PES Institute of Medical Sciences & Research
Kuppam- 517 425, Chittoor Dist., Andhra Pradesh
Tel: 08570 - 277999, 277799, 277666
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NAAC Criterion 8: Part B - Medical

8.1 Medical Indicator

8.1.6: Students are exposed to the organization and operational features of the Immunization Clinic functioning in the hospital as per WHO guidelines for childhood immunization

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Quality maintenance records in compliance with WHO guidelines during the preceding academic year

World Health Organization
India

To

The Principal,
PES Institute of Medical Sciences,
Kuppam,
Chittoor.

Date: 07/09/2023

Respected Sir,

Sub – Deployment of 2nd Year Postgraduates, from Department of Community Medicine for Monitoring IMI 5.0 activity in Chittoor district– SEP – 2023 – reg.

*****

The nationwide implementation of Intensified Mission Indradhanush (IMI) 5.0 aims to enhance immunization coverage for all vaccines specified in the National Immunization schedule, including **Measles and Rubella vaccines for children up to 5 years of age with an objective to eliminate Measles and Rubella by the year 2023**. IMI 5.0 will be conducted in three rounds (Aug, Sep, Oct) with 2nd round scheduled from 11 to 16 September 2023 .

Hence, I request to kindly deploy below mentioned 2nd Year Postgraduates from the Community Medicine Department from your esteemed institution as external monitors for monitoring IMI 5.0 vaccination activities in Chittoor district, Andhra Pradesh.

Details of PGs are as below:

1. **DR. MAHESH**
2. **DR. VIGNESH**

Thanking you,

Yours sincerely,

Dr Bhavani Gunta
SMO – SPS Nellore (I/c)

Copy to:

1. The HOD Department of Community Medicine, PES Institute of Medical Sciences, Kuppam, Chittoor

National Polio Surveillance Project – India (WHO), O/o- The District Coordinator Hospital Services,
1st floor of old Jubilee Hospital, Near Vegetable Market, Madras Bus stand, Nellore – 524 001
| Tel:91-861-2323639 | Fax:91-861-2326790 | Mob:91-9849171714.
E-mail: guntab@who.int

NABH ACCREDITED

NABL ACCREDITED

PES

Institute of Medical Sciences & Research

DOCTORS & NURSES HANDBOOK

VERSION 3

(Date of Release 1st January 2022)

Perseverance Excellence Service

PESIMSR

NABH HANDBOOK FOR DOCTORS AND NURSES

Version-1

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What is Quality Council of India (QCI):

- QCI is an autonomous body set up by Govt. of India to establish and operate accreditation structure in the country

Vision Of QCI:

- To be among the world's leading national apex quality facilitation, accreditation and surveillance organizations
- To continuously improve the climate, systems, processes and skills for total quality

Mission Of QCI:

- To Help India Achieve And Sustain Quality And Reliability In All Areas Of Life
  - Work, Environment, Products And Services
  - At Individual, Organizational, Community And Societal Levels

What is NABH?

National Accreditation Board for Hospitals & Healthcare Providers (NABH)

- Set up in association with Govt. of India and the Indian Health Industry.
- Catering to the needs of the consumers and setting standards for progress of the health industry.
- Supported by all stakeholders and having full functional autonomy in its operations.

Vision Of NABH :

- To Be Apex National Healthcare Accreditation and Quality Improvement Body, Functioning At Par With Global Benchmarks.
- To Operate Accreditation And Allied Programs In Collaboration With Stakeholders Focusing On Patient Safety And Quality Of Healthcare Based Upon National / International Standards, Through Process Of Self And External Evaluation

Scope of NABH /Objectives:

- Accreditation Of Healthcare Facilities
- Quality Promotion:
  - Initiatives Like Safe-I, Nursing Excellence, Laboratory Certification Programs (Not Limited To These)
- Education And Training For Quality & Patient Safety
  - Public Lecture, Advertisement, Workshops/ Seminars
- Recognition:
  - Endorsement Of Various Healthcare Quality Courses / Workshops

What is the period of validity for NABH? :

The accreditation is valid for three years.

How do we get NABH renewed?

A surveillance assessment shall be conducted before 18 months

The reassessment shall be conducted before 36 months

A surprise assessment can happen at any time during accreditation

WHAT IS ACCREDITATION?

"A system of external peer review for determining compliance with a set of standards."—WHO 2003.

ACCREDITATION BENEFITS:

Benefits to the Patients:

- Patients are the biggest beneficiary among all the stakeholders.
- Accreditation results in high quality of care and patient safety.
- The patients are serviced by credentialled medical staff.
- Rights of patients are respected and protected.
- Patient's satisfaction is regularly evaluated.

BENEFITS FOR HOSPITAL:

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

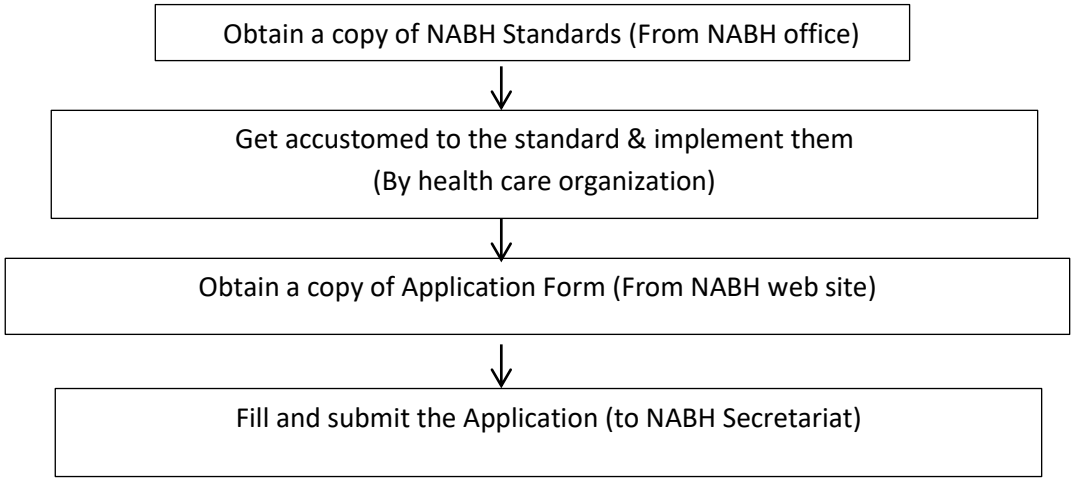
BENEFITS FOR STAFF:

- The staff in an accredited hospital experiences greater job satisfaction as the accreditation process provides for continuous learning, good working environment, leadership and above all ownership of clinical processes.
- It improves overall professional development of Clinicians and Para Medical Staff and provides leadership for quality improvement with medicine and nursing.

BENEFITS TO PAYING AND REGULATORY BODIES

- Finally, accreditation provides an objective system of empanelment by insurance and other third parties.
- Accreditation provides access to reliable and certified information on facilities, infrastructure and level of care.

PREPARING FOR NABH ACCREDITATION



ACCREDITATION PROCEDURE:

- **Opening meeting**
- **Facility review**
- **Department visits: Discussion with HODs, nurses, PGs, review of documents**

OUTLINE OF NABH STANDARDS:

Patient Centered Standards
• Access, Assessment and Continuity of Care (AAC) • Care of Patient (COP) • Management of Medication (MOM) • Patient Right and Education (PRE) • Hospital Infection Control (HIC)
Organisation Centered Standards
• Patient Safety and Quality (PSQ) • Responsibility of Management (ROM) • Facility Management and Safety (FMS) • Human Resource Management (HRM) • Information Management System (IMS)

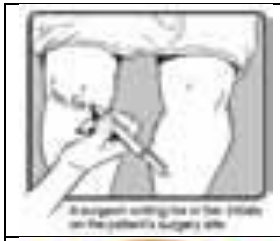
NABH addresses the following very intensively:

- International Patient Safety Goals
- Patient & Family Education
- Patient & Family Rights & Responsibilities
- Pain Management
- Quality Indicators & Monitoring
- Hand Wash & Prevention and Control of Infection
- Fire Safety and Emergency Codes
- Removal of Barriers to Care
- Patient Identifiers
- Care of High Risk Patients (Vulnerable patients)
- Restraint Order

- Rights of Drug administration
- Discharge Planning & Components of Discharge Summary
- WHO Safe Surgery Checklist
- Biomedical Waste Disposal
- Personal Protective Equipments (PPE)
- Hazardous materials management (HAZMAT), Lab, Radiation, Facility Safety
- End of Life Care
- Hospital Mandatory Trainings

INTERNATIONAL PATIENT SAFETY GOAL (IPSG):

	**Identify Patients Correctly** Use two identifiers; Name and UHID for both IPDand OPD. For unknown/ comatose patient broughtin ER, identify as unknown 1 or 2 and UHID
 	**Improve Effective Communication** **(i)** Use read back and verify policy for verbal orderand laboratory test result obtained on the phoneand the process (for handover communication) **(ii)** Comply to handover communication policy(doctors and nurses)
	**Improve the Safety of High-alert medications** Eg..lnj. Potassium Chloride, lnj. Sodium Chloridemore than 0.9%, Inj. Magnesium sulphate equal to ormore than 50% are not to be stored in patient ward butstored only in the IP Pharmacy. Look alike and sound alike medications are stored with proper labelling with red stickers as indication of LASA drugs Prescriptions containing LASA drugs should be written in Tallman letters.

	Ensure Correct Site, Correct-Procedure, CorrectPatient Surgery Follow pre-surgical site markingwith a downwards arrow, pre-operative checklist and WHO safe surgery checklist in OT and Bedside procedures.
	**Reduce the Risk of Health Care Associated infections** Follow the WHO hand hygiene guidelines.
	**Reduce the Risk of Patient Harm Resulting from falls.** ”Safety First Program”

PATIENT IDENTIFIERS

Use at least two patient identifiers (not the patient’s room number) whenever

1) Taking blood samples
2) Administering medications
3) or blood products.

