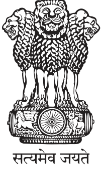
सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

NHSRC

GUIDELINES FOR CERTIFICATION

of Public Health Facilities
based on
NATIONAL QUALITY ASSURANCE STANDARDS



GUIDELINES FOR CERTIFICATION

of Public Health Facilities based on National Quality Assurance Standards

CONTENTS

Introduction	1
Conducting Assessment & certification	3
External Assessment	4
Pre- Assessment	5
Guiding principle for Assessors	7
During Assessment	8
Post Assessment Process	10
Criteria for National Certification	11
Audit man-days	12
Award of certification	13
Result Declaration	15
Record Keeping	16
Validity	17
Surveillance	18
STATE CERTIFICATION	**19**
Overview	*19*
Role of NHSRC in State Certification	*26*
ANNEXURES	
Annexure-I	*27*
Annexure-II	*29*
Annexure-III	*32*

Annexure-IV 33
Annexure - V 33
Annexure - VI 34
Annexure - VII 34
Annexure - VIII 35
Annexure-IX 47
Annexure - X 48
Annexure – XI 49

INTRODUCTION

BACKGROUND

National Quality Assurance Programme under National Health Mission (NHM) has been launched with objective of assuring Quality Services at public health facilities, and also to improve it further for enhanced users' experience at the facilities. The programme envisages implementation of holistic approach for Quality Management System at the public health. Under National Quality Assurance Program, two types of certifications are envisaged state and national level of certification.

State Certification	National Certification
❍ Responsibility of State/SQAU ❍ Validity one year ❍ Facility shall apply for National certification within one year of attaining State Certification	❍ Responsibility of CQSC/NHSRC ❍ Validity three years ❍ After national certification, facility will undergo Surveillance audit by SQAC for next 2 years. ❍ Financial incentives as per level and scope of certification

During the course of implementation states, health facilities' and service providers have felt a need of having guidelines for the certification of the facilities under NQAP; hence this supporting document has been created.

OBJECTIVES

1. To build an institutional framework mechanism for conducting Quality Assessments in health facilities.
2. To maintain a repository of NQAS Certification.
3. To provide holistic view to QA Assessors on methodology, scope of work, technical and managerial aspects for conducting QA assessments.
5. Surveillance assessment of health facilities in second & third year after their National Level certification.

SCOPE

The scope of these Guidelines is limited to:

- Assessment of primary and secondary care public health facilities i.e. District Hospitals, Sub-Divisional Hospitals, Community Health Centres, Primary Health Centres and Urban Primary Health Centres for NQAS certification.
- Surveillance assessment of public health facilities certified at national level.

TARGET AUDIENCE

- State National Health Mission and Quality Assurance Committee.
- District NHM and Quality Assurance Committee.
- Certified Internal and external assessors.
- Hospital Quality Team/Administrators.

CONDUCTING ASSESSMENT & CERTIFICATION

State Quality Team after conducting the state level assessment check for compliance of the facility for Quality certification and submit required documents along with application form to JS (P) & Certification cell at NHSRC

Certification Cell processes the application to NHSRC state consultant to check for documents and verify compliance to certification criteria

Document submitted are satisfactory & meet Certification criteria

No

NHSRC Consultant intimate to state & state QA officer intimates the facility and ask to incorporate necessary changes & re submit

Yes

Certification cell processes the application and finalizes a date of assessment with mutual consent

Certification cell appoint a team of assessors based on Scope of assessment

Assessors prepare for assessment and conveys itinerary to State/ Facility coordinator

Assessors ask for the required documents from the facility

Document submitted are adequate

No

Assessors inform deficiencies to the facility and seek clarifications

Yes

Assessors conduct the assessment. Prepare and submit the report to certification cell

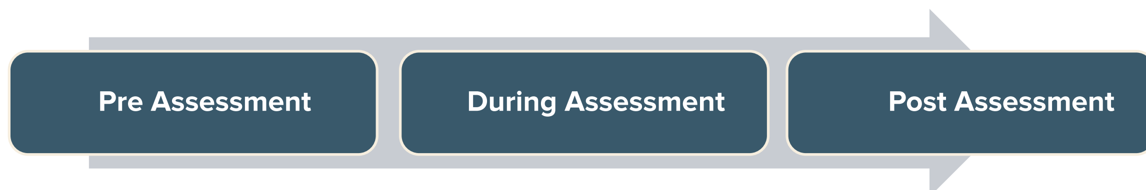
Verification and validation of report by Certification Cell

Final result is prepared and sent to MoHFW

Quality Certification is provided to health facility by MoHFW

EXTERNAL ASSESSMENT

External assessment of a health facility is a dynamic process that involves the facility, state and national team. The process is divided into 3 main steps as given below:-



External assessment is a systematic design, meticulous methodology, decisive leadership, good communication, involvement and the ownership of the work from relevant stake holders with a team spirit. It may be accomplished through support from senior decision makers and engagement with local priorities, availability of resources and finally an element of chance of improvement. External assessment is organized by the organization/institution/health facility marked by the non biased personnel and conducted through standardized test, observation and other techniques by an external agency other than the internal staff. They are all meant to assure or improve elements of quality. External assessments occur less frequently than internal assessment, but they usually have greater importance, more authority and higher stakes attached to them. External assessments have been used as indicators of both the achievement of targets and the quality of care in health facilities.

PRE - ASSESSMENT

STEP – I

A facility performing consistently well in the state level assessment and meeting all certification criteria of National Quality Assurance Standards to be recommended for the National level Certification. (Application form is annexed as Annexure I)

State Quality Assurance Committee/Unit prior to making recommendations for national certification also checks for fulfilment of conditionalities (Checklist for review of documents is attached as Annexure – II)

STEP – II

- The certification cell at NHSRC starts the process of state certification within 1 week of receiving the application and shall complete the entire process within 3 months.
- The date of external assessment is finalized with the mutual consent of the facility, after the finalization of the assessment date a team of assessors is finalized for conducting assessment.
- **Selection of Assessment team:**
  - Team of Assessors are selected from the pool of empanelled external NQAS assessors. Each team have 2–3 assessors that comprise of Clinicians/Nursing professionals/Public health experts and Quality/Management experts. The number may vary depending upon the type of health facility (DH, SDH, CHC, PHC & UPHC) and scope of services applied for the QA certification.
  - Each assessment team would be led by a ' Team Leader' selected by the team members amongst themselves based on experience, qualification and seniority. Assessment team may plan and assess the respective department based on their experience and expertise.
  - It is ensured that the assessors working in state and district would not be deputed for conducting assessment in the same state they belong or have spent more than six months in a state/district. Assessor to sign and submit Declaration form of Impartiality and Confidentiality to NHSRC certification cell before starting assessment (Declaration form of Impartiality and Confidentiality Annexure attached as Annexure III)
  - Assessors are deputed to conduct assessment at every level of facility i.e. DH, SDH, CHC, PHC & UPHC.

- Assessors are contacted through google sheet to confirm their availability for conducting the assessment, once they mark their availability for a stipulated time they are contacted for undertaking assessments.
- All the assessors are contacted for conducting minimum 02 assessments per year.
- Assessors those are engaged in unethical practices/breach of protocol/and against those the facility has submitted negative feedback of the assessment are not deputed for further assessments till the issue is resolved through appeal committee.

- The facility and state shall nominate the nodal person who will undertake further communication regarding assessment and the same is communicated to certification cell at NHSRC.
- Allocated assessor details are communicated to the state/facility with in 10 days of finalization of assessors.
- In case of any change of assessor, it will be communicated through mail to the state in-charge.
- A toolkit comprising of word format report, customized checklist (based on facility requirements), guidelines for assessment, opening & closing meeting format are sent to team of assessors for taking printouts as deemed appropriate to conduct the scheduled assessment.

