सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

SaQushal

Safety and Quality :
Self-Assessment Tool for Health Facilities

2022

Ministry of Health & Family Welfare
Government of India

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Government of India
Department of Health and Family Welfare
Ministry of Health and Family Welfare

Message

Patient safety is being increasingly recognized as an issue of global importance in health care delivery. It is a discipline that emphasizes safety in health care through prevention, reduction, reporting and analysis of errors and other types of unnecessary harm that often lead to adverse patient outcome.

Growing focus on Patient Safety has led to changes in delivery of healthcare, from institutional care to ambulatory care. A cornerstone of the discipline is continuous improvement based on learning from errors and adverse events.

Patient safety is fundamental to delivering quality essential health services. To ensure successful implementation of patient safety strategies; clear policies, leadership, data to drive safety initiatives, skilled health care professionals and effective involvement of patients in their care, are all needed.

National patient safety Implementation Framework was developed in 2018. To implement patient safety framework, the assessment tool "SaQushal" has been designed by National Health Systems Resource Centre. The tool aims at enhancing implementation of patient safety practices in healthcare facilities.

This self-assessment tool for the health facilities will strengthen and streamline the existing quality assurance certification process under the NQAS and is expected to establish a credible system for reporting of adverse events to monitor extent of patient safety issues and learn from them. I am confident that "SaQushal" will help attain patient safety goals in a coordinated manner and contribute to overall agenda of quality improvement in public health facilities.

Place : New Delhi
Date : 13-09-2022

(Rajesh Bhushan)

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Government of India
Ministry of Health & Family Welfare
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MESSAGE

Patient safety is being increasingly recognized as an issue of global importance in health care and also a critical component of quality of care (QoC). In order to bring all the patient safety interventions under one umbrella, the National Patient Safety Framework has been developed by Ministry of Health and Family Welfare, Govt. of India. The framework rests on six pillars of the health system across the country. It includes good Governance, availability of finance, accessible, affordable & acceptable service delivery, competent and skilled human resources, user-friendly information systems and supply of cost-effective medicines & supplies.

Now, 'SaQushal' initiative has been developed to place patient safety at the core of every level of health system viz. national, state and facility levels. These self-assessment tools for the health facilities will strengthen and streamline the existing quality assurance certification process under the NQAS and is also expected to establish a credible system for reporting of adverse events to monitor extent of patient safety issues and learn from them.

I envisage that all stakeholders will commit themselves for meaningful implementation of this self-assessment tool. I also urge them to come forward to ensure delivery of quality assured patient centric care that gives paramount importance to patient safety outcomes in service delivery.

I am sanguine that the SaQushal: Safety and Quality Self-Assessment Tool for Health Facilities will help in attaining patient safety goals in a coordinated manner and contribute to overall agenda of improvement of quality of care within the context of Universal Health Care in India.

(Atul Goel)

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MESSAGE

The global need for quality of care and patient safety was first discussed during the World Health Assembly in 2002. Patient safety is being increasingly recognised as an issue of global importance in health care. India has prioritised patient safety as a public health issue and acknowledged its significance. The National Health Mission, Swachh Bharat Abhiyan, Clinical Establishment Act, National Action Plan on Antimicrobial Resistance, National Quality Assurance Standards for public health care facilities and National Patient Safety Implementation Framework are just a few of the policies and initiatives of the Ministry of Health and Family Welfare.

It was observed that much is being done for patient safety in India but a need exists to bring all such initiatives on one platform. Existing framework of National Quality Assurance Standards has various parameters of clinical safety and physical safety. While the NQAS look at patient safety holistically, a need has been felt to equip the facilities in undertaking self-evaluation with considerable granularity. Therefore, it was decided to strengthen the quality programme further by undertaking patient safety improvement interventions in areas such as reporting & learning system, clinical governance, communications and also interventions to improve high-risk clinical care processes by bringing them under one umbrella.

In order to improve the visibility and adoption of patient safety measures in the health facilities, the self-assessment instrument "SaQushal" for patient safety has been created. This initiative offers a framework that a healthcare facility can use to assess its patient safety status and take appropriate measures to ensure safer patient care.

I believe that having a culture of patient safety is fundamental, and that the change in the professional behaviour becomes effective when knowledge is shared, patient safety and risk awareness is instilled in all healthcare professionals. Patient Safety Self-Assessment Tool has been contextualised to meet the diverse needs of public health facilities in the country, the States are urged to implement the self-assessment instrument "SaQushal" for patient safety to achieve the quality assured patient centric care outcome.

(Roli Singh)

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MESSAGE

The National Health Mission works tirelessly to guarantee the provision of health services through six dimensions of health care quality, of which safety is the one. Delivering high-quality essential health services requires a commitment to patient safety. There is unquestionably a global consensus that effective, secure, and people-centred health services are essential.

The appropriate execution of patient safety methods, such as clear regulations and statistics to drive safety initiative, is essential. The National Patient Safety Implementation Framework, which establishes six pillars of patient safety, was developed in India as part of the efforts to unify all the programmes. There are other programmes around the nation, like Pharmacovigilance Programme of India, Hemovigilance, Materio-vigilance, etc., and these platforms also keep track of relevant occurrences.

National Health System Resource Centre (NHSRC) has been designated as a nodal agency at the national level for implementing the National Quality Assurance Programme in Public Health Facilities and Patient safety is an integral part of NQAS & its domains. The existing framework of NQAS has various parameters of safety such as medication safety, surgical safety, and compliance to infection control practices, ensuring a continuum of care while being referred, safety during blood transfusion, and the physical safety of infrastructure.

While the NQAS takes a comprehensive approach to patient safety, there has been a sense that facilities need to be equipped to conduct self-evaluation with a great deal of detail.

The assessment tool 'SaQushal' (Safety & Quality-Self Assessment Toolkit for Health Facilities) aims at enhancing the visibility and implementation of patient safety practices in healthcare facilities. It also provides a framework through which a health facility can access its status in terms of patient safety and take action to deliver safer patient care. Initially, this initiative is planned for implementation at all District hospital-level facilities.

I hope this self-assessment toolkit will enable the creation of a reliable health system that is responsive to the community's needs and will inculcate a safety culture through sharing and sustaining best practices in a blame-free environment.

(Vishal Chauhan)

Maj Gen (Prof) Atul Kotwal, SM, VSM
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Message

Safety of patients during the provision of quality health services is a prerequisite for strengthening health care systems and making progress towards effective Universal Health Coverage (UHC) and achieving Sustainable Development Goals (SDG).

The occurrence of adverse events due to unsafe care is likely one of the leading causes of deaths and disabilities globally, and present significant challenges to health systems. This indicates a need towards increasing the investments into measures to improve the patient safety and maintain high standards for safety & quality within health care systems.

Unsafe medical care may also act as a significant barrier to access to care, as individuals and families may opt out of using health care services due to dissatisfaction. A lack of focus on patient safety also has significant financial implications for both service seekers and providers.

Patient safety has been recognized as an issue of global importance, and to overcome this issue, Ministry of Health and Family Welfare, GoI has taken several initiatives at all levels of health care across all modalities of health care provision, including prevention, diagnosis, treatment and follow up within overall context of improving quality of care and progressing towards UHC in the coming decade.

Outlining the importance of patient safety, World Health Assembly resolution WHA55.18 urged the member states to establish and strengthen evidence-based systems necessary for improving patient safety and health care quality. In response to the pressing need to develop interventions that address lapses in patient safety, National Health Systems Resource Centre has developed ***"SaQushal"***, the Safety and Quality: Self-Assessment Tool for Health Facilities.

'SaQushal' has been developed to place patient safety at the core of health systems and aims to enhance the visibility and implementation of patient safety practices in health care facilities. It would provide a framework for our health facilities and will enable them to access their status in terms of patient safety and ensure safer patient care. These self-assessment tools will strengthen and streamline the existing quality assurance accreditation process under the NQAS and are also expected to establish a credible system for reporting adverse events to monitor the extent of patient safety issues and address them timely.

I hope that SaQushal would serve as a beacon of light in our endeavours to strengthen our facilities for quality of services and assure patient safety across all levels of health care.

(Maj Gen (Prof) Atul Kotwal)

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Introduction

Ensuring safe care is fundamental to patient care, and it is a critical component of quality of care (QoC) along with accessibility, acceptability, effectiveness, efficiency and people-centeredness. It is defined as reduction of preventable errors or harms associated with health care. Globally, patient safety is being recognised as an issue of concern, influencing the attainment of improved health outcomes.

Burden of Harm

A study[1] mentions that Each year,
13.4 crore adverse events occur in hospitals in low and middle-income countries (LMICs), due to unsafe care, resulting in 26 lakh deaths

Another study[2] mentions that,
4.3 crores people worldwide injured every year,
due to unsafe care, inside hospitals

And Globally, as many as
4 in 10 patients are harmed in primary and outpatient health care.
Up to 80% of harm is preventable

A Harvard study[3] published in 2013 mentions –
52 lakh injuries take place in India due to patient safety issues

Even though statistics on extent of patient harm are not readily available, the morbidity, mortality and economic burden are expected to be huge. In developed countries, 1 in 10 patients experiences adverse event in hospitalised care settings. Available evidence also brings out that 15 per cent of hospital expenditure takes place in fixing the issues related to safety failures. Such evidence excludes economical losses through lost capacity and productivity. More importantly, such instances lead to loss of public trust in the health systems and harm puts extra strain on the scarce resources besides human suffering.

Errors, while delivering the care may happen at many stages such as patient identification, diagnosis, reporting, adverse events following a surgery and medicine administration, unsafe injections and blood transfusion, hospital-associated infections, etc. However, simple adherence to clinical protocols and processes, controlling environmental issues and regulating system-related issues could minimise unintended harm, thereby helping in mitigating the suffering and reducing additional health care costs.

India has recognized the importance of patient safety and prioritized it as a public health concern. Many of the above aspects are addressed in different strategies and programmes of the Ministry of Health and Family Welfare viz. the National Health Mission, Clinical Establishment Act, National Action Plan on Antimicrobial Resistance, etc.

1. https://www.who.int/news-room/fact-sheets/detail/patient-safety
2. https://www.hsph.harvard.edu/news/press-releases/millions-harmed-each-year-from-unsafe-medical-care/
3. https://timesofindia.indiatimes.com/india/india-records-5-2-million-medical-injuries-a-year/articleshow/22832260.cms

It is realised that much is being done for patient safety in India but often in a fragmented manner. Even though many data management systems like Adverse Event Following Immunisation (AEFI), Pharmacovigilance programme, Hemovigilance, etc. exist and there is little documentation on errors, negligence, HAIs, near misses, etc. in few top-notch medical colleges of [1]the country. Taking cognisance of the patient safety challenges, an overarching National Patient Safety Implementation Framework (NPSIF) was developed in 2018 to synergise multiple initiatives for summative effects on the patient safety scenario. The NPSIF lays down six pillars for patient safety in India and aspires delivery of quality assured safe care to patients in the country.

Purpose of the Document

Patient Safety Self-Assessment Tool has been contextualised to meet the diverse need of public health facilities in the country. Due consideration has been given to the universal applicability of the tool across the states. The document elaborates scope, objectives, institutional arrangement for implementation, assessment methodology, action planning methodology, etc. The purpose of the document is to provide implementation guidance to the policy makers, program managers, quality nodal officers at state, district, and facility level, etc. to improve patient safety at all levels of facility-based care.

Scope

In the beginning this initiative is planned for implementation at all District hospital level facilities. Later, the tool could be replicated at the facilities below District Hospitals, in a phased manner. Being cross-cutting concept, scope of the self-assessment tool applies to all national health programmes as well and envisages collaboration of various health departments both at the national and the state level.

Need for a self-assessment tool

The first principle of healthcare is 'to do no harm'. Safety of patients is a prerequisite for building quality health systems. Whenever a patient enters the hospital, he expects to be treated with respect and get early relief of his suffering. The current pandemic of COVID-19 has further exposed the vulnerability of health systems in responding to the sudden surge in demand while ensuring the safety and quality in the care.

As per recent Lancet publication, 86 lakhs people in Low- & Middle-Income Countries die from causes amenable to healthcare[1]; of these 50 lakhs are those who have used the health system but received poor-quality care. Mostly this is due to system failures rather than the actions of individuals. Hence, it becomes fundamentally important for everyone to ensure that the healthcare, which is available to the citizens is safe and meets predefined quality standards. Multiple interventions for mitigating impact of unsafe care need to be developed and implemented in letter and spirit.

Existing framework of NQAS has various parameters of clinical safety such as medication safety, surgical safety, compliance to infection control practices, ensuring continuum of care while being referred, safety during blood transfusion, etc. Apart from the clinical safety, NQAS also looks at the physical safety of infrastructure, e.g., seismic safety, fire safety, electrical safety, preparedness for the disaster, security, Safety of instruments & equipment, etc. While NQAS look at patient safety holistically, a need has been felt to equip the facilities in undertaking self-evaluation with considerable granularity. There are many other initiatives, such as Pharmacovigilance Prog. of India, Hemovigilance, Materio-vigilance etc. in the country and these platforms also record related incidences. Therefore, it is recommended to strengthen the quality programme further by undertaking patient safety improvement interventions in areas such as reporting & learning system, clinical governance, communications, etc. and also interventions to improve high-risk clinical care processes.

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6238021/

The assessment tool 'SaQushal' aims to enhance the visibility and implementation of patient safety practices in health care facilities. The initiative provides a framework through which a health facility can access its status in terms of patient safety and take action to deliver safer patient care.

Progress so far

"Patient Safety is Everyone's Responsibility"

In order to bring all the patient safety interventions under one umbrella, the National Patient Safety Framework has been developed in the country. The framework rests on six pillars of the health system across the country. It includes good Governance, availability of finance, accessible, affordable & acceptable service delivery, competent and skilled human resources, user-friendly information systems and supply of cost-effective medicines & supplies.

The Quality initiative targeting the public health facilities had begun its journey in 2013 with launch of National Quality Assurance Programme (NQAP). The programme has National Quality Assurance Standards (NQAS) for every level of public health facilities i.e. District hospital/Sub-district Hospital, Community Health Centre, Urban and Rural Primary Health Centres, and Health and Wellness Centres. Easy to use checklists allow the providers & other stakeholders to assess the facility, identify the gaps, prioritize them for gap closure action, take up the improvement activities to traverse the gaps and finally meet the standards. The whole process is supported by a well functional institutional framework at the National, State, District & Facility level.

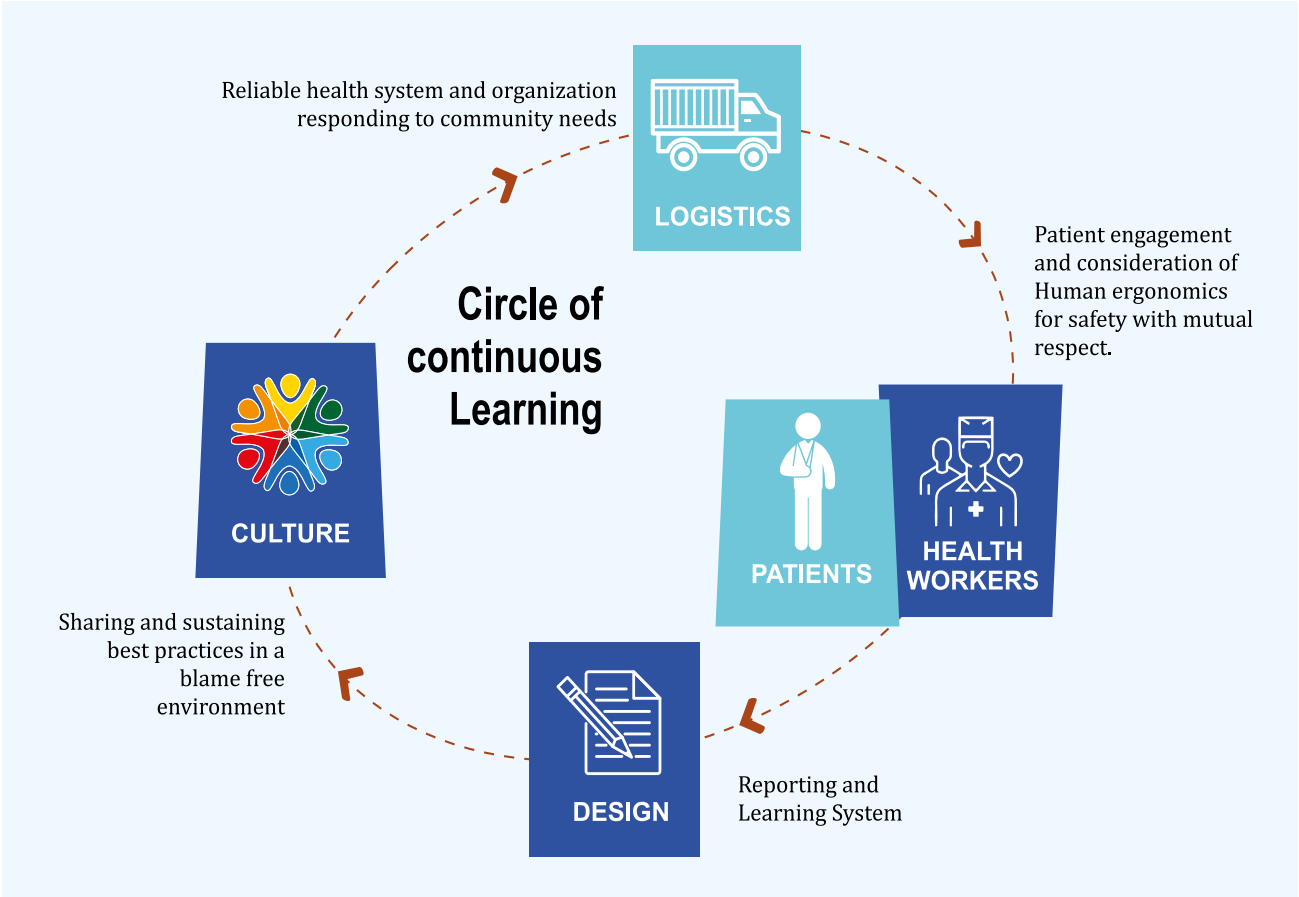
'SaQushal' initiative has been developed to place patient safety at the core of every level of health system viz. national, state and facility levels. These self-assessment tools for the health facilities will strengthen and streamline the existing quality assurance certification process under the NQAS and is also expected to establish a credible system for reporting of adverse events to monitor extent of patient safety issues and learn from them.

Chapter 1

Overview of SaQushal initiative

SaQushal assesses hospitals from patient safety perspective; builds capacity of the staff in patient safety with requisite knowledge & skills; and supports patients and families in decision making. It also strengthens evidence-based practice necessary for improving patient safety and quality of health care. SaQushal is expected to establish a circle of continuous learning by instituting a reporting and learning system wherein due consideration is also given to human ergonomics for safety with mutual respect for service providers and seekers. This will enable in creation of reliable health system which is responsive to the community needs and will inculcate a safety culture through sharing and sustaining best practices in a blame free environment, as summarised in Figure 1.

Figure 1: Circle of Continuous Learning for Patient Safety



Patient Safety: An integral part of the National Quality Assurance Standards (NQAS)

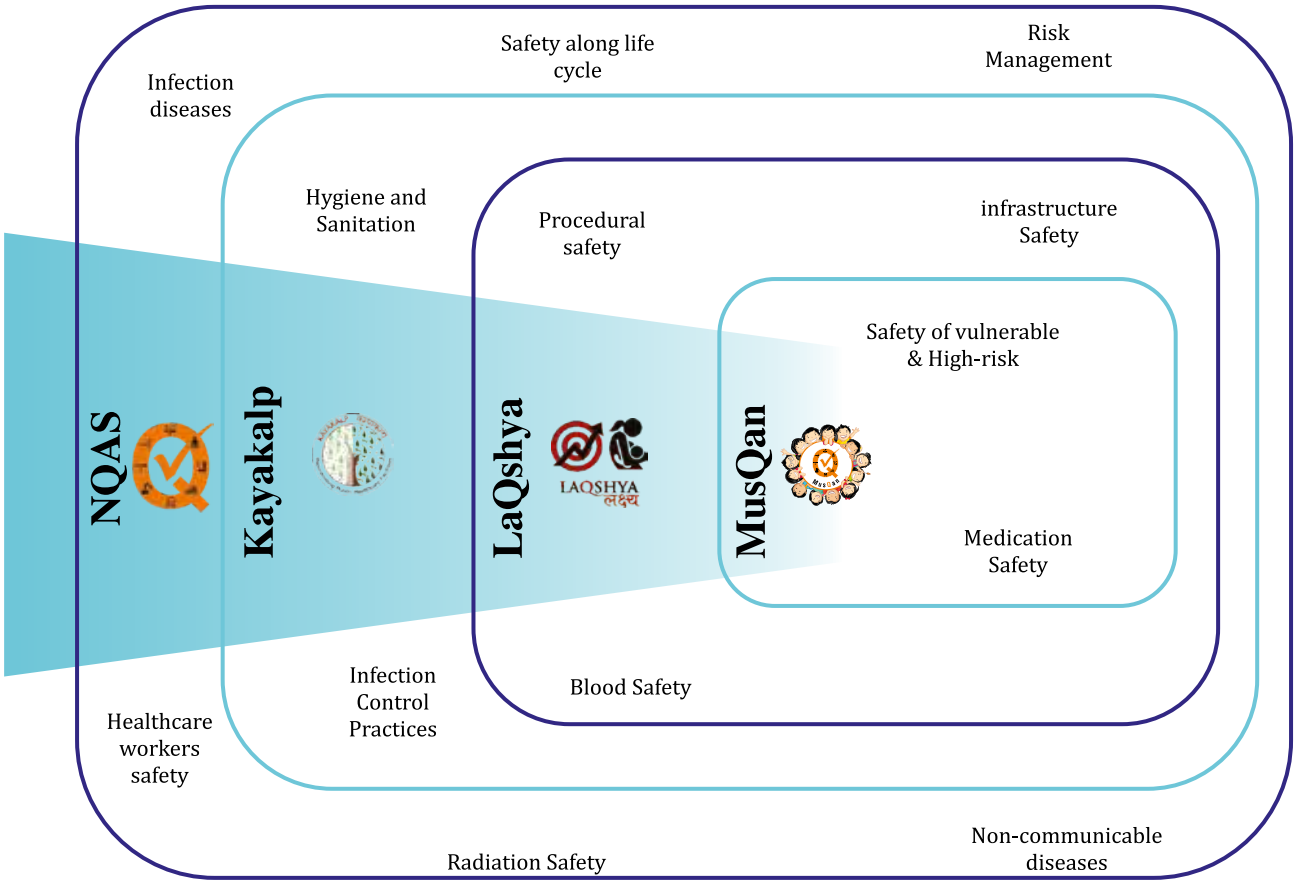
With the mandate of ensuring quality in the delivered services and improving health outcomes, the Ministry of Health and Family Welfare GoI had launched National Quality Assurance Standards (NQAS) for different level of healthcare facilities. The quality standards are nationally and internationally recognised by NHA, IRDA and ISQua.

The main pillars of the initiative are Quality Standards which embodies key principles of Quality Management System. Through 74 quality standards and 362 measurable elements at DH level, many facets of patient safety are already in-built in the existing umbrella, including safety in clinical care and

processes, environmental issues, medication safety, infection prevention and control practices, surgical safety, fire and electrical safety, infectious waste management, etc.