For In-patients: UHID and Name of the patient

Forout-patients :UHIDand Name of patient

For comatose patient in ER: Unknown1/2/3 and UHID

PATIENT's CHARTER

PATIENT RIGHTS	PATIENT'S RESPONSIBILITY	DOCTOR'S CODE OF PRACTICE
1. Care: • Patients have a right to receive treatment irrespective of their type of primary and associated illnesses, socio-economic status, age, gender, sexual orientation, religion, caste, cultural preferences, linguistic and geographical origins or political affiliations, • Right to be heard to his/her satisfaction without the doctor interrupting before completion of narrating their entire problem and concerns. • Expectation from the doctor to write the prescription legibly and explain to the patient on the details on dosage, dos & don'ts & generic options for the medicines. • They have to be provided with information and access on whom tocontact in case of an emergency.	**1. Honesty in Disclosure:** • Will be honest with my doctor & disclose my family/ medical history.	**1. Transparency and Honesty:** • I will provide a printed schedule of my fee for office visits, procedures, testing and surgery, and provide itemized bills. • I will inform you of my qualifications to perform the proposed diagnostic measures or treatments.
2. Confidentiality and Dignity: • Right to personal dignity and to receive care without any form of stigma and discrimination. • Privacy during examination and treatment • Protection from physical abuse and neglect • Accommodating and respecting their special needs such as spiritual and cultural preferences. • Right to confidentiality about their medical condition.	**2. Treatment Compliance:** • Will be punctual for my appointments • Will do my best to comply with my doctor's treatment plan • Will have realistic expectations from my doctor and his treatment • Inform and bring to the doctor's notice if it has been difficult to understand any part of the treatment or of the existences of challenges in complying with the treatment. • Will display intent to participate intelligently in my medical care by actively involving myself in the prescribed do-at-home activities.	**2. Patient Friendly:** • I will schedule appointments in such a manner that it will allow me the necessary time to interact and examine you with minimal waiting times &listen to your problems and concerns without in terruptions or distractions. • I will encourage you to bring a friend or relative into the examining room with you.

3. Information: • The information to be provided to patients are meant to be& in a language of the patient's preference and in a manner that is effortless to understand. • Patients and/ or their family members have the right to receive complete information on the medical problem, prescription, treatment& procedure details. • A documented procedure for obtaining patient's and / or their family's informed consent exists to enable them to make an informed decision about their care. This process is **an important** patient right and needs to be practiced with utmost diligence and transparency. • Patients have to be educated on risks, benefits, expected treatment out comes and possible complications to enable them to make informed decisions, and involve them in the care planning and delivery process. • Patients have the right to request information on the names, dosages and adverse effects of the medication that they are treated with. • Patients or their authorized individuals have the right to request access and receive a copy of their clinical records. • Patients have the right to complete information on the expected cost of treatment. The information should be presented as an itemized structure of the various expenses and charges. • Patients have the right to information on hospital rules and regulations. • Information on organ donation.	**3. Intent for Health Promotion** • I will do everything in my capacity to maintain healthy habits & routines that contribute to good health, and take responsibility for my health.	**3. Effective Communication for Patient Education** • I will explain your prognosis, further diagnostic cactivity and treatment in simple terms such that it facilitates easy understanding to you. • I will prescribe and inform about therapy, and discuss your diagnostic, treatment and medication options, to enable you to make well-informed decisions. • I will not proceed until you are satisfied and convinced that you understand the benefits and risks of each alternative, and I have your agreement on a particular course of action.

4. Preferences: • Patient has the right to a seek a second opinion on his/her medical condition. • Right to information from the doctor to provide the patient with treatment options, so that the patient can select what works best for him/her.	**4. Transparency and Honesty** • I will make a sincere effort to understand my therapies which include the medicines prescribed and their associated adverseeffects and other compliances for effective treatment outcomes. • I will not ask for surreptitious bills and false certificates, and/or advocate forcefully byunlawful means to provide me with one. • If I am not happy, I will inform and discuss with my doctor. • I will report fraud and wrong-doing	**4. Implement the patient charter** • I will implement the patient charter in its true spirit in my everyday medical practice
5. **Right to redress:** • Patient has the right to justice by lodging a complaint through an authority dedicated for this purpose by the healthcare provider organisation or with government health authorities. • The patient has the right to a fair and prompt hearing of his/her concern. • The patient in addition has the right to appeal to a higher authority inthe healthcare provider organisation and insist in writing on the out come of the complaint.	**5. Conduct:** • I will be respect the doctors and medical staff who treat and care for me • I will abide by the hospital / facility rules • I will bear the agreed expenses of the treatment that is explained to me in advance and pay my bills on time.	

PATIENT RIGHTS AND RESPONSIBILITIES – INFORMED CONSENT

The consultant or his/her designee shall be responsible for informing the patient and / or the patient's surrogatedecision maker about the following:

1. The patient's condition;
2. The proposed treatment(s);
3. Potential benefits and risks;
4. Possible alternatives;
5. The likelihood of success / outcomes;
6. Possible problems related to recovery;

7. Possible results of non-treatment; and
8. The staff members who primarily responsible for care of the patient.

RESTRAINT ORDER

- Restraints can be placed with consent and an appropriate order is required which is valid for 24 Hours only. Restraints orders will need to be renewed every 24 hours.
- Review and documentation of orders every 4th hourly (adult) and 2hrs(child) if restraint is for more than four hours
- Restraint monitoring shall be done every hour by nurses
- Need for restraint is documented.

DO NOT RESUSCITATE

- Do Not Resuscitate (DNR) orders are not legal in our country.

CORE PRINCIPLES OF END OF LIFE CARE

- The hospital shall respect the dignity of patient and family
- The hospital shall be sensitive and respect the wishes of patient and family
- The hospital shall use the most appropriate measures consistent to patient choices
- The hospital shall give maximum importance to alleviation of pain and other physical symptoms of patient
- The hospital shall assess and manage psychological, social, spiritual & religious issues related to the patient
- The hospital shall provide services of religious persons, when required
- The hospital shall offer continuity of care, particularly pertaining to palliative treatment as a part of end of life care of patient

VULNERABLE PATIENTS: FEW IMPORTANT CATEGORIES ARE MENTIONED BELOW

VULNERABLE GROUP	POINT OF FIRST CONTACT	ASSESSMENT	CARE	EDUCATION
< 15 years	1. Secure with parents / guardian	1. Pediatric or New born Assessment. 2. OP Assessment	1. Implement Safety First 2. Child Security	Doctor & Nurse verbal education
> 65 years	1. Identify Barriers. 2. Provide Assistance	1. Additional Geriatric Assessment 2. OP Assessment	1. Geriatric Care. 2. Safety First 3. 24h attendant	Doctor & Nurse verbal education
Terminally ill Patients	1. Provide Assistance 2. Assess	1. End Of Life Care Assessment	1. Safety First 2. 24h Attendant 3. Psychological Consultation for patient & family 4.Spiritual and religious needs	Counselling.
Patient in Labor	1. Secure patient 2. Immediate Admission 3. Monitored transport	Maintain Partograph Obtain consent Monitor condition CTG	Pain relief Fluid and medication Foetal condition	Doctor's verbal education
Termination of Pregnancy	Secure patient 2. Immediate Admission 3. Monitored transport	H&P Assessment and Specialized assessment	1. Pain relief 2. Medication 3. Psychological counselling	Doctor's verbal education

EMERGENCY PATIENT:

STAFFING: **Emergency Physician; Nurses; Paramedic**
COMPETENCY: **Physician – ACLS & PALS; Nurses – BLS & PALS; Paramedic – BLS & PALS**
PROCESS: **Initial Triage Accident & Emergency Assessment**
DOCUMENT: **Focus on A&E; History and Examination,consents for procedures, Medication management & critical care**
MONITORING : **Vitals monitored during stay as required & prior to discharge**
EQUIPMENT: **As per need – ECG; Defibrillator, PulseOximeter, Ventilator**

**** Staffs are required to demonstrate competency in operating and handling and caring for the equipmentsin their respective care areas.**

CODE BLUE

STAFFING: Code Blue Team –Doctors , Paramedic, Nursing,Administrative staff

COMPETENCY: All staff – Basic CPR,At least one trained in ACLS

PROCESS: Start BLS algorithm – CPR; Call 7777; Code Blue Team take over, Use Crash cart, Defibrillator, O2 as required

DOCUMENT: Code Blue Sheet , Document the entire process andTransfer notes

MONITORING: Physiological Vital Parameter;No Separate Consent,Defibrillator, O2 as required

EQUIPMENT: Pulse Oximeter; ECG monitor; Defibrillator;Crash Cart and Oxygen Cylinder

BLOOD TRANSFUSION

STAFFING: **Physician and Nursing**

COMPETENCY: **Nurse competency in IV therapy**

PROCESS: **Take consent, Check blood, Check Vitals at initiation, and every 5 minutes for first half hour, then every 15 minutesfor first hour, then every 30 minutes till end.**

DOCUMENT: **Consent; Reason; Rate of Infusion; Pre Transfusion check; sign and date**

Monitoring: **Monitor and report transfusion reaction if any;**

EQUIPMENT: **Blood transfusion set, 18G Cannula**

BLOOD TRANSFUSION REACTION:
Stop transfusion;
Call Doctor/ Consultant and Blood Bank Consultant.
Start IV Fluid.
Fill blood transfusion reaction report ; **take** blood sample from other hand Clotted and EDTA; urine for myoglobin;
Send the blood bag for review to Blood Bank

HAND HYGIENE

Hand hygiene is considered to be the single most important practice in reducing the transmission of infectious agents, including Health Care Associated Infections (HCAI), when providing care.

Before performing hand hygiene:

- Expose forearms;
- Remove all hand/wrist jewellery
- Ensure finger nails are clean, short and that artificial nails or nail products are not worn; and
- Cover cuts or abrasions (if any) with a waterproof dressing.

Performing Hand Hygiene: 5 Moments of Hand Hygiene:

Hand hygiene should be performed:

- Before touching a patient;
- Before clean/aseptic procedures;
- After body fluid exposure risk;
- After touching a patient; and
- After touching a patient's immediate surroundings.

PERSONAL PROTECTIVE EQUIPMENT (PPE)

PPE provide adequate protection to staff against the risks associated with the procedure or task beingundertaken. PPEs include gloves, apron/ gowns, mask, and eye protection (goggles).

Gloves must be:

- Worn when exposure to blood and/or other body fluids is anticipated/likely;
- Changed immediately after each patient and/or following completion of a clinical procedure or task;
- Changed if a perforation or puncture is suspected;
- Hand hygiene must be performed after gloves change/ removal.

Aprons must be:

- Worn to protect uniform or clothes when contamination is anticipated/likely e.g. when in direct care contact with a patient

Full body disposable gowns must be:

- Worn when there is a risk of extensive splashing of blood and/or other body fluids e.g. for care of barrier nursing patients and in the operating theatre; and
- Changed between patients and immediately after completion of a procedure.

Surgical face masks must be:

- Worn if splashing or spraying of blood, body fluids, secretions or excretions onto the respiratory mucosa is anticipated/likely;
- It should be used only when indicated and while using it must be properly worn (fully covering the mouth and nose)

SENTINEL EVENT:

PESIMSR defines its Sentinel Event as an unanticipated death or Major permanent loss of function, not related to the natural course of the patient's illness or underlying condition. The eventis one of the following:

i. An unanticipated death, including, but not limited to, death that is unrelated to the natural course of the patient's illness or underlying condition death of a full-term infant; and
ii. Suicide;
iii. Wrong-site, Wrong-procedure, Wrong-patient surgery;
iv. Transmission of a chronic or fatal disease or illness as a result of infusing blood or blood products
v. Or transplanting contaminated organs or tissues;
vi. Infant abduction or an infant sent home with the wrong parents; and
vii. Rape, workplace violence such as assault or homicide of a patient, staff member, practitioner, medical student, trainee, visitor, or vendor while on hospital property.

