if the quality circle has been constituted and is functional 2. Roles and Responsibility of quality circle has been defined
Standard G3	**Facility have established internal and external quality assurance programs.**				
ME G3.1	Facility has established internal quality assurance program at relevant departments	There is system daily round by matron/hospital manager/ hospital superintendent/ Hospital Manager/ Matron in charge for monitoring of services		SI/RR	
		There is system for periodic check up of Ambulances by designated hospital staff		SI/RR	Inhouse ambulance check is done by designated hospital staff OR ambulance belonging to the agency- the daily checklist is filled, displayed and updated by the designated person
ME G3.2	Facility has established external assurance programs at relevant departments	There is periodic assessment of preparedness for disaster by competent authority		SI/RR	
ME G3.3	Facility has established system for use of check lists in different departments and services	Internal assessment is done at periodic interval		RR/SI	1. NQAS assessment toolkit is used to conduct an internal assessment 2. SaQushal assessment toolkit is used for safety audits.
		Departmental checklist are used for monitoring and quality assurance		SI/RR	Staff is designated for filling and monitoring of these checklists

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Non-compliances are enumerated and recorded		RR	Check the non compliances are presented & discussed during quality team meetings
ME G3.4	Actions are planned to address gaps observed during quality assurance process	Check action plans are prepared and implemented as per internal assessment record findings		RR	Randomly check the details of action, responsibility, time line and feedback mechanism
ME G3.5	Planned actions are implemented through Quality Improvement Cycles (PDCA)	Check PDCA or revalent quality method is used to take corrective and preventive action		SI/RR	Check actions have been taken to close the gap. It can be in form of action taken report or Quality Improvement (PDCA) project report
Standard G4	**Facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.**				
ME G4.1	Departmental standard operating procedures are available	Standard operating procedure for department has been prepared and approved		RR	
		Current version of SOP are available with process owner		OB	
		Work instruction/clinical protocols are displayed		OB	Triage, CPR, Medical clinical protocols like Snake bite and poisoning
ME G4.2	Standard Operating Procedures adequately describes process and procedures	Emergency has documented procedure for Registration and patient calling system		RR	
		Department has documented procedure for triaging		RR	
		Department has documented procedure for taking consent		RR	
		Department has documented procedure for initial screening of patient		RR	
		Department has documented procedure for nursing care		RR	
		Department has documented procedure for admission and transfer of the patient to ward		RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Emergency has documented procedure for Handling medical records		RR	
		Department has documented procedure for maintaining records in Emergency		RR	
		Department has documented procedure to handle brought in dead patient		RR	
		Department has documented procedure for storage, handling and release of dead body		RR	
		Department has documented procedure for storage and replenishing the medicine in emergency		RR	
		Department has documented procedure for equipment preventive and break down maintenance		RR	
		Department has documented procedure for Disaster management		RR	
ME G4.3	Staff is trained and aware of the standard procedures written in SOPs	Check Staff is a aware of relevant part of SOPs		SI/RR	
Standard G 5	**Facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages**				
ME G5.1	Facility maps its critical processes	Process mapping of critical processes done		SI/RR	
ME G5.2	Facility identifies non value adding activities / waste / redundant activities	Non value adding activities are identified		SI/RR	
ME G5.3	Facility takes corrective action to improve the processes	Processes are rearranged as per requirement		SI/RR	
Standard G6	**The facility has defined mission, values, Quality policy & objectives & prepared a strategic plan to achieve them**				
ME G6.5	Mission, Values, Quality policy and objectives are effectively communicated to staff and users of services	Check of staff is aware of Mission , Values, Quality Policy and objectives		SI/RR	Interview with staff for their awareness. Check if Mission Statement, Core Values and Quality Policy is displayed prominently in local language at Key Points

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME G6.7	Facility periodically reviews the progress of strategic plan towards mission, policy and objectives	Check time bound action plan is being reviewed at regular time interval		SI/RR	Review the records that action plan on quality objectives being reviewed at least once in month by departmental in charges and during the quality team meeting. The progress on quality objectives have been recorded in Action Plan tracking sheet
Standard G7	**Facility seeks continually improvement by practicing Quality method and tools.**				
ME G7.1	Facility uses method for quality improvement in services	Basic quality improvement method		SI/OB	PDCA & 5S
		Advance quality improvement method		SI/OB	Six sigma, lean.
ME G7.2	Facility uses tools for quality improvement in services	7 basic tools of Quality		SI/RR	Minimum 2 applicable tools are used in each department
Standards G9	**Facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan**				
ME G9.6	Periodic assessment for Medication and Patient care safety risks is done as per defined criteria.	Check periodic assessment of medication and patient care safety risk is done using defined checklist periodically		SI/RR	Verify with the records. A comprehensive risk assessment of all clinical processes should be done using pre define criteria at least once in three month.
ME G9.7	Periodic assessment for potential risk regarding safety and security of staff including violence against service providers is done as per defined criteria	SaQushal assessment toolkit is used for safety audits.		SI/RR	1. Check that the filled checklist and action taken report are available 2. Staff is aware of key gaps & closure status
ME G9.7	Risks identified are analysed evaluated and rated for severity	Identified risks are analysed for severity		SI/RR	Action is taken to mitigate the risks
Standard G10	**The facility has established clinical Governance framework to improve quality and safety of clinical care processes**				
ME G10.3	Clinical care assessment criteria have been defined and communicated	The facility has established process to review the clinical care processes		SI/RR	Check parameter are defined & implemented to review the clinical care i.e. through Ward round, peer review, morbidity & mortality review, patient feedback, clinical audit & clinical outcomes.
		Check regular ward rounds are taken to review case progress		SI/RR	(1) Both critical and stable patients (2) Check the case progress is documented in BHT/ progress notes-

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Check the patient /family participate in the care evaluation		SI/PI	Feedback is taken from patient/family on health status of individual under treatment
		Check the care planning and co- ordination is reviewed		SI/RR	System in place to review internal referral process, review clinical handover information, review patient understanding about their progress
ME G10.4	Facility conducts the periodic clinical audits including prescription, medical and death audits	There is procedure to conduct medical audits		SI/RR	Check medical audit records (a) Completion of the medical records i.e. Medical history, assessments, re assessment, investigations conducted, progress notes, interventions conducted, outcome of the case, patient education, delineation of responsibilities, discharge etc. (b) Check whether treatment plan worked for the patient (C) progress on the health status of the patient is mentioned (d) whether the goals defined in treatment plan is met for the individual cases (e) Adverse clinical events are documented (f) Re admission
		There is procedure to conduct death audits		SI/RR	(1) All the deaths are audited by the committee. (2) The reasons of the death is clearly mentioned (3) Data pertaining to deaths are collated and trend analysis is done
					(4) A through action taken report is prepared and presented in clinical Governance Board meetings / during grand round (wherever required)

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		There is procedure to conduct prescription audits		RR	(1) Random prescriptions are audited (2) Separate Prescription audit is conducted foe both OPD & IPD cases (3) The finding of audit is circulated to all concerned (4) Regular trends are analysis and presented in Clinical Governance board/ Grand round meetings
		All non compliance are enumerated recorded for medical audits		SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings
		All non compliance are enumerated recorded for death audits		SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings
		All non compliance are enumerated recorded for prescription audits		SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings
ME G10.5	Clinical care audits data is analysed, and actions are taken to close the gaps identified during the audit process	Check action plans are prepared and implemented as per medical audit record findings		SI/RR	Randomly check the actual compliance with the actions taken reports of last 3 months
		Check action plans are prepared and implemented as per death audit record's findings		SI/RR	Randomly check the actual compliance with the actions taken reports of last 3 months
		Check action plans are prepared and implemented as per prescription audit record findings		SI/RR	Randomly check the actual compliance with the actions taken reports of last 3 months
		Check the data of audit findings are collated		RR	Check collected data is analysed & areas for improvement is identified & prioritised
		Check PDCA or revalent quality method is used to address critical problems		SI/RR	Check the critical problems are regularly monitored & applicable solutions are duplicated in other departments (wherever required) for process improvement

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME G10.7	Facility ensures easy access and use of standard treatment guidelines & implementation tools at point of care	Check standard treatment guidelines / protocols are available & followed.		SI/RR	Staff is aware of Standard treatment protocols/ guidelines/best practices
		Check treatment plan is prepared as per Standard treatment guidelines		SI/RR	Check staff adhere to clinical protocols while preparing the treatment plan
		Check the drugs are prescribed as per Standards treatment guidelines		SI/RR	Check the drugs prescribed are available in EML or part of drug formulary
		Check the updated/latest evidence are available		SI/RR	Check when the STG/ protocols/evidences used in healthcare facility are published. Whether the STG protocols are according to current evidences.
		Check the mapping of existing clinical practices processes is done		SI/RR	The gaps in clinical practices are identified & action are taken to improve it. Look for evidences for improvement in clinical practices using PDCA
AREA OF CONCERN - H OUTCOME					
Standard H1	**The facility measures Productivity Indicators and ensures compliance with State/National benchmarks**				
ME H1.1	Facility measures productivity Indicators on monthly basis	No. of trauma cases treated per 1000 emergency cases		RR	
		No. of poisoning cases treated per 1000 emergency cases		RR	
		No. of cardiac cases treated per 1000 emergency cases		RR	
		No of resuscitation done per thousand population		RR	Resuscitation should include: Chest Compression, Airway and Breathing
		Number of emergency cases treated at night per month		RR	Check at lease last 3 month data
Standard H2	**The facility measures Efficiency Indicators and ensure to reach State/National Benchmark**				
ME H2.1	Facility measures efficiency Indicators on monthly basis	Response time for ambulance		RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Proportion of cases referred		RR	
		Response time at emergency for initial assessment		RR	Sum of time taken for initial assessment of all patients who accessed emergency services in a period/Total number of patients who accessed emergency services in that period
		Average Turn Around Time		RR	Average time a patient stays at emergency observation bed
ME H2.2		Proportion of patient referred by state owned/108 ambulance per 1000 referral cases		RR	
Standard H3	**The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark**				
ME H3.1	Facility measures Clinical Care & Safety Indicators on monthly basis	No of adverse events per thousand patients		RR	
		Death Rate		RR	No of Deaths in Emergency/ Total no of emergency attended
Standard H4	**The facility measures Service Quality Indicators and endeavours to reach State/National benchmark**				
ME H4.1	Facility measures Service Quality Indicators on monthly basis	LAMA Rate		RR	No of LAMA X 100/ No of Patients seen at emergency
		Absconding rate		RR	No of Absconding X 100/ No of Patients seen at emergency
		Response Time in Emergency department		RR	The time from entry of patient at emergency department to admission/ transfer-out/discharge
		Percentage of emergency patients for whom the initial assessment was completed within defined timeframe		RR	(Number of patients in emergency for whom the initial assessment was completed within a defined time frame / total number of patients admitted) x 100

ASSESSMENT SUMMARY

Name of the Hospital .....

Date of Assessment .....

Names of Assessors .....

Names of Assessees .....

Type of Assessment (Internal/External) .....

Action plan Submission Date .....

A. SCORE CARD

ACCIDENT & EMERGENCY DEPARTMENT SCORE CARD	
Area of Concern wise score	**Accident & Emergency Score**
A. Service Provision	
B. Patient Rights	
C. Inputs	
D. Support Services	
E. Clinical Services	
F. Infection Control	
G. Quality Management	
H. Outcome	

B. MAJOR GAPS OBSERVED

1. _____
2. _____
3. _____
4. _____
5. _____

C. STRENGTHS/BEST PRACTICES

1. _____
2. _____
3. _____

D. RECOMMENDATIONS/OPPORTUNITIES FOR IMPROVEMENT

_____

_____

_____

Names and Signature of Assessors

Date _____

सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

CHECKLIST-2

OUTDOOR PATIENT DEPARTMENT

CHECKLIST FOR OUTDOOR PATIENT DEPARTMENT

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
AREA OF CONCERN - A SERVICE PROVISION					
Standard A1	**Facility Provides Curative Services**				
ME A1.1	The facility provides General Medicine services	Availability of functional General Medicine Clinic		SI/OB	Dedicated General speciality Medicine Clinic
ME A1.2	The facility provides General Surgery services	Availability of functional General Surgery Clinic		SI/OB	Dedicated General speciality Surgical Clinic
ME A1.3	The facility provides Obstetrics & Gynaecology Services	Availability of Functional Obstetrics & Gynaecology Clinic		SI/OB	(a) Dedicated speciality Obstetrics & Gynaecology Clinic. (b) High-risk pregnancy cases are referred from the ANC clinic and consulted.
		Availability of Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) services		SI/OB	(a) Dedicated clinic of PMSMA (b) Availability MO & ObG specialist (c) 9th of every month - for all pregnant women in 2-3 trimester
		Availability of daycare Gynaecology procedure		SI/OB	(a) PAP smear & biopsy, Cervical VIA staining, Endometrial aspiration, Bartholin cyst excision. (b) MTP (Medical & surgical Method)
ME A1.5	The facility provides Ophthalmology Services	Availability of functional Ophthalmology Clinic		SI/OB	Dedicated ophthalmology clinic providing consultation services
ME A1.6	The facility provides ENT Services	Availability of Functional ENT Clinic for adult and paediatrics		SI/OB	1. Dedicated ENT providing consultation services 2. Foreign Body Removal (Ear and Nose),Stitching of CLW's, Dressings, Syringing of Ear, Chemical Cauterization (Nose & Ear), Eustachian Tube Function Test, Vestibular Function Test/ Caloric Test
ME A1.7	The facility provides Orthopaedics Services	Availability of Functional Orthopaedic Clinic		SI/OB	(a) Dedicated clinical for Orthopaedic consultation (b) Plaster room to conduct Orthopaedic procedure

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME A1.8	The facility provides Skin & VD Services	Availability of functional Skin & VD Clinic		SI/OB	Dedicated Clinic providing consultation services
ME A1.9	The facility provides Psychiatry Services	Availability of functional Psychiatry Clinic		SI/OB	Dedicated Clinic providing consultation services/ provision of private psychiatrist 2-3 days /week
ME A1.10	The facility provides Dental Treatment Services	Availability of functional Dental Clinic		SI/OB	Dedicated Clinic providing consultation services
		Availability of OPD Dental procedure		SI/OB	Accompanied by dental lab. Extraction, scaling, tooth extraction, denture and Restoration.
ME A1.11	The facility provides AYUSH Services	Availability of Functional AYUSH clinic		SI/OB	AYUSH clinic accompanied by dispensary
ME A1.12	The facility provides Physiotherapy Services	Availability of Functional Physiotherapy Unit		SI/OB	Pain Management with cryotherapy, Pain Management with deep heat therapy (SWD), Increase range of motion with mobilization,
ME A1.13	The facility provides services for OPD procedures	Availability of Dressing facilities at OPD		SI/OB	Dressing, Suturing and drainage
		Availability of Injection room facilities at OPD		SI/OB	
ME A1.14	Services are available for the time period as mandated	At least 6 Hours of OPD Services are available		SI/RR	
		PMSMA is conducted 9th of every month		SI/RR	
ME A1.15	The facility provides services for Super specialties, as mandated	Availability of functional Cardiology clinic		SI/OB	
		Availability of functional gastro entomology clinic		SI/OB	
		Availability of functional nephrology clinic		SI/OB	
		Availability of functional Neurology clinic		SI/OB	
		Availability of functional endocrinology Clinic is available		SI/OB	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Availability of functional Oncology Clinic		SI/OB	
Standard A2	**Facility provides RMNCHA Services**				
ME A2.2	The facility provides Maternal health Services	Availability of functional ANC clinic		SI/OB	
ME A2.5	The facility provides Adolescent health Services	Availability of Functional AFHCs		SI/OB	(a) Screening & Counselling on Nutrition, puberty-related concerns, HIV, Contraceptives, Substance abuse, Learning problems, Stress, Depression, Suicidal Tendency, healthy lifestyle, and risky behaviour. (b)Treatment & management for RTI/ STI, ANC for pregnant adolescents, Abortion, Violence, Sexual Abuse, Mental Health Issues, Management of Menstrual problems, Management of Iron deficiency Anaemia, (c) Linkages with de-addiction centres and referrals.
Standard A3	**Facility Provides diagnostic Services**				
ME A3.2	The facility Provides Laboratory Services	Availability of Sample collection Centre		SI/OB	
ME A3.3	The facility provides other diagnostic services, as mandated	Functional ECG Services are available		SI/OB	
		Availability of TMT services		SI/OB	
Standard A4	**Facility provides services as mandated in national Health Programs/ state scheme**				
ME A4.1	The facility provides services under National Vector Borne Disease Control Programme as per guidelines	Availability of OPD Services Under NVBDCP		SI/RR	OPD Management of Malaria, Kala Azar, Dengue
ME A4.2	The facility provides services under national tuberculosis elimination programme as per guidelines.	Availability of Functional DOTS clinic		SI/OB	
ME A4.3	The facility provides services under National Leprosy Eradication Programme as per guidelines	Availability of OPD services under NLEP		SI/RR	
		Assessment of Disability Status		SI/RR	
		Supply of Customized Foot wear		SI/RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME A4.4	The facility provides services under National AIDS Control Programme as per guidelines	Availability of Functional ICTC		SI/OB	
		Availability of HIV Testing and Counselling		SI/RR	
		PPTCT Services for HIV positive Pregnant Women		SI/OB	
		Availability of Functional ART Centre		SI/OB	
		Availability of CD4 testing facility		SI/OB	
ME A4.5	The facility provides services under National Programme for prevention and control of Blindness as per guidelines	Screening and early detection of visual impairment and refraction		SI/RR	Refraction, syringing and probing, foreign body removal, Tonometry and retinoscopy
		Availability of OPD procedures		SI/OB	Syringing and probing, foreign body removal , Tonometry ,Perimetry, Retinoscopy, Retrobulbar Injection
ME A4.6	The facility provides services under Mental Health Programme as per guidelines	Availability of services under MHP			(a) Acute/ chronic headache Epilepsy, Dementia , Vertigo. (b) Anxiety disorders, Substance abuse
		Availability of counselling centre for Suicide prevention		SI/OB	
ME A4.7	The facility provides services under National Programme for the health care of the elderly as per guidelines	Dedicated Geriatric Clinic		SI/OB	(a)Dedicated OPD services for geriatric patients daily (b) Lab investigation & medicine for geriatric cases
ME A4.8	The facility provides services under National Programme for Prevention and control of Cancer, Diabetes, Cardiovascular diseases & Stroke (NPCDCS) as per guidelines	Functional NCD clinic is available		SI/OB	(a) Diagnosis & management of cases of hypertension, diabetes, CVD, Stroke & cancer (b) Follow up chemotherapy cases (c) Rehabilitation and physiotherapy
ME A4.10	The facility provide services under National health Programme for deafness	Management of case referred from PHC/ CHC directly reported to Hospital		SI/RR	
ME A4.11	The facility provides services as per State specific health programmes	Availability of OPD services as per State Health Programs		SI/RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME A4.14	The facility provides services as per National Viral Hepatitis Program	Availability of services under NVHCP		SI/RR	(a) Screening of the suspected cases of HBV & HCV (b) Confirmation of cases - Referral/ Linkage (c) Treatment of uncomplicated cases (d) Referral of complicated cases to Medical college/ Model Hepatitis Treatment Centre (e) Follow-up visits - after starting the treatment
ME A4.15	The facility provide services under National Programme for palliative care	Availability of palliative care OPD		SI/RR	Frequency as mandated the state
Standard A6	**Health services provided at the facility are appropriate to community needs.**				
ME A6.1	The facility provides curatives & preventive services for the health problems and diseases, prevalent locally.	Special Clinics are available for local prevalent endemics		SI/OB	Ask for the specific local health problems/ diseases .i.e.. Kala azar, Swine Flue, arsenic poisoning etc.
AREA OF CONCERN - B PATIENT RIGHTS					
Standard B1	**Facility provides the information to care seekers, attendants & community about the available services and their modalities**				
Standard B1	Facility provides the information to care seekers, attendants & community about the available services and their modalities				
ME B1.1	The facility has uniform and user-friendly signage system	Availability departmental signage's		OB	(Numbering, main department and internal sectional signage
		Display of layout/floor directory		OB	
ME B1.2	The facility displays the services and entitlements available in its departments	List of OPD Clinics are available		OB	
		Names of doctor on duty is displayed and updated		OB	
		Timing for OPD are displayed		OB	
		Entitlements applicable are Displayed		OB	Entitlement under, PMJAY, JSY , JSSK, NSSK and other schemes
		Important numbers like ambulance are displayed		OB	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME B1.3	The facility has established citizen charter, which is followed at all levels	Display of citizen charter		OB	
ME B1.4	User charges are displayed and communicated to patients effectively	User charges for services are displayed		OB	
ME B1.5	Patients & visitors are sensitised and educated through appropriate IEC / BCC approaches	IEC Material is displayed		OB	PMSMA, JSSK, JSY, PMJAY etc
		Education material for counselling are available in Counselling room		OB	
ME B1.6	Information is available in local language and easy to understand	Signage's and information are available in local language		OB	
ME B1.7	The facility provides information to patients and visitor through an exclusive set-up.	Availability of Enquiry Desk with dedicated staff		OB	
ME B1.8	The facility ensures access to clinical records of patients to entitled personnel	OPD slip with UID is given to the patient		RR/OB	
Standard B2	**Services are delivered in a manner that is sensitive to gender, religious and cultural needs, and there are no barrier on account of physical economic, cultural or social reasons.**				
ME B2.1	Services are provided in manner that are sensitive to gender	Separate queue for female at registration		OB	
		Separate Female general OPD		OB	
		Separate toilets for male and female		OB	
		Availability of female staff if a male doctor examination a female patients		OB	
		Availability of Breast feeding corner		OB	
ME B2.3	Access to facility is provided without any physical barrier & and friendly to people with disabilities	Availability of Wheel chair or stretcher for easy access to the OPD		OB	
		Emergency is located at ground floor with availability of ramp and railing		OB	At least 120 cm width, gradient not steeper than 1:12

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		There is no chaos and over crowding in the OPD		OB	Measure are taken to reduce the overcrowding like appointment system/chaos/ token system
		Availability of specially abled friendly toilet		OB	
Standard B3	**Facility maintains the privacy, confidentiality & Dignity of patient, and has a system for guarding patients related information**				
ME B3.1	Adequate visual privacy is provided at every point of care	Availability of screen at Examination Area		OB	
		One Patient is seen at a time in clinics		OB	
		Privacy at the counselling room is maintained		OB	
ME B3.2	Confidentiality of patients records and clinical information is maintained	Confidentiality of HIV reports at ICTC		SI/OB	
ME B3.3	The facility ensures the behaviours of staff is dignified and respectful, while delivering the services	Behaviour of staff is empathetic and courteous		PI/OB	
ME B3.4	The facility ensures privacy and confidentiality to every patient, especially of those conditions having social stigma, and also safeguards vulnerable groups	Privacy and confidentiality of HIV, Leprosy Patients		SI/OB	Check in RTI/STI clinic
Standard B4	**Facility has defined and established procedures for informing and involving patient and their families about treatment and obtaining informed consent wherever it is required.**				
ME B4.1	There is established procedures for taking informed consent before treatment and procedures	Informed consent for before HIV testing at ICTC		SI/RR	
ME B4.2	Patient is informed about his/her rights and responsibilities	Display of patient rights and responsibilities.		OB	
ME B4.4	Information about the treatment is shared with patients or attendants, regularly	Patient is informed about her clinical condition and treatment been provided		PI	Ask patients about what they have been communicated about the treatment plan
		Pre and Post test counselling is given at ICTC		SI/PI/RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME B4.5	The facility has defined and established grievance redressal system in place	Availability of complaint box and display of process for grievance re redressal and whom to contact is displayed		OB	
Standard B5	**Facility ensures that there are no financial barrier to access and that there is financial protection given from cost of hospital services.**				
ME B5.1	The facility provides cashless services to pregnant women, mothers and neonates as per prevalent government schemes	Free OPD Consultation / ANC Check-ups		PI/SI	For JSSK entitlement
ME B5.2	The facility ensures that Medicines prescribed are available at Pharmacy and wards	Check that patient party has not spent on purchasing Medicines or consumables from outside.		PI/SI	
ME B5.3	It is ensured that facilities for the prescribed investigations are available at the facility	Check that patient party has not spent on diagnostics from outside.		PI/SI	
ME B5.4	The facility provide free of cost treatment to Below poverty line patients without administrative hassles	Free OPD Consultation for BPL patients		PI/SI/RR	
ME B5.5	The facility ensures timely reimbursement of financial entitlements and reimbursement to the patients	If any other expenditure occurred it is reimbursed from hospital		PI/SI/RR	
AREA OF CONCERN - C INPUTS					
Standard C1	**The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms**				
ME C1.1	Departments have adequate space as per patient or work load	Clinics has adequate space for consultation and examination		OB	Adequate Space in Clinics (12 sq. ft)
		Availability of adequate waiting area		OB	Waiting area at the scale of 1 sq. ft per average daily patient with minimum 400 sq. ft of area
ME C1.2	Patient amenities are provide as per patient load	Availability of seating arrangement in waiting area		OB	As per average OPD at peak time
		Availability of sub waiting at for separate clinics		OB	For clinics has high patient load

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Availability of cold Drinking water		OB	See if its is easily accessible to the visitors
		Availability of functional toilets		OB	Urinals 1 per 50 person water closet and wash basins 1 per 100 person
		Availability of patient calling system		OB	
ME C1.3	Departments have layout and demarcated areas as per functions	There is designated area for registration		OB	
		Dedicated clinic for each speciality		OB	
		One clinic is not shared by 2 doctors at one time		OB	
		Dedicated examination areas is provided with each clinics		OB	
		Demarcated dressing area /room		OB	
		Demarcated injection room		OB	
		OPD has separate entry and exit from IPD and Emergency		OB	
		availability of clean and dirty utility room		OB	
		Demarcated trolley/ wheelchair bay		OB	
ME C1.4	The facility has adequate circulation area and open spaces according to need and local law	Corridors at OPD are broad enough to manage stretcher and trolleys		OB	
ME C1.5	The facility has infrastructure for intramural and extramural communication	Availability of functional telephone and Intercom Services		OB	
ME C1.6	Service counters are available as per patient load	Availability of Registration counters as per Patient load		OB	Average Time taken for registration would be 3-5 min so number of counter required would be worked on scale of 12-20 patient/hour per counter
ME C1.7	The facility and departments are planned to ensure structure follows the function/ processes (Structure commensurate with the function of the hospital)	Unidirectional flow of services		OB	Layout of OPD shall follow functional flow of the patients, e.g.: Enquiry→Registration→ Waiting→Sub-waiting→ Clinic Dressing room/Injection Room→ Diagnostics (lab/X-ray)→ Pharmacy→Exit

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		All OPD clinics and related auxiliary services are co located in one functional area		OB	
		OPD is located near to the entry of the hospital		OB	
Standard C2	**The facility ensures the physical safety of the infrastructure.**				
ME C2.1	The facility ensures the seismic safety of the infrastructure	Non structural components are properly secured		OB	Check for fixtures and furniture like cupboards, cabinets, and heavy equipment , hanging objects are properly fastened and secured
ME C2.3	The facility ensures safety of electrical establishment	OPD building does not have temporary connections and loosely hanging wires		OB	
ME C2.4	Physical condition of buildings are safe for providing patient care	Floors of the OPD are non slippery and even		OB	
		Windows have grills and wire meshwork		OB	
Standard C3	**The facility has established Programme for fire safety and other disaster**				
ME C3.1	The facility has plan for prevention of fire	OPD has sufficient fire exit to permit safe escape to its occupant at time of fire		OB/SI	
		Check the fire exits are clearly visible and routes to reach exit are clearly marked.		OB	
ME C3.2	The facility has adequate fire fighting Equipment	OPD has installed fire Extinguisher that is Class A , Class B C type or ABC type		OB	
		Check the expiry date for fire extinguishers are displayed on each extinguisher as well as due date for next refilling is clearly mentioned		OB/RR	
ME C3.3	The facility has a system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation	Check for staff competencies for operating fire extinguisher and what to do in case of fire			

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard C4	**The facility has adequate qualified and trained staff, required for providing the assured services to the current case load**				
ME C4.1	The facility has adequate specialist doctors as per service provision	Availability of specialist Doctor at OPD time		OB/RR	(a) Check for specialist are available at scheduled time (b) 1 OBG specialist per 100 ANC - regular or private - for PMSMA
ME C4.2	The facility has adequate general duty doctors as per service provision and work load	Availability of General duty doctor at Screening Clinic		OB/RR	
		Availability of General duty doctor at PMSMA		OB/RR	
ME C4.3	The facility has adequate nursing staff as per service provision and work load	Availability of Nursing staff		OB/RR/SI	At Injection room/ OPD Clinic as Per Requirement
ME C4.4	The facility has adequate technicians/paramedics as per requirement	Availability of dresser/ paramedic at dressing room		OB/SI	
		Counsellor for ICTC		SI/RR	Full Time
		Lab technician for ICTC		SI/RR	Full time
		Counsellor for AFHS clinic		SI/RR	
		Availability of ECG technician		SI/RR	
		Availability of Audiometrician		SI/RR	
		Availability of Ophthalmic assistant		SI/RR	
		Availability of Physiotherapist		SI/RR	
		Availability of Dental technician		SI/RR	
		Availability of rehabilitation therapist		SI/RR	
ME C4.5	The facility has adequate support / general staff	availability of dedicated security guard for OPD		SI/RR	
		Availability of registration clerks as per load		SI/RR	
		Availability of housekeeping staff		SI/RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard C5	**Facility provides Medicines and consumables required for assured list of services.**				
ME C5.1	The departments have availability of adequate Medicines at point of use	Availability of injectables at injection room		OB/RR	ARV, TT
		Availability of drugs for management of GDM			Metformin & insulin
ME C5.2	The departments have adequate consumables at point of use	Availability of disposables at dressing room and clinics		OB/RR	Examination gloves, Syringes, Dressing material , suturing material
		HIV testing Kits I, II and III at ICTC		OB/RR	
		Availability of glucometer & OGTT			for screening of GDM
ME C5.3	Emergency Medicine trays are maintained at every point of care, where ever it may be needed	Emergency Medicine Tray is maintained at injection room & immunization room		OB/RR	
Standard C6	**The facility has equipment & instruments required for assured list of services.**				
ME C6.1	Availability of equipment & instruments for examination & monitoring of patients	Availability of functional Equipment &Instruments for examination & Monitoring		OB	BP apparatus, thermometer, weighting machine, torch, stethoscope, Examination table
ME C6.2	Availability of equipment & instruments for treatment procedures, being undertaken in the facility	Availability of functional Instruments/ Equipment for Gynae and obstetric		OB	PV examination kit, Inch tape, fetoscope, Weighting machine, BP apparatus etc.
		Availability of functional Equipment/ Instruments for Orthopaedic Procedures		OB	X ray view box, Equipment for plaster room
		Availability of functional Instruments / Equipment for Ophthalmic Procedures		OB	Retinoscope, refraction kit, tonometer, perimeter, distant vision chart, Colour vision chart.
		Availability of Instruments/ Equipment Procedures for ENT procedures		OB	Audiometer, Laryngoscope, Otoscope, Head Light, Tuning Fork, Bronchoscope, Examination Instrument Set
		Availability of functional Instruments/ Equipment for Dental Procedures		OB	Dental chair, Air rotor, Endodontic set, Extraction forceps

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Availability of functional Equipment/ Instruments of Physiotherapy Procedures		OB	Traction, Wax bath, Short Wave Diathermy, Exercise table Etc .
ME C6.3	Availability of equipment & instruments for diagnostic procedures being undertaken in the facility	Availability of Equipment for ICTC lab		OB	Micropipettes, Centrifuge, Needle destroyer, Refrigerators
ME C6.5	Availability of Equipment for Storage	Availability of equipment for storage for Medicines		OB	Refrigerator, Crash cart/ Medicine trolley, instrumental trolley, dressing trolley
ME C6.6	Availability of functional equipment and instruments for support services	Availability of equipment for cleaning		OB	Buckets for mopping, mops, duster, waste trolley, Deck brush
		Availability of equipment for sterilization and disinfection		OB	Boiler
ME C6.7	Departments have patient furniture and fixtures as per load and service provision	Availability of Fixtures		OB	Spot light, electrical fixture for equipment, X ray view box
		Availability of furniture at clinics		OB	Doctors Chair, Patient Stool, Examination Table, Attendant Chair, Table, Footstep, cupboard
Standard C7	**Facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff**				
ME C7.1	Criteria for Competence assessment are defined for clinical and Para clinical staff	Check parameters for assessing skills and proficiency of clinical staff has been defined		RR/SI	Check objective checklist has been prepared for assessing competence of doctors, nurses and paramedical staff based on job description defined for each cadre of staff. Dakshta checklist issued by MoHFW can be used for this purpose.
ME C7.2	Competence assessment of Clinical and Para clinical staff is done on predefined criteria at least once in a year	Check for competence assessment is done at least once in a year		RR/SI	Check for records of competence assessment including filled checklist, scoring and grading . Verify with staff for actual competence assessment done
ME C7.9	The Staff is provided training as per defined core competencies and training plan	Infection control & prevention training		SI/RR	Bio medical Waste Management including Hand Hygiene
		Training on Quality Management System		SI/RR	
		Patient Safety		SI/RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		ICTC Team Training		SI/RR	
		Induction and refresher training for ICTC counsellor		SI/RR	
		Induction and refresher training for ICTC lab technician		SI/RR	
ME C7.10	There is established procedure for utilization of skills gained thought trainings by on -job supportive supervision	Check the competency of staff to use OPD equipment like BP apparatus etc		SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps
		At ANC clinic staff is skilled to identify high risk pregnancies		SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps
		Counsellor is skilled for counselling		SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps
		Staff is skilled for maintaining clinical records		SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps
AREA OF CONCERN - D SUPPORT SERVICES					
Standard D1	**The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.**				
ME D1.1	The facility has established system for maintenance of critical Equipment	All equipment are covered under AMC including preventive maintenance		SI/RR	1. Check with AMC records/ Warranty documents 2. Staff is aware of the list of equipment covered under AMC.
		There is system of timely corrective break down maintenance of the equipment		SI/RR	1.Check for breakdown & Maintenance record in the log book 2. Staff is aware of contact details of the agency/person in case of breakdown.

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME D1.2	The facility has established procedure for internal and external calibration of measuring Equipment	All the measuring equipment/ instrument are calibrated		OB/ RR	BP apparatus, thermometer are calibrated
Standard D2	**The facility has defined procedures for storage, inventory management and dispensing of Medicines in pharmacy and patient care areas**				
ME D2.1	There is established procedure for forecasting and indenting Medicines and consumables	There is established system of timely indenting of consumables and Medicines		SI/RR	Stock level are daily updated Indents are timely placed
ME D2.3	The facility ensures proper storage of Medicines and consumables	Medicines are stored in containers/tray/ crash cart and are labelled		OB	Labelled with Medicine name, Medicine strength and expiry date
		Empty and filled cylinders are labelled		OB	
ME D2.4	The facility ensures management of expiry and near expiry Medicines	Medicines expiry dates' are maintained at emergency Medicine tray		OB/RR	
		No expired Medicine found		OB/RR	
		Records for expiry and near expiry Medicines are maintained for Medicine stored at department		RR	Check register/DVDMS/other supply chain software for record of stock of expired and near expiry Medicines
ME D2.5	The facility has established procedure for inventory management techniques	There is established system of calculating and maintaining buffer stock		SI/RR	
		Department maintained stock register of drugs and consumables		SI/RR	Check record of drug received, issued and balance stock in hand and are updated
ME D2.6	There is a procedure for periodically replenishing the Medicines in patient care areas	There is established procedure for replenishing drug tray /crash cart		SI/RR	
		There is no stock out of drugs		SI/RR	Random stock check of some essential medicines. E.g. Paracetamol, Atenolol, Amlodipine, Azithromycin, etc.
ME D2.7	There is process for storage of vaccines and other Medicines, requiring controlled temperature	Temperature of refrigerators are kept as per storage requirement and records twice a day and are maintained		OB/RR	Check for refrigerator/ILR temperature charts. Charts are maintained and updated twice a day

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard D3	**The facility provides safe, secure and comfortable environment to staff, patients and visitors.**				
ME D3.1	The facility provides adequate illumination level at patient care areas	Adequate Illumination in clinics		OB	Examination table
		Adequate Illumination in procedure area		OB	Dressing room, injection room and immunization room
ME D3.2	The facility has provision of restriction of visitors in patient areas	Only one patient is allowed one time at clinic		OB/SI	
		Limited number of attendant/ relatives are allowed with patient		OB/SI	
		Medical representative are restricted in OPD timings		OB/SI	
ME D3.3	The facility ensures safe and comfortable environment for patients and service providers	Temperature control and ventilation in waiting areas		PI/OB	Fans/ Air conditioning/ Heating/Exhaust/Ventilators as per environment condition and requirement
		Temperature control and ventilation in clinics		SI/OB	Fans/ Air conditioning/ Heating/Exhaust/Ventilators as per environment condition and requirement
ME D3.4	The facility has security system in place at patient care areas	Hospital has sound security system to manage overcrowding in OPD		OB/SI	
ME D3.5	The facility has established measure for safety and security of female staff	Ask female staff whether they feel secure at work place		SI	
Standard D4	**The facility has established Programme for maintenance and upkeep of the facility**				
ME D4.1	Exterior of the facility building is maintained appropriately	Building is painted/ whitewashed in uniform colour		OB	
		Interior of patient care areas are plastered & painted		OB	
ME D4.2	Patient care areas are clean and hygienic	Floors, walls, roof, roof topes, sinks patient care and circulation areas are Clean		OB	All area are clean with no dirt,grease,littering and cobwebs
		Surface of furniture and fixtures are clean		OB	
		Toilets are clean with functional flush and running water		OB	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME D4.3	Hospital infrastructure is adequately maintained	Check for there is no seepage , Cracks, chipping of plaster		OB	
		Window panes , doors and other fixtures are intact		OB	
		Patients beds are intact and painted		OB	
		Mattresses are intact and clean		OB	
ME D4.5	The facility has policy of removal of condemned junk material	No condemned/Junk material lying in the OPD		OB	
ME D4.6	The facility has established procedures for pest, rodent and animal control	No stray animal/ rodent/birds		OB	
Standard D5	**The facility ensures 24X7 water and power backup as per requirement of service delivery, and support services norms**				
ME D5.1	The facility has adequate arrangement storage and supply for portable water in all functional areas	Availability of 24x7 running and potable water		OB/SI	
ME D5.2	The facility ensures adequate power backup in all patient care areas as per load	Availability of power back up in OPD		OB/SI	
StandardD6	**Dietary services are available as per service provision and nutritional requirement of the patients.**				
ME D6.1	The facility has provision of nutritional assessment of the patients	Nutritional assessment of patient done as required and directed by doctor		RR/SI	
Standard D7	**The facility ensures clean linen to the patients**				
ME D7.1	The facility has adequate sets of linen	Availability of linen in examination area		OB	
Standard D11	**Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.**				
ME D11.1	The facility has established job description as per govt guidelines	Staff is aware of their role and responsibilities		SI	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME D11.2	The facility has a established procedure for duty roster and deputation to different departments	There is procedure to ensure that staff is available on duty as per duty roster		RR/SI	Check for system for recording time of reporting and relieving (Attendance register/ Biometrics etc)
		There is designated in charge for department		SI	
ME D11.3	The facility ensures the adherence to dress code as mandated by its administration / the health department	Doctor, nursing staff and support staff adhere to their respective dress code		OB	
Standard D12	**Facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations**				
ME D12.1	There is established system for contract management for out sourced services	There is procedure to monitor the quality and adequacy of outsourced services on regular basis		SI/RR	Verification of outsourced services (cleaning/Laundry/ Security/Maintenance) provided are done by designated in-house staff
AREA OF CONCERN - E CLINICAL SERVICES					
Standard E1	**The facility has defined procedures for registration, consultation and admission of patients.**				
ME E1.1	The facility has established procedure for registration of patients	Unique identification number is given to each patient during process of registration		RR	
		Patient demographic details are recorded in OPD registration records		RR	Check for that patient demographics like Name, age, Sex, Address etc.
		Patients are directed to relevant clinic by registration clerk based on complaint		PI/SI	
		Registration clerk is aware of categories of the patient exempted from user charges		SI/RR	
ME E1.2	The facility has a established procedure for OPD consultation	There is procedure for systematic calling of patients one by one		OB	Patient is called by Doctor/ attendant as per his/her turn on the basis of "first come first examine" basis.
		Patient History is taken and recorded		RR	Check OPD records for the same
		Physical Examination is done and recorded wherever required		OB/RR	Check details of the physical examination, provisional diagnosis and investigations (if any) is mentioned in the OPD ticket
		Provisional Diagnosis is recorded		OB/RR	Check treatment plan and confirmed diagnosis is recorded

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		No Patient is Consulted in Standing Position		OB	Proper seating arrangement for the patient and parent-attendant is there. Care is provided in a dignified way.
		Clinical staff is not engaged in administrative work		OB/SI	During OPD hours clinical staff is not engaged in other administrative tasks
ME E1.3	There is established procedure for admission of patients	There is establish procedure for admission through OPD		SI/RR	
		There is establish procedure for day care admission		SI/RR	
Standard E2	**The facility has defined and established procedures for clinical assessment, reassessment and treatment plan preparation.**				
ME E2.1	There is established procedure for initial assessment of patients	There is screening clinic for initial assessment of the patients		OB	
ME E2.2	There is established procedure for follow-up/ reassessment of Patients	There is fixed schedule for reassessment of patient under observation		SI/RR	
		There is system in place to identify and manage the changes in Patient's health status		SI/RR	Criteria is defined for identification, and management of patient as per disease condition
		Check the treatment or care plan is modified as per re assessment results		SI/RR	Check the re assessment sheets/OPD tickets modified, treatment plan or care plan is documented
ME E2.3	There is established procedure to plan and deliver appropriate treatment or care to individual as per the needs to achieve best possible results	Check treatment/care plan is prepared as per patient's need		SI/RR	(a) According to assessment and investigation findings (wherever applicable). (b) Check inputs are taken from patient or relevant care provider while preparing the care plan.
		Check treatment / care plan is documented		RR	Care plan include:, investigation to be conducted, intervention to be provided, goals to achieve, timeframe, patient education, , discharge plan etc
		Check care is delivered by competent multidisciplinary team		SI/RR	Check care plan is prepared and delivered as per direction of qualified physician

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard E3	**Facility has defined and established procedures for continuity of care of patient and referral**				
ME E3.1	Facility has established procedure for continuity of care during interdepartmental transfer	Facility has established procedure for handing over of patients during departmental transfer		SI/RR	
		There is a procedure consultation of the patient to other specialist with in the hospital		SI/RR	
ME E3.2	Facility provides appropriate referral linkages to the patients/ Services for transfer to other/higher facilities to assure their continuity of care.	Availability of referral linkages for OPD consultation.		RR/OB	(a) Check how patient are referred if services are not available (b) Check the referral linkage for PMSMA
		Facility has functional referral linkages to higher facilities		SI/RR	
		Facility has functional referral linkages to lower facilities		SI/RR	
		There is a system of follow up of referred patients		RR	1. Check referral out record is maintained 2. Check randomly with the referred cases (contact them) for completion of treatment or follow up.
		ICTC has functional Linkages with ART and state reference Labs		RR/SI	
ME E3.4	Facility is connected to medical colleges through telemedicine services	Telemedicine service are used for consultation		RR/SI	
		Patient records are maintained for the cases availing the telemedicine services		RR/PI	Check the records for completion.
Standard E5	**Facility has a procedure to identify high risk and vulnerable patients.**				
ME E5.2	The facility identifies high risk patients and ensure their care, as per their need	For any critical patient needing urgent attention queue can be bypassed for providing services on priority basis		OB/SI	
Standard E6	**Facility ensures rationale prescribing and use of medicines**				
ME E6.1	Facility ensured that Medicines are prescribed in generic name only	Check for OPD slip if Medicines are prescribed under generic name only		RR	Check for: 1. No. of medicines prescribed 2. High-end antibiotics are not prescribed 3. polypharmacy 4. No of multivitamins prescribed 5. No of injectables prescribed 6. Medicines are prescribed from EML

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		A copy of Prescription is kept with the facility		RR	
ME E6.2	There is procedure of rational use of Medicines	Check for that relevant Standard treatment guideline are available at point of use		RR	
		Check staff is aware of the Medicine regime and doses as per STG		SI/RR	Check OPD ticket that Medicines are prescribed as per STG
		Availability of Medicine formulary		SI/OB	
ME E6.3	There are procedures defined for medication review and optimization	Complete medication history is documented for each patient		RR/OB	Check complete medication history including over-the-counter medicines is taken and documented
		Established mechanism for Medication reconciliation process		SI/RR	1. Medication Reconciliation is carried out by a trained and competent health professional during the patient's admission, interdepartmental transfer or discharged 2. Medicine reconciliation includes Prescription and non-prescription (over-the-counter) medications, vitamins, nutritional supplements.
		Medicine are reviewed and optimised as per individual treatment plan		SI/RR	Medicines are optimised as per individual treatment plan for best possible clinical outcome specially in chronic cases, Non communicable diseases etc
		Patients are engaged in their own care		PI/SI	Clinician counsel the patient on medication safety using *"5 moments for medication safety app"*
Standard E7	**Facility has defined procedures for safe Medicine administration**				
ME E7.2	Medication orders are written legibly and adequately	Every Medical advice and procedure is accompanied with date , time and signature		RR	
		Check for the writing, It comprehendible by the clinical staff		RR/SI	
ME E7.3	There is a procedure to check Medicine before administration/ dispensing	Medicines are checked for expiry and other inconsistency before administration		OB/SI	Check in Injection room
		Check single dose vial are not used for more than one dose		OB	Check for any open single dose vial with left over content intended to be used later on

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Check for separate sterile needle is used every time for multiple dose vial		OB	In multi dose vial needle is not left in the septum
		Any adverse Medicine reaction is recorded and reported		RR/SI	Adverse drug event trigger tool is used to report the events
ME E7.5	Patient is counselled for self Medicine administration	Patient is advice by doctor/ Pharmacist /nurse about the dosages and timings .		SI/PI	
Standard E8	**Facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage**				
ME E8.1	All the assessments, re-assessment and investigations are recorded and updated	Patient History, Chief Complaint and Examination Diagnosis/ Provisional Diagnosis is recorded in OPD slip		RR	(Manually/e-records)
ME E8.2	All treatment plan prescription/orders are recorded in the patient records.	Written Prescription Treatment plan is written		RR	(Manually/e-records)
ME E8.4	Procedures performed are written on patients records	Any dressing/injection, other procedure recorded in the OPD slip		RR	(Manually/e-records)
ME E8.5	Adequate form and formats are available at point of use	Check for the availability of OPD slip, Requisition slips etc.		OB/SI	
ME E8.6	Register/records are maintained as per guidelines	OPD records are maintained		OB/RR	OPD register, ANC register, Injection room register etc
		All register/records are identified and numbered		OB/RR	
ME E8.7	The facility ensures safe and adequate storage and retrieval of medical records	Safe keeping of OPD records		OB/SI	
Standard E11	**The facility has defined and established procedures for Emergency Services and Disaster Management**				
ME E11.3	The facility has disaster management plan in place	Staff is aware of disaster plan		SI/RR	
		Role and responsibilities of staff in disaster is defined		SI/RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard E12	**The facility has defined and established procedures of diagnostic services**				
ME E12.1	There are established procedures for Pre-testing Activities	Container is labelled properly after the sample collection		OB	
ME E12.3	There are established procedures for Post-testing Activities	Clinics is provided with the critical value of different tests		SI/RR	
MATERNAL & CHILD HEALTH SERVICES					
Standard E17	**Facility has established procedures for Antenatal care as per guidelines**				
ME E17.1	There is an established procedure for Registration and follow up of pregnant women.	Facility provides and updates "Mother and Child Protection Card".		RR/SI	Line listing
		Records are maintained for ANC registered pregnant women		RR	Records of each ANC check-ups is maintained in Mother and child protection card
ME E17.2	There is an established procedure for History taking, Physical examination, and counselling for each antenatal visit.	ANC check-ups is done by Qualified personnel		RR/SI	
		At ANC clinic, Pregnancy is confirmed by performing urine test		RR/SI	
		Last menstrual period (LMP) is recorded and Expected date of Delivery (EDD) is calculated		RR/SI	
		Assessment of Clinical condition of pregnant women & foetus during all ANC Check-up		RR/SI	Gestational Age, general & systemic examination including breast examination , medical, surgical & personal history etc
		Weight & Blood pressure measurement		RR/SI	
		Pallor, oedema and icterus.		RR/SI	
		Abdominal palpation for foetal growth, foetal lie		RR/SI	
		Auscultation for foetal heart sound		RR/SI	
		PV examination during 4th ANC		RR/SI	to check pelvic adequacy - in 37 weeks
		4 ANC & 1 PMSMA check-ups of women is done		RR/SI	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Identification & Management of hypertensive disorders		RR/SI	(a) Confirm hypertension & identify the pregnant women with severe PE/E (b) Manage hypertension as per guidelines
		Management of the Syphilis reactive pregnant women		RR/SI	(a) Treatment as per the guidelines (b) Quantitative & qualitative RPR/VDRL test (c) Test/treat the spouse/ partner
		Management of the Syphilis non reactive high risk pregnant women		RR/SI	Retest high-risk women in third trimester or soon after delivery
		Management of pregnant women with GDM			(a) Medical Nutrition Therapy (MNT) & Physical exercise for 2 weeks (b) After 2 weeks of MNT & physical exercise - 2hrs PPBS - if 2hrs PPBS is less than 120mg/dl- repeat the test as per protocol- one test every month during 2nd & 3rd trimesters - if 2hrs PPBS is more 120mg/ dl - medical management (metformin or insulin therapy to be started as per guidelines (c) Foetal surveillance - Foetal auscultation in Antenatal visit
		Identification & management of hypothyroidism			(a) Screening of high-risk Pregnant women (Areas with moderate to severe iodine deficiency, obesity, history - of thyroid dysfunction/ surgery, to first-degree relatives, mental retardation, autoimmune disease, frequent miscarriage, pre-term delivery etc.) (b) Hormonal assay - TSH & FT4 (c) Treatment as per guidelines- Levothyroxine
ME E17.3	Facility ensures availability of diagnostic and Medicines during antenatal care of pregnant women	Diagnostic test under ANC check up are prescribed by ANC clinic		RR/SI	Check for Haemoglobin, urine albumin, urine sugar, blood group and Rh factor ,Syphilis (VDRL/RPR) HIV, blood sugar, malaria & Hepatitis B
		Oral glucose tolerance test (OGTT) is done for all pregnant women		RR/SI	(a) Universal screening of all pregnant women at the time of first antenatal contact. (b) if the first test is negative second test - 24-28 week of gestation

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME E17.4	There is an established procedure for identification of High risk pregnancy and appropriate treatment/ referral as per scope of services.	High risk pregnant women are referred to specialist		RR/SI	(a) PIH, GDM, Malaria, HIV, syphilis, APH, (b) From ANC clinic to PMSMA (c) Sticker indicating the risk factor/ condition of the pregnant woman - placed in MCP card in PMSMA
ME E17.5	There is an established procedure for identification and management of moderate and severe anaemia	Line listing of pregnant women with moderate and sever anaemia		RR/SI	
		Provision for Injectable Iron Treatment for moderate anaemia		RR/SI	
ME E17.6	Counselling of pregnant women is done as per standard protocol and gestational age	Nutritional counselling		RR/PI	
		Nutrition & Rest		RR/PI	Iron, folic acid & calcium supplementation
		Recognizing danger sign of labour		RR/PI	
		Breast feeding		RR/PI	
		Institutional delivery		RR/PI	
		Arrangement of referral transport		RR/PI	
		Birth preparedness		RR/PI	
		Family planning		RR/PI	
Standard E22	**Facility provides Adolescent Reproductive and Sexual Health services as per guidelines**				
ME E22.1	Facility provides Promotive ARSH Services	Provision of Antenatal natal check up for pregnant adolescent		SI/RR	Nutritional Counselling, contraceptive counselling, Couple counselling ANC check-ups, ensuring institutional delivery
		Counselling and provision of emergency contraceptive pills		SI/RR	Check for the availability of Emergency Contraceptive pills (Levonorgestrel)
		Counselling and provision of reversible Contraceptives		RR/SI	Check for the availability of Oral Contraceptive Pills, Condoms and IUD
		Availability and Display of IEC material		OB	Poster Displayed, Reading Material handouts etc.

