सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

Operational Guidelines for Improving Quality in Public Healthcare Facilities 2021

Ministry of Health and Family Welfare
Government of India

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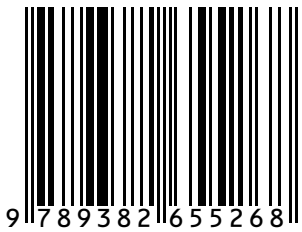
2021



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मनसुख मांडविया
MANSUKH MANDAVIYA

सत्यमेव जयते

स्वास्थ्य एवं परिवार कल्याण
व रसायन एवं उर्वरक मंत्री
भारत सरकार
Minister for Health & Family Welfare
and Chemicals & Fertilizers
Government of India

MESSAGE

The launch of National Quality Assurance Program has paved the path of well-structured efforts improving the Quality in Indian Public Healthcare System. The programme is based on the foundation of sustainable and measurable Quality Standards for the public healthcare facilities and has given good results. Since inception, the National Quality Assurance Program, with the collaborative efforts of the Ministry of Health and Family Welfare and the State Health Departments, has contributed in strategic planning, guiding and evaluating the quality of healthcare delivery in the Public Health Institutions of the country.

Over the years, the programme has expanded its scope, based upon the emerging requirements and responses to newer initiatives taken up by Union Ministry of Health and Family Welfare, to improve the quality standards in service delivery and not only want to keep meeting present day needs but to be future ready and set standards.

The present revised guidelines are a step in that direction. The "Operational Guidelines for Improving Quality in Public Healthcare Facilities, 2021" encompasses the comprehensive framework for measurable improvements in quality of care, by ensuring safe, effective, patient-centered, timely, efficient and equitable healthcare service delivery in the public health facilities.

I am confident that these guidelines would build upon the achievements of the Government of India in assuring quality healthcare, so far and would be utilized by the Union and State Health Ministries and Departments to provide patient-centric service delivery with a sustainable model of quality improvement.

(Mansukh Mandaviya)

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सर्वेसन्तु निरामया

स्वच्छ भारत
एक कदम स्वच्छता की ओर

MESSAGE

The National Health Mission (NHM) strives to provide Quality Healthcare to all citizens of the country in an equitable manner.

The National Health Policy, 2017 clearly states in its objective to improve the health status through concerted policy action in all sectors and to expand preventive, promotive, curative, palliative and rehabilitative services provided through the public health system.

The revised Operational Guidelines for Improving Quality in Public Health Care facilities 2021 have been developed with an aim to strengthen & improve quality of care from national level to facility level. The guidelines have internationally recognized / accepted standards, measurement system and quality improvement interventions at par with universal quality and safety goals.

The guidelines will help the implementing States and Union Territories to work on requirements specific to the scope of services and roles & responsibilities of the health facilities to achieve quality standards.

The guidelines delineate roles and responsibilities of different stakeholder for building the quality systems in the public healthcare system of the States and UTs. It would be advantageous for policy makers, health systems officials, program officers, service providers and service users as well as those who are interested to support and sustain Quality in healthcare services.

I believe that this initiative will go a long way contributing towards Quality Improvement in Public Healthcare Facilities in India.

(Dr. Bharati Pravin Pawar)

"दो गज की दूरी, मास्क है जरूरी"

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Ministry of Health and Family Welfare

MESSAGE

Provision of quality healthcare in the Public Healthcare Facilities to the people accessing the services is the goal of the Government. The need, therefore, is to create an inbuilt and sustainable system of Quality Assurance for the Public Healthcare Facilities to consistently deliver good quality care.

Recognizing that good quality of care with access, is needed to improve the health outcomes, based on the learnings of National Quality Assurance Standards (NQAS) implementation in the country, existing Quality Assurance guidelines have been revised and being released as **'Operational Guidelines for Improving Quality in Public Healthcare Facilities, 2021'**.

These revised guidelines provide a clear roadmap of effective planning & systematic implementation of the Quality Management through various interventions such as NQAS, Kayakalp, LaQshya, MusQan and Mera-Aspataal. These guidelines, if implemented in letter and spirit, would strengthen the Public Health System in the country and facilitate provision of quality healthcare.

The 'Operational Guidelines' have been evolved to serve as a handbook and a resource material for the Planners, Administrators, Program Managers and Clinicians. I am certain that these guidelines will prove to be useful at all levels of health facilities in achieving the quality goals and improved outcomes.

Place : New Delhi
Date : 10-09-2021

(Rajesh Bhushan)

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MESSAGE

Since the launch of National Health Mission in 2005, the country has achieved significant improvement in the Maternal and Child Health mortality and morbidity indicators. India has also made notable progress in curbing childhood illnesses, vaccine preventable deaths and other National Programmes such as for control of HIV, Tuberculosis and Malaria.

Realizing the needs to improve the quality of care to curb inappropriate and unsafe treatment, missed diagnosis and to provide more respectable care from public health institutions; and to address the gaps in understanding, measuring and improving Quality of healthcare services at every level, the MoHFW has further strengthened Quality Assurance Framework under the NQAS inititiative.

Existing Quality Assurance guidelines have been revised as **'Operational Guidelines for Improving Quality in Public Healthcare Facilities, 2021',** to help the stakeholders for creating a culture of quality services delivery across the country.
Achievement the quality standards in all the public health institutions, and sustaining them in the subsequent years should be the key priority for States & UTs. These new Operational Guidelines shall assist State and District officials in identification of gaps, planning, implementation of new initiatives wherever necessary and in plugging such gaps through better implementation of existing initiatives.

I sincerely urge all the States & UTs to ensure that these guidelines and the National Quality Assurance Standards are disseminated among all stakeholders and suitable efforts are undertaken to build capacities for implementation of the Guidelines, so that we collectively build 'quality health systems', to serve the health needs of the citizens.

(Vikas Sheel)

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MESSAGE

National Health Mission is constantly striving towards ensuring the delivery of health services through six domains of Health Care Quality viz. safe, effective, patient-centered, timely, efficient and equitable services. Ministry of Health and Family Welfare (MoHFW) had launched "National Quality Assurance Program" in the year 2013 for the public health facilities. Since then, the initiative has covered substantial ground and many complementary components, such as Kayakalp, LaQshya, MusQan and AEFI surveillance, have been added.

To continue the momentum of building quality health systems, a comprehensive understanding is required for implementation of the National Quality Assurance Standards (NQAS) across facilities at each level. 'Operational Guidelines for Improving Quality in Public Healthcare Facilities, 2021' aims to address the programmatic needs in implementation of the quality standards. Now, the guidelines support the overall quality management in all its dimensions – NQAS, Kayakalp, LaQshya, MusQan, and AEFI surveillance, and also other facets such as quality control, quality assurance and quality improvement.

Mission Directors, Program Officers, State and District Consultants, and Facility in charges could use these guidelines in planning and operationalizing the institutional framework in a meaningful manner, besides extending the NQAS implementation support. It shall also guide the States/UTs in organizing various activities under this initiative which will enable them in the certification process. The efforts of the Quality Improvement Division in developing this manual are commendable. I hope this manual will go a long way in scaling up the culture of quality in delivered services all over the country.

(Vishal Chauhan)

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EXECUTIVE SUMMARY

During last two decades or so, a realisation has drawn, though gradually, that delivered services at the health facilities need to be of minimum quality standards, and such services are benchmarked, equitable and measurable. These intentions have been articulated in five-year plan documents, National Health Mission implementation framework (2005), National health policy (2017) and in various Programme Guidelines. There are ample evidences to suggest that the country has achieved remarkable improvement in morbidity & mortality indicators, more so for pregnancy related conditions, childhood illnesses, vaccine preventable diseases, HIV, Malaria, Tuberculosis, etc. However, country's health system is always challenged due to variability and appropriateness of care for given clinical conditions and quality of services.

The consequences of poor Quality of care exists in form of inappropriate & unsafe treatment, missed diagnosis and disrespectful services, often result into unexpected, ill-timed preventable deaths, poor health, financial burden, and loss of trust in healthcare system. This vicious circle effects most to the poor, marginalized and vulnerable sections. The Lancet Global Health Commission on High Quality Health Systems in the SDG Era in its latest report estimates that in LMIC 60% of deaths occur due to poor quality care, whereas remaining deaths result from non-utilisation of the health system.

Ensuring Quality in delivered services is always a key priority of Ministry of Health & Family welfare, Govt. of India and it is well reflected in National Health policy, Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PM- JAY), Comprehensive primary healthcare CPHC etc. Since 2005, India is constantly working toward improving the Quality of services delivered and it has built its foundation by setting standards for service delivery and Quality (NQAS) for all level of public Healthcare institutions. The minimum standards are aligned with the global benchmarks defined by WHO and it is duly recognized by international organizations. Standards are further linked with well-defined assessment tools and all gaps are traversed through continual quality improvement methods and tools viz PDCA, process improvement, 5S etc. Apart from setting standards in area of Quality-of-care multiple steps are taken to further strengthen the overall health systems environment viz.

(a) Dedicated institutional framework for quality at the National, State, District and Facility level.

(b) Continual capacity building, handholding, and monitoring support to healthcare professionals for implementation of Quality-of-care approaches.

(c) Ensuring ownership and accountability for quality initiatives at state health departments.

(d) Ensuring well laid operational plan with adequate funding through National Mission every financial Year.

(e) Amalgamation of all programmatic quality and patient safety initiatives under one umbrella that is Central Quality Supervisory Committee.

(f) Ensuring measurement and reporting of quality & safety through key performance indicators.

(g) Regular self and peer assessment of public healthcare facilities for ensuring minimum standards for hygiene, safe practices, and improvement in clinical care.

(h) Mechanism for external evaluation of organization's performance against predefined standards and provision of incentives, certification, and awards to excellent performers.

(i) Formalized system for patient/visitor feedback, community, or patient/family engagement & empowerment.

(j) Achieving the National Quality Assurance Standards (NQAS) over a period of the time.

BACKGROUND

National Rural Health Mission (NRHM) launched in 2005 and subsequently becoming National Health Mission (NHM) in 2013 after launch of National Urban Health Mission (NUHM) focuses to provide accessible, affordable, quality healthcare services to all sections of population, especially to the marginalized and vulnerable. Under the NHM, substantial investment has been made for developing state-of-the-art infrastructure and induction of skilled human resource and strengthening supply chain for ensuring availability of drugs and diagnostics. The NHM is an umbrella programme under which various specific programs and strategic actions are undertaken with aim of improving outcome indicators.

National Health Policy, approved and adopted by the Government of India in the year 2017, laid down the broad principles of professionalism, integrity, and ethics; equity; affordability; universality; patient centred quality care; accountability; pluralism; inclusive partnerships and decentralization. The Policy stresses upon the attainment of highest possible level of health & wellbeing for all ages, through preventive & promotive health care orientation in all developmental policies, universal access to good quality healthcare services without having financial hardship. It has definite time bound quantitative goals, which are aligned with existing national efforts as well as the global strategic directions, such as SDG and UHC goals. The health outcomes/ impact envisaged under National Health Policy cannot be achieved without excellent, safe and quality care. Therefore, It has been a priority for Ministry of Health and Family Welfare to strengthen the quality assurance framework by adopting a multi-pronged strategy in term of availability and retention of healthcare workers, improving their knowledge & skill to deliver the quality care, periodic monitoring and evaluations, ensuring safe and effective use of medicines & devices, integrating quality activities within the functioning of the health facilities and measuring their impact on patients' satisfaction and providing financial support and incentive.

Assuring quality in vast country like India is challenging as there is huge variation in terms of population, literacy, socio economic status and other health determinants. To assure the quality within these variations and maintain encouragement among healthcare providers for continual quality improvement, MoHFW has followed two approaches. One rapid approach, is to create the culture of Quality focusing on certain key areas viz. cleanliness, infection prevention (Kayakalp) and Care around birth (LaQshya), breastfeeding practices etc. and second gradual approach, focusing on building & supporting quality and safety in all vertical programmes, clinical and administrative activities undertaken in public health care institutions viz. NQAS

The first approach ensure compliance with minimal department/ function specific standards of quality and safety, it also help for making certain quick gains that further build capacity and confidence among healthcare providers and its end users. While second approach is focused on horizontal integration of all public health functions, hospital functions, quality and patient safety requirements under uniform standards and measurement system (NQAS), which in turn contribute to achieve larger goals committed in universal health coverage (UHCs) and SDGs.

JOURNEY OF QUALITY

Quality in Healthcare in India came into focus with the launch of the RCH in 1997, with one of its main objectives as improvement of quality of services provided by the public health care facilities in the country. Around the same time, the Health Systems Development Project (HSDP) financed by the World Bank also tried to improve quality of services in the district and sub-district hospitals. 12th Five-year plan (2012-17) observed that "Quality of healthcare services varies considerably in both the public and private sector. Many practitioners in the private sector are actually not qualified professionals. Regulatory standards for public and private hospitals are not adequately defined and, in any case, are ineffectively enforced." The plan also endeavoured that "an in-house quality management system will be built into the design of each facility, which will regularly measure its quality achievements. Facilities will be provided with an incentive, which they can share with their teams, to achieve and improve their quality rating."

The National Rural Health Mission, launched in the year 2005, with the mission for improving the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women, and children.

Another watershed moment in the quality improvement initiative came in March 2005, when the Honourable Supreme Court, in Ramakant Rai and Health Watch UP and Bihar vs. the Union of India (Writ Petition (C) No 209 of 2003), directed all states to set up a Quality Assurance Committee (QAC) for Family Planning services at the State and District level.

Almost at the same time, Indian Public Health Standards (IPHS) Guidelines were launched in 2007 and later revised in 2012 for District Hospitals, Community Health Centres, Primary Health centres and Sub Centre. IPHS guidelines serve its purpose in term of guiding the states in term of services, physical infrastructure in broad sense, HR, equipment, drugs, etc. However, it does not devolve into 'how' part in term of care organisation & delivery (process).

Keeping diversity of health systems in mind in the country, it was decided to leverage flexibility of ISO 9001 Quality Management System (QMS) to adopt them for the diverse needs of India's Public Health System. Public Health Facilities were audited against six mandatory requirement of ISO 9001 System and 24 hospital specific procedures. In 2008, pilot project was started in 8 Empowered action group (EAG) states for implementation of Quality Management System using ISO 9001 standards. Later it was scaled-up in other states.

Few good performing states such as Kerala, came out with their own standards. Meanwhile few states undertook endeavour for health quality by implementing NABH (National Accreditation Board for Hospital & Health Care Providers) Standards. By 2012, there were 147- ISO certified & 15 -NABH certified public healthcare facilities in country. These efforts were in bits and pieces and were not having unified approach towards ensuring quality in health.

In Year 2012, the Ministry of Health & Family Welfare (MOHFW) commissioned a study of quality accreditation mechanism in public health facilities through an external consultant. The study report recommended for enacting a Quality Assurance Framework & Standards specific to the public health system, as none of the Standards & Certification program, prevalent then, met the requirement of public health facilities.

Based on consultation with Experts, States, Public Health Professionals, Academic Institutions, Development Partners and other Stakeholders, National Quality Assurance framework was launched in November 2013 with release of 'Operational Guidelines for Quality Assurance in Public Health Facilities" along with Assessors Guidebooks for District Hospitals to bridge the gap between the vision and the realization of Quality. Subsequently, on the same lines, Standards, and guidelines for Primary Health centres (PHC) and Community Health Centres were developed in December 2014. It was followed by development of Quality Standards for Urban Primary Health Centres in January 2016.

For addressing the issue of cleanliness, infection control, biomedical waste management and environmental sanitation in public health facilities, 'Kayakalp Award Scheme' was launched in May 2015 and it is being scaled-up since then.

For making quick gains in term of improving quality care around birth within the shortest span of time, LaQshya (Labour Room Quality Improvement Initiative) was launched in December 2017. Its focus is to reduce preventable maternal & new-born mortality, morbidity, & complications. Compliance to National Quality Assurance Standards (NQAS), ensuring Respectful Maternal Care (RMC), adherence to clinical protocols in care of mother and new-born are few of the critical elements under LaQshya.

Figure 1: Milestones in QOC in India

1

About the OPERATIONAL GUIDELINES

Quality is complex and multifaceted, so setting of the standards of care alone without any supporting and interdependent actions are of limited value. So, to ensure reliable implementation of standards require additional actions such as training, supervision, monitoring for compliance and feedback of healthcare provider etc.

Recognizing the gaps in understanding, measuring and improving Quality of healthcare services, Ministry of Health and Family Welfare, Govt of India has developed **"Operational Guideline for Improving the Quality in Public Healthcare Facilities"** with aim to address the concerns of public and the technical components of service delivery in a comprehensive manner.

Objective of the Guidelines

The Operational Guidelines have been developed with following objectives:

(1) To strengthen and improve; Quality of care, from National level to Facility level, which would essentially include a supportive institutional framework & organisational structure, adoption of the standards, a system of continuous assessment of health facilities, action planning for closure of 'gaps', supportive supervision and lastly, external assessment of the facilities for certification.

(2) To boost the Quality system by defining evidence based, internationally recognized/accepted standards, measurement system and quality improvement interventions in congruence with universal quality and safety goals.

(3) To enable all personnel working in the Public Health System to have a credible quality management system, so that health facilities not only ensure availability of services, but also ensure that the services meet verifiable and objective quality and safety standards.

Scope of Guidelines

Operational Guidelines are intended for policy makers, health systems officials, program officers, services providers and service users as well as those who are interested to support and sustain quality in healthcare services. The document along with its accompanying tools aim to provide programmatic and technical guidance to healthcare professionals in states, regions, districts and facility level.

The guidelines define the overall understanding of Quality, develop dedicated organizational structure that can provide governance and technical capacity in quality at various levels, ensure quality is integrated across health functions, build capacity in ongoing quality activities, establish reporting and learning system for quality and safety, ensure monitoring for quality-of-care results and also guidance for available financial support for quality.

Operational Guidelines for improving Quality in Public Healthcare facilities, its accompanying compendium and volume of 'Assessment Tools' have been developed taking into consideration the health system approach ensuring availability of minimum health services, which should be available at primary and secondary level healthcare facilities, including those in the arena of Reproductive, Maternal, Neonatal, Child & Adolescent Health and Nutrition (RMNCHA-N) and various National Disease Control Programmes.

Scope of existing guidelines covers all activities, undertaken at different level for supporting implementation of National Quality Assurance Standards (NQAS) in all Public Health Facilities and subsequently sustaining it.

Along with standards, a set of departmental checklists have been prepared as per the scope of services in public health facilities. Since health is a state subject in the country, it is realised that scope of the services may vary from one state to another state. The States have the flexibility of adding or deleting services from existing assessment tool as per the Government Office Order. Therefore, a state may customize set of checklists as per state's policy, but without altering the framework of National Quality Assurance Standards (NQAS).

Quality is a continuous and multi-themed process. With the advent of time, its scope has been expanded from facility specific standards to health systems functions like improvement in cleanliness, hygiene and infection prevention practices (Kayakalp), Adverse Event Following Immunization (AEFI) surveillance system, Patient safety, etc. As further progress is made, newer domains may be added as per need of stakeholders.

The guidelines define 'road-map' for implementing quality system in the States. The Quality approach suggested in the document will help in improving compliance to the quality standards by public health facilities in the country. The States are required to meet the minimum standards defined in the guidelines and ensure its achievement over a period of time. The states/UTs / districts/ facilities may divide activities under quality programme, both in term of number of facilities, and within a facility, certain departments/ areas could be identified for a focussed attention. All efforts should be made in achieving the targets and sustaining them. In subsequent years, additional departments/areas and services may be targeted under the ambit of the QA programme at facility level.

Content

The document begins with chapter on background, followed by brief description of the quality journey in the country. The main body of Operational guidelines comprise of four sections:

1. **Section A – 'Understanding Quality in Health care'** describes basic concepts of Quality, generic description of its approaches, dimensions of healthcare quality. Chapters also describe how quality is perceived by its stakeholders i.e. patients, Communities (Society), Clinicians, and Administrators etc.

2. **Section B- 'Framework of Quality of care'** describes importance of "Donabedian model" in the healthcare quality. The section elaborates structure, process, and outcome components of the model in the context of public healthcare facilities, and how the advocated model meets the requirement of various stakeholders. It covers aim and implementation strategies for improvement in quality of care provided by public healthcare facilities. It also describes how the uniformity, reliability and resilience are interwoven within the quality standards, and their measurement system.

3. **Section C – 'Organisational Structures'** Section dwells into the recommended organisational structure for supporting Quality Programmes and its related sub-domains, from National level to facility level. It also provides terms of reference for each level implementation as well as continual improvement in health systems.

4. **Section D – 'Road Map'** describes the sequential steps, which need to be taken by the States, districts and health facilities for implementing the Quality Programme.

5. **Annexures-** Chapters are further followed by annexures, which provides detailed ToRs, specification of financial support available under NHM, and setting of improvement interventions and indicators that have been selected/followed for building and monitor systemwide capacity of public health care facilities to deliver quality of care services.

UNDERSTANDING QUALITY IN HEALTHCARE

Section | A

2

Introduction to **QUALITY**

Assuring and improving quality is an important strategy for all types of industries viz. aviation, chemical, financial, manufacturing, transportation, hotel or healthcare etc. Quality is considered relative and constantly evolving, so one must continue to explore and develop new ways by which it can be defined and measured, and this position was well acknowledged by Quality stalwarts like Shewhart, Deming, Juran, Taguchi, and Crosby through their efforts and contributions. Quality is indeed multifaceted, so it has been described in many ways as in **Figure 1.1**:

Quality is defined as		
Desirable characteristics that a product or service should possess	Fitness for use & it has 2 aspects (a) Set standards/ specification (b) Conformance to requirements	Reduction in variations in its processes & described statistically

Figure 1.1: Description of Quality

Literature on 'quality' is filled with various definitions and approaches to Quality. The more common approaches to quality include, Quality Control, Quality Assurance, and Quality Improvement. When we do literature search on "quality control" or "quality assurance" or "quality improvement" we get different definitions and "quality improvement," is generally understood to comprise the bigger picture, but everyone's understanding on QI also varies. These phrases are often used interchangeably. Although QA, QC and QI are closely related concepts, but are different aspects of quality management. Let us briefly understand these terms:

Quality Control "A part of quality management focused on fulfilling quality requirements" (ISO 9000 standard, clause 3.2.10).

- Quality control can also be defined as "part of *quality management* focused on fulfilling *quality requirements*."
- QC is used to verify the quality of the output.
- quality control is more about the inspection aspect of quality management.
- Quality Control is a reactive process and recognizes the defects.
- QC activities monitor and verify that the product/service meet the defined quality standards.

Quality Control is integrated within the NQAS framework. For example:

- Finding errors in prescriptions using "Prescription Audit".
- Using Daily Departmental Checklist.
- Daily rounds by Superintendent/matron.

Quality Assurance:

- "A part of quality management focused on providing confidence that quality requirements will be fulfilled" (ISO 9000, Clause 3.2.1)
- According to the Health Resources and Services Administration (HRSA), quality assurance (QA) measures compliance against certain necessary standards.
- QA is the process of managing for quality.
- Quality Assurance focuses on preventing defects.
- Quality assurance activities monitor and verify that the processes used to manage and create the deliverables have been followed and are operative.
- Quality Assurance is a proactive process and is preventive in nature. It recognizes flaws in the process.

Like Quality Control, Quality Assurance is also embedded within the framework of NQAS. For example:

- Measuring compliance against established Standards, in itself is Quality Assurance.
- Having details of Drugs, their Quantity, and Expiry date on top of Emergency Tray and monitoring it in every shift.
- Using 'Safe Surgery Checklist'.
- Using 'Safe Birth Checklist'.
- Labelling and maintenance of 'Full' and 'Empty' oxygen cylinders.

Quality Improvement:

- IOM (Institute of Medicine) defines QI as systematic and continuous actions that lead to measurable improvement in health care services and health status of targeted patient groups. It also defines quality in healthcare as direct correlation between the level of improved health services and the desired health outcomes of individuals and populations.
- Quality improvement (QI) is a systematic, formal approach to the analysis of practice performance and efforts to improve performance.
- For Quality improvement efforts are put systematically to identify any room of improvements in the existing standards and procedures. The target is to improve the process that establish the standards of quality.
- Quality improvement (QI) is a continuous improvement process focused on processes and systems.
- A variety of approaches or QI models exist to collect and analyse data and test change.
- Quality improvement models present a systematic, formal framework for establishing QI processes in practice.

Quality Improvement is also integrated within the NQAS framework. Examples of QI models included:

- PDCA (Plan-Do-Check-Act) Cycle or Deming's Cycle.
- Six Sigma
- Lean

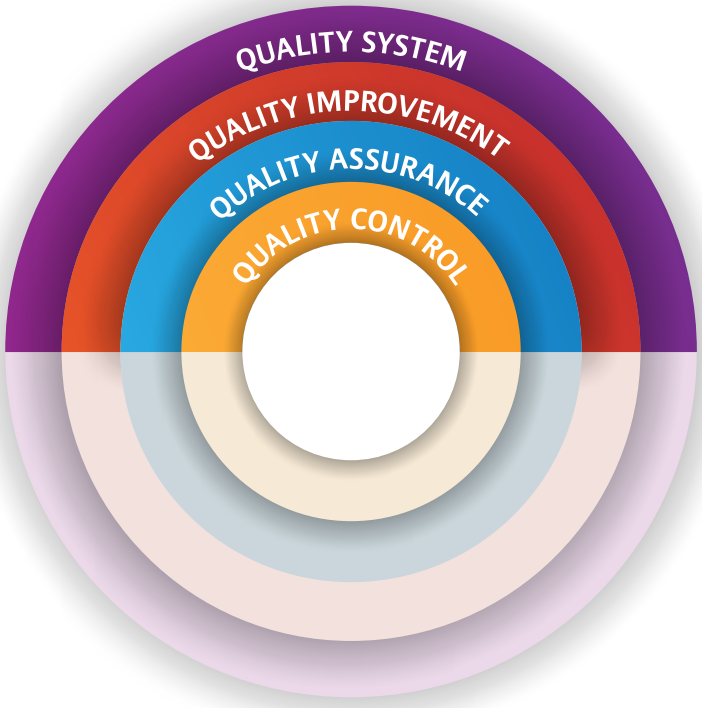

Figure 1.2: Quality System, Quality Improvement, Quality Assurance, and Quality Control Relationships

- We can summarise that the Quality assurance does not eliminate the need for Quality control (QC) as QC lies at the very core of Quality management, that is prevention of defects in the service. Similarly, for preventing of the defects, and for sustaining the quality and improving it further, would require undertaking planned improvement activities. QA, QC, and QI are more alike than being perceived as 'stand-alone' initiatives. Moreover, they add less value when implemented singularly. They should be taken together to form a "Holistic Quality Program" that encompasses all these approaches of QA, QC, and QI as shown in **figure 1.2**.

NQAS: THE HOLISTIC APPROACH TOWARDS QUALITY

The common misconception about NQAS is that its approach is limited to 'Quality Assurance', as NQAS stands for National Quality Assurance Standards. This is far from true. As we have seen that none of the approaches towards quality yields desired improvements in healthcare services if implemented in isolation. For this reason, a holistic and comprehensive, yet simple, strategy has been adopted under NQAS encompassing all approaches and methodologies under Quality including Quality control, Quality Assurance, and Quality Improvement.

We have seen that the puzzling nomenclature creates more confusion amongst the implementors rather than supporting them in improving quality. This is more so in healthcare scenario as the staff is technically trained in Clinical, nursing, and paramedical services not in in Quality or management services. Hence, to keep the jargon to minimal, all the approaches have been embedded under NQAS without naming and demarcating the individual approach.

The basic approach followed can be explained as two Step Process: Step-1: Measuring Quality & Step-2: Improving Quality

Details may be referred from **Annexure 'A'**

Dimensions of Quality of Care

The Institute of Medicine defines quality of Care as *"the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge".*

According to, *Crossing the Quality Chasm: A New Health System for the 21st Century (2001)* report "quality of care" has six basic dimensions viz. Safety, Effectiveness, Patient Centeredness, Timeliness, Efficiency and Equity. In *2018, Crossing the Global Quality Chasm: Improving Healthcare Quality worldwide* has reported modification in six dimensions as per current global context especially applicable to low resource countries in modern times. So, following are the modified dimensions of quality of care:

- Safety: Avoiding harm to patients from the care that is intended to help them.
- Effectiveness: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (that is, avoiding both overuse of inappropriate care and underuse of effective care).
- Person-centeredness: Providing care that is respectful of and responsive to individual preferences, needs, and values and ensuring that people's values

guide all clinical decisions. Care transitions and coordination should not be centered on health care providers, but on recipients.

- Accessibility, Timeliness, Affordability: Reducing unwanted waits and harmful delays for both those who receive and those who give care, reducing access barriers and financial risk for patients, families, and communities; and promoting care that is affordable for the system.
- Efficiency: Avoiding waste, including waste of equipment, supplies, ideas, and energy, and including waste resulting from poor management, fraud, corruption, and abusive practices. Existing resources should be leveraged to the greatest degree possible to finance services.
- Equity: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, race, geographic location, and socioeconomic status.

Quality in Health Care

Quality in Health Systems has two components –

(a) Technical Quality: on which, usually service providers (doctors, nurses & para-medical staff) are more concerned and has a bearing on outcome or end-result of services delivered.

(b) Service Quality: pertains to those aspects of facility-based care and services, which patients are often more concerned, and has bearing on patient experience including satisfaction.

Few common issues have been elaborated in **Figure 1.1**.

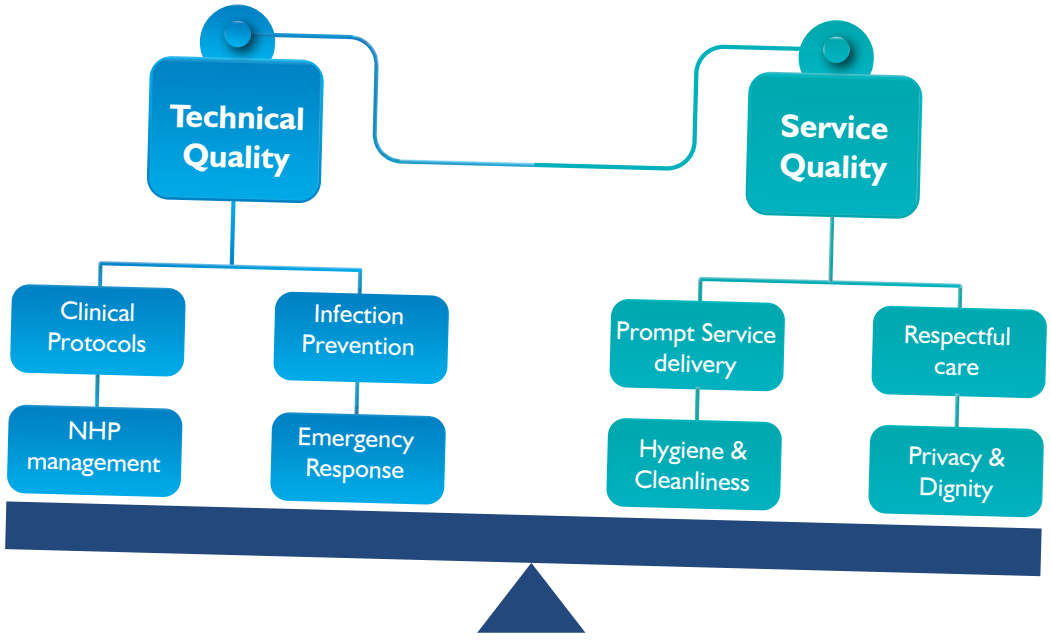

FIG 1.3: **Sub-components of quality**

Quality as perceived by different stakeholders – Although everyone values quality but perceives it differently. Patients, Communities (Society), Clinicians, and Administrators have different definitions of quality as shown in **Figure 1.4**.