Additionally, many of the global patient safety campaigns such as Safe Surgery Checklist, Safe childbirth practices, Safe injections, medication review and optimisation, promotion of usage of non-mercury devices are already part of the NQAS. Additionally, Kayakalp scheme intends to encourage and incentivize Public Health Facilities (PHFs) in the country to demonstrate high levels of cleanliness, hygiene and infection control practices. Another initiative 'LaQshya' was launched to improve intra and immediate partum care, and to provide Respectful Maternity care in the Labour room and Maternity Operation Theatre. To go a step further to address all the social, nutritional, and quality service concerns, a novel initiative namely MusQan was released in the form of a scheme to ensure the provision of Quality Child-friendly services in public health facilities. All of these initiatives support the patient safety under the ambit of NQAS, as illustrated in Figure 2.

Figure 2: Patient safety: An integral part of NQAS and its domains



Chapter 2

Institutional Framework

Patient Safety is an integral part of National Quality Assurance Programme. For implementing the quality activities (NQAS, Kayakalp, LaQshya, MusQan), an institutional framework is in place at various levels. The same institutional framework will be used to support the implementation of SaQushal initiative with the roles and responsibilities defined for each level. Also, it has been stated in the NPSIF that Quality Assurance mechanism under National Health Mission (NHM) as illustrated in Figure 3, will be utilised at the National, State, and District level.

Figure 3: SaQushal Institutional Framework

2.1 National level

Existing Central Quality Supervisory Committee (CQSC) constituted under National Quality Assurance Programme will continue to provide guidance & strategic directions for the roll-out and dissemination of SaQushal. The Quality and Patient Safety Division at the NHSRC will draw technical guidelines and resource material to support the states in conduct of the quality and safety self- assessment at DH and below level of the facilities.

Periodic review of patient safety self-assessment tool and mid-course updation in the tools will be undertaken at the national level as per revision or issue of new technical and programmatic guidelines. Additionally, implementation status of the safety assessment tool at the state level will be presented in the CQSC's meetings.

2.2 State Level

State Quality Assurance Committees (SQACs) are functional in all states/UTs. The committees would also oversee the patient safety activities along with existing quality assurance activities in the states in accordance with National & State guidelines.

Roles & Responsibilities at the State Level

- Ensure availability of required technical resource, such as programme guidelines, standard treatment protocols, Standard Operating Procedures (SOPs), etc and its effective dissemination.
- Capacity Building of Quality teams and Departmental Quality circles in implementation of guidelines, SOPs, protocols, etc.
- Ensure biannual conduct of baseline assessment of targeted health facilities within stipulated timelines, and measurement of the patient safety indicators followed by analysis.
- Mobilise state support for accomplishing gap closure
- Provide inputs for improvement in self-assessment tool and ensure implementation of recommended mid-course corrections.
- The indicators and incident reports are reviewed in biannual meetings for undertaking risk analysis and their corrective actions
- Support for undertaking gap closure activities following to self-assessment through the State National Health Mission's annual Programme Implementation Plans (PIPs)
- Track the improvement in patient safety scores at the facility
- Take regular review, monitoring and provide handholding

2.3 District Level

District Quality Assurance Units (DQAUs) are the functional arm of District Quality Assurance Committees in the States/UTs. The unit shall be responsible for implementation of SaQushal in the public health facilities. The DQAC shall report their implementation status of SaQushal to SQAC.

Roles & Responsibilities at the District Level

- Mentoring and handholding of the facilities for implementing SaQushal.
- Capacity building of facility staff for undertaking self-assessments, generating scores, measuring patient safety indicators, risk analysis, reporting of adverse events, adherence to clinical protocols, gap closure using improvement cycles, etc.
- Ensure biannual conduct of baseline assessment of targeted health facilities within stipulated timelines, and measurement of the patient safety indicators followed by analysis.
- Scores are generated and reported to the state/ any other level
- Support the facilities in undertaking corrective and preventive actions to address the gaps
- Address the local issues on patient safety based on self-assessment score and prepare facilities for NQAS certification.
- Provide onsite support to low/underperforming facilities

2.4 Facility Level

Facility level Quality teams are functional in all public health-care facilities. The team comprises of Medical Superintendent or facility in-charge, Hospital Manager (wherever available), nursing in-charge and representative from other functional and related departments. The quality team will oversee patient safety activities along with quality assurance activities in the facility. The quality team shall oversee the implementation of SaQushal, preparation of annual plan to conduct assessment, discussion of safety score findings in quality team meetings, reporting of the score to state & district quality assurance units, capacity building and sustain the culture of patient safety in the facility.

Chapter 3

Overview of measurement system for Self-Assessment tool

The public health system has evolved considerably during the last couple of years. Many of the National Health Mission initiatives have significantly improved health targets. But one of the greatest challenges still remains that of putting knowledge and skills into the practice.

Often, reporting the near-miss and adverse events has never been easy, more so, in public health facilities. We have had a patient safety assessment tool globally and the country's national patient safety implementation framework. The proposed safety assessment tool has been contextualised to meet the diverse need of the public health system in the country. The tool integrates all patient safety facets related to clinical care, environmental issues and system issues. However, due consideration has also been given to the universal applicability of the self-assessment tool across diverse health systems in the states. Requirements contained in National Quality Assurance Standards, Kayakalp scheme and revised Indian Public Health Standards guidelines (IPHS) 2022 have also been factored into.

Underlying principles of the assessment tools are summarised below:

1. **Comprehensiveness –** The proposed system is all inclusive and captures all aspects of patient safety within the four areas of concerns namely, safe patient care processes, clinical risk management, safe care environment, patient safety system. The self-assessment tool is transposed within sixteen standards, commensurate measurable elements and checkpoints provide an exhaustive matrix to capture all aspects of safety and quality at the Public Health Facilities.

2. **Contextual –** The proposed system has been developed primarily for meeting the requirements of the Public Health Facilities; since Public Hospitals have their own processes, responsibilities, and peculiarities.

3. **Contemporary –** Contemporary Patient Safety assessment tool such as Patient Safety Friendly Health Facilities, NQAS, Australian Commission on Safety and Quality and JCI have been consulted and their relevant practices have been incorporated.

4. **User Friendly –** Conscious efforts have been taken to avoid complex language and jargon, so that the tools remain user-friendly for ease of understanding and implementation by the service providers. Scoring system has been made simpler with uniform scoring rules and weightage. Additionally, a formula fitted excel sheet tool has been provided with the scheme for the convenience, and also to avoid calculation errors. The workable excel sheets and print ready version of the checklists can be downloaded from https://nhsrcindia.org/QImicrosite

5. **Evidence Based –** The areas of concerns and standards have been developed after consulting contemporary resource available on the patient safety. All respective operational and technical guidelines related to secondary care and National Health Programmes have been factored into.

6. **Objectivity –** Ensuring objectivity in measurement of the Safety and Quality has always been a challenge. Therefore, in the proposed self-assessment tool, each standard is accompanied with measurable elements & checkpoints to measure compliance to the standard. At the end of assessment, there would be numeric scores, bringing out extent of safe care in a snapshot, which can be used for monitoring, as well as for inter-hospital/inter-state(s) comparison.

7. **Flexibility –** The proposed system has been designed in such a way that states and Health Facilities can adapt the system according to their priorities and requirements. State or facilities may pick one or two areas of concerns in the initial phase for ensuring safe care.
8. **Balanced –** All three facets of Safety – Clinical Care, Environmental & System issues, have been given due weightage.
9. **Transparency –** All efforts have been made to ensure that the measurement system remains transparent, so that assesses, and assessors have similar interpretation of each tracer.
10. **Enabler –** Though the tool is primarily meant for the self-assessment, it can also be used as a 'roadmap' for attainment of Quality certification under the NQAS.

Arrangement of Self-Assessment tool

> **"If you can't measure something, you can't understand it. If you can't understand it, you can't control it. If you can't control it, you can't improve it**

Since considerable awareness exist in the health system regarding NQAS & Kayakalp, the arrangement of SaQushal amalgates both these approaches, as elaborated below:

1. **Area of Concern (AOC):** These are broad area/ themes for assessing different aspects of the safety viz. Patient Care Processes, Clinical Risk Management, Safe Care Environment, and Patient Safety Systems
2. **Standard:** These are generic statement of commitments under each area of concern
3. **Measurable Element:** These are the specific elements of safe care under each standard
4. **Checkpoint:** These are few of specific attributes of a measurable elements which should be looked into for assessing the degree of compliance.
5. **Means of Verification (MOV):** Tangible measurable checkpoints are those, which are expected to be objectively observed and scored.

Amalgamation of all these five parameters in a systemic manner constitute a checklist in the form of self-assessment tool.

Following four Areas of Concern are there under SaQushal

A. Safe Patient Care Process

B. Clinical Risk Management

C. Safe Care Environment

D. Patient Safety Systems

Each area of concern has four safety standards, each elaborating different parameters of the AOC. Thus, there are a total of sixteen standards. Overview of each area of concern and standards is given in figure 4 and functional relationship between components of self-assessment tool is depicted in figure 5. Intent of each Area of Concern and Standard along with corresponding measurable elements for an average District Hospital is given in the Chapter 4.

Figure 4: Overview of area of concerns and standards of self-assessment tool

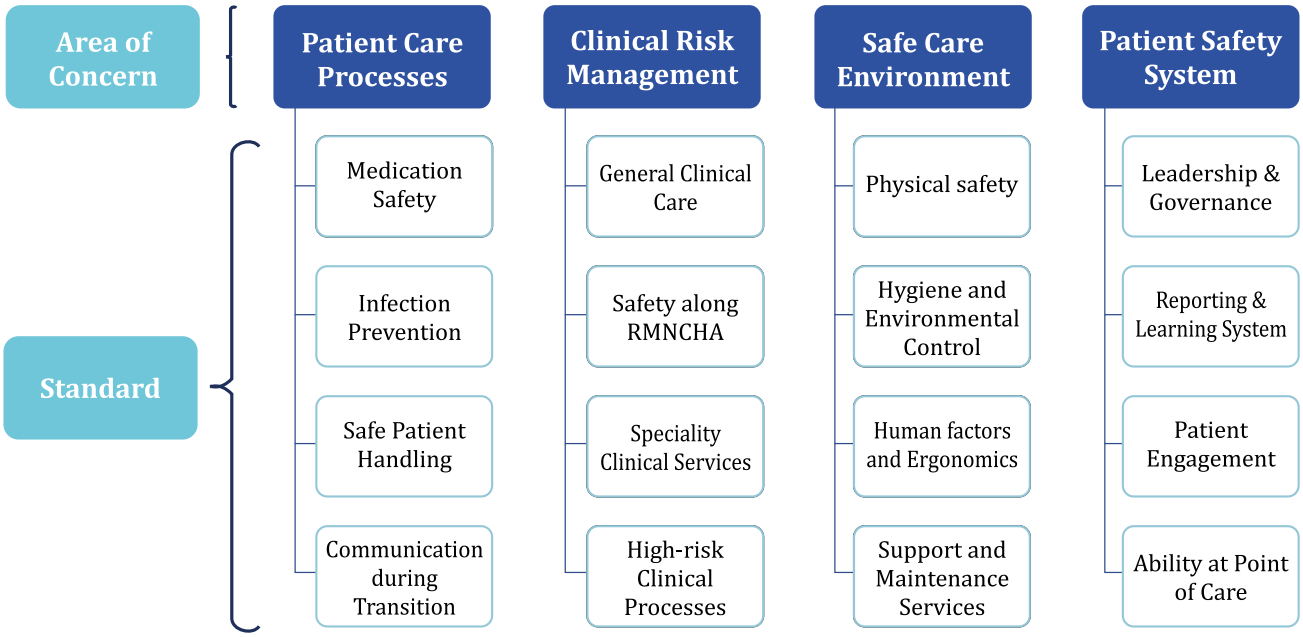


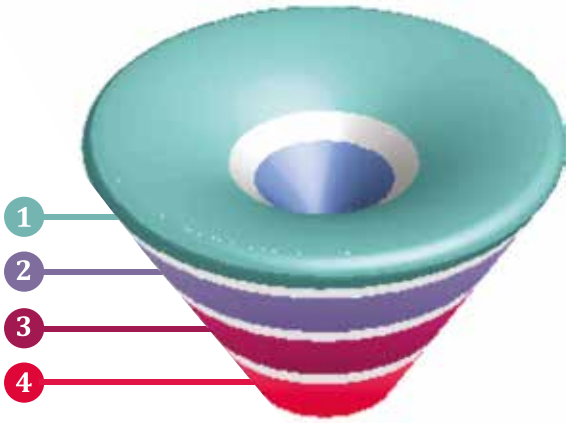
Figure 5: An example to elaborate the arrangement of SaQushal

01 AREA OF CONCERN
Safe Patient Care Process

02 STANDARD
Standard A1: Medication Safety-
The hospital has a medication management system to ensure safe medication practices at all times

03 MEASURABLE ELEMENT
ME A1.1 Safe prescription practices

04 CHECKPOINT
Uniform and comprehensive prescription format is used



MEANS OF VERIFICATION are measurable explanation of Checkpoint, which can be objectively scored e.g.

1. The facility has standardized prescription format in all departments.
2. The format has provision of documenting all elevant information related to patients and service provider as per Prescription Audit guidelines from NHSRC

Chapter 4

Area of Concerns and their Intent

This chapter briefs the intent of all four (04) areas of concern and sixteen (16) safety standards for universal applicability of assessment tool at the facility. Each safety standard has five (05) measurable elements in it, details of which are given under Annexure A.

STANDARDS AND THEIR INTENT

Area of Concern A – Safe Patient Care Processes

This area of concern ensures safety in delivered clinical services like medication safety, adherence with infection prevention & control practices, etc. It also ensures that safe patient handling and harm prevention mechanism are available in all clinical settings.

There are following four standards in this area of concern:

Standard A1: Medication Safety-The hospital has a medication management system to ensure safe medication practices at all times

The Standard measures the safe practices of prescribing. It measures availability of policy and procedures in place for rational use of drugs. The Standard also measures storage and dispensing practices for drugs, preparation & administration of medicines as per standard guidelines. It also measures process of medication optimization and reconciliation at the facility.

Standard A2: Infection prevention and control-The hospital has an infection control programme to ensure safe infection control practices at all times

The standard is concerned with practices of hand washing. Standard also looks into adherence and correct practice of using PPE. The standard also covers decontamination, cleaning, disinfection and sterilization of equipment and instruments. Also, the standard is concerned with Bio-Medical Waste & its management including segregation, transportation, storage and disposal of Bio-Medical Waste. Standards covers all aspect of injection safety.

Standard A3: Safe patient handling and harm prevention-The hospital has an established system to ensure safe patient handling and harm prevention in all clinical care settings

The Standard pertains to provision of established process for prevention of accident & fall, decubitus ulcer, venous thromboembolism. It checks availability of standardised protocols for patient identification in all hospital care settings. It also pertains to established protocols for safe patient referral.

Standard A4: Communication at transition of care-The hospital has an established system to ensure safe patient transport and referrals

The Standard is concerned with established procedure for communication during intramural and extramural referral. The standard looks availability of uniform emergency response codes and capacity building of staff to respond to alert codes. The standard also ensures that staff is trained on risk and hazard communication. It also covers established criteria for patient's discharge from the facility.

Area of Concern B – Clinical Risk Management

The standards in this area concern are the opportunities for improvement to enhance safety across RMNCHA inclusive level of care like general, secondary, specialised & high-risk clinical processes.

There are following four standards in this area of concern:

Standard B1: Safety in General Clinical Care-The hospital has an established mechanism to reduce the risk of errors for general clinical care

This Standard is concerned with prevention of error in diagnostic services, administrative services, dental practices, various national health programmes. This standard also covers established mechanism for identification of cases with multimorbidity.

Standard B2: Safety in RMNCHA-The hospital has an established mechanism to ensure safety in Reproductive, Maternal, Newborn, Child and Adolescent Health

The standard is related to ensure safe & quality family planning services. Standard measures availability and compliance to established procedures and standard protocols for management of different stages of labour including AMTSL (Active Management of third stage of labour), routine care of new-born immediately after birth & newborn resuscitation and procedure for management/referral of Obstetrics Emergencies, adherence with safe processes of immunization as per scope of services.

Standard B3: Speciality Clinical Services-The hospital has an established mechanism to ensure safety in speciality clinical services

The Standard enfolds provision of established process and adherence to clinical guidelines for management of dialysis services, ophthalmology services, mental health care, intensive care and palliative & geriatric care.

Standard B4: High-risk clinical processes-The hospital has an established mechanism to ensure safety in all high-risk clinical processes

The Standard looks processes related with Operation Theatre. It includes processes for OT scheduling, pre-operative, Post-operative practices of surgical safety. The standard includes processes related with safe anaesthesia practices. It also measures safe practices followed to ensure radiation safety. Standard B4 is concerned with functioning of blood bank and transfusion services and emergency care.

Area of Concern C – Safe Care Environment

Safety in all clinical outcome cannot be envisaged in absence of sturdy support services. This area of concern includes structural safety, seismic safety, security & access control, maintenance of proper illumination, air quality, humidity and temperature. Safety components relevant to human factors & ergonomics and other supportive and maintenance services have also been included in this area of concern.

There are following four standards in this area of concern:

Standard C1: Physical Safety -The hospital ensures safety of the patient, staff and infrastructure

This Standard is concerned with safety of the patient, staff, and infrastructure. It ensures availability of adequate arrangements for the safety and security of hospital and patients in terms of structural safety, seismic safety, electric safety, fire safety, etc.

Standard C2: Hygiene and environment control- The hospital ensures all aspects of environment control within the premises

The standard measures availability of environment control arrangements. The Standard covers provision of adequate illumination in patient care areas, established mechanism for water testing, adherence with standard practices for cleaning and disinfection of patient care areas, spill management process, etc. The

standard enfolds provision of comfortable work environment in terms of air, humidity and temperature control.

Standard C3: Human factors and ergonomics-The hospital ensures preventive measurements are in place for safe patient handling

The Standard pertains to maintenance of facility's layout for safe process flow like availability of ramps at 1:10 slope, reflexion free tiles, optimum floor gradient, etc. The Standard covers safe techniques of machine and material handling in terms of their movement, stability while standing, safe patient lifting techniques, etc. It checks availability of an established mechanism to safely manage hard tasks at the working station like availability of height-adjustable stands, and chairs to prevent musculoskeletal injuries. This standard also ensures availability of hazard communication program at the facility to prevent any mishap during hazardous substance handling.

Standard C4: Support and maintenance services-The hospital ensures safety in all support and auxiliary services

The Standard is about established mechanism for equipment maintenance processes, such as AMC, daily and breakdown maintenance processes, calibration and availability of operating instructions. Standard C4 covers established procedure of laundry and kitchen service management which includes cleanliness and hygiene protocols. This standard also pertains to infectious waste management (solid & liquid) as per latest guidelines. The Standard covers protocols and mechanism to ensure data and information security at the facility in terms of availability, accessibility, storage, retention and disposal. Standard C4 also ensures that the facility has a comprehensive disaster preparedness plan and staff is competent enough to manage the disaster.

Area of Concern D – Patient Safety System

This area of concern measures availability of patient safety systems with a health facility. Availability of functional system for reporting and learning through reported adverse events, safety surveillance and key safety indicators. Furthermore, the facility should have a provision of utilizing information for improving the safety. This AOC also measures that the facility has an established framework to ensure healthcare delivery processes are patient centred and patient & family are involved in decision making about their treatment.

There are following four standards in this area of concern:

Standard D1: Leadership and Governance-The hospital has an established Leadership and Governance Framework to ensure the implementation of patient safety policy and plan are in place

This Standard is concerned with availability and implementation of a comprehensive patient safety policy in the facility. The facility has prepared a patient safety charter that includes patients' and health care providers' rights and responsibilities. It ensures that existing quality teams at the facility level also implements and review patient safety activities therefore, quality team has been renamed as quality and patient safety teams. This standard covers adherence with all requisite statutory and regulatory compliance by the facility. The facility has a well-established clinical governance system which will ensures that treatment protocol for common ailments and emergency services are available and implemented, clinical care effectiveness criteria have been defined and communicated, audits are performed at periodic intervals and audit results are analysed and used for improvement in clinical processes, availability of standard treatment guidelines, etc. Standard D1 also covers that quality and patient safety team conducts periodic assessment using self-assessment tool and evaluates their performance through a system of peer assessment and independent review.

Standard D2: Reporting and Learning System- The health system has established a functional system for reporting and learning of adverse events

The standard measures that the facility has established a user-friendly mechanism to report patient safety incident in terms of having defined definitions, classifications and format for reporting of near miss, adverse events, and sentinel events. Structured program for training and capacity building on learning and reporting system is in place. Standard covers periodic risk evaluation using assessment tool (like FMEA), measuring patient safety indicators, conduct of active surveillance for hospital associated infections in all high-risk departments, etc. Furthermore, the facility has a mechanism of aggregating all data (patient safety indicators, surveillance, adverse events, near miss) to a common data management information system and all data is analysed and processed to some useful information in the form of an incident report. The standard also ensures that findings of incident reporting, surveillance and indicators are utilized for identifying opportunities for improvement and for improving safety of the clinical and support processes through Corrective and Preventive Action Plan.

Standard D3: Patient Engagement-There is an established framework to ensure healthcare delivery processes are patient centred

The Standard pertains to the facility encourages patient and care givers to express their religious & cultural preferences and health outcome expectations while delivering healthcare services and preparation of the treatment or care plan involving individual patient to achieve the best possible results. Standard D3 covers many aspects of patient's rights including privacy, confidentiality, availability of information to the patients, informed consent from the patients and their family involvement in the decision making, self-care. This standard also covers principles of patient empowerment through involvement of patient and support group in improvement activities, in educating and for peer support and counselling services. This standard also covers availability of communication and grievance redressal system at the facility for complaint registration, it's timely resolution and disclosure.

Standard D4: Ability at point of care-The hospital has competent work force and work environment to ensure the provision of point of care

The Standard is concerned with two aspects, one is with availability of competent and skilled multidisciplinary team having basic patient safety concepts. The staff has defined tasks based on minimum qualifications and experience. This standard also requires that performance evaluation criteria should also be defined for each cadre of staff. These criteria may have some indicators measuring competency of the staff on patient safety activities. Based on these defined criteria the competence and performance of staff should be evaluated at least once in a year. Based on these assessment and evaluation, the training needs of each staff are identified, and training plan is prepared. Staff should be trained and educated on various aspect of patient safety according to the training plan. Facility should also ensure that skills gained through training are retained and utilized and feedback is given to individual staff on their competence and performance. Beside this, the standard also ensures psychological safety of the healthcare staff, promotion of positive teamwork culture, and established mechanism for healthcare staff burn-out, support to the staff in coping Second Victim Syndrome (SVS).

Chapter 5

Assessment Protocols

A. General Principles

Administration of the tools in the hospital's department is based on general principles of integrity, confidentiality, objectivity and replicability:

1. Integrity – The facility staff and quality team managing self-assessment programme should observe following cardinal principles, while assessing the facility.

- Perform their work with honesty, diligence and responsibility
- Demonstrate their competence while performing assessment
- Perform assessment in an impartial manner

2. **Fair Presentation -** Assessment findings should represent the assessment activities truthfully and accurately.

3. **Confidentiality –** The quality team should ensure that information acquired by them during the course of self-assessment is not shared with any unauthorised person including media. The information should not be used for personal gain.

