Road Map for NQAS Certification

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National Health Systems Resource Centre-QI

Organizational framework

1

- ✓The existing framework for quality assurance i.e., State Quality Assurance Committee (SQAC), District Quality Assurance Committee (DQAC), and Quality Team at the facility level, would continue to support implementation of NQAS and Part NQAS certification of SUMAN facilities.
- ✓Nodal officers for MH, CH, Immunisation & Family Planning would especially focus on improving quality care in respective departments of their domain.

2

Empanelment of Assessors

- Internal Assessors:- Internal Assessment, Peer Assessments
    - Training at State level
- External Assessors:- For State and National Assessment
    - Training at National level

3

Customization

- Consultative process between SQAC and NHSRC with intimation to MoHFW
- No negotiation for IPHS essential services
- No deletion of Standards and MEs
- Full or Part certification
- State can add more standards along with ME and Checkpoints

The minimum departments/themes/packages for certification

Sl. No	Level of Facilities	Department
1	District Hospitals / SDH	OPD (should prioritize antenatal & pediatrics services), Labour room, Maternity OT, Maternity ward, Pediatric ward, SNCU, Post-Partum unit, Blood Bank/Blood storage unit, General Administration
2	CHC	OPD (Antenatal clinic & pediatrics services), Labour room, OT, IPD, NBSU, Post-Partum unit, Blood Storage Unit, General Administration
3	PHC	All departments (LR, OPD, IPD, General Administration, National Health Programme & Laboratory). States may take exemptions for the National Health Programme & Laboratory, if needed.
4	UPHC	General clinic, Maternal Health, New born and Child health, Immunization, Family Planning, Outreach, General Administration

The minimum departments/themes/packages for certification

Sl. No	Level of Facilities	Department
5	HWC-SC (7 mandatory packages)	Care in pregnancy & child-birth, Neo-natal & infant health care services, Family planning and contraceptive services and other Reproductive Health Care Services, Management of communicable diseases including National Health Programme, Management of common communication diseases & outdoor care for acute simple illness and minor ailments, Screening, prevention, control and management of non-communicable diseases

Training and Capacity building

4

Awareness Workshop	Assessors Training	Service Provider Training	Assessor cum Service Provider	External Assessor Training
• 1 Day • To sensitize State level officials	• 2 Days • To acquaint about NQAS measurement System	• 3 Days • Basic concepts of Quality improvement approach	• 3 Days • Both NQAS measurement system and concepts for improving Quality	• 5 Days at National level • Detailed discussion on NQAS measurement System

Implementation of Quality at facility level

Operational Quality Team

1

1. Supporting Document/Office order regarding constitution of Quality Team.
2. Quality Team is multi-disciplinary with representation from all departments (Clinical, Admin, Support)
3. Records of proceedings (MOM) of at least three consecutive monthly meeting.

Quality Team at DHs/SDHs

- I/C Hospital/Medical Superintendent: Chairperson
- I/C Operation Theatre/Anaesthesia/ Surgeon
- I/C Obstetrics and Gynaecology
- I/C Lab services (Microbiologist/ Pathologist)
- I/C Nursing
- I/C Dialysis unit/ dialysis technician
- I/C Ancillary Services
- I/C Transport
- I/C Stores
- I/C Records
- Hospital Manager/Quality Consultant or equivalent (Member Secretary)