The Quality Department along with Safety Committee screens the sentinel event and completes a root cause analysisthat does not exceed **45 days** from the date of the event or when made aware of the event.

NEAR MISS:

Near Miss is any process variation which did not affect the outcome but for which a recurrence carries a significant chance of a serious adverse outcome.

SERIOUS ADVERSE EVENTS INCLUDE –

- Major Hemolytic transfusion reactions
- Serious adverse drug even and medication errors,
- Major discrepancies between preoperative and postoperative diagnoses
- Adverse events during moderate or deep sedation and anesthesia use

WASTE DISPOSAL

- Segregation of waste at source is very important and waste disposal should be done in correct color bags as perhospital policy.
- For the disposal of sharps use sharp box.
- For other waste disposal use color coded bins as per infection control guidelines.

QUICK REFERENCE:

Standards and KEYwords:

AAC – ACCESS ASSESSMENT CONTINUTY OF CARE	
AAC - 1 HCO defines & displays services a. Services defined b. Services have appropriate diagnostic and treatment facilities ;qualified personnel c. Services displayed d. Staff oriented	**AAC - 2- Registration and Administration** a. P & P – registration & admission b. P & P – OP,I P, Emergency patients c. UHID number d. Pts accepted only if HCO has the service e. P & P - non availability of beds f. Access to healthcare is prioritized g. Staff aware of the process
AAC - 3 Mechanism for transfer (in & out) or referral of patients a. P & P transfer-in of patients b. P & P transfer-out/ referral of unstable patients c. P & P transfer-out/referral of stable patients d. Procedures identify staff responsible for transfer e. Transfer summary issued	**AAC – 4 Established Initial assessment** a. Contents of assessment defined – OP, IP, EP b. Assessors & Role predetermined c. Time frame predetermined d. Initial assessment documented within 24hrs e. Nursing assessment at the time of admission f. Screening for nutritional needs included g. Plan of care documented h. Desired treatment results in care plan i. Plan of care countersigned by clinician within 24 hours j. Plan of care includes goals or desired results

AAC – 5 Regular reassessment a. Reassessed at appropriate intervals b. Outpatients informed of their next follow-up c. Plan of care is monitored and modified d. Reassessment documented by direct clinical care staffs e. Response to treatment reassessed – further treatment or discharge planned f. Early warning signs are identified	**AAC – 6 Laboratory services** a. Scope of services b. Adequate infrastructure c. Qualified and trained personal- Adequate manpower d. P & P sample collection, identification, handling, safe transportation, processing and disposal of specimens e. Results as per time frame f. Intimation of critical results g. Standardized reporting h. Procedure for outsourcing of tests i. There is a mechanism to address recall/amendment of reports whenever applicable.
AAC – 7 Laboratory quality assurance a. Documentation of QAP b. Verification & validation of test methods c. Surveillance of test results d. Periodic calibration & maintenance of equipment e. Documentation of corrective & preventive action	**AAC – 8 Laboratory safety programme (LSP)** a. Documentation of LSP b. Aligned with the HCO's safety programme c. P & P regarding handling and disposable of infectious and hazardous materials d. Appropriate training of staff e. Appropriate safety equipment/devices
AAC - 9 Imaging services a. Legal and other requirements b. Scope of services c. Adequate infrastructure d. Qualified and trained staff e. P & P – identification and safe transportation f. Results as per time frame g. Intimation of critical results h. Standardized reporting i. Procedure for recall/amendment of reports j. Procedure for outsourcing of tests	**AAC - 10 QAP –Imaging services** a. Documentation of QAP b. Surveillance of test results c. Review of imaging protocols d. Appropriate investigation as per clinical indication e. Periodic internal and external peer review f. Clinico radiological meetings g. Periodic calibration & maintenance of equipment h. Documentation of corrective & preventive action

AAC – 11 Radiation safety a. Radiation safety programme – documentation b. Aligned with organizations safety programme c. Patients screened for safety or risk prior to undergoing imaging d. P & P on handling and disposal of radio-active and hazardous materials e. Appropriate radiation safety and monitoring device - imaging personnel f. Radiation safety devices periodically tested g. Personnel including ancillary, are trained in radiation safety h. Imaging signage display	**AAC – 12 Patient care – Multidisciplinary nature** a. Qualified individual responsible for care b. Coordinated care c. Information shared among carers d. Information exchange – shift change/transfer e. Safe transportation between departments/units f. All patient records available g. P & P for referral of patients h. Continuity of care within defined timelines; schedule change information shared to caregiver/patient i. Monitor clinical care intervention after critical value alert.
AAC - 13 Documented discharge process a. Discharge planned collaboratively b. P & P regarding coordination of all departments c. P & P regarding LAMA d. Discharge summary given to all patients e. Time taken for discharge defined and monitored	**AAC-14 Content of Discharge summary** a. Discharge summary at discharge b. Contains name, UHID, DOA & DOD c. Contains reasons for admission, significant findings, diagnosis and patient's condition d. Investigations, procedures, medication other treatment e. Follow up advice, medication and other instructions f. Instructions on how to obtain urgent care g. Death summary includes cause of death
COP –CARE OF PATIENTS	
COP - 1 Uniform care a. Uniform in all settings for similar care b. 2 identifiers for patients c. P & P for uniform care	**COP – 2 Emergency services** a. Easily accessible area for emergency patients b. Overcrowding prevention/crowd management c. P & P documented with statutory requirements

d. As per applicable laws & regulations e. Evidence based medicine and clinical practice guidelines used f. Clinical care pathway g. Multidisciplinary care/rounds h. Multispecialty care/rounds	d. P & P handling medico legal cases e. Care given as per P & P f. P & P triage g. Patient reassessment at periodic intervals h. Admission, Discharge or Transfer documented i. Discharge note given j. Quality assurance program documented and implemented k. P & P for patients dead on arrival.
COP - 3 Ambulance services a. Adequate access & space b. Statutory requirements c. Appropriate equipment d. Trained personnel e. Check list - equipment, emergency medications f. Equipments to be checked daily g. Emergency medications checked daily h. Proper communication system i. Opportunities for early treatment identified for patient in transit to the organisation	**COP -4Community emergencies, epidemics and other disasters** a. Potential emergencies b. Disaster management plan c. Medical & other supplies d. Staff training e. Testing of plan – twice in a year
COP -5 P & P for Cardio Pulmonary resuscitation a. P & P uniform use of resuscitation b. Training of staff c. Events during CPR d. Post event analysis **e.** Corrective & preventive action	**COP-6 P & P for Nursing Care** a. P & P for all activities of nursing care b. P & P reflects current standards of nursing services c. Patient care assignment as per good clinical practices d. Acuity based staffing e. Aligned and integrated with overall nursing care f. Nursing care documented g. Adequate equipments for nurses h. Empowered to take nursing related decisions
COP-7 P & P for Safe performance of various procedures a. Based on clinical needs of patient b. Documented procedures c. Qualified personnel order, plan, perform and assist d. Documented procedures to prevent adverse events	**COP – 8 P & P of Transfusion Services(Blood Bank/Blood products)** a. P & P – Scope of services documented/use of blood & blood products b. Procedures govern transfusion of blood and blood products c. Rational use of blood and blood products

e. Informed consent taken before procedure f. Adherence to standard precautions and asepsis g. Monitoring during and after procedure h. Documentation of procedures in patient record	d. Informed consent e. Patient & family education regarding donation f. Availability and transfusion of blood/blood products for use in emergency g. Post transfusion form,Transfusion reactions – corrective & preventive actions h. QAP
COP - 9 Intensive care and high dependency units a. P & P guiding the care of ICU patients b. ICU – admission & discharge criteria c. Adequate staff & equipment d. Upgrade infrastructure-National and internal guidelines e. P & P shortage of beds f. Infection control practices g. Quality assurance programme h. Change in patient's condition- Patient and family counselled	**COP - 10 P&P Care of high risk obstetrical patients** a. P & P for safe obstetric services b. Scope of high risk obstetric services defined and displayed c. Competent persons provided care d. Provision of ante-natal services e. Maternal nutrition advised f. Pre natal, peri natal and post natal monitoring g. Adequate facilities for neonatal care
COP - 11 P & P Care of paediatric patients a. P & P for paediatric services organised and safe b. Care as per national / international guidelines c. Age specific competency d. Provisions for special care of children e. Assessment includes nutrition, growth, immunization, and psychosocial development f. P & P child/neonate abduction & abuse g. Family members' education regarding nutrition, immunization & safe parenting	**COP - 12 Procedural Sedation** a. Procedure for administration of procedural sedation b. Informed consent c. Competent and trained persons perform sedation d. Different person administer & monitor sedation e. Intra procedures monitoring f. Recovery monitoring g. Transfer as per criteria h. Rescue equipment & manpower
COP - 13 P & P Administration of Anaesthesia a. P & P documented b. Pre – anaesthesia assessment-Documented anaesthesia plan	**COP - 14 P & P Surgical procedures** a. P & P documented b. Pre-operative assessment provisional diagnosis and instructions documented

c. Documented pre –induction assessment d. Informed consent e. Monitoring during procedure f. Monitoring during recovery g. Transfer as per criteria h. Type of anaesthesia and anaesthesia medications used are documented i. Comply with infection control guidelines j. Adverse event monitoring and recorded	c. Informed surgical consent d. P & Procedures – adverse events-wrong site, patient e. Operative notes documented f. Post-operative plan of care documented-operating surgeon g. Conforms to infection control practices h. Appropriate equipments/instrument available i. QAP for surgical service j. QAP includes surveillance of OT environment
COP - 16Identify and manage vulnerable patients a. P & P documented with reference to laws and guidelines-monitoring twice a day, Informed consent – legal representative b. Safe & secure environment c. Identify and manage patients at risk for fall d. Identify and manage patients at risk for pressure ulcers e. Identify and manage patients at risk for DVT f. Identify and manage patients with restraints	**COP – 17 P & P Pain management** a. P & P management of pain b. Pain screening for all patients c. HCO ensures detailed assessment & periodic reassessment d. Pain medications adjusted appropriately e. HCO respects and supports management of pain f. Patient & family members are educated
COP - 18 P & P Rehabilitation a. P & P rehabilitative services and scope b. Provided in consistent manner c. Service by multi – disciplinary team d. Adequate space and equipment e. Functional assessment and periodic reassessment by qualified individuals and documented f. Adheres to infection control and safe practices g. Clinical care pathway	**COP - 19 P & P Nutritional therapy** a. P & P on nutritional assessment & therapy b. Collaborative Planning of nutritional therapy c. Written order for diet d. Food as per clinical needs e. Safe preparation, handling, storage & distribution of food f. Family education regarding patient diet restriction
COP - 20 P & P End of life care a. Documented P & P EOL care	