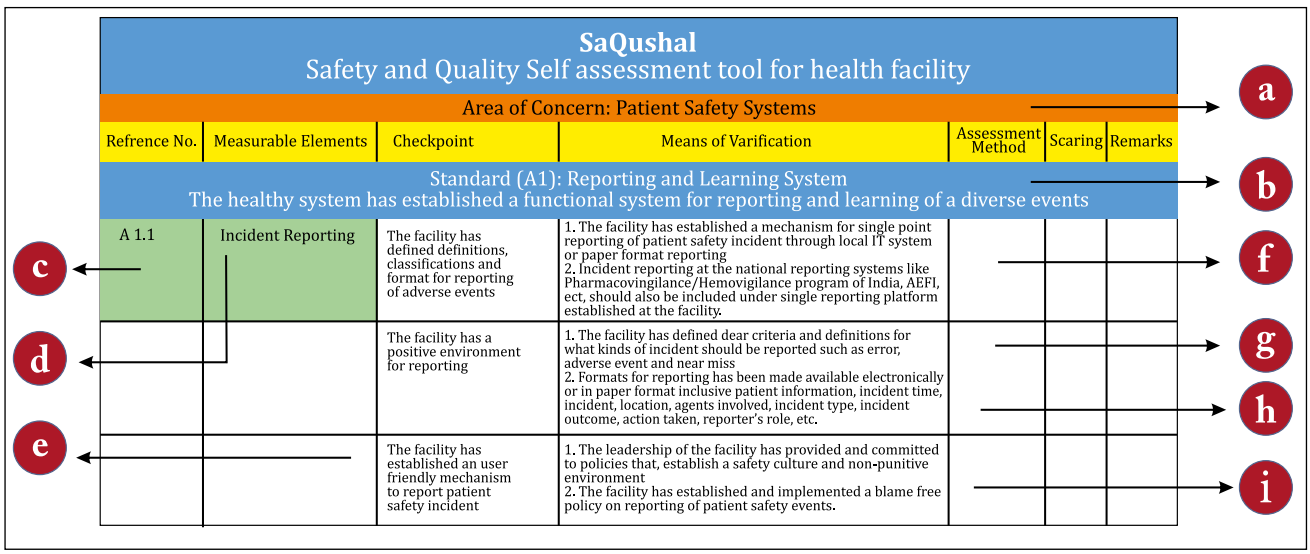
4. **Independence –** The staff should not assess his or her own department and process. Assessment should be independent and should be conducted in a manner that is free from bias and conflict of interest.

5. **Evidence based approach -** Conclusions are based on evidences, which are objective, verifiable and reproducible.

B. Arrangement of Checklist

Checklist is the main tool for the self-assessment. Hence, familiarity with the tools would be important. A snapshot of checklist is illustrated in figure 6.

Figure 6: Self-Assessment Tool Checklist



a) The horizontal bar in orange colour contains the name of the Area of Concern for which the underlying standard belong.

b) Blue horizontal bar contains the statement of standard which is being measured.

c) Extreme left column of checklist in green colour contains the reference number of Standard and Measurable Element. The Reference number helps in identification and traceability of a Standard.

d) Second column contains text of the measurable element for the respective standard.

e) The column next to measurable element on right side has Checkpoint for measuring compliance to respective measurable element and the standard.

f) Column next to Checkpoint contains Means of Verification. It denotes what to see in a particular Checkpoint. It may a be list of equipment or procedures to be observed, or example questions which may be asked to interviewee or some benchmark, which could be used for comparison, or reference to some other guideline or legal document.

g) Column right to Means of Verification column contains the assessment method column. This denotes the 'HOW' to gather the information. Generally, there are four primary methods for assessment – SI means staff interview, OB means observation, RR means record review & PI means patient interview.

h) Next column on right to assessment method is a blank column where scoring of assessment in term of Full Compliance (2 marks), Partial Compliance (1 marks) and Non-Compliance (0 marks) should be written.

i) A remark section also is given for filling by quality team whenever partial or non-compliance is given.

C. Assessment Methods

Before administering these tools, the assessor should read checkpoints and means of verification and try to gather information and evidence to assess the compliance to the requirements of measurable elements and checkpoints. Information can be gathered by four methods, Observation (OB), Record Review (RR), Patient Interview (PI) and Staff Interview (SI).

I. **Observation –** Compliance to many of the measurable elements can be assessed by directly observing the articles, process, and surrounding environment. Few examples are given below:

a) Adherence to infection control practices and safety protocols

b) Display of signage, work instructions and important information

c) Availability of personal protective equipment, vaccines, illumination, etc.

d) Environment like seepage, cleanliness, loose hanging wires, etc.

e) Procedures like filling CGA tool, counselling, segregation of biomedical waste, etc.

f) Close observation of behaviour, knowledge, attitude and practice by the service providers and their communication within the team

II. **Record Review –** As all processes especially clinical/consultation procedures cannot be observed, review of records may provide more objective evidence and triangulate within findings of the observation. Few of examples of record review are given below:

a) Review of clinical records for assessing adequacy of processes like History, maintenance of records of referral, medication review and optimisation, assessment and reassessment of patients at each visit.

b) Review of license, formats for legal compliances like authorisation certificate for Biomedical Waste Management.

c) Review of Work Instructions for adequacy and compliance.

d) Review of records for incident reporting, surveillance reports, PSG meetings etc.

e) Randomly reviewing the forms and formats to ascertain their completeness.

f) Reviewing the patients' records to check follow-up care, post referral, etc.

III. **Staff Interview –** Interaction with the staff helps in assessing the knowledge and skill level, required for performing job functions. Examples of staff interview are given below:

a) Competency testing - Asking staff how they perform certain diagnostic procedures, identification of early sign and symptoms of disease condition.

b) Demonstration – Asking staff to demonstrate certain activities like hand washing technique or newborn resuscitation.

c) Awareness – Asking staff about awareness of patient's right, patient safety quality policy, etc.

d) Perception about psychological safety, problems in performing work, other safety issues, etc.

IV. **Patient Interview** – Interaction with patients & relatives may be useful in getting information about quality of services and their experience at the facility. It should include Feedback on quality and safety of services, patient engagement in decision making, counselling on self-medication, counselling on home care, etc.

D. Scoring System

After assessing all the measurable elements, checkpoints and marking compliance as per the assessment methods, scores of the department/facility can be calculated.

Rules of Scoring

- 2 marks for full compliance
- 1 mark for each partial compliance
- 0 marks for every non-compliance

All checkpoints have equal weightage to keep scoring simple. Each checkpoint has two means of verification, if requirements for both MOVs are met, full compliance will be accorded to the checkpoint. Likewise, if requirements for one MOV are met, partial compliance will be given and if none of the MOV are fulfilled, non-compliance will be given against the checkpoint. Figure 7 briefs the process with the help of an example.

Figure 7: An example narrating arrangement of tool

Area of Concern A: Safe Patient Care Processes						
Reference No.	**Measurable Element**	**Checkpoints**	**Means of Verification**	**Assessment Method**	**Scoring**	**Remarks**
Standard (A1): Medication Safety The hospital has a medication management system to ensure safe medication practices at all times						
A 1.1	Safe prescribing of medicines	Uniform and comprehensive prescription format is used	1. The facility has standardized prescription format in all departments 2. The format has provision of documenting all relevant information related to patients and service provider as per Prescription Audit guidelines from NHSRC	RR/OB	**2/1/0**	

In the above-cited example, the scoring will be done against the checkpoints "Uniform and Comprehensive prescription format is used" based on fulfilment of the intent of the checkpoints as per means of verification. Intent compliance will be checked by using "Record Review/Observation" assessment method like availability of standardised prescription format and documentation of all patient's information as per Prescription Audit guidelines. If both the requirements are met, full compliance (2) will be given. Similarly, if none of the requirement is met, non-compliance will be marked.

Once scores have been assigned to each checkpoint, Standard wise score can be calculated by adding the individual scores for each checkpoint. The final score should be given in percentage, so it can be compared with other health facilities.

Calculation of percentage is as follows:

Score obtained x 100/No. of checkpoints in checklist x 2

Scores can be calculated manually, or scores can be entered into excel sheet given.

Filled checklist would generate Scorecard, which will include an overall score for the Health Facility (figure 8). Apart from this score card can also be generated for Area of Concern wise and Standard wise scores (figure 9).

Figure 8: Score Card - Overall Score & Area of Concern wise Scores

Overall Score & Area of Concern wise Scores				
Patient Care Processes	**Clinical Risk Management**	**Overall Score**	**Safe Care Environment**	**Patient Safety System**
50%	**50%**	**50%**	**50%**	**50%**

Figure 9: Standards wise Score Card

Reference No	Standard	Percentage
Area of Concern A- Safe Patient Care Processes		
Standard A1	**Medication Safety:** The hospital has a medication management system to ensure safe medication practices at all times	50%
Standard A2	**Infection prevention and Control:** The hospital has an infection control programme to ensure safe infection control practices at all times	50%
Standard A3	**Safe patient handling and Harm prevention:** The hospital has an established system to ensure safe patient handling and harm prevention in all clinical care settings	50%
Standard A4	**Communication at transition of care:** The hospital has an established system to ensure safe patient transport and referrals	50%
Area of Concern B- Clinical Risk Management		
Standard B1	**Safety in General Clinical Care:** The hospital has an established mechanism to reduce the risk of errors for general clinical care	50%

Standard B2	**Safety in RMNCHA:** The hospital has an established mechanism to ensure safety in Reproductive, Maternal, Newborn, Child, and Adolescent Health	50%
Standard B3	**Speciality clinical services:** The hospital has an established mechanism to ensure safety in speciality clinical services	50%
Standard B4	**High-risk clinical processes:** The hospital has an established mechanism to ensure safety in all high-risk clinical processes	50%
Area of Concern C- Safe Care Environment		
Standard C1	**Physical safety:** The hospital ensures safety of the patient, staff and infrastructure	50%
Standard C2	**Hygiene and environment control:** The hospital ensures all aspects of environment control within the premises	50%
Standard C3	**Human Factors and Ergonomics:** The hospital ensures preventive measurements are in place for safe patient handling	50%
Standard C4	**Support and maintenance services:** The hospital ensures safety in all support and auxiliary services	50%
Area of Concern D- Patient Safety System		
Standard D1	**Leadership and Governance:** The hospital has an established Leadership and Governance Framework to ensure the implementation of patient safety policy and plan are in place	50%
Standard D2	**Reporting and Learning System:** The health system has established a functional system for reporting and learning of adverse events	50%
Standard D3	**Patient Engagement:** There is an established framework to ensure healthcare delivery processes are patient centred	50%
Standard D4	**Ability at point of care:** The hospital has competent work force and work environment to ensure the provision of point of care	50%

Chapter 6

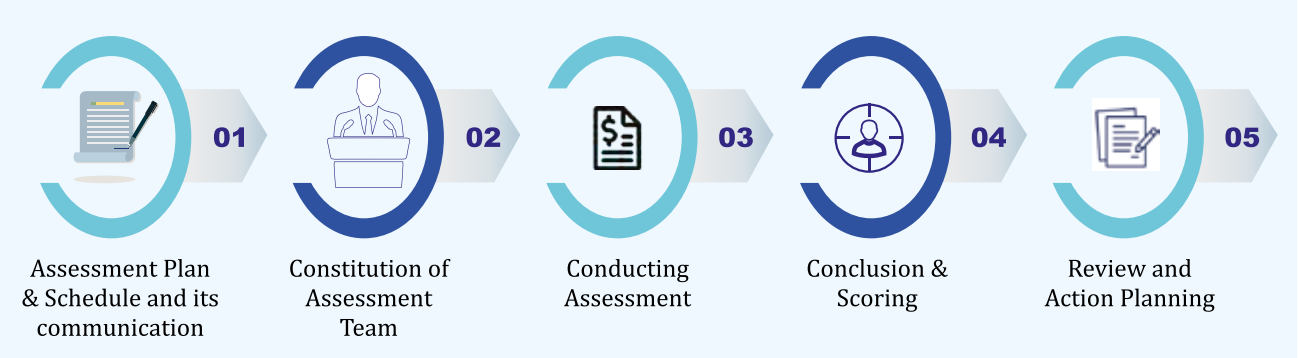
Conduct of the assessment at the facility

All district hospitals and large sub-districts hospitals are encouraged to participate. Self-assessment is a voluntary assessment but needs to be mandatorily undertaken before state level NQAS certification. The State Quality Assurance Unit is expected to provide technical support as needed. The facility staff will be trained to evaluate their hospital internally for patient safety. The facility should conduct the assessment twice in a year, as summarised in figure 10. The assessment should be conducted in consultation with all the departments of the health facility.

For conduct of the self-assessment, the quality team should appoint a coordinator, preferably the hospital manager whose main responsibilities are given below:

1. Preparing assessment plan and schedule
2. Constitute an assessment team composed of at least a doctor/specialist and a nurse
3. Arrangement of stationary (forms & formats) and communicating and coordinating with all departments to conduct the assessment
4. Monitor and review of the annual report on patient safety performance and patient safety indicators
5. Disseminate the findings of self-assessment tool followed by preparation of action plan based on the findings of self-assessment, surveillance data, incident reports and patient safety indicators

Figure 10: Assessment Process



Chapter 7

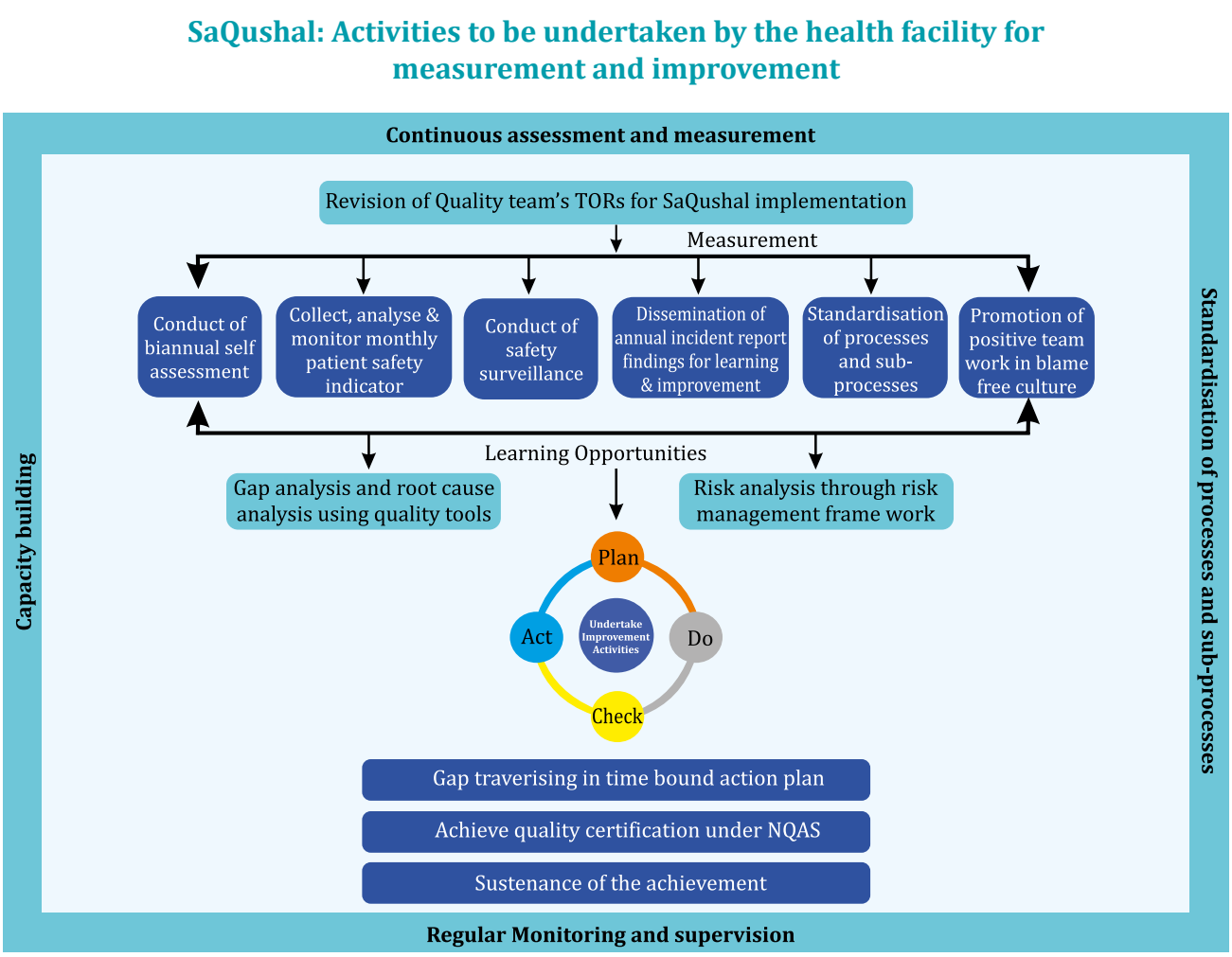
Monitoring and Supervision Framework

Unfortunately, most of the implementers considers "Measuring/Assessment" to be the ultimate goal of improvement activities. If we have measured something and the findings are not used to make improvement, it is of no value and in addition it results into waste of resources. Every measurement exercise brings out the gaps and are opportunities for improvement.

The monitoring and supervision framework for SaQushal, as summarised in figure 11, encompasses a systematic approach for measurement and improvement. Figure 8 briefly summarises the key activities to be undertaken by the facility after completion of self-assessment on patient safety activities. These activities include identification of training needs of clinical and para-clinical staff, capacity building, standardisation of clinical processes and sub-processes, availability of resources, risk analysis through risk management framework and calculation of patient safety indicators.

The general principles of improvement methodology have been laid down in Operation Guidelines for improving Quality in Public Healthcare Facilities 2021.

Figure 11: SaQushal-Monitoring and Supervision Framework



Steps for monitoring and supervision framework at the facility level

1. **Defining Quality team's TORs:** The existing quality team at the facility level will undertake the self-assessment to measure the patient safety activities. The quality team shall oversee the implementation of SaQushal and sustain the culture of patient safety in the facility.

2. **Assessing Safety of Care:** The quality team will undertake bi-annual self-assessment of the facility utilizing SaQushal tool. Simultaneously the quality team will capture the patient safety indicators, every month. This will be followed by regular conduct of safety surveillance, preparation of annual incident report and its dissemination to all departments for learning and improvement. The team will ensure that all measuring activities and analysis findings are utilized for better compliance, positive teamwork in a blame free culture.

3. **Learning opportunities:** The findings of self-assessment, safety indicators and incident report will help the facility to identify and prioritize the gaps using quality tools. Each of these gaps will be further classified as per the Donabedian model structure, process and outcome. Findings of the safety surveillance and annual incident report will assist the facility in risk identification followed by calculation of Risk Probability Number, based on which the facility could prepare a risk management plan to reduce the preventable harm.

4. **Undertaking improvement activities:** Once the facility completes the self-assessment and has identified & prioritized the gaps based on their findings, the facility/department is expected to undertake specific steps for improvement or closure of identified gaps. The improvement methodology is based on PDCA (Plan-Do-Check-Act) principles. However, it would be imperative for the facility to set up SMART objectives before undertaking PDCA approach followed by implementation of improvement strategies.

5. **Traversing gaps in a time-bound manner:** Based on the Gap analysis, the facilities will prepare a time-bound corrective and preventive action plan (CAPA) which will be reviewed in Quality and Patient Safety team's quarterly meetings providing handholding support to the facility. There will be resource requirements for organizing training, assessment, mobility support, and other incidental expenses. Therefore, the state may allocate budget for gap traversing in relevant financial heads through the NHM PIPs.

6. **Achieve Quality Certification under NQAS:** Once the facility has attained a baseline score of 70% in the quality and safety self-assessment, it should be followed by undertaking the facility for National NQAS certification. The score of the self-assessment could be shared with the district/state quality assurance unit along with the other documents' submission for external assessment under NQAS.

7. **Sustenance of the achievement:** SaQushal facilities achieving the NQAS certification shall be assessed on yearly basis to ensure sustenance and further facility improvement.

Chapter 8

Roadmap for Patient Safety

Although all the components of SaQushal are critical and facility must thrive to improve its safety score through a process of continuous improvement by strengthening the systems within the facility and also sustaining the gains. The ultimate aim of the SaQushal initiative is to support the facilities in progressing towards attainment of **"Zero Preventable Harm".** After completion of baseline assessment, a facility may define few Safe Patient Objectives in all departments, which would guide to undertake improvement activities. Such objectives should be in sync. with overall Quality Management System at the facility. Some of the immediate and long-term activities could be planned at the facility and state level, and are summarised below:

IMMEDIATE ACTIVITIES

A. At facility level

- Conduct of patient safety self-assessment, biannually
- Gap identification, prioritization of gaps, preparation of time-bound action plan

B. At state level

- Reviewing safety score in SQAU meetings and monitor the improvement in safety score
- Handhold the facility in gap closure and provide support through the State National Health Mission's annual Programme Implementation Plans (PIPs)

LONG-TERM ACTIVITIES

A. At facility level

- Setting Safe Patient Objectives in all departments
- Submission of incident reports to DQAU and SQAU on quarterly basis
- Recognition of safety champions at the facility level for motivation and encouragement

B. At state level

- Benchmarking of the health facilities based on safety score and indicators
- Sharing of best practices at within the state and nationally as well
- Recognition of best performing facilities and their felicitation
- Institutional support for the care of second victim

Conclusion

The patient safety self-assessment tools are envisaged to support the health facilities in defining objective criteria for measuring the status of patient safety activities. The tool will assist facilities in measuring baseline patient safety score and patient safety indicators, encouraging patient engagement, defining specific policy interventions and taking priority actions for ensuring safer delivery of health care in all settings. This assessment will establish a patient safety system, trigger actions for reporting and learning system for improvement and build an enabling policy environment, where genuine errors are reported, lessons learnt and interventions are sustained. This would be pivotal for realisation of UHC goals by the country.