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Information and advice ob. sexual and reproductive health related issues		SI/RR	Advice on topic related to Growth and development,puberty,sexuality cancers, myths & misconception, pregnancy, safe sex, contraception, unsafe abortion, menstrual disorders,anemia, sexual abuse ,RTI/STI's etc.
ME E22.2	Facility provides Preventive ARSH Services	Services for Tetanus immunization		SI/RR	TT at 10 and 16 year
		Services for Prophylaxis against Nutritional Anaemia		SI/RR	Haemoglobin estimation, weekly IFA tablet, and treatment for worm infestation
		Nutrition Counselling		SI/RR	
		Services for early and safe termination of pregnancy and management of post abortion complication		SI/RR	MVA procedure for pregnancy up to 8 week Post abortion counselling
ME E22.3	Facility Provides Curative ARSH Services	Treatment of Common RTI/STI's		SI/RR	Privacy and Confidentiality, treatment Compliance, Partner Management, Follow up visit and referral
		Treatment and counselling for Menstrual disorders		SI/RR	Symptomatic treatment , counselling
		Treatment and counselling for sexual concern for male and female adolescents		SI/RR	
		Management of sexual abuse amongst Girls		SI/RR	ECP, Prophylaxis against STI, PEP for HIV and Counselling
ME E22.4	Facility Provides Referral Services for ARSH	Referral Linkages to ICTC and PPTCT		SI/RR	
		Privacy and confidentiality maintained at ARSH clinic		SI/RR	Screens and curtains for visual privacy,confidentaility policy displayed, one client at a time
Standard E23	**Facility provides National health program as per operational/Clinical Guidelines**				
ME E23.1	Facility provides service under National Vector Borne Disease Control Program as per guidelines	Ambulatory care of uncomplicated P. Vivax malaria		SI/RR	As per Clinical Guidelines for Treatment of Malaria
		Ambulatory care of uncomplicated P. Falciparum Malaria		SI/RR	As per Clinical Guidelines for Treatment of Malaria
		Ambulatory care of Medicine resistant malaria		SI/RR	As per Clinical Guidelines for Treatment of Malaria

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME E23.2	Facility provides service under National TB Elimination Program as per guidelines	Staff is aware of symptoms or signs Presumptive pulmonary TB as per revised guidelines		SI/RR	Cough >2 weeks, fever >2 weeks, significant weight loss, haemoptysis, any abnormalities in chest radiography. Addition, contact of microbiologically confirmed TB patients, PL HIV, diabetics, malnourished, cancer patients, patients on immunosuppressive therapy
		Staff is aware of Signs and symptoms of Extra pulmonary Tuberculosis		SI/RR	Organ specific symptoms and signs like swelling of lymph nodes, pain & swelling in joints, neck stiffness, disorientation, etc or constitutional symptoms like weight loss, fever> 2 weeks night sweat
		Staff is aware of signs and symptoms of presumptive paediatric TB cases as per revised guidelines		SI/RR	Child with persistent fever and/ or cough for more than 2 weeks. Unexplained Loss of weight/no weight gain in past 3 months/here loss of body weight loss of >5% body weight as compared to highest weight recorded in the last 3 months.
		Staff is aware of presumptive DRTB cases as per revised guidelines		SI/RR	(1)TB patients who have failed treatment with first-line anti-tubercular Medicines (ATD). (2)Paediatric TB non-responded. (3)TB patients who are contacts of DRTB. (4)TB patients who are found positive on any follow-up sputum smear examination during treatment with first-line ATD. (5) Previously treated TB cases (6)TB patients with HIV co-infection
		Staff is aware of classification done on the basis of Medicine resistance as per revised guidelines		SI/RR	1. Mono resistance (MR) – Biological specimen of TB Patient resistant to one first line anti TB Medicine only. 2. Poly resistance (PDR) – Biological specimen resistant to more than one anti TB Medicine, other than INH & Rifampicin. 3. Multi-Medicine resistance (MDR) – Biological specimen resistant to both INH and Rifampicin or with or without resistance to other first line ATD 4. Rifampicin resistance (RR) – Resistance to Rifampicin detected by phenotypic or genotypic method with or without resistant to other ATD excluding INH. Patient with RR manged as if MDR-TB case.

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
					5. Extensive Medicine resistance- MDR TB case whose biological specimen resistant to Fluroquinolone (FQ) and a second-line injectable ATD
		Diagnosis and treatment of Presumptive pulmonary TB as per revised guidelines		RR/SI	All the presumptive TB cases undergo sputum smear examination (spot early morning or spot-spot). If first sputum is positive not at risk of DRTB, it is microbiologically confirmed. Treatment of New Cases: Treatment in IP will consist of 8weeks of INH, Rifampicin, Pyrazinamide and Ethambutol in daily dose as per weight band categories. Only Pyrazinamide will be stopped in CP rest 3 Medicines will be continue for 16 weeks. (Daily regimen with administration of daily fixed dose combination of first line ATD as per weight band)
		Diagnosis and treatment of smear positive and presumptive multi Medicine resistance TB (MDR-TB) as per revised guidelines		RR/SI	Cartridge based Nucleic Acid Amplification test (CBNAAT) performed to rule out Rifampicin resistance and categorized as microbiologically confirmed Medicine sensitive TB or RIF resistant. Treatment: IP will be of 12 weeks, where injection Streptomycin will be stopped after 8 weeks and remaining four Medicines in daily dose for another 4 weeks as per weight band. At CP, Pyrazinamide will be stopped while rest of Medicines will be continue for another 20 weeks as daily dosage
		Diagnostic algorithm for pulmonary, extra pulmonary and paediatric TB as per revised guidelines are readily available		RR/SI	Check algorithm for all the three cases are available.

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Management of extra pulmonary TB cases as per revised guidelines		RR/SI	The CP in both new and previously treated cases may be extended 3-6 months in cases such as CNS, skeletal etc. ATD given in fixed dose on daily basis as per weight band
		Management of MDR/RRTB(without additional resistance) as per revised guidelines		RR/SI	6-9 months of IP with Kanamycin, Levofloxacin, Ethambutol, Pyrazinamide, Ethionamide, And Cyclomerize. !8 month of CP with Levofloxacin, Ethambutol, Ethionamide, And Cyclomerize
		Management of Paediatric Tuberculosis		SI/RR	As per revised RNTCP Technical Guidelines
		Management of Patients with HIV infection and Tuberculosis		SI/RR	As per revised RNTCP Technical Guidelines
		Patient and family is counselled before initiating TB treatment		SI/PI/RR	Educate patient and family about disease, dose schedule, duration, common side effects, methods of prevention, consequence of irregular treatment or premature cessation of treatment
		Treatment card and TB identity card is given		PI/RR	Treatment card will be issued in duplication if required
		Monitoring and follow up of patient done as per protocols		SI/RR	**Clinical follow up:** Should be at least monthly – the patient may visit the clinical facility or medical officer call for review may even visit the house of patient. **Laboratory follow up:** Sputum smear examination at the end of IP & end of treatment (for every patient) **Long term follow up:** After completion of treatment, the patient should be followed up at the end of 6, 12, 18 and 24 months. Any clinical symptoms and/or cough, sputum microscopy and/or culture should be considered.
		There is functional Linkage between DMC and ICTC		SI/RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME E23.3	Facility provides service under National Leprosy Eradication Program as per guidelines	Validation and Diagnosis of Referred and Directly Reported Cases		SI/RR	As per Operation/ Clinical Guidelines of NLEP
		Treatment of all diagnosed cases including Reaction and Neuritis		SI/RR	As per Operation/ Clinical Guidelines of NLEP
		Assessment of Disability Status		SI/RR	As per Operation/ Clinical Guidelines of NLEP
		Management of Lepra Reactions		SI/RR	As per Operation/ Clinical Guidelines of NLEP
		Management of Complicated Ulcers		SI/RR	As per Operation/ Clinical Guidelines of NLEP
		Management of Eye Complications		SI/RR	As per Operation/ Clinical Guidelines of NLEP
		Physiotherapy including Pre and Post Operative Care		SI/RR	As per Operation/ Clinical Guidelines of NLEP
		Follow-up of cases treated at tertiary Level		SI/RR	As per Operation/ Clinical Guidelines of NLEP
		Supply of Customized Foot wear		SI/RR	As per Operation/ Clinical Guidelines of NLEP
		Self care Counselling		SI/RR	As per Operation/ Clinical Guidelines of NLEP
		Outreach Services to Leprosy Clinics		SI/RR	As per Operation/ Clinical Guidelines of NLEP
		Screening of Cases of RCS		SI/RR	As per Operation/ Clinical Guidelines of NLEP
ME E23.4	Facility provides service under National AIDS Control program as per guidelines	Pre Test Counselling is done as per protocols		SI/RR	basic information and benefits of HIV testing potential risks such as discrimination. The client is also informed about their right to refuse, follow-up services . Pregnant women are given additional information on nutrition, hygiene, the importance of an institutional delivery and HIV testing so as to avoid HIV transmission from mother to child.

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Post test counselling given as per protocol		SI/RR	window period, a repeat test is recommended, clients with suspected tuberculosis are referred to the nearest microscopy centre. In case of a positive test result, the counsellor assists the client to understand the implications of the positive test result and helps in coping with the test result. The counsellor also ensures access to treatment and care, and supports disclosure of the HIV status to the spouse.
		Diagnosis and treatment of opportunistic Infections		SI/RR	As per NACO guidelines
		Screening of PLHA for initiating ART		SI/RR	As per NACO guidelines
		Monitoring of patients on ART and management of side effects		SI/RR	As per NACO guidelines
		Counselling and Psychological support for PLHA		SI/RR	As per NACO guidelines
ME E23.6	Facility provides service under Mental Health Program as per guidelines	Identification and treatment of mental illness as per guidelines			(a) Management of the acute psychosis, obsession, anxiety, depression, neurosis & epilepsy (b)Ensure availability medicines & regular follow up (c) Referferal of the cases as per requirement
		Identification of the cases for substance abuse		SI/RR	Treat/ refer to the de addiction centre
		Psychosocial support is provided		SI/RR	(a) Basic psycho education about treatment adherence (b) Motivation enhancement (c) Reduction of high risk behaviour (d) Relapse prevention (e) Counselling for occupational rehab. (d) Patient support group / individual counselling
ME E23.7	Facility provides service under National programme for the health care of the elderly as per guidelines	Geriatric Care is provided as per Clinical Guidelines		SI/RR	(a) Linkage with specialists like medicine, ortho, health., ENT services (b) Referral services to Regional Geriatric centre/MC

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME E23.8	Facility provides service under National Programme for Prevention and Control of cancer, diabetes, cardiovascular diseases & stroke (NPCDCS) as per guidelines	Opportunistic screening for diabetes, hypertension, cardiovascular diseases		SI/RR	Screening of persons above age of 30 - History of tobacco examination, BP Measurement and Blood sugar estimation Look for records at NCD clinic
		Screen women of the age group 30-69 years approaching to the hospital		SI/RR	for early detection of cervix cancer and breast cancer
		Health Promotion through IEC and counselling		OB	Increased intake of healthy foods, Increased physical activity through sports, exercise, etc.; Avoidance of tobacco and alcohol; stress management & warning signs of cancer etc
		Counselling the identified cases for self care		PI/RR	Council the patient for monitoring of their BP (using digital BP apparatus) , sugar (using glucometer) , self care for ulcer etc
ME E23.9	Facility provide service for Integrated disease surveillance program	Weekly reporting of Presumptive cases on form "P" from OPD clinic		SI/RR	(a) Submitted to District surveillance officer (b) Data is submitted manually or through IHIP (integrated health information platform)
ME E23.10	Facility provide services under National program for prevention and control of deafness	Early detection and screening for detection of deafness		SI/RR	As per Clinical guidelines
ME E23.11	Facility provides services under National Viral Hepatitis Control Programme	Assessment & treatment of uncomplicated cases of Viral Hepatitis		SI/RR	(a) Routine assessment of HBsAg & LFT (b) Assessment of the severity of liver disease (c) Management of the cases with evidence of compensated or decompensated cirrhosis- as per guidelines
		Follow up of the cases of the Viral Hepatitis		SI/RR	(a) Medication refill- after 25 days (b) Educate the patient on adherence & regular follow up (c) Check for side effects & investigate as per requirements & guidelines (d) Update the investigation in the treatment card

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME E 23.12	Facility provide services under National program for palliative care	Clinical assessment by trained & competent physician		SI/RR	(a) Assessment, treatment plan & prescription for cases (b) Pain Management (c) Counselling & psycho social interventions
AREA OF CONCERN - F INFECTION CONTROL					
Standard F1	**Facility has infection control program and procedures in place for prevention and measurement of hospital associated infection**				
ME F1.4	There is Provision of Periodic Medical Check-ups and immunization of staff	There is procedure for immunization of the staff		SI/RR	Hepatitis B, Tetanus Toxic etc
		Periodic medical check-ups of the staff		SI/RR	
ME F1.5	Facility has established procedures for regular monitoring of infection control practices	Regular monitoring of infection control practices		SI/RR	Hand washing and infection control audits done at periodic intervals
ME F1.6	Facility has defined and established antibiotic policy	Check for Doctors are aware of Hospital Antibiotic Policy		SI/RR	
Standard F2	**Facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis**				
ME F2.1	Hand washing facilities are provided at point of use	Availability of hand washing Facility at Point of Use		OB	Check for availability of wash basin, elbow operated tap near the point of use
		Availability of running Water		OB/SI	Ask to Open the tap. Ask Staff water supply is regular
		Availability of antiseptic soap with soap dish/ liquid antiseptic with dispenser.		OB/SI	Check for availability/ Ask staff if the supply is adequate and uninterrupted
		Availability of Alcohol based Hand rub		OB/SI	Check for availability/ Ask staff for regular supply.
		Display of Hand washing Instruction at Point of Use		OB	Prominently displayed above the hand washing facility , preferably in Local language
ME F2.2	Staff is trained and adhere to standard hand washing practices	Adherence to 6 steps of Hand washing		SI/OB	Ask of demonstration
		Staff aware of when to hand wash		SI	
ME F2.3	Facility ensures standard practices and materials for antisepsis	Availability of Antiseptic Solutions		OB	
		Proper cleaning of procedure site with antisepsis		OB/SI	like before giving IM/IV injection, drawing blood, putting Intravenous and urinary catheter

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard F3	**Facility ensures standard practices and materials for Personal protection**				
ME F3.1	Facility ensures adequate personal protection equipment as per requirements	Clean gloves are available at point of use		OB/SI	
		Availability of Masks		OB/SI	
ME F3.2	Staff is adhere to standard personal protection practices	No reuse of disposable gloves, Masks, caps and aprons.		OB/SI	
		Compliance to correct method of wearing and removing the gloves		SI	Gloves, Masks, Cap, Aprons etc
Standard F4	**Facility has standard Procedures for processing of equipment and instruments**				
ME F4.1	Facility ensures standard practices and materials for decontamination and cleaning of instruments and procedures areas	Decontamination of operating & Procedure surfaces		SI/OB	Ask staff about how they decontaminate the procedure surface like Examination table , dressing table, Stretcher/ Trolleys etc. (Wiping with 0.5% Chlorine solution
		Proper Decontamination of instruments after use		SI/OB	Ask staff how they decontaminate the instruments like Stethoscope, Dressing Instruments, Examination Instruments, Blood Pressure Cuff etc (Soaking in 0.5% Chlorine Solution, Wiping with 0.5% Chlorine Solution
		Contact time for decontamination is adequate		SI/OB	10 minutes
		Cleaning of instruments after decontamination		SI/OB	Cleaning is done with detergent and running water after decontamination
		Proper handling of Soiled and infected linen		SI/OB	No sorting ,Rinsing or sluicing at Point of use/ Patient care area
		Staff know how to make chlorine solution		SI/OB	
ME F4.2	Facility ensures standard practices and materials for disinfection and sterilization of instruments and equipment	Equipment and instruments are sterilized after each use as per requirement		OB/SI	Autoclaving/HLD/Chemical Sterilization

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		High level Disinfection of instruments/ equipment is done as per protocol		OB/SI	Ask staff about method and time required for boiling
		Autoclaved dressing material is used		OB/SI	
Standard F5	**Physical layout and environmental control of the patient care areas ensures infection prevention**				
ME F5.1	Layout of the department is conducive for the infection control practices	Facility layout ensures separation of general traffic from patient traffic		OB	
		Clinics for infectious diseases are located away from main traffic		OB	Preferably in remote corner with independent access
		Sitting arrangement in TB clinic is as per guideline		OB	
ME F5.2	Facility ensures availability of standard materials for cleaning and disinfection of patient care areas	Availability of disinfectant as per requirement		OB/SI	Chlorine solution, Glutaraldehyde, carbolic acid
		Availability of cleaning agent as per requirement		OB/SI	Hospital grade phenyl, disinfectant detergent solution
ME F5.3	Facility ensures standard practices followed for cleaning and disinfection of patient care areas	Staff is trained for spill management		SI/RR	
		Cleaning of patient care area with detergent solution		SI/RR	
		Staff is trained for preparing cleaning solution as per standard procedure		SI/RR	
		Standard practice of mopping and scrubbing are followed		OB/SI	Unidirectional mopping from inside out
		Cleaning equipment like broom are not used in patient care areas		OB/SI	Any cleaning equipment leading to dispersion of dust particles in air should be avoided
Standard F6	**Facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.**				
ME F6.1	Facility Ensures segregation of Bio Medical Waste as per guidelines	Availability of colour coded bins at point of waste generation		OB	
		Availability of colour coded non chlorinated plastic bags		OB	Adequate number. Covered. Foot operated.

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Segregation of Anatomical and soiled waste in Yellow Bin		OB/SI	Human Anatomical waste, Items contaminated with blood, body fluids, dressings, plaster casts, cotton swabs and bags containing residual or discarded blood and blood components.
		Segregation of infected plastic waste in red bin		OB	Items such as tubing, bottles, intravenous tubes and sets, catheters, urine bags, syringes (without needles and fixed needle syringes) and vacutainers' with their needles cut) and gloves
		Display of work instructions for segregation and handling of Biomedical waste		OB	Pictorial and in local language
		There is no mixing of infectious and general waste			
ME F6.2	Facility ensures management of sharps as per guidelines	Availability of functional needle cutters		OB	See if it has been used or just lying idle
		Segregation of sharps waste including Metals in white (translucent) Puncture proof, Leak proof, tamper proof containers		OB	Should be available nears the point of generation. Needles, syringes with fixed needles, needles from needle tip cutter or burner, scalpels, blades, or any other contaminated sharp object that may cause puncture and cuts. This includes both used, discarded and contaminated metal sharps
		Availability of post exposure prophylaxis		SI/OB	Ask if available. Where it is stored and who is in charge of that.
		Staff knows what to do in condition of needle stick injury		SI	Staff knows what to do in case of shape injury. Whom to report. See if any reporting has been done
		Contaminated and broken Glass are disposed in puncture proof and leak proof box/ container with Blue colour marking		OB	Vials, slides and other broken infected glass

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME F6.3	Facility ensures transportation and disposal of waste as per guidelines	Check bins are not overfilled		SI/OB	
		Transportation of bio medical waste is done in close container/ trolley			
		Staff is aware of mercury spill management		SI/RR	Check for: 1. Spill area evacuation 2. Removal of Jewellery 3. Wear PPE 4. Use of flashlight to locate mercury beads 5. Use syringe without a needle/eyedropper and sticky tape to suck the beads 6. Collection of beads in leak-proof bag or container 7. Sprinkle sulphur or zinc powder to remove any remaining mercury 8. All the mercury spill surfaces should be decontaminated with 10% sodium thiosulfate solution 9. All the bags or containers containing items contaminated with mercury should be marked as "Hazardous Waste, Handle with Care" 10. Collected mercury waste should be handed over to the CBMWTF
AREA OF CONCERN - G QUALITY MANAGEMENT					
Standard G1	**The facility has established organizational framework for quality improvement**				
ME G1.1	The facility has a quality team in place	There is a designated departmental nodal person for coordinating Quality Assurance activities		SI/RR	1. Check if the quality circle has been constituted and is functional 2. Roles and Responsibility of quality circle has been defined
Standard G2	**Facility has established system for patient and employee satisfaction**				
ME G2.1	Patient Satisfaction surveys are conducted at periodic intervals	OPD Patient satisfaction survey done on monthly basis		RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard G3	**Facility have established internal and external quality assurance programs wherever it is critical to quality.**				
ME G3.1	Facility has established internal quality assurance program at relevant departments	There is system daily round by matron/hospital manager/ hospital superintendent/ Hospital Manager/ Matron in charge for monitoring of services		SI/RR	
		Internal Quality Assurance is established at ICTC lab		SI/RR	
ME G3.2	Facility has established external assurance programs at relevant departments	External Quality assurance program is established at ICTC lab		SI/RR	
ME G3.3	Facility has established system for use of check lists in different departments and services	Internal assessment is done at periodic interval		RR/SI	1. NQAS assessment toolkit is used to conduct internal assessment 2. SaQushal assessment toolkit
		Departmental checklist are used for monitoring and quality assurance		SI/RR	Staff is designated for filling and monitoring of these checklists
		Non-compliances are enumerated and recorded		RR	Check the non compliances are presented & discussed during quality team meetings
ME G3.4	Actions are planned to address gaps observed during quality assurance process	Check action plans are prepared and implemented as per internal assessment record findings		RR	Randomly check the details of action, responsibility, time line and feedback mechanism
ME G3.5	Planned actions are implemented through Quality Improvement Cycles (PDCA)	Check PDCA or revalent quality method is used to take corrective and preventive action		SI/RR	Check actions have been taken to close the gap. It can be in form of action taken report or Quality Improvement (PDCA) project report
Standard G4	**Facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.**				
ME G4.1	Departmental standard operating procedures are available	Standard operating procedure for department has been prepared and approved		RR	
		Current version of SOP are available with process owner		OB/RR	
		Work instruction/ clinical protocols are displayed		OB	Relevant protocols are displayed like Clinical Protocols for ANC check-ups

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME G4.2	Standard Operating Procedures adequately describes process and procedures	OPD has documented procedure for Registration		RR	
		OPD has documented procedure for patient calling system in OPD clinics		RR	
		OPD has documented procedure for receiving of patient in clinic		RR	
		OPD has documented process for OPD consultation		RR	
		OPD has documented procedure for investigation		RR	
		OPD has documented procedure for prescription and Medicine dispensing		RR	
		OPD has documented procedure for nursing process in OPD		RR	
		OPD has documented procedure for patient privacy and confidentiality		RR	
		OPD has documented procedure for conducting, analysing patient satisfaction survey		RR	
		OPD has documented procedure for equipment management and maintenance in OPD		RR	
		Department has documented procedure for Administrative and non clinical work at OPD		RR	
		Department has documented procedure for No Smoking Policy in OPD		RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		OPD has documented procedure for duty roaster, punctuality, dress code and identity for OPD staff		RR	
ME G4.3	Staff is trained and aware of the standard procedures written in SOPs	Check Staff is a aware of relevant part of SOPs		SI/RR	
Standard G 5	**Facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages**				
ME G5.1	Facility maps its critical processes	Process mapping of critical processes done		SI/RR	
ME G5.2	Facility identifies non value adding activities / waste / redundant activities	Non value adding activities are identified		SI/RR	
ME G5.3	Facility takes corrective action to improve the processes	Processes are rearranged as per requirement		SI/RR	
Standard G6	**The facility has defined mission, values, Quality policy & objectives & prepared a strategic plan to achieve them**				
ME G6.4	Facility has de defined quality objectives to achieve mission and quality policy	Check if SMART Quality Objectives have framed		SI/RR	Check short term valid quality objectivities have been framed addressing key quality issues in each department and cores services. Check if these objectives are Specific, Measurable, Attainable, Relevant and Time Bound.
ME G6.5	Mission, Values, Quality policy and objectives are effectively communicated to staff and users of services	Check of staff is aware of Mission , Values, Quality Policy and objectives		SI/RR	Interview with staff for their awareness. Check if Mission Statement, Core Values and Quality Policy is displayed prominently in local language at Key Points
ME G6.7	Facility periodically reviews the progress of strategic plan towards mission, policy and objectives	Check time bound action plan is being reviewed at regular time interval		SI/RR	Review the records that action plan on quality objectives being reviewed at least once in month by departmental in charges and during the quality team meeting. The progress on quality objectives have been recorded in Action Plan tracking sheet
Standard G7	**Facility seeks continually improvement by practicing Quality method and tools.**				
ME G7.1	Facility uses method for quality improvement in services	Basic quality improvement method		SI/RR	PDCA & 5S
		Advance quality improvement method		SI/OB	Six sigma, lean.

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME G7.2	Facility uses tools for quality improvement in services	7 basic tools of Quality		SI/RR	Minimum 2 applicable tools are used in each department
Standards G9	**Facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan**				
ME G9.6	Periodic assessment for Medication and Patient care safety risks is done as per defined criteria.	Check periodic assessment of medication and patient care safety risk is done using defined checklist periodically		SI/RR	Verify with the records. A comprehensive risk assessment of all clinical processes should be done using pre define criteria at least once in three month.
ME G9.7	Periodic assessment for potential risk regarding safety and security of staff including violence against service providers is done as per defined criteria	SaQushal assessment toolkit is used for safety audits.		SI/RR	1. Check that the filled checklist and action taken report are available 2. Staff is aware of key gaps & closure status
ME G9.8	Risks identified are analysed evaluated and rated for severity	Identified risks are analysed for severity		SI/RR	Action is taken to mitigate the risks
Standard G10	**The facility has established clinical Governance framework to improve quality and safety of clinical care processes**				
ME G10.3	Clinical care assessment criteria have been defined and communicated	The facility has established process to review the clinical care		SI/RR	Check parameter are defined & implemented to review the clinical care i.e. through Ward round, peer review, morbidity & mortality review, patient feedback, clinical audit & clinical outcomes.
		Check regular ward rounds are taken to review case progress		SI/RR	(1) Both critical and stable patients (2) Check the case progress is documented in BHT/ progress notes-
		Check the patient / family participate in the care evaluation		SI/PI	Feedback is taken from patient/ family on health status of individual under treatment
		Check the care planning and co-ordination is reviewed		SI/RR	System in place to review internal referral process, review clinical handover information, review patient understanding about their progress

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME G10.4	Facility conducts the periodic clinical audits including prescription, medical and death audits	There is procedure to conduct prescription audits		SI/RR	(1) Random prescriptions are audited (2) Separate Prescription audit is conducted foe both OPD & IPD cases (3) The finding of audit is circulated to all concerned (4) Regular trends are analysis and presented in Clinical Governance board/Grand round meetings
		All non compliance are enumerated recorded for prescription audits		SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings
ME G10.5	Clinical care audits data is analysed, and actions are taken to close the gaps identified during the audit process	Check action plans are prepared and implemented as per medical audit record findings		SI/RR	Randomly check the actual compliance with the actions taken reports of last 3 months
		Check action plans are prepared and implemented as per prescription audit record findings		SI/RR	Randomly check the actual compliance with the actions taken reports of last 3 months
		Check the data of audit findings are collated		RR	Check collected data is analysed & areas for improvement is identified & prioritised
		Check PDCA or revalent quality method is used to address critical problems		SI/RR	Check the critical problems are regularly monitored & applicable solutions are duplicated in other departments (wherever required) for process improvement
ME G10.7	Facility ensures easy access and use of standard treatment guidelines & implementation tools at point of care	Check standard treatment guidelines / protocols are available & followed.		SI/RR	Staff is aware of Standard treatment protocols/ guidelines/best practices
		Check treatment plan is prepared as per Standard treatment guidelines		SI/RR	Check staff adhere to clinical protocols while preparing the treatment plan
		Check the drugs are prescribed as per Standards treatment guidelines		SI/RR	Check the drugs prescribed are available in EML or part of drug formulary

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Check the updated/ latest evidence are available		SI/RR	Check when the STG/protocols/ evidences used in healthcare facility are published. Whether the STG protocols are according to current evidences.
		Check the mapping of existing clinical practices processes is done		SI/RR	The gaps in clinical practices are identified & action are taken to improve it. Look for evidences for improvement in clinical practices using PDCA
AREA OF CONCERN - H OUTCOME					
Standard H1	**The facility measures Productivity Indicators and ensures compliance with State/National benchmarks**				
ME H1.1	Facility measures productivity Indicators on monthly basis	Proportion of follow-up patients		RR	
		No of ANC done per thousand		RR	
		ICTC OPD per thousand		RR	
		ART patient load per thousand		RR	
		ARSH OPD per thousand		RR	
		No. of Geriatric cases admitted in geriatric Ward		RR	
Standard H2	**The facility measures Efficiency Indicators and ensure to reach State/National Benchmark**				
ME H2.1	Facility measures efficiency Indicators on monthly basis	Medicine OPD per Doctor		RR	
		Surgery OPD per Doctor		RR	
		OBG OPD per Doctor		RR	
		Dental OPD per Doctor		RR	
		Ophthalmology OPD per doctor		RR	
		Skin & OPD per doctor		RR	
		TB/DOT pod per doctor		RR	
		ENT OPD per doctor		RR	
		Psychiatry OPD per doctor		RR	
		AYUSH OPD per doctor		RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard H3	**The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark**				
ME H3.1	Facility measures Clinical Care & Safety Indicators on monthly basis	Consultation time at ANC Clinic		RR	Time motion study
		Consultation time at General Medicine Clinic		RR	
		Consultation time for General Surgery Clinic		RR	
		Proportion of High risk pregnancy detected during ANC		RR	No of High Risk Pregnancies X100/ Total no PW used ANC services in the month
		Proportion of severe anaemia cases		RR	
Standard H4	**The facility measures Service Quality Indicators and endeavours to reach State/National benchmark**				
ME H4.1	Facility measures Service Quality Indicators on monthly basis	Patient Satisfaction Score		RR	
		Waiting time at registration counter		RR	
		Waiting time at ANC Clinic		RR	
		Waiting time at general OPD		RR	
		Waiting time at paediatric Clinic		RR	
		Waiting time at surgical clinic		RR	
		Average door to Medicine time		RR	

ASSESSMENT SUMMARY

Name of the Hospital .....

Date of Assessment .....

Names of Assessors .....

Names of Assessees .....

Type of Assessment (Internal/External) .....

Action plan Submission Date .....

A. SCORE CARD

OUTDOOR PATIENT DEPARTMENT SCORE CARD	
Area of Concern wise score	**Outdoor Patient Department Score**
A. Service Provision	
B. Patient Rights	
C. Inputs	
D. Support Services	
E. Clinical Services	
F. Infection Control	
G. Quality Management	
H. Outcome	

B. MAJOR GAPS OBSERVED

1. _____
2. _____
3. _____
4. _____
5. _____

C. STRENGTHS/BEST PRACTICES

1. _____
2. _____
3. _____

D. RECOMMENDATIONS/OPPORTUNITIES FOR IMPROVEMENT

_____

_____

_____

Names and Signature of Assessors

Date _____

सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

CHECKLIST-3

OPERATION THEATRE

CHECKLIST FOR OPERATION THEATRE

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
AREA OF CONCERN - A SERVICE PROVISION					
Standard A1	Facility Provides Curative Services				
ME A1.2	The facility provides General Surgery services	Availability of General Surgery procedures		SI/OB	Appendectomy, Intestinal Obstruction, Perforation, Tongue Tie, Inguinal Hernia, haemorrhoidectomy, Abscess drainage (perianal), Liver abscess, Cholecystectomy, superficial tumour excision.
ME A1.3	The facility provides Obstetrics & Gynaecology Services	Availability of Gynaecology procedures		SI/OB	(a) D & C, Hysterectomy, Cervical Cautery, Bartholin cyst excision, explorative laparotomy (uterine perforation, twisted ovarian), sling operation, haematocolpus drainage colpotomy (b) Lump excision, Simple mastectomy, Mammary fistula excision, Abscess drainage (breast)
ME A1.4	The facility provides Paediatric Services	Availability of Paediatric Surgery procedure		SI/OB	I&D, Pepuceal Dilation, Meatomy, Gland Biopsy, Reduction Paraphimosis, Brachial/Thyroglossal Cyst and Fistula, Inguinal Herniotomy, Neonatal Intestinal Obstruction
ME A1.5	The facility provides Ophthalmology Services	Availability of Ophthalmic Surgery procedures		SI/OB	Cataract Extraction with IOL, Canthotomy, Paracentesis, Enucleation, Glaucoma surgery, Conjunctival Cyst,
ME A1.6	The facility provides ENT Services	Availability of ENT surgical procedure		SI/OB	Nose, Ear and Throat surgical procedures Packing, therapeutic removal of granulation (nasal, aural, oropharynx), Mastoid abscess, myringoplasty, endoscopic sinus surgery, Antral Puncture, Fracture Reduction, Mastoid Abscess I & D, periauricular sinus excision, stitching of CLW (nose & ear)
ME A1.7	The facility provides Orthopaedics Services	Availability of Orthopaedic surgical procedures		SI/OB	Open and Closed Reduction, Nailing and Plating, Amputation, Disarticulation of Hip and Shoulder
ME A1.10	The facility provides Dental Treatment Services	Availability of Oral surgery procedures		SI/OB	Trauma Including Vehicular Accidents , Fracture Wiring
ME A1.14	Services are available for the time period as mandated	OT Services are available 24X7		SI/RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME A1.16	The facility provides Accident & Emergency Services	Availability of Emergency OT services as and even when required		SI/OB	Check the number of emergency surgeries conducted in last 3 months
Standard A2	**Facility provides RMNCHA Services**				
ME A2.4	The facility provides Child health Services	Availability of Paediatric surgical Procedure under RBSK		SI/OB	Developmental Dysplasia of the Hip, Congenital Cataract, cleft lip and palate
Standard A3	**Facility Provides diagnostic Services**				
ME A3.1	The facility provides Radiology Services	Availability of portable x-ray machine		SI/OB	Check availability of functional C arm for 300 and above beds
ME A3.2	The facility Provides Laboratory Services	Availability of point of care diagnostic test		SI/OB	Blood gas analyser& USG
Standard A4	**Facility provides services as mandated in national Health Programs/ state scheme**				
ME A4.3	The facility provides services under National Leprosy Eradication Programme as per guidelines	Availability of Reconstructive Surgery		SI/OB	Reconstruction of hand (tendon repair), polio surgery
		Availability of Amputation Surgery		SI/OB	
AREA OF CONCERN - B PATIENT RIGHTS					
Standard B1	**Facility provides the information to care seekers, attendants & community about the available services and their modalities**				
ME B1.1	The facility has uniform and user-friendly signage system	Availability of departmental & directional signages		OB	Numbering, main department and internal sectional signage are played
		Signage for restricted area are displayed		OB	
		Zones of OT are marked		OB	
ME B1.2	The facility displays the services and entitlements available in its departments	Information regarding services are displayed		OB	Display doctor/ Nurse on duty and updated OT schedule displayed
		OT schedule displayed		OB	
ME B1.6	Information is available in local language and easy to understand	Signage's and information are available in local language		OB	
Standard B2	**Services are delivered in a manner that is sensitive to gender, religious and cultural needs, and there are no barrier on account of physical, economic, cultural or social reasons.**				
ME B2.1	Services are provided in manner that are sensitive to gender	Availability of female staff if a male doctor examination/ conduct surgery of a female patients		OB/SI	Availability of female staff in pre and post operative room
ME B2.3	Access to facility is provided without any physical barrier & and friendly to people with disabilities	Availability of Wheel chair or stretcher for easy Access to the OT		OB	
		Availability of ramps with railing		OB	At least 120 cm width, gradient not steeper than 1:12

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard B3	**The facility maintains privacy, confidentiality & dignity of patient, and has a system for guarding patient related information.**				
ME B3.1	Adequate visual privacy is provided at every point of care	Availability of screen between OT table		OB	
		Patients are properly draped/ covered before and after produce		OB	
ME B3.2	Confidentiality of patients records and clinical information is maintained	Patient Records are kept at secure place beyond access to general staff/visitors		SI/OB	
		No information regarding patient identity and details are unnecessary displayed		SI/OB	
ME B3.3	The facility ensures the behaviours of staff is dignified and respectful, while delivering the services	Behaviour of staff is empathetic and courteous		PI/OB	
ME B3.4	The facility ensures privacy and confidentiality to every patient, especially of those conditions having social stigma, and also safeguards vulnerable groups	Privacy and Confidentiality of HIV cases		SI/OB	
Standard B4	**Facility has defined and established procedures for informing and involving patient and their families about treatment and obtaining informed consent wherever it is required.**				
ME B4.1	There is established procedures for taking informed consent before treatment and procedures	Consent is taken before major surgeries		SI/RR	
		Anaesthesia Consent for OT		SI/RR	
ME B4.4	Information about the treatment is shared with patients or attendants, regularly	Patient attendant is informed about clinical condition and treatment been provided		PI/SI	
Standard B5	**Facility ensures that there are no financial barrier to access and that there is financial protection given from cost of care.**				
ME B5.1	The facility provides cashless services to pregnant women, mothers and neonates as per prevalent government schemes	Free medicines and consumables are available		PI/SI	JSSK
		All surgical procedure are free of cost as per entitlements		PI/SI	PMJAY beneficiaries/ state scheme etc
ME B5.2	The facility ensures that drugs prescribed are available at Pharmacy and wards	Check that patient party has not spent on purchasing drugs or consumables from outside.		PI/SI	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME B5.3	It is ensured that facilities for the prescribed investigations are available at the facility	Check that patient party has not spent on diagnostics from outside.		PI/SI	
ME B5.4	The facility provide free of cost treatment to Below poverty line patients without administrative hassles	Surgical services are free for BPL patients		PI/SI/RR	
AREA OF CONCERN - C INPUTS					
Standard C1	The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms				
ME C1.1	Departments have adequate space as per patient or work load	Adequate space for accommodating surgical load		OB	
		Availability of OT for elective major surgeries		OB	100-200 -1OT, 200-300-2, 300-400 -3
		Availability of OT for Emergency surgeries		OB	Emergency OT 1
		Availability of OT ophthalmic/ENT		OB	Ophthalmic/ENT- 1
		Waiting area for attendants		OB	
ME C1.2	Patient amenities are provide as per patient load	Functional toilets with running water and flush are available		OB	In the OT waiting area for patient relatives/ in the vicinity of OT
		Availability of drinking water		OB	Check for availability of Hot water facility
		Availability of seating arrangement		OB	
ME C1.3	Departments have layout and demarcated areas as per functions	Demarcated of Protective Zone		OB	
		Demarcated Clean Zone		OB	
		Demarcated sterile Zone		OB	
		Demarcated disposal Zone		OB	
		Availability of Changing Rooms		OB	
		Availability of Pre & post Operative Room		OB	
		Availability of Scrub Area		OB	
		Availability of Autoclave room/ TSSU		OB	
		Availability of dirty utility area		OB	
		Availability of store		OB	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME C1.4	The facility has adequate circulation area and open spaces according to need and local law	Corridors are wide enough for movement of trolleys		OB	2-3 meters
ME C1.5	The facility has infrastructure for intramural and extramural communication	Availability of functional telephone and Intercom Services		OB	
ME C1.6	Service counters are available as per patient load	OT tables are available as per load		OB	Hydraulic OT Tables As per case load at least two for 100 - 200 bedded DH and 4 for More than 200 beds
ME C1.7	The facility and departments are planned to ensure structure follows the function/processes (Structure commensurate with the function of the hospital)	Unidirectional flow of goods and services		OB	No cris cross of infectious and sterile goods
Standard C2	**The facility ensures the physical safety of the infrastructure.**				
ME C2.1	The facility ensures the seismic safety of the infrastructure	Non structural components are properly secured		OB	Check for fixtures and furniture like cupboards, cabinets, and heavy equipment , hanging objects are properly fastened and secured
ME C2.3	The facility ensures safety of electrical establishment	OT does not have temporary connections and loosely hanging wires		OB	
		Adequate electrical socket provided for safe and smooth operation of equipment		OB	Power boards are marked as per phase to which it belongs
		Availability of three phase electricity supply		OB	
		OT has mechanism for periodical check / test of all electrical installation by competent electrical Engineer		OB	
		Wall mounted digital display is available in OT to show earth to neutral voltage		OB	
		Quality output of voltage stabilizer is displayed in each stabilizer as per manufacturer guideline		OB	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME C2.4	Physical condition of buildings are safe for providing patient care	Floors of the ward are non slippery and even		OB	
		Walls and floor of the OT covered with joint less tiles		OB	
		Windows/ ventilators if any in the OT are intact and sealed		OB	
Standard C3	**The facility has established Programme for fire safety and other disaster**				
ME C3.1	The facility has plan for prevention of fire	OT has sufficient fire exit to permit safe escape to its occupant at time of fire		OB/SI	
		Check the fire exits are clearly visible and routes to reach exit are clearly marked.		OB	
ME C3.2	The facility has adequate fire fighting Equipment	OT room has installed fire Extinguisher that is Class A , Class B, C type or ABC type		OB	
		Check the expiry date for fire extinguishers are displayed on each extinguisher as well as due date for next refilling is clearly mentioned		OB/RR	
ME C3.3	The facility has a system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation	Check for staff competencies' for operating fire extinguisher and what to do in case of fire		SI/RR	
Standard C4	**The facility has adequate qualified and trained staff, required for providing the assured services to the current case load**				
ME C4.1	The facility has adequate specialist doctors as per service provision	Availability of Obg & Gynae Surgeon		OB/RR	As per case load
		Availability of general surgeon		OB/RR	As per case load
		Availability of Orthopaedic Surgeon		OB/RR	As per case load
		Availability of ophthalmic surgeon		OB/RR	As per case load
		Availability of ENT surgeon		OB/RR	As per case load
		Availability of anaesthetist		OB/RR	As per case load