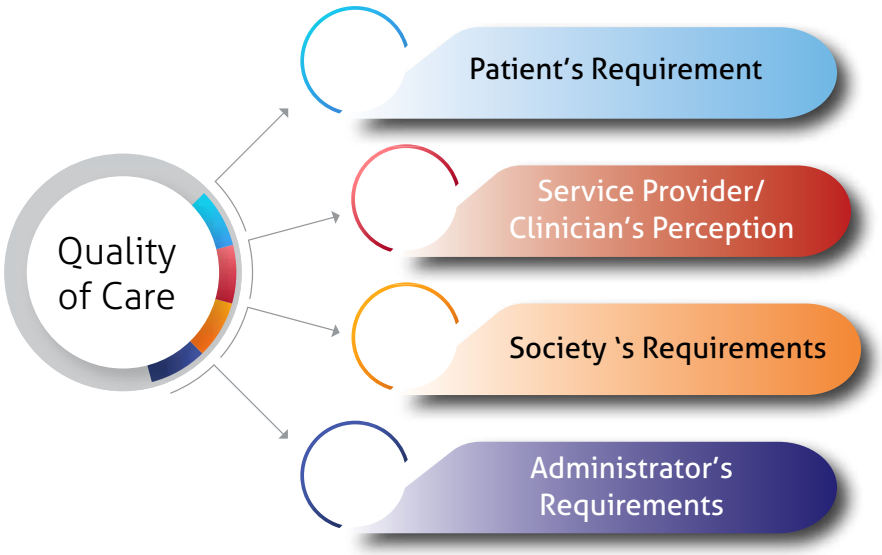

Figure 1.4: **Quality as perceived by different stakeholders**

Patient's Requirement – Although patients are deeply concerned, how good clinical care is, but very often, they themselves are not able to judge the technical aspect of the care. Patients are mostly concerned about the issues, other than clinical guidelines & protocols. Usual expectations of patients are given in the **table 1.1**.

Table 1.1: **Expectations of Patients**

Care	Cure
1. Clean and inviting atmosphere	1. Correct, speedy, low cost & lasting treatment
2. Courteous and respectful behaviour	2. Emergency response
3. Personalised approach	3. No new diseases
4. Psychological well-being,	4. No harmful procedure/ complication
5. Quality care without variation	5. No overuse of unnecessary/ ineffective care

Users' experiences of health care in a facility, whether personal or shared, have a major impact in their decision of seeking the services at a facility. People do not wish to go to a facility where they receive rude treatment.

Society's Definition – At the broader societal level, the definition of quality of care reflects concern of cost effectiveness, equal access and equity in service delivery, transparency and extent of out-of-pocket expenditure. Society also perceives quality in terms of protection of health rights specially of marginalized and vulnerable populations.

Healthcare Providers – Clinicians, who provide healthcare services, tend to equate quality of care with technical performance. Often for health care providers, the desired outcomes are related to successful treatment of patients with reduction in morbidity, mortality and disability limitation. For example, doctors' expectation of quality services is that investigation reports are available on time, drugs are available in the dispensary, and patients are getting cured timely.

Governments/ Administrators Definitions – An administrator perceives quality in terms of optimal and rational utilization of resources, maximum satisfaction by the users of health facility, delivery of all components under the health programmes, compliance to treatment guidelines & clinical protocols, and improvement in the health status of population.

FRAMEWORK OF QUALITY OF CARE (QOC)

Section | B

QUALITY OF CARE (QOC)

The most accepted framework for assessing the quality of care is by the 'Donabedian model', which classifies QOC in terms of three aspects – structure, process, & outcome.

a. Structure – Structural aspect of QOC includes material resources like infrastructure, drugs and equipment; and Human Resources such as availability of adequate number of personnel, who have requisite knowledge and skills. Evaluation of the quality that relies on such structural elements implicitly assumes that well qualified people with well-appointed and well-organized settings will provide high quality care. However, it is not always the case. Also, it is acknowledged that in the Public Health System, full compliance to infrastructure and HR norms may not be possible. However, after meeting the minimum infrastructure and HR norms for a Public Health Facility, it would be logical to expect a minimum quality in the available services at the Public Health Facility. The proposed system strives to provide QOC within these constraints.

b. Process – Care can also be evaluated in terms of processes & sub-processes, required for delivering the clinical and non-clinical care. This refers to what takes place during its delivery – such as how quickly registration of a patient is done, and s/he is attended, courteous behaviour of the service providers, especially of doctors & nurses, conduct of examination with respect to privacy, confidentiality and for patient's right, etc. It also includes adherence to clinical, infection prevention and safety protocols, clinical Governance mechanism including clinical risk management, clinical audits, peer review and individual feedback to ensure accountability, transparency and effectiveness of care provided.

c. Outcome – The other aspect of quality of care can be assessed in terms of outcome measurements, which denote to what extent goals of the care have been achieved.

All three aspects of the QOC have different connotation to different stakeholders, viz. Patients, Service providers and Health System, as given in **Table 2.1**.

Table 2.1: QOC IN TERM OF INPUTS, PROCESS & OUTCOME			
Stakeholders	**Inputs**	**Process**	**Outcome**
Patients' Expectations	• Barrier Free Access - Prompt & courteous services - No exclusion based on caste and socio-economic status • Clean & Inviting environment at the health facility • Availability of services • Availability of drugs and consumables	• Minimal waiting time & Prompt referral, if required • Good behaviour by service providers • Privacy & confidentiality • Grievance Redressal • Access to Information and involvement in decision making for the care	• No out-of-pocket expenditure • Availability of services as guaranteed • High Patient Satisfaction • Treatment and Cure
Service Providers Requirements	• Adequate and planned infrastructure • Serviceable & calibrated Equipment • Availability of Quality Drugs • Human Resource in numerical adequacy with knowledge and skills • Enabling Work Environment	• Adherence to clinical Protocols • Infection Control Practices • Training and Skill Development • Safe and effective Nursing care	• Low Mortality, Morbidity, complications, and Referrals, etc. • Effectiveness of the care in term of average length of stay, bed occupancy, etc • Low Adverse drug reactions and Hospital acquired infection • High Employees' Satisfaction
Health Systems Requirements	• Allocation of adequate resources • Facilities provide full range of services • Adequate Technical Support	• Efficient logistics management • Monitoring and Supervision • Effective implementation of programmes	• Optimal utilization of resources • Measurable deliverables of programmes • Improvement in Health Indicators • Enhanced Productivity in terms of volume

Aim

The National Health Policy was launched in the year 2017 with objective- *"To improve health status through concerted action in all sectors and expand preventive, promotive, curative, palliative and rehabilitative services provided through the public health sector with focus on quality."* The policy envisages expansion of health services through assured availability of comprehensive primary health care services, optimal use of existing resources, collaboration with non Govt sector and ensure improved quality in public health care facilities that reinforce trust of users in public health systems. Almost from a decade under National Health Mission (NHM) has made substantial investment in terms of infrastructure, availability of skilled human resources, setting up minimum quality and safety standards, clinical treatment protocols, mechanism for clinical and mortality audits, patient feedback etc along with budgetary allocation for all interventions.

Ministry of Health and Family Welfare, Government of India is committed to improve the Quality of services of public health care facilities and it supports and facilitates National Quality Assurance Programme, which meet the needs of Public Health System in the country and is sustainable. Main focus of proposed Quality Assurance Programme would be (a) Ensuring access to quality health services and financial risk protection for all and in turn support to achieve universal health coverage and Sustainable development goals (b) ensuring advocacy and implementation of global best practices, evidences and policy recommendations viz use of Standard Treatment Guidelines and Protocols; infection prevention and safety protocols; certification using checklist, assessments and improvement cycles; continuous training and skill enhancement; implementation of reporting and feedback mechanisms etc are continually followed to reduce the harm to patients & support to strengthen the overall quality of health systems and, (c) enhancing satisfaction among users of the Government Health Facilities and reposing trust in the Public Health System.

Key Strategies for implementation of Quality-of-Care Framework

India is the second most populace country with diverse ecosystem and this diversification is reflected in its health systems also. Regardless of variation in states, their health care needs, human resources, their capabilities and financing patterns, the nature of healthcare quality challenges is more or less similar in country that is lack of accountability, impaired clinical effectiveness, poor compliance to set norms, unsatisfactory users, their families and community, confusion due to multiple quality approaches, lack of systemic capacities for quality activities as well as poor reporting and monitoring of quality of care results. To deal with the concerns following steps would be taken for creating a credible quality of care framework

1. Dedicated Organizational Structure for Quality: To strengthen the Quality-of-care framework, a dedicated organizational structure has been set up from National level to Facility. Under institutional framework, there is Central Quality Supervisory committee (CQSC) at National level having representation from all program division of the Ministry of Health & Family Welfare & Quality Improvement Division at National Health Systems Resource Centre (NHSRC) as secretariat of the CQSC. Its mandate is implementation & monitoring of Quality framework in the country. Similarly, at the State & District level, there are State Quality Assurance Committees (SQAC) and District Quality Assurance Committees (DQAC) respectively. SQAC are usually headed by the State Health Secretaries & supported by State Quality Assurance unit (SQAU) which operate as functional arm of SQAC, and responsible for implementation & monitoring of Quality-of-Care activities in the state.

Similar role District Quality Assurance Unit (DQAU) undertake in districts. At facility and department level, there are facility Quality teams (named as DQT – District hospital level) & quality circles respectively. All the quality units and team at the state, district or facility level are staffed with full time quality professionals

2. **Integration of Quality approaches:** National Quality framework, launched in 2013, is based on the Health System's approach to Quality of Care. It has worked for establishing the institutional framework, defining the standards of care, its measurement system, capacity building and resource allocation. Key interventions under the programme are assessment of health facilities using checklists, gap identification, prioritisation and quality improvement through PDCA approaches viz. quality circles & champions, testing & implementing improvement ideas and finally certification, etc. Although Quality Improvement is part of the existing systems, still there are discrete local improvement project that keep on demonstrating small gains especially at department levels. These discrete efforts may not reach desired goal and optimal improvement in long run, more so from health system perspective. So, these discrete improvement efforts need to channelize through continual Quality Assurance and Quality Planning. As the quality system in the country is progressing towards maturity, it requires integration of quality approaches such as quality assurance, quality improvement and certification to create complete comprehensive picture of quality of care. It will include seamless integration of activities of operationalizing of quality committees, activities for quality assessment, certification programs and local quality improvement events, as shown in **Figure 2.1.**

Figure 2.1 : Quality Certification and Accreditation

3. **Setting standards and measurement system:** To provide consistently high-quality services, the foremost requirement is to set quality standards against which the performance can be measured. These standards must meet the specific requirements

of Public Health System and encompassing all three aspects of Quality of care i.e., Structure, Process and outcome.

Quality Assurance Standards have been developed at National level which have been further categorized into 8 broad Areas of Concern i.e., Service Provision, Patient Rights, Input, Support Services, Clinical Care, Infection Control, Quality Management and Outcome.

A set of Standards & Measurable Elements for a District Hospital/ Sub Divisional Hospital, Community Health Centre, Primary Health Centre (Rural & Urban) is given in compendium – National Quality Assurance Standards for Public Health care facilities.

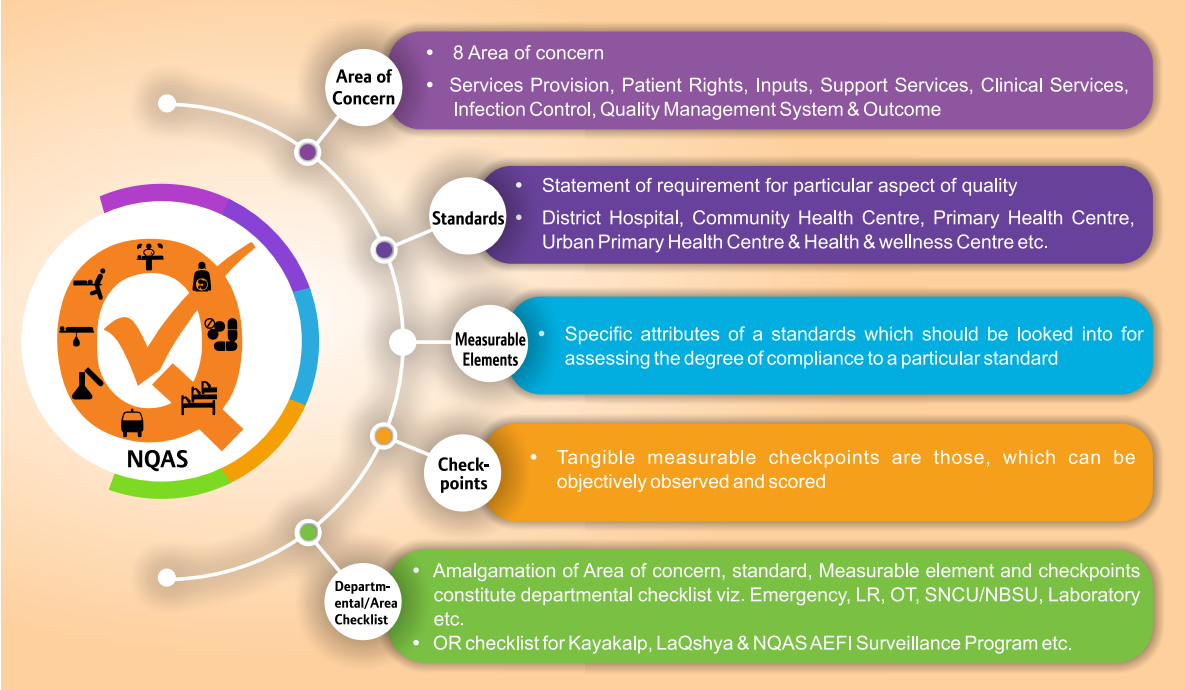

Figure 2.2: **Relationship between different elements of NQAS measurement system**

These checkpoints would be compiled in form of departmental checklist, so the compliance to all relevant standards for a department of healthcare facility can be checked systematically, objectively and in a user-friendly way. Action planning for the gap assessed against checkpoints needs to be fulfilled within a set time frame. This process should be reviewed periodically for compliance and further improvement, as shown in **Figure 2.2.** The checkpoints can be of two types, 'essential', one which are non-negotiable and would be required to be adhered by the facility for being quality certified and 'desirable' which are optional and should be fulfilled in due course.

An example to understand the whole system- one of the standards for RCH services would be "Facility has established procedures for Antenatal care as per guidelines". For this standard there would be a set of measurable elements and further checkpoints that would objectively assess the compliance to this standard and score antenatal care at the facility accordingly. The assessment would be done with help of assessment tools e.g., Check list for OPD, Laboratory Services, Pharmacy, etc. where all relevant checkpoints pertaining to Antenatal care would be arranged according to standards and measurable elements.

4. Quality Assessment and use of quality improvement methods: Quality in healthcare is quite dynamic in nature where many different methods are used to assure and improve quality viz. internal & external assessments, medical or clinical audits, use of rapid improvement cycles of change, review of clinical decisions through clinical Governance mechanism, patient/ client satisfaction etc. To ensure the high-quality healthcare services one must use combination of these multiple interventions based on existing capacities and capabilities. Under National Quality framework, following steps would require to be taken for implementing a credible Quality System at Public Health Facilities –

(a) Quality Assessment– This is an activity that measures various elements of service provision and quality of care against pre-determined standards of care. Such an assessment provides an understanding of the areas where the actual position falls short of the set standards. It includes both periodic reviews in terms of internal scoring of a health facility, followed by assessment by the external assessors, who themselves are not directly responsible for the implementation, so as to avoid a 'conflict of interest situation'.

(b) Identification and prioritization of gaps is an important and integral part of the assessment. It is also important to do root cause analysis and prioritization of gaps base on severity level using quality tools and methods.

(c) Action planning - The most important step following the 'assessment and gap identification' is developing time bound action plan for traversing the gaps. It is imperative that for each gap found above, corrective measures are defined along with the person responsible to take action and the time frame for the same. If the observed gaps are many, phased action plan may be developed.

(d) Quality improvement is an improvement approach to find real and sustainable solution for the identified gaps. Through quality circles & champions, an aim, its measure and change ideas are identified, tested and implemented for shorter duration using PDCA. Results of change ideas are monitored, and practical & sustainable solutions are finally adapted or adopted. The process establishes a newer level of quality assurance (also known as breakthrough).

(e) Follow-up Assessment - After passage of an agreed timeframe, follow-up assessment is required to be done to ensure that the plan has been adhered and the gaps have been closed. As the elements related to quality are dynamic in nature, gaps may be found in those areas also, where none existed in the past /previous assessment(s). Therefore, it is important to repeatedly assess a facility for incremental changes for the improvement.

5. Measurement of patient or client satisfaction: Client or patient satisfaction is key measurement that determine the quality of services provided. There have been considerable efforts in measuring of satisfaction of patient and clients through satisfaction surveys. MoHFW has also launched 'Mera Aspataal' system to measure the satisfaction using telecommunication and IT tools. Through these initiatives measure client perception of service quality in an objective manner, the efforts will be done to further expand the scope of this exercise to patient reported experience of care. An initiative will be taken to develop tools that measure experience of care with emphasis on elements like ensuing dignity, privacy, comfort and warmth of care provided during delivery, c-section etc.

6. Use of digital technology for monitoring, learning and reporting of Quality of care: Although key indicators to measure quality is defined under existing framework but it lacks

continues monitoring due to untapped ICT potential. So, these indicators will be made part of monitoring system and a dashboard will be created for continuous monitoring, improvement and learning.

7. **Progress from pro public hospital to sector wide approach –** Majority of efforts in improving quality of care are concentrated in the Public Health Facilities. As private or non-Government sector is a major provider of healthcare services, existing quality initiatives such as NQAS and LaQshya etc. would be extended to non-government sector later. A comprehensive step by step approach with quality of care as core value will be worked out to improve quality of services in private/non govt. health care facilities.

SUMMARY OF ASSESSMENT PROTOCOL

1. *Make an Assessment of severity of the Gaps*
2. *Collate all gaps and allocate severity level*
    a. *High – Directly impacting quality of care - e. g. closure of Operation Theatre*
    b. *Moderate – Indirectly impacting quality of care – e. g. Non-segregation of Biomedical Waste*
    c. *Low – May impact quality of care – e. g. non-calibration of scale*
3. *Phasing of Actions – Initially action planning for high priority gaps should be done*
4. *Allocate resources, define timeline, and allocate responsibility*
5. *Review progress*
6. *Quality improvement -through quality circles & champions, improvement ideas, testing & implementing improvement ideas*
7. *Plan for risk management.*

Points to remember .....

- *Quality Assessment is a cyclical process.*
- *It is a continuous process, and not a one-time effort.*
- *It is an incremental process where improvements are added with each cycle.*
- *It is primarily an internal process, driven by motivated staff of the facility.*

THE ORGANIZATIONAL STRUCTURES

Section | C

The Organizational STRUCTURES

For strengthening the Quality activities, following organisational arrangements need to be set up at various levels with the roles and responsibilities defined for each level, as shown in **Figure 3.1**.

1. National level: Central Quality Supervisory Committee (CQSC)
2. State level:
    a) State Quality Assurance Committee (SQAC)
    b) State Quality Assurance unit (SQAU)
    c) QA assessors (Empanelled)
3. District level:

- a) District Quality Assurance Committee (DQAC)
- b) District Quality Assurance unit (DQAU)

4. Hospital level: Quality Teams (QT)

Quality teams will be constituted at all levels of health care facilities i.e., District hospital, Community health centre, Primary health centre (rural & urban) including Health & wellness centres etc. The name of Quality team in district hospital level will be District Quality team (DQT); other than quality team at hospital level there will be quality circles or quality champions at site/ department level for co ordinating or leading site/department specific quality improvement activities. All the quality circles constitute at different sites Will be functional arm of with hospital quality team.

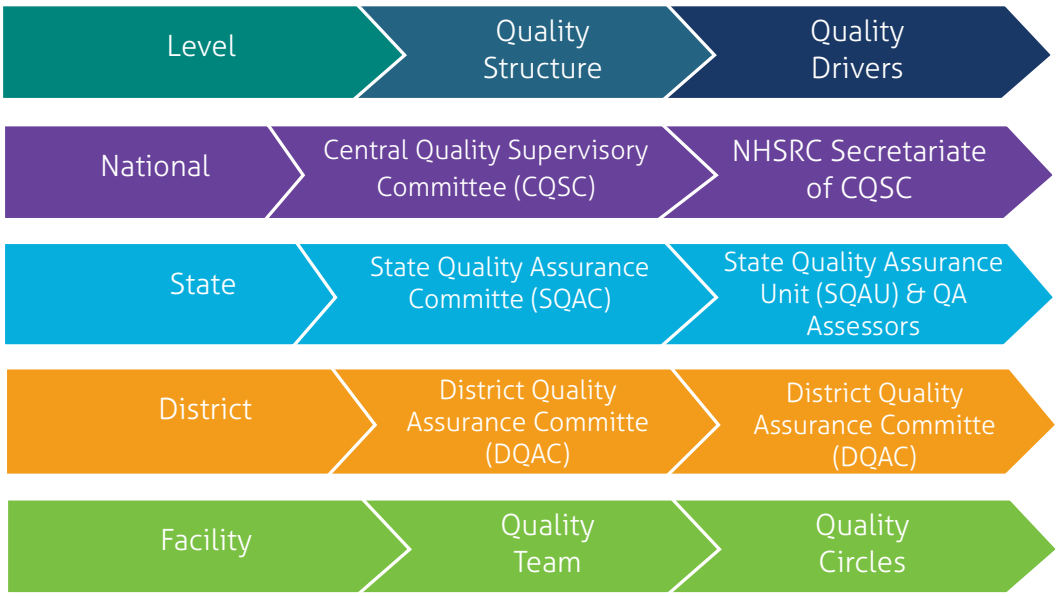

Figure 3.1: The Organizational Structure

National level

At national level, Quality Assurance activities for public health facilities are broadly arranged around two distinct entities.

I. **Development & ratification of quality standards and oversight function for the quality certification of public health facilities to National Quality Assurance Standards:**

   These functions are undertaken by the Central Quality Supervisory Committee (CQSC). Certification Unit at NHSRC will be the nodal agency for certification of public health facilities under the NQAS.

Central Quality Supervisory Committee (CQSC)

The Central Quality Supervisory Committee (CQSC) constituted at the national level is responsible for setting the quality standards as per requirement of different stakeholders and overseeing the certification function. CQSC will consist of representatives from the programme divisions (maternal health, child health, family planning, adolescent health, malaria, TB, leprosy, Urban health, Comprehensive Primary Health Care, etc.) of the Ministry of Health and Family Welfare, Government of India and National Health Systems Resource Centre. Technical Experts from other fields can be co-opted in the CQSC as per requirement.

The members of the CQSC are approved by the Secretary (HFW) and would comprise of the following:

1. Additional Secretary & Mission Director (AS&MD), National Health Mission, MoHFW (Chairperson)
2. Joint Secretary (Policy)-Convener
3. Joint Secretary (RCH)

4. Joint Secretary (Urban Health)
5. Additional/Joint Commissioner Maternal Health
6. Additional/Joint Commissioner Child Health
7. Additional/Joint Commissioner Immunization
8. Additional/Joint Commissioner Family Planning
9. Additional/Joint Commissioner Adolescent Health
10. Additional/Joint Commissioner NCD Division
11. Director NHM
12. Director NVBDCP
13. Director Statistical Division
14. ED, NHSRC
15. Head, QI NHSRC
16. Any other technical expert as approved by the Chairperson CQSC

All members of the CQSC are nominated as per their designation in the Ministry of Health and Family Welfare, not in individual capacity. Therefore, in case of transfer/promotion/ retirement, the concerned position is filled automatically by the in-coming official. Being government officials, their tenures are decided by the controlling department. An orientation programme will be planned for all newly appointed CQSC members to orient them regarding their responsibilities and duties as CQSC member.

The primary role of the CQSC is to provide inputs for overall planning & development of standards and monitoring of program implementation in the states and UTs. It would essentially include:

1. Drawing up the Technical Guidelines and Protocols:

The Programme Divisions of the Ministry will draw various guidelines for Ministry of Health & Family Welfare, Government of India as per need and perceived requirement for improving the service delivery and quality of care. Such guidelines shall be part of resource material for setting the quality standards.

National Health Systems Resource Centre (NHSRC) is mandated to develop the quality standards for public health facilities and periodically review such standards. Request for developing standards usually comes from the Ministry of Health and Family Welfare (MoHFW) through one of its Program Divisions. The standards proposed in the QA document are based on various GoI guidelines, IPHS Standards[1] , WHO guidelines, examples of good practices & also standard textbooks & journals. Approved standards are further submitted

1 National Rural Health Mission (NRHM) was launched in the year 2005 later changed to NHM after launch of National Urban Health Mission (NUHM) in 2013 to strengthen the Rural Public Health System to provide effective health care to the States and Union Territories (UTs), which have weak public health indicators and/or weak infrastructure. Towards this end, the Indian Public Health Standards (IPHS) guidelines for Sub-centres, Primary Health Centres (PHCs), Community Health Centres (CHCs), Sub-District and District Hospitals, published in 2007 and revised in 2012; have been used as the reference point for public health care infrastructure planning and up-gradation in the States and UTs.

for ratification by Central Quality Supervisory Committee (CQSC). However, in view of the wide variations in the conditions of the existing burden of diseases and a felt need after issue of new technical guidance issued by Ministry of Health and Family Welfare or any other national technical agencies, the standards will be reviewed periodically. Dissemination of the revised standards would reside with the CQSC.

2. Monitoring the QA activities:

The committee will monitor the implementation of QA standards through various means, which include:

a) Evaluation surveys measuring outcome level data, including patient satisfaction status.

b) Visits by the central team members

c) Bi-annual review of the reports, sent by the state teams, KPI data etc. and provide analytical report to the Programme Divisions of the GoI and the Ministry of health and Family Welfare. Based on the reports and feedback, periodical advisory to the states and facilities will be issued for undertaking sustenance and improvement activities.

3. Drawing up the Certification Criteria under NQAS:

The CQSC shall define and document guiding principles, norms, and criteria for certification of various health facilities under the National Quality Assurance Standards. This shall also include:

a) Decision on quality certification would be based on recommendations from the Certification Unit and External Assessors report of assessment.

b) Seek explanation from stakeholders, in case of any discrepancy in adhering to certification norms

c) Final decision on certification of a health facility resides with the CQSC to avoid any conflict of interest between stakeholders i. e. NHSRC, State and External Assessor.

d) Issuance of quality certificate after all criteria have been met.

4. Planning processes:

The CQSC would be responsible for formulating and overseeing the strategic and annual plan of the certification unit. The committee will declare annual financial budget for all certification activities including honorarium of empanelled external assessors under the NQAS.

5. Creation of a pool of National Assessors:

A pool of external assessors with professional experience of more than ten years in the domain of quality and safety could be created at the national level. The external assessors will conduct National Level assessments under NQAS. This pool of assessors could also be utilised as trainer for capacity building. Additionally, they could be used by the states for conduction of the state level surveillance audits of nationally certified health facilities, avoiding any conflict of interest. Also, this pool of assessors will provide support and guidance to the health facilities in implementation of quality standards.

For this purpose, a 5-day external assessor training would be conducted at NHSRC or at regional level by the Quality division. The training shall include a rigorous process of

participant's selection, skill enhancement and evaluation for empanelment as an 'external assessor' under the NQAS. It needs to be ensured that assessors have high integrity with no conflict of interest nor there is any commercial interest of assessors while performing their duties. Therefore, all the assessors must be selected based on pre-defined criteria.

The empanelled assessors should be given a hand-on experience of assessment methodology by field visits at health facilities followed by proficiency test.

6. Ethical norms:

To address the issues/complaints/grievances raised by the stakeholders and to oversee the certification assessment process, complaint and representation disposal, an ethical & appeal committee will be formed under the ambit of Central Quality Supervisory Committee.

The ethical appeal committee would comprise of 5 members nominated from the pool of empanelled external assessors and approved by the Chairperson CQSC. The members of appeal committee will have initial tenure of two years. The tenure of members/member could extend further by one year. All the members shall meet at least once in six months or more often for review and disposal of the appeals.

The appeal committee shall broadly cover:

a) The committee works within the mandate provided by CQSC.

b) Design the code of conduct to guide the coordination between Certification Unit, External Assessors, States/UTs, Public Health Facilities and other stakeholders

c) Review the certification process including scheduling of assessment and assignment of assessors.

d) Review of the feedback of assessors submitted by the health facilities after completion of the external assessment.

e) Address the issues/complaints/grievances raised by the health facilities, those who have undergone external assessment.

f) Addressing the issues/complaints/grievances against the assessors those who have conducted the assessments.

g) Entertaining appeals of review of post training evaluation scores of candidates appeared in External Assessors' Training

h) Make recommendations for strengthening of the certification process under NQAS.

i) Apprise CQSC on suggestions and recommendations through NHSRC.

II. Implementation and operationalization of QA activities across the nation.

The Quality Improvement Division at National Health Systems Resource Centre will provide support and guidance to the states and UTs for the implementation of quality standards at public health facilities. Their performance will be monitored in the bi-annual Executive Committee and annual Governing Body (GB) meetings. Implementation activities supported by QI division include:

a) Mentoring the State QA teams:

The QI Division of NHSRC will disseminate guidelines and mentor the state and district quality assurance units under the overall guidance of the NHSRC Executive Committee and GB as per requirement of key priorities of the Ministry of health and Family Welfare.

b) Development of resource material:

The division will develop guiding manual/series of handbooks for the implementers of the quality standards which not only describe roadmap for implementing the quality assurance standards, but also describe minimum standards and regulatory compliances which a facility should meet to attain quality certification under NQAS. The division will also facilitate development of short duration videos to provide hand-holding support on use of quality tools in identification of gaps and area of improvement, followed by an action plan for gap closure.

c) Support for establishing institutional framework:

The National Health Mission (NHM) will issue periodical advisory to the states for creating institutional structure for Quality Assurance namely, State and District Quality Assurance Committees and Units. Support for establishing the organizational framework may be asked by the states under National Health Mission's Programme Implementation Plans (PIP).

d) Training:

The Quality Division of NHSRC would be responsible for training of State QA Committees and other key stakeholders. A pool of National trainers will be created for meeting the training needs of the States. These national trainers will provide directions and support for improving quality of services. Training needs will be identified by the states/UTs which includes trainings on softer skills as well as on clinical protocols, Standard Treatment Guidelines, Medical/Death audits, etc.

e) Empanelment of Quality Assurance Assessors:

The broad objective of empanelling quality assurance assessors will be to provide mentoring support at district and state level to strengthen the internal mechanism of implementing quality assurance activities at the health facility. To fulfil the objective, a pool of internal assessors will be created. These assessors would conduct internal assessment of the health facilities, prepare assessment report and facilitate development of 'gap-closure' action plan at the facility level followed by periodic review of improvement activities. Those with Hospital Management/Public Health background, willing to undertake the task, would be trained in the assessment and scoring methodology by the states with support of Quality Improvement Division NHSRC. These assessors will also conduct periodic assessments within the state on behalf of State Quality Assurance Committee.