Patient safety Self-Assessment Toolkit

SaQushal Safety and Quality: Self-assessment tool for health facility					
Area of Concern A: Safe Patient Care Processes					
Reference No.	**Measurable Element**	**Checkpoints**	**Means of Verification**	**Assessment Method**	**Scoring**
Standard (A1): Medication Safety The hospital has a medication management system to ensure safe medication practices at all times					
A 1.1	Safe prescribing of medicines	Uniform and comprehensive prescription format is used	1. The facility has standardized prescription format in all departments 2. The format has provision of documenting all relevant information related to patients and service providers as per Prescription Audit guidelines of NHSRC	RR/SI	
		The facility has policy and procedures in place for rational use of drugs	1. Medications are prescribed in generic name as per state's EML/ formulary 2. Clinicians adhere to standard treatment guidelines (STG) for rational usage of medicines and antibiotics	SI/RR	
		Standard practices of prescription prescribing are followed	1. Prescriptions are legible & written in capital letters, and are complete in all respect, such as patient, doctor's, medicine details, route of administration, precautions to be observed, etc. 2. Use of symbols, abbreviations, trailing zeros, and stemmed medicine names are avoided	RR/OB	
		Prescription audit is conducted, analysed and reviewed regularly at pre-defined interval	1. Audit is performed on a minimum sample of 30 prescriptions and have a representation from all clinical departments 2. Data are analysed and lowest performing indicators are presented during monthly quality and pateint safety team meetings	RR/SI	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		Follow-up action plan is prepared and implemented	1. Time-bound action plan is prepared to improve the indicators and prescription practices 2. Follow-up audit is conducted to review the progress made and timely feedback is given to the prescriber	RR/SI	
A1.2	Storage and dispensing	There is adequate space and optimal environmental conditions for safe storage of drugs in medical stores and pharmacy	1. Adequate space for storage of drugs is available and drugs are not stored on the floor 2. Temperature, Humidity, light senstivity and other environmental conditions, as recommended by the manufacturers are maintained	OB/SI	
		Drugs are stored and arranged in a scientific manner to avoid errors	1. Drugs are stored alphabetically and are labelled as per TALLMAN lettering in separate storage area for LASA drugs 2. Expiry and near expiry (having residual life of less than 6-months) drugs are stored at a separate and demarcated place	OB/SI	
		Special storage arrangements are made for storing critical drugs	1. Substances specified in Schedule X are stored under lock and key in cupboard or drawer as per Narcotic Drugs and Psychotropic Substance Act under Drug & Cosmetic Act and Rules 2. Combustible or inflammables are stored separately at secured place and labelled appropriately	OB/SI	
		Drugs are dispensed as per the prescriptions of clinician	1. No substitution of generic drug is undertaken by the pharmacist without permission from clinician 2. Patients are counselled on dose, frequency and direction of drugs by the pharmacist	RR/PI	
		Safe dispensing practices are followed	1. Strip cutting, as required, is performed without loosing expiry date, batch no and manufacturing date 2. Medicines are dispensed with intact original packaging	OB/SI	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
A1.3	Preparation and administration of medicines	There is an established policy and process for following 7R (Rights) of medication	1. 7R policy is developed and disseminated by the staff in all patient care settings 2. 7R approach-Right Patient, Right Medicine, Right Time, Right Dose, Right Route, Right Review and Right Documentation for indoor patients, is followed	SI/RR	
		Manufacturer's instructions are followed before drug administration	1. "Shake well" instructions are meticulously followed, wherever applicable 2. Drugs are diluted as per manufacturer's instructions before administration	SI/OB	
		Drugs are administered as per standard guidelines	1. Drugs those are not supposed to be broken into pieces, are administered in one piece (e.g. sustained released preparation) 2. Infusion Pumps with standardised technical specifications are procured and alarm system is used for administrating low dosage of drugs at uniform rate	SI/OB	
		Drugs dosage are calculated accurately	1. Drug dose for elderly and paediatric patients is displayed, and doses are calculated as per Standard Treatment Guidelines while prescribing 2. Antibiotics are prescribed after culture and senstivity test, if possible	SI/RR	
		There is an established procedure for verbal orders	1. A Verbal order policy is available for emergency advise, defining the steps who, when and how to take verbal orders are clearly mentioned 2. All verbal orders are documented and attested by prescribing doctor within 24 hrs of verbal order	RR/SI	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
A1.4	Medication review, optimization and reconciliation	Complete medication history is documented for each patient	1. Document all medications the patient is taking currently including over-the-counter medicines at the time of admission 2. Nurse/paramedic confirms patient's name, prescription details and medical history before drug administration at bed-side, during transfer of care and at the time of discharge	RR/OB	
		Established mechanism for Medication reconciliation process	1. Medication Reconciliation is carried out by a trained and competent health professional during the patient's admission, interdepartmental transfer or discharged 2. Medicine reconciliation includes Prescription and non-prescription (over-the-counter) medications, vitamins, nutritional supplements, potentially interactive food items, herbal preparations, and recreational drugs	SI/RR	
		Medicine are reviewed and optimised as per individual treatment plan	1. Medication review is performed for some groups like patients taking multiple medicines, people with chronic or long term conditions, older people, etc. 2. Medicines are optimised as per individual treatment plan for best possible clinical outcome	SI/RR	
		Complete medication history is documented and communicated for each patient at the time of discharge	1. Discharge summary includes known drug allergies and reactions to medicines or their ingredients, and the type of reaction experienced 2. Changes in prescribed medicines, including medicines started or stopped, or dosage changes, and reason for the change are clearly documented in the case sheet and case summary	RR/SI	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		Patients are engaged in their own care	1. Clinician/Nurse/ Paramedics counsel the patient on medication safety using *"5 moments for medication safety app"* 2. Nurse/Pharmacist highlights the medications to be taken by the patient at home and counsel the patient and family on drug intake as per treatment plan for discharge	PI/SI	
A1.5	Managing high-alert drugs and adverse drug events	High-alert medicines are identified in each department	1. List of High-alert medicines for each department are available and displayed in each department 2. Maximum therapeutic dose of each high-alert medicine is defined and documented	OB/RR	
		High-alert medicines are labelled and stored at a safe place	1. High-alert medicines are stored in secure, safe and demarcated place with a warning label on the containers 2. High-alert medicines are labelled with the name, concentration and date of expiry in bold letters	OB/SI	
		Extra precautions are taken before and during administration of high-alert medicines	1. An INDEPENDENT DOUBLE CHECK is performed before administrating high-alert drugs, especially for paediatric patients and vulnerable patients 2. High-alert medications required to be administered through IV/epidural route are transfused using SMART Infusion Pumps and auxillary labelling is placed at the distal end of the lines	SI/OB	
		Left-over High-alert drugs are immediately discarded after consumption	1. Vials, syringes, or infusion bags containing high-alert drugs are discarded immediately after consumption 2. The left-over high alert drugs are returned to the store/pharmacy immediately	SI/OB	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		A rapid response team is available within the facility to address any adverse drug event following administration	1. A rapid response team is available for responding to patient, family, and staff concerns as per adverse drug event trigger tool 2. Availability, accessibility of emergency drugs and functionality of equipment are ensured	SI/RR	
Standard (A2): Infection prevention and Control The hospital has an infection control programme to ensure safe infection control practices at all times					
A2.1	Personal Protection	Personal Protective Equipment (PPE) are available in all patient care areas	1. PPEs (Mask, Gloves, Apron/Coat, Head cap, Face shield, goggles, Footwear) are available at point of care in sufficient quantity as per patient load 2. PPEs are available in different sizes (adult, paediatric, etc.) and types (disposable, reusable, etc.), as per need	OB/RR	
		Standard protocol for PPE selection and usage	1. Staff is aware of the type of PPE (i.e. transmission based, type of material, etc.) to be worn for specific disease conditions 2. No reuse of disposable gloves and masks	SI/OB	
		Staff adheres with the protocols of PPE	1. Availability of demarcated area for PPE donning and doffing 2. Step-wise sequence and instructions for Donning and Doffing PPE are displayed and adhered by staff in all patient-care areas	OB/SI	
		Training on correct use of PPE	1. Staff is trained on minimum duration for which PPE is used 2. Staff is trained on what to do in the case of an equipment failure or detection of a breach in PPE	SI/RR	
		PPEs are disposed as per norms	1. PPEs are disposed in accordance with the current guidelines 2. Time to time amendments/specific advisories issued by pollution control board are adhered with	SI/OB	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
A2.2	Hand Hygiene	Availability of hand washing Facility at Point of Use	1. It includes wash basin with elbow/foot operated tap, running water, soap at point of use 2. Availability of alcohol based hand rub at point of care	OB/RR	
		Staff is trained on standard hand washing practices	1. Training imparted on 6 steps of hand washing to all HCWs 2. Training imparted on the importance of hand hygiene, "My 5 moments for hand hygiene" to all HCWs	SI/RR	
		Staff adheres to standard hand washing practices	1. Staff adheres to the 6 steps of hand washing 2. Staff is aware of 5 moments of hand washing and follows it	SI/OB	
		Regular monitoring and feedback given on compliance to hand washing	1. Hand hygiene audits are performed regularly (at least quarterly) to monitor hand hygiene practices 2. The result of the audits are shared with staff to improve compliance	RR/SI	
		Availability of reminders for hand wash at the point of care/procedure	1. Display of Hand washing Instruction at Point of Use/ Procedure 2. Instructions are visible and easy to understand	OB/SI	
A2.3	Instrument Processing	Availability of a Hospital Disinfection Policy	1. A hospital disinfection policy is prepared and disseminated in all patient care areas 2. Staff is aware of appropriate cleaning, disinfection and sterilization of equipment and instruments	RR/SI	
		Equipment are reprocessed and cleaned as per standard practices	1. Equipment/devices are disassembled prior to cleaning as per manufacturer's instructions 2. Equipment are thoroughly cleaned (manual or mechanical) with detergent and running water solution or as per manufacturer's instructions	SI/OB	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		Equipment are thermally sterilized or sterilised as per protocols	1. Instruments are packed for autoclaving as per standard protocol and sterilized at standardized temperature (121 degree Celsius), pressure (15 lbs) and time (20 min-unpacked/30 min-packed) 2. High level disinfection (HLD) may be used where autoclave is not available	SI/OB	
		Equipment are chemically sterilized or disinfected as per protocols	1. Instruments are chemically sterilised using 2% Glutaraldehyde by immersing the instruments as per manufacturer's instruction 2. High level disinfection is done by immersing instruments in 2% Glutaraldehyde for 20 min followed by rinsing with sterile water	SI/OB	
		Regular validation of sterilization processes is done	1. Using physical, chemical (chemical indicator tapes, strips) and biological (Geobacillus or Bacillus spores) indicators 2. Records of the autoclave process including colour change strips are maintained and monitored on regular basis	SI/OB	
A2.4	Isolation and Nursing Barrier	Dedicated isolation area (bed/room/ward/floor) is available	1. Criteria for admission, prioritization, monitoring, discharge and referral are defined 2. Criteria are followed and adhered with	OB/SI	
		Isolation area is designed as per protocol	1. Signages at isolation areas are in place 2. Self-closing door and 'Hands free' hand washing facility (elbow or foot operated, etc.) is available	OB/SI	
		Standard Practices are followed while managing the patient	1. Aseptic techniques are used (changing dressings, bed linen, medications, patient handling, etc.) 2. Surfaces are decontaminated with 1%hypochlorite in case of Accidental spills/exposure to contaminated fluids	SI/RR/OB	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		Standard Aseptic methods used to clean the isolation area	1. Separate cleaning equipment and Three bucket system are used to clean the isolation areas 2. Housekeeping equipment are washed, dried followed by storing them in a separate area	OB/SI	
		Environment control practices are ensured in isolation area	1. Minimum of 12 air changes per hour is ensured 2. A dedicated exhaust system is available for the isolation area	OB/SI	
A2.5	Injection Safety	Safe injection practices are followed universally in the health facility	1. The facility follows one needle, one syringe, one injection policy 2. The facility uses a single-dose vial and disposable syringes for every patient	SI/RR	
		Single-use medications are not used for multiple purposes	1. Single dose medications (vials/ampules/bags/ bottles) and Tubings and connectors (IV set, BT set, etc.) are used one time and are not used for more than one patient 2. Do not combine the left over contents of a single used vial for later use	RR/SI/OB	
		Standard practices are followed for administration of multi-dose medications	1. Multi-dose vials are dated when they are opened and discarded within 28 days or as per expiry date, whichever comes first 2. No needle is left in septum to avoid contamination	OB/RR/SI	
		There is an established mechanism for safe handling, removal and disposal of sharp devices	1. Needles are disposed in white coloured, translucent, leak proof and temper proof containers 2. “No needle recapping and needle bending” practice is followed within the health facility	SI/OB	
		There is an established mechanism for management and reporting of needle-stick injuries	1. There is provision of Post Exposure Prophylaxis in case of needle-stick injuries 2. The staff is aware of the availability of PEP in the facility and knows whom to report and what to do in case of needle-stick injuries	SI/RR	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
Standard (A3): Safe patient handling and Harm prevention The hospital has an established system to ensure safe patient handling and harm prevention in all clinical care settings					
A3.1	Accident and Falls	Established processes for identification and assessment of the patient prone to fall	1. Identification and assessment of patients prone to fall like old age, previous H/O fall, gait instability, urine incontinence, impaired judgement, Eclampsia, Epilepsy, Shock etc. 2. Instructions to prevent falls are documented in the care plan	PI/RR/SI	
		Communicating and educating patients and caregivers	1. Patients and caregivers are informed about the conditions when patient might fall like when patient is on sedatives or medications causing drowsiness 2. Patients and caregivers are involved in prevention practices for accidental falls like wearing shoes or non-slippery slippers, use of unmoving objects for stabilisation, keeping eye glasses or hearing aids near to the patient, etc.	PI/SI	
		Safety measures are in place while transferring the patients	1. Availability of walking aids and the floor is anti-skid especially inside patient's washroom 2. While transferring the patients on ramp, appropriate fastening mechanisms are ensured like wheelchairs and stretcher	OB/PI	
		Patient's surroundings are less prone to falls	1. Availability of Beds with adjustable height and bed safety rails 2. Aisle and passageways are clear and unobstructed	OB/PI	
		Medication risk assessment performed during treatment plan preparation	1.Review of all medication for treatment plan that increases risk of falls particularly psychotropic medication 2. Modification of medications which is as effective but to reduce the risk of fall	SI/RR	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
A3.2	Decubitus Ulcers	Established processes for identification and assessment of the patient prone to decubitus ulcer	1. Identification and assessment of patients prone to decubitus ulcer like limited mobility, on palliative care, poor nutrition, comatose, etc. 2. Instructions to prevent bed sores are documented in the care plan	SI/RR/PI	
		Communicating and educating patients and caregivers	1. Patients and caregivers are informed of the risks associated with pressure injuries 2. Patients and caregivers are involved in prevention strategies and management of pressure injuries	PI/SI	
		There are established procedures for prevention of decubitus ulcer	1. Water bed/air bed is provided to all patients prone to bed sores 2. Pressure prevention practices like regular re-positioning and turning, skin cleaning, moisture barrier ointment, keeping head >30 degree	PI/SI	
		There are established procedures for management of decubitus ulcer	1. Standard Treatment Guidelines including medical and surgical management of bed sores are documented and disseminated 2. Staff adheres with the guideline norms	SI/RR	
		Regular monitoring of the patient for decubitus ulcer and related complications	1. Risk is reassessed on a regular basis, as per STGs 2. Bed sore related complications are monitored	SI/RR	
A3.3	Venous Thromboemb bolism	Identify the patient prone to Venous Thromboemb olism	1. Timely assessment of VTE risk using a locally endorsed evidence-based tool e.g. (Adult VTE Risk Assessment Tool) 2. The result is documented and accessible to all clinicians involved in the patient's care	RR/SI	
		Communicating with patients and carers	1. Patients and caregivers are informed of the risks associated with blood clots 2. Patients and caregivers are involved in prevention strategies and management of blood clots	PI/SI	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		There are established procedures for management of Venous Thromboembolism	1. Standard treatment guidelines are documented and disseminated to the staff 2. Staff adheres with the guideline norms	SI/RR	
		Document and communicate the VTE prevention plan	1. VTE prevention plan is documented in patient's medical records 2. Clinicians involved in the patient's care are aware of the VTE prevention plan	SI/RR	
		Reassess risk and monitor the patient for VTE-related complications	1. Risk is reassessed on a regular basis, as per STGs 2. VTE-related complications are monitored each time risk is reassessed	SI/RR	
A3.4	Patient Identification	Standardized protocols for patient identification	1. Patient identification policy is available, documenting standardized approaches for patient identification among different departments of a health facility 2. Staff is aware of the protocols and adheres with them without compromising patient confidentiality and privacy	SI/RR	
		Patient identification system is developed	1. At least three patient identifiers are recorded at the time of admission (name, DOB, Gender, Address, ID no/Registration number) 2. Patient's bed or room number is not used as identifier	RR/PI	
		Distinct methods of identification for newborn patients	1. Minimum two patient identifiers are confirmed with the parent, guardian, or relative 2. Identity bands/wrist band are not too-tight on wrist of the newborn	OB/SI	
		Patient identification system is utilized in all high-risk procedures	1. Patient identifiers are used when administering medications, blood, or blood components and any other procedure 2. Blood samples and other specimens for clinical testing are labelled at bedside only	OB/SI	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		Patient identification system is utilized in treating high-risk and vulnerable patients.	1. Availability of protocols for identifying patients without identification like Orphans, lawaris, patient without attendant or next of kin, prisoners, etc. 2. Use other non-verbal approaches, such as birth marks, birth scars, mole, etc. for orphans, lawaris, etc.	RR/SI	
A3.5	Safety during patient referral	There are established protocols for patient referral	1. Availability and adherence with protocols and standardized referral form/ slip 2. List of LASA and high-alert drugs are displayed	RR/SI	
		Primary stabilisation and timely referral	1. All the patients are referred only after stabilisation 2. There is no delay in patient referral	RR/PI	
		Availability of emergency transport	1. Ambulance with life-saving medicines and equipment is available in-house 2. Ambulance with life-saving medicines and equipment is accessible (108/102) without any delay (15-30 minutes)	OB/RR	
		There is an established mechanism to ensure periodic maintenance of ambulance	1. Ambulance is regularly serviced as per manufacturer's instructions 2. Regular pressure drop test to ensure optimum pressure is maintained for oxygen system	OB/RR	
		Ambulance staff is trained	1. Ambulance staff including driver is trained in CPR 2. Ambulance staff is trained in emergency procedures like Oxygen administration, IV infusion, Defibrillation, etc.	SI/RR	
Standard (A4): Communication at transition of care The hospital has an established system to ensure safe patient transport and referrals					
A4.1	Communica-tion during intramural referral	There is an established procedure for inter-departmental transfers	1. Availability of bed is ensured in advance from the referral department and documented in referral registry 2. Prior information is provided to the referring department using SBAR or I-PASS	SI/RR	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		All referred patients are provided with transfer slip/ BHT	1. Transfer slip has the details of the department (e.g. name of the department, doctor, etc.) in legible handwriting 2. Transfer slip has details of the patients (e.g. name of the patient, past medical history, allergy if any, provisional diagnosis, etc.) in legible handwriting	RR/PI	
		Transfer slip is complete in all respect	1. Investigations done, any drug interaction, and reasons for transfer (second opinion or treatment) are clearly indicated in the transfer slip 2. Treatment provided during first aid stabilization is clearly written in the transfer slip	RR/OB	
		Communicating with patients and caregivers	1. Patients and caregivers are informed and counselled about the need of transfer 2. Communication is done in local language without using any jargon	PI/SI	
		The facility has necessary amenities for intramural communication	1. The facility has 24*7 functional telephone connection and broadband internet connectivity 2. All departments connected with one another through centralised intercom facility	OB/SI	
A4.2	Communica-tion during extramural referral	There is an established procedure for referral of patients to higher facility	1. Availability of bed is ensured in advance from the referral facility and documented in referral registry 2. Patient's medical status is communicated in advance to ensure that referral facility is prepared for case management	SI/RR	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		All referred patients are provided with referral card	1. Referral card has the details of the referral facility (e.g. name of the facility, department, doctor, contact details etc.) in legible handwriting 2. Referral card has the details of the patients (e.g. name of the patient, investigations done, procedure performed and treatment provided, etc.) in legible handwriting	RR/OB	
		Referral card is complete in all respect	1. The H/O patient, reasons for referral and provisional diagnosis is clearly indicated in the referring card 2. Treatment provided during first aid stabilization is clearly written in the referring card	OB/RR	
		Communicating with patients and caregivers	1. Patients and caregivers are informed and counselled about the need of referral 2. Communication is done in local language without using any jargon	PI/OB	
		The facility has necessary amenities for extramural communication	1. The facility has provision of 24*7 functional linkage with 108/102 ambulance service/equivalent service 2. Response time for ambulance service is less than 20 minutes	PI/SI/RR	
A4.3	Hospital alert codes	There are established uniform emergency response codes for communication	1. The facility has identified various emergency situations demanding an immediate and collective response 2. Each emergency situations (fire, cardiac arrest, child abduction, internal emergency, etc.) is coded by a colour as per national/international guidelines	SI/RR	
		A team is constituted for each emergency response code	1. Each team comprises of competent and experienced personnel and are available during each shift 2. Team members are aware of roles and responsibilities	SI/RR	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		There are established methods for emergency response notification	1. There is an established notification method for each emergency code like call notification, on-site alarms or short message service 2. The expected response time is 0-3 min	SI/RR/OB	
		Regular conduct of the trainings for capacity building	1. Periodic training is imparted for the staff about when, who, how and what to do on activation of emergency response code 2. Mock drills are conducted for all emergency situations and the results are documented and evaluated	SI/RR	
		There is an established procedure for reporting	1. Documented SOP with key components of managing emergency situation and SOPs are adhered with 2. The code incident report is prepared at the end of the event and is reviewed by top management	RR/SI	
A4.4	Discharge and follow-up communication	Discharge criteria are established	1. There are an established criteria for discharge of the patient 2. Patient is assessed by the doctor in-charge before discharge	SI/RR	
		Discharge card with case summary and follow-up instructions is provided	1. Discharge summary adequately mentions date and time of admission & discharge, diagnosis, treatment given, investigations done, procedure performed and follow-up instructions 2. All the medication to be taken by the patient at home and any possible medication interaction are highlighted in the summary	RR/SI	
		Engagement of patient and family members in discharge process	1. Date and time of the discharge is communicated before-hand to the patients and attendants 2. Patient and attendants are counselled on diet, special instructions, alarming signs, do's & don'ts and contact details in case of emergency	PI/SI	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		Established process for discharge of LAMA cases	1. Medical consequences of leaving the facility against medical advice and refusal to procedure is explained and documented on discharge summary 2. Signed declaration form is taken from the LAMA cases	SI/RR	
		Established process for discharge of cases on life-support system	1. Medical consequences of withdrawing patients from life-support is explained and documented on discharge summary 2. Signed declaration form is taken from the family/ relatives of such cases	RR/SI	
A4.5	Risk and hazard communication	Risk and Hazard identification	1. Potential risks and hazards (occupational diseases, musculoskeletal injuries, radiation, noise, heat, needle-stick injury, etc.) are identified and listed 2. List of risks and hazards is available in all departments	RR/SI	
		Periodic monitoring and evaluation of risks and hazards	1. Area samples are collected periodically to measure the extent of potential worker exposure to hazardous substances 2. Periodic medical examination of staff for any acute or chronic effects of exposure to risk is conducted, regularly	SI/RR	
		Hazardous chemicals are labelled appropriately	1. The chemical name, code number or batch number of the chemical (laboratory reagents, disinfectants, cleaning agents, etc.) is labelled 2. Signal words ("Danger"/"Warning") are used to indicate the relative level of severity of the hazard	OB/RR	
		Toxicological and health effects information is communicated	1. Information on the likely routes of exposure (inhalation, ingestion, skin and eye contact) is documented 2. Preventive measures to be taken to minimize or prevent adverse effects are known to the staff	SI/RR	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		Training imparted to all Health care workers on risk and hazard communication	1. The staff is trained on identification of signs of clinical illness on exposure 2. Staff is trained on preventive measures to minimize the adverse effects	SI/RR	
Area of Concern B: Clinical Risk Management					
Standard (B1): Safety in General Clinical Care The hospital has an established mechanism to reduce the risk of errors for general clinical care					
B1.1	Diagnostic Errors Prevention	There is an established procedure for Pre-testing activities	1. Laboratory has system in place for specimen collection, label and transport to prevent errors 2. Instructions for collection and handling of primary sample are communicated to those responsible for collection	OB/SI	
		There is an established procedure for testing activities	1. Laboratory has biological reference interval for its investigation 2. Laboratory has identified critical intervals for which immediate notification is done to concerned physician for appropriate test interpretation	OB/SI	
		There is an established procedure for Post-testing activities	1. Laboratory has a system to provide the reports within defined time interval 2. Laboratory results written in reports are legible without error in transcription	RR/PI	
		There is an established mechanism for internal quality assurance	1. Periodic validation of results of reagents, stains, media, kits, etc. is performed 2. Control charts are prepared, outliers identified and corrective action is taken on the identified outliers	OB/RR	
		There is an established mechanism for external quality assurance	1. Cross-validation of lab tests are done and Corrective actions are taken on abnormal values 2. Periodic calibration of automated analysers is undertaken	RR/SI	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
B1.2	Administrative Errors Prevention	There is an established process for patient record completion	1. Standardized patient record i.e. either electronic or paper based is implemented across the health facility 2. All the assessments, re-assessment, investigations, treatment and procedure conducted are updated regularly in patient medical records	RR/SI	
		The facility has uniform and user-friendly signage system in local language	1. The facility has established directional signage in uniform colour scheme 2. The facility displays the services and entitlements available in all its departments	OB/PI	
		The facility ensures implementation of health insurance schemes as per National /state scheme	1. Two step authentication system is done for the beneficiaries empanelled under health insurance schemes 2. Manual process is in place in case smart card is not working	OB/PI	
		The facility has established procedure for monitoring the quality of outsourced services and adheres to contractual obligations	1. The facility has defined tendering system for selection of outsourced agencies 2. The facility regularly monitors and reviews quality of outsourced services	RR/SI	
		The facility is compliant with all statutory and regulatory requirement imposed by local, state or central government	1. The facility has valid authorization for operation of health facility and different activities 2. Updated copies of relevant laws, regulations and government orders are available at the facility	RR/SI	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
B1.3	Multimorbidity Prevention	The facility has an established mechanism for identification of cases with multimorbidity	1. The facility proactively identifies cases with multimorbidity using health records and opportunistically during routine care 2. The facility has a provision of recording this information in the health records of the identified cases with multimorbidity	RR/SI	
		Patient and carers are involved in the decision-making process	1. The facility discusses the multimorbidity condition with the patient and their attendants 2. Preference for care on multimorbidity condition is included in the patient's treatment plan	RR/PI	
		The treatment care plan for multimorbidity documents clear roles and responsibilities for coordinating patient's care	1. The treatment care plan of an individual with multimorbidity clearly mentions about who is responsible for coordinating their care. 2. The treatment care plan is shared with the patient and other people involved in the care, including other healthcare professionals, family members and carers.	RR/PI	
		Existing medication and other treatment plan are reviewed for multimorbidity	1. The health service provider reviews patient's existing medicines and other treatments for multimorbidity whether any can be stopped or changed to better serve the patient's condition 2. Any change in the medication and treatment plan is recorded and documented in the health records of the patient	RR/SI	
		There is an established mechanism of reviewing to monitor effects of changes made in the treatment plan	1. The service provider periodically (based on the condition) reviews the effects of changes made in the treatment plan 2. Following the review, overall benefit of continuing the treatment is compared and discussed against the prognosis of quality of life of the patient	SI/PI	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
B1.4	Safety in Dental Practices	Established mechanism for prevention of procedural errors	1. Pre-procedure verification is done by marking the operative site on the dental diagram or x-ray (IOPA) 2. Marking of syringes to prevent mixing of LA and hypochlorite syringe	OB/SI	
		Error prevention strategies for tooth extraction are ensured	1. LA hypersensitivity test protocols and clinical assessment (past medical history, allergy status, BP, Blood Sugar) is recorded before LA administration 2. The socket is checked for loose bone/tooth fragments and the extraction site is compressed using digital technique	RR/SI	
		Error prevention strategies during restoration procedures are ensured	1. Rubber dam is placed during the restoration to prevent accidental ingestion by the patient 2. Occlusal adjustment is ensured by removal of high points	OB/SI	
		Error prevention strategies during endodontic procedures are ensured	1. K-type/Reamers file/ Broaches/rotary burs are discarded in case of bending, lose/open flutes and dull burs 2. Passive irrigation and side-vented needle are used to prevent hypochlorite accident	OB/SI	
		Capacity building of the staff to manage emergency situations	1. Staff is trained and skilled to manage emergency situations like syncope, anaphylactic shock, gingival burns, hypochlorite accident, etc. 2. Staff is trained on Postoperative instructions for all dental procedures	SI/RR	
B1.5	Safety in National Health Programmes	Established mechanism for early screening and detection at the first point of contact	1. Staff is aware of the symptoms and signs as per current national health programme guidelines 2. Staff is aware of disease classification on the basis of drug resistance as per current national health programme guidelines	SI/OB	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		Established mechanism for diagnosis and treatment	1. Staff is aware of and adheres with algorithm for timely diagnosis of cases as per current national health programme guidelines 2. Staff is aware of and adheres with algorithm for treatment of cases as per protocols	SI/OB	
		Established mechanism for counselling and psychological support	1. Patient and family is counselled about disease, pre-test and methods of prevention before initiating treatment 2. Patient and family is counselled and supported on dose schedule, duration, common side effects of treatment, consequence of irregular treatment or premature cessation of treatment	PI/SI	
		Monitoring and follow up of patient done as per protocols	1. Patients are monitored periodically for treatment compliance and management of side effects as per protocols 2. Follow-up of cases treated at tertiary level as per current health programme guidelines	PI/RR	
		Minimum performance standards for specialists and health care staff is defined as per IPHS 2022	1. One day per week/2hrs per day is dedicated by the health programme nodal officer to provide support to that health programme 2. Ensuring effective implementation of all National Health Programmes through intersectoral coordination	OB/SI	
Standard (B2): Safety in Reproductive, Maternal, Newborn, Child and Adolescent Health The hospital has an established mechanism to ensure safety in Reproductive, Maternal, Newborn, Child and Adolescent Health					
B2.1	Reproductive and Adolescent Health	Established mechanism for clinical assessment and screening	1. Proper history (menstrual, obstetric, contraceptive and medical history) is recorded to ensure Medical Eligibility Criteria (MEC) 2. It is ensured that she is not pregnant before adopting any method of family planning	RR/SI	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		Established mechanism for PPIUCD insertion	1. The provider ensures that IUCD is placed at the uterine fundus and is not visible at the cervical os 2. PPIUCD is not inserted between 48 hours and 6 weeks to prevent perforation and overall complication rate	OB/SI	
		Established mechanism for Laparoscopic Tubal Occlusion	1. Laparoscopic Tubal Occlusion is not performed in the postpartum period or after 2nd trimester post-abortion to prevent uterus injury 2. Veress needle is removed after insufflating 1.5 to 2.0 litres of carbon dioxide	OB/SI	
		Established mechanism for No Scalpel Vasectomy (NSV)	1. Standardised process of vas occlusion is performed to avoid damaging the vas artery 2. Haemostasis is ensured before ligature of the testicular end	OB/SI	
		Pre & Post procedure counselling and discharge	1. Beneficiaries have been made to understand what may happen before, during and after the surgery, its side effects and potential complications 2. Cases are counselled on normal signs and symptoms to expect for few days/ weeks after the IUCD insertion and about warning signs (PAINS) indicating need to return to the facility	PI/SI	
B2.2	Maternal Health	There is an established mechanism for ensuring safety before delivery	1. Pregnant women are triaged and examined for segregation of high and low risk patients 2. Every woman is offered the option to experience labour and childbirth with the companion of her choice	SI/PI	
		There is an established mechanism for ensuring safety during delivery	1. The facility staff is aware and trained of Labour Care Guide-WHO tool and Surgical safety checklist 2. Labour care guide tool and surgical safety checklist is filled for every women to ensure a positive childbirth experience for women	SI/RR	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		There is an established mechanism for ensuring safety after pregnancy	1. The facility adheres to protocol for assessment of condition of mother and newborn ensuring adequate postpartum care 2. The facility provides counselling to the mothers on danger signs, Kangaroo mother care, exclusive breast feeding, post-partum family planning to mother at discharge	SI/PI	