STEP – III

Preparation of Assessment by Assessors

- The assessor team undertakes desktop review of all the documents provided to them by the facility.
- The team leader will prepare a mutually agreed assessment plan (Format is attached as Annexure IV) amongst the team of members and share with the facility. The work is allocated in line of expertise, skill set and experience of concerned team members.
- The team leader shall coordinate with the nodal person of the facility for seeking any clarifications and resolving queries.
- Once all team members are satisfied with the desktop review of documents the team leader informs the facility about the preparedness of the team for the assessment.
- Cost of travel, boarding, lodging local transport and per-diem payment shall be borne by the State/District. District/State may either book tickets (as per the operational guideline norms) for the assessors or alternatively reimburse travel expense while making per-diem payment at the end of assessment. The payment must be made within 15 days of completion of assessment.
- Assessors must arrange the print outs (checklists, forms, authorization letter)/soft copies of the documents required by them for assessment.
- Some of the information that will help in assessment includes:
  - Review of findings of state assessments conducted by SQAU.
  - Locally prevalent diseases.
  - Health seeking behaviour of population catered by the facility.
  - Social and cultural preferences of the community, dependent upon the health facility.
  - Social, Legal, Economical, Political and Technological environment of the state.

GUIDING PRINCIPLES FOR ASSESSORS

National Certification Cell at NHSRC expects that the Assessors/State QA Unit/Health facilities observe the highest standard of ethics and professionalism & un-biased during the execution of such assessments and ensures that no “corrupt practice”, “fraudulent practice” or “coercive practice” is practiced.

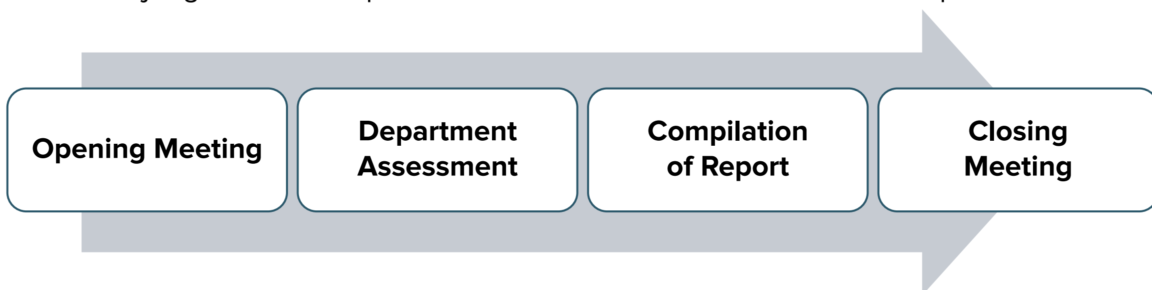
Few of the guiding principle for the assessors are mentioned below:

1. Assessors are expected to treat facility’s staff with respect.
2. Assessors must depict patience with review of documents in departments.
3. Assessors must follow unbiased and fair presentation while assigning and reporting the scores during the assessments.
4. Assessors must exhibit honesty, integrity and sincerity while conducting assessments.
5. Assessors to ensure confidentiality in conducting assessment and ensure that no support to be seeked from the facility while entering scores in the excel tool to maintain confidentiality in the assessment conducted.
6. Assessors to follow evidence based approach.
7. Assessors to adhere not to communicate any false, erroneous or misleading information that may compromise the integrity of any assessment.
8. Assessors are discouraged in accepting any inducement, commission or gift or any other benefit from any interested party while conducting assessments.
9. Cooperate fully with any inquiry in the event of a complaint about their performance as an assessor, or any alleged breach of this code
10. Refrain from making any comments on any other assessor, NHSRC or MoHFW.
11. Respect patients’ rights during any interaction especially when assessing vulnerable patients.

Assessors must refer the ISO rules 19011:2011 clause 4 and Annexure A & B before going for assessments.

DURING ASSESSMENT

Assessment is the ongoing process of gathering, analyzing and reflecting on evidence to make informed and consistent judgements to improve future outcome as “What measured improves”.



1. OPENING MEETING

Assessors must reach the facility well before the scheduled time and meet the nominated nodal person in the facility for facilitatory support.

A formal opening meeting to be conducted between the assessor’s team and head of departments/ designated department in-charge in the hospital (Format of Opening meeting is attached as Annexure - V). During the meeting the hospital management shall introduce all the assessors with stake holders for the ease of assessment. The assessors shall discuss their assessment schedule (Format is attached as Annexure – VI) and methodology with the stake holders and confirm convenience of the departments. As far as possible, efforts should be made so as not to disturb normal functioning of the hospital.

2. FACILITY ROUNDS

The assessors will proceed for assessment in their selective departments. Assessment is based on rationale and measurable evidence. Assessors may use either Gunak app/paper checklist/excel tool[1] to generate the scorecard. The excel tool has department wise checklist i.e. 18, 12, 06 & 12 checklists in District Hospital, Community Health Centre, Primary Health Centre and Urban Primary Health Centre respectively.

Assessors may collect the information and evidence from various methods, but with not limited to few which are enlisted below:

Assessment methods

- Observation
- Patient Interview*

1 Excel tool – the checklists provided for assessments.

- Staff Interview*
- Record Review

Knowing the checklist beforehand may ease the assessment in the department. Assessors are required to correlate the things where ever possible or required. Every possible effort should be made to collect accurate and measurable information by reliable and justified evidence.

**For conducting interviews few points should be kept in mind i.e. willingness of the candidate, providing conducive environment and lastly maintaining the confidentiality of the shared information.*

Scoring Rule

All the assessors' needs to put score against all the checkpoints:-

Full compliance (2 Marks)

- All requirements in checkpoint & tracers are meeting.
- Intent of measurable element is being met.

Partial compliance (1 Mark)

- Atleast 50% or more requirements mentioned in the checkpoints and means of verification is met.
- Intent of measurable element is partially met.

Non-Compliance (0 Mark)

- Less than 50% of the requirements mentioned in checkpoint and means of verification are met.
- Intent of measurable element is not met.
    - Only option available against each checkpoint is 0, 1, or 2. There is no option of NA (Not Applicable) as customization is done by state at the time of adoption of standards.
    - It is mandatory to provide justification and rationale in "Remarks" column for each partial and non-compliances i.e. scores of 0 and 1. There must be sufficient and concrete evidence for partial and non-compliances.

3. COLLATION & COMPILATION OF REPORTS

All the assessors will submit their department wise reports to the team leader. The team leader shall compile the scorecard and will prepare the final report. The team leader will circulate the final report to the team members and seek support for verification and completion. If deemed appropriate the assessors may re-visit the departments for verification or collection of evidence. The team leader will provide the collated data in an excel tool for ease of analysis which will provide overall hospital, department wise and area of concern wise score.

4. CLOSING MEETING

After completion of the assessment, a closing meeting is to be scheduled (Format is attached as Annexure – VII). Underlying principle of closing meeting is to highlight achievements/good practices, which were observed and mention about few points for improvement without disclosing actual scores of the facility and department. Final result of the assessment in term of facility's certification status is not expected to be discussed and disclosed. These major hospital & departmental gaps must be shared with the hospital management team and department heads for pursuing further improvement.

POST ASSESSMENT PROCESS

On completion of the facility assessment the team leader shall submit the final report to the Certification Cell at NHSRC within 03 days of completion of assessment. In case of any delay it is the responsibility of the assessor has to communicate the reason of delay to NHSRC through mail. With no reason the report should be submitted in more than 07 working days of completion of assessment. The assessor has to submit the following (No coloured printouts/pen drive are required):

i) One set of filled excel sheets of the departments assessed.

ii) Word format report of the facility. (format attached as Annexure –VIII)

iii) Declaration form of impartiality and confidentiality.

Certification cell collates the post assessment feedback against each assessor from the department those have been assessed by them. The department in-charge/facility in-charge provide feedback on the assessment process including conduct of the assessors within three days of completion of assessment to Certification Cell at NHSRC. Format for the feedback is given at Annexure – IX.