b. P & P as per legal requirement c. Unique need identified d. Symptomatic treatment provided and measures taken for alleviation of pain e. Staff trained	
MOM – MANAGEMENT OF MEDICATION	
MOM - 1 P & P Pharmacy services & usage of medication a. P & P – pharmacy services & medication usage b. P & P for Multi-disciplinary committee(MDC) and comply with laws & regulations c. Update medication management process by MDC d. P& P-Obtain medications when pharmacy is closed e. Inform staff of key changes in pharmacy/medication usage	**MOM - 2 Hospital formulary** a. Hospital formulary made available b. Collaboratively developed-reviewed annually c, d . Available to clinicians-refer and adhere to f. Defined Acquisition Process g. Out of formulary drugs-Process
MOM - 3 P & P Storage of medication a. P & P storage of medication b. Proper inventory control practices c. HRM identified d. HRM-Stored where clinically necessary e. HRM including LASA identification and storage f. List of emergency medications and storage g. Emergency medications available at all and replenished promptly	**MOM - 4 Safe and rational prescription of medications** a. P & P Prescription of medications -Includes good practices/guidelines b. Minimum requirements of prescription c. Known drug allergies ascertained-Prescription d. Mechanism to assist clinician in prescribing appropriate medication- identified e. P & P verbal orders f. Audit of medication orders/prescription g. Corrective and Preventive actions h. Medication reconciliation-Transition points
MOM -5 Medication order written in Uniform manner a. Authorised person writes the order b. Uniform location of orders c. Clear, legible, dated, timed, named, signed orders d. Orders contain name of drug, route, dose and	**MOM-6 P & P Safe dispensing of medications** a. P & P documented b. P & P – medication recall c. Pre dispensing- checking of expiry dates andProcedure for near expiry medications

frequency / time of administration	d. Labelling requirements e. High risk medications verified prior to dispensing f. Return of medication to pharmacy
MOM – 7 Safe administration of Medication a. Legally permitted staff administer b. Proper labelling of prepared medication c. Patient identification-two identifiers d. Medication verified; physically inspected prior to administration e. Dosage/Strength verified;prior to administration f. Routes verified;prior to administration g. Time verified;prior to administration h. Catheter and tubings misconnection-Preventive measures i. Medication administration documented j. P & P on self-administration of medications k. P & P on medication bought from outside the organization	**MOM-8 Post medication administration -monitoring** a. P & P for monitoring b. Medications changed where appropriate c. Near miss, medication error and adverse drug event definedand captured. d. Time frame for reporting e. Collection and analysis f. CAPA based on analysis
MOM - 9 P & P Narcotic &Psychotropic substances, chemotherapeutic drugs and Radioactive drugs. a. P & P exists and is as per local & national regulations b. Prescribed by appropriate persons c. Secured storage d. Chemodrugs-Safe preparation and administration-Qualified personnel e. Chemo drugs and Narcotics register- Use, administration & disposal f. Handling by appropriate personal RADIOACTIVE DRUGS ARE NOT USED IN THE HOSPITAL.	**MOM – 10 P & P implantable prosthesis and medical devices** a. Proper selection & usage of implantable prosthesis based on scientific criteria b. P & P for procurement, storage/stocking, issuance and usage as per manufacturer's specifications c. Counselling of patients/family members d. Master log book and discharge summary-batch and serial number e. Recall of implants and medical devices.
MOM – 11 P & P medical supplies and consumables a. Defined process for acquisition b. Safety issues addressed	

c. Storage as per manufacturer's recommendations d. Sound inventory control practices e. Verification-medical supplies and consumables before dispensing/usage	
PRE – PATIENT RIGHTS AND EDUCATION	
PRE - 1 Organization protects patients and family rights and informs them about their responsibilities during care a. Documentation and display of patient rights & responsibilities b. Information regarding rights & responsibilities c. Organisation protects patient & family rights & responsibilities d. Violation of patient and family rights- Reporting mechanism e. Violation recorded and CAPA taken	**PRE - 2 Patient and family rights support individual beliefs, values & involve the patient and family in decision making processes** a. Address special preferences, cultural and spiritual needs b. It includes personal dignity, privacy during examination, procedures & treatment c. Protection from physical abuse and neglect included d. Confidentiality included e. Refusal of treatment included f. Patient can take additional opinion-organisation to allow g. Informed consent included h. Right to complain and how to voice a complaint included i. Expected cost of treatment included j. Access to clinical record included k. Information on plan of care, progress and information on their health care needs included l. What information to be given to patient and family documented. Sensitive info given to family with patient's consent.
PRE-3 Educated to make informed decisions and are involved in the care planning and delivery process a. Explained about the proposed care, risks alternatives and benefits b. Explained about expected results c. Explained about possible complications d. Care plan prepared and modified in consultation with patient/family	**PRE - 4 A documented process for obtaining patient and/or families consent exists for informed decision making about their care** a. Informed consent list prepared b. Informed consent- Adheres to statutory norms c. Informed consent includes information, risks , benefits & alternatives &performers name- patient's language d. Surrogate consultant-kith and kin, legal guardian etc e. Informed consent taken by person performing the procedure

e. Informed about the results of diagnostic tests and diagnosis f. Explained about changes in patient condition- Timely manner g. Multidisciplinary counselling provided where necessary.	
PRE - 5 Patients & families have a right to information and education about their health care needs a. Language and format as per patient understanding b. Safe & effective use of medication & potential side effects c. Food drug interactions d. Diet & nutrition e. Immunizations f. Pain management techniques. g. Educated regarding disease process, complications &prevention h. Educated about preventing healthcare associated infections- Hand hygiene and avoid overcrowding near patient i. Special education needs- addressed.	**PRE - 6 Patient and families have right to information on expected costs** a. Uniform pricing policy b. Tariff list available on request c. Information on costs and treatment d. Information on cost when settings/patient's condition and care plan is changed
PRE-7 Patient feedback and Complaint redressal procedure a. Documented procedure for patient feedback-satisfaction b. Capture patient experience. c. Documented complaint redressal procedure d. Patient & family awareness- Feedback and complaint lodging e. Feedback and Complaints analysed-defined timeframe f. CAPA where appropriate-based on analysis	**PRE-8 Effective communication with patients and family** a. P& P for effective communication - patient and family b. Situations for enhanced communications-identified c. Enhanced communication effectively done. d. Unacceptable communication- defined and staff made aware e. Effective communication- monitor &review

HIC –HOSPITAL INFECTION CONTROL	
HIC - 1 The organization has a well- designed, comprehensive and coordinated infection control programme aimed at reducing/eliminating risks to patients , visitors and providers of care a. HIC Programme documented b. Identifies high risk areas & implements P & P to prevent infection. c. Continuous process. This is updated yearly. d. Review based on Infection control assessment tool. e. Infection control committee f. Infection control team-coordinate IC activities g. Infection control officer h. Infection control nurse i. Information, education and communication for ICP activities for the community. j. Participates in management of community outbreaks	**HIC – 2 Proper facilities & adequate resources are provided to support the infection control programme** a. Resources made available b. Budgetary allocation c. Adequate gloves, masks, soaps and disinfectants are available & used correctly d. Hand washing facilities-Adequate, appropriate & accessible e. Isolation/barrier nursing
HIC-3Organisation identifies infection control program in clinical areas a. Adherence to standard precautions b. Hand hygiene guidelines c. Transmission based precautions d. Safe injection and infusion practices e. Antibiotic policy-documented f. Implements antibiotic policy –monitors antibiotic usage g. Antibiotic stewardship program.	**HIC 4- Infection Prevention and control in support services.** a. Laundry & linen management b. Reduce risk of infection during renovation c. Kitchen sanitation & food handling d. BMW segregation, collection and handling safely e. Engineering controls f. Housekeeping procedures g. Pre and Post exposure prophylaxis to all staff

HIC – 5Actions to prevent or reduce HAI in patients a. Monitors CAUTI b. VAP c. CLABSI d. SSI	**HIC – 6 Infection control team is responsible for surveillance activities in identified areas of the hospital** a. Tracking & analysing if infection risks, rates & trends b. Regular verification of data-IC Team c. High risk area surveillance, collection of surveillance data- on going process d. Compliance with hand hygiene guidelines e. Occurrence of MDRO, virulent organisms, epidemiological diseases-monitored f. House – keeping services monitored g. Feedback regarding HAI rates to appropriate personnel h. Outbreaks of infection- identified and action taken i. Surveillance data analysis and corrective and preventive action/s taken.
HIC – 7 Documented procedures for sterilization activities a. Adequate space & zoning for sterilization activity b. P & P for cleaning, packing, disinfection and / or sterilization, storing and issue of items c. Reprocessing of instruments/equipments(single use) d. Validation tests for sterilization / documentation e. Established recall procedure-failure in sterilisation system	**HIC – 8 Organisation takes action to reduce HAI in staff** **a.** Occupational health and safety practices- Reduce risk of transmission among HCW **b.** Immunisation policy for staff **c.** Work restriction for those with transmissible infections **d.** P/P on prevention of blood and body fluid exposure **e.** Post exposure prophylaxis to all staff.
PSQ- Patient Safety and Quality	
PSQ-1 Structured patient safety programme a. Documented patient safety programme maintained by Patient safety committee b. Comprehensive and covers all elements related to patient safety & risk management c. Scope of programme-Adverse events ranging from “no harm” to “sentinel events” d. Patient Safety Officer and Safety champions/representatives identified and developed across the organisation	**PSQ 2 There is a structured quality improvement and continuous monitoring programme in the organization** a. Committee develops QI program b. Quality improvement program- documented, comprehensive & covers all major elements related to QA c. Improves process efficiency and effectiveness d. Designated individual-coordinate and implement. Quality Champions identified and developed across organisation e. Identify opportunities for improvement based on review at predefined intervals

e. Clinical Safety officer f. Identifies opportunities for improvement g. Proactive analysis and improvements- HIRA FMEA- At least one patient safety risk identified yearly h. Continuous process , reviewed and updated yearly i. Adapts & implements national/international patient safety goals/solutions	f. Updating of QA programe and manual- yearly g. Internal audits- regular intervals h. Established process for monitoring and improving quality of nursing care- Nursing audits /QI used
PSQ- 3 The organization identifies key indicators to monitor structure, process and outcome which are used for continual improvement a. Key indicators identified to oversee clinical structure , process and outcomes. 1. Patient assessment 2. Lab/Radiology safety 3. Medication management 4. Anesthesia –Use , modification, adverse event and mortality 5. Surgical Services-Unplanned return,Rescheduling, Adverse events-safe surgery checklist,Appropriate prophylactic antibiotics-defined time frame 6. Blood + Blood products 7. Mortality & morbidity indicators-Mortality rate,Return to ICU within 48 hours,Return to emergency within 72 hours,Re-intubation rate b. Key indicators identified to oversee Hospital infection control activities 1. CAUTI 2. VAP 3. CLABSI 4. SSI **c. Managerial Key indicators** 1. Medication procurement-Local purchase,Stock out	**PSQ -4 The organisation uses quality improvement tools for its Quality Improvement activity** a. Quality improvement projects- At least two b. Appropriate analytical tools used for QI activities c. Appropriate statistical tools used for QI activities d. Appropriate managerial tools used for QI activities