		There is an established referral mechanism for emergency cases with condition(s) that cannot be dealt effectively with the available resources	1. Labour room is in close proximity of maternity OT and SNCU/NICU for provision of shifting of patient in case of emergency 2. The health facility has written, up-to-date clinical protocols and guidelines for the identification, management (including pre-referral care) and referral of women with complications related to pregnancy and childbirth	OB/RR	
		The staff have appropriate competence and skills to meet requirements during labour, childbirth and the early postnatal period	1. Staff is trained and able to identify and manage the obstetric complications 2. Staff is trained under Skill Birth Attendant (SBA) and Respectful Maternal Care trainings	SI/RR	
B2.3	Newborn care	The facility has safety and security system in place at patient care areas	1. Identification tags are used for ensuring the identification of baby 2. Newborn is kept in a cot supported by rails to prevent fall at a room temperature of 26-28 °C	OB/SI	
		The facility has an established mechanism for provision of essential newborn care immediately after birth	1. The facility adheres with immediate drying, KMC and additional simulation norms before initiating positive-pressure ventilation 2. Early breastfeeding practices and techniques are followed by the facility and any kind of promotion and advertisement of infant milk substitutes is prohibited	SI/PI	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		The facility has an established mechanism for provision of essential postnatal care	1. The care giver is counselled to identify danger signs during postnatal care 2. Bed side hand over is given using SBAR (situation, background, assessment and recommendation) protocols	PI/RR	
		The facility adheres with the immunization schedule for newborn	1. Inject hepatitis B vaccine IM and BCG intradermally, as per national guidelines 2. Inject a single dose of vitamin K (Phyto menadione) 1 mg IM soon after birth	SI/RR	
		The facility has an established mechanism for management of newborn and young infant illnesses	1. Emergency & OPD criteria has been established and implemented for receiving and sorting of the newborns 2. The facility has documented and implemented work instructions for management of newborn and young infant illnesses	RR/SI	
B2.4	Child health Care	The facility has a provision of dedicated services for child health care	1. The facility has a dedicated paediatric ward for assessment, investigation and treatment of admitted sick children 2. The facility has provision of functional immunization clinic, Infant and Young Child Feeding counselling room, NRC, Comprehensive Lactation Management Centres, KMC room and SNCU/NBSU/Mother & Newborn Care Unit, as applicable	OB/SI	
		The facility has adequate functional equipment and consumables	1. The facility has adequate number of functional resuscitation equipment of appropriate size for children (self-inflating ventilation bag, Laryngoscope, Suction machines, ET tubes, etc.) 2. The facility has adequate number of functional resuscitation consumables of appropriate size for children (Nasogastric tube, Suction Catheter, Uncuffed tracheal tube, oropharyngeal airway, etc.)	OB/RR	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		The facility has a safety and security mechanism for child care	1. The facility has a provision of identification band for all children admitted in Paediatric ward 2. The facility has a provision of bedside call bell with indicator light and location indicator in the nurses' duty station along with the side railings with the bed to prevent fall	OB/PI	
		The staff is competent to handle emergencies	1. The staff is trained on child care including but not restricted to infant and young child feeding practices, Emergency Triage Assessment and Treatment, Integrated Management of Neonatal and Childhood Illness (INMCI), communication skills, etc. 2. The staff is trained on management of Adverse Events Following Immunization (AEFI)	SI/RR	
		The facility has appropriate linkages for transfer to higher facilities to assure the continuity of care	1. The facility has established linkage for referral and management with tertiary care unit (Paediatric Intensive Care Unit-PICU) after primary stabilization 2. The facility has established linkage with appropriate higher level facility for management of defects at birth, deficiencies, childhood diseases, developmental delays and disabilities (4Ds)	SI/RR	
B2.5	Immunization Safety	There is an established mechanism to ensure safe cold-chain practices	1. Vaccines are kept at required temperature as recommended in national immunization guidelines 2. Vaccines are never kept on the floor of the ILR with freeze-sensitive vaccines at the top of the basket and heat-sensitive vaccines in the bottom of the basket	SI/OB	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		Safe practices are in place for reconstitution and proper use of diluents	1. Diluents are cooled between +2 degree Celsius and +8 degree Celsius before reconstitution 2. Sterile water for injection must NOT be used as a vaccine diluent	OB/SI	
		Safe use of opened multi-dose vials of vaccine in subsequent immunisation sessions	1. Multi-dose vials used in subsequent immunization sessions are not used beyond four weeks 2. Reconstituted vaccine vials must be discarded at the end of each immunization session or at the end of six hours, whichever comes first	SI/OB	
		The facility ensures safe injection practices are followed at immunization site	1. A new sterile AD syringe and needle is used for every injection 2. Always pierce the septum of multi-dose vial with a sterile needle and never leave a needle in the septum	SI/OB	
		There is an established mechanism for management of AEFI cases	1. The facility has an established system for detection and reporting of AEFI cases 2. The vaccinator is trained and prepared for preventing, identifying and management of any adverse event following immunization	SI/RR	
Standard (B3): Speciality clinical services The hospital has an established mechanism to ensure safety in speciality clinical services					
B3.1	Safety in Dialysis services	There is an established criteria for before initiation of dialysis session	1. All the patients are weighed before the initiation of dialysis session 2. A dialysis plan is documented and have details of Ultra filtration goal (amount of fluid to be removed), Ultra-filtration rate, dialysis duration, any expected complications, etc.	SI/PI/RR	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		The facility has defined safety check criterion during dialysis session	1. Safety checks for blood tubing in terms of secured cannula, air detection/line clamps and patency of the circuit is ensured 2. Safety checks for dialysis machine in terms of disinfection, alarm limit and dialysate flow rate is ensured	OB/SI	
		Facility has system to identify the malfunctional equipment	1. Functionality checklist and servicing schedules for dialysis machines, Reverse Osmosis (RO) water testing, water viral marker testing and other supporting equipment's are maintained 2. Breakdown time is recorded and reported, properly	OB/RR	
		The facility has defined and established procedure for care after completion of dialysis	1. Patient is counselled for self-care and a diet plan is provided to them 2. Only dialysers clearing the 'Test of performance' are reused on the same patient	PI/RR	
		There is an established system for periodic and regular monitoring of the patient	1. Dialysis session is regularly monitored for needle dislodgement and clotted circuit 2. Patient is advised and monitored for rotation of the needle to prevent coring and damage to the vessel wall	SI/OB	
B3.2	Safety in Ophthalmology services	The facility has established criteria for perioperative care	1. The patient is advised not to come empty stomach on the day of the surgery 2. The patient is counselled to take their normal medication on the day of the surgery	PI/SI	
		There is an established mechanism to ensure prophylaxis of infection and sterility	1. Prior to start of operation, proper infection prophylaxis is ensured by the surgeon 2. All equipment and instruments are sterilised before using for another patient	SI/RR	
		The facility has established criteria to prevent cataract surgery related errors	1. Biometry assessment results are reverified before IOL implantation 2. Measures are in place to check the IOL characteristics before implementation	SI/RR	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		The facility has established criteria for refractive errors	1. The prescription is legible and easy to interpret 2. Snellen chart is placed 20 feet away from the patient	OB/RR	
		The facility has established criteria for postoperative care	1. Patient is monitored for 24-h in case of intraoperative complication 2. Doctor visits the patient once in 24-h in case of uncomplicated operation	PI/SI	
B3.3	Safety in Mental Health Care	The facility adheres to safe practices during admission	1. Facility maintains a patient register recording details of past medical history, and records of psychological intervention 2. The facility has an established mechanism for identification of patients who are prone to self-harm	SI/RR	
		The facility ensures safety of female and minor patients	1. Facility ensures part time availability or on call availability of a gynaecologist in case of female patients 2. Facility ensures part time availability or on call availability of a paediatricians in case of minors	SI/RR	
		The facility ensures safe infrastructure for safety of patients	1. Windows and doors are guarded 2. Facility ensures there are no dangerous objects - sharp edged, ligature points or inflammable material present in the premises.	OB/SI	
		The facility has safe practices in place to prevent elopement of the patient	1. The facility ensures that doors or windows are not left unguarded 2. Facility has provision for discharge of a minor by its nominated representative	OB/SI	
		The facility ensures collaborative treatment planning with patient and patient's relative	1. Facility ensures patients or patient's representative (in cases the patient is incapable) are included in the decision-making and treatment plan 2. Informed and signed consent is taken for each patient includes risks of each treatment and possibility of no treatment	PI/RR	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
B3.4	Safety in Intensive Care	Layout of ICU ensure safety checks as per functions	1. There is no throughfare through ICU 2. ICU is located in close proximity of Emergency room, operation theatre, blood bank, etc.	OB/SI	
		The ICU department has established parameters for safety of electrical establishment	1. ICU has dedicated earthling pit system available 2. No adapter is used for ensuring provision of electric outlet/inlet	OB/SI	
		The facility has robust system to check and monitor the functionality of equipment	1. Up to date instructions for operation and maintenance of equipment are readily available with staff 2. All critical equipment are supported with power backup/UPS	OB/RR	
		The facility has defined and established procedure for intensive care	1. Staff has explicit clinical criteria for providing intubation & extubating and adheres 2. Staff is trained and follows clinical protocols for management of critical clinical conditions	OB/SI	
		The facility has system for high risk medicine storage and dispensing	1. Drugs as specified in Schedule X and Narcotic drugs and Psychotropic Substance Act 1985, are stored under lock and key in cupboard 2. Maximum dose of high alert drugs are defined, communicated and displayed in department	OB/RR	
B3.5	Safety in palliative and Geriatric care	Established procedure for assessment and treatment plan preparation for the provision of Geriatric Care	1. Comprehensive Geriatric Assessment (CGA) tool is used for early identification of complications of chronic conditions and for specific clinical presentations like falls, gait & balance assessment, geriatric depression, mental capacity issues, urinary incontinence, etc. 2. The staff prepares follow up treatment plan as per the findings of the CGA tool	SI/RR	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		Established procedure for assessment and treatment plan preparation for the provision of Palliative Care	1. Palliative assessment tool is used for comprehensive assessment of the patient's pain and symptom management including identification of physical, psychological, and social needs of the patient 2. Pain and symptom management based on identified needs are included in the care plan	SI/RR/OB	
		The services are easily available and accessible to the care-seekers	1. The facility provides supporting aids for elderly person like walking sticks, callipers, infrared lamp, etc. as per the need 2. The facility has a provision of home-based palliative care for basic nursing care for bed-ridden patients	PI/SI/OB	
		Effective communication takes place between the patient, their family and the care provider	1. Family members and care providers are educated on management of pain, distress and other symptoms in the patient in an empathetic, compassionate and supportive manner 2. The family members are engaged and educated for looking after disabled elderly person at home	PI/SI	
		The facility has a provision of End-of-Life care	1. The patient and their family are given information about the signs and symptoms of approaching death in a manner appropriate to their individual needs and circumstances 2. The facility provides out of hours care, nursing care and bereavement support in a socially and culturally appropriate manner.	PI/SI	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
Standard (B4): High-risk clinical processes The hospital has an established mechanism to ensure safety in all high-risk clinical processes					
B4.1	Surgical Safety	There is an established procedure for taking informed consent before surgery	1. Informed consent is taken before major surgeries. 2. Patient and relatives are informed about the approaches and prognosis of the surgery verbally by the surgeon	PI/RR	
		There is an established mechanism of ensuring safety before surgery	1. The OT nurse verbally confirms the name, surgical site and procedure to be performed on the patient 2. The prophylactic antibiotics are administered 60 minutes prior to surgical incision	SI/OB	
		The facility follows patient safety procedures intraoperatively	1. The facility follows WHO surgical safety checklist 2. The sterility of the surgical equipment is verified using indicator	SI/RR	
		Ensuring instruments, sponge and needles match pre and post operative.	1. The OT nurse count all the instruments, sponge and needles before the surgery 2. The OT nurse recount all the instruments, sponge and needles after the surgery	SI/RR	
		There is an established mechanism of ensuring safety after surgery	1. Patient's vital parameters are monitored and recorded before discharging to ward 2. Post operative orders are recorded and compliance is monitored	SI/RR	
B4.2	Anaesthesia Safety	The facility has established safety criteria before Anaesthesia induction	1. Pre Anaesthesia evaluation must include patient's name, past medical and allergy history, vitals, food intake status and procedure to be performed 2. All emergency medicines and functional equipment are in place to perform ABCD	OB/RR/SI	
		Anaesthesia plan is defined and documented	1. Ananaesthesia plan is prepared for every patient based on patient's clinical history including anticipated complications and its management 2. Patient is well explained about the anaesthesia and procedure of administration	RR/PI	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		The facility has established safety criteria during Anaesthesia induction	1. Breathing system that delivers gas to the patient is securely and correctly assembled 2. Patient's intravenous access is functional	SI/OB	
		The facility has established procedures for monitoring during Anaesthesia	1. Patients heart and respiratory rate, oxygen saturation levels, BP, temperature, Cardiac rhythm and tidal carbon dioxide levels are regularly monitored and recorded during surgery 2. Potency and level of anaesthesia is monitored regularly	RR/OB	
		The facility has established safety criteria after Anaesthesia induction	1. The staff monitors and documents the post aesthetic status of the patient 2. The facility has defined criteria for shifting the patient from operating room to recovery room and staff is aware of it	SI/RR	
B4.3	Radiation Safety	The Facility follows AERB Guidelines	1. Lay-out of the Radiology department follows AERB guidelines 2. The facility holds AERB authorisation for operationalisation of X-ray unit	RR/OB	
		The facility complies with ALARA (as low as reasonably possible) principle to ensure radiation safety	1. The radiology department follows the dose limitations to ensure that no individual is exposed to a risk 2. All three basic factors for radiation protection in terms of exposure time, distance (positioning) and shielding material are considered to minimise the radiation exposure	OB/SI	
		The facility ensures proper signages in and around radiation department	1. The radiation symbol shall be conspicuously and prominently displayed at all places inclusive department, storage area, trolleys carrying radioactive materials, etc. 2. Warning sign for pregnant women is displayed at the entrance door of the radiology department	OB/PI	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		The facility has established mechanism to ensure occupationally safety	1. Availability of TLD Badges, lead aprons, protective rubber flaps and trained Radiation Safety Officer or equivalent 2. QA tests of X-ray equipment are performed through AERB recognised QA agencies to ensure that the equipment functioning is safe	SI/RR	
		Facility ensures mechanisms of safe patient handling	1. High-risk patients like renal failure, multiple morbidity, pregnant/ lactating women are identified before the start of the procedure 2. The facility has established mechanisms to manage hypersensitivity reaction post injection of contrast agents	SI/RR	
B4.4	Blood and Transfusion Safety	The facility has established safety criteria for blood collection from donors	1. The facility uses National AIDS Control Organisation's criteria for donor selection 2. Collected blood sample is placed at 4-6 degree Celsius to +/- 2 degree Celsius except if it is used for component preparation	SI/OB	
		The facility has established safety criteria for cold chain management of blood bank or storage unit	1. Blood bank has separate power backup or UPS in place. 2. The storage unit has alarm system for power backup or for temperature control unit.	OB/SI	
		The facility has established safety criteria for blood testing and labelling	1. The facility performs all tests (Blood group, type, infectious diseases, sterility) as per NACO guidelines 2. A system for labelling of container is in place for blood unit identification like name of the product, date of collection and expiry, storage temperature, license number of collecting facility	OB/RR/SI	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		Patient safety precautions are taken before blood transfusion	1. Blood bank has system to test and cross match the recipient blood with donor blood 2. A written consent is taken from the patient after informing about his/her need for blood, alternatives available, as well as risks involved in transfusion and non-transfusion	OB/RR/SI	
		The facility has robust system to avoid blood transfusion reactions	1. The doctor/transfusionist verifies the patient identity, the blood unit, blood group and cross matching report just before transfusion 2. Warming of blood to body temperature is done in case of rapid transfusion and massive transfusion	SI/OB	
B4.5	Safety in Emergency Care	The staff is trained and skilled enough to ensure safety in emergency care	1. The staff is trained and skilled for emergency services like triage, mass casualty management, ALS, BLS, etc. 2. The staff is skilled and trained to use defibrillator and performs resuscitation	SI/RR	
		The facility has an established safety criteria to perform critical interventions for high-risk conditions	1. The emergency staff performs trauma survey to identify life-threatening injuries 2. Emergency protocols are defined for life-threatening injuries	RR/SI	
		The facility has established safety criteria for admission	1. A separate demarcated triage area is available for receiving the patient 2. The facility has defined a colour coding system for bed allocation based on triage assessment findings	OB/SI	
		The facility has critical available equipment	1. The facility has all resuscitation/airway management equipment 2. The facility has all basic equipment like cervical collar, pelvic binder and bed-sheets, brose low tape, fluid warmer, etc.	OB/SI	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		The facility has an established mechanism to ensure proper transfer of care	1. Ambulance appropriately equipped for BLS with trained personnel 2. There is a mechanism of replenishment of all emergency medications	OB/SI	
Area of Concern C: Safe care Environment					
Standard (C1): Physical safety The hospital ensures safety of the patient, staff and infrastructure					
C1.1	Structural safety	Physical conditions of the buildings are safe for providing patient care	1. All windows have grills and wire meshwork 2. Building including terrace, roof, balconies and stair case have protective railing and walls are free of fungal growth and plaster chipping	OB	
		Location of the building is safe for providing patient care	1. Facility is not located near a large water body reservoir, grazing area, earthquake prone areas, etc. or low lying areas 2. Critical care departments are located away from the main traffic moving in and out of the hospital	OB/SI	
		Design of the building is safe for providing patient care	1. Number of building floors (storeys) are less than five, especially in areas that are vulnerable to earthquake or are as per government guidelines 2. Floor of the departments is non-slippery and even	OB/SI	
		Adequate arrangements are in place for the safety and security of hospital and patient's personal belongings	1. Entry to the critical care areas like OT, Labour Room, ICU, etc. is restricted 2. Bed-side locker for safety and security of patient's personal belongings are provided	OB/PI	
		Adequate arrangements are in place for ensuring safety near oxygen storage area/ manifold room as per OSHA guidelines	1. Oxygen cylinders are not stored near combustible material or stored at a minimum distance of 20 feet from highly combustible material, especially oil and grease 2. Distance between two manifolds shall be at least 50 feet (15m) apart in a same room	OB/SI	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
C 1.2	Seismic safety	The facility has an established mechanism of maintenance and inspection for hospitals	1. The facility conducts structural safety assessment at periodic interval (every 5 years as per national disaster management guidelines 2016) by a competent licensed structural engineer 2. The facility maintains a list of all structural and non-structural components and their maintenance schedule	RR/SI	
		Mechanisms are in place to secure the non-structural elements	1. All non-structural-elements (fixtures and furniture's as per IPHS 2022) are properly secured and fastened 2. Furnishing items are kept away from sitting area, corridors, doorways and exit path	OB/SI	
		Safety strategies are in place to avoid any connection between structural and non-structural elements	1. False ceilings are not used in hospital building 2. Wall mounted items like cabinets, air conditioning unit, exhaust, HVAC system, TV units, Geysers are secured and fastened	OB/SI	
		The facility ensures the seismic safety of the infrastructure	1. All the floor of a building are in alignment with each other and difference is not more than 5% 2. Hospital buildings, new and old are retrofitted in seismic zone IV and V as per NDMA guidelines	OB/SI	
		The staff is trained in management of seismic situation	1. There is a set protocol for transfer of patients and provision of additional beds during emergency 2. The facility conducts periodic mock drill to assess the level of staff preparedness and hospital system response	SI/RR	
C 1.3	Electrical safety	The facility has established mechanism of periodic inspection	1. The facility has a system for conducting electric audit at defined intervals 2. Digital display is installed to monitor the voltage between neutral and earthing and it is not more than 5 volts	OB/RR	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		Safety checks are in place to avoid adverse event	1. The electrical switch room is situated on the ground floor and is located outside the main building near the perimeter wall 2. All electrical panels and outlets are covered and have restricted access	OB/SI	
		The facility ensures safety of electrical establishments	1. The facility do not have temporary connections and loosely hanging wires 2. Two numbers of copper plate earthing is ensured at each electrical installation	OB/SI	
		The facility ensures adequate power backup in all patient care areas as per load	1. Availability of 24*7 power backup in all critical areas with noise limit of 75 dB at 1 meter from the enclosure surface for new diesel generator 2. Sensitive equipment (like in ICU) are provided with UPS	SI/OB	
		The facility has established mechanism to prevent overloading	1. The facility has estimated power consumption of different department to avoid overloading 2. Automatic voltage regulators are installed to regulate fluctuations input power voltage	OB/RR	
C 1.4	Fire safety	The facility has a plan for fire prevention	1. The facility has glowing fire exits signages and strips to permit safe escape to its occupant at the time of fire 2. The fire escape routes are not obstructed, motorable and validated periodically to ensure that routes are not obstructed	SI/OB	
		The facility has adequate firefighting equipment	1. The facility has fire suppression system with one exclusively around the electric board with sufficient number of ABC and CO2 type fire extinguishers, Hose reel, sprinkler, yard hydrant, etc. in place 2. There is system to track the expiry dates and periodic refilling of the extinguishers	OB/RR	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		The staff is prepared to manage the fire mishaps	1. All category staff is trained periodically on using fire-fighting appliances 2. Mock drills are conducted at fixed intervals	SI/RR	
		The facility has measures in place to detect the fire	1. The facility conducts periodic fire safety audit by competent authority 2. The facility has manual/ automatic fire detection and warning system in place	OB/RR	
		Instructions are in place for fire prevention and management	1. "No smoking sign" is displayed inside and outside the working area and fuel for DG set is not stored near electric board 2. Instructions (RACE/PASS) to operate fire alarm and fire extinguishers are displayed	OB/SI	
C 1.5	Security and access control	The facility has provision of restriction of visitors in patient areas	1. The facility has implemented visitor pass policy in indoor areas 2. There is restriction on entry of vendors and hawkers inside the premise of the facility	OB/RR	
		The facility has security system in place at patient care areas	1. There is established procedure for safe custody of keys 2. Only Authorised persons are allowed to enter the department/room/store and person has taken basic training on self-defence & crowd management	SI/RR	
		The facility ensures safe and comfortable environment for patients and service providers	1. The facility has adequate number of security guards in accordance with IPHS norms 2. No female staff is posted alone at night or otherwise must be posted in pairs	SI/OB/RR	
		The facility has established security and access control protocols	1. The staff has an identification card and uniform for easy recognition 2. The facility has access control plan for restricted entry of the staff in different areas of the facility	SI/OB	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		The facility has protocols for safe and secure access to hospital assets	1. Security staff is available at critical departments, medical record room, store room, etc. 2. There is a system of alarm or alert announcement in case of breach in restricted area	OB/SI	
Standard (C2): Hygiene and environment control The hospital ensures all aspects of environment control within the premises					
C2.1	Illumination	The facility provides adequate illumination level at patient care areas	1. The facility has provision of natural light in the patient care area 2. The facility adheres with illumination norms defined in IPHS guidelines/BIS norms for patient care areas	OB/SI	
		There is adequate illumination in front of hospital and access road	1. Facility name is well illuminated at night 2. Facility front, entry gate and access road are well illuminated	OB/PI	
		There is an established mechanism to ensure the appropriate illumination level	1. The facility has luxmeter to monitor the illumination norms and conducts a illumination audit at night on quarterly basis, especially in toilets 2. Shadow less lights in the operation theatre and delivery rooms	SI/RR/OB	
		There is adequate illumination in auxiliary area	1. Auxiliary area of the facility like Pharmacy, Kitchen, Laundry, Mortuary, Administrative offices, Abandoned area/building are well illuminated 2. Lights are not fused and the switches are functional	OB/SI	
		The facility promotes low energy-lighting source	1. The facility uses LED lamps/bulbs/solar lights 2. No blackened, flickering, dim or failed tube lights/ bulbs are present	SI/OB	
C2.2	Water and sanitation	The facility receives adequate quantity of water as per requirement	1. The water is available on 24x7 basis at all points of usage 2. RO/ Filters are available for potable drinking water	PI/OB	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		There is storage tank for the water and tank is cleaned periodically	1. The hospital has a capacity to store 48 hours water requirement 2. Water tank is cleaned at six month interval	SI/OB/RR	
		The facility has established mechanism for water testing	1. Physical testing for hardness, total dissolved solids (TDS) is done at least once a year on samples taken directly from the source of water 2. Microbial testing of water is done every three months	SI/RR	
		The facility educates the patient/family on sanitation practices	1. The facility has a mechanism of Social Behaviour Change Communication (SBCC) regarding water sanitation and toilet usage in local language 2. IEC material is displayed at appropriate height; preferably at eye-level	SI/OB	
		The facility follows standard protocols for cleaning of toilets	1. Sinks and cistern are cleaned daily and as and when required 2. Toilets have running water and functional cistern	OB/PI	
C2.3	Cleaning services and surface disinfection	Facility ensures standard practices followed for cleaning and disinfection of patient care areas	1. Manufacturer's instructions are followed for proper dilution and contact time for cleaning and disinfecting solutions 2. In a sequential mopping like in three bucket system, last mop is always done with disinfectant solution	SI/OB/RR	
		General Cleaning practices are followed	1. Progress from the least soiled areas to the most soiled areas and from high surfaces to low surfaces 2. Mops and other cleaning items are not stored in patient care areas	SI/OB	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		The facility uses standard methods of Cleaning	1. The staff follows unidirectional and outward mopping/away from patient as per defined frequency in Kayakalp implementation guidebook 2. Adequate protective clothing and equipment (eye-shield, mask, rubber gloves, gum-boot, PVC shield) is provided to the staff engaged in the cleaning	OB/SI	
		The facility uses standardised cleaning and disinfectant agents	1. Material Safety Data Sheet (MSDS) is followed for preparation and storage of cleaning and disinfectant agents 2. Sodium hypochlorite is freshly prepared or after every. 8hrs as per required level of dilution i.e., 0.05%, 0.1%, 1%, etc.	RR/SI/OB	
		The facility has a established mechanism of cleaning and disinfectant agents storage	1. Storage area is away from sluice room and disinfectant agents are stored in a cool & dry place away from direct sunlight and heat sources 2. Hazardous label on the cupboard and on the chemical containers are available	SI/OB	
C2.4	Spill management	The facility has established mechanism for spill management	1. There are written policy and procedures for spill management 2. Protocols for spill management are displayed at points of use	SI/OB/RR	
		Safety of the staff handling the spill is ensured	1. The staff has access to and wear PPE before spill management 2. The area is confined where spill has occurred	SI/OB	
		The facility has supplies for spill management	1. The facility has spill management kit 2. Facility has adequate quantity of 1% and 10% sodium hypochlorite solution	SI/OB/RR	
		The facility has established protocols for management of the Blood or body fluids spill	1. Cleaning is performed immediately after spill or as per protocols 2. Availability of absorbent paper, waste bins, PPE, hypochlorite solution	SI/OB/RR	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		The facility has established protocols for management of the mercury spill	1. The staff is aware of the spill management procedure and Mercury storage, if facility has any mercury filled instrument 2. The facility aspires for mercury free facility	SI/OB	
C2.5	Air quality, humidity and temperature	Critical parameters for air quality are ensured	1. Positive pressure is maintained in critical areas like OT, Labour room, ICU, etc. while negative pressure is maintained in isolation room 2. Efficacy of filters is validated as per manufacturer's requirement	OB/SI	
		The facility has safety mechanism in place to control temperature and humidity	1. The facility has thermostatic control system and alarm or warning mechanism in place for sounding alert when temperature increases beyond certain limits 2. Air sampling is done regularly once a week for OTs	OB/SI/RR	
		Temperature is maintained in patient care areas	1. Optimal temperature and warmth is maintained as per environmental condition and requirement 2. General areas are well ventilated if they are not air-conditioned	OB/SI	
		Air quality is maintained in patient care areas	1. There is a public display system of scrolling of AQI in the facility and critical care departments 2. No garbage or biomass burning within the facility premises	OB/SI	
		Humidity is maintained in patient care areas	1. The facility maintains humidity between 30% and 60% to inhibit bacterial multiplication 2. Natural Ventilation is maintained in the hospital premises	SI/OB/RR	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
Standard (C3): Human Factors and Ergonomics The hospital ensures preventive measurements are in place for safe patient handling					
C3.1	Layout and process flow	Stairways and ramps in the facility are designed for safe movement	1. Stairways in the facility have handrails, slip-resistant coating for steps, high visibility (clear of obstructions), non- slip markings for the edges of steps, and adequate illumination 2. Ramps in the facility are with less than 10 Degree slope (1:10) and provided with handrails	SI/OB	
		Floors of the facility are maintained for safe process flow	1. Floors are free of holes, clutter and broken tiles with no rough surfaces 2. Tiles are reflexion free and floor has gradient to prevent water accumulation in one corner	OB	
		Patient hallways are maintained for safe process flow	1. Hallways are large enough to provide easy movement for equipment, staff and furniture 2. Hallways have provision of convex mirror to prevent collision	OB	
		Patient rooms are maintained for safe process flow	1. Rooms are large enough for easy access of furniture, equipment and staff 2. Bedside power, suction and equipment outlets are easy to access	OB	
		Storage area are maintained for safe process flow	1. Frequently used and heavy items are kept within easy reach between hip and shoulder height 2. Storage shelves are kept between waist and shoulder height	SI/OB	
C3.2	Material and machine handling	The facility uses safe hospital beds and furniture	1. Beds and Furniture are light weight to move easily 2. Beds and other furniture have wheels or casters, which roll easily, noiseless and have good brakes	SI/OB	
		The facility uses safe handles, carts or other equipment	1. Handles on beds, carts or other equipment are of appropriate size for grips 2. Handles on beds, carts or other equipment are placed at an appropriate place	SI/OB	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		The facility ensures safe usage of IV/Med stand	1. The IV/Med stand are attached with wheels or casters roll easily 2. Base of IV/Med stand are wide enough to ensure stability without hitting feet of the staff	SI/OB	
		The facility uses safe medical equipment (X-ray monitors, microscopes, etc)	1. The medical equipment can be easily moved manually or self-propelled if very heavy 2. The equipment is not too high or wide to see over or around	SI/OB	
		The facility practices safe technique for movement of medical equipment	1. All the equipment are pushed with whole body not just pulled by using arms 2. Use small equipment like oxygen cylinders with handles to reduce weight and allow for easier gripping.	SI/OB	
C3.3	Safe patient handling	Facility practices safe lifting and movement practices	1. Patient condition (Weight, physical, medical, acuity and behaviour) is assessed before lifting or moving the patient unable to walk 2. Availability of wheel-chair/stretcher to reduce the manual lifting	SI/OB	
		Facility practices ''call for help'' technique for safe patient lifting and movement	1. "Call for help" from team members including attendant during lifting and movements 2. Choose team member who are trained and have similar understanding of proper technique	SI/OB	
		Facility practices safe lifting techniques	1. Safe lifting practices like keep lifted patient close to the body, move the person towards you, Push don't pull technique, usage of smooth movements and do not jerk, etc. are used 2. Availability of assist equipment and devices like total body lifts, stand-assist, ambulation lifts, gait belts, etc. (Selection depends on the patient 'weight-bearing status and his or her medical condition) for lifting instead of manual lifting	SI/OB	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		Facility practices safe lateral transfer of patients	1. Safe practices like lower the rails on both surfaces, have team members on both side of the surfaces, count down and synchronize the lift, use a smooth, coordinated push-pull motion, etc. are used for these movements 2. Availability of draw sheets or incontinence pads with friction reducing devices e.g. Slide boards, slippery sheets with handles, low friction mattress covers etc. for safe lateral transfer of patients	SI/OB	
		Facility has safe ambulating, repositioning and manipulating practices	1. Safe practices like keep the patients as close as possible, avoid bending, reaching or twisting back etc. are used for these movements. 2. Gait belts, transfer belts with handles, slippery sheets, plastic bags, draw sheets are used for these movements.	SI/OB	
C3.4	Workstation management	The facility uses safe working ergonomics at work station	1. Availability of height-adjustable stands (ladder/ stool) to reach above shoulder height shelves to prevent musculoskeletal injuries 2. Fully adjustable and well-padded chairs are provided with optional armrest	OB/SI	
		The facility uses safe working practices at Operation theatre and labour room	1. Position operating/labour table or other surfaces at waist height 2. Frequently shift position or stretch during long operation/procedures	OB/SI	
		The facility has system in place to safely manage hard tasks at the working station	1. Hard tasks are scheduled early in the work shift 2. Tasks are shared equally among shift	SI/OB	
		The facility provides safety gear at work station	1. Height-adjustable chairs or stools are available for the staff 2. Provision of back belts to maintain proper curvature of the spine during physical exertion	OB/SI	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		The facility has system in place for usage of mobile phones	1. The facility has policy in place delineating appropriate and inappropriate smartphone use and notify staff of these policies 2. The facility has system in place that prevent usage of mobile phone during performing procedures like smartphones set to "silent", or "do not disturb" mode, turn-off app notifications,	SI/RR	