Quality Team

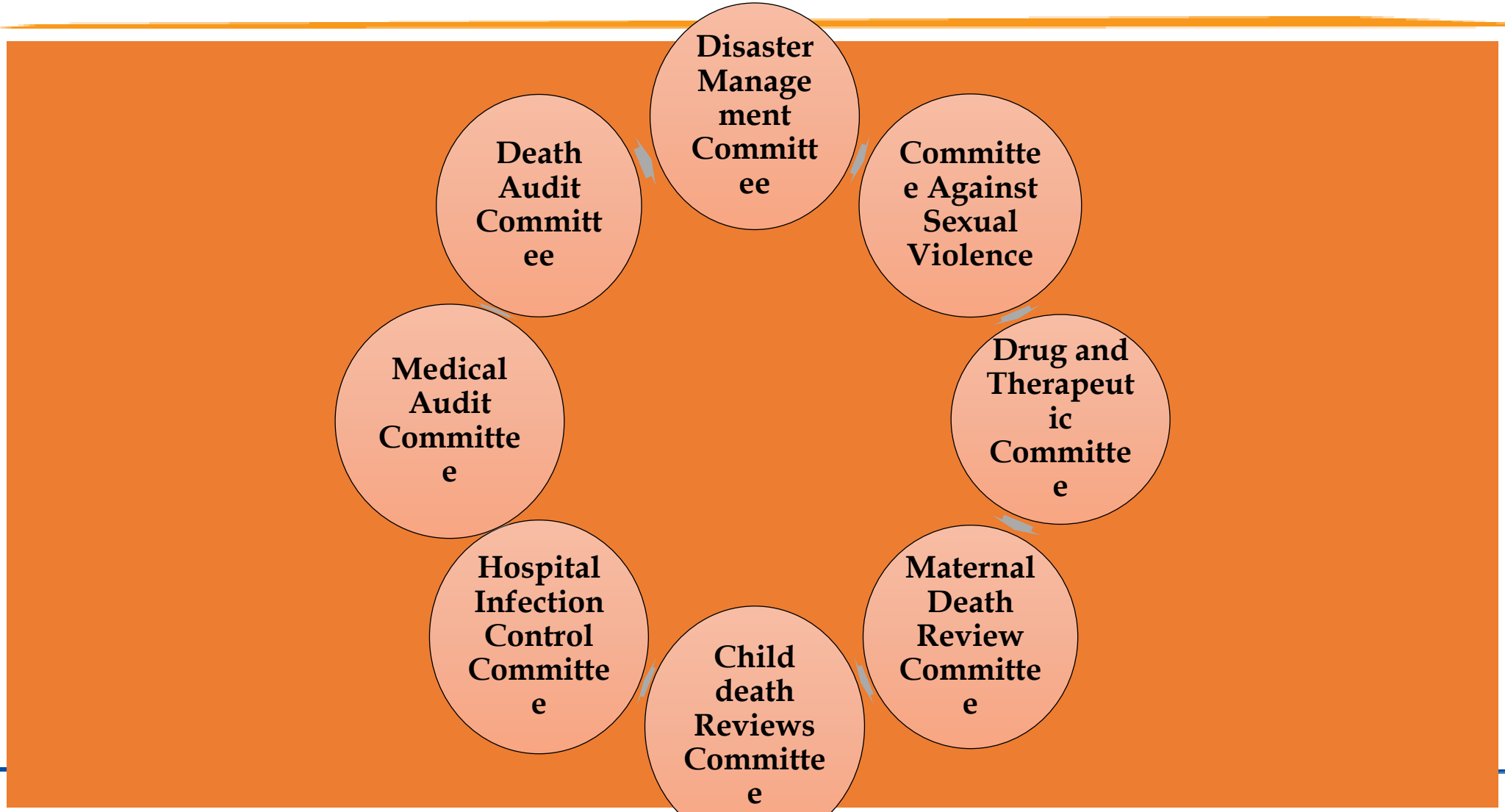
CHCs/UCHCs

- Medical Officer/Medical Superintendent: Chairperson
- Nursing IC / Staff Nurse
- General Surgeon
- Obstetrician & Gynaecologist
- Paediatrician
- Medical officer
- Lab technician
- Pharmacist
- I/C Stores
- I/C Administration
- One representative from all specialist services

PHCs/UPHCs

- Medical Officer: Chairperson
- Staff Nurse
- Lab Technician
- Pharmacist
- Health Assistant. (Female)/Lady Health Visitor
- Public health manager (Urban)

Formation of Quality Teams and Committees



Internal Assessment

2

- ✓Undertake an internal Assessment using NQAS checklists at fixed interval, preferably quarterly covering all critical departments.
- ✓Identify the Gaps
- ✓Prioritize the Gaps

Use other methods for Identification of Gaps

PSS, KPIs, Medical and Death Audits, EQAS etc.

3

Patient Satisfaction Surveys

1. Records of Calculation of PSS for both OPD & IPD - at least 3 consecutive Patient satisfaction surveys
2. Frequency of calculation of PSS
3. Analysis of PSS
4. Identification of Two lowest scoring attributes
5. CAPA of the identified lowest scoring attributes
6. Adequate sample size

PSS- OPD

Sl. No.	Attributes	Poor (1)	Fair (2)	Good (3)	Very Good (4)	Excellent (5)
1	Availability of sufficient information in Hospital (Directional & location signages, Registration counter, Laboratory, Radiology Department, Dispensary, etc.)					
2	Waiting time at the registration counter					
3	Behaviour and attitude of Hospital Staff					
4	Amenities in waiting area (chairs, fans, drinking water and cleanliness of bathrooms & toilets)					
5	Attitude & communication of Doctors					
6	Time spent on consulting, examination and counselling					
7	Availability of Lab and Radiology investigation facilities within the hospital					
8	Promptness at medicine distribution counter					
9	Availability of prescribed drugs at the hospital dispensary					
10	Your overall satisfaction during the visit to the hospital					

Sample Size

Population (OPD Attendance/ IPD Admissions)	Sample Size (Number of patients to be surveyed)			
	Margin of Error -10% Confidence Level -90%	Margin of Error -10% Confidence Level -95%	Margin of Error -5% Confidence Level -90%	Margin of Error -5% Confidence Level -95%
10	9	9	10	10
20	16	17	19	20
50	29	34	43	45
100	41	50	74	80
200	51	66	116	132
300	56	73	143	169
500	60	81	176	218
1000	64	88	214	257
3000	67	94	249	278
5000	67	95	257	341
10000	68	96	264	370
15000	68	96	266	375
20000	68	96	268	377
30000	68	96	269	380
50000	68	96	270	382
100000	68	96	270	383

IPD-PSS

Sl. No.	Attributes	Poor (1)	Fair (2)	Good (3)	Very Good (4)	Excellent (5)
1	Availability of sufficient information at registration/admission counter (Directional & location signages, Registration Counter, Laboratory, Radiology Department, Dispensary etc.)					
2	Waiting time at the Registration/ Admission counter					
3	Behaviour and attitude of hospital staff at the registration/admission counter					
4	Your feedback on discharge process					
5	Cleanliness of the ward					
6	Cleanliness of Bathrooms & toilets					
7	Cleanliness of Bed sheets, pillow-covers etc.					
8	Cleanliness of surroundings and campus drains					
9	Regularity of Doctor's attention					
10	Attitude and communication of Doctors					
11	Time spent for examination of patient and counselling					
12	Promptness in response by Nurses/ ward boys or girls in the ward					
13	Round the clock availability of Nurses/ ward boys or girls in the ward					
14	Attitude and communication of Nurses/ ward boys or girls					

Key Performance indicators and outcome indicators

4

- ✓Collate critical data from the departments and calculate performance indicators and monitor them on monthly basis.
- ✓KPI should be reported to DQAC and SQAC on monthly basis for monitoring purpose.