Rejection rate,Variation in purchase process 2. Utilization rates- OT/ICU 3. Patient and staff Satisfaction- Patient: OP satisfaction,IP Satisfaction,Waiting time,Discharge time Staff/employee : Employee satisfaction Index,Employee attrition rate,Absenteeism rate,Awareness rate 4. Down time of equipment 5. Bed occupancy rate/average length of stay 6. Nurse/patient ratio d. Patient safety Activities: 1.Risk management: Mock drills 2.Patient safety goals 3.Incidence of communication errors including handovers 4. patient identification error. 5. Compliance to Hand Hygiene 6. Compliance-Medication prescription in capitals e) Mechanism to capture patient related outcome measures f. Verification of data- Quality team and errors corrected g. Analysis of data-opportunities for improvement h. Opportunities for improvement-implemented & evaluated i. Feedback communicated to staff- internal	
PSQ – 5 Clinical Audit a. Performed to improve quality of patient care- disease based, community based/morbidity based- At least one/per dept/year. b. Parameters to be audited- defined and no bias c. Medical/Nursing participation in committee d. Parameters to be audited	**PSQ – 6 management Supports Patient Safety and Quality Improvement Programme** a. Culture of Safety created- measured using validated tool annually. b. Leaders aware of intent of the program. c. Departmental Leaders / designated person involved – Achievement of department objectives/key performance

e. Patient and staff anonymity f. Documentation g. Remedial measures	indicators. d. Adequate resources e. Earmarks budget f. Identifies organizational performance ad improvement targets g. Employee feedback from workforce- Improve patient safety and quality program
PSQ-7 Incidents collected and analysed a. Incident reporting system b. Identify sentinel events- Defined list c. Process for analysis of incidents d. CAPA based on analysis e. Incorporate these into Risk management system. f. Feedback to all about near miss/adverse event	
ROM- RESPONSIBILITIES OF MANAGEMENT	
ROM - 1 Responsibilitiesfor governance are defined a. Roles and Responsibilities are defined and documented b. Vision, Mission & Values defined c. Strategic and operational plans and annual budget (capital and operational expenditure) d. Monitor and measure the performance VS. mission e. Appoint senior leaders, Organogram f. Safety initiatives and quality improvement plans-Risk management and quality improvement activities- department head involved. g. Ethical activities, resolving ethical issues and conflict of interest. Ethical conduct of research activities **h.** Inform public the quality and performance of services	**ROM-2 Applicable legislations and regulations** a. Ensures P & P for patient care are in compliance with law and regulations b. Ensures implementation c. Updates amendments d. Updating of licenses, registration, certificates **ROM 2 – Ethical management** a. Vision, Mission & Values statement publicized b. Ethical management-documented c. Process to manage issues with ethical implication, dilemas and concerns, including documentation of the same d. Ownership disclosure e. Honestly portrays its affiliations & accreditations f. Accurately bills-standard tariff
ROM- 3 Leader for day today operations a. Head has requisite and appropriate administrative qualifications. b. Head has requisite and appropriate administrative experience	**ROM –4 Professionalism in functioning** a. Strategic & operational plans including short term & long term goals b. Coordinates functioning with departments & external agencies and monitors the progress in achieving the defined goals and

c. Conversant with laws & regulations and its applicability- License tracker d. Participates in recruitment of senior leaders- Assist day-today operations e. Effective leadership- each service/department f. Performance review of senior leaders	objectives c. Budget-annually d. Committee review e. Documents employee rights & responsibilities f. Service standards g. Change management- Systems and Processes
ROM – 5 Patient safety aspects and Risk management a. Proactive risk management- across organisation-reviewed annually b. Resources for proactive risk management & risk reduction activities- directed at preventive action where feasible. c. Integration between quality improvement , risk management and strategic planning d. Internal and external reporting of system process failures e. Outsourced services- Documented agreement including service parameters. f. Quality of outsourced services monitored- NOT MANDATORY for services which are as per govt/statutory norms	
FMS – FACILITY MANAGEMENT AND SAFETY	
FMS-1 Safe and secure environment a. Patient safety devices installed and inspected periodically and is a Non-smoking area. b. Facility for differently abled c. Facility rounds monthly – checklist: twice in patient care and once in non-patient care areas d. Inspection reports & CAPA- one accreditation cycle e. Before construction, renovation- risk assessment	**FMS - 2 Environment and facilities operate in a planned manner and promotes environment friendly measures** a. Facilitates as per scope b. Update drawings-Site layout, floor plans and fire escape routes c. Internal and external sign postings-bilingual d. Potable water & electricity e. Alternate sources- water and electricity as back up f. Regular testing of alternate sources g. Energy efficient and environment friendly hospital-Initiatives

FMS -3 The organisation's environment and facilities operate to ensure safety of patients, their families, staff and visitors h. Space provision as per Indian/international standards & directives from government agencies and patient safety aspects i. Documented operational plan- includes access to different areas by vendor, staff and visitor j. Electrical safety audits yearly . k. P & P -Identification and disposal of unused materials. l. Documented policies for identification and safe use of HAZMAT (hazardous material) m. Documented polices -Spill management of HAZMAT/Kits/storage/	**FMS-4 Engineering support services** a. Equipment planning-Collaborative process b. Inventory & proper logs maintained c. Documented operational & maintenance plan d. Utility Equipment-Periodical inspection/calibration e. Qualified and trained personnel-Operate, inspect, test and maintain equipment & utility Systems f. Maintenance staff for emergency repairs -24 hours g. Inspection to implementing CAPA-Downtime/Response times monitored for critical equipments h. Equipment replacement and disposal-Documented process
FMS-5 Biomedical engineering a. Equipment planning- Scope and strategic plan/Collaborative process b. Inventory & proper logs maintained c. Documented operational & maintenance plan d. Periodic inspection and calibration e. Qualified and trained personnel f. Equipment replacement and disposal-documented policy g. Procedure- Medical Equipment Recalls h. Inspection to implementing CAPA-Downtime/Response times monitored for critical equipments	**FMS - 6 Programme for medical gases, vacuum and compressed air** a. P & P:Procurement, handling, storage, distribution, usage and replenishment of medical gases b. Handling,Storage, distribution and usage-Safe manner c. Addresses safety issue at all levels d. Alternate sources available e. Testing of alternate sources f. Operational and maintenance plan for piped medical gas, compressed air and vacuum installation
FMS - 7 Fire and non-fire emergencies a. Early detection, containment and abatement of fire and non-fire emergencies b. Documented safe exit plan in case of fire and non fire	

emergencies c. Mock drills / twice in a year d. Maintenance plan for fire related equipments& infrastructure e. Service continuity plan for critical operations-Tested at regular intervals	
HRM – HUMAN RESOURCE MANAGEMENT	
HRM – 1 Documented system of human resource planning a. Supports the HCOs current & future ability to meet the care, treatment & service needs of patients b. Adequate number and mix of staff c. Contingency plans-long term, short term and unplanned shortages d. Job specifications and job description-documented P/P e. Antecedent check of the potential employee f. Reporting for each category-Organogram g. Exit interviews-tool to improve HR services	**HRM -2 Staff Recruitment and orientation** a. Documented recruitment procedure b. Pre-employment medical examination c. Code of conduct-defined d. Admin procedures- documented policies
HRM -3 Staff Induction a. Induction training-all category including visiting b. Vision, mission & values c. Employee &Patient's rights and responsibilities d. Patient, staff, visitor –Safety training including emergency codes. e. Training on CPR- Direct patient care staff f. Training on Hospital infection control g. Orientation to Service standards h. Orientation to Administrative procedures i. Aware of department and hospital wide policies and procedures	**HRM – 4 Professional training and development** a. Documented training and development policy b. Training record c. Change of jobs/ new equipment introduced d. Feedback mechanisms for assessment of training e. Evaluation of training effectiveness f. The organisation supports professional development

HRM -5 Staff are appropriately trained based on their specific job description a. Blood transfusion services-handling of blood and blood products b. Handling vulnerable patients c. Restraint techniques d. Healthcare communication techniques e. CPR- Direct patient care staff **f.** Hospital infection control	**HRM- 6 Staff Trained in safety and quality programme** a. Organisation's safety programme b. Detection, handling, minimisation and elimination of identified risks c. Report of an incident d. Occupational safety aspects e. Disaster management plan f. Fire and non-fire emergencies g. Quality Improvement program- Awareness in overall program, QAP for labs, ER, OT, ICU, Blood bank and Radiology**.**
HRM-7 Performance evaluation a. Documented appraisal system b. Aware of appraisal system- Induction c. Performance evaluated as per pre-determined criteria d. Appraisal used for further development e. Performance appraisal at pre-defined intervals + documentation	**HRM – 8 Disciplinary and grievance handling policies and procedures** a. P & P documented b. Staff awareness c. Natural justice d. D/P in consonance with in prevailing laws e. Appeals f. Redress procedure addresses grievance g. Action taken
HRM – 9Staff well being and Health needs a. Staff well-being –promoted **b.** Policy for health problems includingOccupational health hazards **c.** Once a year check-up / documented **d.** Treatment- work place related injuries. **e.** Prevent and handle work place violence	**HRM – 10 Personal record** a. Maintain file b. Maintain personal information c. In-service training & education d. Evaluation
HRM – 11 Medical professionals Credentialing a. Identify staff who have required qualification b. Documentation & periodic updating of related data c. Verification of related data d. Granting privileges e. Requisite services known to medical professionals f. Admit & care as per privileging	**HRM – 12 Nursing professionals Credentialing** a. Identify staff who have required qualification b. Documentation & periodic updating of related data c. Verification of related data d. Granting privileges e. Requisite services known to medical professionals f. Nursing care as per privileging
HRM 13 Para clinical professionals a. Identify staff who have required qualification	

b. Documentation & periodic updating of related data after verifying. c. Granting privileges d. Requisite services known to medical professionals e. Care as per privileging	
IMS –INFORMATION MANAGEMENT SYSTEM	
IMS – 1 P&P information needs of Patient/visitors/HCP/Management/ outside agencies a. Information needs of patients/visitors, staff/management/external agencies/community. b. P& P to meet needs c. Commensurate to identified information needs d. Maintenance plan for IT e. Contingency plan for continuity of information capture, integration and dissemination. f. Accurate and meet stakeholder requirements g. Contribution to external data bases	**IMS – 2 Effective management and control of data** a. Effective ad standardized process for data collection/standardized formats b. Data analysis –necessary resources c. Data dissemination-timely and accurate d. Data storing & retrieval e. Data analysis by clinical and managerial staff
IMS - 3 Every patient has a complete and accurate record a. UHID b. Contents identified & documented c. Complete, updated and chronological order d. P & P – Who can enter e. Name, sign, date and time f. Author entry identification g. Authorised abbreviations only	**IMS – 4 Continuity of care** a. Reasons for admission, diagnosis and plan of care b. Assessments, reassessments and consults c. Test results and care provided d. Operative and other procedures e. Transfer out notes f. Discharge summary g. Death summary & certificate h. Access to current and past medical record