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME C4.3	The facility has adequate nursing staff as per service provision and work load	Availability of Nursing staff		OB/RR/SI	As per patient load , at least two
ME C4.4	The facility has adequate technicians/paramedics as per requirement	Availability of OT technician		OB/SI	
ME C4.5	The facility has adequate support / general staff	Availability of OT attendant/assistant		SI/RR	
		Availability CSSD/ TSSU Asstt.		SI/RR	
		Availability of Security staff		SI/RR	
Standard C5	**Facility provides drugs and consumables required for assured list of services.**				
ME C5.1	The departments have availability of adequate drugs at point of use	Availability of Medical gases		OB/RR	Availability of Oxygen Cylinders / Piped Gas supply, Nitrogen
		Availability of Anti-Infective medicines - Antibiotics, Antifungal		OB/RR	Inj. Ampillicin, Inj. metronidazole Inj. Gentamycin,
		Availability of Antihypertensive medicines		OB/RR	Injectable preparations
		Availability of analgesics and antipyretics		OB/RR	Tab Paracetamol, Ibuprofen, Inj. Diclofenac, Sodium plasma expender
		Availability of Solutions Correcting Water, Electrolyte Disturbances and Acid-Base Disturbances		OB/RR	IV fluids, Normal saline, Ringer lactate,
		Availability of anaesthetic agents		OB/RR	As per the State's EML - Topical agents: Lignocaine, Xylocaine Inhaled agents: Halothane, Nitrous oxide. Injectable: Barbiturates (Thiopental, Thiamylal, methohexital, Benzodiazepines)
		Availability of other medicines			Tab B complex, Inj. Betamethasone, Inj. Hydralazine, Methyldopa, HIV drugs
		Availability of emergency drugs		OB/RR	Inj. Magnesium sulphate 50%, Inj. Calcium Gluconate 10%, Inj. Dexamethasone, Inj. Hydrocortisone Succinate, Inj. Diazepam, Inj. Pheniramine maleate, Inj Corboprost, Inj. Pentazocine, Inj. Promethazine, Betamethason, Inj. Hydrazaline, Nifedipine, Methyldopa, Ceftriaxone

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME C5.2	The departments have adequate consumables at point of use	Availability of dressings and Sanitary pads		OB/RR	
		Availability of syringes and IV Sets		OB/RR	
		Availability of Antiseptic Solutions		OB/RR	Ethyl Alcohol, Povidone Iodine Solution
		Availability of consumables for new born care		OB/RR	
		Availability of personal protective equipment		OB/RR	
ME C5.3	Emergency drug trays are maintained at every point of care, where ever it may be needed	Emergency drug tray is maintained in OT in pre and post operative room		OB/RR	
Standard C6	**The facility has equipment & instruments required for assured list of services.**				
ME C6.1	Availability of equipment & instruments for examination & monitoring of patients	Availability of functional Equipment &Instruments for examination & Monitoring		OB	BP apparatus, Thermometer, Pulse Oxy meter, Multiparameter , PV Set
ME C6.2	Availability of equipment & instruments for treatment procedures, being undertaken in the facility	Availability of functional General surgery equipment		OB	Diathermy (Unit and Bi Polar), Proctoscopy set, general Surgical Instruments for Piles, Fistula, & Fissures. Surgical set for Hernia & Hydrocele, Cautery
		Availability of functional orthopaedic surgery equipment		OB	C arm, check OT table is C arm compatible, Thomas Splint, IM Nailing Set, SP Nailing, Compression Plating Kit, Dislocation Hip Screw Fixation
		Availability of Ophthalmic surgery equipment		OB	Operating Microscope, IOL Operation Set, Ophthalmoscope Keratometer, A Scan Biometer
		Availability of functional ENT surgery equipment		OB	Operating Microscope, ENT Operation set, Mastoid Set, Tracheotomy set, Microdrill System set
		Operation Table with Trendelenburg facility		OB	
ME C6.3	Availability of equipment & instruments for diagnostic procedures being undertaken in the facility	Availability of Point of care diagnostic instruments		OB	Portable X-Ray Machine, Glucometer, HIV rapid diagnostic kit, USG and Blood gas analyser
ME C6.4	Availability of equipment and instruments for resuscitation of patients and for providing intensive and critical care to patients	Availability of functional Instruments Resuscitation		OB	Ambu bag, Oxygen, Suction machine , laryngoscope scope, Defibrillator (Paediatric and adult) , LMA, ET Tube
		Availability of functional anaesthesia equipment		OB	Boyles apparatus, Bains Circuit or Soda lime absorbent in close circuit

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME C6.5	Availability of Equipment for Storage	Availability of equipment for storage for drugs		OB	Refrigerator, Crash cart/Drug trolley, instrument trolley, dressing trolley
		Availability of equipment for storage of sterilized items		OB	Instrument cabinet and racks for storage of sterile items
ME C6.6	Availability of functional equipment and instruments for support services	Availability of equipment for cleaning		OB	Buckets for mopping, Separate mops for patient care area and circulation area duster, waste trolley, Deck brush
		Availability of equipment for CSSD/TSSU		OB	Autoclave Horizontal & Vertical, Steriliser Big & Small
ME C6.7	Departments have patient furniture and fixtures as per load and service provision	Availability of functional OT light		OB	Shadow less Major & Minor, Ceiling and Stand Model, Focus Lamp
		Availability of attachment/ accessories with OT table		OB	Hospital graded mattress , IVstand, Bed pan
		Availability of Fixtures		OB	Trey for monitors, Electrical panel for anaesthesia machine, cardiac monitor etc, panel with outlet for Oxygen and vacuum, X ray view box.
		Availability of furniture		OB	Cupboard, table for preparation of medicines, chair, racks,
Standard C7	**Facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff**				
ME C7.1	Criteria for Competence assessment are defined for clinical and Para clinical staff	Check parameters for assessing skills and proficiency of clinical staff has been defined		SI/RR	Check objective checklist has been prepared for assessing competence of doctors, nurses and paramedical staff based on job description defined for each cadre of staff.
ME C7.2	Competence assessment of Clinical and Para clinical staff is done on predefined criteria at least once in a year	Check for competence assessment is done at least once in a year		SI/RR	Check for records of competence assessment including filled checklist, scoring and grading . Verify with staff for actual competence assessment done
ME C7.9	The Staff is provided training as per defined core competencies and training plan	Advance Life support		SI/RR	ALS and CPR by recognized agency to all category of staff.
		OT Management		SI/RR	OT scheduling, maintenance, Fumigation, Surveillance, equipment-operation and maintenance, infection control, surgical procedures and emergency protocols.
		Infection control & prevention training		SI/RR	Bio medical Waste Management including Hand Hygiene

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Training on processing/ sterilization of equipment		SI/RR	
		Patient Safety		SI/RR	Assessment, action planning, PDCA, 5S & use of checklist
		Training on Quality Management System		SI/RR	To all category of staff. At the time of induction and once in a year.
ME C7.10	There is established procedure for utilization of skills gained thought trainings by on -job supportive supervision	Staff is skilled for resuscitation and intubation		SI/RR	
		Nursing Staff is skilled for maintaining clinical records		SI/RR	
		Staff is Skilled to operate OT equipment		SI/RR	
		Staff is skilled for processing and packing instrument		SI/RR	
AREA OF CONCERN - D SUPPORT SERVICES					
Standard D1	**The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.**				
ME D1.1	The facility has established system for maintenance of critical Equipment	All equipment are covered under AMC including preventive maintenance		SI/RR	1. Check with AMC records/ Warranty documents 2. Staff is aware of the list of equipment covered under AMC.
		There is system of timely corrective break down maintenance of the equipment		SI/RR	(1) Check log book is maintained & it shows time taken to repair equipment. (2) Backup of critical equipment (3) Check staff is aware of Contact details of the agencies/ person responsible for maintenance
		There has system to label Defective/Out of order equipment and stored appropriately until it has been repaired		OB/RR	
		Staff is skilled for trouble shooting in case equipment malfunction		SI/RR	
		Periodic cleaning, inspection and maintenance of the equipment is done by the operator		SI/RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME D1.2	The facility has established procedure for internal and external calibration of measuring Equipment	All the measuring equipment/ instrument are calibrated		OB/ RR	Boyles apparatus, cautery, BP apparatus, autoclave etc.
		There is system to label/ code the equipment to indicate status of calibration/ verification when recalibration is due		OB/ RR	
ME D1.3	Operating and maintenance instructions are available with the users of equipment	Up to date instructions for operation and maintenance of equipment are readily available with staff.		OB/SI	
Standard D2	**The facility has defined procedures for storage, inventory management and dispensing of drugs in pharmacy and patient care areas**				
ME D2.1	There is established procedure for forecasting and indenting drugs and consumables	There is established system of timely indenting of consumables and drugs		SI/RR	Stock level are daily updated Indent are timely placed
ME D2.3	The facility ensures proper storage of drugs and consumables	Drugs are stored in containers/tray/ crash cart and are labelled		OB	Check drugs and consumables are kept at allocated space in Crash cart/ Drug trolleys and are labelled. Labelled with drug name, drug strength and expiry date. Look alike and sound alike drugs are kept separately from their identical one in look or sound.
		Empty and filled cylinders are labelled		OB	Flow meter , humidifier, key & updated data sheet is available with in use cylinders
ME D2.4	The facility ensures management of expiry and near expiry drugs	Expiry dates' are maintained at emergency drug tray		OB/RR	Records for expiry and near expiry drugs are maintained for emergency tray FIRST EXPIRY and FIRST OUT (FEFO) is in practice
		No expired drug found		OB/RR	Check drug sub store & emergency tray
		Records for expiry and near expiry drugs are maintained for drug stored at department		RR	Records for expiry and near expiry drugs are maintained for drug stored at department FIRST EXPIRY and FIRST OUT (FEFO) is in practice
ME D2.5	The facility has established procedure for inventory management techniques	There is practice of calculating and maintaining buffer stock		SI/RR	Minimum stock and reorder level are calculated based on consumption Minimum buffer stock is maintained all the time

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Department maintained stock register of drugs and consumables		RR/SI	Check record of drug received, issued and balance stock in hand and are maintained
		Drugs are categorized in Vital, Essential and Desirable		OB/RR	Check all Vital drugs are available
ME D2.6	There is a procedure for periodically replenishing the drugs in patient care areas	There is procedure for replenishing drug tray /crash cart		SI/RR	Procedure for replenishing drug in place
		There is no stock out of drugs		OB/SI	Random stock check of some drugs
ME D2.7	There is process for storage of vaccines and other drugs, requiring controlled temperature	Temperature of refrigerators are kept as per storage requirement and records twice a day are maintained		OB/RR	Check for refrigerator/ILR temperature charts. Charts are maintained and updated twice a day. Refrigerators meant for storing drugs should not be used for storing other items such as eatables.
ME D2.8	There is a procedure for secure storage of narcotic and psychotropic drugs	Narcotic and psychotropic drugs are kept in lock and key		OB/SI	Separate prescription for narcotic and psychotropic drugs by a registered medical practioner
		Anaesthetic agents are kept at secure place		OB/SI	
Standard D3	**The facility provides safe, secure and comfortable environment to staff, patients and visitors.**				
ME D3.1	The facility provides adequate illumination level at patient care areas	Adequate Illumination at OT table		OB	100000 lux
		Adequate Illumination at pre operative and post operative area		OB	
ME D3.2	The facility has provision of restriction of visitors in patient areas	Entry to OT is restricted		OB	
		Warning light is provided outside OT and its been used when OT is functional		OB/SI	
ME D3.3	The facility ensures safe and comfortable environment for patients and service providers	Temperature is maintained and record of same is kept		SI/RR	20-25OC, ICU has functional room thermometer and temperature is regularly maintained
		Humidity is maintained at desirable level		SI/RR	50-60%
		Positive pressure is maintained in OT		SI/RR	
ME D3.4	The facility has security system in place at patient care areas	Security arrangement at OT		OB	
ME D3.5	The facility has established measure for safety and security of female staff	Female staff feel secure at work place		SI	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard D4	**The facility has established Programme for maintenance and upkeep of the facility**				
ME D4.1	Exterior of the facility building is maintained appropriately	Building is painted/ whitewashed in uniform colour		OB	
		Interior of patient care areas are plastered & painted		OB	
ME D4.2	Patient care areas are clean and hygienic	Floors, walls, roof, roof topes, sinks patient care and circulation areas are Clean		OB	All area are clean with no dirt,grease,littering and cobwebs
		Surface of furniture and fixtures are clean		OB	
		Toilets are clean with functional flush and running water		OB	
ME D4.3	Hospital infrastructure is adequately maintained	Check for there is no seepage , Cracks, chipping of plaster		OB	
		Window panes , doors and other fixtures are intact		OB	
		OT Table are intact and without rust		OB	Check Mattresses are intact and clean
ME D4.5	The facility has policy of removal of condemned junk material	No condemned/ Junk material in the OT		OB	
ME D4.6	The facility has established procedures for pest, rodent and animal control	No pests are noticed		OB	
Standard D5	**The facility ensures 24X7 water and power backup as per requirement of service delivery, and support services norms**				
ME D5.1	The facility has adequate arrangement storage and supply for portable water in all functional areas	Availability of 24x7 running and potable water		OB/SI	
		Availability of Hot water supply		OB/SI	
ME D5.2	The facility ensures adequate power backup in all patient care areas as per load	Availability of power back up in OT		OB/SI	2 tier backup with UPS
		Availability of UPS		OB/SI	
		Availability of Emergency light		OB/SI	
ME D5.3	Critical areas of the facility ensures availability of oxygen, medical gases and vacuum supply	Availability of Centralized /local piped Oxygen, nitrogen and vacuum supply		OB	
Standard D7	**The facility ensures clean linen to the patients**				
ME D7.1	The facility has adequate sets of linen	OT has facility to provide sufficient and clean linen for surgical patient		OB/RR	Drape, draw sheet, cut sheet and gown

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		OT has facility to provide linen for staff		OB/RR	
		Availability of Blankets, draw sheet, pillow with pillow cover and mackintosh		OB/RR	
ME D7.2	The facility has established procedures for changing of linen in patient care areas	Linen is changed after each procedure		OB/RR	
ME D7.3	The facility has standard procedures for handling , collection, transportation and washing of linen	There is system to check the cleanliness and Quantity of the linen received from laundry		SI/RR	
		Check dedicated closed bin is kept for storage of dirty linen		OB	Check linen is kept closed bin & emptied regularly. Plastic bag is used in dustbin & these bags are sealed before removed & handed over
Standard D11	**Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.**				
ME D11.1	The facility has established job description as per govt guidelines	Job description is defined and communicated to all concerned staff		RR	Regular + contractual
		Staff is aware of their role and responsibilities		SI	
ME D11.2	The facility has a established procedure for duty roster and deputation to different departments	There is procedure to ensure that staff is available on duty as per duty roster		RR/SI	Check for system for recording time of reporting and relieving (Attendance register/ Biometrics etc)
		There is designated in charge for department		SI	
ME D11.3	The facility ensures the adherence to dress code as mandated by its administration / the health department	Doctor, nursing staff and support staff adhere to their respective dress code		OB	
Standard D12	**Facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations**				
ME D12.1	There is established system for contract management for out sourced services	There is procedure to monitor the quality and adequacy of outsourced services on regular basis		SI/RR	Verification of outsourced services (cleaning/ Dietary/Laundry/Security/ Maintenance) provided are done by designated in-house staff

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
AREA OF CONCERN - E CLINICAL SERVICES					
Standard E2	**The facility has defined and established procedures for clinical assessment, reassessment and treatment plan preparation.**				
ME E2.1	There is established procedure for initial assessment of patients	There is procedure for Pre Operative assessment		RR/SI	Physical examination, results of lab investigation, diagnosis and proposed surgery
ME E2.3	There is established procedure to plan and deliver appropriate treatment or care to individual as per the needs to achieve best possible results	Check care is delivered by competent multidisciplinary team		SI/RR	Check care plan is prepared and delivered as per direction of qualified physician
		Check treatment / care plan is documented		RR	The care plan include:, investigation to be conducted, intervention to be provided, goals to achieve, timeframe, patient education, discharge plan etc
Standard E3	**Facility has defined and established procedures for continuity of care of patient and referral**				
ME E3.1	Facility has established procedure for continuity of care during interdepartmental transfer	There is procedure of handing over & receiving patient		SI/RR	form OT to ward and ICU/HDU
		There is a procedure for consultation of the patient to other specialist with in the hospital		RR/SI	
ME E3.3	A person is identified for care during all steps of care	Duty Doctor and nurse is assigned for each patients		RR/SI	
Standard E4	**The facility has defined and established procedures for nursing care**				
ME E4.1	Procedure for identification of patients is established at the facility	There is a process for ensuring the patient's identification before any clinical procedure		OB/SI	Patient id band/ verbal confirmation etc.
ME E4.2	Procedure for ensuring timely and accurate nursing care as per treatment plan is established at the facility	There is a process to ensue the accuracy of verbal/telephonic orders		SI/RR	(1) Check system is in place to give telephonic orders & practised (2) Verbal orders are verified by the ordering physician within defined time period
ME E4.3	There is established procedure of patient hand over, whenever staff duty change happens	Patient hand over is given during the change in the shift		SI/RR	
		Nursing Handover register is maintained		RR	
ME E4.5	There is procedure for periodic monitoring of patients	Patient Vitals are monitored and recorded periodically		RR/SI	Check for use of cardiac monitor/multi parameter
Standard E5	**Facility has a procedure to identify high risk and vulnerable patients.**				
ME E5.1	The facility identifies vulnerable patients and ensure their safe care	Vulnerable patients are identified and measures are taken to protect them from any harm		OB/SI	Check the measure taken to prevent new born theft, sweeping and baby fall

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME E5.2	The facility identifies high risk patients and ensure their care, as per their need	High risk patients are identified and treatment given on priority		OB/SI	HIV, Infectious cases
Standard E6	**Facility ensures rationale prescribing and use of medicines**				
ME E6.1	Facility ensured that drugs are prescribed in generic name only	Check for BHT if drugs are prescribed under generic name only		RR	
ME E6.2	There is procedure of rational use of drugs	Check staff is aware of the drug regime and doses as per STG		SI/RR	Check BHT that drugs are prescribed as per STG
		Availability of drug formulary		SI/OB	
ME E6.3	There are procedures defined for medication review and optimization	Complete medication history is documented for each patient		RR/OB	Patient's name, prescription details and medical history is taken before surgery. Check complete medication history including over-the-counter medicines is taken and documented
		Medicine are reviewed and optimised as per individual treatment plan		SI/RR	Medicines are optimised as per individual treatment plan for the best possible clinical outcome"
Standard E7	**Facility has defined procedures for safe drug administration**				
ME E7.1	There is process for identifying and cautious administration of high alert drugs (to check)	High alert drugs available in department are identified		SI/OB	Electrolytes like Potassium chloride, Opioids, Neuro muscular blocking agent, Anti thrombolytic agent, insulin, warfarin, Heparin, Adrenergic agonist etc. as applicable
		Maximum dose of high alert drugs are defined and communicated		SI/RR	Value for maximum doses as per age, weight and diagnosis are available with nursing station and doctor
		There is process to ensure that right doses of high alert drugs are only given		SI/RR	A system of independent double check before administration, Error prone medical abbreviations are avoided
ME E7.2	Medication orders are written legibly and adequately	Every Medical advice and procedure is accompanied with date , time and signature		RR	
		Check for the writing, It comprehendible by the clinical staff		RR/SI	
ME E7.3	There is a procedure to check drug before administration/ dispensing	Drugs are checked for expiry and other inconsistency before administration		OB/SI	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Check single dose vial are not used for more than one dose		OB	Check for any open single dose vial with left over content intended to be used later on
		Check for separate sterile needle is used every time for multiple dose vial		OB	In multi dose vial needle is not left in the septum
		Any adverse drug reaction is recorded and reported		RR/SI	Adverse drug event trigger tool is used to report the events
ME E7.4	There is a system to ensure right medicine is given to right patient	Check Nursing staff is aware 7 Rs of Medication and follows them		SI/RR	Administration of medicines done after ensuring right patient, right drugs, right route, right time, Right dose, Right Reason and Right Documentation
Standard E8	**Facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage**				
ME E8.1	All the assessments, re-assessment and investigations are recorded and updated	Records of Monitoring/ Assessments are maintained		RR	PAC, Intraoperative monitoring
ME E8.2	All treatment plan prescription/orders are recorded in the patient records.	Treatment plan, first orders are written on BHT		RR	Treatment prescribed in nursing records (Manually/e-records)
ME E8.4	Procedures performed are written on patients records	Operative Notes are Recorded		RR	Name of person in attendance during procedure, Pre and post operative diagnosis, Procedures carried out, length of procedures, estimated blood loss, Fluid administered, specimen removed, complications etc. (Manually/e-records)
		Anaesthesia Notes are Recorded		RR	(Manually/e-records)
ME E8.5	Adequate form and formats are available at point of use	Standard Formats available		RR/OB	Consents, surgical safety check list
ME E8.6	Register/records are maintained as per guidelines	Registers and records are maintained as per guidelines		RR	OT Register, Schedule, Infection control records, autoclaving records etc
		All register/records are identified and numbered		RR	
ME E8.7	The facility ensures safe and adequate storage and retrieval of medical records	Safe keeping of patient records		RR	
Standard E11	**The facility has defined and established procedures for Emergency Services and Disaster Management**				
ME E11.3	The facility has disaster management plan in place	Staff is aware of disaster plan		SI/RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Role and responsibilities of staff in disaster is defined		SI/RR	
Standard E12	**The facility has defined and established procedures of diagnostic services**				
ME E12.1	There are established procedures for Pre-testing Activities	Container is labelled properly after the sample collection		OB	
ME E12.3	There are established procedures for Post-testing Activities	OT is provided with the critical value of different test		SI/RR	
Standard E13	**The facility has defined and established procedures for Blood Bank/Storage Management and Transfusion.**				
ME E13.8	There is established procedure for issuing blood	Availability of blood units in case of emergency with out replacement		RR/SI	The blood is ordered for the patient according to the MSBOS (*Maximum Surgical Blood Order Schedule*)
ME E13.9	There is established procedure for transfusion of blood	Consent is taken before transfusion		RR	
		Patient's identification is verified before transfusion		SI/OB	
		blood is kept on optimum temperature before transfusion		RR	
		Blood transfusion is monitored and regulated by qualified person		SI/RR	
		Blood transfusion note is written in patient recorded		RR	
ME E13.10	There is a established procedure for monitoring and reporting Transfusion complication	Any major or minor transfusion reaction is recorded and reported to responsible person		RR	
Standard E14	**Facility has established procedures for Anaesthetic Services**				
ME E14.1	Facility has established procedures for Pre Anaesthetic Check up	There is procedure to ensure that PAC has been done before surgery		RR/SI	
		There is procedure to review findings of PAC		RR/SI	
		Minimum PAC for emergency cases		RR/SI	in emergency & life saving conditions, surgery may be started with General physical examination of the patient & sending the sample for lab. Examination
ME E14.2	Facility has established procedures for monitoring during anaesthesia	Anaesthesia plan is documented before entering into OT		RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Anaesthesia Safety Checklist is used for safe administration of anaesthesia		RR	Check use of WHO Anaesthesia Safety Checklist
		Anaesthesia equipment are checked before induction		RR	Sufficient reserve of gases. Vaporizers are connected, Laryngoscope, ET tube and suction App are ready and clean
		Food intake status of Patient is checked		RR/SI	
		Patients vitals are recorded during anaesthesia		RR	Heart rate , cardiac rate , BP, O2 Saturation,
		Airway security is ensured		RR/SI	Breathing system is securely and correctly assembled
		Potency and level of anaesthesia is monitored		RR/SI	
		Anaesthesia note is recorded		RR	Check for the adequacy
		Any adverse Anaesthesia Event is recorded and reported		RR	
ME E14.3	Facility has established procedures for Post Anaesthesia care	Post anaesthesia status is monitored and documented		RR/SI	
Standard E15	**Facility has defined and established procedures of Surgical Services**				
ME E15.1	Facility has established procedures OT Scheduling	There is procedure OT Scheduling		RR/SI	Schedule is prepared in consonance with available OT house and patients requirement
ME E15.2	Facility has established procedures for Preoperative care	Patient evaluation before surgery is done and recorded		RR/SI	Vitals , Patients fasting status etc.
		Antibiotic Prophylaxis given as indicated		RR/SI	
		Tetanus Prophylaxis is given if Indicated		RR/SI	
		There is a process to prevent wrong site and wrong surgery		RR/SI	Surgical Site is marked before entering into OT
		Surgical site preparation is done as per protocol		RR/SI	Cleaning , Asepsis and Draping
ME E15.3	Facility has established procedures for Surgical Safety	Surgical Safety Check List is used for each surgery		RR/SI	Check for Surgical safety check list has been used for surgical procedures
		Sponge and Instrument Count Practice is implemented		RR/SI	Instrument, needles and sponges are counted before beginning of case, before final closure and on completing of procedure

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Adequate Haemostasis is secured during surgery		RR/SI	Check for Cautery and suture legation practices
		Appropriate suture material is used for surgery as per requirement		RR/SI	Check for what kind of sutures used for different surgeries . Braided Biological sutures are not used for dirty wounds, Catgut is not used for closing fascial layers of abdominal wounds or where prolonged support is required
		Check for suturing techniques are applied as per protocol		RR/SI	
ME E15.4	Facility has established procedures for Post operative care	Post operative monitoring is done before discharging to ward		RR/SI	Check for post operative operation ward is used and patients are not immediately shifted to wards after surgery
		Post operative notes and orders are recorded		RR/SI	Post operative notes contains Vital signs, Pain control, Rate and type of IV fluids, Urine and Gastrointestinal fluid output, other medications and Laboratory investigations
Standard E16	**The facility has defined and established procedures for the management of death & bodies of deceased patients**				
ME E16.1	Death of admitted patient is adequately recorded and communicated	Death note is written on patient record		RR	
ME E16.2	The facility has standard procedures for handling the death in the hospital	Death note including efforts done for resuscitation is noted in patient record		RR	Includes both maternal and neonatal death
		Death summary is given to patient attendant quoting the immediate cause and underlying cause if possible		RR/SI	
AREA OF CONCERN - F INFECTION CONTROL					
Standard F1	**Facility has infection control program and procedures in place for prevention and measurement of hospital associated infection**				
ME F1.2	Facility has provision for Passive and active culture surveillance of critical & high risk areas	Surface and environment samples are taken for microbiological surveillance		SI/RR	Swab are taken from infection prone surfaces
ME F1.3	Facility measures hospital associated infection rates	There is procedure to report cases of Hospital acquired infection		SI/RR	Patients are observed for any sign and symptoms of HAI like fever, purulent discharge from surgical site .

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME F1.4	There is Provision of Periodic Medical Check-ups and immunization of staff	There is procedure for immunization of the staff		SI/RR	Hepatitis B, Tetanus Toxoid etc
		Periodic medical check-up of the staff		SI/RR	
ME F1.5	Facility has established procedures for regular monitoring of infection control practices	Regular monitoring of infection control practices		SI/RR	Hand washing and infection control audits done at periodic intervals
ME F1.6	Facility has defined and established antibiotic policy	Check for Doctors are aware of Hospital Antibiotic Policy		SI/RR	
Standard F2	**Facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis**				
ME F2.1	Hand washing facilities are provided at point of use	Availability of hand washing Facility at Point of Use		OB	Check for availability of wash basin near the point of use
		Availability of running Water		OB/SI	Ask to Open the tap. Ask Staff water supply is regular
		Availability of antiseptic soap with soap dish/ liquid antiseptic with dispenser.		OB/SI	Check for availability/ Ask staff if the supply is adequate and uninterrupted
		Availability of Alcohol based Hand rub		OB/SI	Check for availability/ Ask staff for regular supply.
		Display of Hand washing Instruction at Point of Use		OB	Prominently displayed above the hand washing facility , preferably in Local language
		Availability of elbow operated taps		OB	
		Hand washing sink is wide and deep enough to prevent splashing and retention of water		OB	
ME F2.2	Staff is trained and adhere to standard hand washing practices	Adherence to 6 steps of Hand washing		SI/OB	Ask of demonstration
		Adherence to Surgical scrub method		SI/OB	procedure should be repeated several times so that the scrub lasts for 3 to 5 minutes. The hands and forearms should be dried with a sterile towel only.
		Staff aware of when to hand wash		SI	
ME F2.3	Facility ensures standard practices and materials for antisepsis	Availability of Antiseptic Solutions		OB	
		Proper cleaning of procedure site with antisepsis		OB/SI	like before giving IM/IV injection, drawing blood, putting Intravenous and urinary catheter

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Proper cleaning of perineal area before procedure with antisepsis		SI	
		Check Shaving is not done during part preparation/ delivery cases		SI	
		Check sterile field is maintained during surgery		OB/SI	Surgical site covered with sterile drapes, sterile instruments are kept within the sterile field.
Standard F3	**Facility ensures standard practices and materials for Personal protection**				
ME F3.1	Facility ensures adequate personal protection equipment as per requirements	Clean gloves are available at point of use		OB/SI	
		Availability of Masks		OB/SI	
		Sterile s gloves are available at OT and Critical areas		OB/SI	
		Use of elbow length gloves for obstetrical purpose		OB/SI	
		Availability of gown/ Apron		OB/SI	
		Availability of Caps		OB/SI	
		Personal protective kit for infectious patients		OB/SI	HIV kit
ME F3.2	Staff is adhere to standard personal protection practices	No reuse of disposable gloves, Masks, caps and aprons.		OB/SI	
		Compliance to correct method of wearing and removing the PPE		SI	Gloves, Masks, Caps, Aprons
Standard F4	**Facility has standard Procedures for processing of equipment and instruments**				
ME F4.1	Facility ensures standard practices and materials for decontamination and clean ing of instruments and procedures areas	Decontamination of operating & Procedure surfaces		SI/OB	Ask staff about how they decontaminate the procedure surface like OT Table, Stretcher/ Trolleys etc. (Wiping with 0.5% Chlorine solution
		Proper Decontamination of instruments after use		SI/OB	Ask staff how they decontaminate the instruments like ambubag, suction canulae, Surgical Instruments (Soaking in 0.5% Chlorine Solution, Wiping with 0.5% Chlorine Solution or 70% Alcohol as applicable
		Contact time for decontamination is adequate		SI/OB	10 minutes

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Cleaning of instruments after decontamination		SI/OB	Cleaning is done with detergent and running water after decontamination
		Proper handling of Soiled and infected linen		SI/OB	No sorting ,Rinsing or sluicing at Point of use/ Patient care area
		Staff know how to make chlorine solution		SI/OB	
ME F4.2	Facility ensures standard practices and materials for disinfection and sterilization of instruments and equipment	Equipment and instruments are sterilized after each use as per requirement		OB/SI	Autoclaving/HLD/Chemical Sterilization
		High level Disinfection of instruments/ equipment is done as per protocol		OB/SI	Ask staff about method and time required for boiling
		Chemical sterilization of instruments/ equipment is done as per protocols		OB/SI	Ask staff about method, concentration and contact time required for chemical sterilization
		Formaldehyde or glutaraldehyde solution replaced as per manufacturer instructions		OB/SI	
		Autoclaved linen are used for procedure		OB/SI	
		Autoclaved dressing material is used		OB/SI	
		Instruments are packed according for autoclaving as per standard protocol		OB/SI	
		Autoclaving of instruments is done as per protocols		OB/SI	Ask staff about temperature, pressure and time
		Regular validation of sterilization through biological and chemical indicators		OB/SI/RR	
		Maintenance of records of sterilization		OB/SI/RR	
		There is a procedure to ensure the traceability of sterilized packs		OB/SI/RR	
		Sterility of autoclaved packs is maintained during storage		OB/SI	Sterile packs are kept in clean, dust free, moist free environment.
Standard F5	**Physical layout and environmental control of the patient care areas ensures infection prevention**				

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME F5.1	Layout of the department is conducive for the infection control practices	Facility layout ensures separation of general traffic from patient traffic		OB	Faculty layout ensures separation of general traffic from patient traffic
		Zoning of High risk areas		OB	
		Facility layout ensures separation of routes for clean and dirty items		OB	
		Floors and wall surfaces of ICU are easily cleanable		OB	
		CSSD/TSSU has demarcated separate area for receiving dirty items, processes, keeping clean and sterile items		OB	
ME F5.2	Facility ensures availability of standard materials for cleaning and disinfection of patient care areas	Availability of disinfectant as per requirement		OB/SI	Chlorine solution, Glutaraldehyde, carbolic acid
		Availability of cleaning agent as per requirement		OB/SI	Hospital grade phenyl, disinfectant detergent solution
ME F5.3	Facility ensures standard practices followed for cleaning and disinfection of patient care areas	Staff is trained for spill management		SI/RR	
		Cleaning of patient care area with detergent solution		SI/RR	
		Staff is trained for preparing cleaning solution as per standard procedure		SI/RR	
		Standard practice of mopping and scrubbing are followed		OB/SI	
		Cleaning equipment like broom are not used in patient care areas		OB/SI	
		Use of three bucket system for mopping		OB/SI	
		Fumigation/ carbolization as per schedule		SI/RR	
		External footwares are restricted		OB	
ME F5.4	Facility ensures segregation infectious patients	Isolation and barrier nursing procedure are followed for septic cases		OB/SI	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME F5.5	Facility ensures air quality of high risk area	Positive Pressure in OT		OB/SI	
		Adequate air exchanges are maintained		SI/RR	
Standard F6	**Facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.**				
ME F6.1	Facility Ensures segregation of Bio Medical Waste as per guidelines	Availability of colour coded bins & Plastic bags at point of waste generation		OB	Adequate number. Covered. Foot operated.
		Segregation of Anatomical and soiled waste in Yellow Bin		OB/SI	Human Anatomical waste, Items contaminated with blood, body fluids,dressings, plaster casts, cotton swabs and bags containing residual or discarded blood and blood components.
		Segregation of infected plastic waste in red bin		OB	Items such as tubing, bottles, intravenous tubes and sets, catheters, urine bags, syringes (without needles and fixed needle syringes) and vacutainers' with their needles cut) and gloves
		Display of work instructions for segregation and handling of Biomedical waste		OB	Pictorial and in local language
		There is no mixing of infectious and general waste		OB	
ME F6.2	Facility ensures management of sharps as per guidelines	Availability of functional needle cutters & puncture proof, leak proof, temper proof white container for segregation of sharps		OB	See if it has been used or just lying idle.
		Availability of post exposure prophylaxis & Protocols		OB/SI	Ask if available. Where it is stored and who is in charge of that. Also check PEP issuance register Staff knows what to do in condition of needle stick injury
		Contaminated and broken Glass are disposed in puncture proof and leak proof box/ container with Blue colour marking		OB	Vials, slides and other broken infected glass
ME F6.3	Facility ensures transportation and disposal of waste as per guidelines	Check bins are not overfilled		SI	Not more than two-third.
		Disinfection of liquid waste before disposal		SI/OB	Through Local Disinfection

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Transportation of bio medical waste is done in close container/trolley		SI/OB	
		Staff aware of mercury spill management		SI/RR	Look for: 1. Spill area evacuation 2. Removal of Jewellery 3. Wear PPE 4. Use of flashlight to locate mercury beads 5. Use syringe without a needle/eyedropper and sticky tape to suck the beads 6. Collection of beads in leak-proof bag or container 7. Sprinkle sulphur or zinc powder to remove any remaining mercury 8. All the mercury spill surfaces should be decontaminated with 10% sodium thiosulfate solution 9. All the bags or containers containing items contaminated with mercury should be marked as "Hazardous Waste, Handle with Care" 10. Collected mercury waste should be handed over to the CBMWTF
AREA OF CONCERN - G QUALITY MANAGEMENT					
Standard G1	**The facility has established organizational framework for quality improvement**				
ME G1.1	The facility has a quality team in place	Quality circle has been formed in the OT		SI/RR	Check if quality circle formed and functional with a designated nodal officer for quality
Standard G3	**Facility have established internal and external quality assurance programs wherever it is critical to quality.**				
ME G3.1	Facility has established internal quality assurance program at relevant departments	There is system daily round by matron/hospital manager/ hospital superintendent/ Hospital Manager/ Matron in charge for monitoring of services		SI/RR	Check for entries in Round Register
ME G3.2	Facility has established external assurance programs at relevant departments				
ME G3.3	Facility has established system for use of check lists in different departments and services	Internal assessment is done at periodic interval		RR/SI	NQAS, Kayakalp, SaQushal tools are used to conduct internal assessment

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Departmental checklist are used for monitoring and quality assurance		SI/RR	Staff is designated for filling and monitoring of these checklists
		Non-compliances are enumerated and recorded			Check the non compliances are presented & discussed during quality team meetings
ME G3.4	Actions are planned to address gaps observed during quality assurance process	Check action plans are prepared and implemented as per internal assessment record findings			Randomly check the details of action, responsibility, time line and feedback mechanism
ME G3.5	Planned actions are implemented through Quality Improvement Cycles (PDCA)	Check PDCA or revalent quality method is used to take corrective and preventive action			Check actions have been taken to close the gap. It can be in form of action taken report or Quality Improvement (PDCA) project report
Standard G4	**Facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.**				
ME G4.1	Departmental standard operating procedures are available	Standard operating procedure for department has been prepared and approved		RR	
		Current version of SOP are available with process owner		OB/RR	
		Work instruction/ clinical protocols are displayed		OB	processing and sterilization of equipment,
ME G4.2	Standard Operating Procedures adequately describes process and procedures	Department has documented procedure for scheduling the Surgery and its booking		RR	
		Department has documented procedure for pre operative procedure, in-process check and post operative care		RR	
		Department has documented procedure for pre operative anaesthetic check up		RR	
		Department has documented procedure for post operative care of the patient		RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Department has documented procedure for operation theatre asepsis and environment management		RR	
		Department has documented procedure for OT documentation.		RR	
		Department has documented procedure for reception of dirt packs and issue of sterile packs from TSSU		RR	
		Department has documented procedure for maintenance and calibration of equipment		RR	
		Department has documented procedure for general cleaning of OT and annexes		RR	
ME G4.3	Staff is trained and aware of the standard procedures written in SOPs	Check staff is a aware of relevant part of SOPs		SI/RR	
Standard G 5	**Facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages**				
ME G5.1	Facility maps its critical processes	Process mapping of critical processes done		SI/RR	
ME G5.2	Facility identifies non value adding activities / waste / redundant activities	Non value adding activities are identified		SI/RR	
ME G5.3	Facility takes corrective action to improve the processes	Processes are rearranged as per requirement		SI/RR	
Standard G6	**The facility has defined mission, values, Quality policy & objectives & prepared a strategic plan to achieve them**				
ME G6.4	Facility has de defined quality objectives to achieve mission and quality policy	Check if SMART Quality Objectives have framed		SI/RR	Check short term valid quality objectivities have been framed addressing key quality issues in each department and cores services. Check if these objectives are Specific, Measurable, Attainable, Relevant and Time Bound.

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME G6.5	Mission, Values, Quality policy and objectives are effectively communicated to staff and users of services	Check of staff is aware of Mission , Values, Quality Policy and objectives		SI/RR	Interview with staff for their awareness. Check if Mission Statement, Core Values and Quality Policy is displayed prominently in local language at Key Points
ME G6.7	Facility periodically reviews the progress of strategic plan towards mission, policy and objectives	Check time bound action plan is being reviewed at regular time interval		SI/RR	Review the records that action plan on quality objectives being reviewed at least once in month by departmental in charges and during the quality team meeting. The progress on quality objectives have been recorded in Action Plan tracking sheet
Standard G7	**Facility seeks continually improvement by practicing Quality method and tools.**				
ME G7.1	Facility uses method for quality improvement in services	Basic quality improvement method		SI/OB	PDCA & 5S
ME G7.2	Facility uses tools for quality improvement in services	7 basic tools of Quality		SI/RR	Minimum 2 applicable tools are used in each department
Standards G9	**Facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan**				
ME G9.6	Periodic assessment for Medication and Patient care safety risks is done as per defined criteria.	Check periodic assessment of medication and patient care safety risk is done using defined checklist periodically		SI/RR	Verify with the records. A comprehensive risk assessment of all clinical processes should be done using pre define criteria at least once in three month.
ME G9.7	Periodic assessment for potential risk regarding safety and security of staff including violence against service providers is done as per defined criteria	SaQushal assessment toolkit is used for safety audits.		SI/RR	1. Check that the filled checklist and action taken report are available 2. Staff is aware of key gaps & closure status
ME G9.8	Risks identified are analysed evaluated and rated for severity	Identified risks are analysed for severity		SI/RR	Action is taken to mitigate the risks
Standard G10	**The facility has established clinical Governance framework to improve quality and safety of clinical care processes**				
ME G10.3	Clinical care assessment criteria have been defined and communicated	The facility has established procedures to review the clinical care processes		SI/RR	Check parameter are defined & implemented to review the clinical care i.e. through Ward round, peer review, morbidity & mortality review, patient feedback, clinical audit & clinical outcomes.
		Check that the patient /family participate in the care evalution		SI/RR	Feedback is taken from patient/family on health status of individual under treatment

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Check the care planning and co- ordination is reviewed		SI/RR	System in place to review internal referral process, review clinical handover information, review patient understanding about their progress
ME G10.4	Facility conducts the periodic clinical audits including prescription, medical and death audits	There is the procedure to conduct surgical audits		SI/RR	Check medical audit records (a) Completion of the medical records i.e. Medical history, assessments, re assessment, investigations conducted, progress notes, interventions conducted, outcome of the case, patient education, delineation of responsibilities, discharge etc. (b) Check whether treatment plan worked for the patient (C) progress on the health status of the patient is mentioned (d) whether the goals defined in treatment plan is met for the individual cases (e) Adverse clinical events are documented (f) Re admission
		There is procedure to conduct death audits		SI/RR	(1) All the deaths are audited by the committee. (2) The reasons of the death is clearly mentioned (3) Data pertaining to deaths are collated and trend analysis is done (4) A through action taken report is prepared and presented in clinical Governance Board meetings / during grand round (wherever required)
		All non compliance are enumerated and recorded for surgical audits		SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings
		All non-compliance are enumerated and recorded for death audits		SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings
ME G10.5	Clinical care audits data is analysed, and actions are taken to close the gaps identified during the audit process	Check action plans are prepared and implemented as per surgical audit record findings		SI/RR	Randomly check the actual compliance with the actions taken reports of last 3 months
		Check action plans are prepared and implemented as per death audit record's findings		SI/RR	Randomly check the actual compliance with the actions taken reports of last 3 months

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Check the data of audit findings are collated		SI/RR	Check collected data is analysed & areas for improvement is identified & prioritised
		Check PDCA or revalent quality method is used to address critical problems		SI/RR	Check the critical problems are regularly monitored & applicable solutions are duplicated in other departments (wherever required) for process improvement
ME G10.7	Facility ensures easy access and use of standard treatment guidelines & implementation tools at point of care	Check standard treatment guidelines / protocols are available & followed.		SI/RR	Staff is aware of Standard treatment protocols/ guidelines/best practices
		Check treatment plan is prepared as per Standard treatment guidelines		SI/RR	Check staff adhere to clinical protocols while preparing the treatment plan
		Check the drugs are prescribed as per Standards treatment guidelines		SI/RR	Check the drugs prescribed are available in EML or part of drug formulary
		Check the updated/ latest evidence are available		SI/RR	Check when the STG/ protocols/evidences used in healthcare facility are published. Whether the STG protocols are according to current evidences.
		Check the mapping of existing clinical practices processes is done		SI/RR	The gaps in clinical practices are identified & action are taken to improve it. Look for evidences for improvement in clinical practices using PDCA
AREA OF CONCERN - H OUTCOME					
Standard H1	**The facility measures Productivity Indicators and ensures compliance with State/National benchmarks**				
ME H1.1	Facility measures productivity Indicators on monthly basis	No. of Major surgeries done per 1 lakh population		RR	
		No. of emergency surgeries done		RR	
		Proportion of other emergency surgeries done in the night		RR	
		No. of elective surgeries performed		RR	
		CSSD/TSSU productivity index		RR	No. of packs sterilized against the no. of surgeries

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard H2	**The facility measures Efficiency Indicators and ensure to reach State/National Benchmark**				
ME H2.1	Facility measures efficiency Indicators on monthly basis	Downtime critical equipment		RR	
		Skin to skin time		RR	
		No of major surgeries per surgeon		RR	
		Proportion emergency surgeries		RR	
		Cycle time for instrument processing		RR	
Standard H3	**The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark**				
ME H3.1	Facility measures Clinical Care & Safety Indicators on monthly basis	Surgical Site infection Rate		RR	No. of observed surgical site infections*100/total no. of Major surgeries
		Proportion of cases with post surgical complications			Complication grading using Clavien-Dindo scale. All the cases with complication more than graded >2 on the Clavien-Dindo scale
		No of adverse events per thousand patients		RR	
		Incidence of re-exploration of surgery		RR	
		% of environmental swab culture reported positive		RR	
		Perioperative Death Rate		RR	Deaths occurred from pre operative procedure to discharge of the patient
		Proportion of General Anaesthesia to spinal anaesthesia		RR	
		Proportion of PAC done out of total elective surgeries		RR	
		No. of autoclave cycle failed in Bowie dick test out of total autoclave cycle		RR	
Standard H4	**The facility measures Service Quality Indicators and endeavours to reach State/National benchmark**				
ME H4.1	Facility measures Service Quality Indicators on monthly basis	Operation Cancellation rates		RR	(a) No. of cancelled operation*1000 /total operation done Planned operations cancelled due to any reason like clinical, non clinical (theatre), or by patient
		Average time taken to conduct the emergency surgery		RR	Time taken from presentation in emergency department to non-elective surgery conducted

ASSESSMENT SUMMARY

Name of the Hospital ..... Date of Assessment .....

Names of Assessors ..... Names of Assessees .....

Type of Assessment (Internal/External) ..... Action plan Submission Date .....