KPIs for DHs/SDHs

D1	Bed Occupancy Rate				
D2	Lab test done per thousand Patients				
D3	Percentage of cases of high-risk pregnancy / obstetric complications treated out of total registered pregnancies at the facility				
D4	Percentage of surgeries done at night (8PM to 8 AM)				
D5	LSCS rate				
D6	Blood transfusion rate				
D7	Percentage of NCD cases managed in OPD				
	Efficiency				
D8	Percentage of emergency cases admitted at night (8PM to 8AM)				
D9	Percentage of referrals out of Total registered patient				
D10	No of major surgeries per surgeon (in a month)				
D11	OPD per Doctor				
D12	Percentage of EQAS (i.e., VIS or Z score) with in normal limits (VIS < 200 and Z < +/- 2)				
D13	Percentage of Stock outs as per EML				
	Clinical Care / Safety				
D14	No of Maternal Deaths out of total admission during ANC, INC, PNC				
D15	No of Neonatal Deaths out of total live births and neonatal admission				
D16	Death Rate (Include all deaths except Maternal & newborn)				

D17	Percentage of Deaths in which death Review is done				
D18	Average Length of Stay				
D19	Percentage of Surgical Site Infection out of total surgeries				
D20	No. of needle stick injuries reported				
D21	Percentage of prescriptions with more than one anti-microbial agent (calculated using sampling methods)				
D22	Family Planning indicators (as per HMIS reporting)				
D23	LaQshya Indicators (As per Annexure 'C' of LaQshya Guidelines)				
	Service Quality				
D24	Percentage of LAMA out of Total Admission				
D25	Patient Satisfaction Score for IPD				
D26	Patient Satisfaction Score for OPD				
D27	Registration to Drug Time (average)				
D28	Consultation time in OPD (average)				

KPI for PHCs

	Productivity				
D1	OPD per month				
D2	Percentage of deliveries conducted out of expected				
D3	Percentage of deliveries conducted at night				
D4	Percentage of MTP conducted				
D5	Percentage of OPD cases referred from HWC- Sub centre/ Sub Centre				
D6	Percentage of NCD cases managed in OPD				

	Efficiency				
D7	Percentage of stock out as per EML				
D8	Percentage of high-risk pregnancy treated / obstetric cases referred to FRU				
D9	Percentage of client accepting limiting or long- term contraception methods				
D10	Dropout rate of Pentavalent				
	Clinical Care / Safety				
D11	Percentage of high-risk pregnancies detected				
D12	Percentage of women stayed for 48hrs after normal delivery				
D13	IUCD complication rate				
D14	Percentage of anaemia cases treated successfully				
D15	Percentage of AEFI cases reported				
D16	Percentage of cases on DOTs completed treatment successfully				
D17	Percentage of Children with diarrhoea treated with ORS & Zinc				
	Service Quality				
D18	Left against medical advice (LAMA) cases				
D19	Patient Satisfaction Score for IPD				
D20	Patient Satisfaction Score for OPD				

Audit

5

Maternal Death	• Number of review done out of total death • Corrective and preventive action plan
New born death	• Number of review done out of total death • Corrective and preventive action plan
Clinical audit	• Number of time audit done, sample size • Corrective and preventive action plan
Prescription audit	• Number of time audit done, sample size • Corrective and preventive action plan
Death Audit	• Number of review done out of total death • Corrective and preventive action plan

Prescription Audit Format		
S.No.	**Criteria**	**Response (Yes/No/NA)**
1	OPD Registration Number mentioned	
2	Complete Name of the Patient is written	
3	Age in years (≥ 5 in years) in case of < 5 years (in months)	
4	Weight in Kg (Only patients of paediatric age group)	
5	Date of consultation - day / month / year	
6	Gender of the Patient	
7	Handwriting is Legible in Capital letter	
8	Brief history Written	
9	Allergy Status mentioned	
10	Salient features of Clinical Examination recorded	
11	Presumptive / definitive diagnosis written	
12	Medicines are prescribed by generic names	
13	Medicines prescribed are in line with STG.	
14	Medicine Schedule / doses clearly written	
15	Duration of treatment written	
16	Date of next visit (review) written	
17	In case of referral, the relevant clinical details and reason for referral given	
18	Follow-up advice and precautions (Do's and Don'ts) are recorded	
19	Prescription duly signed (legibly)	
20	Medicines prescribed are as per EML/Formulary	
21	Medicines advised are available in the dispensary	
22	Vitamins, Tonics or Enzymes prescribed	
23	Antibiotics prescribed	
24	Antibiotics are prescribed as per facility's Antibiotic Policy	
25	Investigations advised	
26	Injections Prescribed	
27	Number of Medicines Prescribed	Number

Audits

6

- Death audits for all deaths happened at the facility.
- Medical and Prescription audits on sample basis.
- Root cause analysis
- CAPA

External Quality Assurance Programme

7

- Calibration of measuring equipment
- EQAS for Laboratories
- Take necessary actions for non-conformity

Competency and Performance Assessment 8

- Competency assessment of all clinical and Para clinical staff
- Competency and performance assessment annualy
- Feedback for improvement
- Training needs

Risk Management framework

9

1. Tools for mitigation of risk – Checklists, relevant records for verify availability of a valid plan for risk management and whether risk management activities have been conducted as per plan.
2. Review risk register to see how facility has graded their risks and prioritized them for action.

FMEA

- Describe the Process- Process flow diagram, Error and correction data, Internal problem data, Customer feedback
- Define Functions
- Identify Potential failure modes- (Too much, too little, too early, too late, death, incorrect etc.)
- Describe effects of failures (How it affects the patients or the process- Immediate/Delayed)
- Determine causes
- Current Controls (To prevent errors, detect the causes, detect the defects e.g.. Check lists, Mistake proofing, trainings, IT Etc.)
- Calculate Risks (Severity of effects* Probability of occurrence*capability of current control= Risk Priority numbers
- Take actions
- Assess Results

Ranking of severity

Criteria for Ranking	Effects	Rating
Failure occurs without warning	Deadly	10
Failure Occurs with Warning	Hazardous	9
Loss of function	Very Serious	8
Loss of performance	Serious	7
Loss of comfort	Moderate	6
Low effect on performance	Low	5
Noticeable effect by most of person	Very low	4
Noticeable effect by few person	Minor	3
Noticeable effect by single person	Very Minor	2
No effect	None	1

Ranking of Occurrence

Occurrence	Failure Rate	Criteria	Rank
Very High	>1 in 10	Failure is almost inevitable	10
High	1 in 20	Repeated failure	9
	1 in 50		8
	1 in 100		7
Moderate	1 in 500	Occasional failure	6
	1 in 2000		5
	1 in 10000		4
Low	1 in 1 Lakh	Relatively few	3
	1 in 10 Lakhs		2
No effect	Failure is eliminated through preventive controls	Failure is unlikely	1