CRITERIA FOR NATIONAL CERTIFICATION

S.No.	Criteria	Aggregate Score (%)		
		DH	SDH/CHC	PHC/UPHC
1.	Aggregate score of the health facility	≥ 70%	≥ 70%	≥ 70%
2.	Score of each department of the health facility	≥ 70%	≥ 70%	NA
3.	Segregated score in each Area of Concern	≥ 70%	≥ 70%	≥ 60%
4.	Score of Standard	Standard A2, Standard B5 and Standard D10 is >70%	Standard A2, Standard B5 and Standard D8 is >60%	Standard A2, Standard B4 and Standard F6 (PHC)/F4 (U-PHC) is ≥ 60%
5.	Individual Standard wise score	≥ 50%	≥ 50%	≥ 50%
6.	Patient Satisfaction Score	70% or Score of 3.5 on Likert Scale	65% or Score of 3.2 on Likert Scale	60% or Score of 3.0 on Likert Scale

AUDIT MAN-DAYS

Type of Health Facility	Number of Assessor	Number of Working days
District Hospital* (for 18 departments)	03	03
Community Health centre	02	03
Primary Health Centre	02	02

** Number of deputed assessor may vary based on the number of departments to be assessed.*

AWARD OF CERTIFICATION

S. No.	Criteria	Quality Certified		
		DH	SDH/CHC	PHC/UPHC
1.	Aggregate score of the health facility	✓	✓	✓
2.	Score of each department of the health facility	✓	✓	NA
3.	Segregated score in each Area of Concern	✓	✓	✓
4.	Score of Core Standard	✓	✓	✓
5.	Individual Standard wise score	✓	✓	✓
6.	Patient Satisfaction Score	✓	✓	✓

<table>
<tr><th rowspan="2">S. No.</th><th rowspan="2">Criteria</th><th colspan="3">Quality Certified with Conditionality</th></tr>
<tr><th>DH</th><th>SDH/CHC</th><th>PHC/UPHC</th></tr>
<tr><td>1.</td><td>Aggregate score of the health facility</td><td>✓</td><td>✓</td><td>✓</td></tr>
<tr><td>2.</td><td>Score of each department of the health facility</td><td rowspan="5">At least three criteria out of remaining five
(✓)</td><td rowspan="5">At least three criteria out of remaining five
(✓)</td><td>NA</td></tr>
<tr><td>3.</td><td>Segregated score in each Area of Concern</td><td rowspan="4">At least three criteria out of remaining four (✓)</td></tr>
<tr><td>4.</td><td>Score of Core Standard</td></tr>
<tr><td>5.</td><td>Individual Standard wise score</td></tr>
<tr><td>6.</td><td>Patient Satisfaction Score</td></tr>
</table>

<table>
<tr><th rowspan="2">S. No.</th><th rowspan="2">Criteria</th><th colspan="3">Deferred</th></tr>
<tr><th>DH</th><th>SDH/CHC</th><th>PHC/UPHC</th></tr>
<tr><td>1.</td><td>Aggregate score of the health facility</td><td>✓</td><td>✓</td><td>✓</td></tr>
<tr><td>2.</td><td>Score of each department of the health facility</td><td rowspan="5">Does not meet at least three criteria out of remaining five</td><td rowspan="5">Does not meet at least three criteria out of remaining five</td><td>NA</td></tr>
<tr><td>3.</td><td>Segregated score in each Area of Concern</td><td rowspan="4">Does not meet at least three criteria out of remaining four</td></tr>
<tr><td>4.</td><td>Score of Core Standard</td></tr>
<tr><td>5.</td><td>Individual Standard wise score</td></tr>
<tr><td>6.</td><td>Patient Satisfaction Score</td></tr>
</table>

S. No.	Criteria	Declined		
		DH	SDH/CHC	PHC/UPHC
1.	Aggregate score of the health facility	Overall score is < 70%	Overall score is < 70%	Overall score is < 70%
2.	Score of each department of the health facility			
3.	Segregated score in each Area of Concern			
4.	Score of Core Standard			
5.	Individual Standard wise score			
6.	Patient Satisfaction Score			

RESULT DECLARATION

The certification cell abides by the Central Quality Supervisory Committee (CQSC) approved certification criteria for assuring the certification status of the health facility.

Based on the assessment report sent by a team of assessors, the certification cell shall proceed for certification/reassessment/not for certification and will communicate the same to the MoHFW. After receiving the final signed certification letter from AS & MD (NHM) the certification status of the health facility is declared to the state through mail and hard copy of the letter is dispatched. The certification cell at NHSRC appraises the Central Quality Supervisory Committee and Appeal Committee about the certification status of the assessed health facilities during the subsequent meetings.

Certification cell prepares the final certificates those are signed by AS & MD (NHM) and Advisor QI based on the certification Status of the facility. The Certificate depict the following:-

- Name of Health facility & Scope of department assessed.
- Certificate No.
- Date of Certification, its validity & due date of Surveillance assessment.

The certificate of certification shall be handed over to the facility within one month of the completion of declaration of assessment result.

POST RESULT DECLARATION ACTIVITIES

1. If the health facility meets all the certification criteria they are awarded with the Quality Certification under NQAS.
2. The health facilities those are certified with conditionality, the SQAU/DQAU is expected to plan for supportive visit to extend the technical support. The facility has to submit the evidences report for the closure of gaps found during the external assessment within six months of receipt of final report.
3. In case the facility does not meet all the certification criteria, the facility has to reapply for the certification. Before applying for the re-assessment, the district/state quality team must satisfy that the facility has made reasonable progress and expected to meet the certification criteria.

RECORD KEEPING

REPOSITORY OF CERTIFIED FACILITY DATA

Record keeping is an essential process. The record keeping at national level is done in both hard and soft copies. An updated national status of all the facilities is prepared and updated fortnightly by the certification cell. Scan copy of all the national certified facilities certificates are kept as a repository with the certification cell at NHSRC.

A track of all the facilities those have completed one year of assessment is maintained and a surveillance assessment mail to the respective States/UTs are is sent for submission of yearly surveillance assessment report.

RESOLUTION OF CONFLICTS/APPEAL

An appeal against hospital/assessors/breach in assessment protocol shall be made in writing to the Advisor QI, NHSRC. In following circumstances the appeal could be made through MD as enumerated below:

- In case the facility is not satisfied with certification results shared by the certification cell, the facility may appeal in writing to the certification.nqas@gmail.com with cc marked to jn.nhsrc@gmail.com with in 1 week of receiving the formal communication.
- If there is any disagreement amongst the team of assessors regarding the scores obtained by the facility, they may appeal in writing to certification.nqas@gmail.com within 4 working days of the completion/submission of the final scores to Certification Cell.
- Alleged for fraudant, corrupt, misleading practices; if any.

An Appeal Committee has been constituted at national level to resolve the issue. In case of non-acceptance of the decision of the appeal committee by the applicant, the appeal can be made to the AS & MD, NHM. The AS & MD shall go through the representations and come to a prima-facie view regarding the subject and AS & MD NHM will then appoint an arbitrator for the purpose. The arbitration shall be held in the state and decision shall be taken by AS & MD NHM based on relevant evidences for the same.

VALIDITY

- Certification/recertification is valid for a period of three years, subject to validation of compliance to the QA Standards by the SQAC team every year for subsequent two years.
- In the third year, the facility would undergo re-certification assessment by the national assessors after successful completion of two surveillance audits by the SQAC.

SURVEILLANCE

SURVEILLANCE ASSESSMENT

To ensure adherence to standards and delivery of Quality of Care in the certified departments, the State QA Unit will undertake surveillance assessment on the yearly basis for subsequent 02 years after attaining national certification and submit a report to QI Division within one week of due date of surveillance. QI division shall verify the report submitted. State Quality Assurance Committee reserves the right to carry out more frequent surveillance as & when necessary and in case of complaints/ concerns against the departments.

For undergoing surveillance assessment, the facility has to submit the action taken report in r/o all gaps observed during assessment.