IMS – 5 P & P confidentiality , integrity and security of information a. P & P exist b. Integrity of records, data and information c. Safeguarding of records, data and information d. Use of appropriate technology- confidentiality, integrity and security e. Patient authorization of release of privileged information f. P & P for request for records by patients/physicians and public agencies	**IMS - 6 P & P regarding availability and retention time of data, information records** a. P&P exist b. Local & national laws c. Confidentiality & security d. Destruction of records
IMS - 7 Medical records review a. Periodic review of medical records b. Representative sample c. Identified care providers d. Focus on timelines, legibility and completion e. Active & discharge patients f. Deficiencies discussed and documented g. Appropriate corrective & preventive action within defined time frame	

NABH RELATED DOCUMENTATION FOR DOCTORS (MANY OF THEM ARE ALSO APPLICABLE TO NURSES)

- All Patients To Have A Treating / Admitting Consultant
- All Patients To Have An Initial Assessment
    - OPD
    - Emergency
    - In Patients
    - Ideal To Create Department Specific Content Defined Initial Assessment
- **<u>OUTPATIENT ASSESSMENT</u>**
- Minimum Documentation
    - Presenting Complaints
    - Vital Signs
    - Salient Examination Findings
    - Provisional Diagnosis

    - Documentation Of Allergies
    - Screening Or Assessment For Nutritional Needs
    - Consultation Request
    - Laboratory Investigation
    - Radiology & Imaging Investigations
    - Advice Regarding
        - Medication
        - Diet
        - Preventive & Promotive Aspects
        - Review
- **IN PATIENT ASSESSMENT:**
- Initial Assessment shall Lead To a Documented Care Plan In IP And Day Care Patients (NOT FOR OP)
    - Documented Need for Admission
    - Documents Provisional Or Working Diagnosis
    - Identifies Pt. Care Needs
    - Lists Strategy To Meet The Needs
    - Documents Treatment Goals And Objectives
    - Criteria For Ending Interventions
    - Includes Preventive, Promotive, Curative And Rehabilitative Aspects
- Needs Individualized To Particular Diseases
- Care Plan Generated By Juniors Should Be Signed With In 24 Hours By The Consultant
- Daily Reassessment Based On Care Plan
- Changes To Care Plan Based On Reassessment
- Discharge Planning Based On Such Reassessment
- **Precise referrals**
    - Why?
        - For Diagnosis or Co - management or take over
    - How Quickly?
        - Immediate, Urgent, Priority or Routine
- **Clinical Details Completed On**
    - X-ray, USG,CT, MRI Special Imaging Requests
    - HPE Requests/ FNAC Requests/laboratory requests

- **DAILY MEDICATION ORDERS:**
  - Only Drugs From Formulary
  - Generic Based
  - Capitals Ideally; Legible At Least
  - Stop Order Is To Be Signed
  - No RPT All
  - NO " CST"
  - Avoid Unapproved & Dangerous Abbreviations
  - Medications In Discharge Summary Needs Special Care
  - Use English Rather Than Latin Terms

- **DOCUMENTED EDUCATION TO PATIENTS ON:**
  - Care Plan
  - Complications
  - Duration Of Stay
  - Costs
  - Medications
  - Nutritional Aspects Of Care
  - Food & Drug Interactions If Any
  - Preventive Aspects Of Care
  - Use Purpose Designed Brochures

DOCUMENTED DISCHARGE PLANNING & PROCESS:

- A Complete Discharge Summary
- Handed Over @ Discharge
- Even For LAMA Patients
- Patient Identification Details
- Reasons For Admission
- Significant Findings
- Diagnosis
- Course In Hospital
- Review Of Investigations
- Condition @Discharge
- Procedure Performed

    - Medications Administered
    - Other Treatment Given
    - Follow Up Advice
    - Medication & Other Instructions
        - In An Understandable Manner
    - When To Obtain Urgent Care
        - Relate To The Diagnosis Or Procedure
        - Headache, Vomiting And Seizures In Post Head Injury Or Neurosurgery Patients
        - Chest Pain , Sweating, Palpitation, Breathlessness In CAD, CAG, CABG Patients
        - Recurrence Of Symptoms In Most Other Patients
- How To Obtain Urgent Care
- Death Summary Must
- COMPLETION OF MEDICAL RECORD MUST
    - After Closed Medical Record By MRD
- All Entries In Medical Record To Be Dated, Timed, Named & Signed By Every One And Especially Consultants

- **MANDATORY LISTS: THE FOLLOWING LISTS are to be used In your day today practice:**
    - Formulary
    - Look Alike & Sound Alike
    - High Risk Medications List
    - Do Not Crush List
    - Tips For Prescription Writing
    - List Of Approved Abbreviations
    - List Of Abbreviations To Be Avoided
    - Revised Patient Rights & Responsibilities
    - HIV Pre & Post Test Counselling Guidelines

INFORMED CONSENT

- Is definitely needed before
    - Anaesthesia
    - Surgery
    - Invasive Procedures
    - Blood Transfusion
    - HIV Testing

- LAMA
- End Of Life Care, esp. if there are limitations of therapy

- Pre Operative And Post Operative Diagnosis Must
- All Portions To Be Completed And Signed By The Person Performing The Procedure
- Special Form For Prevention Of 'Wrong Site, Side, Person, Procedure' For Surgeons and Anaesthesiologist And People Performing Procedures
- **MANDATORY HIV TESTING:**
- NACO Guidelines on HIV Testing:
- "The fear and apprehension that exists among health care workers in managing HIV infected individuals and AIDS patients are largely *due to the minimal risk that exists of HIV transmission due to a needle stick or other sharp injury*. Thus the *demand for mandatory HIV testing* of patients admitted in hospitals or undergoing surgery, etc*is not rational.* This demand is neither rational nor appropriate. A *mandatory HIV test is no substitute for Standard Work Precautions that* need to be adopted for every patient in a hospital or any other health care setting. On the other hand testing without explicit consent of the patient has been proven to be counterproductive in the long run."
- **PESIMSR Guidelines On HIV Testing:**
- No individual should be made to undergo a mandatory testing for HIV.
- No mandatory HIV testing should be imposed as a precondition for employment or for providing health care facilities during employment.
- HIV testing should be carried out on a voluntary basis with appropriate pre-test & post- test counselling.
- Doing A Mandatory HIV Testing Before All Invasive Procedure Is Unethical & Probably Illegal
  - This Is Against NACO Guidelines
  - Please Avoid

- Mandatory HIV Testing Is Acceptable Only For
  - Blood Or Blood Product Donation
  - Before Initiating Haemodialysis
  - Before Organ Donation
- Guidelines for Pretest & Post Test Counseling Is Available.
- Please follow them in day to practice
- **IT IS THE DUTY OF THE CONSULTANT TO DOCUMENT THAT PRE & POST TEST COUNSELLING HAVE BEEN DONE**

- **EVERY CONSULTANT SHOULD HAVE KNOWLEDGE ABOUT:**
  - Hospital Wide Policies & Procedures
  - Departmental Policies & Procedures
  - Administrative Policies & Procedures
  - Credentialing Process & Privileges Allowed

- Patient & Employee Rights & Responsibilities
- Continuous Quality Improvement Initiatives
- Participation In Clinical Audit, Mortality & Morbidity Reviews
- Hospital Infection Control Practices
- Fire & Non Fire Safety
- Disaster Management
- Hazardous Material Management
- Risk Reduction

Dangerous Abbreviation or Dose Designation NOT TO BE USED in the Medical Record.

MUST USE	MEANING	DO NOT USE	RATIONALE
mcg	Microgram	µg	µg can be mistaken for mg
Spell out: ”units”	Units	U or u	Could be read as a zero (0) or a our (4)
1mg	**DO NOT** Use trailing zero	1.0 mg	Misread as 10 times amount intended if decimal point is not seen
0.5 mg	**Do** use leading zero	.5mg	Misread as 10 times amount intended if decimal point is not seen
q day, daily Every Other Day	Every day, Every other day	q.d., QD, q.o.d, Q.O.D.	Mistaken for each other The period after the Q can be mistaken for an “I” and the “O” can be mistaken for an “I
Spell out: “Morphine”,“MagnesiumSulfate”	“Morphine”, Sulfate Magnesium Sulfate	MgsSO4, MS	Can mean “Morphine Sulfate” or“MagnesiumSulfate”
Spell out : “International Units”	IU for International Units	IU	Mistaken for IV(intravenous or10(ten)
ml	c.c. for cubic centimeters	c.c	Mistaken for U(units) when written poorly

Key to Best Practice in Documentation

- History& Physical examination notes and OT notes to be counter signed by consultant
- All signatures to carry the name, ID, date and time
- All case records are to be filled completely with no column left unfilled
- All drug chart entries to be made and signed by the physician with date and time

- Non drug orders to be documented in the appropriate section of non-drug order form
- Draw single lines across errors
- Mention“not applicable” where necessary, while filling forms
- Draw line across unused spaces in the medical record

PROGRAMS PUT IN PLACE FOR NABH :

1) **Quality Management Program**
2) **Continuous Quality Improvement**
3) **Quality Assurance program**
   -laboratory services
   -radiology services
   -ICU
   -Surgical Services
   -Blood Bank
   -Emergency Services
   -Nursing Services
4) **HIC program**
5) **Internal Audit Program**
6) **Clinical Audit Program**
7) **Safety Programs**
   -Radiology Services
   -Laboratory services
   -Patient Safety
   -Facility safety- FIRE, NON –FIRE, HAZMAT. Disaster Management
   -Clinical Safety
8) **Medication Management**
9) **Satisfaction surveys**
   -In-Patient
   - Out patient

10) **Patient complaint Processing procedure**
11) **Incident Review and Management**
12) **Litigation management**
13) **Medical record audit**
14) **Death audit**
15) **Committee review**

QUALITY INDICATORS: Annexure 1

ANNEXURE III: NABH INDICATORS

Anaesthesia Department

PSQ Indicators

Sl.No	Indicator	NABH Standard	Description	Numerator (A)	Denominator (B)	Formula	Data To Be Collected By/analysed by
1.	Percentage modification of anaesthesia plan	PSQ 3a i	The modification could be captured in a register/system before the patient is shifted out of the OT.	Number of patients in whom anaesthesia care plan was modified in the theatre	Total number of patients who underwent anaesthesia	% = A / B X100	Anesthesiology dept/Quality team
2.	Percentage of unplanned ventilation following anesthesia	PSQ 3a ii	Every anaesthesia plan shall invariably mention if there is a possibility of the patient requiring ventilation following ventilation. Every case wherein a patient required ventilation but this was not captured in the anaesthesia plan shall be part of the numerator	Number of patients who needed unplanned ventilation following anaesthesia	Total number of patients who underwent anaesthesia	% = A / B X100	Anesthesiology dept/Quality team
3.	Percentage of adverse anaesthesia events	PSQ 3a iii	Adverse anaesthesia events include events which happen during the procedure like hypoxia, arrhythmias, cardiac arrest etc.	Total number of patients who developed adverse anaesthesia event	Total number of patients who underwent anaesthesia	% = A / B X100	Anesthesiology dept/Quality team
4.	Anaesthesia related mortality rate	PSQ 3a iv	Any death where the cause is possible (likely) or certain to be due to anaesthesia shall be included.	Number of patients who died due to anaesthesia	Number of patients who underwent anaesthesia	% = A / B X100	Anesthesiology dept/Quality team