Ranking of detection of failure mode

Chance of detection of failure mode	Rank
No known controls available	10
Very remote chances of detection	9
Remote chances of detection	8
Very low chances of detection	7
Low chances of detection	6
Moderate chances of detection	5
Moderately high chances of detection	4
High chance of detection	3
Very high chance of detection	2
Most certain to detect	1

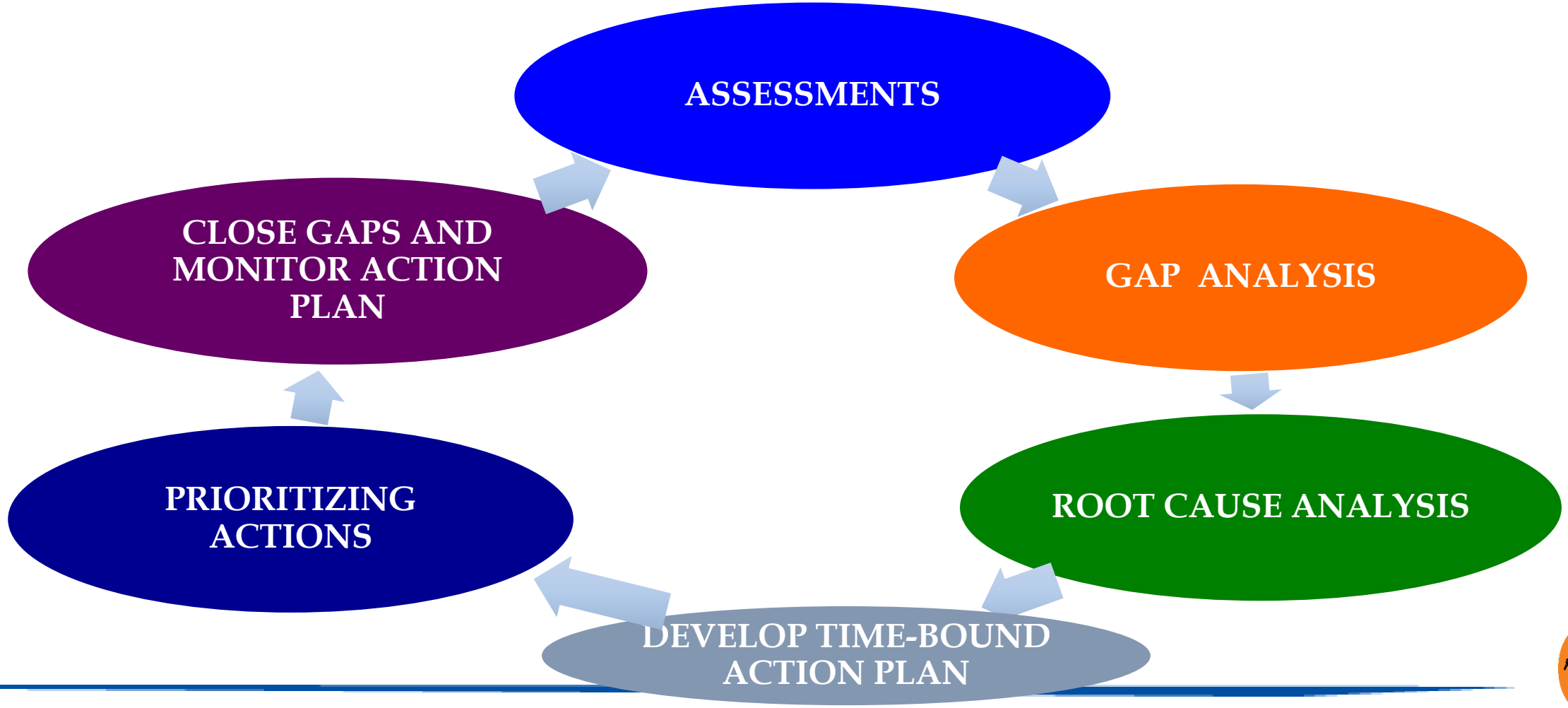
Failure Mode- Wrong site surgical procedure

- Effect- Patient operated on wrong side – Severity-9
- Causes- Mismatch in identification- Occurrence- 4
- Detection Chances
  - High Chance of detection-3

  - ***Risk Priority Number (RPN)= 9*4*3= 108***


STANDARDS
BENCHMARKS
QUALITY
MEASUREMENT
(FINDING GAPS)
NQAS
PSS, ESS
AUDITS
BEST PRACTICES
OBJECTIVES
KPI
INTERNAL QA
EXTERNAL QA
Plan
Do
Act
Check
TEAMWORK
MOTIVATION
LEADERSHIP
ROOT
CAUSE
PRIORITIZE
ACTION
PLAN
QUALITY
IMPROVEMENT
(CLOSING GAPS)
QUALITY TOOLS
QUALITY
METHODS
MONITOR
CLOSE
GAPS

What after Gap Analysis



ACTION PLANNING

ACTION PLANS

- Specify **steps or actions** required to attain an objective.
- Designate **who** will be held accountable for seeing the each step or action is completed.
- Define **when** these steps or actions will be carried out.
- Define **resources needed** to be allocated in order to carry out the required steps or actions.
- Define **feedback mechanisms** needed to monitor progress within each action step.