The CQSC reserve the right to cancel/suspend the Quality Certificate of the hospital in case of any reasons as mentioned below, but not limited to:

- In case the facility does not meet the CQSC approved certification criteria in its subsequent surveillance assessment by SQAC / NHSRC.
- Discontinuity in Quality delivery of care.
- Non compliance or violation of the NQAS requirements.
- Providing insufficient or incorrect information to SQAC.
- Changes without SQAC and NHSRC approval.
- Improper use of Certification.
- Failure to report any major legal (mandatory compliance) changes.
- Any other condition deemed appropriate by SQAC.

STATE CERTIFICATION

OVERVIEW

State Certification is an integral part of the entire certification process. The State level assessment process stands same as the national assessment process as enumerated above in this document; the state must replicated the same process of assessment for state level certification. The additional guideline for State level certification is given below:

FUNCTION OF SQAU FOR QUALITY CERTIFICATION

A small secretariat needs to be constituted at state level within SQAU under the MD/Nodal Officer as the overall in-charge. One consultant shall be assign with a task of coordinating external assessment and keeping record. The key responsibility of this secretariat would be:

1. To receive application for state certification.
2. To review the documents submitted by facility.
3. To assign assessors for state certification.
4. Create a pool of external and internal assessors.
5. To maintain all records related to state certification e.g. applications, documents submitted, assessment reports, certification status and certificates.
6. Analysis of the reports submitted by assessors.
7. Analysis of the feedback of assessors received from facilities.
8. To schedule 'Surveillance Audit' one month prior to due date of national level certified facilities.
9. Issue certificates.
10. Training and capacity building of assessors as and when required.

PRE- ASSESSMENT PROCESS

The process stands the same as of national assessment process, however for finalization of assessors, State can select assessors from State's pool of Certified NQAS internal and external assessors. The below mentioned criteria to be ascertained while selection of assessors for State level certification assessment.

- Certified Internal & External Assessors of the state who have undergone five day & two days training programme respectively under National Quality Assurance Program and have been issued proficiency empanelment certificate from NHSRC.

- Assessors having atleast 5 years of experience in Public health.
- Assessors would not be conducting assessment in the district where they have been working during preceding 05 years.
- Assessor are expected to sign and submit Declaration form of Impartiality and confidentiality to SQAU before starting assessment (Declaration form of Impartiality Annexure attached as Annexure III).
- Each team is expected to have One (01) NQAS certified external assessor along with another NQAS certified assessors.
- Each assessment team would be led by a 'Team Leader' selected and designated by SQAU (State Quality Assurance Unit) based on experience, qualification and seniority.

DURING- ASSESSMENT PROCESS

During assessments activities remains same as national level assessment protocol.

POST ASSESSMENT PROCESS

Post assessment the score cards to be submitted to SQAU for final report preparation. The assessors support the healthcare in improving its delivery of services by discussing their gaps and way forward for preparation of time bound action plan. (Format attached as Annexure–X) for the observed gaps.

The hospital management shall fill an Assessor Performance Appraisal form (APA) and submit it to SQAU with in one week of completion of the assessment (Format attached as Annexure–IX).

State Certification Criteria

S. No.	Criteria	Aggregate Score (%)		
		DH	SDH/CHC	PHC/UPHC
1.	Aggregate score of the health facility	≥ 65%	≥ 65%	≥ 65%
2.	Score of each department of the health facility	≥ 65%	≥ 65%	NA
3.	Segregated score in each Area of Concern	≥ 65%	≥ 65%	≥ 55%
4.	Score of Core Standard	Standard A2, Standard B5 and Standard D10 is >65%	Standard A2, Standard B5 and Standard D8 is >55%	Standard A2, Standard B4 and Standard F6 (PHC)/ F4 (U-PHC) is ≥ 55%
5.	Individual Standard wise score	≥ 45%	≥ 45%	≥ 45%
6.	Patient Satisfaction Score	65% on Mera Aspatal or Score of 3.2 on Likert Scale	60% on Mera Aspatal or Score of 3.0 on Likert Scale	55% on Mera Aspatal or Score of 2.75 on Likert Scale

RESULT DECLARATION

The SQAC shall abide by the Central Quality Supervisory Committee (CQSC) approved certification criteria for assuring the certification status of the health facility.

Based on the assessment report, the State Quality Assurance Unit shall proceed for certification/ reassessment/not for certification and will communicate the same to the District Quality Assurance Committee and to the facility. The State Quality Assurance Unit shall appraise the State Quality Assurance Committee about the certification status of the assessed health facilities during the subsequent meetings.

SQAU shall approach to designated authorities for signing of the certificate. The certificate must clearly depict the following:

- Name of Health facility & Name of Quality Certified department
- Address of the facility
- Certificate No
- Date of Certification, its validity & due date of Surveillance

The certified facility certificates to be signed by Health Secretary, Mission Director NHM and Nodal Officer of the State. The certificate of certification shall be handed over to the facility within 1 month of the completion of final assessment.

Copy of following shall be shared with NHSRC for all state certified facilities:

- Filled checklist for all assessed departments (Soft copy of excel sheet).
- Duly signed Declaration form of assessors (Scanned copies of forms).
- Scanned copy of attached report format.

RECORD KEEPING

Repository of Certified Facility Data

Record of both hard & soft copies of filled excel sheets, word format report and scanned copy of NQAS certificates should be kept at state level for five years. Thereafter scanned copies of all the reports may be retained for 10 years and hard copies may be discarded as per the condemnation policy of the state.

A master excel tool of certified facilities may be prepared by the State Quality Assurance Unit along with a Master register, both of these shall highlighted the below mentioned items :-

1. Name of the certified facility
2. Address of the certified facility
3. Scope of the services certified in the facility
4. Date of certification
5. Date of renewal of certification
6. Due dates of subsequent visit

The master register shall be signed quarterly by the Chairperson of State Quality Assurance Committee.

Repository of Monthly data

The SQAU shall maintain the repository of monthly KPI data reported to them from all the DQAC's, especially of the state certified facilities. The data can be utilized for decision making at State & District level Programs Implementation.

Resolution of Conflicts/Appeal

An appeal against hospital/assessors/breach in assessment protocol shall be made in writing to the Chairperson SQAC. An Appeal Committee will be constituted out of the State Quality Assurance Committee to resolve the issue.

In case of non-acceptance of the decision of the Appeal Committee by the applicant, the appeal can be made to the MD, NHM/Health Secretary of the State. The MD NHM/Health Secretary shall go through the representations and come to a prima-facie view regarding the subject and MD NHM/Health Secretary will then appoint an arbitrator for the purpose. The arbitration shall be held in the State and decision shall be taken by MD NHM/Health Secretary based on relevant evidences for the same.

In following circumstances the appeal could be made to the SQAC as enumerated below:

- The facility is not satisfied with certification results shared by the State Quality Assurance Unit (SQAU), the facility may appeal in writing to the SQAC with in 1 week of receiving the formal communication.
- Disagreement amongst the team of assessors regarding the scores obtained by the facility, they may appeal in writing to the SQAC within three working days of the completion/submission of the final scores to SQAU.
- Alleged for fraudant, corrupt, misleading practices; if any.

SURVEILLANCE ASSESSMENT

The State Quality Assurance Unit shall conduct an annual surveillance. State Quality Assurance Committee reserves the right to carry out more frequent surveillance as necessary and in case of complaints/concerns against the hospitals.

The facility has to submit gap analysis report and time bound action plan undertaken for closure of the gaps found during last state level assessment.

The SQAC may suspend or cancel an approval because of any of the points mentioned in National level suspension clause including below mentioned points, but not be limited to:

1. In case the facility does not meet the CQSC approved certification criteria in its subsequent surveillance assessment by SQAC.
2. Lapse in reporting monthly KPI of consecutive 3 months to SQAC.
3. Changes without SQAC approval.
4. Failure to report any major legal (mandatory compliance) changes.
5. Any other condition deemed appropriate by SQAC.