A. SCORE CARD

OPERATION THEATER SCORE CARD	
Area of Concern wise score	**Operation Theater Score**
A. Service Provision	
B. Patient Rights	
C. Inputs	
D. Support Services	
E. Clinical Services	
F. Infection Control	
G. Quality Management	
H. Outcome	

B. MAJOR GAPS OBSERVED

1. _____
2. _____
3. _____
4. _____
5. _____

C. STRENGTHS/BEST PRACTICES

1. _____
2. _____
3. _____

D. RECOMMENDATIONS/OPPORTUNITIES FOR IMPROVEMENT

_____

_____

_____

Names and Signature of Assessors

Date _____

सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

CHECKLIST-4

INTENSIVE CARE UNIT (ICU)

CHECKLIST FOR INTENSIVE CARE UNIT (ICU)

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
AREA OF CONCERN - A SERVICE PROVISION					
Standard A1	**Facility Provides Curative Services**				
ME A1.1	The facility provides General Medicine services	Availability of Intensive care services for medical cases		SI/OB	Major medical cases like CVA,Haematomas, CAD, Haemoptysis, Snake bite, Br. Asthma Poisoning etc
ME A1.2	The facility provides General Surgery services	Availability of Intensive care services for Surgical cases		SI/OB	Major surgical cases including trauma
ME A1.3	The facility provides Obstetrics & Gynaecology Services	Availability of Intensive care services for Gynae and obstetrics cases		SI/OB	If ICU services are not available then facility ensure linkages (Partial Compliance)
ME A1.14	Services are available for the time period as mandated	Availability of ICU services 24X7		SI/RR	
ME A1.17	The facility provides Intensive care Services	Availability of Intensive care services.		SI/OB	Intubation, Tracheotomy, Mechanical Ventilation, short term cardio respiratory support, Defibrillation, CPR, Mobilization, Chest Tube, ventilator
Standard A3	**Facility Provides diagnostic Services**				
ME A3.1	The facility provides Radiology Services	Availability of Portable X ray services		SI/OB	
		Availability of USG services		SI/OB	
ME A3.2	The facility Provides Laboratory Services	Functional side laboratory services are available		SI/OB	ABG & Electrolyte
ME A3.3	The facility provides other diagnostic services, as mandated	Functional ECG Services are available		SI/OB	12 lead ECG
Standard A4	**Facility provides services as mandated in national Health Programs/ state scheme**				
ME A4.8	The facility provides services under National Programme for Prevention and control of Cancer, Diabetes, Cardiovascular diseases & Stroke (NPCDCS) as per guidelines	Availability of cardiac care unit		SI/OB	5 bedded ICU

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
AREA OF CONCERN - B PATIENT RIGHTS					
Standard B1	**Facility provides the information to care seekers, attendants & community about the available services and their modalities**				
ME B1.1	The facility has uniform and user-friendly signage system	Availability of departmental & directional signages		OB	Numbering, main department and internal sectional signage are displayed
		Restricted area signage are displayed		OB	
ME B1.2	The facility displays the services and entitlements available in its departments	Services provision in ICU are displayed		OB	
		Services not available in ICU are displayed		OB	
		Names of doctor and nursing staff on duty are displayed and updated		OB	
		Important numbers including ambulance, blood bank and referral centres displayed		OB	
ME B1.4	User charges are displayed and communicated to patients effectively	User charges in r/o ICU services are displayed		OB	
ME B1.5	Patients & visitors are sensitised and educated through appropriate IEC / BCC approaches	IEC material displayed in waiting area		OB	
ME B1.6	Information is available in local language and easy to understand	Signage's and information are available in local language		OB	
ME B1.8	The facility ensures access to clinical records of patients to entitled personnel	Discharge summary is given to the patient		OB	
Standard B2	**Services are delivered in a manner that is sensitive to gender, religious and cultural needs, and there are no barrier on account of physical, economic, cultural or social reasons.**				
ME B2.1	Services are provided in manner that are sensitive to gender	Availability of female staff if a male doctor examination a female patients		OB/SI	
ME B2.3	Access to facility is provided without any physical barrier & and friendly to people with disabilities	Availability of Wheel chair or stretcher for easy Access to the ICU		OB	
		ICU is connected to lift/ ramp		OB	for easy , safe and fast transport of bed/trolley of critically sick patient

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard B3	**The facility maintains privacy, confidentiality & dignity of patient, and has a system for guarding patient related information.**				
ME B3.1	Adequate visual privacy is provided at every point of care	Availability of screen/ curtain at the examination and procedural area		OB	
ME B3.2	Confidentiality of patients records and clinical information is maintained	Patient Records are kept at secure place beyond access to general staff/ visitors		SI/OB	
		No information regarding patient identity and details are unnecessary displayed		SI/OB	
ME B3.3	The facility ensures the behaviours of staff is dignified and respectful, while delivering the services	Behaviour of staff is empathetic and courteous		PI/OB	
ME B3.4	The facility ensures privacy and confidentiality to every patient, especially of those conditions having social stigma, and also safeguards vulnerable groups	Privacy and confidentiality of HIV cases		SI/OB	
Standard B4	**Facility has defined and established procedures for informing and involving patient and their families about treatment and obtaining informed consent wherever it is required.**				
ME B4.1	There is established procedures for taking informed consent before treatment and procedures	Informed consent for ICU		SI/RR	Admission, intubation, blood transfusion
		Consent for Invasive procedure		SI/RR	
ME B4.3	Staff are aware of Patients rights responsibilities	Staff is aware of patients rights and responsibilities		SI	
ME B4.4	Information about the treatment is shared with patients or attendants, regularly	ICU has system in place to communicate with patient/ their family member the nature and seriousness of the illness at least once in day		PI/SI	Ask patients relative about whether they have been communicated about the treatment plan and progress
ME B4.5	The facility has defined and established grievance redressal system in place	Availability of complaint box and display of process for grievance re addressal and whom to contact is displayed		OB	

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard B5	**Facility ensures that there are no financial barrier to access and that there is financial protection given from cost of care.**				
ME B5.1	The facility provides cashless services to pregnant women, mothers and neonates as per prevalent government schemes	ICU services are free for beneficiaries		PI/SI	PMJAY, JSSK and any other beneficiary
ME B5.2	The facility ensures that drugs prescribed are available at Pharmacy and wards	Check that patient party has not incurred expenditure on purchasing drugs or consumables from outside.		PI/SI	
ME B5.3	It is ensured that facilities for the prescribed investigations are available at the facility	Check that patient party has not incurred expenditure on diagnostics from outside.		PI/SI	
ME B5.4	The facility provide free of cost treatment to Below poverty line patients without administrative hassles	ICU services are free for BPL patients		PI/SI/RR	
Standard B6	**Facility has defined framework for ethical management including dilemmas confronted during delivery of services at public health facilities**				
ME B6.6	There is an established procedure for 'end-of-life' care	End of life policy & procedure are available and followed		SI/RR	The policy clearly defines the procedures for managing critical cases in the ward, HDU/ICU, brain-dead patients, conscious patients with serious diseases like motor neurons and brought-in dead cases. It also includes:
					(a) Patient and family have the right to be informed about their condition and make choices about the treatment (b) Withhold or withdraw life-sustaining treatment (c) Organ donation as per NOTTO &India's Governing organ donation law (d) All the decisions should be transparent and documented
		Staff is educated & trained for end of life care		SI/RR	
		The patient's Relatives informed clearly about the deterioration in the health condition of Patient.		SI/RR	Periodic update on the patient's condition is given to the family.

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Policy & procedures like DNR , DNI etc for critical cases are in consonance with legal requirement		SI/RR	Patient right "Do not resuscitate" or " Do not intubate"/ allow natural death are respected
		The is a standard procedure for removal of life-sustaining treatment as per law		SI/RR	(1) Check about the policy and practice for removing life support (2)Patient or family is involved in decision-making, and patient's or family's choice is respected
		There is a procedure to allow patient relative/ Next of Kin to observe patient in last hours		SI/OB	
		Staff is aware of events indicating that conversations about end-of-life care need to start with patient or family		RR/SI	(a) a patient living with or diagnosed with life-limiting illness (b) a patient who is likely to die in the short or medium term is admitted, or deteriorates during their admission (c) a patient is dying where Patient (or family member, if the patient lacks capacity) expresses interest in discussing end-of-life care (d) a previously well person who has suffered an acute life-threatening event or illness is admitted (e) unexpected, significant physical deterioration occurs
		Hospital has documented policy for pain management		SI/OB	
		Screening of the patient for pain		SI/RR	Symptomatic treatment is given to the patient to prevent complications to extent possible
		Pain alleviation measures or medication is initiated & titrated as per need and response		SI/RR	
ME B 6.7	There is an established procedure for patients who wish to leave hospital against medical advice or refuse to receive specific c treatment	Declaration is taken from the LAMA patient		RR/SI	Consequences of LAMA are explained to patient/ relative

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
AREA OF CONCERN - C INPUTS					
Standard C1	**The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms**				
ME C1.1	Departments have adequate space as per patient or work load	ICU has adequate space as per requirement		OB	Space requirement in ICU is 100-125 sq. feet area per bed in patient care area including space for storage and duty room etc
		Availability of adequate waiting area		OB	
ME C1.2	Patient amenities are provide as per patient load	Availability of seating arrangement		OB	
		Availability of cold Drinking water		OB	
		Availability of functional toilets		OB	
ME C1.3	Departments have layout and demarcated areas as per functions	ICU has single entry and exit		OB	There is no thoroughfare through ICU
		Central nursing station is available in ICU		OB	All monitors/ patients must be observable from nursing station either directly or through central monitoring station
		ICU has designated Isolation room		OB	
		Availability of Ancillary area		OB	Ancillary area includes: Nursing station, clean and dirty utility area, Unit stores, Hand washing and gowning area,
		ICU has dedicated change room for staff		OB	Separate doctor and nurse change room are available
		ICU has dedicated counselling room		OB	
ME C1.4	The facility has adequate circulation area and open spaces according to need and local law	Corridors are wide enough for easy movement of Trolleys		OB	2-3 Meters
		There is sufficient space between two bed to provide bed side nursing care and movement		OB	
ME C1.5	The facility has infrastructure for intramural and extramural communication	Availability of functional telephone and Intercom Services		OB	
ME C1.6	Service counters are available as per patient load	Availability of ICU beds as per load		OB	

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME C1.7	The facility and departments are planned to ensure structure follows the function/processes (Structure commensurate with the function of the hospital)	Unidirectional flow of services		OB	There is separate nursing station for each ward
		There is a separate nursing station		OB	Location of nursing station and patients beds enables easy and direct observation of patients
		ICU is in Proximity of OT and has functional linkage with OT		OB	
Standard C2	**The facility ensures the physical safety of the infrastructure.**				
ME C2.1	The facility ensures the seismic safety of the infrastructure	Non structural components are properly secured		OB	Check for fixtures and furniture like cupboards, cabinets, and heavy equipment's , hanging objects are properly fastened and secured
ME C2.3	The facility ensures safety of electrical establishment	ICU building does not have temporary connections and loose hanging wires		OB	
		ICU has mechanism for periodical check / test of all electrical installation by competent electrical Engineer		OB/RR	
		ICU has dedicated earthling pit system available		OB/RR	
		Wall mounted digital display is available in ICU to show earth to neutral voltage		OB	
		Quality output of voltage stabilizer is displayed in each stabilizer as per manufacturer guideline		OB	
		Power boards are marked as per phase to which it belongs		OB	
ME C2.4	Physical condition of buildings are safe for providing patient care	Floors of the ICU are non slippery and even		OB	
		Windows/ ventilators if any in the OT are intact and sealed		OB	
Standard C3	**The facility has established Programme for fire safety and other disaster**				
ME C3.1	The facility has plan for prevention of fire	ICU has sufficient fire exit to permit safe escape to its occupant at time of fire		OB/SI	

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Check the fire exits are clearly visible and routes to reach exit are clearly marked.		OB	
ME C3.2	The facility has adequate fire fighting Equipment	OPD has installed fire Extinguisher that is Class A , Class B C type or ABC type		OB	
		Check the expiry date for fire extinguishers are displayed on each extinguisher as well as due date for next refilling is clearly mentioned		OB	
		ICU has provision of Smoke and heat detector		OB/RR	
		ICU has electrical and automatic fire alarm system or alarm system sounded by actuation of any automatic fire extinguisher		OB/RR	
ME C3.3	The facility has a system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation	Check for staff competencies for operating fire extinguisher and what to do in case of fire		SI/RR	
Standard C4	**The facility has adequate qualified and trained staff, required for providing the assured services to the current case load**				
ME C4.1	The facility has adequate specialist doctors as per service provision	Availability of full time intensivist		OB/RR	
ME C4.2	The facility has adequate general duty doctors as per service provision and work load	Availability of General duty doctor		OB/RR	Duty doctor in 1: 5 ratio
ME C4.3	The facility has adequate nursing staff as per service provision and work load	Availability of Nursing staff as per requirement		OB/RR/SI	As per guideline
ME C4.4	The facility has adequate technicians/paramedics as per requirement	Availability of paramedic staff		OB/SI	1: 5 ratio
ME C4.5	The facility has adequate support / general staff	Availability of ICU attendant		SI/RR	
		Availability Security staff		SI/RR	1 in each shift
		Availability of housekeeping staff		SI/RR	

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard C5	**Facility provides drugs and consumables required for assured list of services.**				
ME C5.1	The departments have availability of adequate drugs at point of use	Availability of Analgesics/ Antipyretics/Anti Inflammatory		OB/RR	As per State EDL
		Availability of Anti Infectives -Antibiotics, Antifungal, Antiprotozoal		OB/RR	As per State EDL
		Availability of Infusion Fluids		OB/RR	As per State EDL
		Availability of Drugs acting on Cardiovascular System		OB/RR	As per State EDL
		Availability of drugs action on Central Nervous system, Peripheral Nervous System		OB/RR	As per State EDL
		Availability of dressing material and antiseptic liquid/lotion		OB/RR	As per State EDL
		Drugs for Respiratory System		OB/RR	As per State EDL
		Hormonal Preparation and Anti- Hormonal Preparation		OB/RR	As per State EDL
		Availability of Medical gases		OB/RR	Availability of Oxygen Cylinders
ME C5.2	The departments have adequate consumables at point of use	Availability of disposables		OB/RR	examination gloves, Syringes,
		Resuscitation Consumables / Tubes		OB/RR	Masks, Ryles tubes, Catheters, Chest Tube, ET tubes etc
ME C5.3	Emergency drug trays are maintained at every point of care, where ever it may be needed	Emergency and resuscitation tray are maintained		OB/RR	
Standard C6	**The facility has equipment & instruments required for assured list of services.**				
ME C6.1	Availability of equipment & instruments for examination & monitoring of patients	Availability of functional Equipment &Instruments for examination & Monitoring		OB	Bed side monitor, pulse oximeter, thermometer, BP apparatus, ECG
ME C6.2	Availability of equipment & instruments for treatment procedures, being undertaken in the facility	Availability of dressing tray for ICU Surgical Ward		OB	
ME C6.3	Availability of equipment & instruments for diagnostic procedures being undertaken in the facility	Availability of Point of care diagnostic instruments		OB	ABG Machine, Glucometer,

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME C6.4	Availability of equipment and instruments for resuscitation of patients and for providing intensive and critical care to patients	Availability of Functional Intensive care equipment and instruments		OB	Ventilator, Infusion pump, C-PAP,
		Availability of Functional Resuscitation equipment's		OB	Bag and mask, laryngoscope, ET tubes, fibro optic bronchoscope Oxygen cylinder/central line, oxygen hood, Trey for procedures like central line, Defibrillator (Ambu bag)
ME C6.5	Availability of Equipment for Storage	Availability of equipment for storage for drugs		OB	Refrigerator, Crash cart/ Drug trolley, instrument trolley, dressing trolley
ME C6.6	Availability of functional equipment and instruments for support services	Availability of equipment's for cleaning		OB	Buckets for mopping, Separate mops for patient care area and circulation area duster, waste trolley, Deck brush
ME C6.7	Departments have patient furniture and fixtures as per load and service provision	Availability of specialized ICU bed		OB	ICU bed (shock proof -fibre).
		Availability of attachment/ accessories with patient bed		OB	Over bed tables, Head end panel, IV stand, Bed pan, bed rail,
		Availability of Fixtures		OB	Trey for monitors, Electrical panel with bed, bedhead panel with outlet for Oxygen and vacuum, X ray view box.
		Availability of furniture		OB	Cupboard, nursing counter, table for preparation of medicines, chair.
Standard C7	**Facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff**				
ME C7.1	Criteria for Competence assessment are defined for clinical and Para clinical staff	Check parameters for assessing skills and proficiency of clinical staff has been defined		RR/SI	Check objective checklist has been prepared for assessing competence of doctors, nurses and paramedical staff based on job description defined for each cadre of staff. Dakshta checklist issued by MoHFW can be used for this purpose.
ME C7.2	Competence assessment of Clinical and Para clinical staff is done on predefined criteria at least once in a year	Check for competence assessment is done at least once in a year		RR/SI	Check for records of competence assessment including filled checklist, scoring and grading . Verify with staff for actual competence assessment done

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME C7.9	The Staff is provided training as per defined core competencies and training plan	Bio Medical waste Management		SI/RR	
		Infection control and hand hygiene		SI/RR	
		Advance life support Training		SI/RR	
		Code Blue		SI/RR	
		Patient safety		SI/RR	
		Training on Quality Management System		SI/RR	To all category of staff. At the time of induction and once in a year.
ME C7.10	There is established procedure for utilization of skills gained thought trainings by on -job supportive supervision	Staff is skilled to operate ICU equipments		SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps
		Staff is skilled for resuscitation and intubation		SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps
		Nursing staff is skilled identifying and managing complication		SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps
		Nursing Staff is skilled for maintaining clinical records		SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps
AREA OF CONCERN - D SUPPORT SERVICES					
Standard D1	**The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.**				
ME D1.1	The facility has established system for maintenance of critical Equipment	All equipments are covered under AMC including preventive maintenance		SI/RR	1. Check with AMC records/ Warranty documents 2. Staff is aware of the list of equipment covered under AMC.

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		There is system of timely corrective break down maintenance of the equipments		SI/RR	(1) Check log book is maintained & it shows time taken to repair equipment. (2) Backup of critical equipment such as Ventilator, Infusion pump, C-PAP,etc. is available (3) Check staff is aware of Contact details of the agencies/ person responsible for maintenance
		There has system to label Defective/Out of order equipments and stored appropriately until it has been repaired		OB/RR	
		Staff is skilled for trouble shooting in case equipment malfunction		SI/RR	
		Periodic cleaning, inspection and maintenance of the equipments is done by the operator		SI/RR	
ME D1.2	The facility has established procedure for internal and external calibration of measuring Equipment	All the measuring equipments/ instrument are calibrated		OB/ RR	
		There is system to label/ code the equipment to indicate status of calibration/ verification when recalibration is due		OB/ RR	
ME D1.3	Operating and maintenance instructions are available with the users of equipment	Up to date instructions for operation and maintenance of equipments are readily available with staff.		OB/SI	Check the down time of equipments
Standard D2	**The facility has defined procedures for storage, inventory management and dispensing of drugs in pharmacy and patient care areas**				
ME D2.1	There is established procedure for forecasting and indenting drugs and consumables	There is established system of timely indenting of consumables and drugs at nursing station		SI/RR	Stock level are daily updated Indents are timely placed
ME D2.3	The facility ensures proper storage of drugs and consumables	Drugs are stored in containers/tray/crash cart and are labelled		OB	Away from direct sunlight and temperature is maintained as per instructions of manufacturer.
		Empty and filled cylinders are labelled		OB	

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME D2.4	The facility ensures management of expiry and near expiry drugs	Expiry dates' are maintained at emergency drug tray		OB/RR	Records for expiry and near expiry drugs are maintained for emergency tray FIRST EXPIRY and FIRST OUT (FEFO) is in practice
		No expired drug found		OB/RR	Check the drug expiry of drug sub store
		Records for expiry and near expiry drugs are maintained for drug stored in ICU		RR	Check the record of expiry and near expiry drug
ME D2.5	The facility has established procedure for inventory management techniques	There is practice of calculating and maintaining buffer stock		SI/RR	Minimum stock and reorder level are calculated based on consumption Minimum buffer stock is maintained all the time
		Department maintained stock register of drugs and consumables		RR/SI	Check record of drug received, issued and balance stock in hand and are regularly updated
		Drugs are categorized in Vital, Essential and Desirable		OB/RR	Check all Vital drugs are available
ME D2.6	There is a procedure for periodically replenishing the drugs in patient care areas	There is established system for replenishing drug tray /crash cart		SI/RR	
		There is no stock out of drugs		OB/SI	Check stock of some vital drugs
ME D2.7	There is process for storage of vaccines and other drugs, requiring controlled temperature	Temperature of refrigerators are kept as per storage requirement and records twice a day and are maintained		OB/RR	Check for temperature charts are maintained and updated twice a daily.
ME D2.8	There is a procedure for secure storage of narcotic and psychotropic drugs	Narcotic ,psychotropic drugs are kept separately in lock and key		OB/SI	Separately kept, away from other drugs and labelled
Standard D3	**The facility provides safe, secure and comfortable environment to staff, patients and visitors.**				
ME D3.1	The facility provides adequate illumination level at patient care areas	Adequate Illumination at nursing station		OB	General Patient Care - 200-50 Lux Procedure Spot Light - 1500 Lux
		Adequate illumination in patient care unit		OB	
ME D3.2	The facility has provision of restriction of visitors in patient areas	Entry to ICU is restricted		OB	
		Visiting hour are fixed and practiced		OB/PI	

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME D3.3	The facility ensures safe and comfortable environment for patients and service providers	Temperature is maintained in ICU and record of same is kept		SI/RR	20-25OC, ICU has functional room thermometer and temperature is regularly maintained
		Humidity is maintained in ICU and record of same is maintained		SI/RR	50-60%
		ICU has system to maintain its ventilation and its environment is dust free		SI/RR	
		ICU has system to control the sound producing activities and gadgets' (like telephone sounds, staff area and equipments)		SI/RR	
ME D3.4	The facility has security system in place at patient care areas	Security arrangement at ICU		OB	
		Identification band for all		OB	Check mechanism at place to track the patient based on UID
ME D3.5	The facility has established measure for safety and security of female staff	Female staff feel secure at work place		SI	
Standard D4	**The facility has established Programme for maintenance and upkeep of the facility**				
ME D4.1	Exterior of the facility building is maintained appropriately	Building is painted/ whitewashed in uniform color		OB	
		Interior of patient care areas are plastered & painted		OB	
ME D4.2	Patient care areas are clean and hygienic	Floors, walls, roof, roof topes, sinks patient care and circulation areas are Clean		OB	All area are clean with no dirt,grease,littering and cobwebs
		Surface of furniture and fixtures are clean		OB	
		Toilets are clean with functional flush and running water		OB	
ME D4.3	Hospital infrastructure is adequately maintained	Check for there is no seepage , Cracks, chipping of plaster		OB	
		Window panes , doors and other fixtures are intact		OB	

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Patients beds are intact and painted		OB	Mattresses are intact and clean
ME D4.5	The facility has policy of removal of condemned junk material	No condemned/Junk material in the ICU		OB	
ME D4.6	The facility has established procedures for pest, rodent and animal control	No rodent/pests are noticed		OB	
Standard D5	**The facility ensures 24X7 water and power backup as per requirement of service delivery, and support services norms**				
ME D5.1	The facility has adequate arrangement storage and supply for portable water in all functional areas	Availability of 24x7 running and potable water		OB/SI	
ME D5.2	The facility ensures adequate power backup in all patient care areas as per load	Availability of power back up in ICU		OB/SI	Power back for all critical equipments
		Availability of UPS		OB/SI	
		Availability of Emergency light		OB/SI	
ME D5.3	Critical areas of the facility ensures availability of oxygen, medical gases and vacuum supply	Availability of Centralized /local piped Oxygen and vacuum supply		OB	
StandardD6	**Dietary services are available as per service provision and nutritional requirement of the patients.**				
ME D6.1	The facility has provision of nutritional assessment of the patients	Nutritional assessment of patient done as required and directed by doctor		RR/SI	
ME D6.2	The facility provides diets according to nutritional requirements of the patients	Check for the adequacy and frequency of diet as per nutritional requirement		OB/RR	Check that all items are as per clinical advice
		Check for the Quality of diet provided in ICU		PI/SI	Ask patient/staff weather they are satisfied with the Quality of food
ME D6.3	Hospital has standard procedures for preparation, handling, storage and distribution of diets, as per requirement of patients	There is procedure of requisition of different type of diet from ward to kitchen		RR/SI	
Standard D7	**The facility ensures clean linen to the patients**				
ME D7.1	The facility has adequate sets of linen	Clean Linens are provided for all occupied bed		OB/RR	
		Gown is provided to all patients		OB/RR	
ME D7.2	The facility has established procedures for changing of linen in patient care areas	Linen is changed every day and whenever it get soiled		OB/RR	

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME D7.3	The facility has standard procedures for handling , collection, transportation and washing of linen	There is system to check the cleanliness and Quantity of the linen received from laundry		SI/RR	
		Check dedicated closed bin is kept for storage of dirty linen		OB	Check linen is kept closed bin & emptied regularly. Plastic bag is used in dustbin & these bags are sealed before removed & handed over
Standard D11	**Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.**				
ME D11.1	The facility has established job description as per govt guidelines	Job description is defined and communicated to all concerned staff		RR	Regular + contractual
		Staff is aware of their role and responsibilities		SI	
ME D11.2	The facility has a established procedure for duty roster and deputation to different departments	There is procedure to ensure that staff is available on duty as per duty roster		RR/SI	Check for system for recording time of reporting and relieving (Attendance register/ Biometrics etc)
		There is designated in charge for department		SI	
ME D11.3	The facility ensures the adherence to dress code as mandated by its administration / the health department	Doctor, nursing staff and support staff adhere to their respective dress code		OB	
Standard D12	**Facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations**				
ME D12.1	There is established system for contract management for out sourced services	There is procedure to monitor the quality and adequacy of outsourced services on regular basis		SI/RR	Verification of outsourced services (cleaning/ Dietary/Laundry/Security/ Maintenance) provided are done by designated in-house staff
AREA OF CONCERN - E CLINICAL SERVICES					
Standard E1	**The facility has defined procedures for registration, consultation and admission of patients.**				
ME E1.1	The facility has established procedure for registration of patients	Unique identification number is given to each patient during process of registration		RR	
		Patient demographic details are recorded in admission records		RR	Check for that patient demographics like Name, age, Sex, Chief complaint, etc.

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME E1.3	There is established procedure for admission of patients	There is established criteria for admission at ICU		SI/RR	Criteria based on Vital sign, Laboratory value/ Diagnostic values and Physical finding
		There is no delay in admission of patient		SI/RR/OB	
		Admission is done on written order by authorized doctor		SI/RR/OB	
		Time of admission is recorded in patient record		RR	
ME E1.4	There is established procedure for managing patients, in case beds are not available at the facility	Procedure cope with surplus patient load		OB/SI	Check for admission criteria. Check for linkage with higher facilities
Standard E2	**The facility has defined and established procedures for clinical assessment, reassessment and treatment plan preparation.**				
ME E2.1	There is established procedure for initial assessment of patients	Initial assessment of all admitted patient done as per standard protocols		RR/SI	Assessment criteria of different kind of medical /surgical conditions is defined and practiced
		Patient History is taken and recorded		RR	
		Physical Examination is done and recorded wherever required		RR	
		Provisional Diagnosis is recorded		RR	
		Initial assessment and treatment is provided immediately		RR/SI	
		Initial assessment is documented preferably within 1 hours		RR	
ME E2.2	There is established procedure for follow-up/ reassessment of Patients	There is fixed schedule for reassessment of patient under observation		RR/OB	
		For critical patients admitted in the ward there is provision of reassessments as per need		RR/OB	
		There is system in place to identify and manage the changes in Patient's health status		SI/RR	Criteria is defined for identification, and management of high risk patients/ patient whose condition is deteriorating

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Check the treatment or care plan is modified as per re assessment results		SI/RR	Check the re assessment sheets/ Case sheets modified treatment plan or care plan is documented
ME E2.3	There is established procedure to plan and deliver appropriate treatment or care to individual as per the needs to achieve best possible results	Check healthcare needs of all hospitalised patients are identified through assessment process		SI/RR	Assessment includes physical assessment, history, details of existing disease condition (if any) for which regular medication is taken as well as evaluate psychological ,cultural, social factors
		Check treatment/care plan is prepared as per patient's need		RR	(a) According to assessment and investigation findings (wherever applicable). (b) Check inputs are taken from patient or relevant care provider while preparing the care plan.
		Check treatment / care plan is documented		RR	Care plan include:, investigation to be conducted, intervention to be provided, goals to achieve, timeframe, patient education, , discharge plan etc
		Check care is delivered by competent multidisciplinary team		SI/RR	Check care plan is prepared and delivered as per direction of qualified physician
Standard E3	**Facility has defined and established procedures for continuity of care of patient and referral**				
ME E3.1	Facility has established procedure for continuity of care during interdepartmental transfer	There is procedure for hand over for patient transferred from ICU to IPD /OT/HDU		SI/RR	Check for how hand over is given from ICU to ward and vice versa etc.
		Check for the procedure if patient is to be consulted with other specialist		RR/SI	Check for the procedure for calling specialist on call to ICU for opinion /advice. Is there any list of specialist with phone no. available
ME E3.2	Facility provides appropriate referral linkages to the patients/ Services for transfer to other/higher facilities to assure their continuity of care.	Patient referred with referral slip		RR/SI	

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Reason for referral is clearly stated and referral is written by authorized competent person (Medical Officer on duty)		RR/ SI	(1) Verify with referral records that reasons for referral were clearly mentioned (2) ICU staff confirms the suitability of referral with higher centres to ascertain that case can be managed at higher centre and will not require further referrals
		Advance communication is done with higher centre & Referral vehicle is being arranged		SI/PI/RR	(1) Check ICU staff facilitates arrangement of ambulance for transferring the patient to higher centre
					(2) Patient attendant are not asked to arrange vehicle by their own (3) Check if ICU staff checks ambulance preparedness in terms of necessary equipment, drugs, accompanying staff in terms of care that may be required in transit
		Referral in or referral out register is maintained		RR	(1) Referral check list is filled before referral to ensure all necessary steps have been taken for safe referral (2) Check referral records has information regarding advance communication, transport arrangement, accompanying care provider, reason for referral , time taken for referral etc. along with demographics, date & time of admission, date & time of referral, and follow up
		Facility has functional referral linkages to facilities		SI/RR	Check the mechanism of referral linkages to lower/ higher facilities
		There is a system of follow up of referred patients		RR	

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME E3.3	A person is identified for care during all steps of care	Doctor and nurse is designated for each patient admitted to ICU ward		RR/SI	Treating doctor is designated
		There is established procedure for co ordination of care between duty doctor and treating doctor/specialist		RR/SI	Duty doctor takes round with treating doctor
		Patient condition is reviewed during hand over between duty doctors		RR/SI	
Standard E4	**The facility has defined and established procedures for nursing care**				
ME E4.1	Procedure for identification of patients is established at the facility	There is a process for ensuring the patient's identification before any clinical procedure		OB/SI	Patient id band/ verbal confirmation/Bed no. etc.
ME E4.2	Procedure for ensuring timely and accurate nursing care as per treatment plan is established at the facility	Treatment chart are maintained		RR	Check for treatment chart are updated and drugs given are marked. Co relate it with drugs and doses prescribed.
		There is a process to ensue the accuracy of verbal/telephonic orders		SI/RR	(1) Check system is in place to give telephonic orders & practised (2) Verbal orders are verified by the ordering physician within defined time period
ME E4.3	There is established procedure of patient hand over, whenever staff duty change happens	Patient hand over is given during the change in the shift		SI/RR	
		Nursing Handover register is maintained		RR	
		Hand over is given bed side		SI/RR	
ME E4.4	Nursing records are maintained	Nursing notes are maintained adequately		RR/SI	Check for nursing note register. Notes are adequately written
ME E4.5	There is procedure for periodic monitoring of patients	Patient Vitals are monitored and recorded periodically		RR/SI	Check for TPR chart, IO chart, any other vital required is monitored
		Critical patients are monitored continually		RR/SI	Check for use of cardiac monitor/multi parameter

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard E5	**Facility has a procedure to identify high risk and vulnerable patients.**				
ME E5.1	The facility identifies vulnerable patients and ensure their safe care	Vulnerable patients are identified and measures are taken to protect them from any harm		OB/SI	Unconscious and comatose patient, stupors patient, patient with suppressed immune system
ME E5.2	The facility identifies high risk patients and ensure their care, as per their need	High risk patients are identified and treatment given on priority		OB/SI	
Standard E6	**Facility ensures rationale prescribing and use of medicines**				
ME E6.1	Facility ensured that drugs are prescribed in generic name only	Check for BHT if drugs are prescribed under generic name only		RR	
ME E6.2	There is procedure of rational use of drugs	Check for that relevant Standard treatment guideline are available at point of use		RR	
		Check staff is aware of the drug regime and doses as per STG		SI/RR	Check BHT that drugs are prescribed as per STG
		Availability of drug formulary		SI/OB	
ME E6.3	There are procedures defined for medication review and optimization	Complete medication history is documented for each patient		RR/OB	Check complete medication history including over-the-counter medicines is taken and documented
		Established mechanism for Medication reconciliation process		SI/RR	1. Medication Reconciliation is carried out by a trained and competent health professional during the patient's admission, interdepartmental transfer or discharged 2. Medicine reconciliation includes Prescription and non-prescription (over-the-counter) medications, vitamins, nutritional supplements.
		Medicine are reviewed and optimised as per individual treatment plan		SI/RR	Medicines are optimised as per individual treatment plan for best possible clinical outcome
		Complete medication history is documented and communicated for each patient at the time of discharge		SI/RR	1. Discharge summary includes known drug allergies and reactions to medicines or their ingredients, and the type of reaction experienced 2. Changes in prescribed medicines, including medicines started or stopped, or dosage changes, and reason for the change are clearly documented in the case sheet and case summary

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Patients are engaged in their own care		PI/SI	1. Clinician/Nurse/ Paramedics counsel the patient on medication safety using ""5 moments for medication safety app"" 2. Nurse/Pharmacist highlights the medications to be taken by the patient at home and counsel the patient and family on drug intake as per treatment plan for discharge
Standard E7	**Facility has defined procedures for safe drug administration**				
ME E7.1	There is process for identifying and cautious administration of high alert drugs (to check)	High alert drugs available in department are identified		SI/OB	Electrolytes like Potassium chloride, Uploads, Neuro muscular blocking agent, Anti thrombolytic agent, insulin, warfarin, Heparin, Adrenergic agonist etc. as applicable
		Maximum dose of high alert drugs are defined and communicated		SI/RR	Value for maximum doses as per age, weight and diagnosis are available with nursing station and doctor
		There is process to ensure that right doses of high alert drugs are only given		SI/RR	A system of independent double check before administration, Error prone medical abbreviations are not used
ME E7.2	Medication orders are written legibly and adequately	Every Medical advice and procedure is accompanied with date , time and signature		RR	
		Check for the writing, It comprehendible by the clinical staff		RR/SI	
ME E7.3	There is a procedure to check drug before administration/ dispensing	Drugs are checked for expiry and other inconsistency before administration		OB/SI	
		Check single dose vial are not used for more than one dose		OB	Check for any open single dose vial with left over content indented to be used later on
		Check for separate sterile needle is used every time for multiple dose vial		OB	In multi dose vial needle is not left in the septum
		Any adverse drug reaction is recorded and reported		RR/SI	Adverse drug event trigger tool is used to report the events

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME E7.4	There is a system to ensure right medicine is given to right patient	Check Nursing staff is aware 7 Rs of Medication and follows them		SI/RR	Administration of medicines done after ensuring right patient, right drugs, right route, right time, Right dose, Right Reason and Right Documentation
Standard E8	**Facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage**				
ME E8.1	All the assessments, re-assessment and investigations are recorded and updated	Patient progress is recorded as per defined assessment schedule		RR	(Manually/e-records)
ME E8.2	All treatment plan prescription/orders are recorded in the patient records.	Treatment plan, first orders are written on BHT		RR	Treatment prescribed in nursing records (Manually/ e-records)
ME E8.3	Care provided to each patient is recorded in the patient records	Maintenance of treatment chart/ treatment registers		RR	Treatment given is recorded in treatment chart (Manually/e-records)
ME E8.4	Procedures performed are written on patients records	Procedure performed are recorded in BHT		RR	Mobilization, resuscitation etc (Manually/e-records)
ME E8.5	Adequate form and formats are available at point of use	Standard Formats are available		RR/OB	Check for the availability of ICU slip, Requisition slips etc.
ME E8.6	Register/records are maintained as per guidelines	Registers and records are maintained as per guidelines		RR	General order book (GOB), report book, Admission register, lab register, Admission sheet/ bed head ticket, discharge slip, referral slip, referral in/referral out register, OT register, Diet register, Linen register, Drug intend register
		All register/records are identified and numbered		RR	
ME E8.7	The facility ensures safe and adequate storage and retrieval of medical records	Safe keeping of patient records		OB	
Standard E9	**The facility has defined and established procedures for discharge of patient.**				
ME E9.1	Discharge is done after assessing patient readiness	ICU has established criteria for discharge of the patient		SI/RR	Patient is shifted to ward/step down after assessment
		Assessment is done before discharging patient		SI/RR	
		Discharge is done by an authorised doctor		SI/RR	

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Patient / attendants are consulted before discharge		PI/SI	
		Treating doctor is consulted/ informed before discharge of patients		SI/RR	
ME E9.2	Case summary and follow-up instructions are provided at the discharge	Discharge summary is provided		RR/PI	See for discharge summary, referral slip provided.
		Discharge summary adequately mentions patients clinical condition, treatment given and follow up		RR	
		Discharge summary is give to patients going in LAMA/Referred out		SI/RR	
ME E9.3	Counselling services are provided as during discharges wherever required	Patient is counselled before discharge		PI/SI	
		Time of discharge is communicated to patient before hand		PI/SI	
Standard E10	**The facility has defined and established procedures for intensive care.**				
ME E10.1	The facility has established procedure for shifting the patient to step-down/ ward based on explicit assessment criteria	ICU has procedure for step down of the patient.		RR/SI	Step down of the patient is planned by on duty doctor in consultation with treating doctor
ME E10.2	The facility has defined and established procedure for intensive care	ICU has protocols for pain management		RR/SI	
		ICU has protocol for sedation		RR/SI	
		ICU has procedure for starting Central lines		RR/SI	
		ICU has protocol for early eternal nutrition		RR/SI	
		Protocol for Care of unconscious paraplegic patients is available		RR/SI	Prevention of decubitus in ICU patient
		ICU has protocol for management of anaphylactic shock		RR/SI	
ME E10.3	The facility has explicit clinical criteria for providing intubation & extubating, and care of patients on ventilation and subsequently on its removal	ICU has criteria defined for non invasive ventilation in case of respiratory failure		RR/SI	C -PEP and V -PEP
		Criteria for intubation		RR/SI	
		Criteria for extubating		RR/SI	

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Criteria of tracheotomy		RR/SI	
		ICU has protocols for care and Monitoring of patient on ventilator		RR/SI	Monitoring include subjective responses, physiological responses, blood gas measurement
Standard E11	**The facility has defined and established procedures for Emergency Services and Disaster Management**				
ME E11.3	The facility has disaster management plan in place	Staff is aware of disaster plan		SI/RR	
		Role and responsibilities of staff in disaster is defined		SI/RR	
Standard E12	**The facility has defined and established procedures of diagnostic services**				
ME E12.1	There are established procedures for Pre-testing Activities	Container is labelled properly after the sample collection		OB	
ME E12.3	There are established procedures for Post-testing Activities	ICU has critical values of various lab test		SI/RR	
Standard E13	**The facility has defined and established procedures for Blood Bank/Storage Management and Transfusion.**				
ME E13.8	There is established procedure for issuing blood	There is a procedure for issuing the blood promptly for life saving measures		RR/SI	
ME E13.9	There is established procedure for transfusion of blood	Consent is taken before transfusion		RR	
		Patient's identification is verified before transfusion		SI/OB	
		Blood is kept on optimum temperature before transfusion		RR	
		Blood transfusion is monitored and regulated by qualified person		SI/RR	
		Blood transfusion note is written in patient recorded		RR	
ME E13.10	There is a established procedure for monitoring and reporting Transfusion complication	Any major or minor transfusion reaction is recorded and reported to responsible person		RR	
Standard E14	**Facility has established procedures for Anaesthetic Services**				
ME E14.1	Facility has established procedures for Pre Anaesthetic Check up	Pre anaesthesia check up is conducted for elective / Planned surgeries		SI/RR	

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
MATERNAL & CHILD HEALTH SERVICES					
Standard E16	**The facility has defined and established procedures for the management of death & bodies of deceased patients**				
ME E16.1	Death of admitted patient is adequately recorded and communicated	ICU has procedure to inform patient relatives about poor prognostic status of inpatient		SI	
		ICU has system for conducting bereavement support of patient's relative in case of mortality		RR/SI	
		Death note is written on patient record		RR	
ME E16.2	The facility has standard procedures for handling the death in the hospital	Death note including efforts done for resuscitation is noted in patient record		SI/RR	
		Death summary is given to patient attendant quoting the immediate cause and underlying cause if possible		SI/RR	
		The body of deceased is handled with respect and dignity		SI/RR/OB	
		Socio-cultural beliefs of patient 's family are identified and respected		SI/RR/OB	
AREA OF CONCERN - F INFECTION CONTROL					
Standard F1	**Facility has infection control program and procedures in place for prevention and measurement of hospital associated infection**				
ME F1.2	Facility has provision for Passive and active culture surveillance of critical & high risk areas	Surface and environment samples are taken for microbiological surveillance		SI/RR	Swab are taken from infection prone surfaces
ME F1.3	Facility measures hospital associated infection rates	There is procedure to report cases of Hospital acquired infection		SI/RR	Patients are observed for any sign and symptoms of HAI like fever, purulent discharge from surgical site .
ME F1.4	There is Provision of Periodic Medical Check-ups and immunization of staff	There is procedure for immunization of the staff		SI/RR	Hepatitis B, Tetanus Toxoid etc
		Periodic medical check-ups of the staff		SI/RR	
ME F1.5	Facility has established procedures for regular monitoring of infection control practices	Regular monitoring of infection control practices		SI/RR	Hand washing and infection control audits done at periodic intervals

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME F1.6	Facility has defined and established antibiotic policy	Check for Doctors are aware of Hospital Antibiotic Policy		SI/RR	
Standard F2	**Facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis**				
ME F2.1	Hand washing facilities are provided at point of use	Availability of hand washing Facility at Point of Use		OB	FNBC guideline: Each unit should have at least 1 wash basin for every 5 beds
		Availability of running Water		OB/SI	Ask to Open the tap. Ask Staff water supply is regular
		Availability of antiseptic soap with soap dish/ liquid antiseptic with dispenser.		OB/SI	Check for availability/ Ask staff if the supply is adequate and uninterrupted
		Availability of Alcohol based Hand rub		OB/SI	Check for availability/ Ask staff for regular supply. Hand rub dispenser are provided adjacent to bed
		Display of Hand washing Instruction at Point of Use		OB	Prominently displayed above the hand washing facility , preferably in Local language
		Availability of elbow operated taps		OB	
		Hand washing sink is wide and deep enough to prevent splashing and retention of water		OB	
ME F2.2	Staff is trained and adhere to standard hand washing practices	Adherence to 6 steps of Hand washing		SI/OB	Ask of demonstration
		Staff aware of when to hand wash		SI	
ME F2.3	Facility ensures standard practices and materials for antisepsis	Availability of Antiseptic Solutions		OB	
		Proper cleaning of procedure site with antisepsis		OB/SI	like before giving IM/IV injection, drawing blood, putting Intravenous and urinary catheter
Standard F3	**Facility ensures standard practices and materials for Personal protection**				
ME F3.1	Facility ensures adequate personal protection equipments as per requirements	Clean gloves are available at point of use		OB/SI	
		Availability of Mask		OB/SI	
		Availability of gown/ Apron		OB/SI	Staff and visitors
		Availability of shoe cover		OB/SI	Staff and visitors
		Availability of Caps		OB/SI	Staff and visitors

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Personal protective kit for infectious patients		OB/SI	
ME F3.2	Staff is adhere to standard personal protection practices	No reuse of disposable gloves, Masks, caps and aprons.		OB/SI	
		Compliance to correct method of wearing and removing the PPE		SI	Gloves, Masks, Caps and Aprons
Standard F4	**Facility has standard Procedures for processing of equipments and instruments**				
ME F4.1	Facility ensures standard practices and materials for decontamination and clean ing of instruments and procedures areas	Cleaning & Decontamination of patient care Units		SI/OB	Ask staff about how they decontaminate the procedure surface like Examination table , Patients Beds Stretcher/ Trolleys etc. (Wiping with 0.5% Chlorine solution
		Proper Decontamination of instruments after use		SI/OB	Ask staff how they decontaminate the instruments like abusage, suction cannula, Airways, Face Masks, Surgical Instruments (Soaking in 0.5% Chlorine Solution, Wiping with 0.5% Chlorine Solution or 70% Alcohol as applicable
		Contact time for decontamination is adequate		SI/OB	10 minutes
		Cleaning of instruments after decontamination		SI/OB	Cleaning is done with detergent and running water after decontamination
		Proper handling of Soiled and infected linen		SI/OB	No sorting ,Rinsing or sluicing at Point of use/ Patient care area
		Staff know how to make chlorine solution		SI/OB	
ME F4.2	Facility ensures standard practices and materials for disinfection and sterilization of instruments and equipments	Equipment and instruments are sterilized after each use as per requirement		OB/SI	Autoclaving/HLD/Chemical Sterilization
		High level Disinfection of instruments/equipments is done as per protocol		OB/SI	Ask staff about method and time required for boiling
		Autoclaving of instruments is done as per protocols		OB/SI	Ask staff about temperature, pressure and time

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Chemical sterilization of instruments/equipments is done as per protocols		OB/SI	Ask staff about method, concentration and contact time required for chemical sterilization
		Autoclaved linen are used for procedure		OB/SI	
		Autoclaved dressing material is used		OB/SI	
		There is a procedure to ensure the traceability of sterilized packs		OB/SI	
		Sterility of autoclaved packs is maintained during storage		OB/SI	Sterile packs are kept in clean, dust free, moist free environment.
Standard F5	**Physical layout and environmental control of the patient care areas ensures infection prevention**				
ME F5.1	Layout of the department is conducive for the infection control practices	Facility layout ensures separation of general traffic from patient traffic		OB	
		Facility layout ensures separation of routes for clean and dirty items		OB	
		Floors and wall surfaces of ICU are easily cleanable		OB	
ME F5.2	Facility ensures availability of standard materials for cleaning and disinfection of patient care areas	Availability of disinfectant as per requirement		OB/SI	Chlorine solution, Glutaraldehyde, carbolic acid
		Availability of cleaning agent as per requirement		OB/SI	Hospital grade phenyl, disinfectant detergent solution
ME F5.3	Facility ensures standard practices followed for cleaning and disinfection of patient care areas	Staff is trained for spill management		SI/RR	
		Cleaning of patient care area with detergent solution		SI/RR	
		Staff is trained for preparing cleaning solution as per standard procedure		SI/RR	
		Standard practice of mopping and scrubbing are followed		OB/SI	Unidirectional mopping from inside out
		Cleaning equipments like broom are not used in patient care areas		OB/SI	Any cleaning equipment leading to dispersion of dust particles in air should be avoided
		Use of three bucket system for mopping		OB/SI	

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Fumigation/ carbonization as per schedule		SI/RR	
		External foot wares are restricted		OB	
ME F5.4	Facility ensures segregation infectious patients	Isolation and barrier nursing procedure are followed for septic cases		OB/SI	
ME F5.5	Facility ensures air quality of high risk area	Negative pressure is maintained in Isolation		OB/SI	
Standard F6	**Facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.**				
ME F6.1	Facility Ensures segregation of Bio Medical Waste as per guidelines	Availability of colour coded bins at point of waste generation		OB	Adequate number. Covered. Foot operated.
		Availability of colour coded non chlorinated plastic bags		OB	
		Segregation of Anatomical and soiled waste in Yellow Bin		OB/SI	Human Anatomical waste, Items contaminated with blood, body fluids, dressings, plaster casts, cotton swabs and bags containing residual or discarded blood and blood components.
		Segregation of infected plastic waste in red bin		OB	Items such as tubing, bottles, intravenous tubes and sets, catheters, urine bags, syringes (without needles and fixed needle syringes) and vacutainers with their needles cut) and gloves
		Display of work instructions for segregation and handling of Biomedical waste		OB	Pictorial and in local language
		There is no mixing of infectious and general waste			
ME F6.2	Facility ensures management of sharps as per guidelines	Availability of functional needle cutters		OB	See if it has been used or just lying idle.