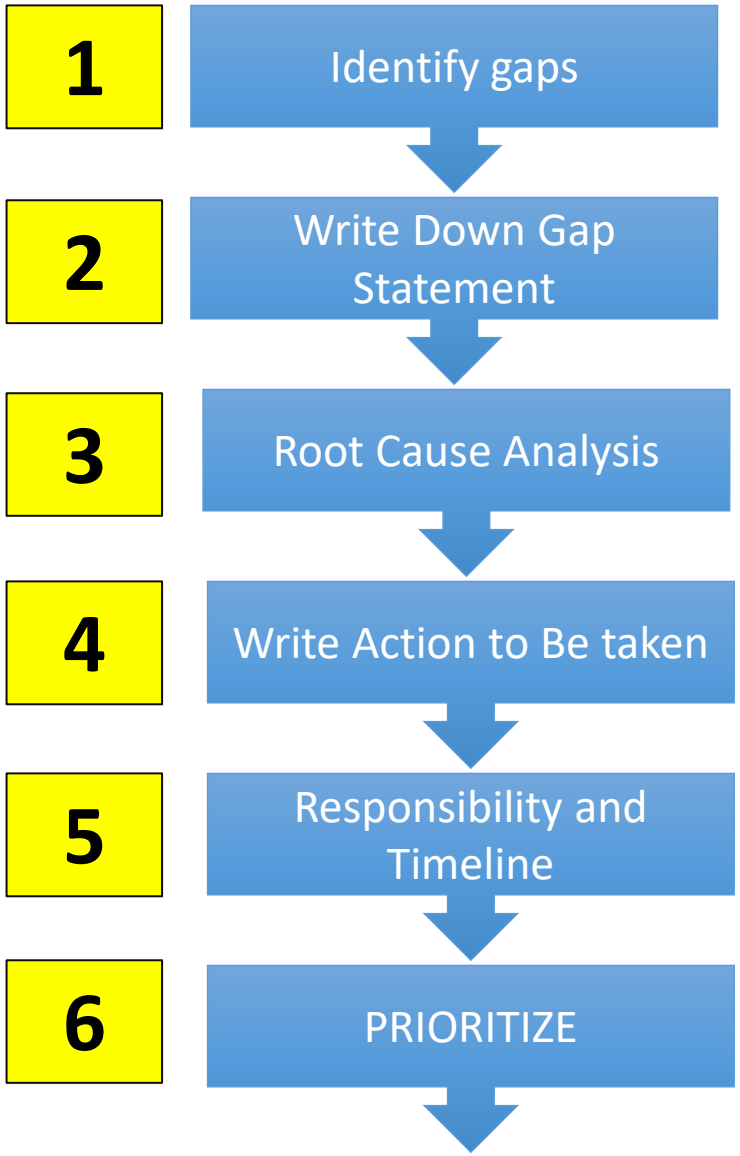
Sample action plan

Gap statement	Root causes	Actions required	Responsibility	Time framework	Prioritization Score	End of the month status
No system of taking clients feedback	Feedback form is not available	A new Feedback form will be developed	Hospital Manager	31st October 2021	I- Implement immediately	Open/Closed

PRIORITIZATION

PICK Chart

	PICK Chart Results	
	BIG payoff (Benefits)	**SMALL** payoff (Benefits)
EASY to implement	**Implement** **I** **Severe Gap needs no or very less resources** **Severe Gap Requires needs local action** **Visible Changes with less efforts**	**Possible** **P** **Moderate or Low Gaps require Low resources or efforts** **Desirable Improvement Action**
HARD to implement	**Challenge** **C** **Severe Gaps Needs High Resource** **Severe Gaps Needs State level Intervention** **Major change in the processes**	**Kick out** **K** **Low level Gaps require high efforts or resources** **Efforts adding no value in quality**


1
Identify gaps
2
Write Down Gap Statement
3
Root Cause Analysis
4
Write Action to Be taken
5
Responsibility and Timeline
6
PRIORITIZE

SOP

1. All required SOPs are submitted.
2. All SOPs should be drafted and approved by competent Authority.
3. All SOPs adequately describes the process and have details as per NQAS.

S. No	Name of Document
1	Accident & Emergency Department
2	Out Patient Department
3	Labor Room
4	Maternity Ward
5	Paediateric Ward
6	Nutritional Rehabilitation Centre
7	Sick New Born Care Unit
8	Operation Theater & Maternity OT
9	Post Partum Unit
10	Intensive Care Unit
11	Inpatient Department
12	Laboratory Services
13	Radiology & USG
14	Pharmacy Services
15	Laundry Services
16	Dietary Services
17	Medical Record Department
18	Post Mortem
19	Blood Bank
20	TSSU/CSSD
21	Inventory & Store
22	Hospital Improvement manual
23	General Admin

Suggested Format for SOP

Title

Purpose

Scope

Responsibility

Definitions

Procedure

Forms/formats/records

Work instructions.

Revision history

Process Description

4.11	**Handling Medico-legal cases:** a) For MLC cases, police is informed after starting the treatment & entry is made in Police information book. Medico-legal record is maintained for cases under that category. b) In case the patient dies, or is received as dead, appropriate action is initiated towards conducting the autopsy.	EMO/ Medical Superintendent	Police Information Book, MLC Register, Death Management