VALIDITY

- State certification is valid for one year.
- The certified facilities in the previous year would have to show an improvement in the scores by atleast 5% from previous year score. There should also be improvement in KPI and other outcomes. If the certified facility does not meet the said criteria the facility shall not be receiving state certification for current year.
- The facility shall proceed for national level certification within one year of receiving state level certification. In case the facility does not apply for National Certification, the same may not be eligible for state certification for consecutive year.

ROLE OF NHSRC IN STATE CERTIFICATION

1. Status of the state certified hospitals to be shared with NHSRC within one week of state certification.
2. 5% of the state certified facilities would be re-verified by the QI Division at NHSRC.
3. While resolution of conflicts, representation from QI Division, NHSRC to be ensured.
4. Copy of state level certified facilities reports (format attached as Annexure-XI), copy of certificate issued and list of external assessors used for assessment to be submitted to QI Division, NHSRC.
5. In case of any discrepancy found in the entire certification process/reports, QI Division, NHSRC holds the right to escalate the same to MoHFW for undertaking necessary actions.

ANNEXURE – I

APPLICATION FORM FOR EXTERNAL CERTIFICATION OF QUALITY OF SERVICES

No. 01/15/09/18

- *Kindly Fill the form in BLUE Ink only*

From

State Quality Assurance Committee

....

....

No. Date:

To,
Joint Secretary (Policy)
Ministry of Health & Family Welfare
Government of India
Nirman Bhawan, Maulana Azad Road,
New Delhi – 110011

REQUEST FOR ASSESSMENT OF HEALTH FACILITY FOR QUALITY CERTIFICATION

Sir,

We are happy to inform that Quality Assurance Programme at following Health facility in the State/UT has made substantial progress and the health facility has scored .... (percentage of marks obtained in SQAC Assessment) –

Name of Health Facility:
Full Address:

Hence, we request you to issue instructions for assessment of the health facility for the MoHFW GoI Quality Assurance certification. Detail information on the health facility is given in the attached **Appendix-I.**

Thanking you.

Yours Sincerely

(......................................)

Chairperson
SQAC

HOSPITAL DATA SHEET

(to be enclosed with the application for External Quality Certification)

1. Name of Health Facility	
2. Full Address	
3. Contact Details	
a. SQAU	i. Nodal Officer: ii. Email: iii. Tel: iv. Score of the facility on SQAU Assessment:
b. DQAU	i. Nodal Officer: ii. Email: iii. Tel: iv. Score of the facility on DQAU Assessment:
c. Facility	i. In-charge: ii. Email: iii. Tel: iv. Score of the facility on internal Assessment:
4. No. of departments in hospital as per NQAS	
5. No. of departments applied for assessment	
6. Nearest Railway Station	
7. Nearest Airport	
8. Details of Hospital	
a. Number of Beds	i. Sanctioned beds: ii. Functional Inpatient beds:
b. Distribution of Beds	i. Medical: ii. Surgical: iii. Gynae: iv. Maternity:
	v. Paediatrics: vi. Orthopaedics: vii. Ophthalmology: viii. ENT: ix. ICU: x. SNCU: xi. Other (Please add):
9. Maternal Services	a. Number of deliveries in a month b. Number of Caesarean Section in a month
10. OPD Services	
11. Laboratory Services	Average Number of tests conducted per month
12. Radiological Services –	a. No. of X-ray machines b. No. of Ultrasound assessment b. CT Scan d. Any other

ANNEXURE – II

CHECKLIST FOR REVIEW OF DOCUMENTS

CHECKLIST FOR REVIEW OF DOCUMENTS			
OBSERVATION	**YES**	**NO**	**REMARKS**
Customization of National Quality Assurance Standards			
Has the state customized NQAS			
If yes, is the customized version approved by SQAC & NHSRC			
Copy of customised Standards and Assessment Tools submitted.			
Internal Assessment by Facility with involvement of DQAC/DQAU			
Facility has conducted internal Assessment with involvement of DQAC/DQAU.			
Complete Assessment Report and Scores submitted?			
Details of Assessment Team (Name & Designation) provided.			
Approved Internal Assessment Plan for One year submitted.			
Quality Policy and Quality Objectives			
Quality Policy submitted.			
Quality Policy is approved by head of institution?			
Overall Quality Objectives of Hospital Submitted?			
Quality objectives of all Departments submitted?			
Quality objectives are in line with Quality Policy?			
Quality objectives are SMART?			
Defined Mechanism to monitor and Track Quality Objectives.			
Operational Quality Team			
Supporting Document/Office order submitted regarding constitution of Quality Team?			
Quality Team is multi-disciplinary with representation from all departments (Clinical, Admin, Support)			
Records of proceedings (MOM) of at least three consecutive monthly meeting?			
Standard Operating Procedures (SOP)			
All required SOPs are submitted.			
All SOPs are drafted and approved by competent Authority?			
All SOPs adequately describes the process and have details as per National Quality Assurance Standards.			

CHECKLIST FOR REVIEW OF DOCUMENTS			
OBSERVATION	**YES**	**NO**	**REMARKS**
Quality Improvement Manual			
Quality Improvement Manual submitted.			
Manual is approved by competent Authority.			
Manual is complete in all respects and adequately describes the process as per NQAS?			
Defined Hospital wide Policies			
Condemnation Policy			
End of Life Care Policy			
Antibiotic Policy			
Visitor Policy			
Non-Discrimination to Gender Policy			
Religious and Cultural Preferences Policy.			
Social Non-Discrimination Policy.(including policy on disability friendly atmosphere)			
Privacy, Dignity and Confidentiality Policy			
Maintenance of Patient Records and information Policy.			
Privacy of patients with social stigma Policy.			
Consent Policy			
Change of linen in patient care area Policy.			
Judicial use of PPEs Policy			
Prescription by Generic names Policy			
Reporting of Adverse Events Policy			
Referral of patients if services cannot be provided Policy			
Consultation of patients within Hospital Policy			
Handover during interdepartmental transfer Policy			
Internal adjustments in case of non-availability of beds Policy			
Dress Code Policy			
Narcotic Drugs and Psychotropic substances Policy			
Policy for avoiding stock outs of drugs and consumables and ensuring availability of drugs as per EDL.			
Policy for regular competence testing as per job description.			
Policy for Timely reimbursements of entitlements and compensation.			

CHECKLIST FOR REVIEW OF DOCUMENTS			
OBSERVATION	**YES**	**NO**	**REMARKS**
Policy for ensuring free of cost treatment to BPL patients.			
Grievance redressal Policy			
No smoking Policy			
Quality Policy.			
Patient Satisfaction Surveys			
Records of at least 3 consecutive surveys submitted.			
Analysis of the surveys submitted.			
CAPA undertaken to improvise the PSS			
Key Performance Indicators (KPIs)			
Records of at least 3 months of KPIs.			
Action plan prepared.			
Action plan is based on internal Assessment's findings.			
Actions taken.			
Audits			
Audit reports of 3 consecutive Medical Audits			
Audit report of 3 consecutive Death Audits			
Audit reports of 3 consecutive Prescription Audits.			