C3.5	Hazardous substance handling	The facility has hazard orientation program for the staff handling hazardous substance	1. Availability of hazard classification of the chemical (e.g., flammable, toxic, irritant, corrosive, etc.) 2. Staff is oriented and trained on safe usages of hazardous substance during induction or whenever a new hazard is introduced into the work area	SI/RR	
		The facility maintain a hazardous substance inventory list	1. The facility maintains a hazardous substance inventory list for all hazardous materials used in the facility and update periodically 2. The facility ensures that each container of hazardous substance contains an appropriate warning (i.e., that it is labelled, tagged or marked)	SI/RR	
		The facility maintains Safety Data Sheets (SDSs) for hazardous substances	1. The facility ensures that up-to-date Safety data sheets are available for all hazardous substance, and it includes information about ingredients, degree of hazard, susceptibility to fire, preventive measures and first aid. 2. The staff are aware about where the sheets are located and how to find pertinent information on safe use and first aid measures	RR/SI	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		Transportation and Storage of hazardous substance	1. Transport hazardous substance only in closed containers with tight-fitting lids to minimize the potential for spills 2. Unused material is stored in tightly covered containers at a cool, secured, and properly labelled area	OB/SI	
		The facility is taking measures to protect employees from exposure	1. The facility provides and ensures employees use PPE (e.g., goggles, gloves, splash aprons, as appropriate) 2. Ensures availability of first aid and medical care after accidental exposures	OB/SI	
Standard (C4): Support and maintenance services The hospital ensures safety in all support and auxiliary services					
C4.1	Equipment maintenance	There is a system to maintain the records of the equipment	1. Operating and maintenance instructions are available with the users of equipment. 2. Every medical equipment must be tagged with a unique identification number or a bar code for easy breakdown call via Toll free number	SI/RR	
		The facility has provision of equipment inspection, testing, maintenance and calibration of equipment	1. The facility has established contract for AMC and CMC of critical Equipment and maintains log book for internal and external calibration of measuring Equipment 2. The facility has established mechanism to report any adverse events/ Near miss incidents due to medical equipment/devices its consumables, IVDs, Implants, Surgical & PPEs as per protocols	SI/RR	
		The facility has an inventory of spare parts	1. The facility forecasts requirement of items like batteries, filters, valves, tubing's etc. in a scientific manner 2. Cleaning and lubricating material is procured in advance	RR/SI	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		The technical staff is trained for safety and appropriate use of medical equipment	1. Technical staff is trained for operationalisation of new equipment and trouble shooting in case of equipment malfunction 2. The staff is provided continual training on every equipment	RR/SI	
		The facility has measures in place for condemnation of Biomedical Equipment	1. There is a system to label Defective/Out of order equipment 2. Defective/out of order equipment are stored separately until it has been condemned as per condemnation policy	OB/SI	
C4.2	Safety in hospitals support services (Laundry & Kitchen)	The facility has established procedure of laundry and linen management	1. Soiled linen are not rinsed, shaken or sorted in the clinical area 2. Dirty and soiled linens are stored, transported separately away from patient care area	SI/OB	
		The facility follows the standard protocol for linen disinfection and sluicing	1. All infected linens are soaked in 0.5% bleaching solution for 10-15 minutes 2. Infected linen (patients with HIV, Hep B & C, any other infectious disease) is treated with hot water and detergent having temp of more than 71 degree Celsius with a minimum wash cycle for 25 minutes after disinfection	SI/OB	
		The facility follows the standard protocol for linen disposal	1. Soiled linens are discarded in non-chlorinated yellow plastic bags as per BMW rules 2016 and as per CPCB guidelines 2. Severely damaged linens are discarded or condemned as per the facility condemnation policy	SI/OB	
		The facility has established procedure of Kitchen service management	1. Cleaning equipment like mops, buckets and cleaning chemicals are not stored in the kitchen 2. Pest control protocols for kitchen are followed	OB/SI/RR	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		Cleanliness and hygienic protocols are followed	1. Equipment that comes in contact with food (cutting boards, knives, utensils) are washed with soap and water followed by immersion in 0.5% chlorine solution for one minute 2. Kitchen staff is vaccinated for Hepatitis, Typhoid, Tetanus and undergoes for medical check-up once in a year	OB/SI	
C4.3	Infectious waste management (solid & liquid)	Safety protocols are followed for biomedical waste collection and transportation	1. Bags are filled only 3/4th of their capacity for waste collection 2. Covered wheelbarrow based waste trolleys with bio hazard logo are used for waste transportation through a route away from patient care area	SI/OB	
		Safety protocols are followed for biomedical waste storage	1. Storage area is not located near the water reservoir resource 2. Storage area is kept ventilated through the use of exhaust fan or wire meshes	SI/OB	
		Safety protocols are followed for radioactive waste management	1. The silver X-ray film developing fluid is sent to authorised recyclers for resource recovery 2. The facility aspires for digital X-ray technology	SI/OB	
		The facility manages solid waste as per Solid Waste Management Rules 2016	1. The solid waste is segregated into bio-degradable and non-biodegradable waste 2. The solid waste is not mixed with the general waste generated from the facility	SI/OB	
		Safety protocols are followed for Liquid waste management	1. Infectious liquid waste like blood, body fluids, secretions, discarded samples, etc. must be pre-treated before discharging into municipal drains 2. Liquid waste is disinfected and disposed as per biomedical waste management guidelines 2016 and as per CPCB guidelines	SI/OB	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
C4.4	Data and information system safety	The facility follows the principles of data privacy and confidentiality	1. The patient have the privileges to restrict access to and disclosure of individually identifiable health information 2. The facility follows National AIDS Control Organisation's policy for data sharing	SI/PI	
		The facility ensures safe storage and access of information and records of services	1. Records and registers are stored at a secure place with access to authorised persons 2. Records and information is easily retrievable as per data ownership held by the patient, healthcare provider	SI/OB	
		The facility follows principles of data change	1. The facility follows "As-Is-Principle" means no change is made in the data or its format, applies both for physical or digital information 2. In case of changes after approval from patient/ doctor, complete audit trail of such change is maintained by the facility	SI/RR	
		The facility follows principles of data security	1. Only the authorised person has key for the medical record department 2. Desktop/Tablets are password or fingerprint protected for log in authentication and not shared with any other than authorised person	SI/OB	
		The facility follows principles of records and data retention	1. Physical records are retained and preserved as per NMC guidelines/state specific guidelines 2. Electronic records must compulsorily be preserved for a period as per life expectancy	SI/RR	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
C4.5	Disaster preparedness	Availability of a comprehensive disaster plan	1. The facility has analysed the possible requirement of the resources (medical/ paramedical staff, equipment, medicines, casualty evacuation vehicle, stretchers/trolleys) and have clear plan to mobilise these within approved timeline 2. The plan clearly describes the chronological sequence of actions to be taken with defined task and distribution of duties to the staff	SI/RR	
		The facility is prepared to manage the disaster	1. The facility has identified and documented nearby sources for arrangement of emergency supply of medical supplies inclusive of antidotes (in poisoning cases) 2. The facility has identified and listed nearby blood banks for unforeseen contingencies	SI/RR	
		The facility has earmarked a control centre for disaster management and response	1. The facility has identified a person for casualty management such as answering the queries of relatives and briefing the public/media, preferably by Head of the facility 2. The facility has documented process for information to civil authorities and NGOs	SI/RR	
		The staff is prepared to manage the disaster	1. Periodic mock drills are conducted at different times of the day/night in the presence of an outside observer 2. A report is prepared for review with details of the timings for various steps, deficiencies observed and the corrective actions incorporated in the plan	SI/RR	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		The measures are in place to evaluate the quality of disaster management system	1. The time taken during the mock drill for informing all the staff is not more than 10-15 min 2. The response time of the staff is not more than 15-30 min	SI/RR	
Area of Concern D: Systems for Patient Safety					
Standard (D1): Leadership and Governance The hospital has an established Leadership and Governance Framework to ensure the implementation of patient safety policy and plan are in place					
D 1.1	Patient Safety Policy and Plan	A comprehensive patient safety policy is established	1. The facility has defined a hospital-wide patient safety policy 2. The patient safety policy is communicated to all departments and staff members	RR/SI	
		Patient Safety Policy has been developed involving all stakeholders and considering local context	1. Patient Safety policy and implementation plan have been evolved with consultation of all cadres of staff including clinical, para clinical, nursing, support and auxiliary staff 2. The policy reflects locally prevalent diseases and opinions of members of RKS/Municipal Corporation/PRIs	SI/RR	
		Patient Safety Policy integrates with health system components	1. Potential safety risks have been identified in each of the department 2. Patient safety components have been integrated in all clinical and auxiliary departments (like safe surgery, medication safety, safe birth, fire and electrical safety, etc.)	SI/RR	
		An implementation plan is prepared for patient safety policy	1. The facility has prioritised its potential patient safety risks 2. An action plan has been prepared aligning with patient safety guidelines, protocols and standard operating procedures	SI/RR	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		Leadership recognizes patient safety as a key priority of the facility	1. The facility has prepared a patient safety charter that includes patients' and health care providers' rights and responsibilities 2. Observance of world patient safety day every day and conduct of local campaigns	RR/OB	
D 1.2	Institutional structure and teams	There is well established organisational structure for patient safety at facility level	1. Quality and Patient Safety team is formed at the facility and a leader is designated to coordinate patient safety activities 2. The committee has defined roles and responsibilities of all members	RR/SI	
		Roles and responsibilities of various committees are well defined	1. The facility has a defined standard operating procedure to coordinate for different programmes like NQAS, SaQushal, LaQshya, MusQan etc. 2. The Standard Operating Procedure has defined that how information and data will be shared and utilised for collective action plan	RR/SI	
		The facility reviews patient safety activities at periodic intervals	1. The team members meet regularly, preferably every month 2. The team reviews safety issues and progress on planned actions in quarterly meeting and minutes are recorded	RR/SI	
		The quality and patient safety team reviews patient safety assessment tool findings	1. Results of patient safety assessment are discussed in the meeting 2. Decisions developed through consultative processes are meaningfully communicated to all staff members	SI/RR	
		Quality and Patient Safety team identifies need for training and capacity building	1. The facility has identified need for trainings and capacity building for patient safety and quality 2. Continual Medical Education is imparted to improve patient safety practices in day-to-day clinical care	RR/SI	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
D 1.3	Licenses and statutory requirements	The facility adheres with requisite mandatory regulatory requirements	1. The facility has valid no objection certificate from fire safety authority 2. The facility has valid certificate of inspection of electrical installation and Lift license, if applicable	RR/OB	
		The facility adheres with applicable acts and rules for drugs	1. The facility has updated copy of Drugs and Cosmetic Act 1940 and rules 1945 2. The facility prescribes, dispense substance specified in Schedule H, Schedule H1 and Schedule X as per drug and cosmetic act and rules	RR/OB	
		Updated copies of relevant regulations and government orders are available at the facility	1. The facility has valid Biomedical waste authorisation for handling and disposal of waste, blood bank license, AERB authorisation, etc. 2. The facility has valid licences for ambulances and ambulance service audit is done at periodic interval	RR/OB	
		There are legal provisions for protecting health workforce	1. The facility adheres with all regulations regarding work place safety 2. The facility acknowledges and follows rules pertaining to health worker protection from violence, vandalism and unnecessary litigation	SI/RR	
		Patient's rights are displayed and adhered by all	1. There is an established mechanism for grievance redressal mechanism 2. The facility displays patient rights and their entitlements prominently	RR/PI/SI	
D 1.4	Credible Clinical Governance System	Treatment protocol for common ailments and emergency services are available and implemented	1. The facility has made available updated treatment protocol for common ailments and emergency services in all clinical departments 2. There are mechanism to review the adherence to protocols and training of clinical staff on new protocols	RR/SI	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		Clinical care effectiveness criteria have been defined and communicated	1. The facility has defined clinical care effectiveness criteria for all clinical departments 2. The facility measures the performance of clinical processes as per clinical care effectiveness criteria	RR/SI	
		The facility has a well-established clinical audit programme	1. The facility conducts periodic medical, prescription and death audits, preferably monthly 2. The audit results are analysed and used for improvement in clinical processes	RR/SI	
		Established mechanism to review the accountability for clinical care	1. Top management reviews the audit reports periodically 2. The data relating to audit reports and grievances are discussed, decisions to improve clinical processes are made and progress is followed	RR/SI	
		Implementation tools for clinical guidelines developed and implemented	1. The facility has implemented clinical guidelines through implementation tools 2. The facility has integrated STGs and other implementation tool to support clinical decision system	RR/SI	
D 1.5	Performance Management	Implementation of Patient Safety Self-Assessment Tool at the facility	1. The facility is aware of patient safety self-assessment tool and uses it for periodic assessment and improvement 2. The quality and patient safety team has been provided copy of assessment tool and all members are aware of the tool	RR/SI	
		System of periodic peer and independent review	1. The facility participates in regular peer assessment in collaboration with other healthcare facilities 2. The facility implements best practices identified during peer assessment within their health facility	RR/SI	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		The facility ensures that patient safety core competencies are part of regulatory requirements for health professionals.	1. The facility conducts periodic patient safety competencies assessment among health professionals 2. The facility has established a system to utilize safety performance for the purpose of their performance appraisal	RR/SI	
		The facility has integrated patient safety and quality certification mechanism	1. The facility implementing patient safety assessment tool aspire for full quality certification under National Quality Assurance Standards (NQAS) 2. The facility has prepared a time bound action plan for achieving it in short or midterm course	RR/SI	
		The facility meets the national benchmarks	1. The facility staff and top management are aware of the national safety norms 2. The facility measures their performance against the national benchmark and strives to achieve them	SI/RR	
Standard (D2): Reporting and Learning System The health system has established a functional system for reporting and learning of adverse events					
D 2.1	Incident reporting	The facility has established an user friendly mechanism to report patient safety incident	1. The facility has established a mechanism for single point reporting of patient safety incidents through local IT system or paper format reporting 2. Incident reported at the national reporting systems like Pharmacovigilance/ Hemovigilance/ Materiovigilance program of India, AEFI, etc. are also included under single reporting platform established at the facility	SI/RR	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		The facility has defined definitions, classifications and format for reporting of adverse events	1. The facility has defined clear criteria and definitions for incident reporting such as error, adverse event and near miss 2. Formats for reporting has been made available electronically or in paper format inclusive patient information, incident time, incident location, agents involved, incident type, incident outcome, action taken, reporter's role, etc.)	SI/RR	
		The facility has an encouraging environment for the reporting	1. The leadership of the facility has provided and committed to policies that establish a safety culture and non-punitive environment 2. The facility has established and implemented a blame free policy on reporting of patient safety events	SI/RR	
		Provisions have been made to ensure confidentiality and security of data being reported	1. The leadership ensures that all reports of patient safety incidents are anonymised so that no patient, staff member or other person can be identified 2. Patient's information is safeguarded as per Right To Information Act 2005	SI/RR	
		Structured program for training and capacity building on learning and reporting system is in place	1. The staff is provided with training on definitions, classifications of adverse events 2. The staff is provided with training on how to complete an incident report form, what information to be captured and reported in the format	SI/RR	
D 2.2	Safety Surveillance	The facility has a robust system of identifying and investigating sentinel adverse events, error and near miss incidents	1. The facility has an explicit list of reportable serious/ sentinel events 2. The facility has prepared and documented SOPs/work instructions for internal investigation and root cause analysis of incident occurred	SI/RR	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		Periodic risk evaluation is done using assessment tools	1. The facility has identified hazardous, risk prone conditions and other unsafe risks 2. The facility conducts periodic risk assessment using Failure Mode Effective Analysis (FMEA) to calculate Risk Probability Number as per NHSRC's Risk Management Framework	SI/RR	
		Active surveillance and monitoring activities are carried out to understand harm for the unsafe care	1. The facility conducts active surveillance for hospital associated infections in all high-risk departments 2. The facility conducts active surveillance within the context of emergencies, disease outbreaks or any other extreme adversity to rule out potential risks	RR/SI	
		The facility prioritises the findings of active surveillance	1. The facility uses PICK chart to prioritise the findings of the active surveillance and monitoring activities 2. The facility uses the findings to highlight broad pattern and trends in the burden of harm	RR/SI	
		The facility has established system for use of assessment tool in different departments and services	1. The facility conducts baseline assessment to establish burden of harm due to unsafe care using self-assessment tool 2. The baseline assessment includes findings from all departments and services	SI/RR	
D 2.3	Patient Safety Indicators	Indicators for Safe Patient Care Process	1. The facility has defined indicators for Safe patient care process 2. The facility measures indicators for Safe patient care process	SI/RR	
		Indicators for Clinical Risk Management	1. The facility has defined indicators for Clinical risk management 2. The facility measures indicators for Clinical risk management	SI/RR	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		Indicators for Safe Care Environment	1. The facility has defined indicators for Safe care environment 2. The facility measures indicators for Safe care environment	SI/RR	
		Indicators for Patient Safety Systems	1. The facility has defined indicators for patient safety systems 2. The facility measures indicators for patient safety systems	SI/RR	
		Indicators for Incident reporting and Learning system	1. The facility measures adverse events and near miss in all departments 2. All patient safety indicators are reported on monthly basis	SI/RR	
D 2.4	Analysis, alerts and feedback	Collated data is analysed and processed to information	1. The facility has a mechanism of aggregating all data (patient safety indicators, surveillance, adverse events, near miss) to a common data management information system 2. All data are analysed and processed to some useful information in the form of a incident report	SI/RR	
		Incident reports are examined through a structured approach	1. The incident reports are analysed to observe and compare pattern of trends from baseline report 2. Root cause analysis is performed for all types of reported incidents	SI/RR	
		The facility uses the reporting and learning system to identify patient safety priorities	1. There is an established mechanism to address patient safety priorities based on outcome 2. The facility addresses prioritized issues by improvement activities	RR/SI	
		Findings of the incident reports reflects all types of care	1. Incident report includes all types of harm (sentinel, adverse, near miss, no harm, etc.) 2. Based on the findings, changes are incorporated in the alert system of the facility	SI/RR	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		Feedback given to healthcare providers on the results of investigations and preventive measures taken	1. Feedback is given to all relevant staff, patients and families on the results of an incident report 2. Feedback is given to healthcare providers on the preventive measures to be taken to mitigate the occurrence of incidents in near future	PI/SI	
D 2.5	Learning and Improvement	The facility has a provision of utilizing information for improving the safety	1. The facility ensures that findings of reporting, surveillance and indicators are utilized for identifying opportunities for improvement 2. There is a provision of utilizing the data for improving safety of the clinical and support processes	SI/RR	
		There is a provision of periodic review of alert system based on analysis of report	1. The facility establishes mechanism for communicating alerts on emerging patient safety issues using different channels of communication 2. The Staff is aware of these codes and knows what to do in specific alert conditions	SI/RR	
		The facility prepares corrective and preventive action plan (CAPA) for improvement	1. Based on the nature of safety issue, departmental CAPA is prepared and implemented 2. Action plan clearly mentions who, what, how part of the improvement strategies with defined time period	RR/SI	
		The facility has an established mechanism for dissemination of learnings and lessons	1. The facility prepares an annual report on patient safety performance, including the frequency, nature and burden of avoidable harm in the facility, and implementation plans to reduce it 2. This annual report is reviewed and approved by appropriate authority	RR/SI	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		There is an established mechanism for periodic evaluation of the impact of improvement programmes	1. There is an on-going mechanism of rigorous evaluation to ensure that progress is made in reducing harm and improving the patient safety 2. The facility ensures that gained efforts are sustained for a defined time period	RR/SI	
Standard (D3): Patient Engagement There is an established framework to ensure healthcare delivery processes are patient centred					
D 3.1	Patient Centred Design	There is a mechanism to factor in the patient preferences while designing healthcare delivery processes	1. The facility encourages patient and care givers to express their religious & cultural preferences and health outcome expectations while delivering healthcare services 2. The treatment or care plan is prepared involving individual patient to achieve the best possible results	PI/SI	
		The facility ensures privacy, dignity and confidentiality of the patients	1. Measures are in place to maintain privacy and confidentiality of patient's information and records 2. Adequate visual and speech privacy is provided at every point of care	PI/SI	
		Access to facility is provided without any physical barrier & friendly to people with disability	1. Availability of ramps with railings/lifts/wheelchairs/ stretchers, as applicable to ensure adequate physical access without any barriers 2. Availability of sign language for impaired hearing and tactile signs with good contrast between letters and background for visually impaired person	OB/PI	
		There is well defined processes for care of high-risk and vulnerable patients	1. The facility takes special precaution for maintaining privacy & confidentiality of cases having social stigma 2. There are linkages of care, Counselling and Protection of vulnerable and marginalized section including Victims of Violence, terminally ill patients, orphan, elderly etc.	OB/PI	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		Patient experience is measured and improved	1. The facility has formal processes in place that were co-designed with patients/community for sharing patient and family experience, concerns and expectations 2. These feedbacks are adequately recorded, analysed and used for improvement and safety concerns of the patients	RR/PI	
D 3.2	Patient Information	Information on patient's rights, available services and entitlements	1. Facility prominently displays patient and family's/attendants' right charter, available services and their entitlements at all critical places in local language 2. Patients are proactively informed and educated about their rights while availing services in the facility	OB/PI	
		Safety and security information has been standardised and made available	1. The facility has identified all areas which require proactive display of information about safety precautions 2. Adequate information and signages have been placed at all risk prone areas (radiology, infectious waste handling areas, electricity panels, fire hazardous area, restricted areas, slippery floor, etc.) as mandated by national guidelines	OB/PI	
		The facility educates the patients and communities on patient safety issues	1. The facility conducts patient safety campaign on identified thematic area on a quarterly basis 2. The facility has developed pamphlets or brochures on patient safety components including basic safe practices such as hand hygiene or prevention of spread of communicable diseases	RR/PI	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		Safety information regarding specific procedures is provided	1. The facility informs patients about procedure and expected outcomes including risk involved 2. The facility informs patients and families about safety and contraindications of using new medicines or devices in the market in specific health conditions	PI/SI	
		System in place to ensure that medical records are available to patient and community	1. The facility has defined procedure on how information regarding the medical health records of the patient can be accessed by the patient and family 2. The facility has a system of providing a print-out of prescription after teleconsultation services	PI/RR	
D 3.3	Patient and Family Engagement	There is an established process for informed consent	1. The facility has defined, documented and disseminated a facility wide consent policy to relevant departments 2. The policy mentions about specific risks and adverse events that may occur during the procedure which is briefly explained to patients and relatives in the local language	RR/PI	
		Patients are involved in incident reporting	1. The facility has an established mechanism for systemic collection of incidents reporting made by the patients without disclosing the identity of the reporting person 2. The facility has IEC materials like poster, pamphlet, video, etc. that educate patient and relatives about their responsibility of reporting any unsafe staff behaviour or adverse incident (medication error, electrical or fire safety error)	OB/PI	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		Patient and family engagement tools have been developed and implemented	1. The facility ensures availability of patient engagement tools such as 5 Moments of medication safety, communication tool for safe surgery, self-care after discharge, etc. 2. Patient engagement tools are available in local and user-friendly language	OB/PI	
		Patient and family are involved in decision making about their treatment	1. The facility support involvement of family in management of care and decision making such as birth companion during delivery, involving family members in counselling before discharge 2. The facility includes informed decision making and second opinion in patient's rights charter	PI/SI	
		Norms and practices for self-care and self-management are defined and practiced	1. The facility counsels and train patients and family members for self-management and safer care 2. There is a provision of counselling for self-medication, home care during rehabilitation after discharge and regular review of self-management for chronic diseases	PI/SI/RR	
D 3.4	Patient Empowerment	A system for identifying and engaging patient groups and partners has been implemented	1. The facility has identified and engaged the local patients as partners who has experienced care from the facility 2. The facility has defined qualification criteria, roles and responsibilities of patient group and partners	SI/RR/PI	
		Patient groups and partners are involved in patient safety improvement initiatives	1. The facility involves patient group or partners on specific patient safety initiatives and quality improvement projects 2. The facility involves patient group or partners in various committees and clinical governance meetings	SI/PI/RR	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		Patient groups and partners are involved in education and research activities	1. The facility utilises patient partners for educating staff members on patient centered care and communication activities 2. Patient partners are used to educate patients and family members about their rights and responsibilities in a facility	SI/PI/OB	
		Adequate resources are available for enabling patient as partners and leadership role	1. There is a provision of training and capacity building for patient partners to ensure meaningful patient group contribution for counselling 2. The facility has a mechanism for provision of financial and logistic assistance to patient group so that they can participate in safety and other health related activities	SI/PI	
		There is a formal process of peer support to the patients through patient group	1. The patient group is available and accessible to patients for peer support and counselling services 2. Contact details and time of availability is displayed in the facility	OB/RR/PI	
D 3.5	Communication and Grievance Redressal	There is a dedicated team or person to handle the grievance related activities	1. The facility has designated a staff for receiving and processing the grievances related to service provided including safety issues 2. The designated staff has adequate time, resources and skills to do justice with the task	RR/SI/PI	
		Channels for grievance registration are established and easily accessible to patient and community	1. The facility has established mechanism for complaint registration in terms of compliant box/ website via mail/face to face interaction 2. The information about where and how to register complaint is prominently displayed in the facility	RR/OB/PI	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		There is established criteria for categorising the complaints and escalating it to higher level	1. The facility has defined and established procedure for categorising complaints and escalating them to responsible personal for actions 2. The facility records the progress of complaint resolution within defined time framework and same is communicated to the patient/family	RR/PI	
		Corrective action has been integrated with grievance redressal mechanism	1. The facility has kept record of evidences for action taken against the complaint 2. The facility analyses the complaints and use them for improving safety and quality of the delivered care	RR/PI	
		There is an established procedure for disclosure and resolution in case of unexpected harm to the patient	1. The facility has implemented a mechanism for identifying, disclosing and resolution of unexpected patient safety events that has caused severe harm to the patient 2. The staff is trained for effective, empathetic and transparent disclosure of such events to the patient and their family	RR/SI	
Standard (D4): Ability at point of care The hospital has competent work force and work environment to ensure the provision of point of care					
D 4.1	Multidisci-plinary teams	The facility has a multidisci-plinary team	1. The facility has an optimum mix of clinical, nursing, administration and para-clinical staff to deliver safe care 2. The overall goal for multidisciplinary team is to improve treatment efficiency and patient care	OB/SI	
		The roles and responsibilities of staff incorporate basic patient safety concepts	1. Job descriptions for all categories of health care staff are clearly defined and documented 2. Job descriptions for all categories of health care staff supports provision of safe care	RR/SI	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		Professional standards are clearly defined	1. The facility staff is aware of code of conduct and job descriptions 2. The facility staff adheres with code of conduct and job descriptions	RR/SI	
		Team has established just blame free culture and open communication	1. The facility has established just blame free culture across the system 2. The facility has defined internal strategies for fostering teamwork and communication	OB/SI	
		Measures are in place to avoid conflict among team members	1. Multidisciplinary team responds to the needs of the population concerned while still being small enough to allow members to know each other 2. Line of authority is clearly defined keeping patient safety in the center	RR/SI	
D 4.2	Competence based task assignment	There is system for credentialing of clinical staff	1. The facility has defined minimum qualification, experience and licencing requirements for various clinical and nursing positions 2. The facility assigns task based on the staff competency in terms of qualification and experience	RR/SI	
		Patient safety core competence and skills mix has been defined for various healthcare staff	1. The healthcare facility has defined the competence criteria for each of clinical and support staff based on task assignment 2. The healthcare facility has defined the patient safety skill sets for each of clinical and support staff	RR/SI	
		Conduct periodic patient safety competencies assessment among healthcare staff	1. The facility conducts competency assessment for Clinical and nursing staff on predefined criteria at least once in a year 2. The facility conducts competency assessment for Para clinical staff on predefined criteria at least once in a year	RR/SI	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		Patient safety rewards used for performance management	1. The facility has internal appraisal system to monitor performance of the staff 2. The appraisal system has given due weightage to healthcare staff's competence on patient safety	RR/SI	
		Training calendar is prepared for skill enhancement	1. Based on the competence assessment a training plan is prepared for skill enhancement ensuring patient safety 2. Outcome of the training is monitored through on-going performance evaluation	RR/SI	
D 4.3	Psychological Safety	The facility has mechanisms to prevent and eliminate violence in the facility in accordance with national laws	1. The facility has updated copy of national laws and policies to protect healthcare staff against violence 2. The facility has enforced prevention and implementation strategies to protect healthcare staff against violence like alert system to notify the staff on duty for back up	RR/SI	
		The facility has established mechanism to support psychological self-care for healthcare workers	1. The facility has an employee assistance program/peer for the provision of free counselling and advice on work-life balance 2. The facility supports the staff in coping Second Victim Syndrome (SVS)	RR/SI	
		Promotion of positive team work culture	1. The facility promotes team work through instituting multidisciplinary teams in patient care departments 2. The facility promotes interdepartmental teams/ committees collaboration	RR/SI	
		Staff is supported for financial and legal liabilities	1. The facility has established mechanism for provision of indemnity cover to clinical staff through hospital sponsored schemes 2. The facility provides legal assistance in case of a compensation claim	RR/SI	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
		The facility has established mechanism for healthcare staff burn-out	1. The facility has established mechanism for appropriate and fair duration of deployments with defined working and resting hours 2. The facility conducts regular survey to assess the healthcare provider's experience with the job	RR/SI	
D 4.4	Training and Education	Induction training is provided to all the staff	1. All newly recruited staff is provided induction training 2. Induction training includes patient safety concepts, principles, guidelines and overview of patient safety assessment tool	SI/RR	
		The facility has system of in service training on patient safety	1. The facility has a system for identifying the training needs 2. The facility prepares training calendar as per training need assessment and executes training plan to address the gap	SI/RR	
		The facility has established mechanism for training record maintenance	1. Training records are maintained and updated regularly 2. The facility has a feedback mechanism for evaluating the effectiveness of trainings	RR/SI	
		There is established procedure for utilization of skills gained through trainings by on job supportive supervision	1. The facility has policy for regular competence testing after imparting training 2. The facility has a mechanism to assess the impact of the training on performance of the staff	SI/RR	
		There is an established process of continuous professional development at the facility	1. The facility provides opportunities to the staff to attend workshops/ seminars/CMEs in the field of patient safety and related domain 2. There is a mechanism to share feedback on best practices and innovations within the facility to ensure information sharing and wider application	SI/RR	