Public Relations

PSQ Indicators

Sl.No	Indicator	NABH Standard	Description	Numerator (A)	Denominator (B)	Formula	Data collected by/Data assessed by
1.	Out patient satisfaction index (Percentage)	PSQ 3c i		Score achieved	Maximum possible score	A % = ---- X100 B	Patient guides/quality team
2.	Waiting time for consultation OPD	PSQ 3c iii	Sample size- 2%	Time taken from the time the patient registered to the time patient is actually seen	Number of patients studied	A ---- B = average time per patient	Patient guides/quality team
3.	Waiting time for diagnostics	PSQ 3c iii		Time taken from the time the patient registered to the time patient is actually gets diagnosis procedure done	Number of patients studied	A ---- B = average time per patient	Patient guides/quality team

Medical Record Department PSQ Indicators

Sl.No	Indicator	NABH Standard	Description	Numerator (A)	Denominator (B)	Formula	Data collected by/Data assessed by
1.	Percentage of medical records not having discharge summary	PSQ 3c i		Number of medical records not having discharge summary	Total number of discharges and deaths in a month	A % = ---- X100 B	MRD dept
2.	Percentage of medical records not having codification as per ICD	PSQ 3c ii	ICD coding shall be done by the concerned staff within the specified period following discharge	Number of medical records not having codification as per ICD	Total number of discharges and deaths in a month	A % = ---- X100 B	MRD dept
3.	Percentage of medical records having incomplete and/or improper consent	PSQ 3c iii		Number of medical records having incomplete and/or improper consent	Total number of discharges and deaths in a month	A % = ---- X100 B	MRD dept
4.	Percentage of missing records	PSQ 3c iv	Missing records include records within the retention time only	Number of missing records in retention period	Total number of records maintained	A % = ---- X100 B	MRD dept
5.	Mortality Rate	PSQ 3a v		Number of deaths	Total number of discharges & deaths	A % = ---- X100 B	MRD dept

HIC Quality Educators

PSQ Indicators

Sl.No	Indicator	NABH Standard	Description	Numerator (A)	Denominator (B)	Formula	Data collected by/Data assessed by
1.	Catheter associated urinary tract infection rate	PSQ 3b	As per the latest CDC/NHSN definition	No. of Catheterized patients developing UTI in the hospital	Total no of urinary catheter days	A = ---- X 1000 B	ICN and Quality educators
2.	Ventilator Associated Pneumonia rate	PSQ 3b	As per the latest CDC/NHSN definition	No. of patients developing ventilated associated pneumonia	Total number of ventilator days	A = ---- X 1000 B	ICN and Quality educators
3.	Central line associated blood Stream infection	PSQ 3b	As per the latest CDC/NHSN definition	No.of central line associated blood stream infections in a month (CRBSI)	Total number of central line days in that month	A = ---- X 1000 B	ICN and Quality educators
4.	Surgical site infection rate	PSQ 3b	As per the latest CDC/NHSN definition	No. of patients developing SSI after surgery	No. of patients undergoing same surgeries	A % = ---- X 100 B	ICN and Quality educators
5.	Incidence of bed sores after admission	PSQ 3d	A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction	Number of patients developing new/worsening of pressure ulcer	Total number of patient days	A = ---- X 1000 B	ICN and Quality educators
6.	Incidence of blood & body fluid exposures	PSQ 3d	An exposure is wen blood, blood components or other potentially infectious materials come in contact with staff's eyes, mucous membranes, non intact skin or mouth All exposures to blood/body fluids should be assessed on a case-by-case basis	Number of blood/body fluid exposures in a month	Number of i npatient days	A = ---- X 100 B	ICN and Quality educators
7.	Incidence of needle stick injuries	PSQ 3d	Needle stick injury is a penetrating stab wound from a needle (or other sharp object) that may result Parenteral exposure means injury due to any sharp	Number of Parenteral exposures in a month	Number of inpatient days	A % = ---- X 100 B	ICN and Quality educators

Facility & Safety Department

PSQ Indicators

Sl.No	Indicator	NABH Standard	Description	Numerator (A)	Denominator (B)	Formula	Data collected by/Data assessed by
1.	Number of variations observed in mock drill	PSQ 3c		Data from safety Committee			Facility safety officer
2.	No of Thefts	PSQ 3c		Data from the security			Facility safety officer/safety team
3.	Timely refilling of fire Extinguishers	PSQ 3c		Number of fire extinguishers not filled on time	Total number of extinguishers available	$\% = \frac{A}{B} \times 100$	Facility safety officer/safety team

Biomedical Engineering Department

PSQ Indicators

Sl.No	Indicator	NABH Standard	Description	Numerator (A)	Denominator (B)	Formula	Data collected by/Data assessed by
1.	Critical equipment down time	PSQ 3c		Number of equipment utilized days	Number of equipment days available in a month	$\% = \frac{A}{B} \times 100$	Bio Medical Engineering

Blood Bank

PSQ Indicators

Sl.No	Indicator	NABH Standard	Description	Numerator (A)	Denominator (B)	Formula	Data collected by/Data assessed by
1.	Percentage of transfusion reaction	PSQ 3a		Number of patients with transfusion reactions	Number of Patients transfused in a month	$\% = \frac{A}{B} \times 100$	Blood Bank officer
2.	Percentage of wastage of blood product	PSQ 3a	Wastage includes blood products found unfit for use	Number of blood & blood products used in a month	Number of blood & blood products issued from the blood bank	$\% = \frac{A}{B} \times 100$	Blood Bank officer
3.	Percentage of blood component usage	PSQ 3a		Total number of blood component used	Total number of Blood & blood products used	$\% = \frac{A}{B} \times 100$	Blood Bank officer
4.	Turnaround time for issue of blood and blood components	PSQ 3a	Time shall begin from the time that the order is raised to blood/component reaching the clinical unit	Sum of time taken	Total number of Blood and Blood components issued	$\% = \frac{A}{B} \times 100$	Blood Bank officer

Laboratory

PSQ Indicators

Sl.No	Indicator	NABH Standard	Description	Numerator (A)	Denominator (B)	Formula	Data collected by/Data assessed by
1.	Number of reporting errors per 1000 investigations	PSQ 3a	Number of reporting errors picked up before and after dispatching of report. (It shall include transcription errors also)	Number of reporting errors picked up before and after dispatching of Report	1000 investigations	$= \frac{A}{B} \times 1000$	HOD-laboratory/ NABH team
2.	Percentage of Re-dos - laboratory	PSQ 3a	Number of Re-dos in Biochemistry/Hematology. This shall also include tests repeated before release of the result.(to confirm the finding)	Number of Re-dos in Biochemistry	Total number of investigations	$\% = \frac{A}{B} \times 100$	HOD-laboratory/ NABH team
3.	Percentage of laboratory reports correlating with clinical diagnosis	PSQ 3a	Correlation means that the test results should match either the diagnosis or differential diagnosis written in the requisition form	Number of test performed	Number of reports correlating with clinical diagnosis	$\% = \frac{A}{B} \times 100$	HOD-laboratory/ NABH team
4.	Percentage of adherence to safety precautions by employees working in lab	PSQ 3a		Number of employees sampled	Number of employees adhering to safety precautions	$\% = \frac{A}{B} \times 100$	HOD-laboratory/ NABH team

Radiology

PSQ Indicators

Sl.No	Indicator	NABH Standard	Description	Numerator (A)	Denominator (B)	Formula	Data collected by/Data assessed by
1.	Number reporting errors per 1000 investigations	PSQ 3a	Number of reporting errors picked up before and after dispatching of report. (It shall include transcription errors also)	Number of reporting errors picked up before and after dispatching of Report	1000 investigations	A = ---- X1000 B	HOD-Radiology/NABH team
2.	Percentage of Re-dos - Radiology	PSQ 3a	Number of Re-dos in Radiology. This shall also include tests repeated before release of the result.(to confirm the finding)	Number of Re-dos in Radiology	Total number of investigations	A % = ---- X100 B	HOD-Radiology/NABH team
3.	Percentage of Radiology reports correlating with clinical diagnosis	PSQ 3a	Correlation means that the test results should match either the diagnosis or differential diagnosis written in the requisition form	Number of test performed	Number of reports correlating with clinical diagnosis	A % = ---- X100 B	HOD-Radiology/NABH team
4.	Percentage of adherence to safety precautions by employees working in Radiology	PSQ 3a		Number of employees sampled	Number of employees adhering to safety precautions	A % = ---- X100 B	HOD-Radiology/NABH team

Human Resources Department

PSQ Indicators

Sl.No	Indicator	NABH Standard	Description	Numerator (A)	Denominator (B)	Formula	Data collected by/Data assessed by
1.	Employee satisfaction index (Percentage)	PSQ 3c	Sample Size- 10%	Score achieved	Maximum possible score	A % = ---- X100 B	Manager-HRM
2.	Employee attrition rate	PSQ 3c		Number of employees leaving the	Number of employees at the	A % = ---- X100	Manager-HRM

				organization per month	beginning of the month + newly joined staff	B	
3.	Employee absenteeism rate	PSQ 3c		Number of employees Who are on unauthorized absence	Total number of employees per month	A % = ---- X100 B	Manager-HRM
4.	Percentage of employees who are aware of employee rights, responsibilities & welfare schemes	PSQ 3c	Sample Size- 2 %	Number of employees aware of employee rights, responsibilities & welfare schemes	Number of Employees interviewed	A % = ---- X100 B	Manager-HRM
5.	Percentage of employees provided pre exposure prophylaxis	PSQ 3c		Number of employees who were due to be provided pre-exposure prophylaxis	Number of employees who were provided pre-exposure prophylaxis	A % = ---- X100 B	Manager-HRM

Operation Theatre

PSQ Indicators

Sl.No	Indicator	NABH Standard	Description	Numerator (A)	Denominator (B)	Formula	Data collected by/Data assessed by
1.	Percentage of unplanned return to OT	PSQ 3a		Number of unplanned return to OT	Number of patients operated	A % = ---- X100 B	OT-IN-CHARGE
2.	Percentage of rescheduling of surgeries	PSQ 3a	Rescheduling of patients includes cancellation & postponement of the surgery beyond 4 hours	Total number of Cases rescheduled	Number of surgeries performed	A % = ---- X100 B	OT-IN-CHARGE
3.	Percentage of cases where the organization's procedure to prevent adverse events like wrong site, wrong patient and wrong surgery have been adhered to.	PSQ 3d		Number of cases where the procedure was not followed.	Number of surgeries performed	A % = ---- X100 B	OT-IN-CHARGE
4.	Percentage utilization of OT	PSQ 3c		Number of hours theaters have been utilized in a month	Number of hours theaters are available in a month	A % = ---- X100 B	OT-IN-CHARGE
5.	Re-exploration rate	PSQ 3d		Number of re-exploration done during same admission	Total number of surgeries	A % = ---- X100 B	OT-IN-CHARGE