Note- *Copy to act should be available at facility level.*

ANNEXURE – III

DECLARATION BY ASSESSORS

Name of Assessment of Public Health Facilities under National Quality Assurance Standard

National/State Assessment

Declaration of Impartiality and Confidentiality

(To be filled in by each Assessor and to be enclosed with the Assessment Report)

<table>
<tr><td>1.</td><td>Name</td><td></td></tr>
<tr><td>2.</td><td>Address</td><td></td></tr>
<tr><td>3.</td><td>Qualification</td><td></td></tr>
<tr><td>4.</td><td>Organization</td><td></td></tr>
<tr><td>5.</td><td>Designation</td><td></td></tr>
<tr><td>6.</td><td>Date (s) of Assessment</td><td></td></tr>
<tr><td>7.</td><td>Areas to be assessed</td><td></td></tr>
<tr><td>8.</td><td>Name and Address of the health facility going to assess</td><td></td></tr>
<tr><td>9.</td><td colspan="2">I declare that
i) I have not offered any guidance, supervision or other services to the above mentioned health facility, in any way.
ii) I do not have any commercial interest in the above mentioned health facility.
iii) I am not an ex-employee of the health facility and am not related to any person of the management/Employee of the above mentioned health facility.</td></tr>
<tr><td>10.</td><td colspan="2">I under take that
i) I shall maintain strict confidentiality of the information acquired through various documents like health facility records, Quality Manual, Standard Operating Procedures, Internal Reports, etc., of the above mentioned public health facility and other related information that might have been given by NHSRC/State Quality Cell, in the course of discharge of my responsibility and shall not disclose to any person other than that required by National Health Systems Resource Centre- Delhi/State QA Cell, (Name of State ....)
ii) I shall neither copy any documentation nor divulge any information to any third party without the written prior consent of the above mentioned public health facility or National Health System Resource Centre/State QA Cell, (Name of State ....)
iii) I shall maintain an independent entity and act impartially with integrity during assessment. I shall not act in any damage to the reputation or interest of NHSRC/State or the above mentioned public health facility.
iv) In the event of any alleged breach of this undertaking, I shall co-operate fully with National Health Systems Resource Centre - Delhi/State QA Cell.</td></tr>
</table>

Date:

Place   Signature of Assessor

ANNEXURE – IV

ASSESSMENT PLAN

Assessment Plan				
Details of Assessment Team				
	Name	Designation	Email	Mobile
Team Leader				
Team Members				
Itinerary of Assessment Team				
	Date	Time	Flight/Train/Bus Details	
Arrival				
Departure				
Assessment of Facility				
Date	Activities Planned	Departments to be Visited	Support Required From Facility	

ANNEXURE – V

FORMAT FOR OPENING MEETING

Opening Meeting					
Name of the Facility			State/Dist.		
Date	Start Time		Finished Time		
List of Attendees					
Assessors			Facility Representatives		
Team Leader			Name	Designation	Signature
Name	Designation	Signature			
Assessment Team					
Name	Designation	Signature			
Discussion Points					

ANNEXURE – VI

<table>
<tr><th colspan="5">ASSESSMENT SCHEDULE</th></tr>
<tr><td colspan="2" rowspan="2"></td><td colspan="3">Assessment Round:</td></tr>
<tr><td colspan="3">Issue Date:</td></tr>
<tr><td>S. No.</td><td>Department</td><td>Assessor</td><td>Department In Charge</td><td>Assessment Date & Time</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="5">Approved By: Assessment Coordinator</td></tr>
</table>

ANNEXURE – VII

FORMAT FOR CLOSING MEETING

<table>
<tr><th colspan="6">Closing Meeting</th></tr>
<tr><td colspan="3">Name of the Facility</td><td colspan="3">State/Dist.</td></tr>
<tr><td>Date</td><td colspan="2">Start Time</td><td colspan="3">Finished Time</td></tr>
<tr><td colspan="6">List of Attendees</td></tr>
<tr><td colspan="3">Assessors</td><td colspan="3">Facility Representatives</td></tr>
<tr><td colspan="3">Team Leader</td><td>Name</td><td>Designation</td><td>Signature</td></tr>
<tr><td>Name</td><td>Designation</td><td>Signature</td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="3">Assessment Team</td><td></td><td></td><td></td></tr>
<tr><td>Name</td><td>Designation</td><td>Signature</td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="6">Discussion Points</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>

ANNEXURE – VIII

NATIONAL QUALITY ASSURANCE STANDARDS

[DOCUMENT TITLE]

Name of the Assessors :

Executive Summary

Introduction

External Assessment of ____________________ against National Quality Assurance Standards was conducted from _______________________.

Name of Assessor's

1. ....

2. ....

3. ....

Assessment has been conducted on standard format of National quality Assurance Programme Checklist for district hospital which contains functional 18 departments.

Main Gaps

- ....
- ....
- ....
- ....
- ....
- ....
- ....

Patient Satisfaction score of Preceding Quarter

Name and Signatures of External assessors

1.

2.

3.

Snapshot of score card

Accident & Emergency	OPD	Labour Room	Maternity	Indoor Department
%	%	%	%	%
Paediatrics Ward	NRC	Hospital Score %	SNCU	ICU
%	%		%	%
Operation Theatre	Post-Partum Unit		Blood Bank	Laboratory
%	%		%	%
Radiology	Pharmacy	Auxiliary Services	Mortuary	General Administration
%	%	%	%	%

Area of Concern wise score

Area of concern and scores	
Service Provision	
Patient Rights	
Inputs	
Support Services	
Clinical Services	
Infection control	
Quality Management	
Outcomes	

Standard wise Score Card

Area of Concern -A Service Provision Overall Score	
Standard	**Score**
Standard A1	
Standard A2	
Standard A3	
Standard A4	
Standard A5	
Standard A6	
Area of Concern B Patient Rights Overall Score	
Standard B1	
Standard B2	
Standard B3	
Standard B4	
Standard B5	
Standard B6	
Area of Concern C Inputs Overall Score	
Standard C1	
Standard C2	
Standard C3	
Standard C4	
Standard C5	

Standard	Score
Standard C6	
Standard C7	
Area of Concern D Support Services Overall Score	
Standard D1	
Standard D2	
Standard D3	
Standard D4	
Standard D5	
Standard D6	
Standard D7	
Standard D8	
Standard D9	
Standard D10	
Standard D 11	
Standard D 12	
Area of Concern E Clinical Services Overall Score	
Standard E1	
Standard E2	
Standard E3	
Standard E4	
Standard E5	
Standard E6	
Standard E7	
Standard E8	
Standard E9	
Standard E10	
Standard E11	
Standard E12	
Standard E13	
Standard E14	
Standard E15	
Standard E16	
Standard E17	
Standard E18	
Standard E19	
Standard E20	
Standard E21	
Standard E22	
Standard E23	
Area of Concern F Infection Control Overall Score	
Standard F1	
Standard F2	

Standard	Score
Standard F3	
Standard F4	
Standard F5	
Standard F6	
Area of Concern G Quality Management Overall Score	
Standard G1	
Standard G2	
Standard G3	
Standard G4	
Standard G5	
Standard G6	
Standard G7	
Standard G8	
Standard G9	
Standard G10	
Area of Concern H Outcome Indicators Overall Score	
Standard H1	
Standard H2	
Standard H3	
Standard H4	

Department wise score card

Accident & Emergency			
Accident & Emergency Score Card			
	Area of Concern Wise Score		Accident & Emergency Score
A	Service Provision	0%	0%
B	Patient Rights	0%	
C	Inputs	0%	
D	Support Services	0%	
E	Clinical Services	0%	
F	Infection Control	0%	
G	Quality Management	0%	
H	Outcome	0%	
Major Gaps Observed			
1			
2			
3			
Evidences (if any............)			
1			
2			
3			

Out-patient Department			
Out-patient Department Score Card			
	Area of Concern Wise Score		Out-patient Department Score
A	Service Provision	0%	0%
B	Patient Rights	0%	
C	Inputs	0%	
D	Support Services	0%	
E	Clinical Services	0%	
F	Infection Control	0%	
G	Quality Management	0%	
H	Outcome	0%	
Major Gaps Observed			
1			
2			
3			
Evidences (if any............)			
1			
2			
3			

Labour Room			
Labour Room Score Card			
	Area of Concern Wise Score		Labour room Score
A	Service Provision	0%	0%
B	Patient Rights	0%	
C	Inputs	0%	
D	Support Services	0%	
E	Clinical Services	0%	
F	Infection Control	0%	
G	Quality Management	0%	
H	Outcome	0%	
Major Gaps Observed			
1			
2			
3			
Evidences (if any............)			
1			
2			
3			

Maternity Ward			
Maternity Ward Score Card			
	Area of Concern Wise Score		Maternity Ward Score
A	Service Provision	0%	0%
B	Patient Rights	0%	
C	Inputs	0%	
D	Support Services	0%	
E	Clinical Services	0%	
F	Infection Control	0%	
G	Quality Management	0%	
H	Outcome	0%	
Major Gaps Observed			
1			
2			
3			
Evidences (if any............)			
1			
2			
3			