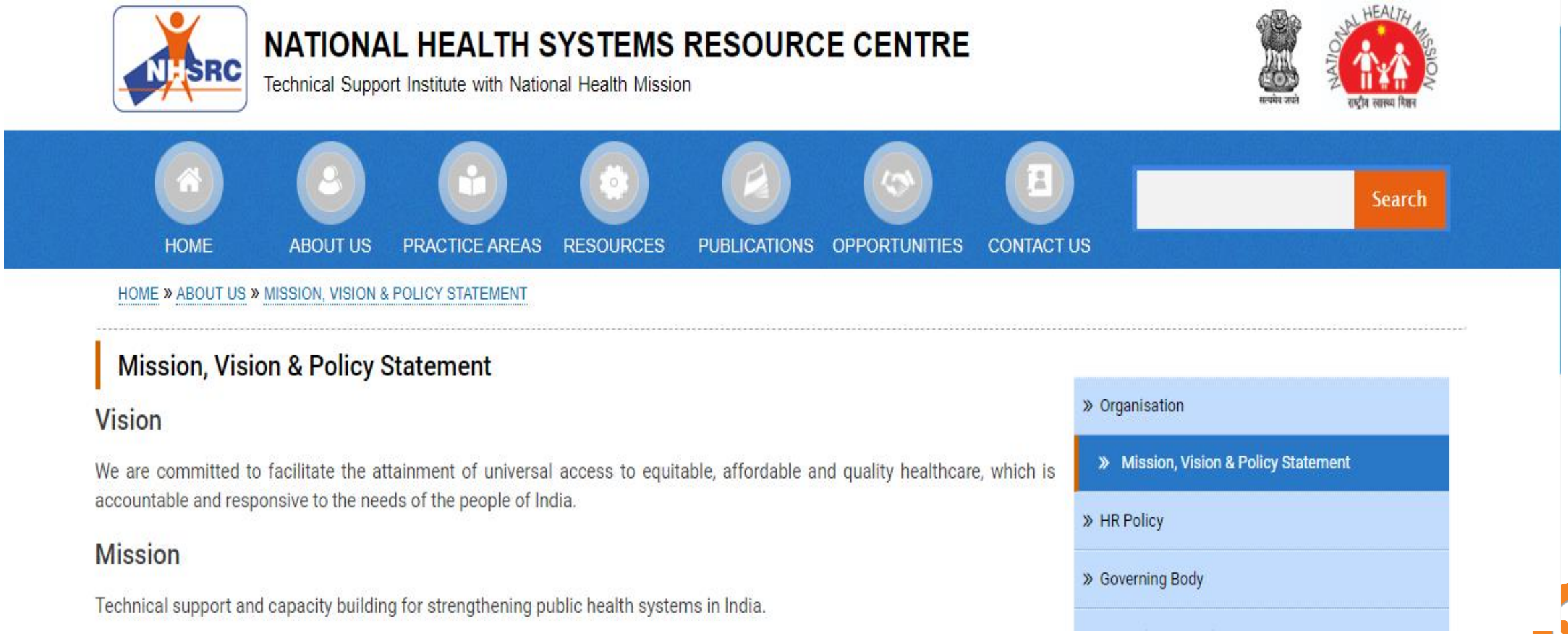
Mission, Vision, Policies, Objectives

1. Check whether they have been defined.
2. Check whether it has been disseminated
3. Check Mission, vision has been displayed at appropriate places

Mission

1. The Mission statement may incorporate ‘what is the purpose of existence’,‘ who are our users’ and ‘what do we intend to do by operating this facility’.
2. Mission statement should be pragmatic and simple so it can be easily understood by target audiences and they can relate it with their work.
3. As the public health facility is part of larger public health system governed by State Health Department, it is recommended the facility’s mission statement should be in congruence with mission of the State’s Health department.
4. Mission statement should be approved and endorsed by administration of facility and effectively communicated in local language through display.
5. Caution should also be taken to keep the language simple and easily understandable

Vision & Mission



Setting Quality Policy & Objectives

QUALITY POLICY:

1. appropriate to the purpose of the hospital, with commitment to comply with requirements and continually improves the effectiveness of the services.
2. Shall be framed by Hospital Quality team
3. Quality Policy Displayed at critical places
4. In local language
5. Quality objectives linked with Quality Policy
6. Quality Objectives linked with KPIs, Assessment Report & PSS

Examples of Quality Policy

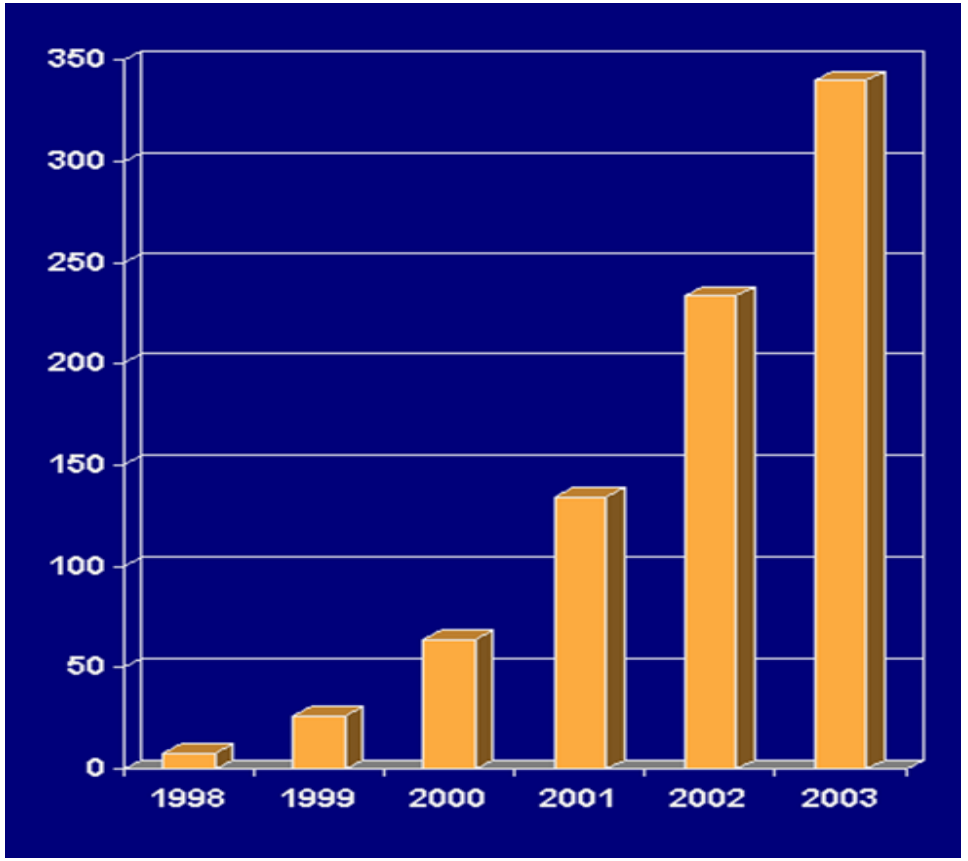
- *"We shall strive to provide preventive, promotive and secondary level of curative healthcare services to the people in the hospital with sustained efforts to ensure that it is equitable, affordable , accountable and responsive to the people needs, with in limitation of its resources" .*
- *"Rogi Kalyan Samiti of the hospital shall mobilize resources and ensure its efficient utilization to improve the functioning of the Hospital".*
- *"We are committed to delight the end users of our services by efficient service delivery".*

SMART WAY TO PERFORM

QUALITY OBJECTIVES - A *quality objective* is a quality oriented goal.