Details of the empanelled assessors like Names, Professional Qualification and Work experience would be shared with NHSRC, who would be maintaining a central registry of Internal Assessors.

f) Periodic update on progress of QA programme:

An update on National Quality Assurance Program could be released by the division to provide the status of the program implementation across the states/UTs twice in a year. This shall aid in fast-tracking the state's effort in achieving quality certification under NQAS.

This should include the newer initiatives/schemes launched by the Quality Improvement Division so as to apprehend the states about the foresight of the program.

State Level

Based on the directions of Honourable Supreme court of India, QA Committees (QACs) have been formed by all the states at state and district levels and have been functioning since then. Their initial mandate was to ensure quality in male and female sterilisation services. The Government of India has expanded scope of these states and district level QA committee beyond family planning following Health systems approach to include all services being provided in the health facilities and at community level.

Keeping in mind the expanded scope of activities that is now brought under the ambit of the QA structures at the state and district levels, these guidelines have been revised as per the structure and function of the QACs and are described below.

State level Quality Assurance Committee (SQAC):

The broad responsibility of this committee will be to oversee the quality improvement activities across the state in accordance with the national & state's guidelines, and also ensure regular and accurate reporting of the various key indicators.

Composition

1. Secretary, Medical and Health (Chairperson)
2. Mission Director – NHM (Vice Chairperson)
3. Director Family Welfare/Director Health Services/Director Public Health Equivalent (Convener): to be nominated by the Chairperson.
4. Additional/Joint Director (FW)/Deputy Director (FW)/Equivalent, designated by the state government as the nodal officer for the Quality Assurance (QA) Cell (Member Secretary)
5. Nodal officers of all programs at state (viz. Maternal Health, Child Health, Family Planning, Adolescent Health, Vector Borne Diseases, TB, Leprosy, Urban Health, NCD, CPCHC, etc.)
6. Director, Medical Education
7. Director/Principal of state training institution e.g., SIHFW/ CTI/ RHFWTC
8. One Empanelled Gynaecologist (from public institutions)
9. One Empanelled Surgeon (from public institutions)
10. One Anaesthetist (from public institutions)
11. One Paediatrician (from public institutions)
12. One Medical Specialist (from public institutions)
13. One nominated Medical Superintendent (or equivalent) of DH
14. One each In-charge of PHC, CHC, and Sub-divisional Hospital

15. State Nursing Adviser (Equivalent)
16. One member from an accredited private sector hospital/ NGO (health care sector)
17. One representative from the legal cell
18. One representative from medical professional bodies e.g., FOGSI/ IMA/ IAP/IAPSM/ Association of Public Health
19. Any other member or representatives of public health organisations of eminence as nominated by the state government.

Note: The Quality Assurance Committee as laid down in the "Quality Assurance Manual for Sterilization Services' shall stand subsumed within the QAC mentioned above.

However, a five-member "State Family Planning Indemnity Subcommittee (SISC)" from within the SQAC would redress, dispose and disburse claims/ complaints received through the DQAC, to the district health society as per procedure and time frame laid down in the latest manual on "Family Planning Indemnity Scheme"- Ministry of Health family welfare, Govt. of India

The subcommittee* would comprise of the following:

1. Mission Director –NRHM (Chairperson).
2. Director Family Welfare/Director Health Services/Director Public Health Equivalent (Convener).
3. Additional/Joint Director (FW)/Deputy Director (FW)/Equivalent (Member Secretary).
4. Empanelled Gynaecologist (from public institutions).
5. Empanelled Surgeon (from public institutions)

(Terms of reference of SISC can be referred from Family Planning Indemnity scheme -MoHFW, GoI)

Terms of reference for SQAC

SQAC is a body for the Policy decision & directions. This is also responsible for all QA initiative, its success & shortcomings. The primary role of the committees at the state level will be to provide overall guidance, mentoring and monitoring of QA efforts in the districts. Some of the ToRs reflected here are operational in nature and shall be implemented by the SQAU, which is the operational and implementation arm of SQAC.

1. Developing the Quality Assurance Policy& Guidelines for the State:

Using national guidelines, the SQACs will develop / adapt QA guidelines specific to their states.

- Composition of the state and district QACs & QAUs
- Recruitment of consultants for QA at state and district levels
- Empanelment of state QA assessors who may be retired/serving, part time/ full time as per the state specific need
- Expanding the scope of QA process as per the states' requirements
- Performance of state and district consultant has to be monitored as per NHM minimum performance benchmarks.

Note: The Recruitment should be done following NHM guidelines. Recruitment committee should include one nominee from the Ministry of Health & Family Welfare, GOI.

2. Ensuring attainment of the Standards for Quality of Care by Public Health Facilities:

- The committee will develop 'road-map' for achieving the national standards
- Assessment of need of Technical Assistance (TA) by the facilities and mobilisation of such TA.

3. Mentoring the state/district level units:

- Ensuring that state/district level orientation and other trainings are conducted timely in a meaningful manner.
- The support of the technical team at the national level may be taken to prepare a pool of master-trainers at the state/district
- Handholding and supervision visits to the facilities who are undertaking the quality assurance activities at least twice a year.

4. Periodic Review of the progress of QA activities:

- Committee will conduct review meetings at six-month interval
- Review of Quality scores attained under quality initiatives (NQAS, Kayakalp, LaQshya, NQAS for AEFI surveillance, Patient safety etc) by different categories of Public Health Facilities including urban health facilities
- Take decisions for corrective actions and preventive actions
- Defining targets and road maps

5. Review and adjudicate compensation claim under the National Family Planning Indemnity Scheme for cases of deaths, complications and failures following male and female sterilisation procedures. *(For detailed procedures to be followed please refer to the latest manual on "Family Planning Indemnity Scheme", Ministry of Health & Family Welfare, Government of India").*

6. Supporting quality improvement process:

- Take visionary decisions for continuous quality improvement and its sustenance.
- Sanction funds for implementation and improvement of quality.
- Reflect fund requirement for Quality Assurance in the annual State PIP along with justification.
- Operationalisation of incentive scheme.
- SISC give directions on implementation of measures to improve quality of sterilization services and review all the quality issues pertaining to Family planning

7. Reviewing Key performance indicators of quality:

- The suggested KPIs for various level of public Hospitals (DH, CHC, PHC & UPHCs) are given in the **Annexure 'B'**. The SQAC may add additional indicators in KPIs list.

- The KPIs for Labour room and M-OTs quality improvement is given LaQshya guidelines (Labour quality improvement initiative)
- Performance of health facilities and departments as assessed by the KPIs would also be discussed during review meetings of CMO/ CS/ CMHO/DHO
- RMNCH score card can be used for assessing the performance of the facilities.

8. Reporting & Sharing:

- The committees' review report should be put on the State's website and shared with NHSRC/MoHFW
- The reports would also be shared with all district committees and other stakeholders.
- Details of SQAC Composition, minutes of meeting and action taken report of last meeting should be displayed on state's website

Process:

a) The state quality assurance committee will meet at least once in six months.

b) The convener will issue meeting notice at least seven working days before the scheduled date of meeting with the approval of the chairperson/ vice chairperson.

c) While every attempt should be made to ensure that the chairperson and/or the vice-chairperson are able to attend the meeting, however, in the absence of the chair, the Convenor shall have the right to convene the meeting and conduct it according to the set agenda. Under such circumstances, the minutes of the meeting should be sent to the chairperson and vice-chairperson for information and ratification.

d) The member secretary will ensure the preparation of the agenda notes for meeting, minutes of the last meeting and action taken report (ATR), which will also be circulated in advance to all committee members, at least seven days before the scheduled date for the meetings.

e) An attendance by at least one-third of the Committee members will constitute the quorum required for a valid meeting.

f) Member secretary will ensure follow-up actions with responsibilities and timelines for the same.

g) The "State Family Planning Indemnity Subcommittee" would meet every six month or sooner if warranted. At least three members would constitute the quorum of this subcommittee.

h) SISC will visit both public and private facilities providing family planning services in the state to ensure implementation of national standards.

State Quality Assurance Unit:

SQAU is the working arm under SQAC that will be responsible for undertaking various activities as per ToRs of the unit, and other tasks, as entrusted to them from time to time by the SQAC.

Composition:

1. Additional/ Joint Director (FW)/Deputy Director (FW)/ Equivalent designated by the state government as the nodal officer for the Quality Assurance (QA) Unit (Member Secretary - SQAC).
2. State Nodal Officers of Programme Divisions
3. State Nodal Officer for Urban Health
4. State Consultant (Quality Assurance)
5. State Consultant (Public health)
6. State Consultant (Quality Monitoring)
7. Administrative-cum-Programme Assistant

The SQAU is headed by the SQAC's member secretary, who along with the state programme officers provide support to the SQAC for implementation of QA activities in the state. All the positions of this unit should preferably be regular from the state cadre, however in case of non- availability from the state cadre, the posts at Sl. no 4 to 7 can be hired under NHM till the posts are filled-in from the state cadre.

The number of full-time technical persons (consultants) may be increased once the state decides to expand QA for the Disease Control and other programmes as part of the mandate of the State QAC.

Terms of reference:

The terms of reference for the regional remain the same as of SQAC, since it is the working arm of SQAC. However, some of the important activities of the RQAU are listed below:

1. Adapt checklists for RMNCH-A services (as well as for Disease Control Programme implementation) to match the state needs.
2. Develop a plan for the Quality Improvement at each level of health institution including Urban healthcare facilities in a phased manner.
3. Orient the state level assessors, district level QA units on the quality standards, tools for assessment and improvement plans, and the processes to be followed for QA activities. Assistance of QI Division of NHSRC may be taken for organising the orientation programme.
4. Disseminating the quality improvement guidelines, tools and methodology to be followed in all levels of public healthcare facilities.
5. Develop a field travel plan for independent and joint (with district teams) visits to the districts by members of the SQAU and programme officers and provide 'on-site' support for underperforming districts for various quality initiatives
6. Following these visits, prepare draft report and recommendations for review.
7. Mentor the program officers and facility in-charges at the districts for implementing quality improvement measures at the facilities.

8. Compile and collate monthly data received from districts on especially those related to cases of adverse outcomes/complications in maternal, neonatal & child health; maternal, infant & child deaths (all cases), disease control programmes and share it with the SQAC members and discuss at the SQAC meeting.

9. SQAU encourage districts to document the case studies of improvement and share it with NHSRC/ upload on National Healthcare innovation portal - http://www.nhinp.org/

10. Send the regular reports on sterilisation related indicators (deaths, complications, failures) to the centre after ratification of the same by the Chairperson of the SQAC.

11. Review the implementation of the National Family Planning Indemnity Scheme/ payment of compensation in the state, based on reports received from the districts as well as from the visits undertaken by the QAU members.

Linkages with program divisions:

- Meetings with various programme officers including SIHFW shall be organised every quarter and if required more frequently for discussion and adaptation of the programme guidelines, orientation of district QA committee (DQAC) and district QA unit (DQAU), sharing the field visit reports on quality assessment and discussing the way forward for improving services.
- The programme officers and SQAU should visit the facility with similar check list and provide supportive supervision. The tour report must be shared with each other.
- SQAU shall be responsible for implementation of all quality related observations.
- SQAU participate & support mentoring activities undertaken by designated state mentoring groups for various program viz LaQshya to improve performance of healthcare facilities. Status report of activities/visits are presented in SQAC meetings
- SQAU will create an enabling environment for sharing and learning within districts and promote DQAU, facility level quality teams and champions to share their Quality-of-care results and improvement efforts and also recognize and motivate them.

TORs for the contractual position at State Quality Assurance Unit are given at **Annexure 'C'**.

Regional Quality Assurance Units (RQAU):

Large states may have Regional Quality Assurance Units at the division/regional level, as per need. and the regional unit will report to SQAU.

District level

District Level Quality Assurance Committee (DQAC):

Composition:

1. District Collector/ Dy. Commissioner, Chairperson
2. Chief Medical Officer/Deputy Director/ CDMO / District Health Officer/ Equivalent (convener)
3. District Family Welfare Officer/RCHO/ ACMO/ equivalent (member secretary)

4. Deputy Superintendent/ Civil Surgeon/ Chief Medical Superintendent of District Hospital(s) or equivalent
5. In-charge of CHC & PHC (one each, by rotation)
6. Nodal Officers of Programme Divisions at districts (viz. Maternal Health, Child Health, Family Planning, Adolescent Health, Vector Borne Diseases, TB, Leprosy, Urban Health, NCD, CPHC, etc.)
7. One empanelled gynaecologist (from public institutions)
8. One empanelled surgeon (from public institutions)
9. One Medical Specialist (from public institutions)
10. One anaesthetist (from public institutions)
11. One paediatrician (from public institutions)
12. One representative from the nursing cadre
13. One representative from the legal cell
14. One member from an accredited private sector hospital/ NGO (health care sector)
15. One representative from medical professional bodies e.g., FOGSI/IMA/IAP/IAPSM/ Association of Public Health

However, a 5 member "District Family Planning Indemnity Subcommittee (DISC)" from within the DQAC would process claims received from the clients and complaints/claims lodged against the surgeons and accredited facilities, as per procedure and time frame laid down in the latest manual on "Family Planning Indemnity Scheme"- Ministry of Health & Family welfare, Govt. of India

The subcommittee would comprise of the following:

1. District Collector, (Chairperson)
2. Chief Medical Officer/District Health Officer/ CDMO/ CMHO (convener)
3. District Family Welfare Officer/RCHO/ ACMO/ equivalent (member secretary)
4. Empanelled Gynaecologist (from public institutions)
5. Empanelled surgeon (from public institutions).

(Terms of reference of DISC can be referred from Family Planning Indemnity scheme -MoHFW, GoI)

Terms of reference:

1. Dissemination of QA policy and guidelines:

- The district QAC will be responsible for disseminating the QA guidelines to all the stakeholders.

2. Ensuring Standards for Quality of Care:

- The committee will ensure that QA standards under key quality programmes have been implemented at designated health facilities.

3. **Review, report and process compensation claims** for onward submission to the SISC under the National Family Planning Indemnity Scheme for cases of deaths, complications and failures following male and female sterilisation procedures. (For detailed procedures to be followed please refer to the latest manual on "Family Planning Indemnity Scheme, Ministry of Health & Family Welfare, Government of India").

- In case a facility reports a sterilisation related death, the convenor of the DISC should inform the convenor of the SISC within 24 hours. Death audit needs to be undertaken mandatorily for all deaths related to Sterilization and sending reports to the State QA committee office.

4. Capacity building of DQAU and DQT:

- Ensuring that district level orientation and trainings are accomplished in time for DQAU and also DQT.

6. Monitoring QA efforts in the district:

- The committee needs to ensure that facility assessments and subsequent quality improvement efforts are executed as per plan.

7. Periodic Review of the progress of QA activities:

- Will conduct quarterly review meetings and more if needed.
- Take decisions for corrective actions
- Define targets and road maps
- During the district level program review meetings, the Key performance indicators (KPI) of quality can be reviewed
- RMNCH score card can be used for assessing the performance of the facilities.
- District Family planning indemnity subcommittee (DISC) will collect information on all hospitalization cases related to complications following sterilization, as well as sterilization failure
- Reviewing all static institutions i.e., Government and accredited Private/ NGOs and selected camps providing sterilization services for quality of care as per the standards and recommend remedial actions for institutions not adhering with standards.

8. Supporting quality improvement process:

- Sanction and release of funds for implementation and improvement of quality
- Reflect fund requirement in the annual DHAP along with justification
- Taking all required actions for incentivization of the facilities on attaining the certified status

9. Coordination with the state for:

- Dissemination and implementation of guidelines
- Facilitator support for the visits of SQAC/SQAU to the districts
- Sharing minutes of DQAC meeting and monthly reports
- Corrective actions & Preventive actions

10. Reporting:

- The committees' review report to be put on the state NHM website
- Share with all district committee members and other stakeholders.
- Share the QA reports with the concerned facility.

Process:

- The district quality assurance committee will meet at least once in a quarter.
- The convener will issue meeting notice at least seven working days before the scheduled date of the meeting with the approval of the chairperson.
- While every attempt should be made to ensure that the chairperson is able to attend the meeting, however, in the absence of the chair, the Convenor shall have the right to convene the meeting. Under such circumstances, the minutes of the meeting should be sent to the chairperson for information and ratification.
- Member secretary will ensure the preparation of agenda notes, and action taken reports, which will be circulated in advance to all committee members preceding the DQAC meetings.
- An attendance by at least one third of the Committee members will constitute the quorum required for a valid meeting.
- Member secretary will ensure follow-up actions with responsibilities and timelines for the same.
- The "District Family Planning Indemnity Subcommittee" **would meet every three months or sooner if warranted.** At least three members would constitute the quorum of DISC subcommittee.
- Districts are encouraged to document the improvement projects and share with SQAC

District Quality Assurance Unit

DQAU is the working arm under DQAC that will be responsible for undertaking various activities as per the ToRs of the committee and also entrusted to them from time to time by the DQA Committee.

Composition:

1. District Family Welfare Officer/RCHO/ ACMO/ equivalent (Head of DQAU)
2. One Clinician (Surgical/ Medical/ any other speciality)
3. District Consultant (Quality Assurance)
4. District Consultant (Public Health)
5. District Consultant (Quality Monitoring)
6. Administrative cum Programme Assistant

The DQAU is headed by the Member Secretary DQAC, who along with the district programme officers provide the support to the DQAC for implementation of QA activities in the district.

All the positions of this unit should preferably be regular staff from the government. However, in case of non- availability of the regular cadre staff, posts at sl. no 3 to 6 can be hired under NRHM till the regular cadre become available.

Terms of reference:

The terms of reference for the QA unit remain the same as of QA Committee, since it is the working arm of DQAC. However, some of the important activities of the DQAU are listed below:

1. Ensure roll out of standard protocols for all hospital services including RMNCH-A services (as well as for Disease Control Programme implementation) under quality domains viz. NQAS, Kayakalp, LaQshya etc.
2. Develop a plan for the Quality Improvement at each level of health institution in a phased manner.
3. Disseminating the quality improvement guidelines, tools and methodology to be followed in all levels of public healthcare facilities.
4. Develop a field travel plan for independent and joint (with State teams) visits to the health facilities in the districts by members of the DQAU and provide 'on-site' support for underperforming facilities for various quality initiatives.
5. Following these visits, prepare the draft report and recommendations.
6. Mentor and handhold the facility in-charges at the districts for implementing quality improvement measures at the facilities.
7. Compile and collate monthly data received from facilities on outcome level indicators especially those related to cases of adverse outcomes/complications in maternal, neonatal & child health; maternal, infant & child deaths (all cases), disease control programmes and share it with the DQAC members and discuss with DQAC meeting.
8. Send the regular reports on sterilisation related indicators (deaths, complications, failures) to the State after ratification of the same by the Chairperson of the DQAC.
9. Review the implementation of the National Family Planning Indemnity Scheme/ payment of compensation in the district, based on reports received from the facilities as well as from the visits undertaken by the DQAU members.
10. DQAU will create an enabling environment for sharing and learning within facilities and promote quality teams and champions to share their Quality-of-care results and improvement efforts. DQAU support facilities to document the best practices and share it with NHSRC/ upload on National Healthcare innovation portal.

TORs for the contractual position at District Quality Assurance Unit are given at **Annexure 'D'.**

District Quality Team (DQT) at District Hospital

The DQT will be functioning exclusively at district hospital level however, quality team should be functional at every level of healthcare facility. Composition of quality team varies as per the level of care, but term of reference may remain same.

Composition:

The suggested composition of the Quality Team at the District Hospital is as follows:

1. I/C Hospital/Medical Superintendent: Chairperson
2. I/C Operation Theatre/Anaesthesia I/C, Surgeon
3. I/C Obstetrics and Gynaecology
4. I/C Lab services (Microbiologist/ Pathologist): for enforcing IMEP & BMW protocols
5. I/C Nursing
6. I/C Dialysis unit/ dialysis technician
7. I/C Ancillary Services
8. I/C Transport
9. I/C Stores
10. I/C Records
11. Hospital Manager/Quality Consultant or equivalent (Member Secretary)

Suggested Composition of Quality Team (QT) at Community Health Centre:

The suggested composition of the Quality Team is as follows:

1. Block Medical Officer/Medical Superintendent: Chairperson
2. Nursing IC / Staff Nurse
3. General Surgeon
4. Obstetrician & Gynaecologist
5. Paediatrician
6. Medical officer
7. Lab technician
8. Pharmacist
9. I/C Stores
10. I/C Administration
11. One representative from all specialist services

Suggested Composition of Quality Team (QT) at Primary Health Centre (Rural & Urban)

The suggested composition of the Quality Team is as follows:

1. Medical Officer: Chairperson
2. Staff Nurse
3. Lab Technician

4. Pharmacist
5. Health Assistant. (Female)/Lady Health Visitor
6. Public health manager (Urban)

Suggested Composition of Quality team (QT) at HWC -Sub centre

1. Community Health officer
2. ANM (Auxiliary nurse midwife)
3. MPW (M) Multipurpose health worker

Terms of Reference:

1. Staff orientation:

- Formal training needs to be conducted for the staff of QT with support from the district QAU.
- QT should orient the medical, paramedical and support staff team including Group C & D to the service standards set by the state Quality improvement initiatives.

2. Ensuring adherence to quality standards:

- Through regular internal assessments, audits, reviews etc the QT members should ensure that the standards set for a health facility (rural/urban) are being met.
- Corrective action plans should be initiated for identified gaps

3. Regular reporting to district QAC:

- The QT needs to report regularly to the district QAC on outcome level indicators such as sterilisation deaths, complications and failures as well as maternal and infant deaths.
- The QT should also report to the district QAC on the internal assessment findings, quality improvement measures undertaken, etc.

4. Ensure interdepartmental coordination:

- The QT should liaise with various departments within the facility for effective implementation of QA activities
- To share the internal assessment findings of QT and external assessment findings of SQAU/ DQAU with all the staff at the health facility.
- QT will ensure that Departmental nodal officers will take corrective actions as per the road map provided by QT
- QT will create an enabling environment for sharing and learning within departments and promote quality circles and champions to share Quality of care results and improvement efforts with DQAC. Facility can share the best practices with NHSRC/ upload it in National Healthcare innovation portal.

Process:

- Once the QT is formed, areas for an initial assessment needs to be identified in the first meeting
- For achieving the standards, QT will undertake the process of filling the check list, scoring the measurable indicators, summing up area wise and services wise gaps.
- Assessment to be carried out and based on its findings follow up actions to be taken.
- Monitoring of the follow up actions has to be done in the subsequent meetings
- Assessments should be followed by time bound action plans along with person responsible for each action shall be prepared.
- Once the QT completes the assessment and gives service wise/area wise scoring then will inform and invite District/State assessors for verification and guidance.
- This process will continue till the SQAC assessors certify the attainment of the quality standards at the hospital. Then onwards QT will ensure maintaining the standards.
- Facility in-charge and Hospital manager/ designated responsible person should do daily rounds to supervise the QA activities and sustain the motivational level of the staff.
- Facility quality team encourage formation of department level Quality circle or champions for onsite improvement using PDCA approach as well as ensure sustainability of Quality efforts in long term.
- The QT should meet once every month.

In case of any death following a sterilisation operation, it should be reported to the DISC (a subcommittee under DQAC). Monthly reports of maternal and infant deaths should also be given to the district QAC. In case there are no deaths, a NIL report should mandatorily be sent. DQAC is responsible for investigating a sterilisation related death and also review of maternal and infant deaths.

TORS for the hospital manager are given at **Annexure 'E'**.

Quality Assessors

Assessment of quality of services in a health facility is a techno-managerial task which requires substantial time, efforts and inputs from the person(s) conducting the assessment. Hence, it is proposed that the state empanels quality assessors who have the technical know-how and are willing to take up such tasks. They should commit for minimum defined duration to ensure continuity of the job. These assessors could be either working experienced professionals or retired senior officials of the department, Medical Colleges faculty and Public Health Professionals, who are willing to spare their time.

TORS for the Quality Assessors are given at **Annexure 'F'**

ROAD MAP

Section | D

THE PROCESS OF IMPLEMENTATION

1. Setting-up Organizational Framework for Quality Improvement

The States may already have quality assurance organizational structure or a well-functioning quality assurance cell for the family planning. These can be restructured or merged with the framework suggested in this guideline. Following framework is recommended to be created by every State for this purpose-

- *Constitution of State Quality Assurance Committee (SQAC)*
- *Constitution of State Quality Assurance Units (SQAU)*
- *Constitution of Regional Quality Assurance Units (RQAU) as per need in large states*
- *Constitution of District Quality Assurance Committee (DQAC)*
- *Constitution of District Quality Assurance Units (DQAU)*
- *Constitution of facility level Quality Teams and Quality circles (e.g., District Quality Team at District Hospital and Quality Circle at department level)*
- *Identification and Empanelment of State Quality Assessors as per the guidelines.*

Note: For State and District Quality Assurance Units, the members should be deputed, preferably from the regular cadre of the department. If internal resources for the same are not available, new recruitments may be undertaken according to the ToRs given in this guideline. Nominee of the Ministry of Health & Family Welfare, GOI should be represented in the recruitment committee.

Proposed budget for setting-up functional state and district quality assurance teams is given in **Annexure 'G'**.

2. Empanelment of assessors

For undertaking the Assessments based on checklists and for providing supportive supervision to the facility, state is expected to have Internal and External Assessors.

(a) Internal Assessors- State can have a pool of internal assessors which may include experienced Doctors, Nurses, paramedics and Hospital/Health Administrators, etc. Internal assessors are trained to conduct self-assessment of their own facility as well as implementation of quality improvement interventions. The state may use trained internal assessors to conduct peer assessments being undertaken for various quality initiatives.

For Internal Assessors, training may be arranged by state, which shall be conducted in coordination NHSRC or its allied technical resource institutes. Post training evaluation shall be taken. Candidates who clear the exam will be certified as "Internal Assessor". State is expected to maintain the list of empanelled Internal Assessors.

(b) External Assessors- State is expected to select the candidates for undertaking training for National level External Assessors. Qualifications and ToRs of assessors are given in guidelines. Training of External Assessors is undertaken by NHSRC or allied technical institutions or states in collaboration with NHSRC. Name of the participants who successfully complete the external assessors' training may be entered in national level of register of external assessors.

3. Adaptations of Standards and Measurement System (Customization of Measurement System) National Quality Assurance Standards have been developed taking into consideration the existing relevant Quality Standards and operational/clinical guidelines through a consultative process with experts and stakeholders and review of best practices globally. Measurement and compliance to these standards and certification criteria will be mandatory for a facility to get State or National level Certification including the certification for RMNCH+A Services. Since priorities of each state may vary, the states could undertake following changes in the norms for Certification–

a) States can add more standards, over and above the existing standards for various level of health facilities, after due consultation with NHSRC. On addition, commensurate measurable elements should also be added along with checkpoints in the relevant checklists for a particular level of healthcare institution i.e., District Hospital, Community Health centre, Primary health centre (rural & Urban) etc.

b) The States may review the Standards & checklist, of various levels of health facility to determine, whether checkpoints would be essential according to the state's scope of services, baseline and feasibility for the implementation. Accordingly, the process of adaptation/ customization shall be undertaken in coordination between NHSRC and State's Quality Assurance Committee. As the checklists and corresponding checkpoints have been made in alignment with Indian Public Health Standards (IPHS) any change whatsoever shall be made in alignment to essential services of exiting Indian Public Health Standards (IPHS) only. Similarly, consideration shall be given to state guidelines /office orders defining the scope of services at various levels of public health facilities across the state. This should

be noted that no deletion of standard and measurable element is permitted. Also, in subsequent years some of the desirable components can be made essential to enhance the level of the existing system.

c) The customization of the measurement system may be done in coordination through a consultative process between SQAC /SQAU and NHSRC under intimation to MoHFW.

d) SQAC/SQAU and NHSRC shall create minutes of adaption/ customization meeting. Any changes in the checklist or checkpoints shall be approved and notified by the State Quality Assurance Committee (SQAC). Office order and minutes of all decision undertaken should be shared with Ministry of Health and Family Welfare, NHSRC as well as it should be displayed at state website.

e) The starting point could be certification of few areas of a health facility. A state may prefer to go for certification of one or more areas such as RMNCH+A Services/ Emergency Department / Blood Bank / Laboratory/ ICU/Labour Room, etc.

f) It is suggested that State may prioritize the certification for delivery points for which the areas to be certified shall be Labour Room, M-OT, SNCU /NBSU, ANC / PNC wards, Lab services, Blood Bank & OPD clinics.

g) Compliance to all points in the check list and obtaining a credible shall be mandatory for any level of Certification. Compliance to all National Quality Assurance standards is mandatory to attain National Level certification even for the chosen area.

h) Dissemination of the guideline and standards: The State approved standards, ME and checklist would be disseminated through state level dissemination workshop(s). The Assessors' Guidebooks elaborate the standards, their measurable components and departmental checklist.

4. Training and Capacity building

Successful implementation of quality assurance programme requires right knowledge, skill and attitude of health professionals for accepted norms, quality and its improvement interventions. Based on training needs and place of work their capacities could be built up and refreshed as or when required. Effective execution of Standards and measurement system requires a cadre of competent assessors, both for undertaking internal assessment by the facility, DQAU and SQAU and also for External Assessment for the National certification. Equally important is to build the capacity of the programme officers, and SQAC members, to enable them to provide directions and support for improving Quality of the Services. Service Providers (doctors, nurses and para-medical staff) would need trainings on implementation of Quality Assurance Standards, gap identification and analysis, undertaking improvement activities, calculating and utilising indicators for improvement etc. Apart from it, service provider shall be trained for softer skills as well as on clinical protocols, Standard Treatment guidelines, Medical / Death audits, etc, which would be essential for improving quality of services.