Pediatrics Ward			
Pediatrics ward Score Card			
	Area of Concern Wise Score		Pediatrics ward Score
A	Service Provision	0%	0%
B	Patient Rights	0%	
C	Inputs	0%	
D	Support Services	0%	
E	Clinical Services	0%	
F	Infection Control	0%	
G	Quality Management	0%	
H	Outcome	0%	
Major Gaps Observed			
1			
2			
3			
Evidences (if any............)			
1			
2			
3			

Nutritional Rehabilitation Centre			
NRC Score Card			
	Area of Concern Wise Score		NRC Score
A	Service Provision	0%	0%
B	Patient Rights	0%	
C	Inputs	0%	
D	Support Services	0%	
E	Clinical Services	0%	
F	Infection Control	0%	
G	Quality Management	0%	
H	Outcome	0%	
Major Gaps Observed			
1			
2			
3			
Evidences (if any............)			
1			
2			
3			

Sick Newborn Care Unit			
Sick Newborn Care Unit Score Card			
	Area of Concern Wise Score		Sick Newborn Care Unit Score
A	Service Provision	0%	0%
B	Patient Rights	0%	
C	Inputs	0%	
D	Support Services	0%	
E	Clinical Services	0%	
F	Infection Control	0%	
G	Quality Management	0%	
H	Outcome	0%	
Major Gaps Observed			
1			
2			
3			
Evidences (if any............)			
1			
2			
3			

Operation Theatre			
Operation Theatre Score Card			
	Area of Concern Wise Score		Operation Theatre Score
A	Service Provision	0%	0%
B	Patient Rights	0%	
C	Inputs	0%	
D	Support Services	0%	
E	Clinical Services	0%	
F	Infection Control	0%	
G	Quality Management	0%	
H	Outcome	0%	
Major Gaps Observed			
1			
2			
3			
Evidences (if any............)			
1			
2			
3			

Post-Partum Unit			
Post-Partum Unit Score Card			
	Area of Concern Wise Score		Post-Partum Unit Score
A	Service Provision	0%	0%
B	Patient Rights	0%	
C	Inputs	0%	
D	Support Services	0%	
E	Clinical Services	0%	
F	Infection Control	0%	
G	Quality Management	0%	
H	Outcome	0%	
Major Gaps Observed			
1			
2			
3			
Evidences (if any............)			
1			
2			
3			

Intensive Care Unit			
Intensive Care Unit Score Card			
	Area of Concern Wise Score		Intensive Care Unit Score
A	Service Provision	0%	0%
B	Patient Rights	0%	
C	Inputs	0%	
D	Support Services	0%	
E	Clinical Services	0%	
F	Infection Control	0%	
G	Quality Management	0%	
H	Outcome	0%	
Major Gaps Observed			
1			
2			
3			
Evidences (if any............)			
1			
2			
3			

Indoor Patient Department			
Indoor Patient Department Score Card			
	Area of Concern Wise Score		Indoor Patient Department Score
A	Service Provision	0%	0%
B	Patient Rights	0%	
C	Inputs	0%	
D	Support Services	0%	
E	Clinical Services	0%	
F	Infection Control	0%	
G	Quality Management	0%	
H	Outcome	0%	
Major Gaps Observed			
1			
2			
3			
Evidences (if any............)			
1			
2			
3			

Blood Bank			
Blood Bank Score Card			
	Area of Concern Wise Score		Blood Bank Score
A	Service Provision	0%	0%
B	Patient Rights	0%	
C	Inputs	0%	
D	Support Services	0%	
E	Clinical Services	0%	
F	Infection Control	0%	
G	Quality Management	0%	
H	Outcome	0%	
Major Gaps Observed			
1			
2			
3			
Evidences (if any............)			
1			
2			
3			

Laboratory			
Laboratory Score Card			
	Area of Concern Wise Score		Laboratory Score
A	Service Provision	0%	0%
B	Patient Rights	0%	
C	Inputs	0%	
D	Support Services	0%	
E	Clinical Services	0%	
F	Infection Control	0%	
G	Quality Management	0%	
H	Outcome	0%	
Major Gaps Observed			
1			
2			
3			
Evidences (if any............)			
1			
2			
3			

Radiology			
Radiology Score Card			
	Area of Concern Wise Score		Radiology Score
A	Service Provision	0%	0%
B	Patient Rights	0%	
C	Inputs	0%	
D	Support Services	0%	
E	Clinical Services	0%	
F	Infection Control	0%	
G	Quality Management	0%	
H	Outcome	0%	
Major Gaps Observed			
1			
2			
3			
Evidences (if any............)			
1			
2			
3			

Pharmacy			
Pharmacy Score Card			
	Area of Concern Wise Score		Pharmacy Score
A	Service Provision	0%	0%
B	Patient Rights	0%	
C	Inputs	0%	
D	Support Services	0%	
E	Clinical Services	0%	
F	Infection Control	0%	
G	Quality Management	0%	
H	Outcome	0%	
Major Gaps Observed			
1			
2			
3			
Evidences (if any............)			
1			
2			
3			

Auxiliary Services			
Auxiliary services Score Card			
	Area of Concern Wise Score		Auxiliary Services Score
A	Service Provision	0%	0%
B	Patient Rights	0%	
C	Inputs	0%	
D	Support Services	0%	
E	Clinical Services	0%	
F	Infection Control	0%	
G	Quality Management	0%	
H	Outcome	0%	
Major Gaps Observed			
1			
2			
3			
Evidences (if any............)			
1			
2			
3			

Mortuary			
Mortuary Score Card			
	Area of Concern Wise Score		Mortuary Score
A	Service Provision	0%	0%
B	Patient Rights	0%	
C	Inputs	0%	
D	Support Services	0%	
E	Clinical Services	0%	
F	Infection Control	0%	
G	Quality Management	0%	
H	Outcome	0%	
Major Gaps Observed			
1			
2			
3			
Evidences (if any............)			
1			
2			
3			

General Administration

<table>
<tr><th colspan="4">General Administration Score Card</th></tr>
<tr><th></th><th colspan="2">Area of Concern Wise Score</th><th>General Administration Score</th></tr>
<tr><td>A</td><td>Service Provision</td><td>0%</td><td rowspan="8">0%</td></tr>
<tr><td>B</td><td>Patient Rights</td><td>0%</td></tr>
<tr><td>C</td><td>Inputs</td><td>0%</td></tr>
<tr><td>D</td><td>Support Services</td><td>0%</td></tr>
<tr><td>E</td><td>Clinical Services</td><td>0%</td></tr>
<tr><td>F</td><td>Infection Control</td><td>0%</td></tr>
<tr><td>G</td><td>Quality Management</td><td>0%</td></tr>
<tr><td>H</td><td>Outcome</td><td>0%</td></tr>
<tr><th colspan="4">Major Gaps Observed</th></tr>
<tr><td>1</td><td colspan="3"></td></tr>
<tr><td>2</td><td colspan="3"></td></tr>
<tr><td>3</td><td colspan="3"></td></tr>
<tr><th colspan="4">Evidences (if any............)</th></tr>
<tr><td>1</td><td colspan="3"></td></tr>
<tr><td>2</td><td colspan="3"></td></tr>
<tr><td>3</td><td colspan="3"></td></tr>
</table>

ANNEXURE – IX

FEEDBACK FORM FOR ASSESSORS

Facility Name:				**Date of Assessment:**
Name of the Assessor:				**Qualifications:**
Technical Knowledge:				
Assessment plan and schedule shared well in advance	Yes	☐	No	☐
Familiar with the requirements on measurement traceability?	Yes	☐	No	☐
Assessor was technically competent and able to translate knowledge into practices by resolving technical issues?	Yes	☐	No	☐
Support provided in preparing action plan	Yes	☐	No	☐
Comments:				
Management System Knowledge:				
Behaviour of the assessor was courteous and Dignified?	Yes	☐	No	☐
Familiar with the Code of Conduct for assessment?	Yes	☐	No	☐
Communicates effectively i.e. verbal and writing was constructive and respectful in all interactions	Yes	☐	No	☐
Support, hand holding and on the job, training provided during assessment	Yes	☐	No	☐
Comments:				
Recommendation:				
Please sign the feedback form and return it to SQAU in a sealed envelope/email the scanned copy.				
Name:				Signature:
Date:				Designation:

ANNEXURE – X

FORMAT FOR ACTION PLAN

Gap statement	Root causes	Actions required	Prioritization	Responsibility	Time framework

Name & Signature of Assessors (1) ....