A *quality objective* is something you aim for or try to achieve.

S- Specific
M- Measurable
A- Attainable
R- Reviewable
T- Time-Bound



Examples of Quality objectives

Hospital

- Increasing OPD Access by BPL population by ‘x% ‘in ‘y’ months
- Increasing overall patient satisfaction by ‘p’ point in ‘Q’ months

Dept.

- Increasing LSCS rate to ‘g%’ in ‘h’ months
- Increasing major surgery by ‘m%’ in ‘n’ months / one year

Labour Room

- Increasing night time deliveries by ‘d%’ in ‘c’ months
- Reducing post-partum infection by ‘k%’ in ‘l’ months

List of Policies

1. Condemnation Policy.
2. End of Life Care Policy
3. Antibiotic Policy
4. Visitor Policy
5. Non-Discrimination to Gender Policy
6. Religious and Cultural Preferences Policy.
7. Social Non-Discrimination Policy.
8. Privacy, Dignity and Confidentiality Policy
9. Maintenance of Patient Records and information Policy.
10. Privacy of patients with social stigma Policy.
11. Consent Policy
12. Change of linen in patient care area Policy.
13. Judicial use of PPEs Policy
14. Prescription by Generic names Policy
15. Reporting of Adverse Events Policy
16. Referral of patients if services cannot be provided Policy

1. Consultation of patients within Hospital Policy
2. Handover during interdepartmental transfer Policy
3. Internal adjustments in case of non-availability of beds Policy
4. Dress Code Policy
5. Narcotic Drugs and Psychotropic substances Policy
6. Policy for avoiding stock outs of drugs and consumables and ensuring availability of drugs as per EDL.
7. Policy for regular competence testing as per job description.
8. Policy for Timely reimbursements of entitlements and compensation.
9. Policy for ensuring free of cost treatment to BPL patients.
10. Grievance redressal Policy
11. No smoking Policy
12. Quality Policy.

Quality Manual

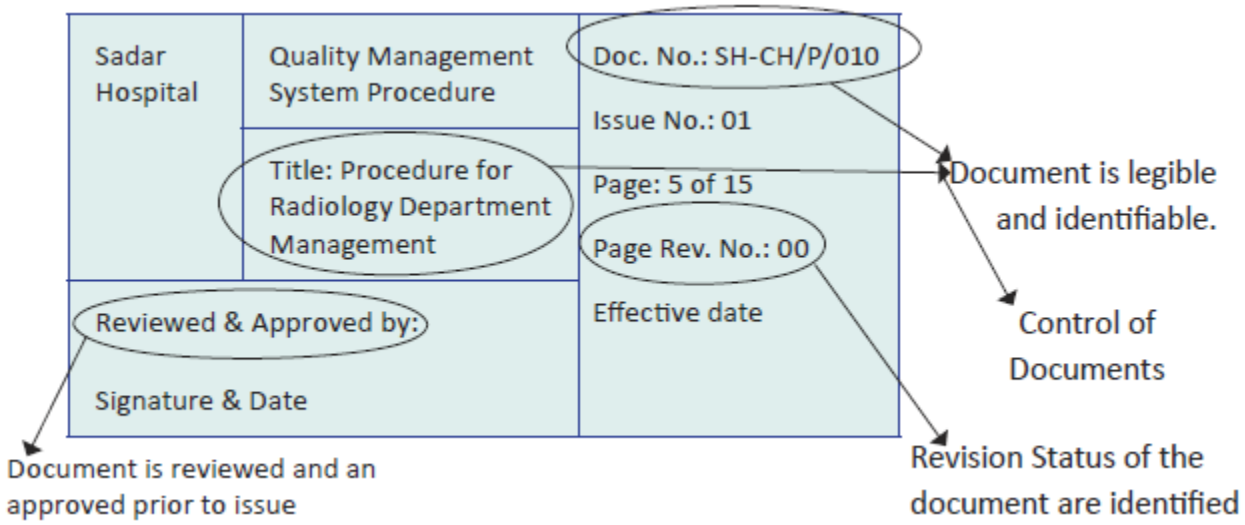
Quality Manual:-

1. A background of the Organization
2. Quality Policy
3. Scope of services to be covered
4. Services excluded from scope
5. Statutory / Regulatory requirements applicable to the organization
6. Interaction of various processes and control
7. Area of concern wise interpretation and application of the standard
8. Responsibilities & Authorities of Key Persons
9. Responsibility Matrix- who will be responsible for which clause of the standard
10. General Process flow diagram of the services
11. Services provided
12. Hospital Wide Policies
13. Abbreviation & Definitions used in the manual

All the QMS documents should have

- Doc Title
- Doc id no
- Revision/ version No.
- Effective date
- Next review date
- Name of the Reviewer
- Name of the Approver
- Copy No.
- Date of Issue
- Control/ Uncontrolled status
- Amendment sheet / Revision status

Control of Documents



Quality Tools

- Check Quality tools and methods applied for improvement

Quality Improvement Tool by Situation	
Working With ideas/concepts	**Working with Numbers**
Brainstorming	Pareto
Cause & effect	Control Charts
Flow charts	Run Charts
Gantt charts	Check sheets
Matrix	Histogram
Story Board	Scatter Diagram