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Segregation of sharps waste including Metals in white (translucent) Puncture proof, Leak proof, tamper proof containers		OB	Should be available nears the point of generation. Needles, syringes with fixed needles, needles from needle tip cutter or burner, scalpels, blades, or any other contaminated sharp object that may cause puncture and cuts. This includes both used, discarded and contaminated metal sharps
		Availability of post exposure prophylaxis		SI/OB	Ask if available. Where it is stored and who is in charge of that.
		Staff knows what to do in condition of needle stick injury		SI	Staff knows what to do in case of shape injury. Whom to report. See if any reporting has been done
		Contaminated and broken Glass are disposed in puncture proof and leak proof box/ container with Blue colour marking		OB	Vials, slides and other broken infected glass
ME F6.3	Facility ensures transportation and disposal of waste as per guidelines	Check bins are not overfilled		SI/OB	
		Disinfection of liquid waste before disposal		SI/OB	
		Transportation of bio medical waste is done in close container/trolley			
		Staff is aware of mercury spill management		SI/RR	Look for: 1. Spill area evacuation 2. Removal of Jewellery 3. Wear PPE 4. Use of flashlight to locate mercury beads 5. Use syringe without a needle/eyedropper and sticky tape to suck the beads 6. Collection of beads in leak-proof bag or container 7. Sprinkle sulphur or zinc powder to remove any remaining mercury 8. All the mercury spill surfaces should be decontaminated with 10% sodium thiosulfate solution 9. All the bags or containers containing items contaminated with mercury should be marked as "Hazardous Waste, Handle with Care" 10. Collected mercury waste should be handed over to the CBMWTF

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
AREA OF CONCERN - G QUALITY MANAGEMENT					
Standard G1	**The facility has established organizational framework for quality improvement**				
ME G1.1	The facility has a quality team in place	Quality circle has been formed in the Intensive Care Unit		SI/RR	Check if quality circle formed and functional with a designated nodal officer for quality
Standard G3	**Facility have established internal and external quality assurance programs wherever it is critical to quality.**				
ME G3.1	Facility has established internal quality assurance program at relevant departments	There is system daily round by hospital superintendent/ Hospital Manager/ Matron in charge for monitoring of services		SI/RR	Check for entries in Round Register
ME G3.3	Facility has established system for use of check lists in different departments and services	Internal assessment is done at periodic interval		RR/SI	NQAS, Kayakalp, SaQushal tools are used to conduct internal assessment
		Departmental checklist are used for monitoring and quality assurance		SI/RR	Staff is designated for filling and monitoring of these checklists
		Non-compliances are enumerated and recorded		RR	Check the non compliances are presented & discussed during quality team meetings
ME G3.4	Actions are planned to address gaps observed during quality assurance process	Check action plans are prepared and implemented as per internal assessment record findings		RR	Randomly check the details of action, responsibility, time line and feedback mechanism
ME G3.5	Planned actions are implemented through Quality Improvement Cycles (PDCA)	Check PDCA or revalent quality method is used to take corrective and preventive action		SI/RR	Check actions have been taken to close the gap. It can be in form of action taken report or Quality Improvement (PDCA) project report
Standard G4	**Facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.**				
ME G4.1	Departmental standard operating procedures are available	Standard operating procedure for department has been prepared and approved		RR	
		Current version of SOP are available with process owner		OB/RR	
		Work instruction/clinical protocols are displayed		OB	Admission and discharge criteria, Intubation protocol, CPR

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME G4.2	Standard Operating Procedures adequately describes process and procedures	Department has documented procedure for receiving, initial assessment, admission, clinical assessment & reassessment of patient in icu		RR	registration, consultation, Procedures, assessment of patient , counselling, Monitoring etc.
		Department has documented procedure for discharge of the patient		RR	
		ICU has documented procedure nursing care for critical patient		RR	
		ICU has documented procedure for collection, transfer and reporting the sample to laboratory		RR	
		ICU has documented procedure for nutrition in critical illness		RR	
		ICU has documented procedure for key clinical protocols		RR	
		ICU has documented procedure for preventive-break down maintenance and calibration of equipments		RR	
		ICU has documented system for storage, retaining, retrieval of records		RR	
		ICU has documented procedure for purchase of External services and supplies		RR	
		ICU has documented procedure for Maintenance of infrastructure of SNCU		RR	
		ICU has documented procedure for thermoregulation		RR	
		ICU has documented procedure for drugs,intravenous,and fluid management of patient		RR	

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		ICU has documented procedure for counselling of the patient attendant		RR	
		ICU has documented procedure for infection control practices		RR	
		ICU has documented procedure for inventory management		RR	
		ICU has documented procedure for entry of visitor in ICU		RR	
ME G4.3	Staff is trained and aware of the standard procedures written in SOPs	Check staff is a aware of relevant part of SOPs		SI/RR	
Standard G 5	**Facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages**				
ME G5.1	Facility maps its critical processes	Process mapping of critical processes done		SI/RR	
ME G5.2	Facility identifies non value adding activities / waste / redundant activities	Non value adding activities are identified		SI/RR	
ME G5.3	Facility takes corrective action to improve the processes	Processes are rearranged as per requirement		SI/RR	
Standard G6	**The facility has defined mission, values, Quality policy & objectives & prepared a strategic plan to achieve them**				
ME G6.3	Facility has defined Quality policy, which is in congruency with the mission of facility	Check if Quality Policy has been defined and approved		SI/RR	Check quality policy of the facility has been defined in consultation with hospital staff and duly approved by the head of the facility . Also check Quality Policy enables achievement of mission of the facility and health department
ME G6.4	Facility has de defined quality objectives to achieve mission and quality policy	Check if SMART Quality Objectives have framed		SI/RR	Check short term valid quality objectivities have been framed addressing key quality issues in each department and cores services. Check if these objectives are Specific, Measurable, Attainable, Relevant and Time Bound.
ME G6.5	Mission, Values, Quality policy and objectives are effectively communicated to staff and users of services	Check of staff is aware of Mission , Values, Quality Policy and objectives		SI/RR	Interview with staff for their awareness. Check if Mission Statement, Core Values and Quality Policy is displayed prominently in local language at Key Points

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME G6.6	Facility prepares strategic plan to achieve mission, quality policy and objectives	Check if plan for implementing quality policy and objectives have prepared		SI/RR	Verify with records that a time bound action plan has been prepared to achieve quality policy and objectives in consultation with hospital staff . Check if the plan has been approved by the hospital management
ME G6.7	Facility periodically reviews the progress of strategic plan towards mission, policy and objectives	Check time bound action plan is being reviewed at regular time interval		SI/RR	Review the records that action plan on quality objectives being reviewed at least once in month by departmental in charges and during the quality team meeting. The progress on quality objectives have been recorded in Action Plan tracking sheet
Standard G7	**Facility seeks continually improvement by practicing Quality method and tools.**				
ME G7.1	Facility uses method for quality improvement in services	Basic quality improvement method		SI/OB	PDCA & 5S
		Advance quality improvement method		SI/OB	Six sigma, lean.
ME G7.2	Facility uses tools for quality improvement in services	7 basic tools of Quality		SI/RR	Minimum 2 applicable tools are used in each department
Standard G9	**Facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan**				
ME G9.6	Periodic assessment for Medication and Patient care safety risks is done as per defined criteria.	Check periodic assessment of medication and patient care safety risk is done using defined checklist periodically		SI/RR	Verify with the records. A comprehensive risk assessment of all clinical processes should be done using pre define criteria at least once in three month.
ME G9.7	Periodic assessment for potential risk regarding safety and security of staff including violence against service providers is done as per defined criteria	SaQushal assessment toolkit is used for safety audits.		SI/RR	1. Check that the filled checklist and action taken report are available 2. Staff is aware of key gaps & closure status
ME G9.8	Risks identified are analysed evaluated and rated for severity	Identified risks are analysed for severity		SI/RR	Action is taken to mitigate the risks
Standards G10	**The facility has established clinical Governance framework to improve quality and safety of clinical care processes**				
ME G10.3	Clinical care assessment criteria have been defined and communicated	The facility has established procedures to review the clinical care processes		SI/RR	Check parameter are defined & implemented to review the clinical care i.e. through Ward round, peer review, morbidity & mortality review, patient feedback, clinical audit & clinical outcomes.

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Check regular ward rounds are taken to review case progress		SI/RR	(1) Both critical and stable patients (2) Check the case progress is documented in BHT/ progress notes-
		Check the patient /family participate in the care evaluation		SI/RR	Feedback is taken from patient/family on health status of individual under treatment
		Check the care planning and co- ordination is reviewed		SI/RR	System in place to review internal referral process, review clinical handover information, review patient understanding about their progress
ME G10.4	Facility conducts the periodic clinical audits including prescription, medical and death audits	There is procedure to conduct medical audits		SI/RR	Check medical audit records (a) Completion of the medical records i.e. Medical history, assessments, re assessment, investigations conducted, progress notes, interventions conducted, outcome of the case, patient education, delineation of responsibilities, discharge etc. (b) Check whether treatment plan worked for the patient (C) progress on the health status of the patient is mentioned (d) whether the goals defined in treatment plan is met for the individual cases (e) Adverse clinical events are documented (f) Re admission
		There is procedure to conduct death audits		SI/RR	(1) All the deaths are audited by the committee. (2) The reasons of the death is clearly mentioned (3) Data pertaining to deaths are collated and trend analysis is done (4) A through action taken report is prepared and presented in clinical Governance Board meetings / during grand round (wherever required)

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		There is procedure to conduct referral audits		SI/RR	Check for -valid sample size, data is analysed, poor performing attributes are identified and improvement initiatives are undertaken
		All non compliance are enumerated & recorded for medical audits		SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings
		All non compliance are enumerated & recorded for newborn death audits		SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings
		All non compliance are enumerated & recorded for referral audits		SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings
ME G10.5	Clinical care audits data is analysed, and actions are taken to close the gaps identified during the audit process	Check action plans are prepared and implemented as per medical audit record findings		SI/RR	Randomly check the actual compliance with the actions taken reports of last 3 months
		Check action plans are prepared and implemented as per death audit record's findings		SI/RR	Randomly check the actual compliance with the actions taken reports of last 3 months
		Check action plans are prepared and implemented as per prescription audit record findings		SI/RR	Randomly check the actual compliance with the actions taken reports of last 3 months
		Check the data of audit findings are collated		SI/RR	Check collected data is analysed & areas for improvement is identified & prioritised
		Check PDCA or revalent quality method is used to address critical problems		SI/RR	Check the critical problems are regularly monitored & applicable solutions are duplicated in other departments (wherever required) for process improvement
ME G10.7	Facility ensures easy access and use of standard treatment guidelines & implementation tools at point of care	Check standard treatment guidelines / protocols are available & followed.		SI/RR	Staff is aware of Standard treatment protocols/ guidelines/best practices

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Check treatment plan is prepared as per Standard treatment guidelines		SI/RR	Check staff adhere to clinical protocols while preparing the treatment plan
		Check the drugs are prescribed as per Standards treatment guidelines		SI/RR	Check the drugs prescribed are available in EML or part of drug formulary
		Check the updated/latest evidence are available		SI/RR	Check when the STG/ protocols/evidences used in healthcare facility are published. Whether the STG protocols are according to current evidences.
		Check the mapping of existing clinical practices processes is done		SI/RR	The gaps in clinical practices are identified & action are taken to improve it. Look for evidences for improvement in clinical practices using PDCA
AREA OF CONCERN - H OUTCOME					
Standard H1	**The facility measures Productivity Indicators and ensures compliance with State/National benchmarks**				
ME H1.1	Facility measures productivity Indicators on monthly basis	Bed Occupancy Rate		RR	
		Proportion of BPL patients admitted		RR	
		Number of the patients screened for pain		RR	
Standard H2	**The facility measures Efficiency Indicators and ensure to reach State/National Benchmark**				
ME H2.1	Facility measures efficiency Indicators on monthly basis	Downtime critical equipments		RR	
		Transfer Rate		RR	
		Re admission rate		RR	
		Patient's fall rate		RR	
Standard H3	**The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark**				
ME H3.1	Facility measures Clinical Care & Safety Indicators on monthly basis	Average length of stay		RR	
		Risk Adjusted Mortality Rate/Standard Mortality Rate		RR	
		No of Pressure Ulcer developed per thousand cases		RR	
		No of adverse events per thousand patients		RR	Injection room : Post exposure prophylaxis, medication error, patient fall.
		UTI rate		RR	

Reference No	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		VAP rate		RR	
		Adverse events are identified		RR	Injection room : Post exposure prophylaxis, medication error, patient fall.
		Reintubation Rate		RR	
		Culture Surveillance sterility rate		RR	% of environmental swab culture reported positive
Standard H4	**The facility measures Service Quality Indicators and endeavours to reach State/National benchmark**				
ME H4.1	Facility measures Service Quality Indicators on monthly basis	LAMA Rate		RR	
		Patient Satisfaction Score		RR	

ASSESSMENT SUMMARY

Name of the Hospital ..... Date of Assessment .....

Names of Assessors ..... Names of Assessees .....

Type of Assessment (Internal/External) ..... Action plan Submission Date .....

A. SCORE CARD

INTENSIVE CARE UNIT SCORE CARD	
Area of Concern wise score	**Intensive Care Unit Score**
A. Service Provision	
B. Patient Rights	
C. Inputs	
D. Support Services	
E. Clinical Services	
F. Infection Control	
G. Quality Management	
H. Outcome	

B. MAJOR GAPS OBSERVED

1. _____
2. _____
3. _____
4. _____
5. _____

C. STRENGTHS/BEST PRACTICES

1. _____
2. _____
3. _____

D. RECOMMENDATIONS/OPPORTUNITIES FOR IMPROVEMENT

_____

_____

_____

Names and Signature of Assessors

Date _____

सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

CHECKLIST-5

INDOOR PATIENT DEPARTMENT

CHECKLIST FOR INDOOR PATIENT DEPARTMENT

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
AREA OF CONCERN - A SERVICE PROVISION					
Standard A1	**The facility provides Curative Services**				
ME A1.1	The facility provides General Medicine services	Availability of general medicine indoor services		SI/OB	
		Availability of isolation ward services		SI/OB	
ME A1.2	The facility provides General Surgery services	Availability of surgery ward/beds		SI/OB	
		Availability of burn ward		SI/OB	
ME A1.5	The facility provides Ophthalmology Services	Availability of ophthalmology indoor services		SI/OB	
ME A1.7	The facility provides Orthopaedics Services	Availability of Orthopaedics indoor services		SI/OB	In IPHS 2022, beds provision is there for Orthopaedic inpatient services
ME A1.9	The facility provides Psychiatry Services	Availability of Psychiatry Indoor services		SI/OB	(a) Assessment by doctor, availability of doctor on call (b) Availability of emergency care round the clock (c) Psycho social interventions
ME A1.12	The facility provides Physiotherapy Services	Availability of Indoor Physiotherapy Procedures		SI/OB	Physiotherapy advices for IPD patient, Physiotherapy procedures like tractions (Lumbar & Cervical), Short Wave Diathermy, Electrical stimulator with TENS, Ultra sonic therapy, Paraffin wax bath, Infra red therapy, Ultraviolet therapy, Electric Vibrator, Vibrator belt message, Post polio exercises, Obesity exercises, cerebral Palsy massage, Breathing exercises & Postural Drainage
ME A1.14	Services are available for the time period as mandated	Availability of nursing services 24X7		SI/OB	

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
ME A1.16	The facility provides Accident & Emergency Services	Availability of accident & trauma ward		SI/OB	
Standard A4	**The facility provides services as mandated in national Health Programmes/ state scheme**				
ME A4.1	The facility provides services under National Vector Borne Disease Control Programme as per guidelines	Availability of Indoor services for Management		SI/RR	Malaria Kalaazar Dengue & Chikunguna AES/ Japanese Encephalitis as prevalent locally
ME A4.2	The facility provides services under national tuberculosis elimination programme as per guidelines.	Indoor treatment of TB patients requires hospitalization		SI/RR	
ME A4.3	The facility provides services under National Leprosy Eradication Programme as per guidelines	Inpatient Management of severely ill cases		SI/RR	
ME A4.4	The facility provides services under National AIDS Control Programme as per guidelines	Inpatient care for cases require hospitalization		SI/RR	
ME A4.5	The facility provides services under National Programme for prevention and control of Blindness as per guidelines	Availabily of Ophthalmic ward		SI/OB	
ME A4.7	The facility provides services under National Programme for the health care of the elderly as per guidelines	IPD services for Geriatric cases		OB	10 bedded Geriatric Ward- 2 beds earmarked for respite care to bedridden
ME A4.15	The facility provide services under National Programme for pallative care	Availability of Indoor services for pallative care		SI/OB	(a) Assessment by doctor, availability of doctor on call (b) Availability of emergency care round the clock (c) Psycho social interventions
Standard A6	**Health services provided at the facility are appropriate to community needs.**				
ME A6.1	The facility provides curatives & preventive services for the health problems and diseases, prevalent locally.	Availability of indoor Services as per local prevalent disease		SI/RR	
AREA OF CONCERN - B PATIENT RIGHTS					
Standard B1	**The facility provides the information to care seekers, attendants & community about the available services and their modalities**				
ME B1.1	The facility has uniform and user-friendly signage system	Availability of departmental & directional signages		OB	Numbering, main department and internal sectional signage are displayed. Directional signages are given from the entry of the facility
		Display of layout/ floor directory		OB	
		Visiting hours and visitor policy are displayed		OB	

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
		All signages are in uniform colour scheme		OB	
ME B1.2	The facility displays the services and entitlements available in its departments	List of services available are displayed		OB	
		Entitlement under different national health program		OB	
		List of drugs available are displayed and updated		OB	
		Contact details of referral transport / ambulance displayed		OB	
ME B1.4	User charges are displayed and communicated to patients effectively	User charges if any displayed		OB	
ME B1.5	Patients & visitors are sensitised and educated through appropriate IEC / BCC approaches	Relevant IEC material displayed at wards		OB	
ME B1.6	Information is available in local language and easy to understand	Signage's and information are available in local language		OB	
ME B1.8	The facility ensures access to clinical records of patients to entitled personnel	Discharge summary is given to the patient		RR/OB	
Standard B2	**Services are delivered in a manner that is sensitive to gender, religious and cultural needs, and there are no barrier on account of physical , economic, cultural or social reasons.**				
ME B2.1	Services are provided in manner that are sensitive to gender	Separate male & female wards		OB	Where ever male and female are kept in same wards male and female area are demarcated
		Male and female toilets are demarcated		OB/SI	
		Access to toilet should not go through opposite sex patient care area		OB	
		Male attendants are not allowed to stay at night in female ward		OB/SI	
		There is no discrimination with transgender patients		SI/PI	

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
		No unnecessary / non-essential disclosure of a person's trans status		SI/PI/RR	
ME B2.3	Access to facility is provided without any physical barrier & and friendly to people with disabilities	Availability of Wheel chair or stretcher for easy Access to the ward		OB	
		Availability of ramps with railing		OB	At least 120 cm width, gradient not steeper than 1:12
		Availability of specially able toilet		OB	
Standard B3	**The facility maintains privacy, confidentiality & dignity of patient, and has a system for guarding patient related information.**				
ME B3.1	Adequate visual privacy is provided at every point of care	Availability of screens / Curtains		OB	Bracket screen
		Examination/ Dressing of patient is done in enclosed area		OB	
		Curtains / frosted glass have been provided at windows		OB	Check all the windows are fitted with frosted glass or curtains have been provided
		No two patients are treated on one bed		OB	
		Partitions separating men and women are robust enough to prevent casual overlooking and overhearing		OB	
ME B3.2	Confidentiality of patients records and clinical information is maintained	Patient Records are kept at secure place beyond access to general staff/visitors		SI/OB	
		No information regarding patient identity and details are unnecessary displayed		SI/OB	
ME B3.3	The facility ensures the behaviours of staff is dignified and respectful, while delivering the services	Behaviour of staff is empathetic and courteous		OB/PI	

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
ME B3.4	The facility ensures privacy and confidentiality to every patient, especially of those conditions having social stigma, and also safeguards vulnerable groups	HIV status of patient is not disclosed except to staff that is directly involved in care		SI/OB	
Standard B4	**The facility has defined and established procedures for informing patients about the medical condition, and involving them in treatment planning, and facilitates informed decision making**				
ME B4.1	There is established procedures for taking informed consent before treatment and procedures	General Consent is taken before admission		SI/RR	
ME B4.4	Information about the treatment is shared with patients or attendants, regularly	Patient is informed about clinical condition and treatment been provided		PI	
ME B4.5	The facility has defined and established grievance redressal system in place	Availability of complaint box and display of process for grievance re redressal and whom to contact is displayed		OB	
Standard B5	**The facility ensures that there are no financial barrier to access, and that there is financial protection given from the cost of hospital services.**				
ME B5.1	The facility provides cashless services to pregnant women, mothers and neonates as per prevalent government schemes	Stay in wards is free for entitled patients under NHP and state scheme		PI/SI	
		Drugs and consumables under NHP are free of cost		PI/SI	
ME B5.2	The facility ensures that drugs prescribed are available at Pharmacy and wards	Check that patient party has not spent on purchasing drugs or consumables from outside.		PI/SI	
ME B5.3	It is ensured that facilities for the prescribed investigations are available at the facility	Check that patient party has not spent on diagnostics from outside.		PI/SI	
ME B5.4	The facility provide free of cost treatment to Below poverty line patients without administrative hassles	All treatments are free of cost for BPL Patients		PI/SI/RR	
ME B5.6	The facility ensure implementation of health insurance schemes as per National /state scheme	Cashless treatment been provide to smart card holders		SI/RR	

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
Standard B6	**Facility has defined framework for ethical management including dilemmas confronted during delivery of services at public health facilities**				
ME B6.6	There is an established procedure for 'end-of-life' care	Staff is educated & trained for end of life care		SI/RR	
		The patient's Relatives informed clearly about the deterioration in the health condition of Patient.		SI/RR	Periodic update on the patient's condition is given to the family.
		Policy & procedures like DNR , DNI etc for critical cases are in consonance with legal requirement		SI/RR	Patient right "Do not resuscitate" or " Do not intubate"/ allow natural death are respected
		Hospital has documented policy for pain management		SI/OB	
		Screening of the patient for pain intensity		SI/RR	Using pain assessment scales /tools
		Check the pain characteristics		SI/RR	In terms of Location, frequency, duration, radiation etc. - Post operating, neuralgia, arthralgia or myalgia
		Pain alleviation measures or medication is initiated & titrated as per need and response		SI/RR	
		Patient & family are educated on various pain management techniques wherever appropriate			Specially in chronic cases
ME B 6.7	There is an established procedure for patients who wish to leave hospital against medical advice or refuse to receive specific c treatment	Declaration is taken from the LAMA patient		RR/SI	Consequences of LAMA are explained to patient/ relative
AREA OF CONCERN - C INPUTS					
Standard C1	**The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms**				
ME C1.1	Departments have adequate space as per patient or work load	Adequate space in wards with no cluttering of beds		OB	Distance between centres of two beds – 2.25 meter

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
ME C1.2	Patient amenities are provide as per patient load	Functional toilets with running water and flush are available as per strength and patient load of ward		OB	one toilet for 12 patients
		Functional bathroom with running water are available as per strength and patient load of ward		OB	
		Availability of drinking water		OB	
		Patient/ visitor Hand washing area		OB	
		Separate toilets for visitors		OB	
		TV for entertainment and health promotion		OB	
		Adequate shaded waiting area is provide for attendants of patient		OB	
ME C1.3	Departments have layout and demarcated areas as per functions	Availability of Dedicated nursing station		OB	
		Availability of Examination room		OB	
		Availability of Treatment room		OB	
		Availability of Doctor's and Nurse Duty room		OB	
		Availability of Store		OB	Drug &Linen store
		Availability of clean and Dirty utility room		OB	
ME C1.4	The facility has adequate circulation area and open spaces according to need and local law	There is sufficient space between two bed to provide bed side nursing care and movement		OB	Space between two beds should be at least 4 ft and clearance between head end of bed and wall should be at least 1 ft and between side of bed and wall should be 2 ft
		Corridors are wide enough for patient, visitor and trolley/ equipment movement		OB	Corridor should be 3 meters wide

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
ME C1.5	The facility has infrastructure for intramural and extramural communication	Availability of functional telephone and Intercom Services		OB	
ME C1.6	Service counters are available as per patient load	There is a separate nursing station for each ward		OB	Location of nursing station and patients beds in enables easy and direct observation of patients
		Availability of IPD beds as per load		OB	
ME C1.7	The facility and departments are planned to ensure structure follows the function/processes (Structure commensurate with the function of the hospital)	Surgical wards has functional linkages with OT		OB	
		Location of nursing station and patients beds enables easy and direct observation of patients		OB	
Standard C2	**The facility ensures the physical safety of the infrastructure.**				
ME C2.1	The facility ensures the seismic safety of the infrastructure	Non structural components are properly secured		OB	Check for fixtures and furniture like cupboards, cabinets, and heavy equipment , hanging objects are properly fastened and secured
ME C2.3	The facility ensures safety of electrical establishment	IPD building does not have temporary connections and loosely hanging wires		OB	Switch Boards other electrical installations are intact
ME C2.4	Physical condition of buildings are safe for providing patient care	Floors of the ward are non slippery and even		OB	
		Windows have grills and wire meshwork		OB	
Standard C3	**The facility has established Programme for fire safety and other disaster**				
ME C3.1	The facility has plan for prevention of fire	Ward has sufficient fire exit to permit safe escape to its occupant at time of fire		OB/SI	
		Check the fire exits are clearly visible and routes to reach exit are clearly marked.		OB	
ME C3.2	The facility has adequate fire fighting Equipment	IPD has installed fire Extinguisher that is Class A , Class B, C type or ABC type		OB	

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
		Check the expiry date for fire extinguishers are displayed on each extinguisher as well as due date for next refilling is clearly mentioned		OB/RR	
ME C3.3	The facility has a system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation	Check for staff competencies for operating fire extinguisher and what to do in case of fire		SI/RR	
Standard C4	**The facility has adequate qualified and trained staff, required for providing the assured services to the current case load**				
ME C4.1	The facility has adequate specialist doctors as per service provision	Availability of specialist doctor on call		OB/RR	
ME C4.2	The facility has adequate general duty doctors as per service provision and work load	Availability of General duty doctor at all time		OB/RR	
ME C4.3	The facility has adequate nursing staff as per service provision and work load	Availability of Nursing staff		OB/RR/SI	As per patient load
ME C4.4	The facility has adequate technicians/paramedics as per requirement	Availability of dresser in surgical ward		OB/SI/RR	
ME C4.5	The facility has adequate support / general staff	Availability of ward attendant/ Ward boy		SI/RR	
		Availability Security staff		SI/RR	
Standard C5	**The facility provides drugs and consumables required for assured services.**				
ME C5.1	The departments have availability of adequate drugs at point of use	Availability of Non-opioid Analgesics/ Antipyretics/Anti Inflammatory medicines		OB/RR	As per State's EML
		Availability of Anti - Infective Medicines - Antibiotics, Antifungal		OB/RR	As per State's EML
		Availability of Solutions Correcting Water, Electrolyte Disturbance and Acid-base Disturbance		OB/RR	As per State's EML

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
		Availability of medicines acting on Cardiovascular System		OB/RR	As per State's EML
		Availability of medicines acting on Central Nervous System/Peripheral Nervous System		OB/RR	As per State's EML
		Availability of dressing material and antiseptic liquid/ cream/ lotion		OB/RR	As per State's EML
		Medicines for Respiratory System		OB/RR	As per State's EML
		Hormonal Preparation and other Endocrine Medicines		OB/RR	As per State's EML
		Availability of Medical gases		OB/RR	Availability of Oxygen Cylinders
ME C5.2	The departments have adequate consumables at point of use	Availability of dressing material in surgical wards		OB/RR	As per State's EML
		Availability of syringes and IV Sets / tubes		OB/RR	
		Availability of Antiseptic Solutions		OB/RR	As per State's EML
ME C5.3	Emergency drug trays are maintained at every point of care, where ever it may be needed	Availability of emergency drug tray		OB/RR	
Standard C6	**The facility has equipment & instruments required for assured list of services.**				
ME C6.1	Availability of equipment & instruments for examination & monitoring of patients	Availability of functional Equipment &Instruments for examination & Monitoring		OB	BP apparatus, Thermometer, fetoscope, baby and adult weighing scale, Stethoscope , Doppler
ME C6.2	Availability of equipment & instruments for treatment procedures, being undertaken in the facility	Availability of dressing tray for Surgical Ward		OB	
ME C6.3	Availability of equipment & instruments for diagnostic procedures being undertaken in the facility	Availability of Point of care diagnostic instruments		OB	Glucometer

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
ME C6.4	Availability of equipment and instruments for resuscitation of patients and for providing intensive and critical care to patients	Availability of functional Instruments for Resuscitation.		OB	Adult bag and mask, Oxygen, Suction machine, Airway, nebulizer, suction apparatus, LMA, Laryngoscope, ET tube
ME C6.5	Availability of Equipment for Storage	Availability of equipment for storage for drugs		OB	Refrigerator, Crash cart/ Drug trolley, instrument trolley, dressing trolley
ME C6.6	Availability of functional equipment and instruments for support services	Availability of equipment for cleaning		OB	Buckets for mopping, mops, duster, waste trolley, Deck brush
ME C6.7	Departments have patient furniture and fixtures as per load and service provision	Availability of attachment/ accessories with patient bed		OB	Hospital graded mattress, Bed side locker , IVstand, Bed pan
		Availability of Fixtures		OB	Spot light, electrical fixture for equipment like suction, X ray view box
		Availability of furniture		OB	cupboard, nursing counter, table for preparation of medicines, chair.
Standard C7	**Facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff**				
ME C7.1	Criteria for Competence assessment are defined for clinical and Para clinical staff	Check parameters for assessing skills and proficiency of clinical staff has been defined		RR/SI	Check objective checklist has been prepared for assessing competence of doctors, nurses and paramedical staff based on job description defined for each cadre of staff. Dakshta checklist issued by MoHFW can be used for this purpose.
ME C7.2	Competence assessment of Clinical and Para clinical staff is done on predefined criteria at least once in a year	Check for competence assessment is done at least once in a year		RR/SI	Check for records of competence assessment including filled checklist, scoring and grading . Verify with staff for actual competence assessment done
ME C7.9	The Staff is provided training as per defined core competencies and training plan	Infection control & prevention training		SI/RR	Bio medical Waste Management including Hand Hygiene
		Patient Safety		SI/RR	
		Basic Life Support		SI/RR	
		Training on Quality Management System		SI/RR	To all category of staff. At the time of induction and once in a year.

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
ME C7.10	There is established procedure for utilization of skills gained thought trainings by on -job supportive supervision	Nursing staff is skilled for maintaining clinical records		SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps
AREA OF CONCERN - D SUPPORT SERVICES					
Standard D1	**The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.**				
ME D1.1	The facility has established system for maintenance of critical Equipment	All equipment are covered under AMC including preventive maintenance		SI/RR	1. Check with AMC records/ Warranty documents 2. Staff is aware of the list of equipment covered under AMC.
		There is system of timely corrective break down maintenance of the equipments		SI/RR	1.Check for breakdown & Maintenance record in the log book 2. Staff is aware of contact details of the agency/person in case of breakdown.
ME D1.2	The facility has established procedure for internal and external calibration of measuring Equipment	All the measuring equipments/ instrument are calibrated		OB/ RR	BP apparatus, thermometers etc are calibrated
Standard D2	**The facility has defined procedures for storage, inventory management and dispensing of drugs in pharmacy and patient care areas**				
ME D2.1	There is established procedure for forecasting and indenting drugs and consumables	There is established system of timely indenting of consumables and drugs at nursing station		SI/RR	Stock level are daily updated Indents are timely placed
ME D2.3	The facility ensures proper storage of drugs and consumables	Drugs are stored in containers/tray/crash cart and are labelled		OB	Away from direct sunlight and temperature is maintained as per instructions of manufacturer.
		Empty and filled cylinders are labelled		OB	
ME D2.4	The facility ensures management of expiry and near expiry drugs	Expiry dates' are maintained at emergency drug tray		OB/RR	Records for expiry and near expiry drugs are maintained for emergency tray FIRST EXPIRY and FIRST OUT (FEFO) is in practice

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
		No expiry drug found		OB/RR	
		Records for expiry and near expiry drugs are maintained for drug stored at department		RR	Check the record of expiry and near expiry drug in drug sub store
ME D2.5	The facility has established procedure for inventory management techniques	There is practice of calculating and maintaining buffer stock		SI/RR	Minimum stock and reorder level are calculated based on consumption Minimum buffer stock is maintained all the time
		Department maintained stock register of drugs and consumables		RR/SI	Check record of drug received, issued and balance stock in hand and are regularly updated
ME D2.6	There is a procedure for periodically replenishing the drugs in patient care areas	There is established system for replenishing drug tray /crash cart		SI/RR	
		There is no stock out of drugs		OB/SI	Check stock of some vital drugs
ME D2.7	There is process for storage of vaccines and other drugs, requiring controlled temperature	Temperature of refrigerators are kept as per storage requirement and records twice a day and are maintained		OB/RR	Check for temperature charts are maintained and updated twice a daily.
ME D2.8	There is a procedure for secure storage of narcotic and psychotropic drugs	Narcotic ,psychotropic drugs are kept separately in lock and key		OB/SI	Separate prescription for narcotic and psychotropic drugs. Separately kept, away from other drugs and labelled
Standard D3	**The facility provides safe, secure and comfortable environment to staff, patients and visitors.**				
ME D3.1	The facility provides adequate illumination level at patient care areas	Adequate Illumination at nursing station		OB	
		Adequate illumination in patient care areas		OB	Potable spot light and it is used whenever it is required
ME D3.2	The facility has provision of restriction of visitors in patient areas	Visiting hour are fixed and practiced		OB/PI	
		There is no overcrowding in the wards during to visitors hours		OB	

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
		One family members is allowed to stay with the patient		OB/SI	
ME D3.3	The facility ensures safe and comfortable environment for patients and service providers	Temperature control and ventilation in patient care area		PI/OB	Fans/ Air conditioning/ Heating/Exhaust/ Ventilators as per environment condition and requirement
		Temperature control and ventilation in nursing station/duty room		SI/OB	Fans/ Air conditioning/ Heating/Exhaust/ Ventilators as per environment condition and requirement
ME D3.4	The facility has security system in place at patient care areas	Security arrangement in IPD		OB/SI	
		Identification band for all		OB	Check mechanism at place to track the patient based on UID
ME D3.5	The facility has established measure for safety and security of female staff	Female staff feel secure at work place		SI	
Standard D4	**The facility has established Programme for maintenance and upkeep of the facility**				
ME D4.1	Exterior of the facility building is maintained appropriately	Building is painted/ whitewashed in uniform colour		OB	
		Interior of patient care areas are plastered & painted		OB	
ME D4.2	Patient care areas are clean and hygienic	Floors, walls, roof, roof topes, sinks patient care and circulation areas are Clean		OB	All area are clean with no dirt,grease,littering and cobwebs
		Surface of furniture and fixtures are clean		OB	
		Toilets are clean with functional flush and running water		OB	
ME D4.3	Hospital infrastructure is adequately maintained	Check for there is no seepage , Cracks, chipping of plaster		OB	
		Window panes , doors and other fixtures are intact		OB	
		Patients beds are intact and painted		OB	Mattresses are intact and clean
ME D4.5	The facility has policy of removal of condemned junk material	No condemned/Junk material in the ward		OB	

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
ME D4.6	The facility has established procedures for pest, rodent and animal control	No stray animal/ rodent/birds		OB	
Standard D5	**The facility ensures 24X7 water and power backup as per requirement of service delivery, and support services norms**				
ME D5.1	The facility has adequate arrangement storage and supply for portable water in all functional areas	Availability of 24x7 running and potable water		OB/SI	
ME D5.2	The facility ensures adequate power backup in all patient care areas as per load	Availability of power back up in patient care areas		OB/SI	
StandardD6	**Dietary services are available as per service provision and nutritional requirement of the patients.**				
ME D6.1	The facility has provision of nutritional assessment of the patients	Nutritional assessment of patient done as required and directed by doctor		RR/SI	
ME D6.2	The facility provides diets according to nutritional requirements of the patients	Check for the adequacy and frequency of diet as per nutritional requirement		OB/RR	Check that all items fixed in diet menu is provided to the patient
		Check for the Quality of diet provided		PI/SI	Ask patient/staff weather they are satisfied with the Quality of food
ME D6.3	Hospital has standard procedures for preparation, handling, storage and distribution of diets, as per requirement of patients	There is procedure of requisition of different type of diet from ward to kitchen		RR/SI	diet for diabetic patients, low salt and high protein diet etc
Standard D7	**The facility ensures clean linen to the patients**				
ME D7.1	The facility has adequate sets of linen	Clean Linens are provided for all occupied bed		OB/RR	
		Gown are provided at least to the cases going for surgery		OB/RR	
		Availability of Blankets, draw sheet, pillow with pillow cover and mackintosh		OB/RR	
ME D7.2	The facility has established procedures for changing of linen in patient care areas	Linen is changed every day and whenever it get soiled		OB/RR	
ME D7.3	The facility has standard procedures for handling , collection, transportation and washing of linen	There is system to check the cleanliness and Quantity of the linen received from laundry		SI/RR	

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
		Check dedicated closed bin is kept for storage of dirty linen		OB	Check linen is kept closed bin & emptied regularly. Plastic bag is used in dustbin & these bags are sealed before removed & handed over
Standard D11	**Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.**				
ME D11.1	The facility has established job description as per govt guidelines	Job description is defined and communicated to all concerned staff		RR	Regular + contractual
		Staff is aware of their role and responsibilities		SI	
ME D11.2	The facility has a established procedure for duty roster and deputation to different departments	There is procedure to ensure that staff is available on duty as per duty roster		RR/SI	Check for system for recording time of reporting and relieving (Attendance register/ Biometrics etc)
		There is designated in charge for department		SI	
ME D11.3	The facility ensures the adherence to dress code as mandated by its administration / the health department	Doctor, nursing staff and support staff adhere to their respective dress code		OB	
Standard D12	**The facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations**				
ME D12.1	There is established system for contract management for out sourced services	There is procedure to monitor the quality and adequacy of outsourced services on regular basis		SI/RR	Verification of outsourced services (cleaning/ Dietary/ Laundry/Security/ Maintenance) provided are done by designated in-house staff
AREA OF CONCERN - E CLINICAL SERVICES					
Standard E1	**The facility has defined procedures for registration, consultation and admission of patients.**				
ME E1.1	The facility has established procedure for registration of patients	Unique identification number is given to each patient during process of registration		RR	
		Patient demographic details are recorded in admission records		RR	Check for that patient demographics like Name, age, Sex, Chief complaint, etc.