Following capacity building trainings are suggested in **Table 4.1** –

Sr. No	Trainings	Target Audience	Duration*	Purpose
1.	Awareness Workshop	SQAC members, State level programme officers, RPM units, Civil Surgeons/ CDMO/ DHO	1 day	To sensitize state level officials for quality assurance program and its steps
2.	Assessor Training	Members of state and district quality assurance units, member of facility level quality assurance teams.	2 days	To acquaint trainees with standards, measurable elements, departmental check lists and scoring system and how to use them
3.	Quality improvement training for service providers	Facility in charges, hospital and programme managers and other hospital staff	3 days	To understand basic concepts of quality improvement approaches, quality tools and how to implement them in their facilities
4.	Internal Assessor cum Service Provider training	Members of state and district quality assurance units, programme managers, Facility in charges, and hospital staff	3 days	To acquaint trainees with standards, measurable elements, scoring system and basic concepts of quality improvement approaches and how to implement them in their facilities
5.	External assessor Training	Assessors who conduct certification / Certification audits (organized at the National level by GOI or its technical resource institutions)	5 days	Detailed discussion about standards and their subcomponents, scoring methodology, filling up assessment forms and code of conduct.
	Thematic Training - Apart from trainings on quality improvement the specific training modules for following areas would be developed – • Infection Control and Bio Medical Waste Management • Measuring and Improving Key performance Indicators and Patient satisfaction • Medical Records Management & Hospital Information System • Quality Improvement tools and techniques • Undertaking Quality Improvement activities in departments viz Labour Room, Maternity Operation Theatre etc. • Components of Clinical governance and its implementation at facility level. • Developing and implementing a risk management framework • Drugs Inventory and Supply Chain Management • Patient safety • Orientation to Six sigma • Quality assurance in Laboratories etc.			
	* Number of training days may change depending upon the state's requirements			

Table 4.1 : Trainings and Capacity Building

Budgetary support for the training is given in **Annexure 'H'**.

Budgetary norms for NQAS, LaQshya, Kayakalp & Urban Health implementation is given under **Annexure 'I'**

5. Implementation of Quality at Facility Level

Quality assurance would be a continual and comprehensive cyclic process. The aim is to cover all the public health facilities. Following set of activities should be undertaken by the facility internally:

a) Formation of Quality Assurance Team at Facility Level – In-charge of Health Facility would form an internal quality assurance team, which should have representation from all departments, nursing staff, laboratory and support staff. The team should meet periodically (more frequently initially) to discuss the status of quality initiative in their area of work. The hospital manager/Facility's Quality Nodal Officer should coordinate conduct of the meeting.

   This facility team along with various sub committees (viz. Infection Control Committee, Drugs and Therapeutic Committee, Medical and Death Audit Committee, Departmental Quality Circle etc.) shall be undertaking Quality Assurance activities based on NQAS and other sub-domain checklists (viz. Kayakalp, LaQshya etc.) under its ambit.

b) Internal Assessment - The team would undertake an internal assessment using NQAS Checklists at fixed interval, preferably quarterly covering all critical departments.

   Followed by an internal assessment facility will identify and enumerate the gaps. After gap identification the facility can prioritize the gaps based on resource & efforts requirement and its impact on patient care.

   While few gaps shall require immediate action, which will require an "Action Plan" to be developed. The action planning would need allocation of resources for traversing the gaps. Therefore, each identified gap and its 'action-plan' would require following three subset of activities –

   i. Resource Allocation for each gap

   ii. Designating a person, responsible for the action

   iii. Time frame for its closure

While few gaps which will be "Critical" or "Process related" shall require a detailed gap analysis / root cause analysis using various methods. Once the gap has been identified facility is required to undertake improvement cycles (facility wise or department wise) using PDCA approach till they reach their desired outcome.

For Gap identification, apart from assessment using NQAS or its subdomain checklists (viz. Kayakalp, LaQshya etc.) facilities shall capture and use following methods/tools for gap identification, analysis and monitoring of improvement:

c) Patient Satisfaction Survey - A quarterly feedback (for OPD – 30 patients, and for IPD – 30 patients in a month, separately) would be taken on a structured format by the hospital manager/ Facility's Quality Nodal Officer and team. This feedback would be collated and analysed to see which are the lowest performing attributes. Similarly, facilities shall get empanelled to "Mera Aspataal" which is an ICT based platform to

capture patients' feedback. Mera Aspataal will also enable the facilities to find out the "dissatisfiers". Based on the findings from Patient Satisfaction Survey/ Mera Aspataal. facility shall undertake activities for improving the score. Methodology of PSS calculation is shared as **'Annexure 'J'**. This is also to be noted attainment of Patient Satisfaction is one of the criteria for the Certification.

d) Key Performance Indicators and Departmental Indicators - The Hospital Manager/ Facility's Quality Nodal Officer and team would collate critical data from the departments and calculate some performance indicators and monitor them on monthly basis. A full set of department wise indicators given in the corresponding departmental Check list in 'Area of concern H – Outcome'. Some of these will be identified as Key performance Indicators and will be reported to DQAC and SQAC for the monitoring purpose. Facilities shall monitor the indicators and identify if there is any change from the expected trend (e.g., Reducing Bed Occupancy rate, decreasing monthly patient satisfaction scores, Increasing surgical site infection rate etc.). Facilities are required to undertake improvement activities if any such change is observed in indicators. A set of suggestive Reporting format depicting a Dashboard with KPIs is given this guideline. States are encouraged to develop an IT based dashboard for reporting and monitoring of the indicators. This will be helpful in creating a transparent and accountable system across health systems.

e) Medical & Death Audits and Prescription Audit- Under quality assurance programme all facilities should establish procedure for death and medical audit. While death audits should be conducted for all deaths happening at the facility, medical audit & prescription audit would be done on a representative sample drawn from medical records. Emphasis should be laid on maternal and infant death audits and death/ failure/ complication following sterilization. Root cause analysis must be done by the Team for critical analysis and to undertake improvement by implementing various "change" ideas to bring out the sustainable improvement.

f) External Quality Assurance of measuring equipment and Laboratories- This includes calibration of measuring equipment and external quality assurance programme for laboratories. Facilities are required to take necessary actions for non-conformity, correction factor or unacceptable scores are found.

g) Competency and Performance Assessment- Facilities are required to prepare competency assessment checklist for their clinical and para clinical staff based on their job responsibilities. It should be ensured that the competency and performance assessment is undertaken at least annually. Based on the assessment, feedback need to be given to the staff for improvement and also their training needs are identified and addressed.

h) Development and implementation of Risk Management Framework: There are risks involved in care processes and these risks have to be timely identified and a plan has to be made for its mitigation. Responsibilities and timelines for risk mitigation is allotted to relevant stakeholders based on risk priority number. Quality team is required review the status of risks from time to time and put efforts to continually identify risks effecting the patient or patient care.

i) Clinical Governance: To ensure the accountability and transparency in clinical and care process there is requirement to develop and implement clinical governance framework. Facilities need to constitute clinical Governance boards and ensure its functionality in totality for desirous results and improvement in clinical care processes.

j) **Standard Operating Procedures & Work instructions -** For standardising the clinical and management processes at facility level, Standard Operating Procedures (SOP) should be documented and implemented. Appropriate training to the staff on SOPs and guidelines may be ensured. Facilities are supposed to revise and update the SOPs whenever there is any change in procedure or any revision in guidelines/ protocols takes place.

k) **Quality Policy & Objectives –** Facility would define its quality policy which is statement of commitment of the facility to provide quality services. This quality policy would be formulated in consultation with DQAC. Further for implementing this quality policy tangible quality objectives would be established at each facility. In large hospitals, key department may have their own objectives. State may opt to define uniform Quality policy and Objectives at the state level.

l) **Undertaking Rapid Improvement Activities:** Facility may uptake the Rapid Improvement Events - Rapid improvement event is quality improvement methodology where one or more areas of hospital are chosen for a more focused quality interventions with specific problem-solving tools. An example of rapid improvement events is given in **Annexure 'K'**. Every facility would choose focused area for Rapid improvement event for every assessment cycle using following steps:

I. Gap identification: Once the facility has identified critical gaps based on assessments (using NQAS, Kayakalp, LaQshya etc.) checklists, departmental and key performance indicators, audits (medical, death, prescription etc.), competence evaluation etc. the facility level quality team or departmental quality circle or quality champion would undertake steps for improvement or process breakthrough.

II. Setting-up an objective – An objective should be Specific, Measurable, Achievable, Realistic and Time bound.

III. Root Cause Analysis – The team/circle will analyse the gap, using tools like Fish bone diagram, why- why analysis etc. The in-depth gap analysis will help the team to not only understand the problem but also to develop certain change ideas.

IV. Setting up the measuring indicators- To assess whether a change idea is affecting the main objectives, the team will have to measure and analyse supportive indicators. Run Charts will be useful to analyse the overall effect of change idea in a particular period.

V. PDCA cycles- When team has certain change ideas, the testing of these ideas become important. This is done using Plan- Do – Check – Act approach. Multiple PDCA are carried down to understand the impact a change idea may have on the objective. Based on it, the idea will be either accepted as it is or may require certain tweaking or alternation before acceptance or it is discarded as it had a negative impact or was unsustainable.

6. Assessment of Facilities

Apart from Internal assessment that is integral part of facility level quality improvement activities, there would be periodic assessments within the state respectively by SQAU and DQAU. (Figure 4.1)

I. **Schedule of assessment visits plan -** The visit plan should be communicated in advance to the facility in charges. As far as possible, Surprise visits are avoided. DQAC internal meetings and DQAC joint meeting with facility in-charges should be planned well in advance.

II. **Assessment by DQAU –** DQAU would undertake following activities to support the facilities:

a. Assess the facility at quarterly interval and share their findings with SQAU. Facility Assessment report would also be shared with SQAC.

b. DQAU would also support the facility in closing the observed gaps. They need to handhold and mentor (on-site as well as off-site support) the facilities for gaps closure in time bound manner.

c. Certification assessment of Primary Health Care facilities (HWC-SC/HWC-PHC/ PHC/U-PHC) in a district may be planned at the district level through a robust system of peer assessment. Such team will have at least one experienced NQAS Internal Assessor from another district.

Note: The first assessment and its score will be considered as baseline score and subsequent QA scores will be compared with the baseline to evaluate the improvement in scores

a. **Assessment by the SQAU -** Every facility should be assessed at least once in a year by SQAU. As a greater number of health facilities are brought under the ambit of QA programme, assistance of empanelled external assessors (of respective State) and experienced internal assessor may be taken by the SQAC. After health facilities have made significant improvement and has been able to meet CQSC Criteria for State Certification, the facility may be awarded the state certification as per Guidelines for Certification of public health facilities based on National Quality Assurance Standards. Once the facility is state certified and has been consistently getting high score on assessment the facility would apply for National assessment.

b. **Assessment Process –** A facility assessment would be done by the team comprising of team members, as shown in **Table 4.2**:

Assessment	Assessor	Department
Clinical processes	Doctor	Clinical Processes of OPD, IPD, OT, Blood Bank, Emergency, Labour Room, Medical Records, National Health programmes, clinical outcome, Medical & Death Audit
Nursing processes	Nurse / Para Clinical Staff	Nursing procedures at different departments, Laboratories, infection control, Bio Medical Waste management, Pharmacy, ambulances, equipment maintenances
Management support and quality processes	Health Administrator or Managers	Facility Management, Support services, quality processes, Patient feedback, Patient Rights, Statutory requirement, Disaster Management, Hospital data and performance, outsourcing

Table 4.2 : Assessment Process

c. Traversing the Assessed gaps: After assessment is completed and the gaps have been identified by the health facility the same will be verified by District QAU and a timeline for traversing the gaps along with assigning a nodal person for timely fulfilment of gaps shall be done in concurrence with the facility in-charge. Similar planning needs to be done for undertaking improvement activities. Once this exercise is complete the report along with the defined actions for different levels i.e., facility/district/state shall be prepared and shared with SQAU which will then arrange the state level assessment for verification, further handholding, state certification.

d. Assessment Protocol: The Assessors independently assess the different areas of concern of checklist of their respective departments/ domains; and fill the sheets as per full, partial or non-compliance. Assessment process would comprise of gathering the information from many sources, such as

- Staff interview,
- Review of records,
- Direct observation, and
- Interviews with the patients and attendant

Detailed list of standards, process and protocols of assessments and scoring are given in compendium- **"National Quality Assurance Standards for Public Health Facilities"** as well as respective Assessor's guidebooks.

7. National Certification

a. Empanelment of External Assessors – State is expected to select the candidates for undertaking training for National level External Assessors. Qualifications and ToRs of assessors are given in annexure of guidelines. Training of External Assessors is undertaken by NHSRC. Name of the participants who successfully complete the external assessors' training may be entered in national level of register of external assessors.

External assessors will be empanelled for three years and further renewal of external assessor's certificate is subject to (a) Mandatory attendance for refresher training conducted by NHSRC (b) Abide to the assessment guiding principles during assessments (i.e., Do's and Don'ts, should be fair, impartial, transparent, ethical and credible, etc during assessments) (c) their feedback from facilities, states as well as co assessors.

b. Selection of Assessor for National Assessment: Selection of external assessor for National assessment shall be done from the pool of empanelled external assessors. Selection of External Assessors shall be done by NHSRC-certification unit in transparent manner following the due process and criteria.

c. Certification Unit at NHSRC- A separate unit would be constituted at NHSRC for co-ordinating activities of National assessment and final issuing of National certificate. The unit would select the external assessor on receipt & clearance of application for national assessment, coordinate between state, MoHFW and external assessor, finalization of assessment report, preparation of assessment summary, declaration of result and issuance of certificate. The unit will also coordinate and support to resolve issues/ complaints related to the assessments through appeal committee.

d. Certification Process:

i. Once the gaps are traversed, the DQAC may inform the SQAU for conduct of assessment for the State level certification.

ii. On meeting all the criteria of state certification, the SQAC would send the application along with the required documents to NHM, Ministry of Health and Family Welfare, GOI requesting for the national assessment. (**Annexure 'L'**). A copy of the application has to be shared with NHSRC.

e. NHSRC shall scrutinise the shared documents and will give clearance to the certification unit for further actions. Certification Unit, NHSRC shall coordinate assessment process and after examining the assessors report appropriate recommendation would be sent to Director, NHM for result declaration. AS & MD, NHM shall be the designated authority for signing the certificate and letter of communication for certification, till any such body is created by the GoI.

f. Compliance criteria for the achievement of certification (State or National) laid down by Central Quality Supervisory Committee (CQSC). Validity of National Certification shall be of three years subject to compliance to norms mentioned in *"Guidelines for Certification of Public Health Facilities based on National Quality Assurance Standards"***/** Refer-**Annexure "M'**

g. Once a facility receives certificate, its validity will be for 3 years (in case of full certification) or one year (in case of conditional certification) respectively. In case the facility is deferred or declined for certification will have to apply afresh once the facility. All certified & conditionally certified facilities.

h. Surveillance: The certified status once achieved is valid for a period of three years, subject to validation of compliances to the QA Standards by the SQAC team every year in subsequent two years.

i. Sustenance of compliance to NQAS and improving further are core activities of the QA activities. SQAC will undertake at least annual assessment of each facility and also review KPIs. In addition, surprise surveillance assessment of Nationally certified facilities could be undertaken by NHSRC through empanelled National assessors every year.

j. After National Certification, it will be state's responsibility to ensure yearly surveillance to ensure continuity of the certification status. SQAC must undertake annual surveillance assessment of the facilities which have been certified. In Annual Surveillance SQAC shall score the facility for ensuring that the standards have been maintained and there is no 'non-conformity' to the standards. Surveillance reports need to be shared with NHSRC for ensuring continuation of the certification status.

k. After three years facility would undergo National Re-Certification audit. The process will begin 3 months before the expiry of Certification for which application will be given to SQAC for recertification. Till the SQAC organises the re-Certification process & sends request to National level, the facility will be deemed to be accredited. Once the National assessors visit the facility, their recommendation will need to be implemented before fresh certification is issued from National level. The details to apply for re certification is given in **Annexure 'L'**.

Cost of External Assessment is given in **Annexure 'I'**.

l. Under special circumstances (viz. pandemic, any kind of natural or manmade disaster, floods, etc.) or in hard-to-reach areas, national/state assessment may be conducted through virtual/online mode, as approved protocol.

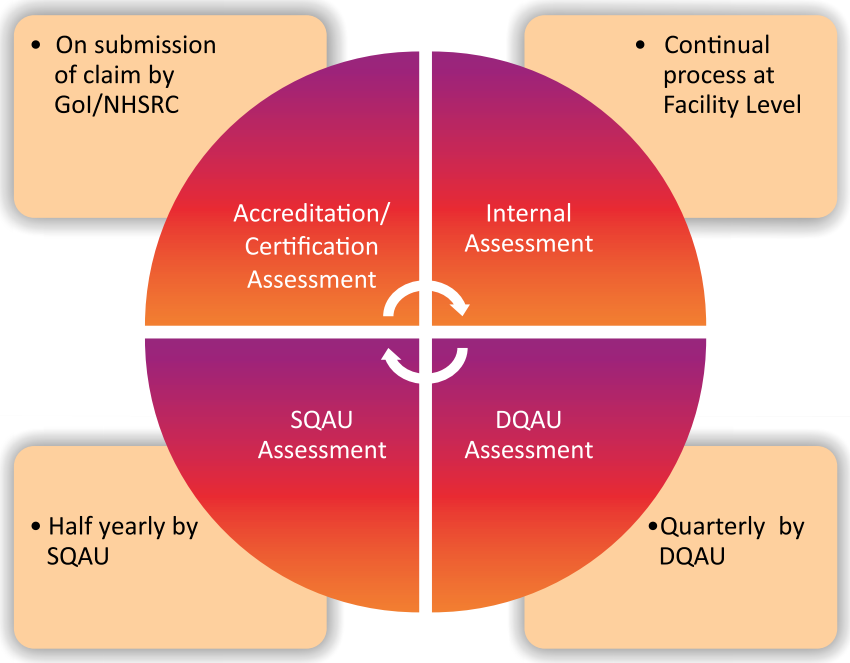

Figure 4.1: Assessments in Quality Assurance Programs

8. Post Assessment Activities

a. Action Planning – After the assessment, the team members should facilitate a closing meeting with facility in-charges along with departmental heads and share the gaps and area for improvement.) The root cause and possible solutions should also be discussed and then time bound action plan is prepared accordingly.

b. Corrective action and periodic review – The facility in charge is expected to take actions for timely closure of the gaps and nominate officials for completing the actions. The progress of gap closure with hospital performance (Key Performance Indicators) would be reviewed in monthly review meeting at district level by DQAC.

c. DQAC should subsequently report the progress of gap closure and KPIs to SQAC in a consolidated report. During the SQAC review meetings, these reports should be discussed; and feedback/ instructions should be given to DQAC. SQAC will also share the report/ KPIs with NHSRC/MoHFW, GoI on quarterly basis or as or when requested.

9. Sustenance and Incentives

Quality culture could be built up with consistent efforts and investments. It is not something which is inherent and cannot be changed. One of the key initiatives for building Quality culture is through 'rewards and recognition' and continuing handholding support from the state & district administration. The facilities, which get National Certification for the quality and have retained such status during subsequent assessments, must be incentivised. The proposal for incentives can be re-visited at the time, when large numbers of facilities are accredited.

Incentives could be classified into following three categories:

i. Institutional incentives - Monetary and Non-monetary

ii. Team incentives - Monetary and Non-monetary

iii. Individual incentives - Monetary and Non-monetary

A. Financial Incentives –

Financial incentives could be given to individuals and quality team, who have been the 'change-agents' at the facility level and District Quality Unit and were instrumental in achieving Quality certification of the Health Facility. A percentage of incentive money could be used for improving infrastructure and amenities for the staff and patients, if such support is not available through other sources.

I. Incentive money can be given to the health facility that succeeds in getting the National Certification. This money can be used for following purposes –

a) 25% of fund could be spent on financial incentives for the staff, who have been active participants of quality assurance programme.

b) Remaining 75% of such fund could be spent in improving working condition at the health facility, provided funding support from other sources is not available. Few activities could be-

   i. Welfare activities like organising recreation event (e. g. annual retreat, cultural function, etc.)

   ii. Strengthening of staff canteen/ rest room (e. g. Purchase of microwave for heating of food by duty staff)

   iii. Library with books, journals, periodical for doctors, nurses and paramedical staff

   iv. Improvement in amenities in duty rooms

   v. Health insurance for contractual employees and for those employees, who are not covered by any other scheme

   vi. In organising functions for recognition of staff, who were instrumental in promoting and sustaining quality assurance programme at the health facility

The facility's Rogi Kalyan Samiti (RKS) may take a decision on the usage of incentive fund.

II. During subsequent two years, the state would conduct the surveillance audit to assess the facility, and checkpoints would be given a numerical score each year. On successful verification of its certification status, the state would provide an incentive of the same amount, which the facility had received on attainment of the initial certification.

III. On quality certification of health facility, there is expected to be considerable increase in the case load, thereby creating additional demand on the services. Thus, the health facility may require additional funds for increasing human resources, additional infrastructure such as expansion of waiting area, hiring of laboratory technicians, construction / repair of staff quarters, etc. Such requirements should be examined on case-to-case basis and would be backed by adequate hospital performance data and KPI. The State should allot additional funds for expansion of such services at the designated facility.

B. Non- Financial Incentives

There could be many approaches for non-financial incentives. Creating a sense of pride in being a part of the quality team would go a long way in sustaining such efforts.

1. Facility getting state certification& national Certification should be facilitated at a state level function. The certificate should be displayed at the facility. In addition, facility in charge & Quality team could be given certificates of appreciation.

2. Achievements are published in local media, and government publication.

3. Staff of the quality certified hospital should be encouraged for higher education / training in reputed institutions. The course fee may be borne by the state. They should also be deputed to attend CMEs programmes/ workshops on the public expense.

4. While undergoing appraisal, due consideration & weightage should be given to those personnel, who worked actively in attaining the certified status and thereafter maintaining the quality status.

5. Idea for certification is to repose confidence and trust of catering population and local community in Quality of services provided by the certified healthcare institution. Certified facility should display GOI's NQAS Logo. This logo can be displayed at the facility, citizen charter, signages, linen etc. and can also be used on hospital stationary. Please ensure the logo should never be tempered. Logo given in **Annexure "N"**

6. A national level Quality Excellence award can also be given by GOI to best performing facility (scoring the highest marks) in each category – DH (Large & small), SDH, CHC, PHC, etc), which is separate from the certification and given to exceptionally well performing health facility in the country (say a Score of 95% or more).

There should also be provision that any facility which is quality certified, which loses its quality certificate in a subsequent year would require thorough investigation and 'root-cause' analysis at the highest level in the state, and corrective and preventive actions are taken. If a number of facilities lose their certification, the Quality Assurance Committee at district and state levels must fix responsibility for whose action or non-action led to loss of certification and corrective actions be initiated on priority.


1
Setting up Organizational Framework
(Constitution & operationalization of SQAC, DQAC, SQAU, DQAU.)
2
Empanelment of Assessors
(Internal and External Assessors)
3
Adaptation of Standards and Measurement System
(Customization of Checkpoints or Checklists as per state requirements & in alignment with IPHS and program guidelines.)
4
Training and Capacity Building
(Awareness workshop, Internal and External Assessors' Training, IA cum SPT, and Thematic Training)
5
Facility Level Quality Improvement
Internal Assessment
Patient Satisfaction Survey
Key Performance Indicators
Competence and Performance Assessment
Rapid Improvement Events
Gap Identification
Root Cause Analysis and Objective Setting
Quality Policy & Objectives
Medical & Death Audits
Standard Operating Procedures
Calibration & EQUAS
Regulatory compliances
6
Planning of Quality Improvement Activities
Accept /alteration or tweak then accept / discard the idea
Implementation of Quality Assurance Mechanisum
Implementing a Change idea
Check
7
Certification & Accreditation
DQAC recommends to SQAU for State Level Certification
Facility assessment & certification by SQAC
SQAC recommend for National Certification.
Certification unit coordinate External Assessment by pool of Empaneled external assessors
If facility meets all the criteria, NHSRC recommends to MoHFW for Certification
Issue of the certificate by MoHFW
8
Sustenance & Incentives
Felicitation and recognition of Achievement, Financial Incentives, Surveillance every year and Recertification after three years

ANNEXURES

Annexure A
NQAS: THE HOLISTIC APPROACH

As discussed, earlier NQAS encompass all the approaches of quality without naming and demarcating the individual approach. The basic approach followed can be explained as two Step Process: (a) Measuring Quality & (b) Improving Quality

Step 1: Measuring Quality:

Irrespective of the approach or methodology, first step in Quality is 'Measurement' because:

"If you can't measure something, you cannot understand it, if you cannot understand it, you cannot control it, and if you cannot Control it, you cannot Improve it."

Measurement is defined as applying numbers to objects or process, according to a set of rules. For example, if we say Ram is 6 feet tall, it means, the distance between the heel and the top of the head of Ram, while standing erect is 6 feet.

Measurement brings objectivity to findings. We don't have to describe processes and objects in terms of adjectives: good, bad, not so good, not up to the mark etc. Anyways, Adjectives are forbidden in the field of quality. Measurement helps to analyse the As-Is situation and to find out the Gaps or Areas of Improvements. Gap is the difference between 'What is" and "What ought to be or should be".

Now to measure Quality we need something against which to measure (the set of rules in definition). We can measure Quality or find Gaps/Areas of improvement against:

- Established Standards. (NQAS, JCI, NABH, ISO, BSI, IPHS, etc.)
- Benchmarks (Best of the class) of the industry. (e.g., LSCS rate of 10-15%, BOR around 85%).
- Best practices. (Well established and proven best practices)

- Aims and objectives. Either set by the facility or the targets provided by top leadership.

There are several tools and techniques that help us to measure Quality and find gaps. Some of them used under NQAS are:

- Checklists and Standards using the checklist and other tools provided e.g., NQAS, JCI, ISO, BSI etc.
- Patient Satisfaction Surveys to find out the level of satisfaction of the beneficiaries visiting the hospital.
- Employee Satisfaction Surveys to measure the level of satisfaction of internal customers i.e., the staff delivering the healthcare services.
- Audits (NQAS assessments, Prescription Audits, Medical Audits, Death Audits, Social Audits, Power Audits, Safety Audits, etc)
- Process mapping to understand how the things are being done and identify the bottlenecks, wastes and non-value adding activities.
- Internal Quality Control: activities done within the facility to control and improve Quality e.g., running controls (provided with the reagents) at recommended periodic intervals to ensure the quality of results and find out variations if any, Daily round taken by the matron/MS etc
- External Quality Assurance: A statistical tool to ensure the accuracy and precision of Lab tests. Here a group of laboratories are empanelled under one mother laboratory and conduct tests on the same lyophilized sample. Then the 'Z Score' or "VIS' (Variance Index scores) are generated based on the closeness of their results to the Central (Mean, median, Mode) value.
- Key Performance Indicators: Measures of effectiveness, Efficiency, patient care and Quality.

Step 2: Improving Quality.

We must here understand that the tools, techniques and methods discussed under Step 1: Measuring Quality help only in understanding and measuring Quality. The purpose and objectives of these exercises is to find out the Gaps or opportunities for improvement. Let us examine what type of gaps we can find after these exercises:

S. No.	Exercise/Tool/Method	What are the Gaps?
1.	NQAS standards	Checkpoints with scores of 0 or 1.
2.	Other Standards	Major and minor non-conformities.
3	Patient Satisfaction surveys	Attributes with lowest scores; that are causing maximum dissatisfaction amongst patients.
4	Employee Satisfaction Surveys.	Attributes with lowest scores; that are causing maximum dissatisfaction amongst employees.
5	Prescription Audits.	Maximum occurring prescription errors.
6	Death Audits.	Identify negligence if any. What could have been done to prevent the death.

S. No.	Exercise/Tool/Method	What are the Gaps?
7	Process mapping	• Value and non-value adding activities. • Process and Functional Bottlenecks. • Wastes in the process.
8.	Internal Quality Control (Lab)	Variations from the prescribed range on Control.
9.	External Quality Control (Lab)	Variations from the Central values. (Accuracy and preciseness)
10	KPI	Indicators showing negative trends.

Unfortunately, most of implementers considers "Measuring Quality" to be the ultimate tools for improvement. What happens is that they consider these exercises to be the means for improvement rather than means of measurement and identifying gaps. As a result, they stop immediately after Step 1 (Measuring Quality) and keep on repeating the same exercises without getting any tangible and positive results.

For example, when you go to a facility and ask, "do you conduct patient satisfaction surveys"? They will immediately say, "Yes". When you ask for records, they will come up with a huge pile of filled survey forms. But when you will ask them, what you do after the survey? The most common answer is, "we again conduct patient Satisfaction Surveys." And the trend goes on.

Now the question is where is "Improvement"? just by repeating the surveys cannot bring improvement in patients' satisfaction. To bring about improvement, we have to "CHANGE" because: "If you always do what you have always done, you will always get what you have always got!"

What is Improvement?

Improvement is "the organized creation of beneficial change". It is an organized creation with involvement of all stakeholders to bring about tangible and positive changes that are beneficial for All.

Improvements creates a 'Win-Win" situation for all stakeholders.

Improvement is the attainment of unprecedented levels of performance. A synonym is "breakthrough."

Quality Improvement in Healthcare:

Batalden-Davidoff defines Quality in Healthcare as "the combined and unceasing efforts of everyone-healthcare professionals, patients, and their families, researchers, Government, planners and educators-to make the changes that will lead to better patient outcomes (health), better system performance (care), and better professional development (learning)." This can be represented graphically as **Figure A.1**:

Figure A.1: **Quality improvement in healthcare**

Different ways of bringing Improvement:

1. By reducing the number and amount of resources required to complete a process or objective. For example, a process can be improved, if we reduce the number of Human Resource required, amount of Money required, duration of time required, raw materials required, equipment required for completion of the process.
2. We can make improvements by reducing the errors.
3. By meeting and exceeding expectations of external customers.
4. By making the process safer.
5. By making the process more satisfying for the person doing it.

The philosophy of Quality Improvement under NQAS follows a simple strategy of: Making CHANGES that will result in IMPROVEMENT.

And the universal methodology of QI i.e., PDCA (Plan-Do-Check-Act) or Deming's Cycle is followed for Quality improvement. This includes but not limited to the following:

1. Teamwork
2. Leadership
3. Motivation
4. Reward and recognitions.
5. Quality methods.
6. Quality tools.

Steps for Improving Quality are (Figure A.2):

i. Root Cause Analysis. Some of the Tools used are:

   a. Brain storming.

   b. Why-why Analysis

c. Cause and effect Diagram.

ii. Prioritization. Some of the Tools used are:

a. PICK Chart.

b. Pareto's Analysis.

iii. Action planning. Preparation of a Time-bound Action Plan with detail of Gap identified, actions to be taken, responsibility, timeline and mechanism of monitoring and feedback.

iv. Feedback and monitoring of the QI process.

v. Gap Closure.