Reference No.	Measurable Element	Checkpoints	Means of Verification	Assessment Method	Scoring
D 4.5	Staffing and rostering	The facility has adequate clinical staff as per service provision	1. The facility has adequate general duty doctor as per service provision and work load/state specific guidelines 2. The facility has adequate specialist doctors as per service provision/state specific guidelines	SI/OB/RR	
		The facility has adequate technicians/ paramedics as per requirement	1. The facility has adequate nursing staff as per service provision and work load 2. The facility has adequate technicians/pharmacists/ counsellors/therapists as per service provision and work load	SI/OB/RR	
		The facility has adequate support/general staff	1. The facility has adequate support staffs (housekeeping, pantry and others) as per service provision and work load 2. The facility has adequate security staff as per service provision and work load	SI/OB/RR	
		The facility has an established procedure for duty roster	1. Duty roster of all clinical staff is prepared, updated and communicated on daily basis 2. Duty roster of all non-clinical (support and administration) staff is prepared, updated and communicated on daily basis	SI/RR	
		The facility has an established procedure for deputation of staff to different departments	1. The facility has a provision of rotatory posting of all cadre of staff 2. The facility has established line of reporting for clinical & administrative staff	RR/SI	

MEASURABLE ELEMENTS

Area of Concern A	Safe patient care process
Standard A1	**Medication safety (The hospital has a medication management system to ensure safe medication practices at all times)**
ME A1.1	Safe prescription practices
ME A1.2	Storage and dispensing
ME A1.3	Preparation and administration of medicines
ME A1.4	Medication review and optimization
ME A1.5	High-alert drugs and response mechanism
Standard A2	**Infection prevention and control (The hospital has an infection control programme to ensure safe infection control practices at all times)**
ME A2.1	Personal protection
ME A2.2	Hand hygiene
ME A2.3	Instrument processing
ME A2.4	Isolation and barrier nursing
ME A2.5	Injection safety
Standard A3	**Safe Patient handling and harm prevention (The hospital has an established system to ensure safe patient handling and harm prevention in all clinical care settings)**
ME A3.1	Accident and Falls
ME A3.2	Bed Sores
ME A3.3	Venous Thromboembolism
ME A3.4	Patient identification
ME A3.5	Safety during patient referral
Standard A4	**Communication at transition of care (The hospital has an established system to ensure safe patient transport and referral to maintain continuity of care)**
ME A4.1	Intramural communication
ME A4.2	Communication during referrals
ME A4.3	Hospital alert codes
ME A4.4	Discharge and follow up communication
ME A4.5	Risk and hazard communication
Area of Concern B	**Clinical risk management**
Standard B1	**Safety in General Clinical Care (The hospital has an established mechanism to reduce the risk of errors for general clinical care)**
ME B1.1	Diagnostic errors prevention
ME B1.2	Administrative errors prevention
ME B1.3	Multimorbidity prevention
ME B1.4	Safety in Dental Practices
ME B1.5	Safety in National Health Programmes