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
ME E1.3	There is established procedure for admission of patients	There is no delay in admission of patient		SI/RR/OB	
		Admission is done by written order of a qualified doctor		SI/RR/OB	
		Time of admission is recorded in patient record		RR	
ME E1.4	There is established procedure for managing patients, in case beds are not available at the facility	There is provision of extra Beds		OB/SI	
Standard E2	**The facility has defined and established procedures for clinical assessment, reassessment and treatment plan preparation.**				
ME E2.1	There is established procedure for initial assessment of patients	Initial assessment of all admitted patient done as per standard protocols		RR/SI	The assessment criteria for different clinical conditions are defined and measured in assessment sheet
		Patient History is taken and recorded		RR	
		Physical Examination is done and recorded wherever required		RR	
		Provisional Diagnosis is recorded		RR	
		Initial assessment and treatment is provided immediately		RR/SI	
		Initial assessment is documented preferably within 2 hours		RR	
ME E2.2	There is established procedure for follow-up/ reassessment of Patients	There is fixed schedule for assessment of stable patients		RR/OB	
		For critical patients admitted in the ward there is provision of reassessment as per need		RR/OB	

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
		There is system in place to identify and manage the changes in Patient's health status		SI/RR	Criteria is defined for identification, and management of high-risk patients and patient whose condition is deteriorating
		Check the treatment or care plan is modified as per re assessment results		SI/RR	Check the re assessment sheets/ Case sheets modified treatment plan or care plan is documented
ME E2.3	There is established procedure to plan and deliver appropriate treatment or care to individual as per the needs to achieve best possible results	Check healthcare needs of all hospitalised patients are identified through assessment process		SI/RR	Assessment includes physical assessment, history, details of existing disease condition (if any) for which regular medication is taken as well as evaluate psychological ,cultural, social factors
		Check treatment/ care plan is prepared as per patient's need		RR	(a) According to assessment and investigation findings (wherever applicable). (b) Check inputs are taken from patient or relevant care provider while preparing the care plan.
		Check treatment / care plan is documented		RR	Care plan include:, investigation to be conducted, intervention to be provided, goals to achieve, timeframe, patient education, , discharge plan etc
		Check care is delivered by competent multidisciplinary team		SI/RR	Check care plan is prepared and delivered as per direction of qualified physician
Standard E3	**The facility has defined and established procedures for continuity of care of patient and referral**				
ME E3.1	The facility has established procedure for continuity of care during interdepartmental transfer	Facility has established procedure for handing over of patients from one department to other department		SI/RR	

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
		There is a procedure for consultation of the patient to other specialist with in the hospital		RR/SI	
ME E3.2	The facility provides appropriate referral linkages to the patients/Services for transfer to other/higher facilities to assure the continuity of care.	Patient referred with referral slip		RR/SI	
		Advance communication is done with higher centre		RR/SI	
		Referral vehicle is being arranged		SI/RR	
		Referral in or referral out register is maintained		RR	
		Facility has functional referral linkages to lower facilities		SI/RR	Check for referral cards filled from lower facilities
		There is a system of follow up of referred patients		RR	
ME E3.3	A person is identified for care during all steps of care	Duty Doctor and nurse is assigned for each patients		RR/SI	
Standard E4	**The facility has defined and established procedures for nursing care**				
ME E4.1	Procedure for identification of patients is established at the facility	There is a process for ensuring the patient's identification before any clinical procedure		OB/SI	Patient id band/ verbal confirmation/Bed no. etc.
ME E4.2	Procedure for ensuring timely and accurate nursing care as per treatment plan is established at the facility	Treatment chart are maintained		RR	Check for treatment chart are updated and drugs given are marked. Co relate it with drugs and doses prescribed.
		There is a process to ensue the accuracy of verbal/telephonic orders		SI/RR	(1) Check system is in place to give telephonic orders & practised (2) Verbal orders are verified by the ordering physician within defined time period
ME E4.3	There is established procedure of patient hand over, whenever staff duty change happens	Patient hand over is given during the change in the shift		SI/RR	

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
		Nursing Handover register is maintained		RR	
		Hand over is given bed side		SI/RR	
ME E4.4	Nursing records are maintained	Nursing notes are maintained adequately		RR/SI	Check for nursing note register. Notes are adequately written
ME E4.5	There is procedure for periodic monitoring of patients	Patient Vitals are monitored and recorded periodically		RR/SI	Check for TPR chart, IO chart, any other vital required is monitored
		Critical patients are monitored continually		RR/SI	
Standard E5	**The facility has a procedure to identify high risk and vulnerable patients.**				
ME E5.1	The facility identifies vulnerable patients and ensure their safe care	Vulnerable patients are identified and measures are taken to protect them from any harm		OB/SI	Unstable, irritable, unconscious. Psychotic and serious patients are identified
ME E5.2	The facility identifies high risk patients and ensure their care, as per their need	High risk patients are identified and treatment given on priority		OB/SI	
Standard E6	**Facility ensures rationale prescribing and use of medicines**				
ME E6.1	The facility ensured that drugs are prescribed in generic name only	Check for BHT if drugs are prescribed under generic name only		RR	
ME E6.2	There is procedure of rational use of drugs	Check for that relevant Standard treatment guideline are available at point of use		RR	
		Check staff is aware of the drug regime and doses as per STG		SI/RR	Check BHT that drugs are prescribed as per STG
		Availability of drug formulary		SI/OB	
ME E6.3	There are procedures defined for medication review and optimization	Complete medication history is documented for each patient		RR/OB	Nurse confirms patient's name, prescription details and medical history before drug administration at bed-side, during transfer of care and at the time of discharge

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
		Established mechanism for Medication reconciliation process		SI/RR	1. Medication Reconciliation is carried out by a trained and competent health professional during the patient's admission, interdepartmental transfer or discharged 2. Medicine reconciliation includes Prescription and non-prescription (over-the-counter) medications, vitamins, nutritional supplements, potentially interactive food items, herbal preparations, and recreational drugs"
		Medicine are reviewed and optimised as per individual treatment plan		SI/RR	1. Medication review is performed for some groups like patients taking multiple medicines, people with chronic or long term conditions, older people, etc. 2. Medicines are optimised as per individual treatment plan for best possible clinical outcome
		Complete medication history is documented and communicated for each patient at the time of discharge		SI/RR	1. Discharge summary includes known drug allergies and reactions to medicines or their ingredients, and the type of reaction experienced 2. Changes in prescribed medicines, including medicines started or stopped, or dosage changes, and reason for the change are clearly documented in the case sheet and case summary"
		Patients are engaged in their own care		PI/SI	"1. Clinician/Nurse counsel the patient on medication safety using ""5 moments for medication safety app"" 2. Nurse highlights the medications to be taken by the patient at home and counsel the patient and family on drug intake as per treatment plan for discharge"

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
Standard E7	**The facility has defined procedures for safe drug administration**				
ME E7.1	There is process for identifying and cautious administration of high alert drugs	High alert drugs available in department are identified		SI/OB	Electrolytes like Potassium chloride, Opioids, Neuro muscular blocking agent, Anti thrombolytic agent, insulin, warfarin, Heparin, Adrenergic agonist etc.
		Maximum dose of high alert drugs are defined and communicated		SI/RR	Value for maximum doses as per age, weight and diagnosis are available with nursing station and doctor
		There is process to ensure that right doses of high alert drugs are only given		SI/RR	A system of independent double check before administration, Error prone medical abbreviations are avoided
ME E7.2	Medication orders are written legibly and adequately	Every Medical advice and procedure is accompanied with date , time and signature		RR	
		Check for the writing, It comprehendible by the clinical staff		RR/SI	
ME E7.3	There is a procedure to check drug before administration/ dispensing	Drugs are checked for expiry and other inconsistency before administration		OB/SI	
		Check single dose vial are not used for more than one dose		OB	Check for any open single dose vial with left over content intended to be used later on
		Check for separate sterile needle is used every time for multiple dose vial		OB	In multi dose vial needle is not left in the septum
		Any adverse drug reaction is recorded and reported		RR/SI	Adverse drug event trigger tool is used to report the events
ME E7.4	There is a system to ensure right medicine is given to right patient	Check Nursing staff is aware 7 Rs of Medication and follows them		SI/RR	Administration of medicines done after ensuring right patient, right drugs, right route, right time, Right dose, Right Reason and Right Documentation

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
ME E7.5	Patient is counselled for self drug administration	Patient is advice by doctor/ Pharmacist /nurse about the dosages and timings .			
Standard E8	**The facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage**				
ME E8.1	All the assessments, re-assessment and investigations are recorded and updated	Day to day progress of patient is recorded in BHT		RR	(Manually/e-records)
ME E8.2	All treatment plan prescription/orders are recorded in the patient records.	Treatment plan, first orders are written on BHT		RR	Treatment prescribed inj nursing records (Manually/e-records)
ME E8.3	Care provided to each patient is recorded in the patient records	Maintenance of treatment chart/ treatment registers		RR	Treatment given is recorded in treatment chat (Manually/e-records)
ME E8.4	Procedures performed are written on patients records	Any procedure performed written on BHT		RR	Dressing, mobilization etc (Manually/e-records)
ME E8.5	Adequate form and formats are available at point of use	Standard Format for bed head ticket/ Patient case sheet available as per state guidelines		RR/OB	Availability of formats for Treatment Charts, TPR Chart , Intake Output Chat Etc.
ME E8.6	Register/records are maintained as per guidelines	Registers and records are maintained as per guidelines		RR	General order book (GOB), report book, Admission register, lab register, Admission sheet/ bed head ticket, discharge slip, referral slip, referral in/referral out register, OT register, Diet register, Linen register, Drug intend register
		All register/records are identified and numbered		RR	
ME E8.7	The facility ensures safe and adequate storage and retrieval of medical records	Safe keeping of patient records		OB	
Standard E9	**The facility has defined and established procedures for discharge of patient.**				
ME E9.1	Discharge is done after assessing patient readiness	Assessment is done before discharging patient		SI/RR	
		Discharge is done by a responsible and qualified doctor after assessment in consultation with treating doctor		SI/RR	Discharge is done in consultation with treating doctor

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
		Patient / attendants are consulted before discharge		PI/SI	
ME E9.2	Case summary and follow-up instructions are provided at the discharge	Discharge summary is provided		RR/PI	See for discharge summary, referral slip provided.
		Discharge summary adequately mentions patients clinical condition, treatment given and follow up		RR	
		Discharge summary is give to patients going in LAMA/ Referral		SI/RR	
ME E9.3	Counselling services are provided as during discharges wherever required	Patient is counselled before discharge		SI/PI	Advice includes the information about the nearest health centre for further follow up. Counsel mother for treatment, follow up, feeding, discharge timings are explained prior
		Time of discharge is communicated to patient in prior		PI/SI	
Standard E11	**The facility has defined and established procedures for Emergency Services and Disaster Management**				
ME E11.3	The facility has disaster management plan in place	Staff is aware of disaster plan		SI/RR	
		Role and responsibilities of staff in disaster is defined		SI/RR	
Standard E12	**The facility has defined and established procedures of diagnostic services**				
ME E12.1	There are established procedures for Pre-testing Activities	Container is labelled properly after the sample collection		OB	
ME E12.3	There are established procedures for Post-testing Activities	Nursing station is provided with the critical value of different tests		SI/RR	
Standard E13	**The facility has defined and established procedures for Blood Bank/Storage Management and Transfusion.**				
ME E13.9	There is established procedure for transfusion of blood	Consent is taken before transfusion		RR	
		Patient's identification is verified before transfusion		SI/OB	

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
		blood is kept on optimum temperature before transfusion		RR	
		Blood transfusion is monitored and regulated by qualified person		SI/RR	
		Blood transfusion note is written in patient recorded		RR	
ME E13.10	There is a established procedure for monitoring and reporting Transfusion complication	Any major or minor transfusion reaction is recorded and reported to responsible person		RR	
Standard E14	**The facility has established procedures for Anaesthetic Services**				
ME E14.1	The facility has established procedures for Pre-anaesthetic Check up and maintenance of records	Pre anaesthesia check up is conducted for elective / Planned surgeries		SI/RR	
Standard E16	**The facility has defined and established procedures for the management of death & bodies of deceased patients**				
ME E16.1	Death of admitted patient is adequately recorded and communicated	Facility has a standard procedure to decent communication of death to relatives		SI	
		Death note is written on patient record		RR	
ME E16.2	The facility has standard procedures for handling the death in the hospital	Death summary is given to patient attendant quoting the immediate cause and underlying cause if possible		SI/RR	
		Death note including efforts done for resuscitation is noted in patient record		RR	
NATIONAL HEALTH PROGRAM					
Standard E23	**The facility provides National health Programme as per operational/Clinical Guidelines**				
ME E23.6	The facility provides services under Mental Health Programme as per guidelines	Management of mental illness as per guidelines		SI/RR	(a) Treatment of mental illness symptoms & associated condition

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
		Psychosocial support is provided		SI/RR	(a) Basic psycho education about treatment adherence (b) Motivation enhancement (c) Reduction of high risk behaviour (d) Relapse prevention (e) Counselling for occupational rehab. (d) Patient support group / individual counselling
ME E23.7	The facility provides services under National Programme for the health care of the elderly as per guidelines	Geriatric Care is provided as per Clinical Guidelines		SI/RR	(a) Linkage with specialists like medicine, ortho, health., ENT services (b) Referral services to Regional Geriatric centre/MC
ME E23.8	The facility provides service under National Programme for Prevention and Control of cancer, diabetes, cardiovascular diseases & stroke (NPCDCS) as per guidelines	Management of Myocardial infarction & stroke		SI/RR	As per treatment protocols
		Management of admitted diabetes cases as per guidelines		SI/RR	As per treatment protocols
		Chemotherapy follow up in cancer cases		SI/RR	Chemotherapy support or services provided as per state mandate
		Counselling the identified cases for self care		PI/RR	Counsel the patient for monitoring of their BP (using digital BP apparatus) , sugar (using glucometer) , self-care for ulcers etc
ME E23.9	The facility provide service for Integrated disease surveillance Programme	Weekly reporting of Presumptive cases on form "P" from IPD		SI/RR	(a) Submitted to District surveillance officer (b) Data is submitted manually or through IHIP (integrated health information platform)
ME E 23.12	Facility provide services under National program for pallative care	Management of pain as per guidelines		SI/RR	(a) Treatment of symptoms, associated condition & referral to the linkage (b) Pain management by the staff trained in pain & pallative care
		Psychosocial support is provided		SI/RR	(a) Basic psycho education about treatment adherence (b) Motivation enhancement (c) Reduction of high risk behaviour (d) Relapse prevention (e) Recreation facility (d) Patient support group / individual counselling

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
AREA OF CONCERN - F INFECTION CONTROL					
Standard F1	**The facility has infection control Programme and procedures in place for prevention and measurement of hospital associated infection**				
ME F1.3	The facility measures hospital associated infection rates	There is procedure to report cases of Hospital acquired infection		SI/RR	Patients are observed for any sign and symptoms of HAI like fever, purulent discharge from surgical site .
ME F1.4	There is Provision of Periodic Medical Check-up and immunization of staff	There is procedure for immunization of the staff		SI/RR	Hepatitis B, Tetanus Toxoid etc
		Periodic medical check-ups of the staff		SI/RR	
ME F1.5	The facility has established procedures for regular monitoring of infection control practices	Regular monitoring of infection control practices		SI/RR	Hand washing and infection control audits done at periodic intervals
ME F1.6	The facility has defined and established antibiotic policy	Check for Doctors are aware of Hospital Antibiotic Policy		SI/RR	
Standard F2	**The facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis**				
ME F2.1	Hand washing facilities are provided at point of use	Availability of hand washing Facility at Point of Use		OB	Check for availability of wash basin near the point of use along with elbow operated tap
		Availability of running Water		OB/SI	Ask to Open the tap. Ask Staff water supply is regular
		Availability of antiseptic soap with soap dish/ liquid antiseptic with dispenser.		OB/SI	Check for availability/ Ask staff if the supply is adequate and uninterrupted
		Availability of Alcohol based Hand rub		OB/SI	Check for availability/ Ask staff for regular supply.
		Display of Hand washing Instruction at Point of Use		OB	Prominently displayed above the hand washing facility , preferably in Local language
ME F2.2	The facility staff is trained in hand washing practices and they adhere to standard hand washing practices	Adherence to 6 steps of Hand washing		SI/OB	Ask of demonstration
		Staff aware of when to hand wash		SI	

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
ME F2.3	The facility ensures standard practices and materials for antisepsis	Availability of Antiseptic Solutions		OB	
		Proper cleaning of procedure site with antisepsis		OB/SI	like before giving IM/IV injection, drawing blood, putting Intravenous and urinary catheter
Standard F3	**The facility ensures standard practices and materials for Personal protection**				
ME F3.1	The facility ensures adequate personal protection Equipment as per requirements	Clean gloves are available at point of use		OB/SI	
		Availability of Masks		OB/SI	
ME F3.2	The facility staff adheres to standard personal protection practices	No reuse of disposable gloves, Masks, caps and aprons.		OB/SI	
		Compliance to correct method of wearing and removing the PPE		SI	Gloves, Masks, Caps and Aprons
Standard F4	**The facility has standard procedures for processing of equipment and instruments**				
ME F4.1	The facility ensures standard practices and materials for decontamination and cleaning of instruments and procedures areas	Decontamination of operating & Procedure surfaces		SI/OB	Ask staff about how they decontaminate the procedure surface like Examination table , Patients Beds Stretcher/ Trolleys etc. (Wiping with 0.5% Chlorine solution
		Proper Decontamination of instruments after use		SI/OB	Ask staff how they decontaminate the instruments like Stethoscope, Dressing Instruments, Examination Instruments, Blood Pressure Cuff etc (Soaking in 0.5% Chlorine Solution, Wiping with 0.5% Chlorine Solution or 70% Alcohol as applicable
		Contact time for decontamination is adequate		SI/OB	10 minutes
		Cleaning of instruments after decontamination		SI/OB	Cleaning is done with detergent and running water after decontamination
		Proper handling of Soiled and infected linen		SI/OB	No sorting ,Rinsing or sluicing at Point of use/ Patient care area
		Staff know how to make chlorine solution		SI/OB	

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
ME F4.2	The facility ensures standard practices and materials for disinfection and sterilization of instruments and equipment	Equipment and instruments are sterilized after each use as per requirement		OB/SI	Autoclaving/HLD/ Chemical Sterilization
		High level Disinfection of instruments/ equipments is done as per protocol		OB/SI	Ask staff about method and time required for boiling
		Autoclaved dressing material is used		OB/SI	
Standard F5	**Physical layout and environmental control of the patient care areas ensures infection prevention**				
ME F5.2	The facility ensures availability of standard materials for cleaning and disinfection of patient care areas	Availability of disinfectant as per requirement		OB/SI	Chlorine solution, Glutaraldehyde, carbolic acid
		Availability of cleaning agent as per requirement		OB/SI	Hospital grade phenyl, disinfectant detergent solution
ME F5.3	The facility ensures standard practices are followed for the cleaning and disinfection of patient care areas	Staff is trained for spill management		SI/RR	
		Cleaning of patient care area with detergent solution		SI/RR	
		Staff is trained for preparing cleaning solution as per standard procedure		SI/RR	
		Standard practice of mopping and scrubbing are followed		OB/SI	Unidirectional mopping from inside out
		Cleaning equipments like broom are not used in patient care areas		OB/SI	Any cleaning equipment leading to dispersion of dust particles in air should be avoided
ME F5.4	The facility ensures segregation infectious patients	Isolation and barrier nursing procedure are followed for septic cases		OB/SI	
Standard F6	**The facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.**				
ME F6.1	The facility Ensures segregation of Bio Medical Waste as per guidelines and 'on-site' management of waste is carried out as per guidelines	Availability of colour coded bins at point of waste generation		OB	Adequate number. Covered. Foot operated.

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
		Availability of colour coded non chlorinated plastic bags		OB	
		Segregation of Anatomical and soiled waste in Yellow Bin		OB/SI	Human Anatomical waste, Items contaminated with blood, body fluids, dressings, plaster casts, cotton swabs and bags containing residual or discarded blood and blood components.
		Segregation of infected plastic waste in red bin		OB	Items such as tubing, bottles, intravenous tubes and sets, catheters, urine bags, syringes (without needles and fixed needle syringes) and vacutainers' with their needles cut) and gloves
		Display of work instructions for segregation and handling of Biomedical waste		OB	Pictorial and in local language
		There is no mixing of infectious and general waste			
ME F6.2	The facility ensures management of sharps as per guidelines	Availability of functional needle cutters		OB	See if it has been used or just lying idle.
		Segregation of sharps waste including Metals in white (translucent) Puncture proof, Leak proof, tamper proof containers		OB	Should be available nears the point of generation. Needles, syringes with fixed needles, needles from needle tip cutter or burner, scalpels, blades, or any other contaminated sharp object that may cause puncture and cuts. This includes both used, discarded and contaminated metal sharps
		Availability of post exposure prophylaxis		SI/OB	Ask if available. Where it is stored and who is in charge of that.

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
		Staff knows what to do in condition of needle stick injury		SI	Staff knows what to do in case of shape injury. Whom to report. See if any reporting has been done
		Contaminated and broken Glass are disposed in puncture proof and leak proof box/ container with Blue colour marking		OB	Vials, slides and other broken infected glass
ME F6.3	The facility ensures transportation and disposal of waste as per guidelines	Check bins are not overfilled		SI/OB	
		Transportation of bio medical waste is done in close container/trolley		SI/OB	
		Staff is aware of mercury spill management		SI/RR	Look for: 1. Spill area evacuation 2. Removal of Jewellery 3. Wear PPE 4. Use of flashlight to locate mercury beads 5. Use syringe without a needle/eyedropper and sticky tape to suck the beads 6. Collection of beads in leak-proof bag or container 7. Sprinkle sulphur or zinc powder to remove any remaining mercury
					8. All the mercury spill surfaces should be decontaminated with 10% sodium thiosulfate solution 9. All the bags or containers containing items contaminated with mercury should be marked as "Hazardous Waste, Handle with Care" 10. Collected mercury waste should be handed over to the CBMWTF
AREA OF CONCERN - G QUALITY MANAGEMENT					
Standard G1	**Facility has established organizational framework for quality improvement**				
ME G1.1	Facility has a quality team in place	Quality circle has been formed in the IPD		SI/RR	Check if quality circle formed and functional with a designated nodal officer for quality

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
Standard G2	**The facility has established system for patient and employee satisfaction**				
ME G2.1	Patient satisfaction surveys are conducted at periodic intervals	Patient satisfaction survey done on monthly basis		RR	
Standard G3	**The facility have established internal and external quality assurance Programmes wherever it is critical to quality.**				
ME G3.1	The facility has established internal quality assurance programme in key departments	There is system daily round by Hospital superintendent/ Hospital Manager/ Matron in charge for monitoring of services		SI/RR	Check for entries in Round Register
ME G3.2	The facility has established external assurance programmes at relevant departments				
ME G3.3	The facility has established system for use of check lists in different departments and services	Internal assessment is done at periodic interval		RR/SI	NQAS, Kayakalp, SaQushal tools are used to conduct internal assessment
		Departmental checklist are used for monitoring and quality assurance		SI/RR	Staff is designated for filling and monitoring of these checklists
		Non-compliances are enumerated and recorded		RR	Check the non compliances are presented & discussed during quality team meetings
ME G3.4	Actions are planned to address gaps observed during quality assurance process	Check action plans are prepared and implemented as per internal assessment record findings		RR	Randomly check the details of action, responsibility, time line and feedback mechanism
ME G3.5	Planned actions are implemented through Quality Improvement Cycles (PDCA)	Check PDCA or revalent quality method is used to take corrective and preventive action		SI/RR	Check actions have been taken to close the gap. It can be in form of action taken report or Quality Improvement (PDCA) project report
Standard G4	**The facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.**				
ME G4.1	Departmental standard operating procedures are available	Standard operating procedure for department has been prepared and approved		RR	

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
		Current version of SOP are available with process owner		OB/RR	
		Work instruction/ clinical protocols are displayed		OB	Patient safety, CPR
ME G4.2	Standard Operating Procedures adequately describes process and procedures	Department has documented procedure for receiving and initial assessment of the patient		RR	
		Department has documented procedure for admission, shifting and referral 0f patient		RR	
		Department has documented procedure for requisition of diagnosis and receiving of the reports		RR	
		Department has documented procedure for preparation of the patient for surgical procedure		RR	
		Department has documented procedure for transfusion of blood		RR	
		Department has documented procedure for maintenance of rights and dignity of Patient		RR	
		Department has documented procedure for record eminence including taking consent		RR	
		Department has documented procedure for counselling of the patient at the time of discharge		RR	

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
		Department has documented procedure for environmental cleaning and processing of the equipment		RR	
		Department has documented procedure for sorting, and distribution of clean linen to patient		RR	
		Department has documented procedure for end of life care		RR	
ME G4.3	Staff is trained and aware of the procedures written in SOPs	Check staff is a aware of relevant part of SOPs		SI/RR	
Standard G 5	**The facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages**				
ME G5.1	The facility maps its critical processes	Process mapping of critical processes done		SI/RR	
ME G5.2	The facility identifies non value adding activities / waste / redundant activities	Non value adding activities are identified		SI/RR	
ME G5.3	The facility takes corrective action to improve the processes	Processes are rearranged as per requirement		SI/RR	
Standard G6	**The facility has defined mission, values, Quality policy & objectives & prepared a strategic plan to achieve them**				
ME G6.3	Facility has defined Quality policy, which is in congruency with the mission of facility	Check if Quality Policy has been defined and approved		SI/RR	Check quality policy of the facility has been defined in consultation with hospital staff and duly approved by the head of the facility . Also check Quality Policy enables achievement of mission of the facility and health department
ME G6.4	Facility has de defined quality objectives to achieve mission and quality policy	Check if SMART Quality Objectives have framed		SI/RR	Check short term valid quality objectivities have been framed addressing key quality issues in each department and cores services. Check if these objectives are Specific, Measurable, Attainable, Relevant and Time Bound.

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
ME G6.5	Mission, Values, Quality policy and objectives are effectively communicated to staff and users of services	Check of staff is aware of Mission , Values, Quality Policy and objectives		SI/RR	Interview with staff for their awareness. Check if Mission Statement, Core Values and Quality Policy is displayed prominently in local language at Key Points
ME G6.6	Facility prepares strategic plan to achieve mission, quality policy and objectives	Check if plan for implementing quality policy and objectives have prepared		SI/RR	Verify with records that a time bound action plan has been prepared to achieve quality policy and objectives in consultation with hospital staff . Check if the plan has been approved by the hospital management
ME G6.7	Facility periodically reviews the progress of strategic plan towards mission, policy and objectives	Check time bound action plan is being reviewed at regular time interval		SI/RR	Review the records that action plan on quality objectives being reviewed at least once in month by departmental in charges and during the quality team meeting. The progress on quality objectives have been recorded in Action Plan tracking sheet
Standard G7	**The facility seeks continually improvement by practicing Quality method and tools.**				
ME G7.1	The facility uses method for quality improvement in services	Basic quality improvement method		SI/OB	PDCA & 5S
		Advance quality improvement method		SI/OB	Six sigma, lean.
ME G7.2	The facility uses tools for quality improvement in services	7 basic tools of Quality		SI/RR	Minimum 2 applicable tools are used in each department
Standard G9	**Facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan**				
ME G9.6	Periodic assessment for Medication and Patient care safety risks is done as per defined criteria.	Check periodic assessment of medication and patient care safety risk is done using defined checklist periodically		SI/RR	Verify with the records. A comprehensive risk assessment of all clinical processes should be done using pre define criteria at least once in three month.
ME G9.7	Periodic assessment for potential risk regarding safety and security of staff including violence against service providers is done as per defined criteria	SaQushal assessment toolkit is used for safety audits.		SI/RR	1. Check that the filled checklist and action taken report are available 2. Staff is aware of key gaps & closure status

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
ME G9.8	Risks identified are analysed evaluated and rated for severity	Identified risks are analysed for severity		SI/RR	Action is taken to mitigate the risks
Standard G10	**The facility has established clinical Governance framework to improve quality and safety of clinical care processes**				
ME G10.3	Clinical care assessment criteria have been defined and communicated	The facility has established procedures to review the clinical care processes		SI/RR	Check parameter are defined & implemented to review the clinical care i.e. through Ward round, peer review, morbidity & mortality review, patient feedback, clinical audit & clinical outcomes.
		Check regular ward rounds are taken to review case progress		SI/RR	(1) Both critical and stable patients (2) Check the case progress is documented in BHT/ progress notes-
		Check the patient / family participate in the care evaluation		SI/RR	Feedback is taken from patient/family on health status of individual under treatment
		Check the care planning and co- ordination is reviewed		SI/RR	System in place to review internal referral process, review clinical handover information, review patient understanding about their progress
ME G10.4	Facility conducts the periodic clinical audits including prescription, medical and death audits	There is procedure to conduct medical audits		SI/RR	Check medical audit records (a) Completion of the medical records i.e. Medical history, assessments, re assessment, investigations conducted, progress notes, interventions conducted, outcome of the case, patient education, delineation of responsibilities, discharge etc. (b) Check whether treatment plan worked for the patient (C) progress on the health status of the patient is mentioned (d) whether the goals defined in treatment plan is met for the individual cases (e) Adverse clinical events are documented (f) Re admission

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
		There is procedure to conduct death audits		SI/RR	(1) All the deaths are audited by the committee. (2) The reasons of the death is clearly mentioned (3) Data pertaining to deaths are collated and trend analysis is done (4) A through action taken report is prepared and presented in clinical Governance Board meetings / during grand round (wherever required)
		There is procedure to conduct referral audits		SI/RR	Check for -valid sample size, data is analysed, poor performing attributes are identified and improvement initiatives are undertaken
		All non compliance are enumerated & recorded for medical audits		SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings
		All non compliance are enumerated & recorded for newborn death audits		SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings
		All non compliance are enumerated & recorded for referral audits		SI/RR	Check the non compliances are presented & discussed during clinical Governance meetings
ME G10.7	Facility ensures easy access and use of standard treatment guidelines & implementation tools at point of care	Check standard treatment guidelines / protocols are available & followed.		SI/RR	Staff is aware of Standard treatment protocols/ guidelines/best practices
		Check treatment plan is prepared as per Standard treatment guidelines		SI/RR	Check staff adhere to clinical protocols while preparing the treatment plan
		Check the drugs are prescribed as per Standards treatment guidelines		SI/RR	Check the drugs prescribed are available in EML or part of drug formulary

Reference No/	Measurable Element	Checkpoints	Compli-ance	Assessment Method	Means of verification
		Check the updated/ latest evidence are available		SI/RR	Check when the STG/ protocols/evidences used in healthcare facility are published. Whether the STG protocols are according to current evidences.
		Check the mapping of existing clinical practices processes is done		SI/RR	The gaps in clinical practices are identified & action are taken to improve it. Look for evidences for improvement in clinical practices using PDCA
AREA OF CONCERN - H OUTCOME					
Standard H1	**The facility measures Productivity Indicators and ensures compliance with State/National benchmarks**				
ME H1.1	Facility measures productivity Indicators on monthly basis	Bed Occupancy Rate of Medical Wards		RR	
		Bed Occupancy Rate for surgical wards		RR	
		Number of the patients screened for pain		RR	
Standard H2	**The facility measures Efficiency Indicators and ensure to reach State/National Benchmark**				
ME H2.1	Facility measures efficiency Indicators on monthly basis	Referral Rate		RR	
		Bed Turnover rate		RR	
		Discharge rate		RR	
		No. of drugs stock out in the ward		RR	
		Percentage of in-patients with complete screening for nutritional needs		RR	
		Patient's fall rate		RR	
Standard H3	**The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark**				
ME H3.1	Facility measures Clinical Care & Safety Indicators on monthly basis	Average length of stay for Medical wards		RR	
		Average length for surgical wards		RR	
		Time taken for initial assessment		RR	
		Medication error per 1000 patient days		RR	
Standard H4	**The facility measures Service Quality Indicators and endeavours to reach State/National benchmark**				
ME H4.1	Facility measures Service Quality Indicators on monthly basis	LAMA Rate		RR	
		Patient Satisfaction Score		RR	

ASSESSMENT SUMMARY

Name of the Hospital ..... Date of Assessment .....

Names of Assessors ..... Names of Assessees .....

Type of Assessment (Internal/External) ..... Action plan Submission Date .....

A. SCORE CARD

INDOOR PATIENT DEPARTMENT SCORE CARD	
Area of Concern wise score	**Indoor Patient Department Score**
A. Service Provision	
B. Patient Rights	
C. Inputs	
D. Support Services	
E. Clinical Services	
F. Infection Control	
G. Quality Management	
H. Outcome	

B. MAJOR GAPS OBSERVED

1. _____
2. _____
3. _____
4. _____
5. _____

C. STRENGTHS/BEST PRACTICES

1. _____
2. _____
3. _____

D. RECOMMENDATIONS/OPPORTUNITIES FOR IMPROVEMENT

_____

_____

_____

Names and Signature of Assessors

Date _____

सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

CHECKLIST-6

BLOOD BANK

CHECKLIST FOR BLOOD BANK

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
AREA OF CONCERN - A SERVICE PROVISION					
Standard A1	**Facility Provides Curative Services**				
ME A1.14	Services are available for the time period as mandated	Blood bank services available 24X7		SI/RR	
ME A1.18	The facility provides Blood bank & transfusion services	Blood bank has facility of whole blood collection and storage		SI/OB	
		Blood Bank has facility for Blood Components preparation		SI/OB	PRC, Platelets Concentrate, FMP, Plasma& Single donor Cryo Precipitate
		Blood bank has emergency stock of blood		SI/OB	For A+, B+, O+ and O-
		Provision of blood donation camps		SI/OB	As per the procedure laid down by the National Blood Transfusion Council
Standard A2	**Facility provides RMNCHA Services**				
ME A2.2	The facility provides Maternal health Services	Availability of transfusion services		SI/OB	
Standard A3	**Facility Provides diagnostic Services**				
ME A3.2	The facility Provides Laboratory Services	Availability of screening and cross matching services		SI/OB	
Standard A4	**Facility provides services as mandated in national Health Programs/ state scheme**				
ME A4.1	The facility provides services under National Vector Borne Disease Control Programme as per guidelines	Availability of platelets for management of Dengue cases		SI/RR	
Standard A6	**Health services provided at the facility are appropriate to community needs.**				
ME A6.1	The facility provides curatives & preventive services for the health problems and diseases, prevalent locally.	Blood Bank provides blood components for thalassemia, dengue, haemophilia etc. as per local need		SI/RR	
AREA OF CONCERN - B PATIENT RIGHTS					
Standard B1	**Facility provides the information to care seekers, attendants & community about the available services and their modalities**				
ME B1.1	The facility has uniform and user-friendly signage system	Availability of departmental & directional signages		OB	Numbering, main department and internal sectional signage are displayed
ME B1.2.	The facility displays the services and entitlements available in its departments	List of services available are displayed		OB	
		Blood bank has displayed of Information regarding donors eligibility		OB	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Blood bank has displayed information regarding number of blood units available		OB	
ME B1.4	User charges are displayed and communicated to patients effectively	User services charges in r/o blood are displayed at entrance		OB	
ME B1.5	Patients & visitors are sensitised and educated through appropriate IEC / BCC approaches	IEC material is available in blood bank to provide information and to promote blood donation		OB	
ME B1.6	Information is available in local language and easy to understand	Signage's and information are available in local language		OB	
Standard B2	**Services are delivered in a manner that is sensitive to gender, religious and cultural needs, and there are no barrier on account of physical economic, cultural or social reasons**				
ME B2.3	Access to facility is provided without any physical barrier & and friendly to people with disabilities	Availability of ramp or alternate for easy access to the blood bank		OB	At least 120 cm width, gradient not steeper than 1:12, if ramp is available
Standard B3	**The facility maintains privacy, confidentiality & dignity of patient, and has a system for guarding patient related information.**				
ME B3.1	Adequate visual privacy is provided at every point of care	Privacy at blood donation and counselling room		OB	
ME B3.2	Confidentiality of patients records and clinical information is maintained	Blood Bank has system to ensure the confidentiality of results of screening test done		SI/OB	Blood bank staff do not discuss the lab result outside. reports are kept in secure place
ME B3.3	The facility ensures the behaviours of staff is dignified and respectful, while delivering the services	Behaviour of staff is empathetic and courteous		PI/OB	
ME B3.4	The facility ensures privacy and confidentiality to every patient, especially of those conditions having social stigma, and also safeguards vulnerable groups	Confidentiality and privacy of HIV patients		SI/OB	
Standard B4	**Facility has defined and established procedures for informing and involving patient and their families about treatment and obtaining informed consent wherever it is required.**				
ME B4.1	There is established procedures for taking informed consent before treatment and procedures	Blood bank is taking informed consent of donor		SI/RR	In consent form, procedure of donation is explained along with informing the donor regarding testing of blood is mandatory for safety of recipient
ME B4.3	Staff are aware of Patients rights responsibilities	Awareness of staff on donor rights and donor responsibilities		SI	About the confidentiality and privacy of donor information

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME B4.4	Information about the treatment is shared with patients or attendants, regularly	Pre donation counselling is done before donation		PI/SI/RR	Procedure include preparation of venepuncture site, use of blood bags and anticoagulant solution, collecting sample for laboratory test
		Post donation counselling for sero reactive donors		PI/SI	Post donation counselling also include counselling on HIV/ Hept B for which blood bank may refer the donor to ICTC /SACS/ MTC
ME B4.5	The facility has defined and established grievance redressal system in place	Availabilty of complaint box and display of process for grievance re addressal and whom to contact is displayed		OB	
Standard B5	**Facility ensures that there are no financial barrier to access and that there is financial protection given from cost of care.**				
ME B5.1	The facility provides cashless services to pregnant women, mothers and neonates as per prevalent government schemes	Free blood for Pregnant woman, Mothers and New Borns		PI/SI	
ME B5.2	The facility ensures that drugs prescribed are available at Pharmacy and wards	Check that patient party has not spent on purchasing blood from outside.		PI/SI	
ME B5.4.	The facility provide free of cost treatment to Below poverty line patients without administrative hassles	Free blood for BPL patients		PI/SI/RR	
AREA OF CONCERN C: INPUTS					
Standard C1	**The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms**				
ME C1.1	Departments have adequate space as per patient or work load	Blood bank has adequate space as per requirement		OB	Space required is more than 100 sq meters
		Availability of waiting area in blood bank		OB	
ME C1.2	Patient amenities are provide as per patient load	Separate toilet facilities for male & female are available		OB	
		Seating arrangement in waiting area		OB	
ME C1.3	Departments have layout and demarcated areas as per functions	Dedicated examination room		OB	
		Dedicated Blood collection room		OB	
		Dedicated transfusion transmissible infection (TTI) lab		OB	
		Availability of refreshment cum rest room		OB	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Dedicated sterilization area		OB	
		Dedicated store cum record room		OB	
		Availability of Duty room for staff		OB	
ME C1.4	The facility has adequate circulation area and open spaces according to need and local law	Availability of adequate circulation area for easy moment of staff and equipments		OB	
ME C1.5	The facility has infrastructure for intramural and extramural communication	Availability of functional telephone and Intercom Services		OB	
ME C1.6	Service counters are available as per patient load	Adequate Donor couches/ donor units as per load		OB	
ME C1.7	The facility and departments are planned to ensure structure follows the function/ processes (Structure commensurate with the function of the hospital)	Blood bank layout ensures smooth flow of donor and services		OB	
Standard C2	**The facility ensures the physical safety of the infrastructure.**				
ME C2.1	The facility ensures the seismic safety of the infrastructure	Non structural components are properly secured		OB	Check for fixtures and furniture like cupboards, cabinets, and heavy equipments , hanging objects are properly fastened and secured
ME C2.3	The facility ensures safety of electrical establishment	Blood bank does not have temporary connections and loosely hanging wires		OB	
		Adequate electrical socket provided for safe and smooth operation of lab equipments		OB/RR	
ME C2.4	Physical condition of buildings are safe for providing patient care	Work benches are chemical resistant		OB	
		Floors of the Laboratory are non slippery and even		OB	
		Windows have grills and wire meshwork		OB	
Standard C3	**The facility has established Programme for fire safety and other disaster**				
ME C3.1	The facility has plan for prevention of fire	Blood bank has sufficient fire exit to permit safe escape to its occupant at time of fire		OB/SI	
		Check the fire exits are clearly visible and routes to reach exit are clearly marked.		OB	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Blood bank has plan for safe storage and handling of potentially flammable materials.		OB	
ME C3.2	The facility has adequate fire fighting Equipment	Blood Bank has installed fire Extinguisher that is Class A , Class BC type or ABC type		OB/RR	
		Check the expiry date for fire extinguishers are displayed on each extinguisher as well as due date for next refilling is clearly mentioned		OB/RR	
ME C3.3	The facility has a system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation	Check for staff competencies for operating fire extinguisher and what to do in case of fire		SI/RR	
Standard C4	**The facility has adequate qualified and trained staff, required for providing the assured services to the current case load**				
ME C4.1	The facility has adequate specialist doctors as per service provision	Availability of dedicated blood bank medical officer		OB/RR	MBBS doctor with one year experience
ME C4.3	The facility has adequate nursing staff as per service provision and work load	Availability of dedicated Nursing Staff		OB/RR/SI	
ME C4.4	The facility has adequate technicians/ paramedics as per requirement	Availability of dedicated Blood Bank Technician round the clock		SI/RR	
ME C4.5	The facility has adequate support / general staff	Availability of housekeeping staff		SI/RR	
		Availability of security staff		SI/RR	
Standard C5	**Facility provides drugs and consumables required for assured list of services.**				
ME C5.1	The departments have availability of adequate drugs at point of use	Departments have availability of adequate emergency drugs at point of use		OB/RR	Inj Adrenaline,Inj Deriphylline,Inj Dexamethasone ,Inj Chlorpheniramine,Inj Metochlorpromide
		Availability Laboratory materials		OB/RR	Evacuated Blood collection tubes, Swabs, Syringes, Glass slides, Glass marker/ paper stickers
ME C5.2	The departments have adequate consumables at point of use	Availability of Reagents / Kits for lab		OB/RR	Standard Grouping Sera Anti A, Anti B & Anti D ,VDRL/RPR Kit for Syphillis,RDK/ ELISA for Malarial Antigen, ELISA kit for Hep B &C, ELISA kit for HIV1 & 2, malarial parasite stains

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard C6.	**The facility has equipment & instruments required for assured list of services.**				
ME C6.1	Availability of equipment & instruments for examination & monitoring of patients	Availability of functional Equipment &Instruments for examination & Monitoring		OB	Adult Weighing machine, BP apparatus , clinical thermometer
ME C6.3	Availability of equipment & instruments for diagnostic procedures being undertaken in the facility	Availability of laboratory equipment & instruments for laboratory		OB	Microscope with water bath, ELISA reader with washer, RH viewer, Sahli's Haemoglobino meter/ Others
ME C6.4	Availability of equipment and instruments for resuscitation of patients and for providing intensive and critical care to patients	Availability of functional Instruments for Resuscitation.		OB	Adult bag and mask and Oxygen
ME C6.5	Availability of Equipment for Storage	Check for availability of storage equipments for blood products		OB	Blood bags refrigerator with thermo graph and alarm device, Insulated carrier boxes with ice packs, Blood bag weighting machine, deep freezer, Platelets agitators
ME C6.6	Availability of functional equipment and instruments for support services	Availability of equipments for cleaning		OB	Buckets for mopping, mops, duster, waste trolley, Deck brush
ME C6.7	Departments have patient furniture and fixtures as per load and service provision	Availability of beds/ Couches in blood bank		OB	Blood collection bed, recovery beds
		Availability of attachment/ accessories		OB	Hospital graded Mattress, bed sheet, blanket, and bed side table
		Availability of Fixtures		OB	Electrical fixture for equipments lab and storage equipments
		Availability of furniture		OB	cupboard, counter for issuing blood, work benches for lab, chair.
Standard C7	**Facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff**				
ME C7.1	Criteria for Competence assessment are defined for clinical and Para clinical staff	Check parameters for assessing skills and proficiency of clinical staff has been defined		RR/SI	Check objective checklist has been prepared for assessing competence of doctors, nurses and paramedical staff based on job description defined for each cadre of staff. Dakshta checklist issued by MoHFW can be used for this purpose.

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME C7.2	Competence assessment of Clinical and Para clinical staff is done on predefined criteria at least once in a year	Check for competence assessment is done at least once in a year		RR/SI	Check for records of competence assessment including filled checklist, scoring and grading . Verify with staff for actual competence assessment done
ME C7.9	The Staff is provided training as per defined core competencies and training plan	Infection control & prevention training		SI/RR	Bio medical Waste Management including Hand Hygiene
		Patient Safety		SI/RR	
		Basic Life Support		SI/RR	
		Training on Quality Management System		SI/RR	To all category of staff. At the time of induction and once in a year.
ME C7.10	There is established procedure for utilization of skills gained thought trainings by on -job supportive supervision	Staff is skilled for operating the equipments		SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps
AREA OF CONCERN - D SUPPORT SERVICES					
Standard D1.	**The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.**				
ME D1.1.	The facility has established system for maintenance of critical Equipment	All equipments are covered under AMC including preventive maintenance		SI/RR	1. Check with AMC records/ Warranty documents 2. Staff is aware of the list of equipment covered under AMC.
		There is system of timely corrective break down maintenance of the equipments		SI/RR	1.Check for breakdown & Maintenance record in the log book 2. Staff is aware of contact details of the agency/person in case of breakdown.
		There has system to label Defective/Out of order equipments and stored appropriately until it has been repaired		OB/RR	
		Staff is skilled for trouble shooting in case equipment malfunction		SI/RR	
		Periodic cleaning, inspection and maintenance of the equipments is done by the operator		SI/RR	
ME D1.2	The facility has established procedure for internal and external calibration of measuring Equipment	All the measuring equipments/ instrument are calibrated		OB/ RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		There is system to label/ code the equipment to indicate status of calibration/ verification when recalibration is due		OB/ RR	
		Blood bank has system to update correction factor after calibration wherever required		SI/RR	Check for records
		Each lot of reagents has to be checked against earlier tested in use reagent lot or with suitable reference material before being placed in service and result should be recorded.		SI/RR	
ME D1.3	Operating and maintenance instructions are available with the users of equipment	Up to date instructions for operation and maintenance of equipments are readily available with staff.		OB/SI	
Standard D2	**The facility has defined procedures for storage, inventory management and dispensing of drugs in pharmacy and patient care areas**				
ME D2.1	There is established procedure for forecasting and indenting drugs and consumables	There is established system of timely indenting of consumables and reagents		SI/RR	Stock level are daily updated Indent are timely placed
ME D2.3	The facility ensures proper storage of drugs and consumables	Reagents and consumables are kept away from water and sources of heat, direct sunlight		OB/RR	Check the storage conditions of reagents, blood,etc.
		Reagents are labelled appropriately		OB/RR	Reagents label contain name, concentration, date of preparation/opening, date of expiry, storage conditions and warning
ME D2.4.	The facility ensures management of expiry and near expiry drugs	Expiry dates' of the blood bags are maintained		OB/RR	
		No expired blood is found in storage		OB/RR	
		Records for expiry and near expiry blood are maintained		RR	Check the record of expiry and near expiry drug in drug substore
ME D2.5	The facility has established procedure for inventory management techniques	There is practice of calculating and maintaining buffer stock of reagents		SI/RR	Minimum stock and reorder level are calculated based on consumption Minimum buffer stock is maintained all the time
		Department maintained stock register of reagents		RR/SI	Check record of drug received, issued and balance stock in hand and are regularly updated

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME D2.6	There is a procedure for periodically replenishing the drugs in patient care areas	There is established procdeure for replenishing drug tray /crash cart		SI/RR	
		There is no stock out of reagents		OB/SI	Check some stock of reagent
ME D2.7	There is process for storage of vaccines and other drugs, requiring controlled temperature	Temperature of refrigerators used for storing lab reagents are kept as per storage requirement and records twice a day are maintained		OB/RR	Check for temperature charts are maintained and updated twice a day for refrigerators used storing lab reagents
		Regular Defrosting is done		SI/RR	
Standard D3	**The facility provides safe, secure and comfortable environment to staff, patients and visitors.**				
ME D3.1	The facility provides adequate illumination level at patient care areas	Adequate illumination at work station in laboratory		OB	Illumination level of blood bank is as per recommendation/ sufficient to carry out blood bank activities
		Adequate illumination at donation area		OB	
ME D3.2	The facility has provision of restriction of visitors in patient areas	Entry is restricted in storage and lab area of the blood bank		OB	
ME D3.3	The facility ensures safe and comfortable environment for patients and service providers	Temperature is maintained and record of same is kept		SI/RR	Air conditioned blood collection room, blood group serology lab, testing lab for Transfusion Transmissible Diseases, refreshment cum rest room
ME D3.5	The facility has established measure for safety and security of female staff	Female staff feel secure at work place		SI	
Standard D4	**The facility has established Programme for maintenance and upkeep of the facility**				
ME D4.1	Exterior of the facility building is maintained appropriately	Building is painted/ whitewashed in uniform colour		OB	
		Interior of patient care areas are plastered & painted		OB	
ME D4.2	Patient care areas are clean and hygienic	Floors, walls, roof, roof topes, sinks patient care and circulation areas are Clean		OB	All area are clean with no dirt,grease,littering and cobwebs
		Surface of furniture and fixtures are clean		OB	
		Toilets are clean with functional flush and running water		OB	
ME D4.3	Hospital infrastructure is adequately maintained	Check for there is no seepage , Cracks, chipping of plaster		OB	
		Window panes , doors and other fixtures are intact		OB	
		Patients beds are intact and painted		OB	Mattresses are intact and clean

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME D4.5	The facility has policy of removal of condemned junk material	No condemned/Junk material in the lab		OB	
ME D4.6	The facility has established procedures for pest, rodent and animal control	No stray animal/rodent/ birds		OB	
Standard D5	**The facility ensures 24X7 water and power backup as per requirement of service delivery, and support services norms**				
ME D5.1	The facility has adequate arrangement storage and supply for portable water in all functional areas	Availability of 24x7 running and potable water		OB/SI	
ME D5.2	The facility ensures adequate power backup in all patient care areas as per load	Availability of power back up in OT		OB/SI	
		Availability of UPS		OB/SI	
Standard D7	**The facility ensures clean linen to the patients**				
ME D7.1	The facility has adequate sets of linen	Blood bank provides Linen for donors		OB/RR	Blankets
Standard D10.	**Facility is compliant with all statutory and regulatory requirement imposed by local, state or central government**				
ME D10.1	The facility has requisite licences and certificates for operation of hospital and different activities	Blood bank has valid license under Rule 122(G) Drug and cosmetic act		RR	
Standard D11.	**Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.**				
ME D11.1	The facility has established job description as per govt guidelines	Job description is defined and communicated to all concerned staff		RR	Regular + contractual
		Staff is aware of their role and responsibilities		SI	
ME D11.2	The facility has a established procedure for duty roster and deputation to different departments	There is procedure to ensure that staff is available on duty as per duty roster		RR/SI	Check for system for recording time of reporting and relieving (Attendance register/ Biometrics etc)
		There is designated in charge for department		SI	
ME D11.3	The facility ensures the adherence to dress code as mandated by its administration / the health department	Doctor, technician and support staff adhere to their respective dress code		OB	
Standard D12.	**Facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations**				
ME D12.1	There is established system for contract management for out sourced services	There is procedure to monitor the quality and adequacy of outsourced services on regular basis		SI/RR	Verification of outsourced services (cleaning/ Dietary/Laundry/Security/ Maintenance) provided are done by designated in-house staff

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
AREA OF CONCERN - E CLINICAL SERVICES					
Standard E1	**The facility has defined procedures for registration, consultation and admission of patients.**				
ME E1.1.	The facility has established procedure for registration of patients	Unique identification number is given to each donor during process of registration		RR	
		Donors demographic details are recorded		RR	Check for that patient demographics like Name, age, Sex, Address etc.
Standard E2	**The facility has defined and established procedures for clinical assessment, reassessment and treatment plan preparation.**				
ME E2.1	There is established procedure for initial assessment of patients	There is procedure for assessment of patient before donation		RR/SI	Initial assessment is recorded
Standard E3	**Facility has defined and established procedures for continuity of care of patient and referral**				
ME E3.1	Facility has established procedure for continuity of care during interdepartmental transfer	Facility has established procedure for handing over of patients during departmental transfer		SI/RR	
		There is a procedure consultation of the patient to other specialist with in the hospital		SI/RR	
ME E3.2	Facility provides appropriate referral linkages to the patients/ Services for transfer to other/higher facilities to assure their continuity of care.	There is procedure for referral of cases for which requested blood group is not available		SI/RR	
		Facility has functional referral linkages to blood storage unit		SI/RR	
Standard E4	**The facility has defined and established procedures for nursing care**				
ME E4.3	There is established procedure of patient hand over, whenever staff duty change happens	Procedure to handover test/ results during shift change		RR/SI	
		Handover register is maintained		RR	
Standard E8	**Facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage**				
ME E8.1	All the assessments, re-assessment and investigations are recorded and updated	Records of donor assessment is maintained		RR	(Manually/e-records)
ME E8.5	Adequate form and formats are available at point of use	Standard Formats available		RR/OB	Format for consent, requisition form, blood transfusion reaction form, referral slip
ME E8.6	Register/records are maintained as per guidelines	Blood bank records are labelled and indexed		RR	(Manually/e-records)
		Records are maintained for blood bank		RR	Records includes daily group wise stock register, daily temperature recording of temperature dependent equipment, stock register of consumables and non consumables, documents of proficiency testing, records of equipment maintenance, records of recipient, compatibility records, transfusion reaction records, donors records etc.