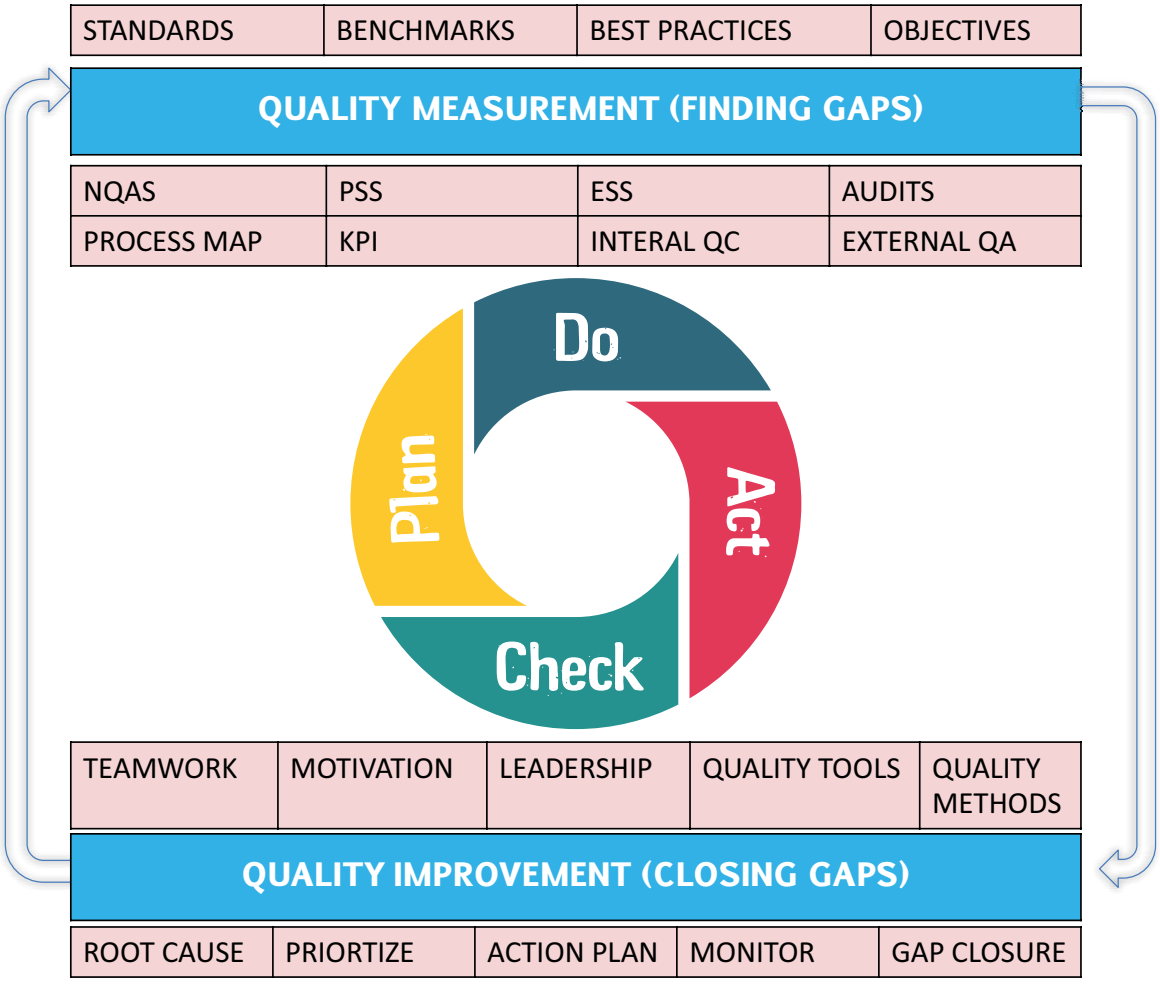

Figure A.2: Quality Improvement Methodology embedded into NQAS

Annexure B
REPORTING FORMAT FOR DH/ SDH OR EQUIVALENT

Monthly Quality Improvement Report			
Name of the Facility		Type of Facility	DH/SDH/ Others
District		State	
Month		Last DQAC Visit	
Last Internal Assessment		Last SQAC Visit	

A Gap Closure Status				
	No of Gaps	**Closed**	**In Process**	**Not Initiated**
A1	Facility Level			
A2	District Level			
A3	State Level			
A4	Total			
A6	Brief Description of Resources required	1		
		2		
		3		
		4		
		5		

B Departmental Score Cards				
	Department	**Baseline**	**Previous Month**	**This Month**
B1	Accident & Emergency			
B2	Outdoor Department			
B3	Labour Room			
B4	Maternity ward			
B5	Paediatric ward			
B6	SNCU/NBSU			

B7	Maternity OT			
B8	Operation Theatre			
B9	Post-Partum Unit			
B10	Intensive Care Unit			
B11	Indoor Patient Dept.			
B12	Nutritional Rehabilitation Centres			
B13	Blood Bank /Blood storage Unit			
B14	Laboratory			
B15	Radiology			
B16	Pharmacy			
B17	Auxiliary Services			
B18	Mortuary			
B19	General Administration			
B20	(others)			
	Overall Score			
C Thematic Score Cards				
	Area of Concern	**Baseline**	**Previous Month**	**This Month**
C 1	Service Provision			
C2	Patient Right			
C3	Inputs			
C4	Support Services			
C5	Clinical Services			
C6	Infection Control			
C7	Quality Management			
C8	Outcome			
	Overall Score			

D Key Performance Indicators (KPI) for DH/SDH or any equivalent					
	Indicator	**Unit**	**Current Month**	**Previous month**	**Previous Year's (same month)**
	Productivity				
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)				

REPORTING FORMAT FOR CHC/ UCHCs

Monthly Quality Improvement Report				
Name of the Facility			Type of Facility	CHC -FRU /Non FRU/ UCHC
District			State	
Month			Last DQAC Visit	
Last Internal Assessment			Last SQAC Visit	
A Gap Closure Status				
	No of Gaps	**Closed**	**In Process**	**Not Initiated**
A1	Facility Level			
A2	District Level			
A3	State Level			
A4	Total			
A6	Brief Description of Resources required	1		
		2		
		3		
		4		
		5		
B Departmental Score Cards				
	Department	**Baseline**	**Previous Month**	**This Month**
B1	Accident & Emergency			
B2	Outdoor Department			
B3	Labour Room			
B4	NBSU			
B5	Operation Theatre			
B6	Indoor Patient Dept.			
B7	Blood storage Unit			
B8	Laboratory			

B9	Radiology			
B10	Pharmacy and Stores			
B11	Auxiliary Services			
B12	General Administration			
B13	(others)			
	Overall Score			
C Thematic Score Cards				
	Area of Concern	**Baseline**	**Previous Month**	**This Month**
C 1	Service Provision			
C2	Patient Right			
C3	Inputs			
C4	Support Services			
C5	Clinical Services			
C6	Infection Control			
C7	Quality Management			
C8	Outcome			
	Overall Score			

D Key Performance Indicators (KPI) for CHCs/ UCHC					
	Indicator	**Unit**	**Current Month**	**Previous month**	**Previous Year's (same month)**
	Productivity				
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 FRU				
D4	LSCS rate				
D5	Percentage of NCD cases managed in OPD				
D6	Percentage of newborn admitted to NBSU out of total live birth at facility				
D7	No. of Blood units transfused				
D8	No. of major surgeries done (except LSCS)				
	Efficiency				
D9	Percentage of referrals out of Total registered patient				
D10	OPD per Doctor				
D11	Critical emergencies (Snake bite, poisoning, drowning trauma, IHD & respiratory distress, CVA) attended out of total emergency patient registered				
D12	Percentage of Stock outs as per EML				
D13	Percentage Emergency call attended per specialist per month (8PM to 8AM)				
	Clinical Care / Safety				
D14	Average Length of Stay				
D15	Surgical Site Infection rate				
D16	Death Rate (Include all deaths)				
D17	Percentage of AEFI cases reported				

D18	Percentage of cases on DOTs completed the treatment successfully				
D19	Family planning indicators (as per HMIS reporting)				
D20	LaQshya Indicators (As per Annexure 'C' of LaQshya Guidelines)				
	Service Quality				
D21	Left against medical advice (LAMA) cases				
D22	Patient Satisfaction Score for IPD				
D23	Patient Satisfaction Score for OPD				
D24	Consultation time in OPD (average)				

REPORTING FORMAT FOR PHC

Monthly Quality Improvement Report			
Name of the Facility		Type of Facility	PHC 24*7 / Others
District		State	
Month		Last DQAC Visit	
Last Internal Assessment		Last SQAC Visit	

A Gap Closure Status				
	No of Gaps	**Closed**	**In Process**	**Not Initiated**
A1	Facility Level			
A2	District Level			
A3	State Level			
A4	Total			
A6	Brief Description of Resources required	1		
		2		
		3		
		4		
		5		

B Departmental Score Cards				
	Department	**Baseline**	**Previous Month**	**This Month**
B1	OPD			
B2	Labour room			
B3	Indoor Dept			
B4	Laboratory			
B5	National Health Program			
B6	General Administration			
B7	(others)			
	Overall Score			

C Thematic Score Cards				
	Area of Concern	**Baseline**	**Previous Month**	**This Month**
C 1	Service Provision			
C2	Patient Right			
C3	Inputs			
C4	Support Services			
C5	Clinical Services			
C6	Infection Control			
C7	Quality Management			
C8	Outcome			
	Overall Score			

D Key Performance Indicators (KPI) for PHC					
	Indicator	**Unit**	**Current Month**	**Previous month**	**Previous Year's (same month)**
	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				

REPORTING FORMAT FOR UPHC

Monthly Quality Improvement Report			
Name of the Facility		Type of Facility	UPHC
District		State	
Month		Last DQAC Visit	
Last Internal Assessment		Last SQAC Visit	

A Gap Closure Status				
	No of Gaps	**Closed**	**In Process**	**Not Initiated**
A1	Facility Level			
A2	District Level			
A3	State Level			
A4	Total			
A6	Brief Description of Resources required	1		
		2		
		3		
		4		
		5		

B Departmental Score Cards				
	Thematic Area	**Baseline**	**Previous Month**	**This Month**
B1	General Clinic			
B2	Maternal Health			
B3	Newborn & child Health			
B4	Immunization			
B5	Family planning			
B6	Communicable Disease			
B7	Non-Communicable Disease			

B8	Dressing & emergency			
B9	Pharmacy			
B10	Laboratory			
B11	Outreach			
B12	General Admin			
B13	(Others)			
	Overall Score			

C Thematic Score Cards				
	Area of Concern	**Baseline**	**Previous Month**	**This Month**
C 1	Service Provision			
C2	Patient Right			
C3	Inputs			
C4	Support Services			
C5	Clinical Services			
C6	Infection Control			
C7	Quality Management			
C8	Outcome			
	Overall Score			

D Key Performance Indicators (KPI) for UPHC					
	Indicator	**Unit**	**Current Month**	**Previous month**	**Previous Year's (same month)**
	Productivity				
D1	OPD per month				
D2	No. of ANC conducted per month				

D3	No. of NCD cases registered				
D4	No. of outreach sessions conducted for vulnerable population				
D5	Follow up rate of OPD cases				
	Efficiency				
D6	No. of outreach sessions conducted per ANM				
D7	Dropout rate for Pentavalent				
D8	No. of stock out days for EML				
	Clinical Care / Safety				
D9	Percentage of high-risk pregnancy detected during ANC				
D10	Percentage of AEFI cases reported				
D11	IUCD complication rate				
D12	Percentage of TB patient on DOTS completed treatment successfully				
	Service Quality				
D13	Patient Satisfaction Score for OPD				
D14	Registration to drug time (Average)				
D15	Consultation time in OPD (average)				

Annexure C
TERMS OF REFERENCE: STATE CONSULTANT (QUALITY ASSURANCE)

Selection Criteria:

MBBS/Dental/AYUSH/Nursing graduate with masters in Hospital administration/ Health Management (MHA-Full time or equivalent) with 5 years' experience in public Health/ Hospital administration, out of which, at least 3 years' work in the field of quality.

Training and experience of implementing a recognised quality system like NQAS/NABH/ISO 9001:2015/Six Sigma/Lean/Kaizen would be preferred.

Recommended Remuneration:

Rs 60,000/- per month. Higher the compensation may be given to highly qualified and experiences candidates.

In addition, a performance linked incentive per month @ 25% remuneration or part thereof may be given on attainment of performance linked milestones or part thereof in previous year.

Roles and Responsibilities:

1. Coordinating and promoting quality related activities and advocacy across the state.
2. To assist, support, conduct assessment & scoring as well as mentoring public health facilities (including Urban health facilities) for certification.
3. Facilitate selection of facilities for state and National Certification and support in the certification process.
4. Grading of healthcare facilities on the basis of scores achieved during quality assessments
5. Estimating state's requirements (in terms of Structure, Process and outputs) for improving quality of healthcare services.
6. Review the status of QA activities in districts.
7. Providing support to Districts in taking appropriate and time-bound actions on closure of the gaps, identified during the assessments.
8. Conducting workshops and training for district personnel on QA and Certification of healthcare facilities.
9. Supporting State Quality nodal officer and authorities to undertake annual PIP (Programme implementation Plan) of quality assurance and related activities.

10. Providing necessary support to DQAC/ DQAU in the area of Quality Improvement and Certification.
11. Ensuring conduct of meetings regularly & taking follow-up actions and presenting 'Action taken report (ATR)' in the SQAC meetings. Ensuring reports and meetings' minutes are displayed on state's website.
12. To provide technical assistance to achieve compliance to statutory requirements such as Atomic Energy Act & AERB Guidelines, Blood bank License, PC PNDT act, Biomedical Management rules, etc.
13. Ensure regular reporting, monitoring and analysis of KPI from District Quality Assurance units (DQAU)/ all healthcare facilities, and its further reporting & sharing with MoHFW/ NHSRC.
14. To review the Patient's & employee's satisfaction and Mera Aspataal scores from different districts, subsequently ensures the district teams develop an action plan to address the concerns of patients, which led to poor satisfaction
15. Liaison to ensure, linkage of all Public Health Facilities (DH/SDH, CHC, UCHC, PHC and UPHC) with Mera Aspataal.
16. Ensure timely declaration of Kayakalp awards for all level of health facilities and organise Kayakalp award function at State level.
17. Advise on the further development of Quality and patient safety across health facilities in the state.
18. Monitoring of recording / reporting system through field visits and submit the visit reports with appropriate suggestions / actions for improvement.
19. To facilitate state and National level assessment and liaison with the Certification for audits, surveillance and re-certification
20. To facilitate customization of NQAS standards as per state's requirements in collaboration with NHSRC.
21. To assist the State Quality Nodal Officer for quality improvement in discharging his duties.
22. Submit QA and related domain reports to MoHFW/NHSRC as and when requested
23. To attend to any other duties / responsibilities assigned by the authorities and the reporting officer.
24. Ensure recording and documentation of all the achievements/ learnings and submitting the same to NHSRC/MoHFW regularly.
25. Ensure incentive or monetary award distribution norms are adapted or adopted as per MOHFW guidelines, approved and notified through appropriate channel.
26. Ensuring proper distribution of incentive and award amount to all National certified or winner facilities and ensuring its utilisation as per guidelines

Apart from this the consultant shall have to meet minimum performance deliverables as defined by NHM or state.

Note: The deliverables may be redistributed among consultant public health and Quality monitoring if state have more than one quality consultant.

TERMS OF REFERENCE: STATE CONSULTANT (PUBLIC HEALTH)

Selection Criteria:

MBBS/BDS/AYUSH/Nursing graduates with master's in public health (MPH), Community Medicine (MD), MBA-(Health Management) with 5 years' experience in public Health/ Hospital administration, out of which, at least one year work in the field of Public Health Quality. Training and experience of implementing a recognised quality system like NQAS/ NABH/ISO 9001:2015/Six Sigma/Lean/Kaizen would be preferred.

Recommended Remuneration:

Rs 60,000/- per month. Higher the compensation may be given to highly qualified and experiences candidates.

In addition, a performance linked incentive per month @ 25% remuneration or part thereof may be given on attainment of performance linked milestones or part thereof in previous year.

Roles and Responsibilities:

1. Coordinating and promoting quality related activities and advocacy especially related to National Health Programs.
2. Coordination with State's Programme Officers for implementation of National Health Programmes at Facility level under ambit of Quality Improvement Activities.
3. Providing technical support in implementing the technical protocols & clinical standards.
4. Estimating state's requirements of resources for Quality Assurance programme and coordinate with the Directorate and SPMU for allocation of resources for the gap closure, found during the assessment process.
5. Ensuring budgeting of QA and related activities in annual PIP and proper utilization of allocated funds provided for activities.
6. To assist, conduct assessment & scoring, support for identification of gaps and regular mentoring of public health facilities for certification (including Urban Health facilities).
7. Grading of healthcare facilities on the basis of scores achieved during quality assessments
8. Review the status of QA activities at different facilities.
9. Facilitate need assessment for training, prepare training curriculum and plan training activities in collaboration with training institutes.
10. Conducting workshops and training for the district personnel on QA and Certification of healthcare facilities.

11. Ensure conduct of meeting regularly & taking follow-up actions and presenting 'Action taken report (ATR) in the SQAC meeting. Ensuring reports and meetings' minutes are displayed on state's website.
12. Ensure that the planned outputs related to Quality Improvement Programme are achieved as per the annual work plan or ROP of the State.
13. Analyse financial and physical progress report and take corrective measures for improving.
14. Identify the cause of any unreasonable delay in the achievement of milestones, or in the release of funds and propose corrective action.
15. Providing necessary support to DQAC/ DQAU in public health.
16. Advise on the further development of Quality and patient safety across health facilities in the state.
17. Monitoring of recording / reporting system through field visits and submit the visit report with appropriate suggestions / actions for improvement.
18. Ensure declaration of Kayakalp awards for all level of facilities and organise Kayakalp award function at State level.
19. To facilitate state and National level assessment and liaison with the Certification for audits, surveillance, and re-certification
20. To facilitate customization of NQAS standards if required in coordination with NHSRC.
21. To assist the State Nodal officers for Quality Improvement in discharging his/her duties.
22. To submit timely reports to MoHFW/NHSRC for all QA activities in the State.
23. To attend to any other duties / responsibilities assigned by the authorities and the reporting officer.
24. Ensuring Recording and Documentation of all the achievements/ learnings and submitting the same to NHSRC/MoHFW regularly.
25. Ensuring proper distribution of incentive and award amount to all facilities and ensuring its utilisation as per guidelines.

Apart from this the consultant shall have to meet minimum performance deliverables as defined by NHM or state.

Note: The deliverables may be redistributed among consultant public health and Quality monitoring if state have more than one quality consultant.

TERMS OF REFERENCE: STATE CONSULTANT (QUALITY MONITORING)

Selection Criteria:

Post graduate degree/ advance qualification in Statistics. Specialization in Biostatistics/ master's in health informatics (MBA health informatics)/ Masters in epidemiology (MPH epidemiology) with two years' experience in Public Health would be an added advantage.

Recommended Remuneration:

Rs 50,000/- per month. Higher the compensation may be given to highly qualified and experiences candidates.

In addition, a performance linked incentive per month @ 25% remuneration or part thereof may be given on attainment of performance linked milestones or part thereof in previous year.

Roles and Responsibilities:

1. To create a single source repository of health care data at the state level.
2. Help the State to create Quality Dashboard to monitor districts' performance.
3. Ensure reporting, monitoring and analysis of monthly Key Performance Indicators (KPI) and other quality indicators as per scope quality assurance initiatives from all districts.
4. Review of KPIs and presenting analysis findings to SQAC.
5. Monitoring the sustenance of the initiatives undertaken to improve quality. Enabling district teams to use data for the improvement.
6. Ensure a mechanism of collation, reporting and analysis of patient feedback system in all the districts through patient satisfaction survey and ''Mera Aspataal''.
7. Collection, compilation and regular updation of data from various sources - Census, HMIS, Periodical surveys (NSSO, NFHS, SRS, AHS, etc), and reports etc.
8. To regularly update SQAC of emerging and changing trends.
9. Capacity building and mentoring of District Consultant (statistics/demographics/ HMIS).
10. To conduct trainings on how to use data for informed decision making and planning e.g., basic graphical representation and understanding the trends and shifts, Statistical Process Control, measure of variance, reducing defects and errors for quality improvement.
11. Monitoring of recording / reporting system through field visits and submit the visit reports with appropriate suggestions / actions for improvement.
12. To provide necessary statistical support to technical consultants of SQAC and DQAC. To provide necessary information to the relevant consultant.

13. Submission of reports to Govt. of India / NHSRC as per GOI guidelines / instructions.
14. To assist the State nodal officer for Quality Improvement in discharging his/her duties.
15. To submit timely reports to MoHFW/NHSRC for all QA activities in the State.
16. To attend to any other duties / responsibilities assigned by the SQAC.
17. Ensure recording and documentation of all the achievements/ learnings and submitting the same to MoHFW /NHSRC regularly.

Apart from this the consultant shall have to meet minimum performance deliverables as defined by NHM or state.

Note: The deliverables may be redistributed among consultant public health and Quality monitoring if state have more than one quality consultant.

TERMS OF REFERENCE: PROGRAM CUM ACCOUNTING ASSISTANT (SQAU)

Selection Criteria:

Recognised Graduate Degree in commerce/ having in depth knowledge of managing accounting process with fluency in MS Office package including having two years' experience of managing office and providing support to Health Programme / NHM. Knowledge of accounting i.e., preparing, summarizing, analysing transactions reports are essential for eligibility. Candidates having drafting skills would be preferred.

Roles and Responsibilities:

1. To provide support to SQAC in its accounting & administration tasks
2. Provide the support for managing travel cum logistics claims of SQAC/SQAU/Assessors/ other deputed for Quality assessments & visits etc.
3. To coordinate all activities of SQAU.
4. Preparation of agenda notes of SQAC/SQAU meetings and ensuring its circulation to members.
5. Preparation of the minutes of meetings and initiating correspondence for follow-up action.
6. Liaison with DQAC and DQAU
7. Facilitating the team for the field visits including logistics arrangement.
8. Liaisonning with the State's -Internal and External Assessors and maintenance of their register at state level.
9. Submission of Utilisation certificates in respect of funds received.
10. Upkeep of files, registers and books of accounts.
11. Support Quality nodal officer or consultants in collation of KPI, Assessment reports, surveillance reports etc.
12. To attend and support in any other duties/responsibilities assigned by the authorities and the reporting officer.

Apart from this the person shall have to meet performance deliverables as defined by NHM or state.

* These norms may not be applicable for already deployed Program Assistants, however, in case of new appointments these norms should be followed

Annexure D
TERMS OF REFERENCE: DISTRICT CONSULTANT (QUALITY ASSURANCE)

Selection Criteria:

MBBS/Dental/AYUSH/Nursing graduate with masters in Hospital administration/ Health Management (MHA-Full time or equivalent) with 2 years' experience in Public Health/ Hospital administration. Training and experience of implementing a recognised quality system like NABH/ISO 9001:2015/Six Sigma/Lean/Kaizen would be preferred. Previous work experience in the field of health quality would be an added advantage.

Roles and Responsibilities:

1. Coordinating and promoting quality related activities and advocacy across the district
2. To assist, support, conduct assessment & scoring, identify gaps and regular mentoring public health facilities for certification (including Urban Health facilities) in the district.
3. Supporting the facilities to undertake improvement initiatives based on the gaps identified.
4. Grading of healthcare facilities based on scores achieved during quality assessments
5. Ensuring that DQAC meets regularly and maintaining their meetings' minutes and ensuring follow-up actions have been taken.
6. Ensuring all the meetings minutes and reports are shared with SQAC and displayed on state's website.
7. Selecting facilities that may go for Certification and supporting them in the process.
8. Estimating district's requirements (in terms of Structure, Process and outputs) for improving quality of healthcare services. Ensuring that the requirements for Quality Assurance Activities are appropriately covered under the annual PIP sent from district to state.
9. Ensuring proper allocation of resources to the facilities based on their requirement.
10. Review the status of QA activities of facilities in the district.
11. To ensure peer assessment of all healthcare facilities (including urban facilities) in district. Ensure timely sharing of peer assessment scores with states and declaration of Kayakalp awards for PHCs.
12. To provide support to facilities in the district in taking appropriate and time-bound actions on closure of the gaps identified during assessments.
13. Conducting workshops and training at district and facility level on QA and Certification of healthcare facilities.

14. To assist the facilities for integration with Mera Aspataal etc.
15. To provide technical assistance to health facilities in achieving compliance to statutory requirements such as Atomic Energy Act & AERB Guidelines, Blood bank, PC PNDT act, BMW Rules, etc. in the district.
16. To review the Patients satisfaction and 'Mera Aspataal' scores from all facilities subsequently support the facility to undertake the improvement initiatives related to lowest scoring attributes.
17. Advise on the further development of QA and patient safety across health facilities in the district.
18. To facilitate State and National level assessments and Certification process.
19. Monitoring of recording / reporting system through field visits and submit the visit reports with appropriate suggestions / actions for improvement.
20. To assist the district nodal officer for Quality Improvement in discharging his/her duties.
21. To attend to any other duties / responsibilities assigned by the DQAC and SQAC.
22. Ensuring recording and documentation of all the achievements/ learnings and submitting the same to SQAC/SQAU regularly.
23. Ensuring proper distribution of incentive and award money to all facilities as per guidelines.
24. Acts as intermediary between facilities, district, and state officials for gearing up the efforts.

Apart from this the consultant shall have to meet minimum performance deliverables as defined by NHM or state. The deliverables may be redistributed among consultant public health and Quality monitoring if state have more than one quality consultant

TERMS OF REFERENCE: DISTRICT CONSULTANT (PUBLIC HEALTH)

Qualification Criteria:

MBBS/Dental/AYUSH/Nursing graduate with degree/diploma in Health Management with 02 years relevant work experience. Training in Health quality like NABH/ISO 9001:2000/Six Sigma/Lean/Kaizen by a reputed organization will be preferable.

Roles and Responsibilities:

1. Coordinating and promoting quality and advocacy especially related to National Health Programs.
2. Coordination with the state programme officers and SQAU for QA related activities at all Health facilities in the district.
3. Providing technical support in assessing and implementing the technical protocols and clinical guidelines
4. Estimating district's requirements for QA program and improving quality of healthcare delivery.
5. Providing District inputs (after analysing the requirements of the facilities) for District PIP and to SQAU on the QA programmes in the State.
6. To assist, support, conduct assessment & score, identify of gaps and regular mentoring public health facilities for certification (including Urban Health facilities) in the district.
7. Grading of health facilities based on basis of scores achieved during quality assessments.
8. Facilitating selection of facilities that may go for Certification and supporting them in the process.
9. Ensuring that DQAC meets regularly and follow-up action is taken. Ensuring all the meetings minutes and reports are shared with SQAC and displayed on state's website.
10. Review the status of QA activities of all facilities.
11. To ensure proper utilization of funds provided for activities under QA.
12. Conducting workshops and training at facilities and district level on QA and Certification of healthcare facilities.
13. Facilitate need assessment for training, prepare training curriculum and plan training activities in collaboration with training institutes.
14. Liaison with district other health programs for ensuring training needs of facilities are fulfilled.
15. Analyse financial and physical progress report and provide supervisory support.

16. Identify the cause of any unreasonable delay in the achievement of milestones, or in the release of funds and propose corrective action.
17. Monitoring of recording / reporting system through field visits and submit the visit reports with appropriate suggestions / actions for improvement.
18. To facilitate State, National level Assessment and Certification process.
19. To assist district nodal officer for Quality Improvement in discharging his/her duties.
20. To attend to any other duties / responsibilities as assigned DQAC/SQAC.
21. Ensuring recording and documentation of all the achievements/ learnings and submitting the same to SQAC/SQAU regularly.
22. Ensuring proper distribution of incentive and award amount to all facilities as per guidelines.

Apart from this the consultant shall have to meet minimum performance deliverables as defined by NHM or state. The deliverables may be redistributed among consultant public health and Quality monitoring if state have more than one quality consultant

TERMS OF REFERENCE: DISTRICT CONSULTANT (QUALITY MONITORING)

Selection Criteria:

Degree in Statistics with good academic record from a reputed University. Specialization in Biostatistics would be an added advantage. Previous work experience of Health/ hospital would be preferred.

Roles and Responsibilities:

1. Collection and compilation of data from various sources- Census, Surveys, and reports, etc. at District level and reporting to SQAC/ SQAU.
2. To develop a system of monthly reporting of Key Performance indicators / other indicators or reports as per scope of various quality assurance initiatives from all the facilities in the district and reporting it to the State.
3. Collection, collation, Analysis and review of Key performance indicators of all health care facilities in district. Ensure dissemination of findings to DQAC and facilities.
4. Supporting facilities to understand trend of indicators and supporting them for the improvement.
5. To develop and maintain Quality Dashboard in the District / ensure integration with State dashboard and regular reporting to facility indicators,
6. To review the Patients satisfaction and 'Mera Aspataal' scores from all facilities subsequently support the facility to undertake the improvement initiatives related to lowest scoring attributes.
7. Monitoring the sustenance of the initiatives undertaken to improve quality.
8. To regularly update SQAC of emerging and changing trends.
9. To conduct trainings on how to use data for informed decision making and planning. How to implement Statistical techniques e.g., basic graphical representation and understanding the trends and shifts, Statistical Process Control, measure of variance, reducing defects and errors for quality improvement.
10. Monitoring of recording / reporting system through field visits and submit the visit reports with appropriate suggestions / actions for improvement.
11. To provide necessary statistical support to SQAC and DQAC.
12. To assist the district nodal officer for Quality Improvement in discharging his/her duties.
13. To attend to any other duties / responsibilities assigned by DQAC and SQAC.
14. Ensuring recording and documentation of all the achievements/ learnings and submitting the same to SQAC/SQAU regularly.

Apart from this the consultant shall have to meet minimum performance deliverables as defined by NHM or state. The deliverables may be redistributed among consultant public health and Quality monitoring if state have more than one quality consultant

TERMS OF REFERENCE: ADMINISTRATIVE CUM PROGRAMME ASSISTANT (DQAU)

Selection Criteria:

Recognised Graduate Degree with fluency in MS Office package with one-year experience of managing office and providing support to Health Programme / NHM. Knowledge of Accountancy would be an added advantage. Candidates having drafting skills would be preferred.

Roles and Responsibilities:

1. To provide support to DQAC in its administration.
2. To coordinate all activities of DQAU.
3. Preparation of agenda notes of DQAC meetings and ensuring its circulation to DQAC members.
4. Preparation of the minutes of meetings and initiating correspondence for follow-up action.
5. Liaison with SQAC and SQAU
6. Submission of reports to SQAU
7. Facilitate support for the field visits including logistics arrangement.
8. Submission of Utilisation certificates in respect of funds received.
9. Upkeep of files, registers and books of accounts
10. Support district consultant to Collate KPI, Assessment reports, surveillance reports etc.
11. To attend or support for any other duties / responsibilities assigned by DQAC and DQAU.

Apart from this the person shall have to meet minimum performance deliverables as defined by NHM or state.