Pharmacy

PSQ Indicators

Sl.No	Indicator	NABH Standard	Description	Numerator (A)	Denominator (B)	Formula	Data collected by/Data assessed by
1.	Percentage of drugs and consumables procured by local purchase	PSQ 3c	These includes drugs & consumables which are not included in the hospital formulary at the time of prescription, but are then arranged by the hospital pharmacy for the patient within a short time	Number of items purchased by local purchase	Number of drugs listed in the hospital formulary and hospital consumables list	$\% = \frac{A}{B} X100$	HOD- Pharmacy
2.	Percentage of stock outs including emergency drugs	PSQ 3c	A stock out is an event which occurs when an item in a pharmacy or consumable store is temporarily unable to provide for an intended patient	Number of stock outs	Number of drugs listed in the hospital formulary and hospital consumables list	$\% = \frac{A}{B} X100$	HOD- Pharmacy
3.	Percentage of drugs & consumables rejected before preparation of goods receipt note	PSQ 3c	All materials received not in conformity with the specifications and requirements ordered for in the purchase order shall be rejected	Total quantity rejected	Total quantity received before GRN	$\% = \frac{A}{B} X100$	HOD- Pharmacy
4.	Percentage of variations from the procurement process	PSQ 3c	Variations from the written standardized procurement process of acquiring supplies from licensed, authorized, agencies, wholesalers/distributors	Total number of variations from the usual procurement process	Total number of items procured	$\% = \frac{A}{B} X100$	HOD- Pharmacy

Quality Educators

PSQ Indicators

Sl.No	Indicator	NABH Standard	Description	Numerator (A)	Denominator (B)	Formula	Data collected by/Data assessed by
1.	Time for initial assessment of inpatient	PSQ 3c	Average time taken for initial assessment of inpatient. (Sample size-20%)	The difference between time of admission to ward and time in which initial assessment chart is completed for inpatients	No. of inpatients admissions	A / B = average time per patient	Quality Educators
2.	Time for initial assessment of emergency patient	PSQ 3c	Average time taken for initial assessment of emergency patient (Sample size-20%)	The difference between time of entry in to emergency room and the time in which initial assessment chart is completed for emergency patients	No. of emergency patients per month	A / B = average time per patient	Quality educators
3.	Percentage of patients with care plan documented and countersigned by in-charge consultant	PSQ 3c	Care plan documented by ward doctor is countersigned by admitting consultant	No. of case sheets where care plan has been counter singed by admitting consultant	No. of inpatient admissions	% = A / B X100	Quality Educators
4.	Percentage of cases wherein screening for nutritional needs has been done.	PSQ 3c	Number of inpatients where screening for nutritional needs has been completed by the dietician. (Sample size-20%)	Number of inpatient records where screening for nutritional needs has been completed by the dietician	No. of inpatient admissions	% = A / B X100	Quality Educators
5.	Percentage of cases (in-patients) wherein the nursing care plan is documented.	PSQ 3c	Nursing care plan shall be the outcome of the nursing assessment done at the time of admission	Number of inpatient case records wherein the nursing care plan has been documented	Sample size (20%)	% = A / B X100	Quality Educators
6.	Percentage of cases who received appropriate prophylactic antibiotics within the specified time frame.	PSQ 3a		Number of patients who did not receive prophylactic antibiotics	Number of surgeries performed	% = A / B X100	Quality Educators/HIC team
7.	Appropriate handovers during shift change	PSQ 3a		Total number of handovers done appropriately	Total number of handover opportunities	% = A / B X100	Quality Educators/Safety team
8.	Incidence of patient identification errors	PSQ 3d		Number of patient identification errors	No of patients	% = A / B X100	Quality Educators/Safety team

9.	Compliance to hand hygiene practices	PSQ 3b		Total number of hand hygiene missed opportunities	Total number of hand hygiene opportunities	A % = ---- X100 B	Quality Educators/Quality team
10	Compliance to Medication prescription in capitals	PSQ 3d		Total number of prescriptions in capital letters	Total number of prescriptions	A % = ---- X100 B	Quality Educators/clinical pharmacologist

Emergency Nursing

PSQ Indicators

Sl.No	Indicator	NABH Standard	Description	Numerator (A)	Denominator (B)	Formula	Data collected by/Data assessed by
1.	Time for initial assessment of emergency patients	PSQ 3c	Average time taken for initial assessment of inpatient (Sample size-20%)	The difference between time of admission to ward and time in which initial assessment chart is completed for inpatients	No. of inpatients admissions	A ---- B = average time per patient	Head-Emergency Nursing
2.	Return to the emergency department within 72 hours with similar presenting complaints	PSQ 3d		Number of returns to the emergency department within 72 hours with similar presenting complaints	Number of patients who have come to the emergency	A % = ---- X100 B	Head-Emergency Nursing

Clinical Pharmacist & Nurse Educator

PSQ Indicators

Sl.No	Indicator	NABH Standard	Description	Numerator (A)	Denominator (B)	Formula	Data collected by/Data assessed by
1.	Incidence of medication errors	PSQ 3d	2% of admissions to be captured.	Total number of medication errors in a month	Total number of discharges and deaths in a month	$\% = \frac{A}{B} \times 100$	Clinical Pharmacist/ Nurse Educator
2.	Percentage of admissions with adverse drug reactions	PSQ 3d		Total number of adverse drug reactions in a month	Total number of discharges and deaths in a month	$\% = \frac{A}{B} \times 100$	Clinical Pharmacist/ Nurse Educator
3.	Percentage of medication charts with error prone abbreviations	PSQ 3d	2% of admissions to be captured.	Number of medication charts with error prone abbreviations	Number of medication charts reviewed	$\% = \frac{A}{B} \times 100$	Clinical Pharmacist/ Nurse Educator
4.	Percentage of patients receiving high risk medications developing adverse drug event	PSQ 3d	Denominator can be captured from the pharmacy by having a master list of inpatients who have been dispensed high-risk medications	Number of patients receiving high risk medications who have an adverse drug event	Number of patients receiving high risk medications	$\% = \frac{A}{B} \times 100$	Clinical Pharmacist/ Nurse Educator
5.	Time taken for discharge	PSQ 3c		Time from which doctor writes discharge order to the time of final clearance	Number of patients studied	$\frac{A}{B}$ = average time per patient	Nurse educator
6.	Inpatient satisfaction index (Percentage)	PSQ 3c		Score achieved	Maximum possible score	$\% = \frac{A}{B} \times 100$	Nurse Educator

QMS/Accreditation Coordinator

PSQ Indicators

Sl.No	Indicator	NABH Standard	Description	Numerator (A)	Denominator (B)	Formula	Data collected by/Data assessed by
1.	Mortality Rate	PSQ 3a		Number of deaths	number of discharges & deaths	% = A / B X100	MRD/QMS department
2.	Percentage bed occupancy	PSQ 3c		Number of inpatients days in a given month	Number of available bed days in that month	% = A / B X100	MRD/QMS department
3.	Average length of stay	PSQ 3c		Number of inpatient days in a given month	Number of discharges and deaths in that month	= A / B	MRD/QMS department
4.	Number of sentinel events reported, collected and analyzed within the defined time frame	PSQ 3d	Data from QA committee	N.A	N.A		QMS Department
5.	Percentage of near misses analyzed	PSQ 3d	A near miss is an unplanned event that did not result in injury, illness, or damage-but had the potential to do so.	Number of near misses reported	Total number of incident reports	% = A / B X100	QMS Department
6	Nurse patient ratio for ICU	PSQ 3c		Number of staff per shift	Number of beds	A / B	Nursing superintendent/QMS Department
7	Caesarian rate	PSQ 3a		No of Caesarians done	Total number of deliveries	A / B	OBG nurse/QMS department
8	Antiplatelet agent prescribed to MI patients at discharge	PSQ 3a		No of patients where antiplatelet was prescribed	Total number of patients with MI	% = A / B X100	CCU nurse/QMS department
9	Timely cessation of antibiotics in Surgical patients	PSQ 3a		Number of patients where antibiotics where stopped on time	Number of patients operated on	% = A / B X100	OT nurse/ QMS department
10	Pain relief following intervention	PSQ 3a		Number of patients where pain scale was zero after intervention	Total number of patients given intervention for pain	% = A / B X100	QMS department
11	Incidence of theft	PSQ 3c		Number of thefts	Number of incidence reported	% = A / B X100	QMS department

12	Timely refilling of fire extinguishers	PSQ 3c		Number of fire extinguishers filled on time	Total Number of extinguishers	A % = ---- X100 B	Facilities/QMS Department
13	Turnaround time for dispensing medicines in Pharmacy	PSQ 3c	Time shall begin from the time when prescription was received in pharmacy till the time when medicine was dispensed	Sum of time taken	Total number of prescriptions	A ---- B	Pharmacy/QMS department
14	Percentage of Absconding cases	PSQ 3c		No of patients absconded	Total number of inpatient days	A % = ---- X100 B	Safety team/QMS department

ICU

PSQ Indicators

Sl.No	Indicator	NABH Standard	Description	Numerator (A)	Denominator (B)	Formula	Data collected by/Data assessed by
1.	Return to ICU within 48 hours	PSQ 3d		Number ofReturns to ICU within 48 hours	Number of discharges /transfers & deaths in the ICU	A % = ---- X100 B	ICU Nurse/ NABH team
2.	Reintubation rate	PSQ 3d	This shall include reintubation within 48 hrs of extubation	Number of reintubations within 48 hrs of extubation	Number of intubations	A % = ---- X100 B	ICU nurse/NABH team
3.	Incidence of fall	PSQ 3d		Number of falls	Number of discharges and deaths	A = ---- X1000 B	ICU nurse/NABH team
4.	Percentage utilization of ICU	PSQ 3c		Number ICU patient days in a month	Number of ICU patient days available in a month	A % = ---- X100 B	ICU/QMS department
5.	Standardised mortality ratio for ICU	PSQ 3a		Actual Death in ICU	Predicted deaths in ICU	A % = ---- X100 B	ICU nurse/NABH team

MEDICAL DIRECTOR

Vision

To emerge as the preferred healthcare provider in the tristate region through quality, safety and reliability.

Mission

To provide, affordable, scientific, ethical and high-quality, tertiary health care services to all.

To assist the medical and nursing colleges with their educational and research goals.

Quality Policy

To provide optimal, timely and cost-efficient care to all our patients through continuous quality improvement.

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