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME E8.7	The facility ensures safe and adequate storage and retrieval of medical records	Safe keeping of patient records		OB	Blood bank has facility to store records for 5 year
Standard E11	**The facility has defined and established procedures for Emergency Services and Disaster Management**				
ME E11.3.	The facility has disaster management plan in place	Blood bank has system of coping with extra demand of blood in case of disaster		SI/RR	
		Staff is aware of disaster plan		SI/RR	
		Role and responsibilities of staff in disaster is defined		SI/RR	
Standard E12	**The facility has defined and established procedures of diagnostic services**				
ME E12.1	There are established procedures for Pre-testing Activities	Container is labelled properly after the sample collection		OB	
Standard E13	**The facility has defined and established procedures for Blood Bank/Storage Management and Transfusion.**				
ME E13.1	Blood bank has defined and implemented donor selection criteria	Blood bank has defined criteria for donor selection		RR/SI	Based on Physical examination, Medical history, condition that affects safety of recipients, donation intervals,
		Blood bank ensures that blood is taken from voluntary donors only		RR/PI/SI	
		Pre donation counselling is done before donation		RR/PI	
		Check for questionnaire is available in local language for taking pre donation information		OB/RR	
ME E13.2	There is established procedure for the collection of blood	Blood bank has standardized procedure for collection of blood from donor		RR/SI	Procedure include preparation of venepuncture site, use of blood bags and anticoagulant solution, collecting sample for laboratory test
		Instructions for collection and handling the collected blood are communicated to those responsible for collection		RR/SI	Mostly numeric or alpha numeric label should be used for tracing
		Blood bank has identified procedure for labelling of blood bag/blood component /pilot tubes		RR/OB	
		Blood bank has system to trace of unit of blood / component from source to final destination		RR/SI	Blood should be kept at 4oC to 6oC except if it is used for component preparation it will be stored at 22oC until platelet are separated

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Blood bank has system to maintain temperature of collected blood immediately after donation		RR/SI	
		Blood bank has system in place to monitor the transportation of the blood from camp site		RR/SI	
ME E13.3	There is established procedure for the testing of blood	Determination of ABO group is done by recommended methods		RR/SI	Tube or Microplate or gel technology
		Determination of Rh (D) Type done as per recommended method		RR/SI	Check for the protocol/ Algorithm followed for determining RH + or RH- Blood type
		Laboratory tests for Infectious diseases done as per recommended method		RR/SI	or infectious diseases (VDRL/RPR/TPHAfor syphilis, ELISA/Rapid test for Hep A, Hep B, HIV and Malaria for malarial parasite
		There is provision of Quarantine Storage untested blood		RR/OB/SI	Check for untested blood is stored in different refrigerator
		Blood units with reactive test result area kept separately		RR/OB/SI	In dedicate secure area with biohazard sign until disposal
		Sterility of Blood units checked with adequate sample size		RR/OB/SI	Check Sterility is checked at least for 1% of blood unit collected or 4 per month which ever higher by appropriate culture method
ME E13.4	There is established procedure for preparation of blood component	Sterility of Blood component is insured during processing		SI/RR	Check for use of aseptic method and availability of Sterile pyrogen free disposable bags and solutions
		Transfusion time limits are adhered one frozen component have been thawed		SI/RR	Within 6 hours
		Blood components are prepared as per technical standards		SI/RR	Check availability and adherence to NACO standards
		Approximate volume of the component is indicated on bag		RR	
ME E13.5	There is establish procedure for labelling and identification of blood and its product	Blood bank has system to ensure that final blood bags are labelled only after all mandatory testing is completed.		RR/SI	
		Blood bank has system of identification traceability of its products		RR/SI	Blood bags are Identified with a numeric or alpha numeric system / Barcode

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Blood bank has system to the affix the product information on bag, after processing		RR/SI	Name of product, numeric information, date of collection and expiry, amount of anticoagulant and approximate blood collected, Name, address and manufacturing license number of collecting facility, storage temperature and expiry date
		Instruction for transfusion are printed on label		RR/SI	
		Blood bank has colour coded scheme for differentiate ABO groups		RR/SI	Blood group O -blue, Blood group A- yellow, Blood group B- Pink, Blood group AB- White
ME E13.6	There is established procedure for storage of blood	Check for refrigerators or freezers for blood storage are not used for storing other items		OB	Lab reagents etc.
		Check for refrigerators used for blood storage are kept at recommended temperature		OB/RR	Check records that temperature is maintained at 4c + 2 C
		Storage temperature is monitored at every 4 hours		OB/RR	Check the records
		Alarm system has been provided with refrigerator		RR/SI	
		Adequate alternate storage facility available		RR/SI	
		Shelf life of blood and components is adhered as per NACO protocols		RR/SI	
ME E13.7	There is established the compatibility testing	Blood bank has system to testing and cross matching the recipient blood		RR/SI	Testing of recipient blood includes Determination ABO type, Rh (D) type, detection of unexpected antibodies etc.
		There is established procedure for selection of blood and components for transfusion		RR/SI	Check for practice in case of ABO type specific groups are not available. Issue of blood to RH+ and Negative recipient
		There is established procedure for re cross matching in case of massive transfusion		RR/SI	
		Paediatric blood collection bags are available		RR/SI	
ME E13.8.	There is established procedure for issuing blood	Blood bank has system to testing and cross matching the recipient blood		RR/SI	Testing of recipient blood includes Determination ABO type, Rh (D) type, detection of unexpected antibodies etc.

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Instructions for collection and handling blood sample of recipient are communicated to those responsible for collection		RR/SI	Blood sample collection vial is label with Patient Name, identification no, name of hospital, ward/bed number, date time , Phlebotomist signature
		Blood bank has system to confirm that information on transfusion requisition form and recipients blood sample label is same		RR/SI	
		Blood bank has system to retain recipient and donor blood sample for 7 days at specified temperature (2-8 c) after each transfusion		RR/SI	
		Blood bank has system to issue the blood along with cross matching report		RR/SI	
		Blood bank has system to identify the person who is performing the cross matching test and issue the blood		RR/SI	Record of same should be available
		Blood bank has procedure to issue the blood in case of its urgent requirement		RR/SI	
ME E13.10	There is a established procedure for monitoring and reporting Transfusion complication	Transfusion reaction form is provided when blood is issued		RR/SI	
		Blood bank has system of detection, reporting and evaluations of transfusion errors		RR/SI	
AREA OF CONCERN - F INFECTION CONTROL					
Standard F1	**Facility has infection control program and procedures in place for prevention and measurement of hospital associated infection**				
ME F1.2	Facility has provision for Passive and active culture surveillance of critical & high risk areas	Surface and environment samples are taken for microbiological surveillance		SI/RR	Swab are taken from infection prone surfaces
ME F1.4	There is Provision of Periodic Medical Checkups and immunization of staff	There is procedure for immunization of the staff		SI/RR	Hepatitis B, Tetanus Toxid etc
		Periodic medical checkups of the staff		SI/RR	
.ME F1.5	Facility has established procedures for regular monitoring of infection control practices	Regular monitoring of infection control practices		SI/RR	Hand washing and infection control audits done at periodic intervals
Standard F2	**Facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis**				
ME F2.1	Hand washing facilities are provided at point of use	Availability of hand washing Facility at Point of Use		OB	Check for availability of wash basin near the point of use
		Availability of running Water		OB/SI	Ask to Open the tap. Ask Staff water supply is regular

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Availability of antiseptic soap with soap dish/ liquid antiseptic with dispenser.		OB/SI	Check for availability/ Ask staff if the supply is adequate and uninterrupted
		Availability of Alcohol based Hand rub		OB/SI	Check for availability/ Ask staff for regular supply.
		Display of Hand washing Instruction at Point of Use		OB	Prominently displayed above the hand washing facility , preferably in Local language
		Availability of elbow operated taps		OB	
		Hand washing sink is wide and deep enough to prevent splashing and retention of water		OB	
ME F2.2	Staff is trained and adhere to standard hand washing practices	Adherence to 6 steps of Hand washing		SI/OB	Ask of demonstration
		Staff aware of when to hand wash		SI	
ME F2.3	Facility ensures standard practices and materials for antisepsis	Availability of Antiseptic Solutions		OB	
		Proper cleaning of procedure site with antisepsis		OB/SI	like before giving IM/IV injection, drawing blood, putting Intravenous and urinary catheter
Standard F3	**Facility ensures standard practices and materials for Personal protection**				
ME F3.1	Facility ensures adequate personal protection equipments as per requirements	Clean gloves are available at point of use		OB/SI	All personal use gloves while drawing sample, examining and disposable of the samples
		Availability of lab aprons/ coats		OB/SI	
		Availability of Masks		OB/SI	
ME F3.2	Staff is adhere to standard personal protection practices	No reuse of disposable gloves, Masks, caps and aprons.		OB/SI	
		Compliance to correct method of wearing and removing the PPE		SI	Gloves, Masks, Caps and Aprons
Standard F4.	**Facility has standard Procedures for processing of equipments and instruments**				
ME F4.1.	Facility ensures standard practices and materials for decontamination and clean ing of instruments and procedures areas	Decontamination of operating & Procedure surfaces		SI/OB	Ask staff about how they decontaminate work benches (Wiping with 0.5% Chlorine solution
		Proper Decontamination of instruments after use		SI/OB	Decontamination of instruments and reusable of glassware are done after procedure in 1% chlorine solution/ any other appropriate method
		Contact time for decontamination is adequate		SI/OB	10 minutes

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Cleaning of instruments after decontamination		SI/OB	Cleaning is done with detergent and running water after decontamination
		Staff know how to make chlorine solution		SI/OB	
ME F4.2	Facility ensures standard practices and materials for disinfection and sterilization of instruments and equipments	Disinfection of reusable glassware		SI/OB	Disinfection by hot air oven at 160 oC for 1 hour
Standard F5	**Physical layout and environmental control of the patient care areas ensures infection prevention**				
ME F5.2	Facility ensures availability of standard materials for cleaning and disinfection of patient care areas	Availability of disinfectant as per requirement		OB/SI	Chlorine solution, Gluteraldehye, carbolic acid
		Availability of cleaning agent as per requirement		OB/SI	Hospital grade phenyl, disinfectant detergent solution
ME F5.3	Facility ensures standard practices followed for cleaning and disinfection of patient care areas	Staff is trained for spill management		SI/RR	
		Cleaning of patient care area with detergent solution		SI/RR	
		Staff is trained for preparing cleaning solution as per standard procedure		SI/RR	
		Standard practice of mopping and scrubbing are followed		OB/SI	Unidirectional mopping from inside out
		Cleaning equipments like broom are not used in patient care areas		OB/SI	Any cleaning equipment leading to dispersion of dust particles in air should be avoided
Standard F6	**Facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.**				
ME F6.1	Facility Ensures segregation of Bio Medical Waste as per guidelines	Availability of colour coded bins at point of waste generation		OB	Adequate number. Covered. Foot operated.
		Availability of colour coded non chlorinated plastic bags		OB	
		Segregation of different category of waste as per guidelines		OB/SI	
		Display of work instructions for segregation and handling of Biomedical waste		OB	Pictorial and in local language
		There is no mixing of infectious and general waste		OB	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME F6.2	Facility ensures management of sharps as per guidelines	Availability of functional needle cutters		OB	See if it has been used or just lying idle.
		Seggregation of sharps waste including Metals in white (translucent) Puncture proof, Leak proof, tamper proof containers		OB	Should be available nears the point of generation. Needles, syringes with fixed needles, needles from needle tip cutter or burner, scalpels, blades, or any other contaminated sharp object that may cause puncture and cuts. This includes both used, discarded and contaminated metal sharps
		Availability of post exposure prophylaxis		SI/OB	Ask if available. Where it is stored and who is in charge of that.
		Staff knows what to do in condition of needle stick injury		SI	Staff knows what to do in case of shape injury. Whom to report. See if any reporting has been done
ME F6.3	Facility ensures transportation and disposal of waste as per guidelines	Disinfection of liquid waste before disposal		SI/OB	
		Disposal of discarded blood bags as per guideline		SI/OB	
		Check bins are not overfilled		SI	
		Transportation of bio medical waste is done in close container/trolley		SI/OB	
		Staff aware of mercury spill management		SI/RR	Look for: 1. Spill area evacuation 2. Removal of Jewellery 3. Wear PPE 4. Use of flashlight to lacate mercury beads 5. Use syringe without a needle/eyedropper and sticky tape to suck the beads 6. Collection of beads in leak-proof bag or container 7. Sprinkle sulphur or zinc powder to remove any remaining mercury 8. All the mercury spill surfaces should be decontaminated with 10% sodium thiosulfate solution 9. All the bags or containers containing items contaminated with mercury should be marked as "Hazardous Waste, Handle with Care" 10. Collected mercury waste should be handed over to the CBMWTF

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
AREA OF CONCERN - G QUALITY MANAGEMENT					
Standard G1	**The facility has established organizational framework for quality improvement**				
ME G1.1	The facility has a quality team in place	Quality circle has been formed in the Blood Bank		SI/RR	Check if quality circle formed and functional with a designated nodal officer for quality
Standard G2	**Facility has established system for patient and employee satisfaction**				
ME G2.1	Patient Satisfaction surveys are conducted at periodic intervals	There is system to take feed back from clinician about quality of services		RR	
		Feedback from donor are taken on periodic basis		RR	
Standard G3	**Facility have established internal and external quality assurance programs wherever it is critical to quality.**				
ME G3.1	Facility has established internal quality assurance program at relevant departments	Internal Quality assurance program is in place		SI/RR	
		Standards are run at defined interval		SI/RR	
		Control charts are prepared and outliers are identified.		SI/RR	
		Corrective action is taken on the identified outliers		SI/RR	
ME G3.2	Facility has established external assurance programs at relevant departments	Cross validation of lab test are done and reports are maintained		SI/RR	It includes participation of laboratory in inter laboratory comparison
		Corrective actions are taken on abnormal values		SI/RR	Blood bank takes corrective action when control criteria are not fulfilled in Interlaboratory comparisons and records of same is maintained
ME G3.3	Facility has established system for use of check lists in different departments and services	Internal assessment is done at periodic interval		RR/SI	NQAS, Kayakalp, SaQushal tools are used to conduct internal assessment
		Departmental checklist are used for monitoring and quality assurance		SI/RR	Staff is designated for filling and monitoring of these checklists
		Non-compliances are enumerated and recorded		RR	Check the non compliances are presented & discussed during quality team meetings
ME G3.4	Actions are planned to address gaps observed during quality assurance process	Check action plans are prepared and implemented as per internal assessment record findings		RR	Randomly check the details of action, responsibility, time line and feedback mechanism
ME G3.5	Planned actions are implemented through Quality Improvement Cycles (PDCA)	Check PDCA or revalent quality method is used to take corrective and preventive action		SI/RR	Check actions have been taken to close the gap. It can be in form of action taken report or Quality Improvement (PDCA) project report

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard G4	**Facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.**				
ME G4.1	Departmental standard operating procedures are available	Standard operating procedure for department has been prepared and approved		RR	
		Current version of SOP are available with process owner		OB/RR	
		Work instruction/clinical protocols are displayed		OB	work instruction for screening of blood, storage of blood, maintaining blood and component in event of power failure
ME G4.2	Standard Operating Procedures adequately describes process and procedures	Blood bank has documented procedure for Donor selection and collection of blood from donor		RR	
		Blood bank has documented procedure for testing of donated blood		RR	
		Blood bank has documented procedure for preparation of blood components		RR	
		Blood bank has documented procedure for storage, transportations of blood and issue of blood for transfusion		RR	
		Blood bank has documented procedure for issue of blood in case of urgent requirement		RR	
		Blood bank has documented procedure to address the transfusion reactions		RR	
		Blood bank has documents procedure for calibration and maintenance of equipment		RR	
		Blood bank has documented procedure for HAI and disposal of BMW		RR	
		Blood bank has documented system for storage, retaining and retrieval of laboratory records, primary sample, Examination sample and reports of results.		RR	

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
		Blood bank has documented system for internal and external Quality control of Equipments, reagent and tests		RR	
ME G4.3	Staff is trained and aware of the standard procedures written in SOPs	Check staff is a aware of relevant part of SOPs		SI/RR	
Standard G 5	**Facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages**				
ME G5.1	Facility maps its critical processes	Process mapping of critical processes done		SI/RR	
ME G5.2	Facility identifies non value adding activities / waste / redundant activities	Non value adding activities are identified		SI/RR	
ME G5.3	Facility takes corrective action to improve the processes	Processes are rearranged as per requirement		SI/RR	
Standard G6	**The facility has defined mission, values, Quality policy & objectives & prepared a strategic plan to achieve them**				
ME G6.3	Facility has defined Quality policy, which is in congruency with the mission of facility	Check if Quality Policy has been defined and approved		SI/RR	Check quality policy of the facility has been defined in consultation with hospital staff and duly approved by the head of the facility . Also check Quality Policy enables achievement of mission of the facility and health department
ME G6.4	Facility has de defined quality objectives to achieve mission and quality policy	Check if SMART Quality Objectives have framed		SI/RR	Check short term valid quality objectivities have been framed addressing key quality issues in each department and cores services. Check if these objectives are Specific, Measurable, Attainable, Relevant and Time Bound.
ME G6.5	Mission, Values, Quality policy and objectives are effectively communicated to staff and users of services	Check of staff is aware of Mission , Values, Quality Policy and objectives		SI/RR	Interview with staff for their awareness. Check if Mission Statement, Core Values and Quality Policy is displayed prominently in local language at Key Points
ME G6.6	Facility prepares strategic plan to achieve mission, quality policy and objectives	Check if plan for implementing quality policy and objectives have prepared		SI/RR	Verify with records that a time bound action plan has been prepared to achieve quality policy and objectives in consultation with hospital staff . Check if the plan has been approved by the hospital management

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
ME G6.7	Facility periodically reviews the progress of strategic plan towards mission, policy and objectives	Check time bound action plan is being reviewed at regular time interval		SI/RR	Review the records that action plan on quality objectives being reviewed at least onnce in month by departmnetal incharges and during the qulaity team meeting. The progress on quality objectives have been recorded in Action Plan tracking sheet
Standard G7	**Facility seeks continually improvement by practicing Quality method and tools.**				
ME G7.1.	Facility uses method for quality improvement in services	Basic quality improvement method		SI/RR	PDCA & 5S
		Advance quality improvement method		SI/OB	Six sigma, lean.
ME G7.2.	Facility uses tools for quality improvement in services	7 basic tools of Quality		SI/RR	Minimum 2 applicable tools are used in each department
Standard G9	**Facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan**				
ME G9.6	Periodic assessment for Medication and Patient care safety risks is done as per defined criteria.	Check periodic assessment of medication and patient care safety risk is done using defined checklist periodically		SI/RR	Verify with the records. A comprehensive risk asesement of all clincial processes should be done using pre define critera at least once in three month.
ME G9.7	Periodic assessment for potential risk regarding safety and security of staff including violence against service providers is done as per defined criteria	SaQushal assessment toolkit is used for safety audits.		SI/RR	1. Check that the filled checklist and action taken report are available 2. Staff is aware of key gaps & closure status
ME G9.8	Risks identified are analyzed evaluated and rated for severity	Identified risks are analysed for severity		SI/RR	Action is taken to mitigate the risks
	Area of Concern - H Outcome				
Standard H1	**The facility measures Productivity Indicators and ensures compliance with State/National benchmarks**				
ME H1.1	Facility measures productivity Indicators on monthly basis	No. of Blood unit issued per thousand population		RR	No. of Unit issued X1000/ Population of serving area
		% of units issued for the transfusion at facility		RR	No. of Unit issued for facility*100/Total no of units issued in the period
		No of voluntary donation done per thousand population		RR	No of Voluntary Donation X1000/Population of the serving area
		No. of units supplied to storage units		RR	Self Explanatory
		Blood donation camps held		RR	Self Explanatory
		Proportion of blood units issued in emergency cases out of total unit issued in month		RR	
		No of blood units issued for free of cost		RR	JSSK, Thalassemia , BPL

Reference No.	Measurable Element	Checkpoint	Compli-ance	Assessment Method	Means of Verification
Standard H2	**The facility measures Efficiency Indicators and ensure to reach State/National Benchmark**				
ME H2.1	Facility measures efficiency Indicators on monthly basis	Downtime critical equipments		RR	Time period for which equipment was out of order/Total no of working hours for equipments
		% of Blood Units discarded		RR	No of unit discarded *100/ Total no of unit collected
		% of unit issued against replacement		RR	No of unit issued on replacement *100/ Total no of unit issued
		% of unit tested seroreactive		RR	No of unit found sero reactiveX100/ No of unit tested
Standard H3	**The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark**				
ME H3.1	Facility measures Clinical Care & Safety Indicators on monthly basis	Blood transfusion reaction rate		RR	No of Blood Transfusion reactions 1000/ No of patient blood issued
		Adverse events are identifies and reported		RR	Chemical splash, Needle stick injuries. Major blood transfusion reaction, wrong cross matching, wrong blood issue
		Component to whole blood ratio		RR	No of component unit issued/No of whole blood issued
		Cross matched/ Transfused Ratio		RR	No of unit are cross matched on request/ No of unit actually transfused
		% of single unit transfusion		RR	% of single use transfusion 100/ Total no of units transfused
		Number of adverse events per thousand patients		RR	Chemical splash, Needle stick injuries. Major blood transfusion reaction, wrong cross matching, wrong blood issue
Standard H4	**The facility measures Service Quality Indicators and endeavours to reach State/National benchmark**				
ME H4.1	Facility measures Service Quality Indicators on monthly basis	Time gap between issuing and requisition of blood in routine conditions		RR	
		Time gap between issuing and requisition of blood in emergency conditions		RR	
		Donor Satisfaction Score at Blood Bank		RR	
		No of refusal cases		RR	No of requisition refused/ referred due to non availability of blood group or any other reason

ASSESSMENT SUMMARY

Name of the Hospital ..... Date of Assessment .....

Names of Assessors ..... Names of Assessees .....

Type of Assessment (Internal/External) ..... Action plan Submission Date .....

A. SCORE CARD

BLOOD BANK SCORE CARD	
Area of Concern wise score	**Blood Bank Score**
A. Service Provision	
B. Patient Rights	
C. Inputs	
D. Support Services	
E. Clinical Services	
F. Infection Control	
G. Quality Management	
H. Outcome	

B. MAJOR GAPS OBSERVED

1. _____
2. _____
3. _____
4. _____
5. _____

C. STRENGTHS/BEST PRACTICES

1. _____
2. _____
3. _____

D. RECOMMENDATIONS/OPPORTUNITIES FOR IMPROVEMENT

_____

_____

_____

Names and Signature of Assessors

Date _____

सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

CHECKLIST-7

LABORATORY SERVICES

CHECKLIST FOR LABORATORY SERVICES

Standard	Measurable Element	Checkpoint	Compli-ance	Audit Method	Means of Verification
AREA OF CONCERN - A SERVICE PROVISION					
Standard A1	**Facility Provides Curative Services**				
ME A1.14	Services are available for the time period as mandated	All lab services are available in routine working hours	2	SI/RR	
		Emergency lab services are available for selected tests of Haematology, Biochemistry and Serology 24X7	2	SI/RR	Check for: 1. Laboratory services are available at night 2. Look for number of lab tests performed at night
Standard A3	**Facility Provides diagnostic Services**				
ME A3.2	The facility Provides Laboratory Services	Availability of Haematology services	2	SI/OB	
		Availability of Biochemistry services	2	SI/OB	
		Availability of Microbiology services	2	SI/OB	
		Availability of Cytology services	2	SI/OB	
		Availability of Histopathology services	2	SI/OB	
		Availability of Clinical Pathology services	2	SI/OB	
		Availability of Serology services	2	SI/OB	
Standard A4	**Facility provides services as mandated in national Health Programs/ state scheme**				
ME A4.1	The facility provides services under National Vector Borne Disease Control Programme as per guidelines	Tests for Diagnosis of maleria (Smear and RDTK)	2	SI/OB	
		Tests for diagnosis of Dengue, Chikengunia	2	SI/OB	
ME A4.2	The facility provides services under national tuberculosis elimination programme as per guidelines.	Availability of Designated Microscoy Center (AFB)	2	SI/OB	
		Availability or Linkage with CBNAAT	2		
ME A4.3	The facility provides services under National Leprosy Eradication Programme as per guidelines	Availability of Skin Smear Examination	2	SI/OB	

Standard	Measurable Element	Checkpoint	Compli-ance	Audit Method	Means of Verification
ME A4.8	The facility provides services under National Programme for Prevention and control of Cancer, Diabetes, Cardiovascular diseases & Stroke (NPCDCS) as per guidelines	Availability of blood test for NCD	2	SI/RR	Haemogram, BT CT, Fasting/PP Sugar, Lipid Profile, Blood Urea , LFT Kidney Function Test
Standard A6	**Health services provided at the facility are appropriate to community needs.**				
ME A 6.1	The facility provides curatives & preventive services for the health problems and diseases, prevalent locally.	Laboratory provides specific test for local health problems/diseases	2	SI/RR	Like Dengue, swine flu, Kala Azar, Lymphatic Filariasis,etc.
AREA OF CONCERN - B PATIENT RIGHTS					
Standard B1	**Facility provides the information to care seekers, attendants & community about the available services and their modalities**				
ME B1.1	The facility has uniform and user-friendly signage system	Availability of departmental & directional signages	2	OB	Numbering, main department and internal sectional signage are displayed
		Restricted area signage are displayed	2	OB	
ME B1.2	The facility displays the services and entitlements available in its departments	List of services available are displayed at the entrance	2	OB	
		Timing for collection of sample and delivery of reports are displayed	2	OB	
ME B1.4	User charges are displayed and communicated to patients effectively	User charges in r/o laboratory services are displayed	2	OB	
ME B1.5	Information is available in local language and easy to understand	Signage's and information are available in local language	2	OB	
ME B1.8	The facility ensures access to clinical records of patients to entitled personnel	Lab Reports are provided to Patient in printed format	2	OB	
Standard B2	**Services are delivered in a manner that is sensitive to gender, religiousand cultural needs, and there are no barrier on account of physical , economic, cultural or social reasons.**				
ME B2.1	Services are provided in manner that are sensitive to gender	Separate queue for females at lab	2	OB	
ME B2.3	Access to facility is provided without any physical barrier & and friendly to people with disabilities	Check the availability of ramp in lab building area / sample collection area	2	OB	At least 120 cm width, gradient not steeper than 1:12, if ramp is available

Standard	Measurable Element	Checkpoint	Compli-ance	Audit Method	Means of Verification
Standard B3	**The facility maintains privacy, confidentiality & dignity of patient, and has a system for guarding patient related information.**				
ME B3.2	Confidentiality of patients records and clinical information is maintained	Laboratory has system to ensure the confidentiality of the reports generated	2	SI/OB	Laboratory staff do not discuss the lab result outside. And reports are kept in secure place
ME B3.3	The facility ensures the behaviours of staff is dignified and respectful, while delivering the services	Behaviour of staff is empathetic and courteous	2	PI/OB	
ME B3.4	The facility ensures privacy and confidentiality to every patient, especially of those conditions having social stigma, and also safeguards vulnerable groups	HIV positive reports/ pregnancy reports are communicated as per NACO guidelines	2	SI/OB	
Standard B4	**Facility has defined and established procedures for informing and involving patient and their families about treatment and obtaining informed consent wherever it is required.**				
ME B4.1	There is established procedures for taking informed consent before treatment and procedures	Informed Consent is taken before HIV testing, Biopsy and any other invasive procedure	2	SI/RR	Before testing HIV patient is informed that test is voluntary and result will be disclosed to him/her only
ME B4.4	Information about the treatment is shared with patients or attendants, regularly	Pre test counselling is given before HIV testing	2	PI/SI/RR	
Standard B5	**Facility ensures that there are no financial barrier to access and that there is financial protection given from cost of care.**				
ME B5.1	The facility provides cashless services to pregnant women, mothers and neonates as per prevalent government schemes	Free Diagnostic tests for Pregnant women, Infant and Children	2	PI/SI	
ME B5.2	The facility ensures that drugs prescribed are available at Pharmacy and wards	Check that patient party has not incurred expenditure on purchasing consumables from outside.	2	PI/SI	
ME B5.3	It is ensured that facilities for the prescribed investigations are available at the facility	Check that patient party has not incurred expenditure on diagnostics from outside.	2	PI/SI	
		Laboratory provides complete list of diagnostic test available to all department of the hospital	2	PI/SI	

Standard	Measurable Element	Checkpoint	Compli-ance	Audit Method	Means of Verification
ME B5.4	The facility provide free of cost treatment to Below poverty line patients without administrative hassles	Tests are free of cost for BPL patients	2	PI/SI/RR	
ME B5.5	The facility ensures timely reimbursement of financial entitlements and reimbursement to the patients	Cashless investigation by empanelled lab for JSSK beneficiaries for test not available within the facility	2	PI/SI/RR	
AREA OF CONCERN - C INPUTS					
Standard C1	**The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms**				
ME C1.1	Departments have adequate space as per patient or work load	Laboratory space is adequate for carrying out activities	2	OB	Adequate area for sample collection, waiting, performing test, keeping equipment and storage of drugs and records
		Availability of adequate waiting area	2	OB	
ME C1.2	Patient amenities are provide as per patient load	Availability of sitting arrangement of sub waiting area	2	OB	
		Availability of patient calling system at lab	2	OB	
		Availability of functional toilets	2	OB	
		Availability of drinking water	2	OB	
ME C 1.3	Departments have layout and demarcated areas as per functions	Demarcated sample collection area	2	OB	
		Demarcated testing area	2	OB	
		Designated report writing area	2	OB	
		Demarcated washing and waste disposal area	2	OB	
		Availability of store	2	OB	
ME C 1.4	The facility has adequate circulation area and open spaces according to need and local law	Availability of adequate circulation area for easy moment of staff and equipments	2	OB	
ME C 1.5	The facility has infrastructure for intramural and extramural communication	Availability of functional telephone and Intercom Services	2	OB	

Standard	Measurable Element	Checkpoint	Compli-ance	Audit Method	Means of Verification
ME C 1.6	Service counters are available as per patient load	Availability of collection counters as per load	2	OB	
ME C 1.7	The facility and departments are planned to ensure structure follows the function/ processes (Structure commensurate with the function of the hospital)	Unidirectional flow of services	2	OB	Sample collection- Sample processing- Analytical area- reporting.
Standard C 2	**The facility ensures the physical safety of the infrastructure.**				
ME C2.1	The facility ensures the seismic safety of the infrastructure	Non structural components are properly secured	2	OB	Check for fixtures and furniture like cupboards, cabinets, and heavy equipments , hanging objects are properly fastened and secured
ME C2.3	The facility ensures safety of electrical establishment	Laboratory does not have temporary connections and loose hanging wires	2	OB	
		Adequate electrical socket provided for safe and smooth operation of lab equipments	2	OB/RR	
ME C2..4	Physical condition of buildings are safe for providing patient care	Work benches are chemical resistant	2	OB	
		Floors of the Laboratory are non slippery and even surfaces and acid resistent	2	OB	
		Windows have grills and wire meshwork	2	OB	
Standard C3	**The facility has established Programme for fire safety and other disaster**				
ME C3.1	The facility has plan for prevention of fire	Laboratory has plan for safe storage and handling of potentially flammable materials.	2	OB/SI	
		Department has sufficient fire exit with signage to permit safe escape to its occupant at time of fire	2	OB	
		Check the fire exits are clearly visible and routes to reach exit are clearly marked.	2	OB	
ME C3.2	The facility has adequate fire fighting Equipment	Lab has installed fire Extinguisher that is Class A , Class B C type or ABC type	2	OB/RR	

Standard	Measurable Element	Checkpoint	Compli-ance	Audit Method	Means of Verification
		Check the expiry date for fire extinguishers are displayed on each extinguisher as well as due date for next refilling is clearly mentioned	2	OB/RR	
ME C3.3	The facility has a system of periodic training of staff and conducts mock drills regularly for fire and other disaster situation	Check for staff competencies for operating fire extinguisher and what to do in case of fire	2	SI/RR	
Standard C4	**The facility has adequate qualified and trained staff, required for providing the assured services to the current case load**				
ME C4.1	The facility has adequate specialist doctors as per service provision	Availability of dedicated pathologist	2	OB/RR	For 100 bed - 1 , 200-1, 300-3, 400-3, 500-4.
		Availability of dedicated Microbiologist	2	OB/RR	For 300-500 bed -1
ME C4.4	The facility has adequate technicians/ paramedics as per requirement	Availability of Lab Technician 24X7	2	SI/RR	For 100 beds- 6, 200-9, 300-12, 400-15, 500-18
ME C4.5	The facility has adequate support / general staff	Availability of Lab assistant	2	SI/RR	In-house/Out-sourced
		Availability of housekeeping staff	2	SI/RR	
		Availability of security staff	2	SI/RR	
Standard C 5	**Facility provides drugs and consumables required for assured list of services.**				
ME C5.2	The departments have adequate consumables at point of use	Availability of stains	2	OB/RR	Iodine Solution, Gram Romanowsky ,StainZiehl-neelsen, Acridine orange, Acridine orange (?)
		Availability of reagents	2	OB/RR	Reagents for auto analyzers, ELISA Readers
		Availability of other Chemicals	2	OB/RR	Acetone, Alcohol, distilled water, Microscope gel etc.
		Availability Laboratory materials	2	OB/RR	Evacuated Blood collection tubes, Swabs, Syringes, Glass slides, Glass marker/ paper stickers
ME C5.3	Emergency drug trays are maintained at every point of care, where ever it may be needed	Emergency Drug Tray is maintained	2	OB/RR	
Standard C 6	**The facility has equipment & instruments required for assured list of services.**				
ME C 6.1	Availability of equipment & instruments for examination & monitoring of patients	Availability of functional Equipment &Instruments for examination & Monitoring	2	OB	BP apparatus, Stethoscope at sample collection area

Standard	Measurable Element	Checkpoint	Compli-ance	Audit Method	Means of Verification
ME C 6.3	Availability of equipment & instruments for diagnostic procedures being undertaken in the facility	Availability of functional auto analyzers	2	OB	Auto/ Semi Auto analyzers according to need
		Availability of functional haematology equipments	2	OB	Cell Counters/ Counting Chambers , Heamoglobinometer , ESR stands with tubes
		Availability of functional Biochemistry Equipment	2	OB	Calorie meter, Blood Gas Analyzer, Electrolyte analyzer
		Availability of functional equipments for sample processing	2	OB	Micropipettes , Centrifuge, Water Bath, Hot air oven.
		Availability of functional Microscopy equipments	2	OB	Binocular Micro scope , FNAC, staining rack
		Availability functional Histopathology equipments	2	OB	Microtome
		Availability of functional Serology Equipments	2	OB	Elisa Reader, Elisa washer
		Availability of functional Microbiology equipments	2	OB	Incubator , Inoculators, safety hood and bio safety cabinet
ME C 6.5	Availability of Equipment for Storage	Availability of equipment for storage of sample and reagents	2	OB	Refrigerators
ME C6.6	Availability of functional equipment and instruments for support services	Availability of equipments for cleaning	2	OB	Buckets for mopping, mops, duster, waste trolley, Deck brush
ME BC 6.7	Departments have patient furniture and fixtures as per load and service provision	Availability of fixtures at lab	2	OB	Illumination at work stations, Electrical fixture for lab equipments and storage equipments
		Availability of furniture	2	OB	Lab stools, Work bench's, rack and cupboard for storage of reagent ,Patient stool, Chair table
Standard C7	**Facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff**				
ME C7.1	Criteria for Competence assessment are defined for clinical and Para clinical staff	Check parameters for assessing skills and proficiency of clinical staff has been defined	2	SI/RR	Check objective checklist has been prepared for assessing competence of doctors, nurses and paramedical staff based on job description defined for each cadre of staff. Dakshta checklist issued by MoHFW can be used for this purpose.

Standard	Measurable Element	Checkpoint	Compli-ance	Audit Method	Means of Verification
ME C7.2	Competence assessment of Clinical and Para clinical staff is done on predefined criteria at least once in a year	Check for competence assessment is done at least once in a year	2	SI/RR	Check for records of competence assessment including filled checklist, scoring and grading . Verify with staff for actual competence assessment done
ME C7.9	The Staff is provided training as per defined core competencies and training plan	Training on automated Diagnostic Equipments like auto analyzer	2	SI/RR	
		Infection control & prevention training	2	SI/RR	Bio medical Waste Management including Hand Hygiene
		Training on Internal and External Quality Assurance	2	SI/RR	
		Laboratory Safety	2	SI/RR	
		Patient Safety	2	SI/RR	
		Basic Life Support	2	SI/RR	
		Training on Quality Management System	2	SI/RR	To all category of staff. At the time of induction and once in a year.
ME C7.10	There is established procedure for utilization of skills gained thought trainings by on -job supportive supervision	Staff is skilled to run automated equipments	2	SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps
		Staff is skilled for maintaining Laboratory records	2	SI/RR	Check supervisors make periodic rounds of department and monitor that staff is working according to the training imparted. Also staff is provided on job training wherever there is still gaps
AREA OF CONCERN - D SUPPORT SERVICES					
Standard D1	**The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.**				
ME D 1.1	The facility has established system for maintenance of critical Equipment	All equipments are covered under AMC including preventive maintenance	2	SI/RR	1. Check with AMC records/ Warranty documents 2. Staff is aware of the list of equipment covered under AMC.
		There is system of timely corrective break down maintenance of the equipments	2	SI/RR	1.Check for breakdown & Maintenance record in the log book 2. Staff is aware of contact details of the agency/person in case of breakdown.

Standard	Measurable Element	Checkpoint	Compli-ance	Audit Method	Means of Verification
		There has system to label Defective/Out of order equipments and stored appropriately until it has been repaired	2	OB/RR	
		Staff is skilled for trouble shooting in case equipment malfunction	2	SI/RR	
		Periodic cleaning, inspection and maintenance of the equipments is done by the operator	2	SI/RR	
ME D1.2	The facility has established procedure for internal and external calibration of measuring Equipment	All the measuring equipments/ instrument are calibrated	2	OB/ RR	
		There is system to label/ code the equipment to indicate status of calibration/ verification when recalibration is due	2	OB/ RR	
		Calibrators are available for Automated haematology analyzers	2	SI/RR	
		Laboratory has system to update correction factor after calibration wherever required	2	SI/RR	
		Each lot of reagents has to be checked against earlier tested in use reagent lot or with suitable reference material before being placed in service and result should be recorded.	2	SI/RR	
ME D1.3	Operating and maintenance instructions are available with the users of equipment	Up to date instructions for operation and maintenance of equipments are readily available with staff.	2	OB/SI	
Standard D2	**The facility has defined procedures for storage, inventory management and dispensing of drugs in pharmacy and patient care areas**				
ME D2.1	There is established procedure for forecasting and indenting drugs and consumables	There is established system of timely indenting of consumables and reagents	2	SI/RR	Stock level are daily updated Indent are timely placed

Standard	Measurable Element	Checkpoint	Compli-ance	Audit Method	Means of Verification
ME D2.3	The facility ensures proper storage of drugs and consumables	Reagents and consumables are kept away from water and sources of heat, direct sunlight	2	OB/RR	Check the storage condition of reagents,etc.
		Reagents are labelled appropriately	2	OB/RR	Reagents label contain name, concentration, date of preparation/opening, date of expiry, storage conditions and warning
ME D2.4	The facility ensures management of expiry and near expiry drugs	No expired reagent found	2	OB/RR	
		Records for expiry and near expiry reagent are maintained	2	RR	Check the record of expiry and near expiry drug in drug substore
ME D2.5	The facility has established procedure for inventory management techniques	There is practice of calculating and maintaining buffer stock of reagents	2	SI/RR	Minimum stock and reorder level are calculated based on consumption Minimum buffer stock is maintained all the time
		Department maintained stock register of reagents	2	RR/SI	Check record of drug received, issued and balance stock in hand and are regularly updated
ME D2.6	There is a procedure for periodically replenishing the drugs in patient care areas	There is established procedure for replenishing drug tray	2	SI/RR	
		There is no stock out of reagents	2	OB/SI	Check the stock of some reagents
ME D2.7	There is process for storage of vaccines and other drugs, requiring controlled temperature	Temperature of refrigerators are kept as per storage requirement and records twice a day and are maintained	2	OB/RR	Check for refrigerator/ ILR temperature charts. Charts are maintained and updated twice a day. Refrigerators meant for storing drugs should not be used for storing other items such as eatables.
		Regular Defrosting is done	2	SI/RR	
Standard D3	**The facility provides safe, secure and comfortable environment to staff, patients and visitors.**				
ME D3.1	The facility provides adequate illumination level at patient care areas	Adequate illumination at work station	2	OB	
		Adequate illumination at Collection area	2	OB	Testing areas, report writing area
ME D3.2	The facility has provision of restriction of visitors in patient areas	Entry is restricted in testing area	2	OB	
ME D3.3	The facility ensures safe and comfortable environment for patients and service providers	Temperature control and ventilation in collection area	2	SI/RR	Fans/ Air conditioning/ Heating/Exhaust/ Ventilators as per environment condition and requirement

Standard	Measurable Element	Checkpoint	Compli-ance	Audit Method	Means of Verification
		Temperature control and ventilation testing area	2	SI/RR	Fans/ Air conditioning/ Heating/Exhaust/ Ventilators as per environment condition and requirement
		In histopathology, for tissue processing separate room with fume hood is available	2	OB	
		Availability of Eye washing facility	2	OB	
ME D3.5	The facility has established measure for safety and security of female staff	Female staff feel secure at work place	2	SI	
Standard D4	**The facility has established Programme for maintenance and upkeep of the facility**				
ME D4.1	Exterior of the facility building is maintained appropriately	Building is painted/ whitewashed in uniform colour	2	OB	
		Interior of patient care areas are plastered & painted	2	OB	
ME D4.2	Patient care areas are clean and hygienic	Floors, walls, roof, roof topes, sinks patient care and circulation areas are Clean	2	OB	All area are clean with no dirt,grease,littering and cobwebs
		Surface of furniture and fixtures are clean	2	OB	
		Toilets are clean with functional flush and running water	2	OB	
ME D4.3	Hospital infrastructure is adequately maintained	Check for there is no seepage , Cracks, chipping of plaster	2	OB	
		Window panes , doors and other fixtures are intact	2	OB	
ME D4.5	The facility has policy of removal of condemned junk material	No condemned/Junk material in the lab	2	OB	
ME D4.6	The facility has established procedures for pest, rodent and animal control	No stray animal/rodent/ birds	2	OB	
Standard D5	**The facility ensures 24X7 water and power backup as per requirement of service delivery, and support services norms**				
ME D5.1	The facility has adequate arrangement storage and supply for portable water in all functional areas	Availability of 24x7 running and potable water	2	OB/SI	Water use for analytical purpose should be of reagent grade

Standard	Measurable Element	Checkpoint	Compli-ance	Audit Method	Means of Verification
ME D5.2	The facility ensures adequate power backup in all patient care areas as per load	Availability of power back up in laboratory	2	OB/SI	
Standard D10	**Facility is compliant with all statutory and regulatory requirement imposed by local, state or central government**				
ME D10.3	The facility ensure relevant processes are in compliance with statutory requirement	Any positive report of notifiable disease is intimated to designated authorities	2	RR/SI	
Standard D11	**Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.**				
ME D11.1	The facility has established job description as per govt guidelines	Job description is defined and communicated to all concerned staff	2	RR	Regular + contractual
		Staff is aware of their role and responsibilities	2	SI	
ME D11.2	The facility has a established procedure for duty roster and deputation to different departments	There is procedure to ensure that staff is available on duty as per duty roster	2	RR/SI	Check for system for recording time of reporting and relieving (Attendance register/ Biometrics etc)
		There is designated in charge for department	2	SI	
ME D11.3	The facility ensures the adherence to dress code as mandated by its administration / the health department	Doctor, technician and support staff adhere to their respective dress code	2	OB	
Standard D12	**Facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations**				
ME D12.1	There is established system for contract management for out sourced services	There is procedure to monitor the quality and adequacy of outsourced services on regular basis	2	SI/RR	Verification of outsourced services (cleaning/ Dietary/Laundry/Security/ Maintenance) provided are done by designated in-house staff
AREA OF CONCERN - E CLINICAL SERVICES					
Standard E1	**The facility has defined procedures for registration, consultation and admission of patients.**				
ME E1.1	The facility has established procedure for registration of patients	Unique laboratory identification number is given to each patient sample	2	RR	
		Patient demographic details are recorded in laboratory records	2	RR	Check for that patient demographics like Name, age, Sex, Chief complaint, etc.