Annexure E
TERMS OF REFERENCE: HOSPITAL MANAGER

Selection Criteria:

MBBS/Dental/AYUSH/Nursing/Life Science/Social Science graduate with masters in Hospital administration/ Health Management with one-year experience in public Health/ Hospital administration. Candidates with experience in Healthcare Quality / formal knowledge of a quality system would be preferred. Fluency in English, computer literacy, knowledge of government legislations and policies are essential. Candidate must have good communication skills both written and verbal.

Roles and responsibilities:

This position carries responsibility for administration (smooth and quality services) of all non-direct patient care services and departments in a District Hospital. Manage non-clinical services (like infection prevention, security, diet etc.), staff and facilitate Rogi Kalyan Samiti meetings and actions. Specific duties and responsibilities will include:

1. Ensuring implementation of all National Quality Assurance Programme initiatives in the facility and liaison with facility's Quality Nodal Officer/Senior Medical Officer/ Medical Superintendent / incharge and Quality team.
2. Ensuring good quality non-clinical services like infection prevention, facility upkeep, security, diet etc in collaboration with the staff responsible for these services.
3. Ensuring clean surroundings, OPD areas, Wards, labour room, OT and Patient amenities in association with the staff responsible for these services.
4. Ensuring and coordinating regular meetings of Quality team and other committees (viz. Clinical Governance committee, drug and therapeutic committee, disaster management committee, infection prevention committee, Medical and death audit committee etc.) and maintaining their minutes of meeting.
5. Ensuring Periodical assessment of hospital based on quality checklist and to arrive at a score for the facility.
6. Identification of gaps, developing the action plan under the guidance of facility in-charge and Quality team of the hospital and to monitor the compliance to it till the facility achieves the Certification (State/National) Status and also ensuring its continuous maintenance of the status.
7. Undertake Quality Improvement activities along with the departmental staff. Also, ensure departments' mentoring and handholding for QI activities along with recording and documentation of the results.
8. Facilitate conduct of meeting of Rogi Kalyan Samiti. It would include ensuring preparation of agenda notes, action taken report and minutes of the meeting.
9. Management of out-sourced services such diet, security, laundry, BMW management etc.

10. Ensuring that the hospital meets all regulatory compliances such as BMW, Blood Bank/ storage license, AERB regulations, etc.
11. Hospital manager is to take a round of the hospital daily and look at the functioning of departments, equipment and ambulance.
12. Keep a record of non-functional and timeline for its repair along with AMC for all equipment.
13. Supervising punctuality, day-to-day working, supervision of other staff members, work output and channel the work input to improve overall efficiency and keep unit's morale up.
14. Planning and work-out modalities towards upliftment, preventive maintenance of equipment and vehicles and modernization of the hospital.
15. Analyse utilization of various hospital services and equipment etc.
16. Periodic information and Assessment on utilization of funds allocated for Quality activities, untied grants, AMGs, RKS grant, incentives, or award money etc. and timely submission of SOEs and UCs.
17. Analyse financial outlays and its effective utilization along with hospital team.
18. Supporting hospital team for preparation of yearly plan for expenditure after assessment.
19. Carrying out exit interviews, satisfaction surveys (external and internal customer), time motion studies etc. to keep hospital services up to quality standards.
20. To ensure integration and regular functioning of the facility under ''Mera Aspataal''.
21. To institute an effective grievance redressal system, both for the employees and the patients.
22. Liaison for Computerization of District Hospital functions.
23. Ensuring proper utilization of incentive and award money in coordination with facility in-charge as per recommended guidelines
24. Undertaking activities for staff motivation and recognition in coordination with facility in-charge.
25. Strengthen District Hospital MIS, collection, collation and analysis of KPI and report actions taken.
26. Prepare monthly/quarterly and yearly report of hospital's progress.
27. Coordination with SQAU/DQAU and timely reporting of all data including KPIs.
28. Perform other duties and work assigned by the hospital in-charge.

Apart from this the manager shall have to meet minimum performance deliverables as defined by NHM or state.

Annexure F
TERMS OF REFERENCE: QUALITY EXTERNAL ASSESSORS

States can nominate candidates for becoming National Assessors from the pool of Experienced Doctors, Nurses, and Hospital/Health Administrators, who have been actively involved in the Patient care and/or Hospital administration and/or related academics (like Community Medicine/ Community Health Administration/ Hospital Administration).

Qualification: MBBS/ BDS/ BAMS/BHMS /B Sc (Nursing) Degree/ Full Time MHA or equivalent

Experience:

- Post degree, at least 10 years' experience of direct care of patient/ Programme Administration/ Health Administration/ Health Consultancy/ Relevant Teaching experience
- Qualified Assessors of NABH/NABL/ISO 9001:2015/Six Sigma/Lean/Kaizen/ internal assessor of NQAS would be preferred.
- Experienced contractual candidates may also be considered subject to submission of an undertaking to serve for a minimum period of 2 (Two) years, if found suitable otherwise.
- Facilities of Medical college, who are willing to travel and spare time for assessment may also be encourage and nominated.

Age: 40 years and above with fitness to travel extensively, sometimes in difficult conditions

Purpose of Empanelment:

The state and central Govt has launched Quality Assurance Programme. The empanelled Assessors are expected to undertake visits to Health Facilities on behalf of State Quality Assurance Committee (SQAC)or Ministry of Health & Family Welfare GOI / NHSRC. They would be working in a team, size of which would depend upon the type of facility and quantum of work.

The selected candidate would be required to successfully undergo the External Assessors training, which would be arranged by NHSRC. Name of the participants who successfully complete the external assessors' training may be entered in national level register of external assessors and will be empanelled for the period of three years. The team of empanelled assessors would assess Health facilities. The assessment would be based on the Standards and Measurable elements, as notified by MoHFW/ State Govt. Such assessment would be undertaken on checklists for respective departments.

Hence it is expected that the incumbent would have following additional attributes, over and above the qualification and experience:

1. The assessors should possess excellent observation and analytical skills.

2. Should have good judgment in assessing performance against set standards & criteria.

3. High degree of communication skills; listening, verbal and written. Ability to write clear and comprehensive assessment report.

4. The candidate would be required to travel within the state and outside the state for approx. 60% of their time.

5. The assessors should be proficient in MS Office and Internet/ email.

6. The assessor is expected to be objective and impartial. He would be required to be self-dependent, efficient, self-organized yet flexible, ability to prioritize work, attention to detail, logical thinking, ability to follow standardized procedures. External Assessors are expected to abide the rules and regulations (Do's and Don'ts) for conducting a fair, impartial, transparent and credible assessment

7. Social skills: acceptable interactions with all categories of hospital staff and ability to attune to relevant internal and external context

8. For renewal of the external assessor's certificate, it is mandatory to undergo a refresher training which is conducted by NHSRC. It is suggested to go through the "Guidelines for Certification of Public Health Facilities based on National Quality Assurance Standards" before conducting any assessment. External assessors are expected to share the undertaking of impartiality and confidentiality before any assessment.

Roles & Responsibilities:

1. The Assessors are expected to assess the facility using the checklists designed for Quality assurance like NQAS, LaQshya etc. Assessor's services can be utilized for national level assessment or state level assessment and surveillance, or any activity specified by MOHFW or state Govt.

2. The assessors would be responsible for ensuring that all relevant standards and criteria are assessed adequately during the survey and producing the final assessment report to accurately reflect the findings within the agreed timelines

3. They are expected to conduct opening and closing meeting in the facility. After completion of the assessment, they are required to prepare assessment report and submit to the Health Facility, District Quality Assurance Committee and SQAC.

4. Role of assessors would also be providing supportive supervision at the facilities.

5. The assessors would facilitate development of 'gap-closure' plan at the facility level through a consultative process.

6. The States can allocate health facilities to each of the NQAS empanelled external assessor for mentoring and handholding for Quality improvement.

Annexure G

OPERATIONAL COST: STATE QUALITY ASSURANCE UNIT (SQAU)

Sl. No	Head	Recurring (R)/ Fixed (F)	Salary per month	No.	Months	Total
						(INR)
1	State Consultant (Quality Assurance) *	R	60000	1	12	720000
2	State Consultant (Public Health) *	R	60000	1	12	720000
3	State Consultant (Quality Monitoring) *	R	50000	1	12	600000
4	Programme cum Accounting Assistant	R	25000	1	12	300000
5	Establishment of Quality Unit at State level - (in first year only) Furniture, fixtures, interiors etc	F	100000			100000
6	Air Conditioners (in first year only)	F	100000			100000
7	2 Computer, 2 Laptop with 1 printer, 1 scanner, 1 FAX and 1 Photocopier (in first year only)	F	250000			250000
8	Cost of Electricity, Telephone, Internet, printing, stationery etc	R	15000		12	180000
9	Contingency & Misc.	R	5000		12	60000
10	Review Meetings at State (Quarterly)	R	10000		4	40000
	Total (for first year) both Fixed and Recurring					**3070000**

*Higher compensation may be given to highly qualified & experienced candidate. In addition, a performance linked incentives per month

(a) 25% of the remuneration or part thereof may be given on attainment of performance linked milestones, or

(b) part thereof in the previous year

SQAU: MONITORING & SUPPORTIVE SUPERVISION						
Sl. No.	**Head**	**Recurring (R)/ Fixed (F)**	**Unit Cost**	**No of man days in field in a month**	**Frequency**	**Total (in INR)**
1	Travel support (to and fro)/ Hiring of vehicle for the team (Reimbursement as per actual)	R	As per State norms	10	12	As per State norms
	Accommodation	R	2000	10	12	240000
2	DA	R	400	10	12	48000
	Total (for one year)					**288000**

OPERATIONAL COST: DISTRICT QUALITY ASSURANCE UNIT						
Sl. No	**Head**		**Salary per month**	**No.**	**Months**	**Total (in INR)**
1	District Consultant (Quality Assurance) *	R	50000	1	12	600000
2	District Consultant (Public Health) *	R	50000	1	12	600000
3	District Consultant (Quality Monitoring) *	R	40000	1	12	480000
4	Programme cum Administrative Assistant	R	20000	1	12	240000
5	Establishment of Quality Unit at District level - (in first year only) Furniture, fixtures, interiors etc	F	50000			50000
6	Air Conditioners	F	50000			50000
7	2 Computer, 2 Laptop with 1 printer, 1 scanner, 1 FAX and 1 Photocopier	F	250000			250000
8	Cost of Electricity, Telephone, Internet, printing, stationery etc	R	12000		12	144000
9	Contingency & Misc.	R	2000		12	24000
10	Review Meeting	R	2000		12	24000
	Total (for first year) both fixed and recurring					**2462000**

* Higher compensation may be given to highly qualified & experienced candidate. In addition, a performance linked incentives per month

(a) 25% of the remuneration or part thereof may be given on attainment of performance linked milestones, or

(b) part thereof in the previous year

District Quality Assessment cum Mentoring Visits Activities						
Sl. No.	**Head**		**Unit Cost**	**Number of Participants**	**Days**	**Total**
1	Travel support (to and fro)/Hiring of vehicle (Reimbursement as per actual)	R	As per State Norms	2	120	As per State norms
2	DA	R	400	2	120	96000
	Total for One year					**96000**

District Hospital Quality Manager						
Sl. No.	**Head**		**Unit Cost**	**Number**	**Months**	**Total**
1	Quality Manager	R	45000	1	12	540000
2	Misc. - Internet, conduct of Meeting, Internal Assessment, etc	R	2000	1	12	24000
	Total					**564000**

OPERATIONAL COST: City Program Manager -Quality Assurance						
Sl. No	**Head**		**Salary per month**	**No.**	**Months**	**Total (in INR)**
1	City Program Manager (Quality Assurance) *	R	50000	1	12	600000
2	Review Meeting	R	2000		12	24000
3	Contingency & Misc.	R	2000		12	24000
	Total					**648000**

* Higher compensation may be given to highly qualified & experienced candidate. In addition, a performance linked incentives per month

(a) 25% of the remuneration or part thereof may be given on attainment of performance linked milestones, or

(b) part thereof in the previous year

Quality Assessment cum Mentoring Visits Activities under NUHM						
Sl. No.	**Head**		**Unit Cost**	**Number of Participants**	**Days**	**Total**
1	Travel support (to and fro)/Hiring of vehicle (Reimbursement as per actual)	R	As per State Norms	1	120	As per State norms
2	DA	R	400	1	120	48000
	Total for One year					**48000**

Annexure H
QUALITY TRAINING NORMS

TRAININGS					
Training Under National Quality Assurance Program					
Sl. No.	**Head**	**Unit Cost**	**No of Participants**	**No. of days ***	**Amount (in INR)**
1	Hiring of Venue	10000		1	10000
2	Tea & Lunch	350	50	1	17500
	Incidental Exp. like study material, course material, Photo copying, job aids, flip charts, LCD etc.	300	50	1	15000
	Travel, Boarding & lodging and DA of Participants	As per State norms	50		As per state norms
	Travel Cost for external faculty (economy class airfare as per actuals)	20000	1		20000
	Per diem for faculty/ Honorarium for National external trainer	1500	1	1	1500
	Per diem for faculty/ Honorarium for State external trainer	1000	1	1	1000
	Boarding & Lodging for external Trainers	4000	1	2	8000
	Hiring of Vehicle for Trainer	As per State norms		3	As per state norms
5	Contingency	10000			10000
	Total (One Training)				**83000**

* No of training days may be vary as per type of training - Awareness Training (1 Day), Internal Assessor Training (2 Days), Service Provider training (3 Days), Internal Assessor cum Service Provider training (3 Days), Any Other thematic training (Varies from 1-3 days)

Training norms are also applicable to QA training conducted under NUHM

$- State may be requested to depute the participants at the National level for External Assessor training

TISS Course Financial Norms				
Financial Norms for PG Diploma in Healthcare Quality Management #				
Sr no	**Expenditure**	**Units Cost**	**No. of days**	**Norms**
1	**Course Fee**			
	(a) Application Form	750		750
	(b) Course Fee	1,00,000		1,00,000
2	Cost of travel (Three times- 2 Contact Programme & Final Exam (No. 3)	As per State norms		Actual Expenses (As per State /UT norms)
3	Local travel in Mumbai (Station to TISS campus & back)	1500	3	4500
4	(a) Boarding & lodging of 2 contact Program (on twin sharing basis*)	2500	40	1,00,000
	(b) Boarding & lodging for examination (on twin sharing basis*)	2500	4	10000
	Total			**2,15,250**

* Night stay to accommodate travel day may be added as per actuals

#As per DO letter Dated 10 September 2019

Annexure I
NQAS CERTIFICATION (STATE & NATIONAL LEVEL ASSESSMENT) NORMS

NQAS State Assessment (DHs/SDHs and Equivalent) & surveillance				
Head	**Unit cost**	**Number of Participant**	**Days**	**Amount (in INR)**
Travel Cost of Assessors (to and fro)/Hiring of vehicle for the team (Reimbursement as per actual)	As per State norms	3	3	As per State norms
Honorarium for assessors	3500	3	3	31500
Boarding & Lodging	4000	3	4	48000
Sub Total				**79500**
Contingency	10000			10000
Total (for one District Hospital)				**89500**

NQAS State Assessment (CHCs/UCHCs and Equivalent) & surveillance				
Head	**Unit cost**	**Number of Participant**	**Days**	**Amount (in INR)**
Travel Cost of Assessors (to and fro)/Hiring of vehicle for the team (Reimbursement as per actual)	As per State norms	2	3	As per State norms
Honorarium for assessors	3500	2	3	21000
Boarding & Lodging	4000	2	4	32000
Sub Total				**53000**
Contingency	10000			10000
Total (for one CHC/UCHC)				**63000**

NQAS State assessment Activities (PHCs/UPHCs Equivalent) & surveillance				
Head	**Unit cost**	**Number of Participant**	**Days**	**Amount (in INR)**
Travel Cost of Assessors (to and fro)/Hiring of vehicle for the team (Reimbursement as per actual)	As per State norms	2	2	As per State norms
Honorarium for assessors	3500	2	2	14000
Boarding & Lodging	4000	2	3	24000
Sub Total				**38000**
Contingency	5000			5000
Total (for one PHC/ UPHC)				**43000**

NQAS State assessment Activities (HWC -SC or Equivalent) & surveillance				
Head	**Unit cost**	**Number of Participant**	**Days**	**Amount (in INR)**
Travel Cost of Assessors (to and fro)/Hiring of vehicle for the team (Reimbursement as per actual)	As per State norms	2	1	As per State norms
Honorarium for assessors	3500	2	1	7000
Boarding & Lodging	4000	2	2	16000
Sub Total				**23000**
Contingency	5000			5000
Total (for one HWC _HSC)				**28000**

NQAS National Assessment (DHs/SDHs and Equivalent) & Recertification				
Head	**Unit cost**	**Number of Participant**	**Days**	**Amount (in INR)**
Travel Cost of Assessors (to and fro)/Hiring of vehicle for the team (Reimbursement as per actual)	20000	3		60000
Honorarium of External Assessor*	7000	3	4	84000
Boarding & Lodging	4000	3	4	48000
Local transport	2000	1	4	8000
Sub Total				**200000**
Contingency	10000			10000
Total (for one District Hospital)				**2,10,000**

* Rs 4000 Per day per assessor for Staff of Health Department.

Rs 7000 Per Day per Assessor for other category (Non-Govt.) -

Reference- DO. No. NHSRC/14-15/QI /01/Assessment of Health facilities Pt-1, Dated 7 Jan 2019

NQAS National Assessment (CHCs/UCHCs and Equivalent) & Recertification				
Head	**Unit cost**	**Number of Participant**	**Days**	**Amount (in INR)**
Travel Cost of Assessors (to and fro)/Hiring of vehicle for the team (Reimbursement as per actual)	20000	2		40000
Honorarium of External Assessor*	7000	2	4	56000
Boarding & Lodging	4000	2	4	32000
Local transport	2000	1	4	8000
Sub Total				**136000**
Contingency	10000			10000
Total (for one CHC /UCHC)				**1,46,000**

* Rs 4000 Per day per assessor for Staff of Health Department.

Rs 7000 Per Day per Assessor for other category (Non-Govt.) -

Reference- DO.No. NHSRC/14-15/QI /01/Assessment of Health facilities Pt-1, Dated 7 Jan 2019

NQAS National Assessment (PHCs/UPHCs and Equivalent) & Recertification				
Head	**Unit cost**	**Number of Participant**	**Days**	**Amount (in INR)**
Travel Cost of Assessors (to and fro)/Hiring of vehicle for the team (Reimbursement as per actual)	20000	2		40000
Honorarium of External Assessor*	7000	2	3	42000
Boarding & Lodging	4000	2	3	24000
Local transport	2000	1	3	6000
Sub Total				**112000**
Contingency	8000			8000
Total (for one PHC/ UPHC)				**1,20,000**

* Rs 4000 Per day per assessor for Staff of Health Department.

Rs 7000 Per Day per Assessor for other category (Non-Govt.) -

Reference- DO.No. NHSRC/14-15/QI /01/Assessment of Health facilities Pt-1, Dated 7 Jan 2019

NQAS National Assessment (HWC-SC and Equivalent) & Recertification				
Head	**Unit cost**	**Number of Participant**	**Days**	**Amount (in INR)**
Travel Cost of Assessors (to and fro)/Hiring of vehicle for the team (Reimbursement as per actual)	20000	2		40000
Honorarium of External Assessor*	7000	2	2	28000
Boarding & Lodging	4000	2	2	16000
Local transport	2000	1	2	4000
Sub Total				**88000**
Contingency	8000			8000
Total (for one HWC_HSC)				**96000**

* Rs 4000 Per day per assessor for Staff of Health Department.

Rs 7000 Per Day per Assessor for other category (Non-Govt.) -

Reference- DO.No. NHSRC/14-15/QI /01/Assessment of Health facilities Pt-1, Dated 7 Jan 2019

LaQshya Certification (State & National Level Assessment) Norms

State Assessment LaQshya (Both Labour Room and OT)				
Head	**Unit cost**	**Number of Participant**	**Days**	**Amount (in INR)**
Travel Cost of Assessors (to and fro)/Hiring of vehicle for the team (Reimbursement as per actual)	As per State norms	2	2	As per State norms
Honorarium for assessors	2000	2	2	8000
Boarding & Lodging	4000	2	2	16000
Sub Total				**24000**
Contingency	6000			6000
Total				**30,000**

State Assessment LaQshya (Only LR or OT)				
Head	**Unit cost**	**Number of Participant**	**Days**	**Amount (in INR)**
Travel Cost of Assessors (to and fro)/Hiring of vehicle for the team (Reimbursement as per actual)	As per State norms	2	1	As per State norms
Honorarium for assessors	2000	2	1	4000
Boarding & Lodging	4000	2	1	8000
Sub Total				**12000**
Contingency	3000			3000
Total (for one District Hospital)				**15,000**

LaQshya National Assessment (Both Labour Room and OT)				
Head	**Unit cost**	**Number of Participant**	**Days**	**Amount (in INR)**
Travel Cost of Assessors (to and fro)/Hiring of vehicle for the team (Reimbursement as per actual)	20000	2		40000
Honorarium for assessors	7000	2	3	42000
Boarding & Lodging	4000	2	3	24000
Local transport	2000	1	3	6000
Sub Total				**112000**
Contingency	7000			7000
Total				**1,19,000**

LaQshya National Assessment (Only LR or OT)				
Head	**Unit cost**	**Number of Participant**	**Days**	**Amount (in INR)**
Travel Cost of Assessors (to and fro)/Hiring of vehicle for the team (Reimbursement as per actual)	20000	2		40000
Honorarium for assessors	7000	2	2	28000
Boarding & Lodging	4000	2	2	16000
Local transport	2000	1	2	4000
Sub Total				**88000**
Contingency	3000			3000
Total (for one District Hospital)				**91000**

KAYAKALP NORMS

Kayakalp Norms				
S.no.	**Activity**	**Unit Cost (Rs.)**	**Unit of Allocation**	**Rationale**
Awards				
1	Best District Hospital	50 lakhs	1 per state	Award money for Best District Hospital as per Kayakalp Award Scheme (Not applicable to small states and Union Territories)
2	Runner up District Hospital	20 Lakhs	1 per large state	Award money for Runner up District Hospital as per Kayakalp Award Scheme. Only for Large States. (More than 30 Districts)
3	Award to best SDH/CHC	15 Lakhs	1 per state	Award money for best Sub Divisional or CHC Hospital as per Kayakalp Award Scheme. (Not applicable to small states and Union Territories)
4	Runner up Award SDH/CHC	10 Lakhs	1 for large state	Runner up Award money for SDH/CHC Hospital as per Kayakalp Award Scheme. (Not applicable for small states and Union Territories of less than 30 districts)
5	Award to best PHC	2 lakhs	Number of districts	Award money for best PHC Hospital as per Kayakalp Award Scheme
6	Award to best HWC SC	1 Lakh	Number of districts	Award money for best HWC as per Kayakalp Award Scheme
7	Runner up Award HWC 2nd Runner up Award HWC	50,000 35,000	Number of operational HWC -SC in each district	Award money for runner up HWC as per Kayakalp Award Scheme
6	Commendation Award DH	3 Lakh	10% of DH or as per state experience for FY 2015-16	Award money for District Hospital scoring more than 70% on assessment criteria in external assessment

7	Commendation award SDH/CHC	1 Lakh	10% of SDH/ CHC	Award money for SDH's/ CHC's scoring more than 70% on assessment criteria in external assessment
	Commendation award PHC	50,000	10% of PHC	Award money for PHC's scoring more than 70% on assessment criteria in external assessment
	Commendation Award HWC- SC	25,000	10% of HWC-SC	Award money for HWC-SC's scoring more than 70% on assessment criteria in external assessment
Training				
1	Awareness Training (For the State who has not conducted Awareness training in FY 2015-2016)	40,000	1 Per State	Half day sensitization workshop at state level for key officials from - State Health Directorate -State Health Society - Members of State level award Committee Representatives of NGOs & Development partners working in state Expected participants-40
2	Master Training on " Swachh Bharat Abhiyan"	1,50,000	1 Per State	2 days TOT training for Cleanliness, infection Control and BMW management training for all districts of the state. Number of participants-50 Two participants from all districts -One from District Award Nomination committee and other member from Infection Control Committee of DH and officers from the State Quality Assurance Cell

3	Awareness cum Internal Assessors Workshop	40,000	1 Per District	4-hour sensitization workshop at District level on the Swachh Bharat Abhiyan and how to use assessment tool targeted for Service providers- Facility In charges Doctors, Nurses, Hospital Managers, DPM, Members of District Quality Assurance Committees, representatives of Development partners & NGOs working at District Level Expected Participants-50
4	Facility level Training on " Swachh Bharat Abhiyan" for DH	20,000	1 Per DH	1 day training for Cleanliness, infection Control and BMW management in District Hospital. Number of participants-100 Participants will be from members of Infection Control Committee, Members of Quality team and other facility staff.
5	Facility level Training on " Swachh Bharat Abhiyaan" for SDH/CHC	15,000	1 Per SDH	1 day training for Cleanliness, infection Control and BMW management in Sub District Hospital/CHC Number of participants-50 Participants will be from members of Infection Control Committee, Members of Quality team and other facility staff.
6	Facility level Training on " Swachh Bharat Abhinaya" for PHC	6,000	1 Per PHC	1 day training for Cleanliness, infection Control and BMW management in PHC Number of participants-20 Participants will be from members of Infection Control Committee, Members of Quality team and other facility staff.

7	External Assessors Training (For the State who has not conducted Awareness training in FY 2015-2016)	1 Lakh	1 Per state 2 for states having more than 30 districts	One day Master Training of State level external assessors for using the assessment tool. At least One official should be nominated from every district who can work as master trainer for district level workshop Expected participants-50 Large states having more than 30 districts may request for 2 External Assessors training
Assessment				
1	Internal Assessment DH	Rs. 2,000	1 per District Hospital in each quarter	Incidental cost for stationary, photocopying, printing reports meeting for preparation of action plan etc
2	Internal Assessment SDH/ CHC	Rs.1,000	1 per SDH/ CHC in each quarter	Incidental cost for stationary, photocopying, printing reports meeting for preparation of action plan etc
3	Internal Assessment PHC	Rs.500	1 per PHC in each quarter	Incidental cost for stationary, photocopying, printing reports meeting for preparation of action plan etc
4	Peer Assessment DH	Rs.25,000	1 per District Hospital	All facilities that scored more than 70% during internal assessment and at least once a time for all DH facilities.
5	Peer Assessment SDH/CHC	Rs.13,000	1 per SDH/ CHC	All facilities that scored more than 70% during internal assessment and at least once a time for all SDH/CHC facilities.
6	Peer Assessment PHC	Rs.5,000	1 per PHC	All facilities that scored more than 70% during internal assessment and at least once a time for all PHC facilities.

7	External Assessment of DH	Rs.61,000	30% of the total District Hospitals or based on State experience in FY 2015-16	Cost of external assessment for short listed DH having 70% score in internal assessment.
8	External Assessment of SDH/CHC	Rs.35,000	30% of the total SDH/ CHC or as per initial score of SDH/CHC	Cost of external assessment for short listed SDH/ CHC having 70% score in internal assessment.
9	External Assessment of PHC	Rs.8,000	30% of the total PHC or as per initial score of PHC	Cost of external assessment for short listed PHC having 70% score in internal assessment.
Contingencies				
1	Contingency for large states	Rs.10,00,000	Per state	Untied fund for organising meeting of state award committees, monitoring visits, travel to attend national level meetings & any other activity carried out to implement Swachh Bharat Abhiyan
2	Contingency for small states	Rs.2,00,000	Per state	Untied fund for organising meeting of state award committees, monitoring visits, travel to attend national level meetings & any other activity carried out to implement Swachh Bharat Abhiyan

Kayakalp Norms for Urban Health			
Sr No	**Particulars**	**Unit Cost (RS)**	**Budget (in Lakh)**
Awards			
	Best UCHC	One UCHC	15,00,000
1	Runner up UCHC (If Applicable)	One UCHC	10,00,000
2	Commendation Award for all UCHC	No. of UCHCs	1,00,000
3	Award for Best UPHC	UPHC/Cluster	2,00,000
4	1st Runner up UPHC (if Applicable)	UPHC/Cluster	1,50,000
5	2nd Runner up UPHC (if Applicable)	UPHC/Cluster	1,00,000
6	Commendation Award for all winner UPHC	No. of UPHCs	50,000
Assessment			
1	Internal Assessment of UCHC	Per UCHC	1000
2	Peer Assessment of UCHC	Per UCHC	13000
3	External Assessment of UCHC	Selected UCHC	35000
4	Internal Assessment of UPHC	Per UPHC	500
5	Peer Assessment of UPHC	Per UPHC	5000
6	External Assessment of UPHC	Selected UPHC	8000
Training			
1	Facility Level training on Swachh Bharat Abhiyan for UCHC	1 Per UCHC	15,000
2	Facility Level training on Swachh Bharat Abhiyan for UPHC	1 Per UPHC	6000
3	Swachh Swath Sarvatra	1 Per UCHC 1 Per UPHC	10,00,000 50,000

Annexure J
MEASURING & IMPROVING PATIENT SATISFACTION IN PUBLIC HEALTHCARE FACILITIES

Affirmation of the fact that citizens of the nation are satisfied with the provided healthcare services can only be done by capturing the "Voice of Patient or users". To capture the feedback of the users a robust system is required which accurately reflect key components of quality. It must include clean and hygienic environment yielding better health outcomes; empathetic communication between patients and healthcare providers; availability of drugs; waiting time; any out-of-pocket expenditure in public health facilities; clinical care provided by healthcare providers etc. Capturing user's /patient voice enables patients to provide feedback and also involve them in making the health care system more accountable to their needs.

To take the feedback, MOHFW has launched Mera Aspataal Application in 2017. As on Feb 2021 the application is used by 7700 HCF in 34 states/UTs.

Other than Mera Aspataal, all the public healthcare facilities are supposed to calculate their monthly patient satisfaction scores manually if they are not integrated with Mera Aspataal.

The methodology to calculate PSS manually & background of Mera Aspataal is given below:

i. Mera Aspataal (My Hospital) Application:

Towards addressing this gap, an open-source, ICT based, multi-channel (SMS, Out Bound Dialling, Mobile app, and Web portal), multi-lingual, simple and intuitive patient feedback system entitled Mera-Aspataal (My Hospital) was developed.

The Mera Aspataal aims to; (i) Establish a patient-driven responsive and accountable health care system; (ii) Establish a mechanism to rank health facilities based on a Patient Satisfaction Score (PSS); (iii) Improve the quality of care at healthcare facilities; (iv) Foster an environment of healthy competition among providers; and (v) Boost staff morale by recognizing top-ranking facilities.

Implementation of the Practice

The application for Mera Aspataal is hosted on the National Informatics Centre (NIC) cloud and is integrated with the online/manual patient registration system at the facility. All integrated facilities share the demographics data (mainly mobile or landline number) of outpatients and inpatients (patients discharged on that given day) with the Mera Aspataal network on a particular day.