Name & Signature of Assessors (2 ....

ANNEXURE - XI

FORMAT OF STATE ASSESSMENT REPORT

Assessment Report: .... (Name of the facility)

Date of Assessment –

Name & Sign of Assessors –

1. Overall Score of facility (in percentage)

2. Area of Concern Score

S. No.	Area of Concern	Score (%)
A	Service Provision	
B	Patient Rights	
C	Inputs	
D	Support Services	
E	Clinical Services	
F	Infection Control	
G	Quality Management	
H	Outcome	

3. Departmental Score

S. No.	Department	Score (%)
1	Accident & Emergency	
2	OPD	
3	Labour Room	
4	Maternity Ward	
5	Indoor Department	
6	NRC	
7	Paediatric Ward	
8	SNCU	
9	ICU	
10	Operation Theatre	

S. No.	Department	Score (%)
11	Post Partum Unit	
12	Blood Bank	
13	Laboratory	
14	Radiology	
15	Pharmacy	
16	Auxiliary Services	
17	Mortuary	
18	General Administration	

4. Score Against Each Standard (as applicable as per Assessors' Guidebook)

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

Standard	Standard Statement	Score (%)
Standard C1.	The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms.	
Standard C2.	The facility ensures the physical safety of the infrastructure.	
Standard C3.	The facility has established Programme for fire safety and other disaster.	
Standard C4.	The facility has adequate qualified and trained staff, required for providing the assured services to the current case load.	
Standard C5.	Facility provides drugs and consumables required for assured list of services.	
Standard C6.	The facility has equipment & instruments required for assured list of services.	
Standard C7.	The facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff	
Standard D1.	The facility has established Programme for inspection, testing and maintenance and calibration of Equipment.	
Standard D2.	The facility has defined procedures for storage, inventory management and dispensing of drugs in pharmacy and patient care areas.	
Standard D3.	The facility provides safe, secure and comfortable environment to staff, patients and visitors.	
Standard D4.	The facility has established Programme for maintenance and upkeep of the facility.	
Standard D5.	The facility ensures 24X7 water and power backup as per requirement of service delivery, and support services norms.	
StandardD6	Dietary services are available as per service provision and nutritional requirement of the patients.	
Standard D7.	The facility ensures clean linen to the patients.	
Standard D8.	The facility has defined and established procedures for promoting public participation in management of hospital transparency and accountability.	
Standard D9.	Hospital has defined and established procedures for Financial Management.	
Standard D10.	Facility is compliant with all statutory and regulatory requirement imposed by local, state or central government.	
Standard D11.	Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.	

Standard	Standard Statement	Score (%)
Standard D12.	Facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations.	
Standard E1.	The facility has defined procedures for registration, consultation and admission of patients.	
Standard E2.	The facility has defined and established procedures for clinical assessment and reassessment of the patients.	
Standard E3.	Facility has defined and established procedures for continuity of care of patient and referral	
Standard E4.	The facility has defined and established procedures for nursing care	
Standard E5.	Facility has a procedure to identify high risk and vulnerable patients.	
Standard E6.	Facility follows standard treatment guidelines defined by state/ Central government for prescribing the generic drugs & their rational use.	
Standard E7.	Facility has defined procedures for safe drug administration	
Standard E8.	Facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage	
Standard E9.	The facility has defined and established procedures for discharge of patient.	
Standard E10.	The facility has defined and established procedures for intensive care.	
Standard E11.	The facility has defined and established procedures for Emergency Services and Disaster Management	
Standard E12.	The facility has defined and established procedures of diagnostic services	
Standard E13.	The facility has defined and established procedures for Blood Bank/ Storage Management and Transfusion.	
Standard E14.	Facility has established procedures for Anaesthetic Services	
Standard E15.	Facility has defined and established procedures of Surgical Services	
Standard E16.	The facility has defined and established procedures for end of life care and death	
Standard E17.	Facility has established procedures for Antenatal care as per guidelines	
Standard E18.	Facility has established procedures for Intranatal care as per guidelines	
Standard E19.	Facility has established procedures for postnatal care as per guidelines	
Standard E20.	The facility has established procedures for care of new born, infant and child as per guidelines	

Standard	Standard Statement	Score (%)
Standard E21.	Facility has established procedures for abortion and family planning as per government guidelines and law	
Standard E22.	Facility provides Adolescent Reproductive and Sexual Health services as per guidelines	
Standard E23.	Facility provides National health program as per operational/Clinical Guidelines	
Standard F1.	Facility has infection control program and procedures in place for prevention and measurement of hospital associated infection	
Standard F2.	Facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis	
Standard F3.	Facility ensures standard practices and materials for Personal protection	
Standard F4.	Facility has standard Procedures for processing of equipments and instruments	
Standard F5.	Physical layout and environmental control of the patient care areas ensures infection prevention	
Standard F6.	Facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.	
Standard G1.	The facility has established organizational framework for quality improvement	
Standard G2.	Facility has established system for patient and employee satisfaction	
Standard G3.	Facility have established internal and external quality assurance programs wherever it is critical to quality.	
Standard G4.	Facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.	
Standard G5.	Facility maps its key processes and seeks to make them more efficient by reducing non value adding activities and wastages	
Standard G6.	The facility has established system of periodic review as internal assessment, medical & death audit and prescription audit	
Standard G7.	The facility has defined and established Quality Policy & Quality Objectives	
Standard G8.	Facility seeks continually improvement by practicing Quality method and tools.	
Standard G9.	The facility has defined, approved and communicated Risk Management framework for existing and potential risks.	

Standard	Standard Statement	Score (%)
Standard G10.	The facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan	
Standard H1.	The facility measures Productivity Indicators and ensures compliance with State/National benchmarks	
Standard H2.	The facility measures Efficiency Indicators and ensure to reach State/ National Benchmark	
Standard H3.	The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark	
Standard H4.	The facility measures Service Quality Indicators and endeavours to reach State/National benchmark	

5. Recommendations for Quality Improvement

a)

b)

c)

d)

e)

To be filled by the State

6. Approval of State Quality Assurance Committee/Designated Authority

State QA Certification of .... (Name of Health Facility) as per National Quality Assurance Standards for DH/CHC/PHC/UPHC is approved/not approved.

Date: Signature

Designation:

Annexures to be Attached		
S. No.	**Document**	**Requirements**
1	Assessment Plan	In original and duly signed by Team leader, Assessment Team and facility In-charge.
2	Assessment Schedule	In original and duly signed by Team leader, Assessment Team and facility In-charge.
3	Record of Opening Meeting	In original and duly signed by Team leader, Assessment Team and facility In-charge.
4	Copies of Evidences Collected	Photocopies, statements, videos etc. hard and soft copies.
5	Hand Holding Support/Training Provided During Assessment	Details as well as evidences.
6	Records of Closing Meeting	In original and duly signed by Team leader, Assessment Team and facility In-charge.
7	Copies of Action Plans	Copy of Overall Hospital Action Plan, and Departmental Action Plans duly signed by Assessor.

National Health Systems Resouce Centre
NIHFW Campus, Baba Gangnath Marg, Munirka,
New Delhi 110067
e-mail: nhsrc[dot]india[at]gmail[dot]com
Website: www.nhsrcindia.org