Standard	Measurable Element	Checkpoint	Compli-ance	Audit Method	Means of Verification
Standard E3	**Facility has defined and established procedures for continuity of care of patient and referral**				
ME E3.2	Facility provides appropriate referral linkages to the patients/ Services for transfer to other/higher facilities to assure their continuity of care.	Laboratory has referral linkage for tests not available at the facility	2	RR/SI	
		Facility gets referred patients from lower level of facility	2	RR/SI	e.g.: linkage for disease surveillance and water testing
Standard E4	**The facility has defined and established procedures for nursing care**				
ME E4.3	There is established procedure of patient hand over, whenever staff duty change happens	Procedure to handover test/ results during shift change	2	RR/SI	
		Handover register is maintained	2	RR	
Standard E8	**Facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage**				
ME E8.5	Adequate form and formats are available at point of use	Standard Formats available	2	RR/OB	Printed formats for requisition and reporting are available
ME E8.6	Register/records are maintained as per guidelines	Lab records are labelled and indexed	2	RR	
		Records are maintained for laboratory	2	RR	Test registers, IQAS/EQAS Registers, Expenditure registers, Accession list etc.
ME E8.7	The facility ensures safe and adequate storage and retrieval of medical records	Laboratory has adequate facility for storage of records	2	OB	
Standard E11	**The facility has defined and established procedures for Emergency Services and Disaster Management**				
ME E11.3	The facility has disaster management plan in place	Staff is aware of disaster plan	2	SI/RR	
		Role and responsibilities of staff in disaster is defined	2	SI/RR	
ME E11.5	There is procedure for handling medico legal cases	Samples of medico legal cases are identified	2	SI/RR	Requisition and reports are marked with MLC and reports are handed over to authorized personnel only
Standard E12	**The facility has defined and established procedures of diagnostic services**				
ME E12.1	There are established procedures for Pre-testing Activities	Requisition of all laboratory test is done in request form	2	RR/OB	Request form contain information: Name and identification number of patient, name of authorized requester, type of primary sample, examination requested, date and time of primary sample collection and date and time of receipt of sample by laboratory,

Standard	Measurable Element	Checkpoint	Compli-ance	Audit Method	Means of Verification
		Instructions for collection and handling of primary sample are communicated to those responsible for collection	2	RR/SI	
		Laboratory has system in place to label the primary sample	2	RR/SI	
		Laboratory has system to trace the primary sample from requisition form	2	RR/SI	
		Laboratory has system to record the identity of person collecting the primary sample	2	RR/SI	
		Laboratory has system in place to monitor the transportation of the sample	2	RR/SI	Transportation of sample includes: Time frame, temperature and carrier specified for transportation
ME E12.2	There are established procedures for testing Activities	testing procedure are readily available at work station and staff is aware of them	2	OB/RR	
		Laboratory has Biological reference interval for its examination of various results	2	OB/RR	
		Laboratory has identified critical intervals for which immediate notification is done to concerned physician	2	RR/SI	
ME E12.3	There are established procedures for Post-testing Activities	Laboratory has system to review the results of examination by authorized person before release of report	2	RR/SI	
		Laboratory has format for reporting of results	2	RR/OB	
		Laboratory has system to provide the reports within defined cycle time/ or each category of patient -routine and emergency	2	RR/SI	
		Laboratory results written in reports are legible without error in transcription	2	RR/SI	
		Laboratory has defined the retention period and disposal of used sample	2	RR/SI	

Standard	Measurable Element	Checkpoint	Compli-ance	Audit Method	Means of Verification
		Laboratory has system to retain the copies of reported result and promptly retrieved when required	2	RR/SI	
NATIONAL HEALTH PROGRAMS					
Standard E23	**Facility provides National health program as per operational/Clinical Guidelines**				
ME E23.9	Facility provide service for Integrated disease surveillance program	Weekly reporting of Confirmed cases on form "L" from laboratory	2	SI/RR	(a) Submitted to District surveillance officer (b) Data is submitted manually or through IHIP (integrated health information plateform)
AREA OF CONCERN - F INFECTION CONTROL					
Standard F1	**Facility has infection control program and procedures in place for prevention and measurement of hospital associated infection**				
ME F1.2	Facility has provision for Passive and active culture surveillance of critical & high risk areas	Surface and environment samples are taken for microbiological surveillance	2	SI/RR	Swab are taken from infection prone surfaces
		Technician is trained for taking and processing surface and air sample	2	SI/RR	
ME F1.4	There is Provision of Periodic Medical Checkups and immunization of staff	There is procedure for immunization of the staff	2	SI/RR	Hepatitis B, Tetanus Toxid etc
		Periodic medical checkups of the staff	2	SI/RR	
ME F1.5	Facility has established procedures for regular monitoring of infection control practices	Regular monitoring of infection control practices	2	SI/RR	Hand washing and infection control audits done at periodic intervals
ME F1.6	Facility has defined and established antibiotic policy	Check for Doctors are aware of Hospital Antibiotic Policy	2	SI/RR	
Standard F2	**Facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis**				
ME F2.1	Hand washing facilities are provided at point of use	Availability of hand washing Facility at Point of Use	2	OB	Check for availability of wash basin near the point of use
		Availability of running Water	2	OB/SI	Ask to Open the tap. Ask Staff water supply is regular
		Availability of antiseptic soap with soap dish/ liquid antiseptic with dispenser.	2	OB/SI	Check for availability/ Ask staff if the supply is adequate and uninterrupted
		Availability of Alcohol based Hand rub	2	OB/SI	Check for availability/ Ask staff for regular supply.

Standard	Measurable Element	Checkpoint	Compli-ance	Audit Method	Means of Verification
		Display of Hand washing Instruction at Point of Use	2	OB	Prominently displayed above the hand washing facility , preferably in Local language
		Availability of elbow operated taps	2	OB	
		Hand washing sink is wide and deep enough to prevent splashing and retention of water	2	OB	
ME F2.2	Staff is trained and adhere to standard hand washing practices	Adherence to 6 steps of Hand washing	2	SI/OB	Ask of demonstration
		Staff aware of when to hand wash	2	SI	
ME F2.3	Facility ensures standard practices and materials for antisepsis	Availability of Antiseptic Solutions	2	OB	
		Proper cleaning of procedure site with antisepsis	2	OB/SI	like before giving IM/IV injection, drawing blood, putting Intravenous and urinary catheter
Standard F3	**Facility ensures standard practices and materials for Personal protection**				
ME F3.1	Facility ensures adequate personal protection equipments as per requirements	Clean gloves are available at point of use	2	OB/SI	
		Availability of lab aprons/ coats	2	OB/SI	
		Availability of Masks	2	OB/SI	
ME F3.2	Staff is adhere to standard personal protection practices	No reuse of disposable gloves and Masks.	2	OB/SI	
		Compliance to correct method of wearing and removing the PPE	2	SI	Gloves, Masks, Caps and Aprons
Standard F4	**Facility has standard Procedures for processing of equipments and instruments**				
ME F4.1	Facility ensures standard practices and materials for decontamination and clean ing of instruments and procedures areas	Decontamination of operating & Procedure surfaces	2	SI/OB	Ask staff about how they decontaminate work benches (Wiping with 0.5% Chlorine solution
		Proper Decontamination of instruments after use	2	SI/OB	Decontamination of instruments and reusable of glassware are done after procedure in 1% chlorine solution/ any other appropriate method
		Contact time for decontamination is adequate	2	SI/OB	10 minutes

Standard	Measurable Element	Checkpoint	Compli-ance	Audit Method	Means of Verification
		Cleaning of instruments after decontamination	2	SI/OB	Cleaning is done with detergent and running water after decontamination
		Staff know how to make chlorine solution	2	SI/OB	
ME F4.2	Facility ensures standard practices and materials for disinfection and sterilization of instruments and equipments	Disinfection of reusable glassware	2	SI/OB	Disinfection by hot air oven at 160 oC for 1 hour
		Autoclaving for used culture media and other infected material	2	SI/OB	
Standard F5	**Physical layout and environmental control of the patient care areas ensures infection prevention**				
ME F5.2	Facility ensures availability of standard materials for cleaning and disinfection of patient care areas	Availability of disinfectant as per requirement	2	OB/SI	Chlorine solution, Gluteraldehye, carbolic acid
		Availability of cleaning agent as per requirement	2	OB/SI	Hospital grade phenyl, disinfectant detergent solution
ME F5.3	Facility ensures standard practices followed for cleaning and disinfection of patient care areas	Staff is trained for spill management	2	SI/RR	
		Cleaning of patient care area with detergent solution	2	SI/RR	
		Staff is trained for preparing cleaning solution as per standard procedure	2	SI/RR	
		Standard practice of mopping and scrubbing are followed	2	OB/SI	Unidirectional mopping from inside out
		Cleaning equipments like broom are not used in patient care areas	2	OB/SI	Any cleaning equipment leading to dispersion of dust particles in air should be avoided
ME F5.4	Facility ensures segregation infectious patients	Precaution with infectious patients like TB	2	OB/SI	
ME F5.5	Facility ensures air quality of high risk area	Air quality in Lab	2	OB/SI	Negative Pressure for microbiology
Standard F6	**Facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.**				
ME F6.1	Facility Ensures segregation of Bio Medical Waste as per guidelines	Availability of colour coded bins at point of waste generation	2	OB	Adequate number. Covered. Foot operated.
		Availability of colour coded non chlorinated plastic bags	2	OB	

Standard	Measurable Element	Checkpoint	Compli-ance	Audit Method	Means of Verification
		Segregation of Anatomical and solied waste in Yellow Bin	2	OB/SI	Human Anatomical waste, Items contaminated with blood, body fluids,dressings, plaster casts, cotton swabs and bags containing residual or discarded blood and blood components.
		Segregation of infected plastic waste in red bin	2	OB	Items such as tubing, bottles, intravenous tubes and sets, catheters, urine bags, syringes (without needles and fixed needle syringes) and vaccutainers with their needles cut) and gloves
		Display of work instructions for segregation and handling of Biomedical waste	2	OB	Pictorial and in local language
		There is no mixing of infectious and general waste	2		
ME F6.2	Facility ensures management of sharps as per guidelines	Availability of functional needle cutters	2	OB	See if it has been used or just lying idle.
		Seggregation of sharps waste including Metals in white (translucent) Puncture proof, Leak proof, tamper proof containers	2	OB	Should be available nears the point of generation. Needles, syringes with fixed needles, needles from needle tip cutter or burner, scalpels, blades, or any other contaminated sharp object that may cause puncture and cuts. This includes both used, discarded and contaminated metal sharps
		Availability of post exposure prophylaxis	2	SI/OB	Ask if available. Where it is stored and who is in charge of that.
		Staff knows what to do in condition of needle stick injury	2	SI	Staff knows what to do in case of shape injury. Whom to report. See if any reporting has been done
		Contaminated and broken Glass are disposed in puncture proof and leak proof box/ container with Blue colour marking	2	OB	Vials, slides and other broken infected glass

Standard	Measurable Element	Checkpoint	Compli-ance	Audit Method	Means of Verification
ME F6.3	Facility ensures transportation and disposal of waste as per guidelines	Disinfection of liquid waste before disposal	2	SI/OB	
		Disposal of sputum cups as per guidelines	2	SI/OB	
		Check bins are not overfilled	2	SI	
		Transportation of bio medical waste is done in close container/trolley	2	SI/OB	
		Staff aware of mercury spill management	2	SI/RR	Look for: 1. Spill area evacuation 2. Removal of Jewellery 3. Wear PPE 4. Use of flashlight to lacate mercury beads 5. Use syringe without a needle/eyedropper and sticky tape to suck the beads 6. Collection of beads in leak-proof bag or container 7. Sprinkle sulphur or zinc powder to remove any remaining mercury 8. All the mercury spill surfaces should be decontaminated with 10% sodium thiosulfate solution 9. All the bags or containers containing items contaminated with mercury should be marked as "Hazardous Waste, Handle with Care" 10. Collected mercury waste should be handed over to the CBMWTF
AREA OF CONCERN - G QUALITY MANAGEMENT					
Standard G1	**The facility has established organizational framework for quality improvement**				
ME G1.1	The facility has a quality team in place	Quality circle has been formed in the Laboratory	2	SI/RR	Check if quality circle formed and functional with a designated nodal officer for quality
Standard G2	**Facility has established system for patient and employee satisfaction**				
ME G2.1	Patient Satisfaction surveys are conducted at periodic intervals	There is system to take feed back from clinician about quality of services	2	RR	
		Client/Patient satisfaction survey done on monthly basis	2	RR	

Standard	Measurable Element	Checkpoint	Compli-ance	Audit Method	Means of Verification
Standard G3	**Facility have established internal and external quality assurance programs wherever it is critical to quality.**				
ME G3.1	Facility has established internal quality assurance program at relevant departments	Internal Quality assurance programme is in place	2	SI/RR	
		Standards are run at defined interval	2	SI/RR	
		Control charts are prepared and outliers are identified.	2	SI/RR	
		Corrective action is taken on the identified outliers	2	SI/RR	
		Internal Quality Control for Public Health lab is in place	2	SI/RR	Routine checking of equipments, new lots of regent, smear preparation, grading etc
ME G3.2	Facility has established external assurance programs at relevant departments	Proficiency Test / EQUAS is done	2	SI/RR	For tests where Nationnal Proficiency Test program is available
		External / Internal split testing is done	2	SI/RR	For test where PT program is not available
		EQAs reporst are analysed and evaluated	2		Staff is aware of EQAS reporting system, how to evaluate, and compare
		Corrective actions are taken on abnormal values/ Outliers	2	SI/RR	
		External quality assurance program implemented as per NTEP program	2	SI/RR	Onsite evaluation done Monthly Random Blinded rechecking (RBRC) done Monthly
		External quality assurance program implemented for NVBDCP	2	SI/RR	
		External quality assurance under NACP	2	SI/RR	
ME G3.3	Facility has established system for use of check lists in different departments and services	Internal assessment is done at periodic interval	2	RR/SI	NQAS, Kayakalp, SaQushal tools are used to conduct internal assessment
		Departmental checklist are used for monitoring and quality assurance	2		Staff is designated for filling and monitoring of these checklists
		Non-compliances are enumerated and recorded	2	RR	Check the non compliances are presented & discussed during quality team meetings

Standard	Measurable Element	Checkpoint	Compli-ance	Audit Method	Means of Verification
ME G3.4	Actions are planned to address gaps observed during quality assurance process	Check action plans are prepared and implemented as per internal assessment record findings	2	RR	Randomly check the details of action, responsibility, time line and feedback mechanism
ME G3.5	Planned actions are implemented through Quality Improvement Cycles (PDCA)	Check PDCA or revalent quality method is used to take corrective and preventive action	2	SI/RR	Check actions have been taken to close the gap. It can be in form of action taken report or Quality Improvement (PDCA) project report
Standard G4	**Facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.**				
ME G4.1	Departmental standard operating procedures are available	Standard operting procedure for department has been prepared and approved	2	RR	
		Current version of SOP are available with process owner	2	OB/RR	
		Work instruction/clincal protocols are displayed	2	OB	Work instruction for Internal Quality control,
ME G4.2	Standard Operating Procedures adequately describes process and procedures	Laboratory has documented process for Collection, handling, transportation of primary sample	2	RR	Look for procedure for transportation of primary sample with specification about time frame, temperature and carrier
		Laboratory has documented process on acceptance and rejection of primary samples	2	RR	
		Laboratory has documented procedure on receipt, labeling, processing and reporting of primary sample	2	RR	
		Laboratory has documented procedure on receipt, labeling, processing and reporting of primary sample for emergency cases	2	RR	
		Laboratory has documented system for storage of examined samples	2	RR	
		Laboratory has documented system for repeat tests due to analytical failure	2	RR	

Standard	Measurable Element	Checkpoint	Compli-ance	Audit Method	Means of Verification
		Laboratory has documented validated procedure for examination of samples	2	RR	
		Laboratory has documented biological reference intervals	2	RR	
		Laboratory has documented critical reference values and procedure for immediate reporting of results	2	RR	
		Laboratory has documented procedure for release of reports including details of who may release result and to whom	2	RR	
		Laboratory has documented internal quality control system to verify the quality of results	2	RR	
		Laboratory has documented External Quality assurance program	2	RR	
		Laboratory has documented procedure for calibration of equipments	2	RR	
		Laboratory has documented procedure for validation of results of reagents ,stains , media and kits etc. wherever required	2	RR	
		Laboratory has documented system of resolution of complaints and other feedback received from stakeholders	2	RR	
		Laboratory has documented procedure for examination by referral laboratories	2	RR	
		Laboratory has documented system for storage, retaining and retrieval of laboratory records, primary sample, Examination sample and reports of results.	2	RR	

Standard	Measurable Element	Checkpoint	Compli-ance	Audit Method	Means of Verification
		Laboratory has documented system to control of its documents	2	RR	
		Laboratory has documented procedure for preventive and break down maintenance	2	RR	
		Laboratory has documented procedure for internal audits	2	RR	
		Laboratory has documented procedure for purchase of External services and supplies	2	RR	
ME G4.3	Staff is trained and aware of the standard procedures written in SOPs	Check staff is a aware of relevant part of SOPs	2	SI/RR	
Standard G 5	**Facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages**				
ME G5.1	Facility maps its critical processes	Process mapping of critical processes done	2	SI/RR	
ME G5.2	Facility identifies non value adding activities / waste / redundant activities	Non value adding activities are identified	2	SI/RR	
ME G5.3	Facility takes corrective action to improve the processes	Processes are rearranged as per requirement	2	SI/RR	
Standard G6	**The facility has defined mission, values, Quality policy & objectives & prepared a strategic plan to achieve them**				
ME G6.3	Facility has defined Quality policy, which is in congruency with the mission of facility	Check if Quality Policy has been defined and approved	2	SI/RR	Check quality policy of the facility has been defined in consultation with hospital staff and duly approved by the head of the facility . Also check Quality Policy enables achievement of mission of the facility and health department
ME G6.4	Facility has de defined quality objectives to achieve mission and quality policy	Check if SMART Quality Objectives have framed	2	SI/RR	Check short term valid quality objectivities have been framed addressing key quality issues in each department and cores services. Check if these objectives are Specific, Measurable, Attainable, Relevant and Time Bound.

Standard	Measurable Element	Checkpoint	Compli-ance	Audit Method	Means of Verification
ME G6.5	Mission, Values, Quality policy and objectives are effectively communicated to staff and users of services	Check of staff is aware of Mission , Values, Quality Policy and objectives	2	SI/RR	Interview with staff for their awareness. Check if Mission Statement, Core Values and Quality Policy is displayed prominently in local language at Key Points
ME G6.6	Facility prepares strategic plan to achieve mission, quality policy and objectives	Check if plan for implementing quality policy and objectives have prepared	2	SI/RR	Verify with records that a time bound action plan has been prepared to achieve quality policy and objectives in consultation with hospital staff . Check if the plan has been approved by the hospital management
ME G6.7	Facility periodically reviews the progress of strategic plan towards mission, policy and objectives	Check time bound action plan is being reviewed at regular time interval	2	SI/RR	Review the records that action plan on quality objectives being reviewed at least onnce in month by departmnetal incharges and during the qulaity team meeting. The progress on quality objectives have been recorded in Action Plan tracking sheet
Standard G7	**Facility seeks continually improvement by practicing Quality method and tools.**				
ME G7.1	Facility uses method for quality improvement in services	Basic quality improvement method	2	SI/OB	PDCA & 5S
		Advance quality improvement method	2	SI/OB	Six sigma, lean.
ME G7.2	Facility uses tools for quality improvement in services	7 basic tools of Quality	2	SI/RR	Minimum 2 applicable tools are used in each department
Standard G9	**Facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan**				
ME G9.6	Periodic assessment for Medication and Patient care safety risks is done as per defined criteria.	Check periodic assessment of medication and patient care safety risk is done using defined checklist periodically	2	SI/RR	Verify with the records. A comprehensive risk asesement of all clincial processes should be done using pre define critera at least once in three month.
ME G9.7	Periodic assessment for potential risk regarding safety and security of staff including violence against service providers is done as per defined criteria	SaQushal assessment toolkit is used for safety audits.	2	SI/RR	1. Check that the filled checklist and action taken report are available 2. Staff is aware of key gaps & closure status
ME G9.8	Risks identified are analyzed evaluated and rated for severity	Identified risks are analysed for severity	2	SI/RR	Action is taken to mitigate the risks

Standard	Measurable Element	Checkpoint	Compli-ance	Audit Method	Means of Verification
AREA OF CONCERN - H OUTCOME					
Standard H1	**The facility measures Productivity Indicators and ensures compliance with State/National benchmarks**				
ME H1.1	Facility measures productivity Indicators on monthly basis	No. of HIV test done per 1000 population	2	RR	
		No. of VDRL test done per 1000 population	2	RR	
		No. of Blood Smear Examined per 1000 population	2	RR	
		No. of AFB Examined per 1000 population	2	RR	
		No. of HB test done per 1000 population	2	RR	
		Lab test done per patients in 100 OPD	2	RR	
		Lab test done per patients100 IPD	2	RR	
		Percentage of lab test done at night	2	RR	
		Proportion of test done for BPL patients	2	RR	
Standard H2	**The facility measures Efficiency Indicators and ensure to reach State/National Benchmark**				
ME H2.1	Facility measures efficiency Indicators on monthly basis	No of test not matched in validation	2	RR	
		Percentage of test not matched in Split test	2		
		VIS / Z scores or equivalent	2		Biochemistry & haematology
		Down time of critical equipments	2		
		Turn around time for emergency lab investigations	2		
		Turn around time for routine lab investigations	2	RR	
		Lab test done per technician	2	**RR**	
Standard H3	**The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark**				
ME H3.1	Facility measures Clinical Care & Safety Indicators on monthly basis	% of critical values reported within one hour	2	RR	
		No of adverse events per thousand patients	2	RR	

Standard	Measurable Element	Checkpoint	Compli-ance	Audit Method	Means of Verification
		Test demography	2	RR	Proportion of Haematology, biochemistry, serology, Microbiology, cytology, clinical pathology
		Report correlation rate	2	RR	Proportion of lab report co related with clinical examination
		Proportion of false positive /false negative	2	RR	For Rapid diagnostic Kit test
Standard H4	**The facility measures Service Quality Indicators and endeavours to reach State/National benchmark**				
ME H4.1	Facility measures Service Quality Indicators on monthly basis	Waiting time at sample collection area	2	RR	
		Number of stock out incidences of reagents	2	RR	

ASSESSMENT SUMMARY

Name of the Hospital .....

Date of Assessment .....

Names of Assessors .....

Names of Assessees .....

Type of Assessment (Internal/External) .....

Action plan Submission Date .....

A. SCORE CARD

LABORATORY SERVICES SCORE CARD	
Area of Concern wise score	**Laboratory Services Score**
A. Service Provision	
B. Patient Rights	
C. Inputs	
D. Support Services	
E. Clinical Services	
F. Infection Control	
G. Quality Management	
H. Outcome	

B. MAJOR GAPS OBSERVED

1. _____
2. _____
3. _____
4. _____
5. _____

C. STRENGTHS/BEST PRACTICES

1. _____
2. _____
3. _____

D. RECOMMENDATIONS/OPPORTUNITIES FOR IMPROVEMENT

_____

_____

_____

Names and Signature of Assessors

Date _____

KEY CHANGES IN NATIONAL QUALITY ASSURANCE STANDARDS, 2020

Reference	National Quality Assurance Standards, 2018	National Quality Assurance Standards, 2020
Broad Changes	8 Area of Concerns 74 Standards 362 Measurable Elements 19 Checklists	8 Areas of Concern 75 Standards 380 Measurable Elements 21 Checklist
Standards Added	**STANDARD B6:** The facility has defined framework for ethical management including dilemmas confronted during delivery of services at public health facilities. **STANDARD C7:** The facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff. **STANDARD G9:** The facility has defined, approved and communicated Risk Management framework for existing and potential risks. **STANDARD G10:** The facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan.	**Standard E24:** The facility has established a procedure for haemodialysis services. **Standard G10 :** The facility has established clinical governance framework to improve the quality and safety of clinical care processes.
Measurable Elements Added	**UNDER STANDARD A4:** **ME A4.12:** The facility provides services as per Rashtriya Bal Swasthya Karyakram. **UNDER STANDARD B6:** **ME B6.1:** Ethical norms and code of conduct for medical and paramedical staff have been established. **ME B6.2:** The facility staff is aware of code of conduct established. **ME B6.3:** The facility has an established procedure for entertaining representatives of drug companies and suppliers. **ME B6.4:** The facility has an established procedure for medical examination and treatment of individual under judicial or police detention as per prevalent law and government directions. **ME B6.5:** There is an established procedure for sharing of hospital/patient data withindividuals and external agencies including non-governmental organization. **ME B6.6:** There is an established procedure for 'end-of-life' care. **ME B6.7:** There is an established procedure for patients who wish to leave hospital against medical advice or refuse to receive specific treatment. **ME B6.8:** There is an established procedure for obtaining informed consent from the patients in case facility is participating in any clinical or public health research. **ME B6.9:** There is an established procedure to issue medical certificates and other certificates.	**Under Standard A1:** **ME A1.19** : The facility provides Dialysis Services. **Under Standard A4:** **ME A4.13:** The facility provides services as per Pradhan Mantri National Dialysis Programme **ME A4.14:** The facility provides services as per National Viral Hepatitis Program **ME A4.15:** The facility provides services as per National Program for palliative care. **Under Standard D5:** **ME D5.4:** The facility has adequate arrangements for an uninterrupted supply of RO water for the dialysis unit. **Under Standard E23:** **ME E23.11:** The facility provides services under the National Viral Hepatitis Control Programme **ME 23.12:** The facility provides services under the National Program for palliative care. **Under Standard E24:** The facility has defined and established a procedure for Pre-Haemodialysis assessment.

Reference	National Quality Assurance Standards, 2018	National Quality Assurance Standards, 2020
	ME B6.10: There is an established procedure to ensure medical services during strikes or any other mass protest leading to dysfunctional medical services. **ME B6.11:** An updated copy of code of ethics under Indian Medical Council Act is available with the facility. **UNDER STANDARD C7:** **ME C7.1:** Criteria for competence assessment are defined for Clinical and Para clinical staff. **ME C7.2:** Competence assessment of Clinical and Para clinical staff is done on predefined criteria at least once in a year. **ME C7.3:** Criteria for performance evaluation of Clinical and Para clinical staff are defined. **ME C7.4:** Performance evaluation of Clinical and Para clinical staff is done on predefined criteria at least once in a year. **ME C7.5:** Criteria for performance evaluation of support and administrative staff are defined. **ME C7.6:** Performance evaluation of support and administration staff is done on predefined criteria at least once in a year. **ME C7.7:** Competence assessment and performance assessment includes contractual, empanelled, and outsourced staff. **ME C7.8**: Training needs are identified based on competence assessment and performance evaluation and facility prepares the training plan. **ME C7.9:** The staff is provided training as per defined core competencies and training plan. **ME C7.10:** There is established procedure for utilization of skills gained through trainings by on-job supportive supervision. **ME C7.11:** Feedback is provided to the staff on their competence assessment and performance evaluation. **UNDER STANDARD E18:** **ME E18.1:** The facility staff adheres to standard procedures for management of second stage of labor. **ME E18.2:** The facility staff adheres to standard procedure for active management of third stage of labor. **ME E18.3:** The facility staff adheres to standard procedures for routine care of newborn immediately after birth. **ME E18.5:** The facility staff adheres to standard protocols for identification and management of Pre Eclampsia/Ecalmpsia	The facility has defined and established procedure for care during haemodialysis. The facility has defined and established procedures for care after the completion of haemodialysis

Reference	National Quality Assurance Standards, 2018	National Quality Assurance Standards, 2020
	ME E18.6: The facility staff adheres to standard protocols for identification and management of PPH **ME E18.7:** The facility staff adheres to standard protocols for Management of HIV in pregnant woman & newborn **ME E18.8:** The facility staff adheres to standard protocol for identification and management of preterm delivery. **ME E18.9:** Staff identifies and manages infection in pregnant woman. **ME E18.11:** The facility ensures physical and emotional support to the pregnant women by means of birth companion of her choice. **UNDER STANDARD E19:** **ME E19.3:** The facility staff adheres to protocol for ensuring care of newborns with small size at birth. **UNDER STANDARD E20:** **ME E20.5:** Management of neonatal sepsis is done as per guidelines. **ME E20.6:** Management of children with Severe Acute Malnutrition is done as per guidelines. **ME E20.10:** The facility ensures optimal breast feeding practices for new born & infants, as per guidelines. **UNDER STANDARD G9:** **ME G9.1:** Risk Management framework has been defined including context, scope, objectives and criteria. **ME G9.2:** Risk Management framework defines the responsibilities for identifying and managing risk at each level of functions. **ME G9.3:** Risk Management Framework includes process of reporting incidents and potential risk to all stakeholders. **ME G9.4:** A comprehensive list of current and potential risk including potential strategic, regulatory, operational, financial, environmental risks has been prepared. **ME G9.5:** Modality for staff training on risk management is defined. **ME G9.6:** Risk Management Framework is reviewed periodically. **UNDER STANDARD G10:** **ME G10.1:** Risk management plan has been prepared and approved by the designated authority and there is a system of its updation at least once in a year. **ME G10.2:** Risk Management Plan has been effectively communicated to all the staff, and as well as relevant external stakeholders. **ME G10.3:** Risk assessment criteria and checklist for assessment have been defined and communicated to relevant stakeholders. **ME G10.4:** Periodic assessment for physical and electrical risks is done as per defined criteria.	

Reference	National Quality Assurance Standards, 2018	National Quality Assurance Standards, 2020
	ME G10.5: Periodic assessment for potential disasters including fire is done as per defined criteria. **ME G10.6:** Periodic assessment for medication and patient care safety risks is done, as per defined criteria. **ME G10.7:** Periodic assessment for potential risk regarding safety and security of staff including violence against service providers is done as per defined criteria. **ME G10.8:** Risks identified are analyzed, evaluated and rated for severity. **ME G10.9:** Identified risks are treated based on severity and resources available. **ME G10.10:** A risk register is maintained and updated regularly to identify risks, their severity and action to be taken. **UNDER STANDARD E19:** **ME E19.3:** The facility staff adheres to protocol for ensuring care of newborns with small size at birth. **UNDER STANDARD E20:** **ME E20.5:** Management of neonatal sepsis is done as per guidelines. **ME E20.6:** Management of children with Severe Acute Malnutrition is done as per guidelines. **ME E20.10:** The facility ensures optimal breast feeding practices for new born & infants, as per guidelines. **UNDER STANDARD G9:** **ME G9.1:** Risk Management framework has been defined including context, scope, objectives and criteria. **ME G9.2:** Risk Management framework defines the responsibilities for identifying and managing risk at each level of functions. **ME G9.3:** Risk Management Framework includes process of reporting incidents and potential risk to all stakeholders. **ME G9.4:** A comprehensive list of current and potential risk including potential strategic, regulatory, operational, financial, environmental risks has been prepared. **ME G9.5:** Modality for staff training on risk management is defined. **ME G9.6:** Risk Management Framework is reviewed periodically. **UNDER STANDARD G10:** **ME G10.1:** Risk management plan has been prepared and approved by the designated authority and there is a system of its updation at least once in a year. **ME G10.2:** Risk Management Plan has been effectively communicated to all the staff, and as well as relevant external stakeholders.	

Reference	National Quality Assurance Standards, 2018	National Quality Assurance Standards, 2020
	ME G10.3: Risk assessment criteria and checklist for assessment have been defined and communicated to relevant stakeholders. **ME G10.4:** Periodic assessment for physical and electrical risks is done as per defined criteria. **ME G10.5:** Periodic assessment for potential disasters including fire is done as per defined criteria. **ME G10.6:** Periodic assessment for medication and patient care safety risks is done, as per defined criteria. **ME G10.7:** Periodic assessment for potential risk regarding safety and security of staff including violence against service providers is done as per defined criteria. **ME G10.8:** Risks identified are analyzed, evaluated and rated for severity. **ME G10.9:** Identified risks are treated based on severity and resources available. **ME G10.10:** A risk register is maintained and updated regularly to identify risks, their severity and action to be taken.	
Measurable Elements Deleted/ Shifted	Shifted under ME C7.9 Shifted under ME C7.8, C7.9, C7.10 & C7.11 Shifted under ME B6.7 Shifted under ME B6.6 Shifted under ME E18.1, E18.2 & E18.3 Shifted under ME E18.5, E18.6 & E18.7	**ME G6.1:** The facility conducts periodic internal assessment – Shifted as a checkpoint in ME G3.3 **ME G6.2** The facility conducts the periodic prescription/medical/death audits". – Shifted as ME G10.4 **ME G6.3:** The facility ensures non compliances are enumerated and recorded adequately" – Shifted as a checkpoint in ME G10.4 **ME G6.4:** Action plan is made on the gaps found in the assessment/audit process" – Shifted as ME G3.4 **ME G6.5:** Planned action are implemented through Quality Improvement Cycle (PDCA)". – Shifted as ME G3.5
Standards Rephrased	**ME E18.10:** There is an established protocol for newborn resuscitation and it is followed at the facility. **ME E19.1:** The facility staff adheres to protocol for assessments of condition of mother and baby and provide adequate postpartum care. **ME E19.2:** The facility staff adheres to protocol for counselling on danger signs, post-partum family planning and exclusive breast feeding. **ME E20.4:** Management of neonatal asphyxia is done as per guidelines **ME G6.5:** Planned actions are implemented through Quality improvement cycle (PDCA). **ME G7.1:** The facility has defined mission statement. **ME G7.2:** The facility has defined core values of the organization.	**Standard E2 :** The facility has defined and established procedure for clinical assessment, reassessment and treatment plan preparation". **Standard E6 :** The facility ensures rationale prescribing and use of medicines". **Standard E16:** The facility has defined and established procedures for the management of death & bodies of deceased patients

Reference	National Quality Assurance Standards, 2018	National Quality Assurance Standards, 2020
	ME G7.3: The facility has defined Quality policy, which is in congruency with the mission of facility. **ME G7.4:** The facility has defined Quality objectives to achieve mission and Quality policy. **ME G7.5:** Mission, Values, Quality policy and objectives are effectively communicated to staff and users of services. **ME G7.6:** The facility prepares strategic plan to achieve mission, Quality policy and objectives. **ME G7.7:** The facility periodically reviews the progress of strategic plan towards mission, policy and objectives. **ME H1.2:** The facility endeavours to improve its Productivity Indicators to meet benchmarks. **ME H2.2:** The facility endeavours to improve its Efficiency Indicators to meet benchmarks. **ME H3.2:** The facility endeavours to improve its Clinical & Safety Indicators to meet benchmarks. **ME H4.2:** The facility endeavours to improve its Service Quality Indicators to meet benchmarks.	
Standard Deleted		**Standard G6:** The facility has established system for periodic review as internal assessment, medical & death audit and prescription audit.
		Apart from above changes National Health Programmes are updated as per latest guidelines.

LIST OF ABBREVIATIONS

5S	Sort, Set In Order, Shine, Standardize, Sustain
A& E	Accident & Emergency
ABC	Airway, Breathing and Circulation
ABPMJAY	Ayushman Bharat Pradhan Mantri Jan Arogya Yojana
ACD	Anti Convulsant Drug
AEFI	Adverse Events Following Immunization
AERB	Atomic Energy Regulatory Board
AES	Acute Encephalitis Syndrome
AFHC	Adolescent Friendly Health Centre
AIDS	Acquired Immuno Deficiency Syndrome
ALS	Advanced Life Support
AMC	Annual Maintenance Contract
AMSTL	Active Management of the Third Stage of Labour
ANC	Anti Natal Check-up
ANM	Auxiliary Nurse Midwife
APH	Ante Partum Haemorrhage
APL	Above Poverty Line
ARF	Acute Renal Failure
ARI	Acute Respiratory Infection
ART	Anti Retroviral Therapy
ARV	Anti Rabies Vaccine
ASHA	Accredited Social Health Activist
ASV	Anti Snake Venom
ATD	Anti Tubercular Medicines
AYUSH	Ayurveda, Yoga, Unani, Sidhha & Homoeopathy
BCC	Behavioural Change Communication
BCG	Bacillus Calmette-Guerin
BHT	Bed Head Ticket
BLS	Basic Life Support
BMEMP	Biomedical Equipment Management & Maintenance Program
BMW	Biomedical Waste
BP	Blood Pressure
BPL	Below Poverty Line
BT	Bleeding Time
BUN	Blood Urea Nitrogen
CBC	Complete Blood Count
CBMWTF	Common Bio medical Waste Treatment Facility
CCU	Cardiac Care Unit
CDR	Child Death Review
CHC	Community Health Centre
CHW	Community Healthcare Worker
CLMC	Comprehensive Lactation Management Centre
CLW	Contused Lacerated Wound
CME	Continuous Medical Education
COPD	Chronic Obstructive Pulmonary Disorder

CPC	Clinical Pathological Case
CPR	Cardiopulmonary Resuscitation
CRT	Cardiac Resynchronization Therapy
CSSD	Centralized Sterile Supply Department
CT	Clotting Time
CVA	Cerebral Vascular Accident
CVS	Cardio-Vascular System
D&C SET	Dilatation & Curettage Set
D&E	Dilation & Evacuation
DEIC	District Early Intervention Centre
DGO	Diploma in Obstetrics & Gynaecology
DLC	Differential Leukocyte Count
DMC	Designated Microscopy Centre
DNI	Do Not Intubate
DNR	Do Not Resuscitate
DOTS	Directly Observed Treatment (Short Course)
DPT	Diphtheria, Pertussis and Tetanus
DQAC	District C}uality Assurance Committee
DRTB	Drug Resistance Tuberculosis
DT	Diphtheria & Tetnus
DVDMS	Drugs and Vaccine Distribution Management System
ECG	Electrocardiography
ECP	Emergency Contraceptive Pills
EDD	Expected Date of Delivery
EDL	Essential Drug List
ELISA	Enzyme-Linked Immunosorbent Assay
EML	Essential Medicine List
ENT	Ear Nose Throat
ETAT	Emergency Triage Assessment and Treatment
ET TUBE	Endotracheal Tube
EVA Tray	Electric Vacuum Aspiration
FBNC	Facility Based Newborn Care
FHR	Foetal Heart Rate
FIFO	First In First Out
FIMNCI	Facility Based Integrated Management of Neonatal and Childhood Illnesses
FMP	Falciparum Malaria Parasite
FP	Family Planning
FSN	Fast Moving, Slow Moving , Non Moving
FT4	Free Thyroxine
GOB	General Order Book
GoI	Government of India
HAI	Hospital Acquired Infection
HB	Haemoglobin
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HDU	High Dependency Unit
HIE	Hypoxic- Ischaemic Encephalophaty
HLD	High-Level Disinfection
HWC	Health & Wellness Centre
I&D	Incision & Drainage
ICU	Intensive Care Unit
IDSP	Integrated Disease Surveillance Program

IDSP	Integrated Disease Surveillance Project
IEC	Information Education Communication
IFA	Iron Folic Acid
IHD	Ischaemic Heart Disease
IM/IV	Intra Muscular/Intra Venous
IMNCI	Integrated Management of Newborn Childhood Illnesses
IMS	Infant Medical Substitute
IO Chart	Input-output Chart
IOL	Intra Ocular Lens
IPD	In Patient Department
IQAS/EQAS	Internal Quality Assessment Services/External Quality Assessment Services
IUCD	Intra Uterine Contraceptive Device
IUGR	Intra Uterine Growth Retardation
IYCF	Infant and Yong Child Feeding
JSSK	Janani —Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojana
JVP	Jugular Venous Pressure
KFT	Kidney Function Test
KMC	Kangaroo Mother Care
LAMA	Leave Against Medical Advice
LDR	Labour-Delivery-Recovery
LFT	Liver Function Test
LMA	Laryngeal Mask Airway
LMP	Last Menstrual Period
LSCS	Lower Segment Caesarean section
LVF	Left Ventricular Failure
MAS	Meconium Aspiration Syndrome
MCP	Mother Child Protection Card
MDR-TB	Multi-Drug Resistance Tuberculosis
ME	Measureable Element
MGPS	Medical Gas Pipeline System
MI	Myocardial Infarction
MLC	Medico Legal Case
MMR	Miniature Mass Radiography
MNCU	Mother Newborn Care Unit
MNT	Medical Nutrition Therapy
MO	Medical Officer
MRD	Medical Record Department
MRO	Medical Record Officer
MRSA	Methicillin-resistant Staphylococcus aureus
MSBOS	Maximum Surgical Blood Order Schedule
MTP	Medical Termination of Pregnancy
MUAC	Mid-Upper Arm Circumference
MVA	Manual Vaccum Aspiration
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NBCC	New Born Care Corner
NCO	Non Communicable Diseases
NHP	National Health Programme
NHSRC	National Health Systems Resource Centre

NICU	Newborn Intensive Care Unit
NOTTO	National Organ & Tissue Transplant Organization
NRC	Nutritional Rehabilitation centre
NRHM	National Rural Health Mission
NSSK	Navjat Shishu Surkasha Karyakram
NSV	No-ScalpelVasectomy
NTEP	National TB Elimination Programme
NVBDCP	National Vector Borne Disease Control Programme
NVHCP	National Viral Hepatitis Control Program
OB	Observation
OBG	Obstetrics and Gynaecology
OCP	Oral Contraceptive Pills
OGTT	Oral Glucose Tolerance Test
OPD	Out Patient Department
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
OT	Operation Theatre
PAC	Pre Anaesthesia Check-up
PASS	Pull, Aim, Squeeze & Sweep
PCPNDT	Pre-Conception and Pre-Natal Diagnostic Techniques
PDCA	Plan Do Check Act
PEM	Protein Energy Malnutrition
PEP	Post-Exposure Prophylaxis
PHC	Primary Health Centre
PI	Patient Interview
PIB	Police Information Book
PICU	Paediatric Intensive Care Unit
PIH	Pregnancy Induced Hypertension
PLHA	People Living with HIV/AIDS
PMJAY	Pradhan Mantri Jab Arogya Yojana
PMSMA	Pradhan Mantri Surakshit Matritva Abhiyan
PPBS	Post Prandial Blood Sugar Test
PPE	Personal Protective Equipment
PPH	Postpartum Haemorrhage
PPIUCD	Postpartum Intra Uterine Contraceptive Device
PPROM	Preterm Premature Rupture of Membranes
PPTCT	Prevention of Parent to Child Transmission
PRC	Packed Red Cells
PV SET	Per Vaginal Set
PVC	Polyvinyl chloride
QA	Quality Assurance
RA Factor	Rheumatoid Arthristis Factor
RACE	Rescue, Alarm, Confine & Extinguish
RBRC	Random Blinded Re Checking
RCS	Re Constructive Surgery
RDK	Rapid Diagnostic Kit
RDS	Respiratory Distress Syndrome
RFT	Renal Function Tests
RKS	Rogi Kalyan Samiti
RKSK	Rashtriya Kishor Swasthya Karyakram

RMNCH	Reproductive, Maternal, Newborn and Child Health
RMNCHA	Reproductive Maternal Neonatal Child Health and Adolescent
RR	Respiratory Rate/ Record Review
RSBY	Rashtriya Swasthya Bima Yojana
RSO	Radiological Safety Officer
RTA	Road Traffic Accident
RTI/STI	Reproductive Tract Infections / Sexually Transmitted Infections
SAM	Severe Acute Malnutrition
SBA	Skilled Birth Attendant
SGA	Small for Gestational Age
SI	Staff Interview
SMART	Specific, Measurable, Attainable Relevant, Time Based
SNCU	Sick Newborn Care Unit
SOP	Standard Operating Procedure
SQAC	State Quality Assurance Committee
STG	Standard Treatment Guideline
SWD	Short Wave Diathermy
TB	Tuberculosis
TLC	Total Leukocyte Count
TLD	Thermoluminescent Dosimeter
TMT	Tread Mill Test
TPHA	Treponema pallidum Hemaglutination Assay
TPR	Temperature, Pulse, Respiration
TSB	Total Serum Bilirubin
TSH	Thyroid stimulating Hormone
TSSU	Theatre Sterile Supply Unit
TT	Tetanus Toxoid
TTI	Transfusion Transmitted Infection
TTNB	Transient tachypnoea of new-born
UID	Unique Identification
UPS	Uninterrupted Power Supply
USG	Ultra Sonography
VAP	Ventilator Associated Pneumonia
VD	Venereal Diseases
VDRL	Venereal Disease Research Laboratory
VED	Vital, Essential and Desirable
V-PEP (PAP)	Variable Positive Air Pressure
VVM	Vaccine Vial Monitor
WHO	World Health Organization

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118. Bio Medical Waste (Management & Handling) 1998

119. Medical Termination of Pregnancy Act 1971

120. Pre Conception & Pre Natal-Diagnostic Test Act 1996

121. Person with Disability act 1995

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1	Abortion	ME E21.4, ME E21.5 and ME E21.6
2	Action Plan	ME G6.4 & ME G6.5
3	Admission	ME E1.2
4	Adolescent health	Standard E22
5	Affordability	Standard B5
6	Ambulances	E11.4
7	Amenities	ME C1.2
8	Anaesthetic Services	Standard 1.6
9	Animals	ME D4.6
10	Antenatal Care	Standard E17
11	Antibiotic Policy	ME F1.5
12	Assessment	Standard E2
13	Behaviour	ME B3.3 for Behaviour of staff towards patients
14	Below Poverty Lime	ME B5.3
15	Bio Medical Waste Management	Standard F6
16	Blood Bank Standard	Standard E13
17	Both Companion of Choice	ME E18.11
18	C- Section ME	E18.2
19	Calibration ME	D1.2
20	Central Oxygen and Vaccum Supply	ME 5.3
21	Citizen Charter	ME B1.3
22	Cleanliness	ME D4.2
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25	Cold Chain	ME D2.7
26	Communication	ME C1.5
27	Community Participation	Standard A6 for Service Provision Standard D8 for processes
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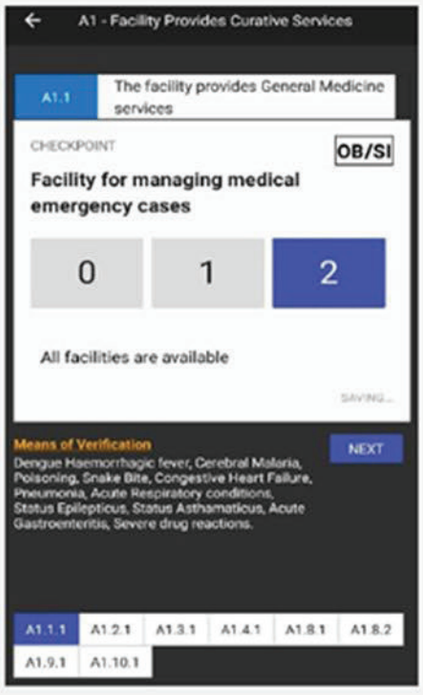
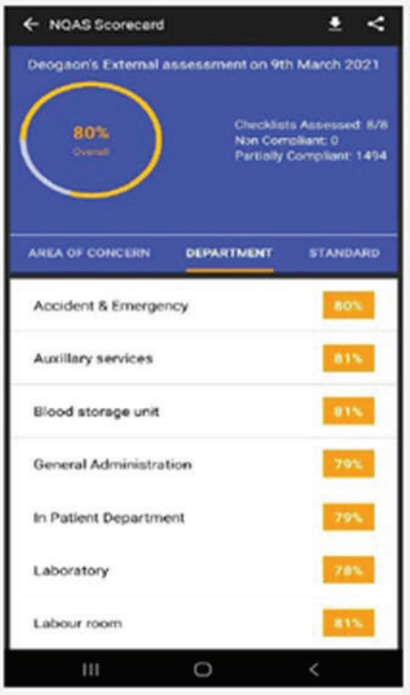
APP FOR QUALITY & KAYAKALP ASSESSMENT

Gunak – Guide for NQAS and Kayakalp





- Digital version of NQAS (National Quality Assurance Standards), Kayakalp, LaQshya and MusQan assessments.
- Availability of State/UTs wise customized checklists.
- User-friendly assessment interface with single-hand navigation.
- Automated scorecard generation that can be shared as an excel sheet or image file.
- Real-time reporting of scores to State/UTs & District Quality Assurance teams.

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