Next day, an SMS is sent to the phone number of patients, seeking their feedback on the services availed in terms of "very satisfied", "satisfied", or "not satisfied". Patients replying

'not satisfied' receive an OBD call to share their feedback on reasons for the same. In case a reply is not sent to the SMS, an OBD call is sent to capture the feedback from the beginning. A mobile app and web portal are also available for patients with smartphone and internet access to provide feedback through.

A user-friendly dashboard has been developed which can be accessed by relevant stakeholders at the national, state and facility levels, to help the facilities understand the major reasons for dissatisfaction with the services and to act upon them. This dashboard enables the users to generate and download the performance reports. In addition, weekly and monthly reports are being automatically generated and dispatched to the email addresses of Mera Aspataal focal points at all the facilities.

MoHFW has made the Patient Satisfaction Score (PSS) as one of the critical criteria for National Quality Assurance Standards (NQAS) certification of the public health facilities. In addition, District Hospital Ranking System of MOHFW and NITI Ayog incorporated PSS as one of the 9 outcome indicators.

In addition to this, an online quality improvement module based on Mera Aspataal patient feedback is under process of piloting, which will help the facility level stakeholders to identify the gaps based on dissatisfaction and generating action plans on a quarterly basis, which will be monitored at the State and National level. Mera Aspataal is also in process of integrating with Tuberculosis, HIV and Maternal and Child health programmes of MOHFW for capturing specific feedback to improve the quality of services provided as part of these programmes.

ii. Manual Process for Patient Satisfaction Measurement

To measure the patient feedback at facility level, require scientific methodology and a system to implement. A comprehensive PDCA methodology is followed for its measurement and action planning where facility use pre-defined PSS formats (for both OPD and IPD patients) and take the feedback based on the sample size defined below. After collecting the feedback, the data is analysed, and action is taken on lowest performing attributes.

Methodology

Patient/Client satisfaction surveys are an integral part of Quality Improvement program at facility level. It gives the valuable information about patient perception and experience about the quality services, which of course will guide service providers to further improve the processes and service delivery. Apart from taking patient feedback a Patient Satisfaction improvement program includes analysing feedback given by patients, root cause analysis to identify the causes of low satisfaction, preparing action plan and taking corrective actions to complete the continual improvement cycle (Plan-Do-Check -Act). Following is a brief description of different steps for patient satisfaction program, as shown in Figure J.1.

1. Plan:

a. **Periodicity:** Plan for frequency of Patient Satisfaction Survey. Large secondary care hospitals like districts hospitals can have survey on monthly basis. Smaller facilities like PHC and CHC may take patient satisfaction on quarterly basis.

b. **Stationary:** Translate patient satisfaction survey in local language and ensure that formats are available in adequate no. at OPD clinics/registration counter/May I Help

you desk and Nursing station in ward. The above-mentioned formats can be used for conducting outpatients and In-patient's satisfaction survey.

c. **Responsibility:** Designate who will be taking and collecting feedback. Hospital Manager / Quality Manager may be responsibility to coordinate the program

d. **Sample Size:** For getting valid results sample size should be adequate. Following table gives simple guidance how much should be the Sample size based on patient load in previous quarter. It should not be less than 30 for being statically valid.

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

2. Do:

Patient feedback should be taken as per decided plan and sample size. While taking feedback it should be taken care of that all departments are equally covered specially the services having high case load like ANC clinic, Maternity ward etc. Feedback should also represent patient those cannot give feedback by their own like illiterates, disabled and children through affirmative measures like verbal feedback from illiterate patients and feedback from parents for new-born and children. Exit feedback should be preferred from who have already availed the services e.g. Like at Pharmacy counter for OPD and at the time of discharge in IPD. Filled forms should be collected and submitted to coordinator.

3. Check:

Feedback collected should be collated and analysed. Analysis should generate overall as well as area/ attribute wise score. Lowest performing two attributes should be identified and root cause analysis should be done for them.

4. Act:

Action plan should be prepared on causes identified during root cause analysis including corrective and preventive action to be taken, timeline and person responsible for taking action. Compliance to action should be reviewed monthly.

Following illustration shows the process and steps of Patient Satisfaction Improvement Program:

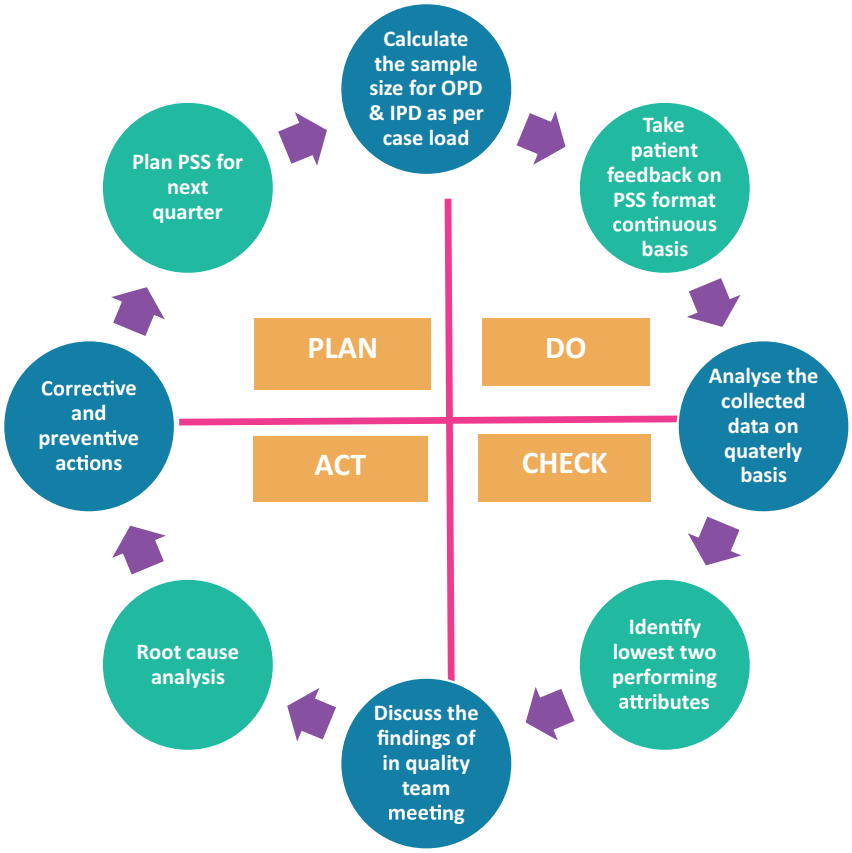

Figure J.1: Manual Process of Patient Satisfaction Measurement

OPD Patient Feedback Format

Dear Client,

You have spent your valuable time in the hospital in connection with your / relative's/ friend's treatment. You are requested to share your opinion about the quality of services, which you experienced, while visiting the hospital. The information provided by you would be kept confidential and would only be used for improving the services.

Please tick the appropriate box and drop the questionnaire in the Suggestion box

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					

1. What improvement would you like to see in the hospital?

2. What made you come to this hospital for treatment?

3. Would you like to return to this hospital next time for treatment?

4. Your valuable suggestions

Date _____ Clinic_____ Age _____Sex_____

Inpatient Feedback Format

Dear Client

You have spent your valuable time in the hospital in connection with your / relative's/ friend's treatment. You are requested to share your opinion about the quality of services, which you experienced, while staying in the hospital. The information provided by you would be kept confidential and would only be used for improving the services.

Please tick the appropriate box and drop the questionnaire in the Suggestion box

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					

Sl. No.	Attributes	Poor (1)	Fair (2)	Good (3)	Very Good (4)	Excellent (5)
15	All prescribed drugs were made available from Hospital supply					
16	Availability of Diagnostics					
17	Timeliness of supply of the diet and its quality					
18	Your overall satisfaction during the treatment as an in-patient					

1. What improvement would you like to see in the hospital?

2. What made you come to this hospital for treatment?

3. Would you like to return to this hospital next time for treatment?

4. Your valuable suggestions

Date _____Ward_____ Age _____Sex_____ Date of Admission _____

Annexure K
RAPID IMPROVEMENT EVENT: CASE SCENARIO

A Primary Health Centre XYZ is aspiring for improving Quality of health care services being provided at their facility. In alignment, facility has initiated implementation of various activities mentioned under National Quality Assurance Standards.

For undertaking activities facility formulated its Quality Team consisted of Medical Officer (2), Nurse (2), a Pharmacist, a Lab technician, and a housekeeping staff. The team chose Smt. Reeta, a Quality enthusiast, Nurse as their leader to undertake all the activities. The facility decided to keep first Saturday of every month for Quality team meetings, where they meet to share & discuss the status of QA activities. The team leader -Medical officers (who have received the training for Quality from DQAC) has also conducted an in-house training for the staff covering details of NQAS, its assessment and implementation methodology.

To initiate, facility conducted a baseline survey using NQAS checklist and found out various gaps, which were hampering the provision of

quality services to the health seekers. One of the critical gaps was no practice of measuring Patient Satisfaction Score. Team leader Smt. Reeta decided that she along with Mr. Hari (Pharmacist) will undertake this monthly activity which shall be part of monthly discussion of QT meeting.

Smt. Reeta developed a survey format in local language for both OPD and IPD patients. The team decided that Smt. Reeta will collect the information from IPD patients (30) over the month and Mr. Hari will undertake the activity for OPD patients (30). The data was collected and analyzed. The average (mean) was found out for each attribute and the overall PSS was also calculated. Findings of OPD Patient survey have been shared in **Table K.1** below:

PHC XYZ, PATIENT SATISFACTION SCORE, Jan'2019																																		
S. No	Attributes	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	P11	P12	P13	P14	P15	P16	P17	P18	P19	P20	P21	P22	P23	P24	P25	P26	P27	P28	P29	P30	AVERAGE
1.	Availability of sufficient information in Hospital (Directional & Location signages, Registration counter, Laboratory, Radiology Department, Dispensary, etc)	5	3	3	5	2	5	5	4	5	5	3	5	5	2	2	3	4	5	2	5	2	2	3	2	5	2	3	3	5	5	3.7
2.	Waiting time at the registration counter	2	2	3	2	5	3	4	5	4	4	2	5	2	5	2	3	2	2	5	3	5	2	5	5	1	5	1	5	2	2	3.3
3.	Behaviour and attitude of Hospital Staff	5	5	5	5	5	5	5	4	5	5	5	4	5	5	5	5	4	4	5	4	5	4	5	4	5	5	4	5	5	5	4.7
4.	Amenities in waiting area (chairs, fans, drinking water and cleanliness of bathrooms & toilets)	5	5	5	5	5	5	5	5	5	3	5	5	4	5	3	5	4	3	5	5	5	5	5	5	4	4	4	4	4	4	4.5
5.	Attitude & communication of Doctors	5	5	4	5	5	5	3	4	5	5	5	3	5	3	5	5	5	5	4	5	5	4	5	4	5	5	5	5	5	5	4.6
6.	Time spent on consulting, examination and counselling	5	5	5	2	5	5	5	5	3	5	5	4	5	3	5	5	5	5	4	5	5	5	5	4	5	4	5	5	5	5	4.6
7.	Availability of Lab and Radiology investigation facilities within the hospital	5	5	5	5	5	5	4	5	4	5	5	5	5	4	5	5	5	5	5	4	5	3	5	4	5	3	5	5	5	5	4.7
8.	Promptness at Medicine distribution counter	5	3	5	5	3	5	5	5	3	5	5	5	3	5	5	3	5	2	5	5	2	5	5	5	5	5	2	5	5	5	4.4
9.	Availability of prescribed drugs at the hospital	5	5	5	5	4	4	1	5	2	1	5	5	1	5	5	1	5	5	5	5	5	5	3	5	5	5	3	5	5	4	4.1
10.	Your overall satisfaction during the visit to the hospital	3	5	5	5	5	4	5	4	5	4	5	4	5	5	3	5	5	3	3	5	3	5	3	5	5	3	5	3	5	3	4.3
4.3																																		

Table K.1: Patient satisfaction score.

As depicted, the overall PSS is 4.3 and the two lowest scoring attributes are:

S. No.	Attributes	Average
1	Availability of sufficient information in Hospital (Directional & location signages, Registration counter, Laboratory, Radiology Department, Dispensary, etc)	3.7
2	Waiting time at the registration counter	3.3

The quality team decided to undertake the improvement process using this as the baseline information, for the two lowest scoring attributes. The team decided to work on both the attributes simultaneously. However, for understanding purpose their journey of improving PSS on "Waiting time at registration counter" is shared below:

1. Gap Identification:

As found out through the patient satisfaction survey the attribute in which many patients were dissatisfied was found out to be "Waiting time at the registration counter" (with 3.3 /5 as its baseline score).

So, in order to improve this, it becomes important to first find out the current (baseline) time a patient is spending in queue for the registration counter while waiting for his / her turn to get registered for availing OPD services in the hospital.

To measure baseline waiting time, the team then mapped /calculated time for 5 patients (randomly) from entry in the hospital till his registration at the counter.

The timings of these 5 patients and overall waiting time are shared in the table below:

	Time spent from entry till registration (minutes)
Patient 1	25
Patient 2	35
Patient 3	25
Patient 4	30
Patient 5	25
Average	28

So, from baseline survey it was clear that patients are spending 28 minutes (average) while waiting for their turn to get registered at the counter.

2. Setting-up an objective:

As a principle for undertaking improvement activities the Quality team first need to develop a SMART objective (Specific, Measurable, Achievable, Realistic and Time Bound).

The facility then formulated their objectives; the primary objective they developed was:

Primary objective:

To increase Patient Satisfaction Score of attribute "Waiting time at the registration counter" from baseline rate of 3.3/5 to 4/5 in two months (March'2019).

While this was the primary objective but to improve this, facility had to work on the current (baseline) waiting time for which they formulated their second objective:

Secondary Objective:

To reduce Patients' waiting time at registration counter from current 28 minutes (average) to 15 minutes in two months (March'2019).

3. Root Cause Analysis:

So, it was clear that the quality team will work on improvement of secondary objective which shall ultimately support the improvement of Primary objective (i.e., Patient Satisfaction Score).

Quality team was well versed with the quality tools and methods. The quality team brainstormed to find out various reasons for the high waiting time at the registration counter. The team leader noted down all the probable reasons and then prepared the fish bone diagram (cause and effect diagram) for addressing the issue **(Figure-K.1)**.

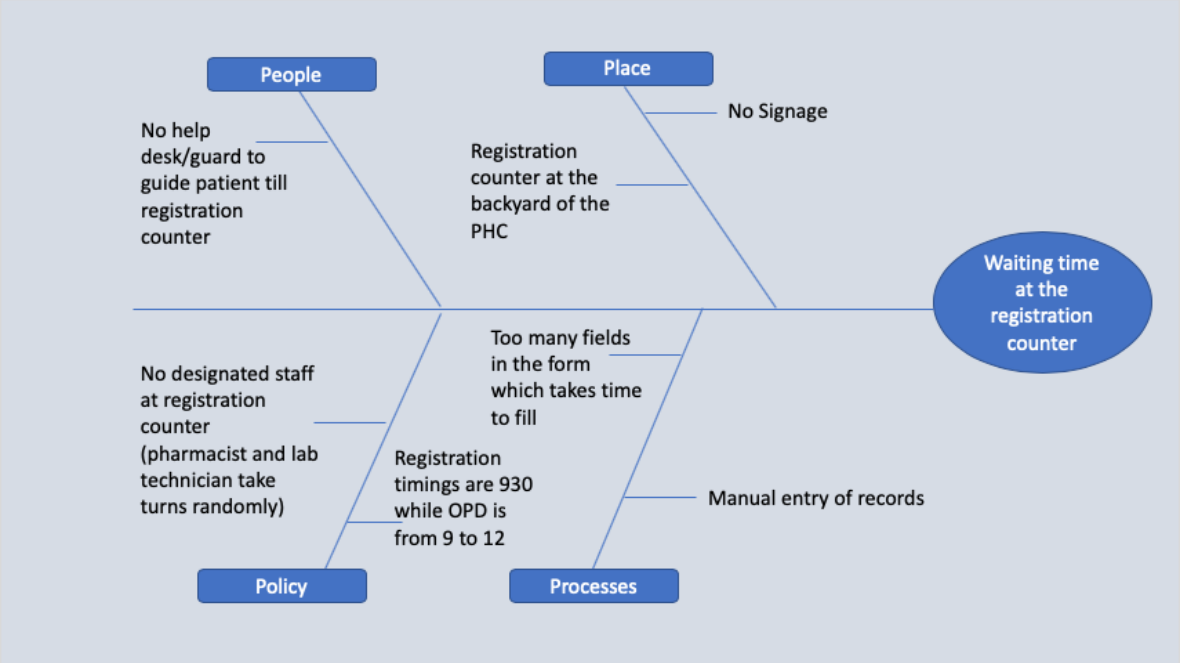

Figure K.1: Root cause analysis

Once the probable reasons of long waiting time were listed; the quality team again undertook the brainstorming activity to find out/develop certain change ideas. Along with the listing of these change ideas it was important to plan the testing of change ideas to evaluate if these ideas are going to bring out the improvement or not.

4. Setting up the measuring indicators:

The Quality team initiated working for the primary and secondary objective and decided to check effectiveness and efficiency of the change idea by using some intermediate measuring indicators while running various PDCA cycles.

(This is also to be understood that apart from the Primary and secondary objective, team shall be using some other measuring indicator (quantitative and qualitative) to test various change ideas in PDCA. Team will also take into account other factors like feasibility of doing, resource expenditure etc. while deciding the change idea is going to be part of the system or not.)

Monitoring through making time -series/ run chart:

I. Team decided to take random sample of 10 patients daily during OPD hours to know the change in waiting time for getting registered at the registration counter. Using this information team decided to develop the time- series chart to evaluate the impact.

II. While team also, decided to simultaneously monitor the primary objective by assessing it weekly by drawing random sample of 10 patients spread over the week.

5. PDCA Cycles:

To check the impact of the change idea it becomes pertinent to plan its execution, execute the idea as per the plan, decide upon indicators to check its impact and to act upon further accordingly.

The team tested their change ideas over the period of two months. Each change idea was tested on small scale (4-7 days). The impact of each change idea was evaluated, and it was decided accordingly whether to accept the idea, tweak a bit and then accept or discard the idea. The table below gives description of various PDCA which team undertook (to be correlated with time series chart):

PDCA Cycle No.	Plan	Do	Check	Act	Impact
1	Shifting of registration counter near front of the PHC gate	The team shifted the registration counter near PHC entrance	• Secondary objective was monitored • Three patients were asked (who were regular in the hospital) regarding approachability to the counter	Accepted	Positive Impact
2	Change of registration timings (OPD timings were 9:00 AM to 12: 00 noon but registration timings were 9:30 AM onwards)	Registration timings were made from 8:30 AM to 11:30 AM	• Secondary objective was monitored	Accepted	Positive Impact

3	Allocating registration responsibility to Lab Technician (LT)	The LT was allocated responsibility to do registration	• Secondary objective was monitored • It was noted the impact of allocating the responsibility to LT also affected the functions of lab and hence was not sustainable	Required tweaking	Impact on waiting time positive/ moderate but Lab functions affected
4	Appointing New Data entry operator	Temporarily a data entry operator was appointed on daily wages for 4 days to make entries	• Secondary objective was monitored	Discarded as it required extra resources	Change idea was Discarded as it was resource intensive
5	Roster for Lab Technician and Pharmacist for rotation services at registration counter	Roster was made for Lab technician and pharmacist (2 hourly services)	• Secondary objective was monitored	Accepted	Positive impact
6	Revision of the OPD registration format (the current format was time taking as it was required to fill too much information by the registration clerk)	Simple, user friendly and easy to use format was developed by team	• Secondary objective was monitored • Also, it was checked to correlate that no information has been missed (corrections were made in between the PDCA phase)	Accepted	Positive impact
7	Signage for easy movement	Broad and clear signages (directional and mentioning registration counter were made and displayed)	• Secondary objective was monitored • 5 patients (availing the OPD services were asked if the signages are useful? to which affirmative response was gathered)	Accepted	Positive impact
8	Building two counters for registration	Team planned for building a separate cabin	• Secondary objective was monitored	Discarded As it was resource intensive	

Results:

I. Average time was reduced to 19 minutes (approx.) in two months, as shown in **Figure K.1.**

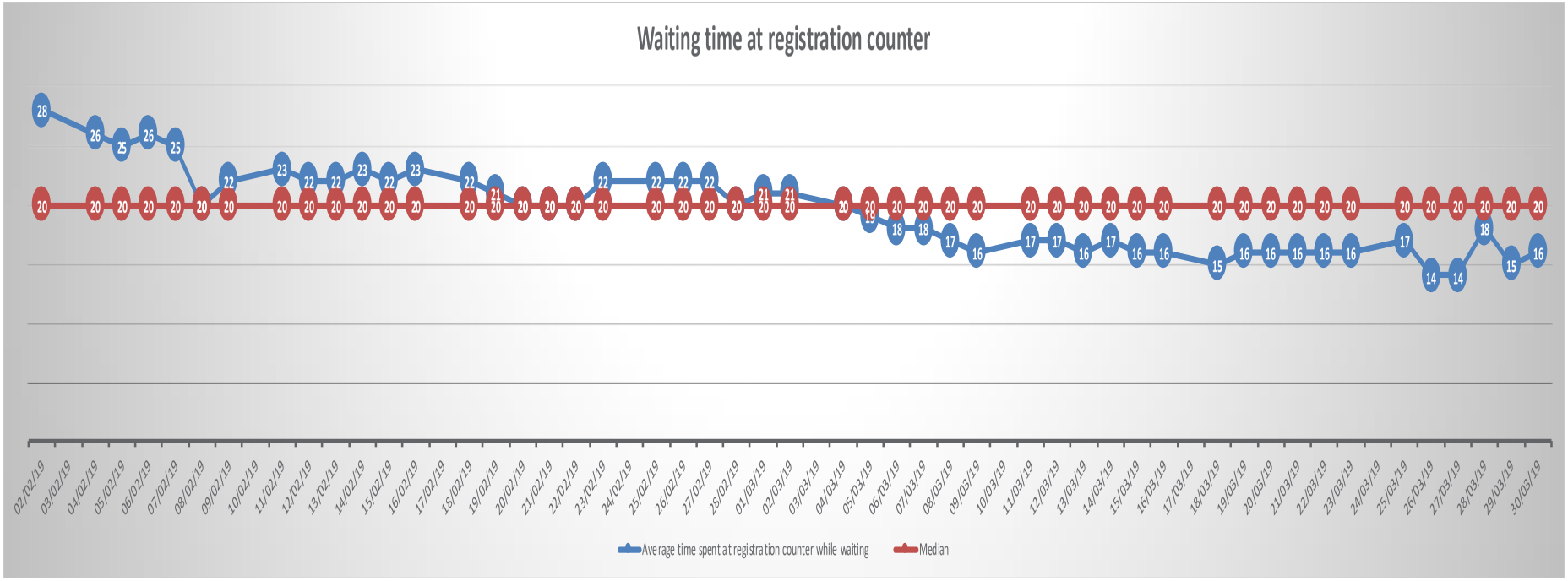

Figure K.2: Waiting at registration counter

II. The improvement was observed in patient satisfaction score from 3.3 to 3.7 (average), as shown in **Figure K.3**.

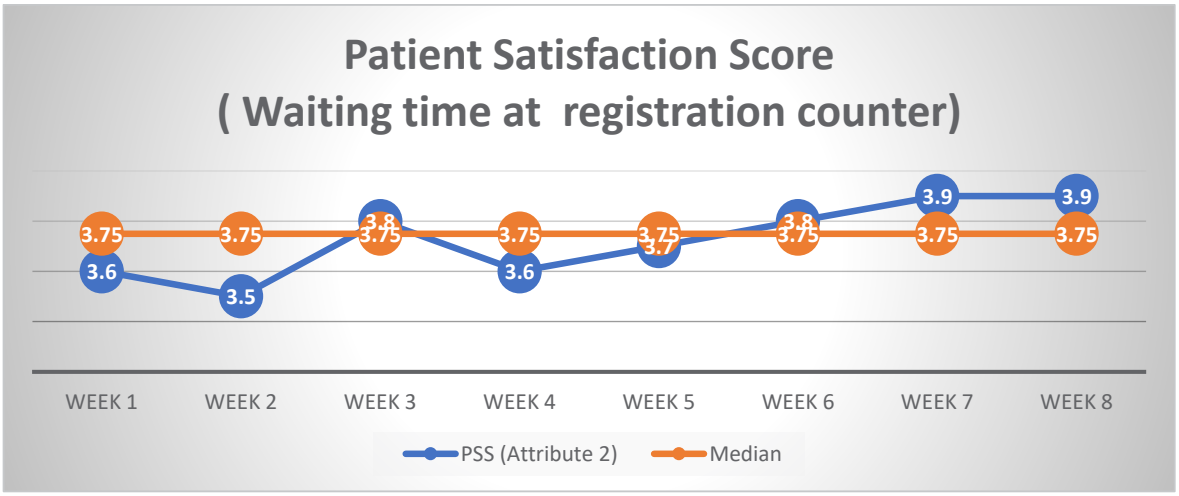

Figure K.3: Patient Satisfaction Score

Road Ahead:

1. Change ideas which brought positive impact were accepted and were incorporated in the system.
2. To ensure sustenance team decided to randomly check the primary and secondary objectives quarterly even after once the facility achieves satisfaction status.

Lessons Learnt:

1. Indicators (Quantitative and Qualitative) are the backbone for undertaking improvement cycle, we need to listen to them.
2. Change ideas need to be tested before incorporating them in the system.
3. Sustenance is more important!

Annexure L

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

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

Please fill the form in English only

<table>
<tr><td>1(a). Name of DH as per official records
1(b). NIN ID</td><td colspan="4"></td></tr>
<tr><td>2. Complete Postal Address with PIN</td><td colspan="4">:</td></tr>
<tr><td>3. Contact Details -</td><td colspan="4">Phone:
Mobile:
E mail:</td></tr>
<tr><td>a) SQAU</td><td colspan="4">i. Nodal Officer -
ii. Email –
iii. Tel –
iv. Score of the facility on SQAU Assessment -</td></tr>
<tr><td>b) DQAU</td><td colspan="4">i. Nodal Officer -
ii. Email –
iii. Tel –
iv. Score of the facility on DQAU Assessment -</td></tr>
<tr><td>c) Facility</td><td colspan="4">i. In-charge –
ii. Email –
iii. Tel –
iv. Score of the facility on internal assessment</td></tr>
<tr><td>4. Nearest Railway Station</td><td colspan="4"></td></tr>
<tr><td>5. Nearest Airport</td><td colspan="4"></td></tr>
<tr><td colspan="5">Details of Hospital</td></tr>
<tr><td rowspan="3">a. Application for Assessment under (please tick)</td><td colspan="2">• NQAS</td><td colspan="2"></td></tr>
<tr><td colspan="2">• LaQshya</td><td colspan="2"></td></tr>
<tr><td colspan="2">• Both</td><td colspan="2"></td></tr>
<tr><td rowspan="7">b. Existing functional departments</td><td>Number</td><td>vi.</td><td>xiii.</td></tr>
<tr><td>Name:</td><td>vii.</td><td>xiv.</td></tr>
<tr><td>i.</td><td>viii.</td><td>xv.</td></tr>
<tr><td>ii.</td><td>ix.</td><td>xvi.</td></tr>
<tr><td>iii.</td><td>x.</td><td>xvii.</td></tr>
<tr><td>iv.</td><td>xi.</td><td>xviii.</td></tr>
<tr><td>v.</td><td>xii.</td><td>Other-</td></tr>
</table>

c. Details of the Departments applied for certification	Number		xiii.
	Name:	vi.	xiv.
	i.	vii.	xv.
	ii.	viii.	xvi.
	iii.	ix.	xvii.
	iv.	x.	xviii.
	v.	xi.	xix.
		xii.	Other-
d. Number of Beds ***excluding floor beds**	i. Sanctioned beds		
	ii. Functional beds*		
e. Distribution of Beds ****excluding newb-born bassinets in Maternity ward, Observation beds, Floor beds, Labour room tables etc.**	i. Medical		
	ii. Surgical		
	iii. Gynae		
	iv. Maternity		
	v. Paediatrics		
	vi. Orthopaedics		
	vii. Ophthalmology		
	viii. ENT		
	ix. ICU		
	x. SNCU		
	xi. Others** (Please add)		
6. Maternal Health Services	d. Average Number of deliveries in a month		
	e. Average Number of Caesarean Section in a month		
	f. Average Percentage of deliv-eries (Normal/Caesarean) conduct-ed during night-time		
7. OPD Services (Please tick)	a) OPD Services available in the hospital for: b) General/ Medical/ Surgical/ Paediatrics/ Gynae. / Obs. / ARSH/ Family Planning/ Immunisation/ ICTC / any specialized service/Any other ----- c) Average OPD/ month • General OPD including RMNCH+A: • Speciality OPD (Orthopaedics, Eye, ENT, Dermatology, VD, Psychiatric etc.):		
9. Laboratory Services –	Average Number of tests conducted per month		

10. Radiological Services –	a) No. of X-ray machines b) No. of Ultrasound Machine c) CT Scan d) Any other	
11. IPD Services ****_including LAMA, Death, Referral, Absconding in the month_	a) Average in-patient bed*** days per month b) Average no of discharges**** per month c) Average number of LAMA per month d) Average number of Referral per month	
12. Mera-Asptaal score or PSS Patient Satisfaction Score calculate manually for preceding 3-months (on a Likert scale of 5)	• Month 1: • Month 2: • Month 3:	

***In-patient bed days is the head count of the patient who stays overnight in a hospital and to calculate the average bed-days of each day to be added for the month and divided by no of days in the month.