Recommendation for Certification

Issue of Certification

Assessment of facility by nominated assessors

Review of Documents, Records and feedback

Processing of Application

Internal Assessment and Quality Improvement

Assessment and review by SQAC

Application to JS (P), MoHFW, GoI

Certification Criteria

Criteria	District Hospital	CHC
Criterion 1- **Aggregate Score**	Aggregate score ≥ 70%	Aggregate score of ≥ 70%
Criterion 2- **Department Score**	Individual Quality Score for all selected Department ≥ 70%	Individual Quality Score for all selected Department ≥ 70%
Criterion 3- **Area of Concern Wise Score**	Individual Quality Score of all 8 area of concern ≥ 70%	Individual Quality Score of all 8 area of concern ≥ 70%
Criterion 4- **Critical Standards**	Standard A2, B5 and D10 ≥70%	Standard A2, B5 and D8 ≥60%
Criterion 5- **Standards wise Score**	Individual Standard wise score ≥ 50%	Individual Standard wise score ≥ 50%
Criterion 6- **Patient Satisfaction Score**	PSS -70% in the preceding Quarter or more (Satisfied & Highly Satisfied on Mera-Aspataal) or Score of 3.5 on Likert Scale	PSS- 65% in the preceding Quarter or more (Satisfied & Highly Satisfied on Mera-Aspataal) or Score of 3.2 on Likert Scale

Application for NQAS

DISTRICT HOSPITAL/SUB-DIVISIONAL HOSPITAL
Application for External Certification for Quality of Services

Letter 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

Dear Sir/Madam,

We are happy to inform that at (Name of District Hospital as per official records .....) health facility of district.....in State/UT of ..... has made substantial progress in the Quality Assurance Programme and the health facility has scored -------- (percentage of marks obtained in latest Assessment) against NQAS in the latest state level assessment -

Hence, we request you to issue instructions for assessment of the health facility for the MoHFW GOI Quality Assurance certification. Detailed information on the health facility is given in the attached appendix I.

Thanking you.

Yours sincerely

(----------)

Chairperson

SQAC

From:

State Quality Assurance Committee

1(a). Name of DH as per official records 1(b). NIN ID			
2. Complete Postal Address with PIN	:		
3. Contact Details -	Phone: Mobile: E mail:		
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. Nearest Railway Station			
5. Nearest Airport			
Details of Hospital			
a. Application for Assessment under (please tick)	• NQAS		
	• LaQshya		
	• Both		
b. Existing functional departments	Number	vi.	xiii.
	Name:	vii.	xiv.
	i.	viii.	xv.
	ii.	ix.	xvi.
	iii.	x.	xvii.
	iv.	xi.	xviii.
	v.	xii.	Other-

List of Documents- DH/SDH

List of Documents to be submitted:			
S. No.	**Documents**	**Status of submission (Y/N)**	**Remarks (if any)**
1	Filled application form along with the Hospital data sheet	Y/N	
2	No. and Names of the Department to be assessed	Y/N	
3	Latest Assessment Report and scores	Y/N	
4	Minutes of last Quality team meeting (MOM)	Y/N	
5	Departmental SOPs	Y/N	
6	Quality Improvement Manual	**Y/N**	
7	**Copy of Hospital Wide Policies/ Procedures. (Government Order/ Single Pager Policy / Procedures):**		
	Vision, Mission, Values, Strategic Plan and Quality Policy	Y/N	
	Condemnation Policy	Y/N	
	Antibiotic Policy	Y/N	
	End of Life care Policy	Y/N	
	Social, Culture and Religious Equality Policy	Y/N	
	Patients Privacy, Dignity and Confidentiality Policy	Y/N	
	Consent Policy	Y/N	
	Prescription by Generic Name Policy	Y/N	
	Adverse Event Reporting Policy	Y/N	
	Referral Policy	Y/N	
	Timely reimbursement of entitlements and compensation	Y/N	
	Grievance Redressal Policy	Y/N	
	Free treatment to BPL patient's Procedure/Policy	Y/N	

List of Documents

8	Scores of last 3 Patient Satisfaction Survey and subsequent corrective and preventive actions undertaken	Y/N	
9	Last 3 months data of Key Performance Indicators (KPI)	Y/N	
10	Prescription/Medical Audit Analysis with Corrective and Preventive Action undertaken (CAPA)		
11	**Statutory/ Regulatory Compliance**		
	Authorization for handling Bio Medical Waste from Pollution Control Board.	**Y/N**	
	Fire Safety NoC	**Y/N**	
	Certificate of inspection of electrical installation	**Y/N**	
	License for operating lift *(if applicable)*	**Y/N**	
	AERB authorization	**Y/N**	
	License of Blood Bank	**Y/N**	
	Copy of registration under PCPNDT Act	**Y/N**	

List of Documents- PHCs/UPHCs

List of Documents to be submitted:			
S. No.	**Documents**	**Status of submission (Y/N)**	**Remarks (if any)**
1	Filled application form along with the Hospital data sheet	Y/N	
2	Latest Assessment Report and scores	Y/N	
3	Minutes of last Quality team meeting (MOM)	Y/N	
4	Departmental SOPs	Y/N	
5	Quality Improvement Manual	**Y/N**	
6	**Copy of Hospital Wide Policies/ Procedures. (Government Order/ Single Pager Policy / Procedures):**		
	Quality Policy	Y/N	
	Condemnation Policy	Y/N	
	Maintaining of Patients record, its security, sharing of information and safe disposal	Y/N	
	Referral Policy	Y/N	
7	Scores of last 3 Patient Satisfaction Survey and subsequent corrective and preventive actions undertaken	Y/N	
8	Last 3 months data of Key Performance Indicators (KPI)	Y/N	
9	Prescription/Medical Audit Analysis with Corrective and Preventive Action undertaken (CAPA)		
10	**Statutory/ Regulatory Compliance**		
	Authorization for handling Bio Medical Waste from Pollution Control Board.	**Y/N**	
	Pre Authorization from SPCB for Sharp and dip burial pit in remote PHCs (If applicable)	**Y/N**	
	Fire safety NOC	**Y/N**	

Thank you