Standard B2	**Safety in RMNCHA (The hospital has an established mechanism to ensure safety in Reproductive, Maternal, Newborn, Child and Adolescent Health)**
ME B2.1	Reproductive and Adolescent Health
ME B2.2	Maternal Health
ME B2.3	Newborn Care
ME B2.4	Child health Care
ME B2.5	Immunization Safety
Standard B3	**Speciality clinical services (The hospital has an established mechanism to ensure safety in speciality clinical services)**
ME B3.1	Safety in dialysis services
ME B3.2	Safety in Ophthalmology services
ME B3.3	Safety in mental health care
ME B3.4	Safety in intensive care
ME B3.5	Safety in Palliative and Geriatric Care
Standard B4	**High risk clinical processes (The hospital has an established mechanism to ensure safety in all high-risk clinical processes)**
ME B4.1	Surgical safety
ME B4.2	Anaesthesia safety
ME B4.3	Radiation safety
ME B4.4	Blood and transfusion safety
ME B4.5	Safety in emergency care
Area of Concern C	**Safe care Environment**
Standard C1	**Physical safety (The hospital ensures safety of the patient, staff and infrastructure)**
ME C.1.1	Structural safety
ME C.1.2	Seismic safety
ME C.1.3	Electrical safety
ME C.1.4	Fire safety
ME C.1.5	Security and access control
Standard C2	**Hygiene and environment control (The hospital ensures all aspects of environment control within the premises)**
ME C2.1	Illumination
ME C2.2	Water and sanitation
ME C2.3	Cleaning services and surface disinfection
ME C2.4	Spill management
ME C2.5	Air quality, humidity and temperature
Standard C3	**Human Factors and Ergonomics (The hospital ensures preventive measurements are in place for safe patient handling)**
ME C3.1	Layout and process flow
ME C3.2	Material and machine handling
ME C3.3	Safe patient handling

ME C3.4	Workstation management
ME C3.5	Hazardous substance handling
Standard C4	**Support and maintenance services (The hospital ensures safety in all support and auxiliary services)**
ME C4.1	Equipment maintenance
ME C4.2	Safety in hospitals support services (Laundry & Kitchen)
ME C4.3	Infectious waste management (solid & liquid)
ME C4.4	Data and information system safety
ME C4.5	Disaster preparedness
Area of Concern D	**Patient safety systems**
Standard D1	**Leadership and Governance (The hospital has an established Leadership and Governance Framework to ensure the implementation of patient safety policy and plan are in place)**
ME D1.1	Patient safety policy and plan
ME D1.2	Institutional structure and teams
ME D1.3	Licenses and statutory requirements
ME D1.4	Credible Clinical Governance System
ME D1.5	Performance management
Standard D2	**Reporting and learning systems (The health system has established a functional system for reporting and learning of adverse events)**
ME D2.1	Incident reporting
ME D2.2	Safety surveillance
ME D2.3	Patient safety indicators
ME D2.4	Analysis, alerts and feedback
ME D2.5	Learning and improvement
Standard D3	**Patient engagement (There is an established framework to ensure healthcare delivery processes are patient centred)**
ME D3.1	Patient centred design
ME D3.2	Patient information
ME D3.3	Patient and family engagement
ME D3.4	Patient Empowerment
ME D3.5	Communication and Grievance Redressal
Standard D4	**Ability at point of care (The hospital has competent work force and work environment to ensure the provision of point of care)**
ME D4.1	Multidisciplinary teams
ME D4.2	Competence based task assignment
ME D4.3	Psychological safety
ME D4.4	Training and education
ME D4.5	Staffing and rostering

LIST OF ABBREVIATIONS

1	AEFI	Adverse Event Following Immunization
2	AMC	Annual Maintenance Contract
3	AMTSL	Active Management of Third Stage of Labour
4	AOC	Area of Concern
5	CAPA	Corrective and Preventive Action Plan
6	CGA	Comprehensive Geriatric Assessment
7	CQSC	Central Quality Supervisory Committee
8	DQAC	District Quality Assurance Committee
9	FMEA	Failure Modes and Effects Analysis
10	HAI	Hospital Acquired Infection
11	IRDA	Insurance Regulatory and Development Authority
12	ISQua	International Society for Quality in Health Care
13	JCI	Joint Commission International
14	LMICs	Low- and Middle-income countries
15	MOV	Means of Verification
16	NHA	National Health Authority
17	NPSIF	National Patient Safety Implementation Framework
18	NQAP	National Quality Assurance Program
19	NQAS	National Quality Assurance Standards
20	QoC	Quality of Care
21	RMNCHA	Reproductive, Maternal, Newborn Child plus Adolescent Health
22	SQAC	State Quality Assurance Committee
23	SVS	Second Victim Syndrome
24	TORs	Terms of References

BIBLIOGRAPHY

1. A Guide for advocating for respectful Maternity care by white ribbon alliance
2. A strategic approach for reproductive, maternal, new born, child and adolescent health (RMNCH+A) in India, MoHFW, Government of India
3. Adverse Drug Event Trigger Tool
4. An Introduction to Quality Assurance in Health Care, Avedis Donabedian
5. Anaesthesia Safety Checklist, WHO
6. APCA Standards for Providing Quality Palliative Care Across Afric,2010
7. Assessment and prevention of falls in older people, NICE clinical guideline 161, June 2013
8. Assessment and Prevention of Falls policy, Camden and Islington Foundation Trust
9. Assessor's Guidebook for Quality Assurance in District Hospitals, Vol-I and Vol-II
10. Best practices for Giving safe injections, WHO
11. Bio Medical Waste (Management & Handling) 1998
12. Compendium of Norms for Designing of Hospitals & Medical Institutions, Government of India, Ministry of Housing & Urban Affairs, Central Public Works Department
13. Comprehensive geriatric assessment toolkit for primary care practitioners, British Geriatrics Society,
14. Creating a Safe Space Strategies to Address the Psychological Safety of Healthcare Workers
15. Department of Health and Family Welfare Government of Gujarat
16. DG set guidelines, The Environment (Protection) Rules, 1986
17. Diagnostic Audit Guide 2002, Guide to Indicators, Operation Theatres, Audit Commission, National Health Services, UK
18. Disability prevention and medical rehabilitation, Guidelines for Primary, Secondary and Tertiary level care, National Leprosy Eradication Program, MoHFW, Government
19. District Health facility Guidelines for Development and Operations, WHO Regional Publication, Western Pacific Series 22, World Health Organization Regional Office for Western Pacific, 1998
20. District Quality Assurance Programme for Reproductive Health Services, An Operational Manual, 2006
21. Donaldson L, Ricciardi W, Sheridan S, Tartaglia R. Textbook of patient safety and clinical risk management. Springer Nature; 2021.
22. Electronic Health Record (EHR) Standards for India,2016, GOI
23. Emergency and Injury Care at Secondary and Tertiary Level Centres in India, NITI Aayog
24. Environmentally sound management of mercury waste in Health Care Facilities, Central Pollution Control Board
25. Essential Standards of Quality and Safety, Guidance about compliance, March 2010, Care Quality Commission, United Kingdom
26. Evaluating the quality of care for severe pregnancy complications, The WHO near miss approach for maternal health, World Health Organization
27. Evaluation and Quality Improvement Program (EQuIP) standards, 4th Edition, Australian Council on Healthcare Standards

28. Facility based New born Care operational Guide, Guideline for Planning and Implementation, Ministry of Health & Family Welfare, Govt. of India
29. Fundamental elements of Quality of Care, A simple framework, Judith Bruce, Studies in family planning 1990
30. Gender Analysis in Health –A review of selected tools, World Health Organization
31. Global action on patient safety, Seventy-second world health assembly.
32. Governing Public Hospitals, Reform strategies and the movement towards institutional autonomy, 2011, World Health Organization
33. Guideline for enhancing optima Infant and Young Child feeding practices, Ministry of Health & Family Welfare, Govt. of India
34. Guideline for implementing Sevottam, Dept. of Administration reform and Public Grievance, Ministry of Personal and Public Grievance and Pension, Govt of India
35. Guidelines for Implementation of KAYAKALP initiative, Ministry of Health and Family Welfare, Government of India
36. Guideline for Janani - Shishu Suraksha Karyakaram (JSSK), Maternal Health Division, Ministry of Health & Family Welfare, Govt. of India
37. Guidelines and Space Standards for Building Barrier Free Built Environment for disabled and elderly persons,1998 CPWD, Ministry of Urban Affairs and Employment
38. Guidelines Approved by the who guild lines review committee updated, WHO 2017
39. Guidelines for Diagnosis and treatment of malaria in India, 2011, National Vector Born disease control program, GoI, MoHFW
40. Guidelines for Eye ward & Operation theatre, National Program for control of Blindness, MoHFW, GoI
41. Guidelines for good Clinical Laboratory practices (GCLP) by Indian council of medical research
42. Guidelines for Good Clinical Laboratory Practices (GCLP), 2008, Indian Council of Medical Research
43. Guidelines for Hospital Emergency Preparedness Planning, National Disaster Management Division, Ministry of Home affairs, Government of India
44. Guidelines for personal protective equipment,2022
45. Guidelines for protecting the safety and health of health care workers, U.S. Department of health and human services, public health services centres for Disease Control.
46. Guidelines on good distribution practices for pharmaceutical products
47. Handbook for Vaccine and Cold Chain Handlers, 2010, MoHFW, Government of India
48. Hazard Communication Standard: Labels and Pictogram, Osha Brief.
49. Hazard Communication Standard: Safety Data Sheets, Osha Brief.
50. Health and Disaster Risk Management in India, National Institute of Public Finance and Policy, New Delhi
51. Health Care Case Laws in India, entre for Enquiry into Health and Allied Themes (CEHAT)
52. Healthcare Quality Standards, Process Guide, National Institute of Clinical Excellence, United Kingdom
53. Hutchinson Clinical Methods, 23rd Edition, Saunders Ltd.2012
54. ICD 10 -International Statistical Classification of Diseases and Related Health problems, 2010 Edition, World Health organization

55. ICU Planning and Designing in India – Guidelines 2010, Guidelines Committee ISCCM
56. ICU Planning and Designing in India – Guidelines 2010, Indian Society for Critical Care Medicine
57. Immunization Handbook, Medical Officers, MoHFW, GOI.
58. Implementation Guide on RCH-II, Adolescent and reproductive Sexual health Strategy, for State and District Program Manager, Ministry of Health & Family Welfare, Govt. of India
59. Improving Patient and Worker Safety, JCI
60. Improving Patient and Worker Safety, Joint Commission
61. India Pharmacopoeia Commission National Coordination Centre (NCC) - Materiovigilance Programme of India (MvPI)
62. Indian Public Health Standards (IPHS), Guidelines for District Hospitals 2022 Volume-I
63. Infection control guidelines by Indian council of medical research
64. Infection Management and Environment Plan, Guidelines for Healthcare workers for waste management and infection control in community health centres
65. Infection Prevention Practices in Emergency Obstetric Care, Engander Health
66. Infection Prevention, Guidelines for Healthcare facilities with limited resources, JHPIEGO
67. Injection Safety Guidelines, Centres for Disease Control and Prevention
68. Injection Safety, Guide for safe injections, WHO
69. Integrated care for older people, Guidelines on community-level interventions to manage declines in intrinsic capacity, WHO
70. Integrated-Health-Conceptual-Framework, WHO 2015
71. International Covenant on Social, Economic and Cultural Rights (ICESCR), 1976
72. Introducing the Patient Safety Friendly Hospital Framework, WHO,2020
73. IS 10905, Part-1, Recommendations for basic requirements of general hospital buildings: Part 1 Administrative and hospital services department buildings, 1984
74. IS 10905, Part-2, Recommendations for basic requirements of general hospital buildings: Part 2 Medical services department buildings, 1984
75. IS 10905, Part-3, Recommendations for Basic Requirements of General Hospital Buildings - Part-3: Engineering Services Department Buildings, 1984
76. IS 12433, Part-1, Basic requirements for hospital planning: Part 1 up to 30 bedded hospitals,1988
77. IS 12433, Part-2, Basic Requirements for Hospital Planning - Part 2: UP to 100 Bedded Hospital,2001
78. IS 13808: Part 1, Quality management for hospital services (Up to 30-bedded hospitals) Guidelines: Part 1 Outpatient department (OPD) and Emergency Services, 1993
79. IS 13808: Part 2, Quality Management Procedures for Diagnostic and Blood Transfusion Services - Guidelines Part 2: Up to 30-Bedded Hospitals, 1993
80. IS 13808: Part 3, Quality management for hospital services (up to 30 bedded hospitals) - Guidelines: Part 3 Wards, nursing services and operation theatre, 1993
81. IS 15195, Performance Guidelines for Quality Assurance in Hospital Services up to 30-Bedded Hospitals, 2002
82. IS 15461, Performance Guidelines for Quality Assurance in Hospital Services up to 100-Bedded Hospitals, 2004 22. IS 4347, Code of practice for Hospital lighting, 1967

83. ISMP Medication Safety Self-Assessment for High-Alert Medications
84. ISO 15189, Medical Laboratories - Particular requirements for quality and competence, Second edition.
85. ISO 19011: 2011, Guidelines for auditing management systems, International Organization for Standardization
86. ISO 9001, Quality Management System requirement, Fourth Edition
87. Isolation Rooms, International Health Facility Guidelines
88. IWA1, Quality Management Systems – Guidelines for Processes improvements in health services organizations, 2005, International Organization for Standardization
89. Janani Suraksha Yojana, Govt of India, Ministry of Health and Family Welfare, Maternal Health Division
90. Joint Commission International Accreditation Standard for Hospital, 4th Edition
91. Joint Commission International Accreditation Standards for Hospitals
92. Laboratory Safety Manual, Third Edition, 2004, World Health Organization
93. Maa, Mother's Absolute affection, programme for promotion of Breastfeeding Ministry of Health & Family Welfare
94. Manual for Medical officers, dealing with child victims of trafficking and commercial sexual exploitation,
95. Manual on Radiation Protection on Radiation protection in hospitals and general practice.
96. Materiovigilance, programme for India, MoHFW
97. Maternal & New-born Health Kit, Maternal Health Division, Ministry of Health & Family welfare, Government of India
98. Matrix of IEC material for earthquake Safety and Preparedness
99. Measurement and Monitoring of Safety Framework e-guide
100. Measuring efficiency of emergency processes using value stream maps at Sick New-born Care unit, Nikhil Prakash, Deepika Sharma, JN Srivastava, EMS 2013
101. Medical records Manual, A Guide for Developing Country, World Health Organization
102. Medical Termination of Pregnancy Act 1971
103. Medication Safety Curriculum Guide, WHO 2019
104. Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation,2012
105. Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes, NICE guideline.
106. Mind the implementation gaps the persistence of avoidable harm in the NHS,7 April 2022
107. Minimal Information Model for Patient Safety Incident Reporting and Learning Systems, WHO
108. Mistake proofing: the design of Health care – AHRQ, USA
109. MoHFW, Government of India
110. Multimorbidity, Quality standard,29 June 2017, NICE
111. National Accreditation Board for Hospital and Healthcare Provider, 3rd Edition
112. National Building Code of India 2016, Bureau of Indian Standards,2016

113. National Centre for Disease Control, Directorate General of Health Services Ministry of Health and Family Welfare, Government of India, January 2020
114. National Disaster Management Guidelines,2016, GOI
115. National Guideline for Improvement of Quality and Safety of Healthcare Institutions (For Line Ministry and Provincial Hospital, First Edition.
116. National Guidelines for Obstetric ICU/HDU
117. National Guidelines on Lactation Management Centre in Public Health Facilities
118. National Guidelines on Lactation Management Centres in Public Health Facilities,2017
119. National List of Essential List, 2011, Ministry of Health & Family Welfare, Government of India
120. National Quality Assurance Standards for Public Health Facilities 2020
121. National Patient Safety Goals Effective January 2019
122. National Safety and Quality Health Service Standards, Australian Commission on Safety and Quality in Health Care,2017
123. National Safety and Quality Primary and Community Healthcare Standards, June 2021, Australian Commission on Safety and Quality
124. Navjaat Sishu Surakasha Karyakram, Training Manual, MoHFW, Government of India
125. Never Events for Hospital Care in Canada, Safer Care for Patients September 2015
126. Nilakantam SR, Ravi MD, Bahuguna J, Dayananda M. Role of Emergency Response Codes in Handling Hospital Emergencies–An Experience of Protocol Designing, Development, and Implementation in a Large Multispecialty Tertiary Care Teaching Hospital, Mysuru, India. International journal of scientific study. 2020 Apr 17;8(1):56-61.
127. NPSA-national-framework-for-reporting-and-learning-from-serious-incidents, National Health Service (NHS)
128. Operational Guidelines for ART Centres, National AIDS control organization, MoHFW, Government of India
129. Operational Guidelines for Elderly Care at HWC, Feb2021, GOI
130. Operational Guidelines for Facility Based Management of Children with Severe Acute Malnutrition, 2011, MoHFW, Government of India
131. Operational Guidelines for Improving Quality in Public Health Facilities 2021
132. Operational Guidelines for Integrated Counselling and testing Centre, 2007, National AIDS Control organization
133. Operational Guidelines for Rogi Kalyan Samitis, Health & Family Welfare Department, Government of West Bengal
134. Operational Guidelines on National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases & Stroke (NPCDCS), MoHFW, Government of India
135. Patient Identification Policy, NHS
136. Patient Safety Curriculum Guide, WHO
137. Patient Safety Incident Reporting and Learning Systems, WHO
138. Patient Safety Indicators, AHRQ Quality Indicators
139. Person with Disability act 1995
140. Planning and implementing palliative care services: a guide for programme managers, WHO

141. Practical Guidelines for Infection Control in Health Care Facilities, World Health Organization
142. Pradhan Mantri Surakshit Matritva Abhiyan
143. Pre Conception & Pre Natal-Diagnostic Test Act 1996
144. Pressure Injury staging guide, Wound Care Education Institute.
145. Preventing and Managing Pressure Injuries,2012, NSQHS Standards.
146. Preventing Falls in Hospitals, A Toolkit for Improving quality of Care, AHRQ or the U.S. Department of Health and Human Services.
147. Preventing Falls in the Hospital, Available in Spanish and Somali
148. Principles of Best Practices in Clinical Audit, National Institute of Clinical Excellence, United Kingdom
149. Quality & Accreditation of Health Services – A Global Review, ISQUA & WHO
150. Quality Health Services, A Planning guide, WHO.
151. Quality Indicators for ICU, 2009, Indian Society of Critical Care Medicine
152. Quality Management in Hospitals, S. K. Joshi, Jaypee Publishers, New Delhi
153. Quality Management in Public Health Facilities – An Implementation Handbook, National Health Systems Resource Centre, New Delhi
154. Quality Management in Public Health Facilities - Traversing Gaps, National Health Systems Resource Centre
155. Radiation Protection and Safety of Radiation Sources: International Basic Safety Standards, IAEA
156. Radiation Protection Principle, AERB -Atomic Energy Regulatory Board
157. Radiation Safety
158. Rapid Assessment of Referral Care Systems A Guide for Program Managers
159. Rashtriya Bal Swasthya Karyakram (RBSK), Operational Guidelines, MoHFW, 2013, Government of India
160. Record of Discussions Standard Development Committee, National Patient Safety Standards
161. Reference Manual for Female Sterilization,2014, GOI
162. Reference Manual for Male Sterilization-2013, GOI
163. Referral-Policy-Guidelines,2012
164. Safe blood & Blood Products, Indicators and Quality of Care, World Health Organization
165. Safe-Injection-Checklist-CDC
166. Safety code for medical diagnostic x-ray equipment and installations, 2001, Atomic Energy Regulation Board
167. Simplified Guidelines for Earthquake Safety of Buildings from National Building Code of India 2016,
168. Site assessment and strengthening for maternal health and new born health programs, JHPIEGO
169. SOP for Support Services, Ist Edition: August; 2016 Quality Assurance Cell
170. Standard Operating Procedure for NACP Data Sharing at NACO and SACS
171. Standardization of Labour Room at Delivery Point by Maternal Health division Ministry of Health & Family Welfare, Government of India-2016

172. Standards For Blood Banks & Blood Transfusion Services, National AIDS Control Organisation 2007
173. Surgical care at District Hospital, World Health Organization
174. Technical and Operational Guidelines for TB Control, Central TB Division, MoHFW, Government of India
175. The Australian Commission for Safety and Quality in Health Care,2006.
176. The Right to Information act, 2005
177. To Err is Human: Building a safer health system, Institute of Medicine
178. Training for mid-level managers (MLM), Immunization safety, WHO
179. Training Manual for Medical Officers for Hospital Based disease Surveillance, Integrated Disease Surveillance Project, National Centre for Disease Control
180. Twelfth Five Year Plan, Social Sectors, 2012-2017, Planning Commission, Government of India
181. Use of Personal Devices in Healthcare: Guidelines from A Roundtable Discussion, Journal of mobile technology in medicine.
182. Value Stream Mapping for Healthcare Made Easy, Cindy Jimerson, CRC press, New York
183. VENOUS Thromboembolism (VTE) Risk Assessment Tool, NSW Government.
184. Venous Thromboembolism Prevention Clinical Care Standard, January 2020
185. Venous Thromboembolism Prevention, Clinical Care Standard, Dec2020
186. WHO Draft Guidelines for Adverse Event Reporting and Learning Systems,2005
187. WHO Labour Care Guide User's Manual,2020
188. WHO Policy Statement: Multi-dose Vial Policy (MDVP),2014
189. Women - Friendly health services experience in maternal care, World Health organization
190. World Health Organization (WHO). Towards eliminating avoidable harm in health care. Global patient safety action plan 2021. 2021;2030.
191. World Health Organization. Administrative errors.
192. World Health Organization. Early essential new-born care: clinical practice pocket guide.
193. World Health Organization. Exploring patient participation in reducing health-care-related safety risks

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