List of Documents to be submitted for DH/SDH Assessment

Name of the Documents	Status of submission
1. Filled application form along with Hospital data sheet	
2. No. & Names of the Department to be assessed	
3. Latest State Assessment Report and scores.	Yes/No
4. Minutes of last Quality Team meeting (MOM).	Yes/No
5. Departmental SOPs.	Yes/No
6. Quality Improvement Manual.	Yes/No
7. Copy of Hospital Wide Policies/ Procedures. (Government Order/ Single Pager Policy / Procedures)	
• Vision, Mission, Values, Strategic Plan and Quality Policy	Yes/No
• Condemnation Policy.	Yes/No
• Antibiotic policy.	Yes/No
• End of Life care policy	Yes/No
• Social, Culture and Religious Equality policy.	Yes/No
• Privacy, Dignity and confidentiality policy of patient.	Yes/No
• Consent policy.	Yes/No
• Prescription by Generic Name policy.	Yes/No
• Adverse Event reporting policy.	Yes/No
• Referral policy.	Yes/No
• Timely reimbursement of entitlements and compensation.	Yes/No
• Grievance Redressal policy.	Yes/No
• Free treatment to BPL patient's procedure/ policy.	Yes/No
8. Scores of Last 3 Patient Satisfaction Surveys and Subsequent Corrective and Preventive actions undertaken.	Yes/No
9. Last 3 months data of Key Performance Indicators (KPI).	Yes/No
10. Prescription/Medical Audit Analysis with Corrective and Preventive Action (CAPA)	Yes/No
11. Statutory/Regulatory Compliance (a) Authorization for handling the Bio medical Waste from pollution Control Board (b) Fire Safety NOC (c) Certificate of inspection of electrical Installation (d) License for operating lift (if applicable) (e) X-ray Layout Approval from AERB (f) License of Blood Bank (g) Copy of registration under PCPNDT Act	Yes/No

COMMUNITY HEALTH CENTRE/ URBAN COMMUNITY HEALTH CENTRE

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 CHC as per Official records) health facility in the district..... 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

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

Please fill the form in English only

1(a). Name of DH as per official records 1(b). NIN ID		
2. Complete Postal Address with PIN		
Contact Details	Phone: Mobile: E mail -	
3. Is the CHC functioning as FRU		
a) SQAU	i. Nodal Officer - ii. Email – iii. Tel – iv. NQAS Score of the CHC in SQAU Assessment -	
b) DQAU	i. Nodal Officer - ii. Email – iii. Tel – iv. NQAS Score of the CHC in DQAU Assessment -	
c) Facility	i. In-charge – ii. Email – iii. Tel – iv. NQAS Score of the facility in 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 in the CHC.	Number	vi.
	Name:	vii.
	i.	viii.
	ii.	ix.
	iii.	x.
	iv.	xi.
	v.	xii.

c. Details of the Departments applied for certification	Number	vi.
	Name:	vii.
	i.	viii.
	ii.	ix.
	iii.	x.
	iv.	xi.
	v.	xii.
d. Number of Beds in CHC ***excluding floor beds**	i. Sanctioned beds	
	ii. Functional beds*	
e. Distribution of Beds ****excluding newb-born bassinets in Maternity ward, Observation beds, Floor beds, Labour room tables etc.**	i. Female Ward	
	ii. Male Ward	
	iii. NBSU	
	iv. Others** (Please add)	
6. Maternal Health Services	g. Average Number of deliveries in a month	
	h. Average Number of Caesarean Section in a month	
	i. Average Percentage of deliveries (Normal/ Caesarean) conducted during night-time	
7. OPD Services (Please tick)	a) OPD Services are available in the hospital for: b) General Medicine/ Gynae. / Obs. / ARSH/ Family Planning/Any other -----	
	b) Average OPD/ month • General OPD including RMNCH+A:	
	c) Any Speciality clinical services	
	• General Surgery	
	• Paediatrics	
	• Ophthalmic	
	• Dental	
	• Geriatric	
	• Psychiatry	
	• NCD	

8. IPD Services *****including LAMA, Death, Referral, Absconding in the month*	a) Average in-patient bed*** days per month b) Average no. of discharges**** per month c) Average number of LAMA per month d) Average number of Referral per month.	
9. Laboratory Services	Average Number of Lab tests conducted per month	
10. Blood Transfusion Services	Number of blood transfusion done per month	
11. Radiological Services –	a) No. of X-ray machines b) No. of Ultrasound Machine c) Any other	
12. Mera-Aspataal score or PSS Patient Satisfaction Score calculate manually for preceding 3-months (on a Likert scale of 5)	• Month 1: • Month 2: • Month 3:	

***In-patient bed days is the head count of the patient who stays overnight in a hospital and to calculate the average bed-days of each day to be added for the month and divided by no of days in the month.

List of Documents to be submitted for CHC/UCHC Assessment

List of Documents	Name of the Facility
1. Filled application form along with Hospital data sheet	
2. No. and Names of departments to be assessed	
3. Latest State Assessment Report and scores.	Yes/No
4. Minutes of last Quality Team meeting (MOM).	Yes/No
5. Departmental SOPs.	Yes/No
6. Quality Improvement manual.	Yes/No
7. Policies/Procedures of the facility	8
• Condemnation Policy.	Yes/No
• Antibiotic policy.	Yes/No
• Social, Culture and Religious Equality policy.	Yes/No
• Privacy, Dignity and confidentiality policy of patient.	Yes/No
• Consent policy.	Yes/No
• Referral policy.	Yes/No
• Policy of timely reimbursement of entitlements and compensation.	Yes/No
• Quality Policy.	Yes/No
8. Scores of last 3 Patient satisfaction Surveys and subsequent Corrective and Preventive actions.	Yes/No
9. Last 3 months data of Key Performance Indicators	Yes/No
10. Prescription Audit Analysis with Corrective and Preventive Action (CAPA) report	Yes/No
11. Statutory/Regulatory Compliance (a) Authorization for handling the Bio medical Waste from pollution Control Board (b) Fire Safety NOC (c) Certificate of inspection of electrical Installation (d) License for operating lift (if applicable) (e) X-ray Layout Approval from AERB (f) License of Blood Storage Unit (g) Copy of registration under PCPNDT Act (if applicable)	Yes/No

PRIMARY HEALTH CENTRE/URBAN HEALTH CENTRE

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 the PHC as per official records) health facility in the district..... 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

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

Please fill the form in English only

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			
6. Type of PHC (24*7/Other as per state nomenclature)			
7. Category of PHC	With beds	If yes, no of beds:	
	Without beds	NA	
8. Service availability	a) OPD Services available in the hospital – General Medicine/ Family Planning/ Gynae/ Obs./ New-born/ ARSH/ Immunization/ Outreach/ NHP/ Any other -----	b) Average attendance in a month i. OPD ii. Emergency iii. Labour Room iv. Others	
9. Laboratory Services –	Average Number of tests conducted per month		
10. IPD Services	a) Average in-patient bed days per month b) Average no of discharges*** per month ***including LAMA, Death, Referral, Absconding in the month		
11. Mera-Aspataal score or PSS Patient Satisfaction Score calculate manually for preceding 3-months (on a Likert scale of 5)	• Month 1: • Month 2: • Month 3:		

***In-patient bed days is the head count of the patient who stays overnight in a hospital and to calculate the average bed-days of each day to be added for the month and divided by no of days in the month.

List of Documents to be submitted for PHC/UPHC Assessment

Name of the Documents	Status of submission
1. Filled Application form along with the Hospital data sheet	
2. Latest State Assessment Report and scores.	Yes/No
3. Minutes of last Quality Team meeting (MOM).	Yes/No
4. Departmental SOPs.	Yes/No
5. Quality Improvement Manual.	Yes/No
6. Copy of Hospital Wide Policies/ Procedures. (Government Order/ Single Pager Policy / Procedures)	4
• Quality Policy	
• Condemnation Policy.	Yes/No
• Maintaining of Patients Record, its security, sharing of information and safe disposal	Yes/No
• Referral Policy	Yes/No
7. Scores of Last 3 Patient Satisfaction Surveys and Subsequent Corrective and Preventive actions undertaken.	Yes/No
8. Last 3 months data of Key Performance Indicators (KPI).	Yes/No
9. Prescription Audit Analysis with Corrective and Preventive Action (CAPA)	Yes/No
10. 1. Statutory/Regulatory Compliance (a) Authorization for handling the Bio medical Waste from pollution Control Board (b) Pre-authorization from SPCB for sharp & deep burial pits in remote PHCs (if applicable) (b) Fire Safety NOC	Yes/No

Recertification of NQAS certified Health Facilities

Background

- National Quality Assurance Standards (NQAS) for various level of Public Health Facilities were launched for improving quality of care delivered at such facilities. These standards are available for District Hospitals, Community Health Centres, Primary Health Centres and Urban Primary Health Centres.
- Facilities meeting the minimum of eligibility criteria are certified and incentivized (Refer, DO letter no- NHSRC/13-14/QI/01/QAP dated 10th March 2017 and DO letter no- NHSRC/13-14/QI/01/QAP dated 24th May 2017 for details).
- The certified status once achieved is valid for a period of three years, subject to validation of compliances to the QA Standards by the SQAC team every year in subsequent two years (Refer, DO letter no- NHSRC/13-14/QI/01/QAP dated 24th May 2017).
- For continuation of the certified status, the facility is expected to undergo re-certification assessment by the national assessors as per the procedure given below.

Prerequisite

NQAS nationally certified health facilities, which had undergone surveillance assessment by the state team during subsequent two years and had demonstrated the NQAS compliance status, are eligible to apply for the NQAS re-certification.

Procedure for NQAS re-certification

1. The request for renewal must be submitted at least 3 months before expiry of validity of the existing certificate.
2. If the facility fails to apply at least two months before the expiry of current certificate, it shall be presumed that facility is not interested in undergoing the re-certification and then the certification status shall remain valid for a period as mentioned in the original certificate.
3. In case, the facility applies later after expiry of the validity period, then afresh application for the certification needs to be processed as per existing protocol for first time certification.
4. While applying for the re certification, the facility may increase the scope i.e., number of departments if the same were not assessed earlier.
5. Public Healthcare facilities may apply for recertification by filling the prescribed Application Form (Annexure A) along with submission of supporting documents (Annexure B). The norms pertaining to days of assessment, assessment protocol, norms for certification criteria, incentivisation, etc. remain same as of "Certification Process" (Refer- Guidelines for Certification of Public Health Facilities based on National Quality Assurance Standards).
6. Application along with the documents need to be sent to certification.nqas@gmail.com with cc marked to Dr J N Srivastava ,Advisor- QI (NHSRC) at jn.nhsrc@gmail.com and respective state consultant .

7. The certificate issued to the facility after re-assessment shall be valid for three years. Criteria for certification and incentive amount shall remain same as mandated by the Central Quality Supervisory Committee (Refer, DO letter no- NHSRC/13-14/QI/01/QAP dated 10th March 2017).

Ineligibility for Recertification:

1. Non closure of conditionalities, as found during previous assessments.
2. Absence of surveillance assessments and its evidence.
3. Facilities not meeting the CQSC approved certification criteria in subsequent surveillance assessments by SQAC / NHSRC.
4. Improper use of NQAS certified status.
5. Downgrading of scope of services.
6. Unethical practices and regulatory non-compliances.

APPLICATION FORM FOR RE-CERTIFICATION UNDER NATIONAL QUALITY ASSURANCE STANDARDS

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 RE- CERTIFICATION UNDER NATIONAL QUALITY ASSURANCE STANDARDS

Sir,

Our facility ..... (Name) was certified as per National Quality Assurance Standards on ..... (Date).

Name of Health Facility

Full Address

Now, in continuation with efforts for sustaining "Quality" in our health facility as per National Quality Assurance Standards, we are happy to inform that we wish to apply for re- certification.

The health facility has successfully undergone surveillance assessments during previous two years by SQAC and assessment reports dated ------ and -------- are attached herewith.

Hence, we request you to issue instructions for assessment of the health facility for the NQAS re-certification. Detail information about the health facility is given in the attached annexure.

Thanking you.

Yours sincerely

(.....)

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

1. a) Full Name of Health Facility b) Category of the facility (DH/ SDH/CHC/ PHC (24*7)/any other please specify) c) NIN ID	Name: Category: NIN ID:
2. Full Address with PIN Code	
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 –
4. Nearest Railway Station	
5. Nearest Airport	
6. Certification Status a) NQAS (Certificate number, date of certification and Validity Period) b) Any other certification (Name, Certificate number, date of certification and Validity Period)	C. No.- Date- Validity period - Name- C. No.- Date- Validity period -
7. Name and No. of departments which have been certified earlier (as mentioned on previous certificate)	Number- Name -

8. Any addition of department/s for assessment in re- certification	Number – Name-			
9. a) Number of Beds *excluding floor beds	i. Sanctioned beds			
	ii. Functional beds*			
b) Distribution of Beds **excluding new-born bassinets in Maternity ward, Observation beds, Floor beds, Labour room tables etc.	i. Medical- ii. Surgical- iii. Gynae- iv. Maternity- v. Paediatrics- vi. Orthopaedics- vii. Ophthalmology- viii.ENT- ix. ICU- x. SNCU- xi. Other** (Please add)-			
10. Maternal Services	a. Number of deliveries in a month (average)- b. Number of Caesarean Section in a month (average)- c. Percentage of deliveries in night (Average)-			
11. Radiological Services	a. No. of X-ray machines- b. Ultrasound availability- c. CT Scan- d. Any other -			
12. IPD Services	a) Average no of discharges per month b) Average number of LAMA per month c) Average number of Referral per month			
13. Patient Satisfaction score of Preceding Three months and Sample size		Month 1	Month 2	Month 3
	Patient Satisfaction Score			
	Sample size			

Documents to be attached:

1. SQAC Verified (year wise)–

   A. Detailed assessment report of last two surveillance assessments (date and team members name to be mentioned) as per the guidelines.

   B. Post surveillance action taken.

   C. Key performance Indicators for each of the preceding 12 months.

   D. Evidence (pictures etc.) for assurance of provision of quality services to the health seekers (Display of certificate, Logo placement at main board and at other relevant signages, inclusion in citizen charter and display of logo in all hospital stationary -OPD slip, case sheet etc.)

2. SOP of departments which shall be taken up for first time for the assessment.

3. Status of Current SOP, Manual and Policies-

S. No.	Name of Departmental SOP/ Policy/ Manual	Date of Revision
1		
2		
3		
4		

Annexure M

Certification Criteria for the Facilities:

Following criteria for Certification of Health facilities are applicable: -

A. Certification of DH

I. Criterion 1 - Aggregate score of the health facility ≥ 70%

II. Criterion 2 – Score of each department of the health facility ≥ 70%

III. Criterion 3 – Segregated score in each Area of Concern (Service Provision, Patient's Right, Inputs, Support Services, Clinical Services, Infection Control, Quality Management, Outcome Indicator) ≥ 70%

IV. Criterion 4 – Score of Standard A2, Standard B5 and Standard D10 is >70% in each applicable department.

- Standard A2 States "The facility provides RMNCHA services".
- Standard B5 states that "the facility ensures that there are no financial barriers to access, and that there is financial protection given from the cost of hospital services".
- Standard D10 states "the facility is compliant with all statutory and regulatory requirement imposed by local, state or central government."

V. Criterion 5 - Individual Standard wise score ≥ 50%

VI. Criterion 6 – Patient Satisfaction Score of 70% in the preceding Quarter or more (Satisfied & Highly Satisfied on Mera-Aspataal) or Score of 3.5 on Likert Scale

B. Criteria for Certification of CHC/U-CHC

Criterion I - Aggregate score of the health facility ≥ 70%

Criterion II – Score of each department of the health facility ≥ 70%

Criterion III – Segregated score in each Area of Concern (Service Provision, Patient's Right, Inputs, Support Services, Clinical Services, Infection Control, Quality Management, Outcome Indicator) ≥ 70%

Criterion IV – Score of Standard A2, Standard B5 and Standard D8 is >60% in each applicable department.

- Standard A2 States "The facility provides RMNCHA services".
- Standard B5 states that "the facility ensures that there are no financial barriers to access, and that there is financial protection given from the cost of hospital services".
- Standard D8 states "the facility is compliant with all statutory and regulatory requirement imposed by local, state or central government."

Criterion V - Individual Standard wise score ≥ 50%

Criterion VI – Patient Satisfaction Score of 65% in the preceding Quarter or more (Satisfied & Highly Satisfied on Mera-Aspataal) or Score of 3.2 on Likert Scale

C. Certification for PHC/U-PHC

Criterion I - Aggregate score of the health facility ≥ 70%

Criterion II – Segregated score in each Area of Concern (Service Provision, Patient's Right, Inputs, Support Services, Clinical Services, Infection Control, Quality Management, Outcome Indicator) ≥ 60%

Criterion III – Score of Standard A2, Standard B5 and Standard F6 (PHC)/F4 (U-PHC) is >60% in each applicable department.

- Standard A2 (PHC/U-PHC) states "The facility provides RMNCHA services".
- Standard B4 (PHC) states that "the facility ensures that there are no financial barriers to access, and that there is financial protection given from the cost of hospital services". OR B3 (U-PHC) states that "The Services provided are affordable".
- Standard F6 (PHC)/F4 (U-PHC) states "the facility has defined and established procedures for segregation, collection, treatment and disposal of Biomedical & Hazardous Waste".

Criterion IV - Individual Standard wise score ≥ 50%

Criterion V – Patient Satisfaction Score of 60% in the preceding Quarter or more (Satisfied & Highly Satisfied on Mera-Aspataal) or Score of 3.0 on Likert Scale.

D. Certification for Health & Wellness Centre- Health Sub Centre

1. Criterion I - Aggregate score of the health facility- ≥ 70%
2. Criterion II- Score of each service package of the health facility (minimum 7 packages*) ≥ 70%.
3. Criterion III- Segregated score in each Area of Concern (Service Provision, Patient's Right, Inputs, Support Services, Clinical Services, Infection Control, Quality Management, Outcome Indicator) ≥ 60%
4. Criterion IV- Score of Standard - ≥60%
    a. Standard A1- The facility provides Comprehensive Primary Healthcare Services
    b. Standard D3- The facility has defined and established procedure for clinical records and data management with progressive use of digital technology.
    c. Standard D4- The facility has defined and established procedures for hospital transparency and accountability.
    d. Standard D5- The facility ensures health promotion and disease prevention activities through community mobilization.
    e. Standard G2- The facility has established system for patient and employee satisfaction.

5. Criterion V- Individual Standard wise score- ≥ 50%

6. Criterion VI- Patient/client Satisfaction Score - 60% or Score of 3.0 on Likert Scale, separately

Award for Certification: -

For DHs/SDHs/CHCs/UCHCs: -

a) Certification – If health facility meets all of above-mentioned criteria.

   ✓ 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.

b) Certification with Conditionality – If a Health Facility's aggregate score is 70% or more (Criterion I), and also meets at least three criteria out of remaining five (Criterion II, III, IV, V & VI).

c) Deferred Certification – The certification may be deferred until follow-up assessment if Hospital overall score is 70% in external assessment but does not meet the criteria for conditional certification as mentioned in Para (b) above. The window for follow-up assessment will be from 6 months to one year from the date of declaration of external assessment result.

d) Certification declined - If hospital does not score 70% in external assessment the certification will be declined. The hospital may freshly apply for certification but not before one year of declaration of external assessment result.

For PHCs/UPHCs: -

a) Certification – If the health facility meets all of above-mentioned 5 criteria of PHCs/ UPHCs.

b) Certification with Conditionality – If a Health Facility's aggregate score is 70% or more (Criterion I), and also meets at least three criteria out of remaining four (Criterion II, III, IV & V).

c) Deferred Certification – The certification may be deferred until follow-up assessment if Health facility's overall score is 70% in external assessment but does not meet the criteria for conditional certification.

For HWC-HSC: -

a) Certification – If the health facility meets all of above-mentioned 6 criteria of PHCs/ UPHCs.

b) Certification with Conditionality – If a Health Facility's aggregate score is 70% or more (Criterion I), and also meets at least three criteria out of remaining five (Criterion II, III, IV, V & VI).

c) Deferred Certification – The certification may be deferred until follow-up assessment if Health facility's overall score is 70% in external assessment but does not meet the criteria for conditional certification.

For State level certification score of above-criteria may be reduced by 5%.

*** Minimum 7 packages as per Certification Criteria of HWC- HSC**

1. Care in pregnancy and childbirth.
2. Neonatal and infant health care services.
3. Childhood and adolescent health care services.
4. Family planning, Contraceptive services and other Reproductive Health Care services.
5. Management of Communicable diseases including National Health Programmes.
6. Management of Common Communicable Diseases and Outpatient care for acute simple illnesses and minor ailments.
7. Screening, Prevention, Control and Management of Non-Communicable diseases.

Annexure N

GLOSSARY

Certification	A formal process by which an Independent and recognized body, assesses and recognizes that a health care organization meets applicable pre-determined and published standards. Certification standards are usually regarded as optimal and achievable, and are designed to encourage continuous improvement efforts within accredited organizations. Certification is often a voluntary process in which organizations choose to participate, rather than one required by law and regulation.
Action plan	Specific actions that respond to short- and longer-term strategic objectives
Analysis	An examination of facts and data to provide a basis for effective decision (s).
Approach	It includes the appropriateness of the methods to the Item requirements and to the organization's operating environment, as well as how effectively the methods are used.
Capacity building	Planned development of (or increase in) knowledge, management, skills, and other capabilities of an individual/organization through acquisition, incentives, technology, and/or training.
Certification	A process by which an authorized body, either a governmental or non-governmental organization, evaluates and recognizes either an individual or an organization as meeting pre-determined requirements or criteria. Certification usually applies only to organizations, while certification may apply to individuals, as well as to organizations. When applied to individual practitioners, certification usually implies that the individual has received additional education and training, and demonstrated competence in a specialty area beyond the minimum requirements set for licensure.
Client satisfaction	Customer's perception of the degree to which the customers' requirements have been fulfilled.
Continual Improvement	A recurring activity to increase the ability to fulfil requirements. In continual improvement you improve a bit, sustain the development over a period of time and then go to the next stage, sustain and again improve and so on.
Corrective action	Action to eliminate the cause of a detected non-conformity or other undesirable situation.

Customer	The actual and potential users of organization's services or programs (referred to as "health care services" in the Health Care Criteria).
Cycle time	The time required to fulfil commitments or to complete tasks.
Defect	The non-fulfilment of a requirement, related to an intended or specified use.
Document	Information and its supporting medium.
Effectiveness	Extent to which planned activities are realized and planned results achieved.
Efficiency	Relationship between the results achieved and the resources used.
Empowerment	Giving people the authority and responsibility to make decisions and take appropriate actions.
Goals	Future condition or performance level that one intends to attain.
Governance	The system of management and controls exercised in the stewardship of the organization.
Health care services	Services delivered by the organization that involves professional clinical/ medical judgment, including those delivered to patients and those delivered to the community.
Internal audit	Audit carried by in house authorities to evaluate the compliance of implemented Quality Management Set up.
Key	The major or most important elements or factors, those that are critical to achieving intended outcome.
Indicators	Numerical information that quantifies input, output, and performance dimensions of processes, programs, projects, services, and the overall organization outcomes.
Key Performance Indicator (KPI)	Metric or measure used to quantify and evaluate progress made relative to the objectives wished to achieve.
Laboratory	Facility for inspection, test or calibration that may include, but is not limited to, chemical, metallurgical, dimensional, physical, electrical, reliability testing.
Licensure:	Process by which a governmental authority grants permission to an individual practitioner or health care organization to operate or to engage in an occupation or profession. Licensure ensures that an organization or individual meets minimum standards to protect public health and safety.
Measurement System	A system of measuring all components of Quality i.e. Standards, Measuring Elements, Check points and score card. *(applicable in the context of current document only)*

Mission	The overall function of an organization. It may define patients, stakeholders, or markets served; distinctive or core competencies; or technologies used.
Partners	Key organizations or individuals who are working in concert with the main or leading organization to achieve a common goal or to improve performance.
Patient	The person receiving health care services including preventive, promotional, acute, chronic, rehabilitative care and all other services in the continuum of care.
Performance	Outputs and outcomes obtained from processes, health care services, and patients and stakeholders that permit evaluation and comparison relative to goals, standards, past results, and other organizations.
Preventive action	Action to eliminate the cause of a potential non-conformity or other undesirable potential situation
Process	Set of activities with the purpose of producing a health care service for patients and stakeholders within or outside the organization. In the Baldrige Scoring System, process achievement level is assessed.
Productivity	The term "productivity" refers to measures of the efficiency of resource use.
Purpose	The fundamental reason of existence of an organization.
Quality	Degree to which a set of inherent characteristics fulfils the requirements.
Quality assurance	Part of quality Management, focussed in providing confidence that quality requirements will be fulfilled.
Quality Improvement	Part of Quality Management, focussed on increasing the ability to fulfil quality requirements.
Quality management	Co-ordinated activities to direct and control an organization with regard quality.
Quality objective	Something sought or aimed for, related to quality.
Quality policy	Overall intentions and direction of an organization related to quality, as formally expressed by top management.
Record	Document stating results achieved or providing evidence of activities performed.
Results	The outputs and outcomes achieved by an organization and evaluated on the basis of current performance; performance relative to appropriate comparisons; the rate, breadth, and importance of performance improvements; and the relationship of results measures to key organizational performance requirements.

Risk Management	Risk Management is a structured approach to manage uncertainty related to threat, through sequence of activities including risk assessment, strategies development to manage it and mitigation of risk using managerial resources.
Stakeholders	Are the marketplace benefits that exert a decisive influence on an organization's likelihood of future success.
Standard	A document established by consensus and approved by a recognized body that provides for common and repeated use, rules, guidelines or characteristics for activities or their results, aimed at the achievement of the optimum degree of order in a given context
SOP(Standard Operating Procedure)	Written procedure prescribed for repetitive use as a practice, in accordance with agreed upon specifications aimed at obtaining a desired outcome. The purpose of a SOP is to carry out the operations correctly and always in the same manner.
Sustainability	It's the organization's ability to address current organizational needs and to have the agility and strategic management to prepare successfully for future organizational, market, and operating environment.
Systematic	The approaches that are well ordered, repeatable, and use data and information making learning possible.
Top management	Person or group of people who directs and an organization, at the highest level
Trends	The numerical information that shows the direction and rate of change for an organization's results. Trends provide a time sequence of organizational performance. Examples of trends called for by the Health Care Criteria include data related to health care outcomes and other health care service performance; patient, stakeholder, and workforce satisfaction and dissatisfaction results
Value	The perceived worth of a product, process, asset, or function relative to cost and to possible alternatives.

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List of ABBREVIATIONS

1	ACMO	Acting Chief Medical Officer
2	AEFI	Adverse Events Following Immunization
3	AERB	Atomic Energy Regulatory Board
4	AHS	Annual Health Survey
5	AMC	Annual Maintenance Contract
6	AMG	Annual Maintenance Grant
7	ANC	Antenatal Care
8	ANM	Auxiliary nurse midwife
9	ARSH	Adolescent Reproductive and Sexual Health
10	AS & MD	Additional Secretary & Managing Director
11	ATR	Action Taken Report
12	AYUSH	Ayurveda, Yoga, Unani, Siddha & Homeopathy
13	BAMS	Bachelor of Ayurvedic Medicine and Surgery
14	BDS	Bachelor of Dental Surgery
15	BHMS	Bachelor of Homeopathic Medicine and Surgery
16	BMW	Bio Medical Waste
17	BPL	Below Poverty Line
18	CAPA	Corrective Action and Preventive Action
19	CDMO	Chief District Medical Officer
20	CHC	Community Health Centre
21	CMHO	Chief Medical Health Officer
22	CMO	Chief Medical Officer
23	CPCPHC	Community Processes- Comprehensive Primary Health Care
24	CPHC	Comprehensive Primary Health Care
25	CQSC	Central Quality Supervisory Committee
26	CS	Civil Surgeon
27	CT	Computed Tomography
28	CTI	Collaborating Training Institute
29	CVA	cerebrovascular accident

30	DH	District Hospital
31	DHAP	District Health Action Plan
32	DHO	District Health Officer
33	DISC	District Family Planning Indemnity Subcommittee
34	DOTs	Directly Observed Treatment, Short-course
35	DPM	District Program Managers
36	DQAC	District Quality Assurance Committee
37	DQAU	District Quality Assurance Unit
38	DQT	District Quality Team
39	ENT	Ears, nose and throat
40	FFHI	Family Friendly Hospitals Initiative
41	FOGSI	The Federation of Obstetric and Gynaecological Societies of India
42	FRU	First Referral Unit
43	FW	Family Welfare
44	FY	Financial Year
45	GoI	Government of India
46	HMIS	Hospital Management Information System
47	HR	Human Resource
48	HSDP	Health System Development Project
49	HWC SC	Health & Wellness Centre- Sub Centre
50	I/C	Incharge
51	IAP	Indian Academy of Pediatrics
52	IAPSM	Indian Association of Preventive and Social Medicine
53	ICT	Information and Communication Technology
54	ICTC	Integrated Counselling and Testing Centre
55	ICU	Intensive Care Unit
56	IHD	Ischemic Heart Disease
57	IMA	Indian Medical Association
58	IMEP	Infection Management and Environment Plan
59	INC	Intranatal Care
60	IPHS	Indian Public Health Standards
61	ISO	International Organization for Standardization
62	KASH	Kerala Accreditation Standards for Hospitals
63	KPI	Key Performance Indicators
64	LAMA	Left Against Medical Advice

65	LMIC	Lower-middle-income countries
66	LR	Labour Room
67	LT	Lab Technician
68	MBBS	Bachelor of Medicine and a Bachelor of Surgery
69	MoHFW	Ministry of Health and Family Welfare
70	MOM	Minutes of Meeting
71	NABH	National Accreditation Board for Hospitals & Healthcare Providers
72	NBSU	Newborn Stabilization Unit
73	NCD	Non-Communicable Disease
74	NFHS	National Family Health Survey
75	NGO	non-governmental organization
76	NHM	National Health Mission
77	NHSRC	National Health Systems Research Centre
78	NIC	National Informatics Centre
79	NIN	National Identification Number
80	NQAS	National Quality Assurance Standards
81	NRHM	National Rural Health Mission
82	NSSO	National Sample Survey Office
83	NUHM	National Urban Health Mission
84	NVBDCP	National Vector Borne Disease Control Programme
85	OBD	Outbound Dialler
86	ORS	Oral Rehydration Solution
87	OT	Operation Theatre
88	PCPNDT	Pre-Conception and Pre-Natal Diagnostic Techniques
89	PDCA	Plan-Do-Check-Act
90	PHC	Primary Health Centre
91	PIP	Programme Implementation Plans
92	PNC	Postnatal Care
93	PSS	Patient Satisfaction Score
94	QA	Quality Assurance
95	QAU	Quality Assurance Unit
96	QC	Quality Control
97	QI	Quality Improvement
98	QOC	Quality of Care
99	RCH	Reproductive and Child Health

100	RCHO	Reproductive and Child Health Officer
101	RHFWTC	Regional Health and Family Welfare Training Centre
102	RKS	Rogi Kalyan Samiti
103	RMC	Respectful Maternal Care
104	RMNCHA	Reproductive, Maternal, Newborn Child & Adolescent Health
105	RQAC	Regional Quality Assurance Committee
106	SDG	Sustainable Development Goal
107	SDH	Sub District Hospital
108	SIHFW	State Institute of Health & Family Welfare
109	SISC	State Family Planning Indemnity Subcommittee
110	SMART	Specific, Measurable, Achievable, Realistic and Time Bound
111	SNCU	Sick Newborn Care Unit
112	SOE	Statement of Expenditure
113	SOP	Standard Operating Procedures
114	SQAC	State Quality Assurance Committee
115	SRS	Sample Registration System
116	TA	Technical Assistance
117	TB	Tuberculosis
118	TORs	Terms of Reference
119	TOT	Training of Trainers
120	UC	Utilization Certificate
121	UHC	Universal Health Coverage
122	UPHC	Urban Primary Health Centre
123	UTs	Union Territories
124	VD	Venereal disease
125	WHO	World Health Organization

National Health Systems Resource Centre